<u>Key concepts developed at the Portman Clinic</u>

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This is a short talk about my clinical experience at the Portman Clinic in London, which is run by the National Health Service and therefore offers free treatment to those who need it. I worked at the Portman Clinic as a Consultant Child and Adolescent Psychoanalytic Psychotherapist for 19 years, at first with just one more senior child-trained colleague, Don Campbell, who some years before had trained as I had as a child analyst at the Hampstead Clinic. As the years went by, the number of us working with children and young people increased to 4. Alongside us were several psychoanalysts and psychotherapists who worked with the adult patients, and during my time at the Clinic I also trained as an adult psychoanalyst at the British Psychoanalytic Society. The Portman Clinic is the only NHS institution where patients of all ages – children, adolescents and adults – who are delinquent, violent or suffering from sexual perversion are offered psychoanalytic psychotherapy to help them face and understand how and why they need to resort to using their bodies as an attempted 'solution' to unbearable feelings, fears and conflicts stemming from extremely traumatic past experiences. The clinicians aim to help the patients to begin to tolerate thinking about themselves rather than using action. In the case of children and adolescents, this way of thinking is also vital in working with the patient's carers and the professionals in the network, both in order to help them to understand better the internal forces propelling the youngster into unacceptable behaviours, and also to help them appreciate how they also may sometimes unwittingly jump into action with the patient and their colleagues out of their own anxiety and feelings of helplessness aroused by the case. For the sake of brevity, I will use the word 'he' to include patients of both genders.

Child psychotherapists working at the Portman Clinic are in the privileged position of being highly valued by the adult psychotherapists and psychoanalysts, and presentations from members of the 'Child Team' at the Clinic's weekly discussion meetings have always been greatly appreciated. For clinicians working with adults, such presentations offer further insight into the developmental roots of disturbance in their patients.

Following Mervin Glasser's understanding of the global character structure of a perversion, (Glasser, (1986, 1992, 1996), which does not become fully established until adulthood, we don't consider children and adolescents with perverse <u>behaviours</u> as having a perversion because their development is still ongoing. Instead, they would be thought of as potentially on the way to developing a perversion. Providing skilled and sensitive therapy can help the young person's development to shift away from that trajectory and get back onto a more normative developmental track. This is also the aim with delinquent and violent patients.

At first, children and adolescents referred to the Clinic were seen by adult psychoanalysts, and it wasn't until the 1970s that the first qualified child and adolescent psychotherapist was employed. Over the ensuing years, this increased to two, three and then four clinicians dedicated to trying to understand the complex needs of young people who have no means other than via the use of their bodies to attempt to deal with the debilitating effects of extremely traumatic experiences in their early years. I would now like to elaborate first on the Core Complex, and then on what we came to call Portman 'lore' and other thoughts about working with young people at the Portman Clinic.

Mervin Glasser, the Director at the Portman Clinic for many years, developed the concept of the CORE COMPLEX, which he elaborated on in the weekly Violence Workshop meetings that I was privileged to be part of during my time at the Clinic. Glasser emphasised the importance of the concept of psychic homeostasis, ie balance –the main task of the ego is to maintain psychic homeostasis as this induces a sense of safety and well-being, ie internal psychic balance. Anything that disturbs this balance will evoke aggression as well as anxiety, and aggression may be used to try to restore homeostasis.

The CORE COMPLEX is part of normative development in early toddlerhood, at the separation-individuation (anal) stage, but it is a complex that can become *fixated* and therefore remain unresolved and cause an impasse in the case of severe disturbance, such as perversion and violence. It also features heavily in more severe disturbances such as narcissistic disorders, delinquency, borderline, psychosis, addiction, psychosomatics, eating disorders, self-harm; but even in neurotics there are still residues of the core complex that can create big emotional problems and lead to quite severe acting out, so you can find it in any patient. It is ultimately about difficulties with intimacy and separation, which we can all have to greater or lesser degrees – how to be with another without feeling taken and controlled over by the object and how to be separate without feeling utterly alone and empty. But for violent and perverse patients these anxieties are extremely intense and crippling. Glasser describes how such patients struggle to deal with the contrasting anxieties of being intruded upon, engulfed, overwhelmed and taken over by another on the one hand; and of being abandoned by the object, completely lost and alone on the other – i.e. too much or not enough closeness (intimacy). Underlying both anxieties is a primitive terror of annihilation – annihilation because of being taken over by another and therefore losing oneself, or annihilation because of being too separate and therefore feeling lost, abandoned and disintegrated. When feeling engulfed by another, the individual tries to protect himself by moving away from that person; but he* then experiences the opposite anxiety of being abandoned and alone, and so he moves towards the other again. This is an impossible situation and he swings back and forth between these two extremes, desperately trying to find a position of safety.

The Core Complex originates in the anal stage of pre-oedipal development outlined in the Freudian developmental model (Freud, A. 1972, 1976, 1992; Freud, S. 1905) where issues of separation-individuation, control and aggression are prominent and the dyadic relationship with the mother is most central. Typically, in the history of such patients, there is a mother whose narcissistic needs take precedence over her child's needs, so that the child cannot experience a safe emotional closeness with her and his capacity to develop a valued sense of himself as separate and different from her is severely compromised. Never feeling seen as himself, but only as a narcissistic extension of the mother, leads to extreme narcissistic vulnerability in the child and intense sensitivity to feelings of humiliation and helplessness. Typically, the lack of an emotionally available father further prevents the child from being able to experience a more healthy attachment relationship and find appropriate separateness from the damaging tie to a narcissistic mother.

Glasser emphasised the central role of aggression and its sexualisation in this Core Complex dilemma: fear of the mother who is experienced as annihilatory (abandoning, engulfing, humiliating) arouses rage and an urge to destroy her, but there's also a desperate longing to reach her and a need to preserve her so as to be protected from abandonment and terrifying aloneness. Faced with the insoluble paradox of constantly trying to find a safe distance to preserve both the object and himself, he resorts unconsciously to sexualising his aggression,

i.e. sado-masochism. Sado-masochism (whether as a full sado-masochistic sexual perversion or a habitual way of relating without actual bodily expression) then becomes the attempted ‘solution’ used to defend against Core Complex anxieties. This enables the feared but much-needed object to be held onto at arm’s length psychically – not too close or too distant – and safely in his control. Glasser contrasts sado-masochistic aggression with self-preservative aggression. Sado-masochistic aggression aims to maintain the tie (at a safe psychic distance) to the other, whereas self-preservative aggression aims to eliminate the other. If something breaks through the sado-masochistic defence, Core Complex anxieties and the ultimate terror of annihilation resurface in full force. The other is now perceived as threatening the survival of the Self, and so has to be destroyed. Self-preservative aggression then erupts in physical violence out of sheer panic for psychic survival. We would have a similar reaction if faced with a tiger in the jungle with no means of escape – we would need to try to kill it, not tease or control it.

In considering a sado-masochistic relationship, one can fall into the trap of seeing one person as the sadistic perpetrator who attacks and controls the other as the masochistic victim. However, one important element of what we call ‘Portman lore’ is that both parties can be sadistic as well as masochistic and both exert some control over the other. This way of thinking does not condone physical violence, of course, or lay blame on victims of abuse; but it does help us to understand how violence becomes an integral part of a relationship which cannot exist without it. It also helps prevent the split of taking sides in relation to ‘perpetrator’ and ‘victim’, which often occurs in the professional network concerned with such cases, as both parties in such a scenario are understood as suffering from Core Complex anxieties, each with a mostly unconscious part to play in what happens.

Sado-masochism isn’t only a habitual mode of relating between the individual and other people, but also features heavily in the interplay between parts of the patient’s own mind. Due to early environmental impingements, these patients have a persecuting superego and an ego that isn’t sufficiently developed to be able to process feelings and anxieties and protect the Self appropriately. With insufficient ego strength to intervene, the sadistic superego attacks and overwhelms the Self, humiliating and torturing it with its punitive ‘voice’; but it also abandons the Self by allowing it no real self-esteem. This dynamic often reflects the child’s experience of overpowering or neglectful parents, and the lack of any stable self-esteem is a characteristic of all Portman patients. Mervin Glasser divided the superego into prescriptive (thou shalt) and proscriptive (thou shalt not), and stresses that there is always a sado-masochistic relationship intrapsychically in the core complex between the superego (as sadistic) and the self (as masochistic). He briefly mentions defiance and deception of the superego, which bring about excited, forbidden (sexualised) thrills. But the passive resistance to the superego’s demands also lead to shame and guilt (that are often heavily defended against and not open to conscious awareness), and thus to low self-esteem and feelings of inadequacy, and sometimes actual under-functioning.

The intricacies of the Core Complex soon became central to the way Portman staff understood that any potentially intimate relationship, including that with the therapist, is a terrifying threat to their patients. This has huge implications for technique and requires very sensitive handling. If the stability of the patient’s defensive sado-masochistic way of relating is threatened because he feels engulfed or abandoned by the therapist, or if his very fragile narcissism is undermined because he feels humiliated, the patient is likely to erupt in violent aggression as a kind of knee-jerk last-ditch attempt at psychic self-preservation. To avoid increasing the patient’s anxieties and breaching their much-needed defences, we have to be

extremely careful about <u>what</u> we say and especially <u>how</u> we say things, as the patient will so easily feel intruded upon, controlled, neglected, dismissed, humiliated and criticised.

It is important to recognise the very early developmental level of the core complex and that it is essentially about a *dyadic <u>2-person</u> <u>relationship</u> – ie pre-oedipal, <u>not</u> oedipal*. Inevitably, the therapist will need to be drawn to some extent into a sado-masochistic dyadic relationship with the patient, because this is the only way that the patient with severe Core Complex anxieties knows how to relate in a relatively safe way with others. One has to allow oneself to have one foot in this sado-masochistic transference/countertransference dynamic, whilst at the same time having one foot outside of it so to speak. There is a technical implication here – how, as the therapist or analyst, to find for oneself some triangulation to offset the hugely intense 2-person transference/ countertransference – eg having one's own thinking ego and supervisor in mind, and trying to help the child in therapy to displace his aggression and terrors into play activity rather than concretely with the therapist .

Out of awareness of the patient's underlying Core Complex fears and the importance of respecting his need to keep at a safe-enough distance from the therapist, Portman staff always place the patient's chair rather than the therapist's nearest the door, to give the patient the security that he could escape if his anxiety became overwhelming, rather than needing to resort to physical attack on the therapist. Also, alarm buzzers were never introduced into consulting rooms at the Clinic, despite the fact that many risky violent patients, such as murderers and rapists, were in therapy.

Unfortunately, this kind of psychoanalytic thinking has been replaced by action in many other settings today where risk is managed by the installation of alarm buzzers, glass screens and coded doors. This can lead patients to feel that their therapists perceive them as horribly dangerous and unbearable to be with, which is likely to arouse feelings of humiliation and fears of being taken over or abandoned, and so actually <u>intensify</u> the risk of their destructiveness.

My colleague Don Campbell candidly illustrates how he initially came to understand this with one of his first violent Portman adult patients, Mr D, who had been referred for habitually getting involved in pub fights after heavy drinking, often using broken bottles as weapons (Campbell, 2011). After discussing Mr D's early sessions with colleagues who asked if it was safe to have a glass ashtray within Mr D's reach, Don Campbell decided to remove the ashtray, but soon realised that this resort to action was a mistake. He had failed to recognise that the ashtray was an important potential weapon that enabled Mr D to feel safe in the presence of the analyst who was to him a very dangerous transference figure. Removing the ashtray disarmed Mr D and "increased his feelings of defencelessness". This heightened his Core Complex terrors and actually put his analyst more at risk of Mr D's violence. Instead of feeling in the presence of someone strong and steady enough to help him, Mr D felt that his analyst was afraid of him and therefore wouldn't be able to see him as a whole person. Campbell reflected, "By acting as I did … I confirmed that I also dealt with my fears by resorting to action", and that "I, like all the authorities he faced before, could not and would not think about his violence with him, but that I would have to do something about it. … if I had thought more about the transference, and, especially, been more sensitive to my countertransference, I could have been more helpful" to Mr D" (p. 4).

Child psychotherapists and child analysts are trained to provide a box of toys appropriate for each patient, but before starting at the Portman Clinic I had discovered the benefit of also

having a cupboard in the room for general use, containing play items for both boys and girls of all age groups. I had been sharing a room with my good friend and colleague Frances Marton, where there was such a toy cupboard, which I'd originally been very sniffy about; but it had proved enormously helpful when I started seeing an 8-year-old boy whose mother worried about his aggressive outbursts at home and his compulsive dressing up in girls' clothes. He was very inhibited with me at first and resisted any fantasy play, but after a while he asked me to close my eyes and went to the big cupboard. Moments later, he told me to open my eyes and I saw a lace-gloved hand bedecked with plastic rings waving shyly at me as he hid behind the desk. From there on he used fantasy play with the "girly" dressing-up things in the big cupboard to express his wish to be a girl and his conflicts about being a boy, which turned out to be about his fear of his aggression, his terror of separating from his mum and his deep anxiety about growing up – so, not really anything much about his gender. Towards the end of therapy, he pretended to be a young deer rubbing its head against a tree and told me with enormous pride that the antlers weren't fully grown yet, but each year they'd get bigger until he had ones like his dad! At the Portman Clinic, I introduced a similar cupboard for general use and it continued to be very useful there, for example with youngsters confused about their sexual identity as well as those who needed to have the opportunity to regress and express their more infantile needs through play, for example with dolls or a baby's bottle.

Play offers an arena for expressing feelings and experiences that cannot be put into words and where anxieties, fears and urges that would otherwise be enacted with the body can be displaced safely. With all children, but especially those with Core Complex anxieties, it is important to be engaged with and share the child's play, but not to intrude by interpreting potential underlying meanings too early. Otherwise, the child's Core Complex anxieties will be intensified because of feeling threatened by an abandoning or engulfing object. Allowing the play to unfold at its own pace gives the child the experience of being with a different kind of object with whom a different way of relating may become possible. The child may now be able to experience their previously unmet needs for concern for their well-being and appropriate care and attentiveness being met by the therapist as a new developmental object (Hurry, 1998).

What applies to playing with younger children also applies to the way of listening to and talking with older children and adolescents. Tom, aged 17, instigated violent fights with boys and had attempted to rape a girl at knifepoint. He found it very hard to be in the room with me and would stare silently at me with a penetrating gaze, which felt both intrusive and dismissive; but underneath his intimidating stare I sensed his fear of me. He wanted me to ask questions but would then feel intruded upon, and if I stayed silent, he seemed to experience me as not being interested or bothered about him. This made his Core Complex dilemma very clear – he felt both engulfed and abandoned by me, and I felt similarly engulfed and also abandoned by him. Eventually I said that I had a dilemma to think about with him – that I thought my words as well as my silence made him feel awful, and he seemed to feel very unsafe and uncomfortable in the room with me. As I tried to explore his discomfort with me, it emerged that he found all verbal communication difficult. He felt he had nothing interesting to say and that nobody noticed him. I said that must make him feel terribly lonely and it might be very hard for him to feel he was a "somebody" worthy of notice. Perhaps it was as if he felt invisible? He agreed and said that the only thing that would always make people pay attention to him was when he talked about his racist political opinions. It didn't matter whether the person agreed or disagreed, all that mattered was to get an intense reaction. I linked this urgent need to get through to people with his helpless isolation of never

having felt noticed in a good way by his parents, especially his mother. I wondered if the only way he felt he could make an impact on someone was by force - by his forceful political views or physical violence. This seemed to reach him, and he responded thoughtfully by saying for the first time that he felt helpless and vulnerable sometimes. Tom had built a pseudo-identity as a ‘tough guy’ to protect himself from feeling vulnerable to humiliation, abandonment and intrusiveness. With violent and negating parents and no age-appropriate allowance for omnipotence in early childhood, the smallest humiliation was experienced by Tom as the most terrible trauma. Underneath the presentation of himself as an all-powerful young man, there was a frightened and humiliated child whose only way of protecting himself from an overwhelming sensitivity to feeling a rejected nobody was to act violently. Coldly calculated violence shaped Tom's identity so that he could try to avoid dealing with terrifying Core Complex anxieties and therefore would not experience the ultimate threats to his psychic survival. (Parsons 2009).

When a patient was referred to the Portman Clinic, be it for a risk assessment, consultation for the professional network, a court report or as a potential psychotherapy patient, we asked for all possible material on the patient and often ended up with a massive number of reports, some of which had missed out vital details of the patient’s history. One of the most important first tasks was to compile a detailed and comprehensive background history of the patient to ensure that we got as full a picture as possible of the patient’s development and to ensure that important facts or events did not get lost. This is in itself could often help professionals when we also offered psychoanalytic understanding in ordinary language about how the patient’s offending bodily behaviour was their attempted unconscious ‘solution’ to the terrors, anxieties and conflicts in their internal world.

When patients came for an assessment, they were usually extremely resistant and anxious, even if they tried to cover up their fear by apparent bravado - often they seemed convinced that they would be perceived only as “bad” because of their problematic behaviours. One adolescent boy said later in therapy that it was as if he had “child abuser” tattooed on his forehead. It is vital to help the youngster to see that we can appreciate their positive characteristics and that we don’t only focus on their problems. Because of their traumatic experiences and the lack of good-enough care in their early years, their emotional development had been stunted and skewed, and so, as Anna Freud noted in writing about very aggressive children, the “appropriate therapy (has) to be directed to the neglected, defective side, ie the emotional libidinal development.“ (Anna Freud, 1949). How does one offer this type of therapy? It’s mostly about the analyst’s attitude to the patient arising from this way of understanding aggression – recognising the lost, frightened, anxious, helpless, humiliated, unwanted, unloved feelings in the patient, and seeing many expressions of aggression as defensive and as arising from anxiety and vulnerability, rather than always seeing the patient’s aggression, contempt or negativity as attacks on the therapist or the therapy (as with Klein). When considering a patient’s aggression, the therapist should have in mind ‘anxiety and defence’, rather than ‘destructive attack.’ The therapist thinks of the roots of the behaviour, seeing inappropriate aggression more like a symptom or defence masking underlying fear, anxiety and pain. (Parsons 2009). To foster the patient’s libidinal development and enhance his self-esteem and capacity to be curious about himself, it is of vital importance to help him to feel seen by the therapist as a whole person with strengths that can be valued (as well as weaknesses that need help). This offers hope to the patient and is essential for a move towards a healthier future.

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