Mental Health for the Young and their Families

**MHYF Vic Newsletter No. 71 June 2020**

**This edition**



## Reflections on Lived Experience in the age of Covid19

This is the theme of a scholarly paper being prepared by Ros Webb as President of the Psychoanalytic Psychotherapy Association of Australasia (PPAA). She has kindly allowed me to preview some of her ideas, as a follow-up to our notes in the last newsletter about the challenges of teleconferencing mental health consultations or therapy.

Therapists were faced with a sudden choice. Cancel all patient sessions for an indeterminate period of time, or work from home applying teletherapy for some form of continuity of care.

As we were advised to isolate, most psychoanalytic practitioners took the decision to move to teletherapy – very quickly. Meetings, individual and peer supervision, forums, and training programs have also moved to online.

Jaron, S. 2020 *… the modification in the setting seeks to prevent the individual from contracting disease or infection. Clinical work has become "guard-like" and, ironically, if we were to understand the word literally, "watchful."*

We did not have the usual time for therapist and patient to carefully prepare for the move to teletherapy, which would occur in more regular circumstances.

Most of the paper is about the psychological issues, but there is also a little on the technical. Prior to each session, it is recommended that we conduct a test of the wifi connection, the audio and visual quality. Poor sound, audio lags or fuzzy, pixelated picture, contribute to the strain experienced in the practice of teletherapy, through trying to deal with these shortcomings and what meanings may be attributed to them.

"We are advised to describe and discuss the nature of teletherapy with patients, including the nature of the technology, devices and platform, logging on and what will be required at both sites prior to commencement of the distance therapy.

We are also advised to check if the patient wishes to proceed with video therapy, or prefers the phone, or may feel they cannot engage in this form of treatment and may opt for a break. As teletherapy proceeds, the patient may choose to change or switch the devices.

As we both engage with online therapy, we conduct an ongoing review of the effectiveness of the service. Open mutual feedback is essential to figuring out what does

and does not work for you and your patient, and what has and hasn't felt supportive for them."

Some colleagues have been practicing teaching, supervision and therapy via teletherapy, so they have more experience and understanding of these platforms and the process of psychotherapy. These colleagues offer a lot of information and support to the many who have not had any or very little experience with distance therapy.
Nevertheless, even these colleagues are affected by the need to suddenly change and move one's whole practice from in offices/rooms to remote therapy.

"We are in the middle of a global pandemic which is frightening and terrifying for everybody including Therapists and Patients. We are all inextricably linked in this disaster and trauma about which we have no idea when or how it is going to end.

→We are all suffering from a sudden and imposed change, with uncertainty, doubt, and massive anxiety
Nancy McWilliams, (2020) expresses that *The hardest thing for me to deal with psychologically has been the fact that dread of the coronavirus is not neurotic anxiety, and grief about its damage is not neurotic depression. I can help patients when realistic fear and loss are complicated by their personal triggers and vulnerabilities, but I cannot reduce emotional pain that is grounded in reality.*

→ *I try also to give my patients the best information I have about keeping themselves safe. For realistic fears, realistic self-protective measures are the best "treatment."*

**Self-reflective quote from a therapist** - *How will this impact on my work? Can I truly facilitate my client to explore their fears and anxiety about what might happen when I have unprocessed fears myself? …*

Jill Scharff reflected that both therapist and patient lost a familiar space and suddenly had to get used to something new, at a time when the whole society is facing the prospect of massive loss.

During this worrisome and stressful time of Covid19, whilst trying to set up different work practices, do whatever we can to support and to provide ongoing help to our patients, we are also worrying about and taking care of our own family, friends, our communities and hopefully ourselves.
… confronting *the guilt of not being able to do more for our patients* (**Varela, Y. 2020**).

A patient's acceptance of teletherapy has a lot to do with a therapist's developing confidence in making the switch and adapting to working online under the Covid19 circumstances.
Many therapists have been concerned about the loss of the 'personal' in the room, i.e. the full 3D body experience. Patients also express feelings and anxieties around this loss of human contact.

*We cannot fail to recognise the importance which the lack of the body and the relative sensorial communication methods between patient and analyst, allow us to work on unconscious dimensions, and are strongly connected to important aspects of the primary relationship … and is a crucial aspect of the therapeutic relationship.* (**Dei, F. 2000**)

It is true, that for some patients, it is more difficult for them to address complex issues, or establish a working therapeutic relationship, when they are sitting in front of a screen – especially with the sudden change.

In contrast, for other patients it is less threatening than being in the room with their

therapist, where they may become overwhelmed by feelings Along these lines, some therapists have noted that, paradoxically, patients can experience more disinhibition in expression of thoughts, feelings and fantasies, in the distance setting.


With an ironic twist, Stadter, (2103) in referring to his consulting room, noted that *"Some patients comment that* the therapy room *is the only place in their lives where they allow themselves to be free of technology, speaking to its nearly constant presence in their lives"*
→ No longer is it so

"One of the greatest barriers for socially distanced therapy is maintaining the privacy of the patient and the therapeutic relationship. A common feedback from therapists is the struggle of no longer being able to maintain a boundary between work and home, which we have usually tried to keep separate.

We and our patients move out of the online therapy space, straight into the household experience with little time for reflection.
It is even more stressful if there are children in the therapist's house, as is the case with the requirement for home schooling. Therapists are torn between being available to their children who may need them, as well as to their patients. This can create a real dilemma for the therapist. To tend to family needs vs guilt at not applying the usual focus to patients in therapy sessions."

Colleagues have been reporting a range of common experiences with the focus on these platforms and devices.

Many of us have described an extraordinary sense of intensity that is required in teletherapy. The platforms require added attentiveness to focus on the screen and work with apparently fewer cues. We are watching/being watched in a different way than in-room therapy.

The most common feedback from therapists about teletherapy is that of utter exhaustion, sore eyes and muddled head. Therapists have been surprised by the fatigue felt after a day of remote sessions.

As therapists we need to look at ourselves and what is going to impact on Us

**→Take care of ourselves**

- To look after our self, in relation to caseload, spacing, transitions
- Our room set-up - e.g. preferably have a chair where we can raise and lower the seat so that knees and hips can be in changed positions; a swivel chair so can move, stretch your muscles.
- Rest your eyes
- Alter the brightness of your screen
- Don't feel you have to sit like a statue throughout the sessions - avoid narrowing your focus on the screen and maintain a free-floating attention.
- Between sessions, preferably go outside and get some fresh air, breathe, stretch, take in near and far scenery, both for pleasure and different position for your eyes.
- Be compassionate with ourselves and be reassured that we can create 'good-enough' conditions for patients and the therapy process (**Erlich,,L. April 2020**)

Once we adapt more to this form of therapy, the 'second-guessing' may decrease, and it is likely that we can relax more into the process and apply the usual free-floating attention in a different modality. We are learning as we go in an evolving, mutual organic process.

Teletherapy feels different from in-room therapy, however most of us will have discovered that the analytic process can still be applied. Meaning is gained in each session through the most subtle nuances of the transference, countertransference, as manifest in the here and now of video or phone teletherapy.

Krzakowski **(**2020) points out that, *the solution through remote sessions can add many new ingredients to the century-old framework.*
In fact, many are surprised by the richness in the work offered through teletherapy.

Despite growing confidence that we are coping with the crisis and are seeing some lessening of restrictions, there is concern about the possibility of a 'second wave'.

The information from medical experts, scientists and modellers, converge to indicate that the virus will be with us for some, yet indeterminate, time.

The idea of being able to see friends and family once again and spend more time outside is welcome news for our physical, mental and emotional health.

The fact that Australia has had relatively less incidence of Covid19-related illness and death is a great achievement. However, this fact also heightens the reality that a greater proportion of the Australian population is still susceptible to becoming infected and will rely on ongoing hyper-alertness and protective measures from the whole community. At least until either a vaccine is developed and/or until there is some more effective treatment.
In particular, this poses the dilemma for therapists as to how and when to transition back from teletherapy to in-room therapy.
The fears, changes in our personal and professional interactions, 'ways of being' both internally and externally, will likely continue.

**Summary**
All the process described in the sections above, highlight how the unconscious minds of psychotherapist and patient continue to interact even in the absence of actual presence.

We are still offering continuity of some form of therapeutic relationship. We are offering a space for expression and processing of external and internal anxieties stirred by the atmosphere of Covid19.

As Varela (2020) commented *…accepting and not denying reality, yet without being suffocated by it. We will have to continue to be linked to life.'*

**Not all is gloom and doom.**

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# EDITORIAL COMMENT

For an elderly citizen, like myself, one of the most striking changes I see in the world around me is the changed attitude towards mental health issues. It seems to me to have become even more evident during the Coronavirus shutdown.

In the past, stigma was so great that people tried to keep mental health difficulties secret. Now, we see daily accounts of footballers and others "taking time out" to get on top of their problems. What a change for the better!

It is also shown in our writing. Ros Webb's feature article not only talks about treating others but also about looking after our own mental health in this time of crisis.

Riding the wave of our improved recognition of the importance of mental health interventions, I offer my own opinion about how we could make our Child Protection system better.

# OPINION

## *Our Child Protection system is broken.*

The Child Protection System exists to stop abuse and neglect damaging our children. It is meant to put them on a healthy pathway to future productivity, wellbeing and citizenship. It fails badly.

Society is no more damaging today than in the past, but legislative changes have resulted in child protection notifications swamping the available resources. The system cannot respond promptly, with many children remaining on unallocated waiting lists for long periods. The eventual response is frequently removal of children from their families to out-of-home care. There are more children in OOHC than ever before and the number is increasing.

Although OOHC is meant to provide a restorative healthy environment, substitute caregivers are often underfunded and inadequately supported to achieve the restoration. Many placements break down, requiring removal to other caregivers. Increasing demand for foster parents exceeds supply, prompting CPS to rely more and more upon relatives to provide the care. Such kinship care for the children is more effective than foster care with strangers, but stressful to caregivers. The necessary special support to deal with intra-familial tensions is not often available.

Alternatively, a trial return to the family of origin may be undertaken, usually without any therapeutic work to ensure that the dysfunctional past will not be re-enacted. Whilst this may succeed in some cases, in others it will lead to a further round of OOHC with yet more strangers.

As well as failing to stem the tide of increasing numbers, the OOHC system fails to provide the healthy alternative required. I am not referring here to the small number of cases of foster parents being abusers, but to the global picture provided by two recent research studies.

The first, by Karen McLean and associates from the Murdoch Children's Research Institute, reported that of OOHC children seen at the Royal Children's Hospital only a quarter had been referred for health check-up after three months. The national standard is that all children should be checked within one month. Of those who were checked, more than half had mental health problems, three quarters had some general health issues and about a

quarter did not have their immunisations up to date.

The second, by Melissa Green and associates from Neuroscience Research Australia, reported that from a long-term follow-up of about 75,000 children, 18.5% had been subjects of reports to child protection services in early childhood. Children who had had previous CPS contact were more than two and a half times more likely to have mental disorders in later childhood. If they had been in OOHC, the rate was more than five times greater.

Thus, short term "protection" fails to address the mental health and general health needs of children in care. Equally, the long-term consequences continue to blight their developmental progress. Many will have a lifetime of sub-optimal functioning. It is clear that the broken system needs to be fixed.

The system is broken because CPS has the wrong focus. Instead of a focus on achieving a healthy developmental outcome for the child, it is focused on the "right" of the child to be free of abuse and neglect. It prioritises this right over other rights, such as the right of the child to have a family and to be with brothers and sisters, the right to stability of relationships and living and schooling arrangements, and the right to have some decision-making power over what happens to them. The paternalistic method denies children these rights, notwithstanding its false rhetoric that "the rights of the child shall be paramount". The plain fact that OOHC does not achieve the desired goal has been persistently ignored and met by more of the same.

The CPS staff have become highly skilled at the adversarial approach to contested protection hearings but totally dissociated from helping services. The "good outcome" is success in Court rather than a healthy child. If dysfunction is noted, referral out to other agencies is the perceived solution, which rarely works but meets the guidelines. Unhappy staff leave the system but those who remain advise the Minister to keep doing more of the same rather than finding a better way.

A better way is to focus on resolving the dysfunction that led to the protective notification. Instead of the Protective Worker gathering information primarily to mount a court case, the information should be about family structure and functioning, past and current history of the problems, and a shared understanding of the issues to be resolved. Negotiation about <u>how</u> those issues are to be resolved, results in a mutually agreed 'Case Plan'. Successful carrying out of the agreed changes will avoid out-of-home care. OOHC would be only for children in life-threatening danger or families who were incapable of resolving dysfunction within the timeframe for healthy development. This latter group would be revealed by the assessment rather than a protracted trial and error process.

This approach requires special training, but it is what therapists do. It is more expensive to implement but it will ultimately be more cost-effective. As it would take time for implementation, it could be phased in progressively, one Region at a time, accompanied by evaluation of its effectiveness. Continuing the present broken system is unacceptable.

Allan Mawdsley

Dr Allan Mawdsley was Victorian Health Department Coordinator of Child Psychiatric Services 1976-1994.

# HISTORY CORNER, 1913

There has been much rancour over the changes to technique determined by the move to Telehealth practice. I have spent a lot

of time reminding supervisees of Freud's adoption of the couch:

Freud (1913) *On Beginning the Treatment:*

"Before I wind up these remarks on beginning analytic treatment, I must say a word about a certain ceremonial which concerns the position in which the treatment is carried out. I hold to the plan of getting the patient to lie on a sofa while I sit behind him out of his sight. This arrangement has a historical basis; it is the remnant of the hypnotic method out of which psycho-analysis was evolved. But it deserves to be maintained for many reasons. The first is a personal motive, but one which others may share with me. I cannot put up with being stared at by other people for eight hours a day (or more)". (pp. 133–134)

For those interested in recent thoughts about the couch and its place in psychoanalytic practice, you might like to access the thoughts of Friedberg and Linn (2012) on *The couch as icon,* the photographs of analyst's offices provided by New York photographer/analyst, Mark Gerald (2019, *In the shadow of Freud's couch: portraits of psychoanalysts in their offices*), and the paper on the couch and its use by Jennifer Kunst (2014): *What's the couch got to do with it*?

The most important part of this is that the couch has not been researched as a valid tool of practice, Friedberg and Linn (2012), called it an icon because that is what it is: a key identifier of longstanding practice. One uses a couch because one wants to appear to be a psychoanalyst. They repeat several times that it was mostly something left over from Freud's hypnosis practice and because he found it convenient to not have to be under scrutiny eight hours a day. The importance of eye contact to therapeutic practice is thoughtfully discussed, as is the power of the prone position to enable free association. But the real value of the couch is yet to be established in spite of over 400 scholarly articles that Friedberg and Linn accessed for their paper.

Sophia Psarra (2019) produced a fascinating collection of papers on architecture that featured her describing the design of Freud's apartment and treatment room in Vienna and described why the couch was used in architectural terms and in psychological ones. Psarra cited Marina Warner (1988) in the preface to *20 Maresfield gardens: a guide to the Freud Museum,* and noted that Freud had the feet of the patient turned toward the fireplace (for winter warmth) and covered with an oriental rug: "a flying carpet for unconscious voyaging" as Freud was said to have described it.

In all this research, I have not found the reference to the reason I was told by some educator that Freud had not known which end to sit. It may be apocryphal, but one day when he sat at the feet end, his female patient had chosen not to wear underwear. From then on he sat at the head, out of sight, and with reduced likelihood of cigar smoke intruding on the thoughts of the patient.

Telehealth is not a couch and most therapists I know prefer the forty-five/forty-five position of two chairs advocated by Sullivan, such that the patient can make eye contact when they need, but both therapist and patient can refresh their mind by looking into space and away from the intensity of gaze.

Most practitioners will have noticed the intensity of Telehealth. This is because we can be much closer than usual, and we might search for the missing information. But Freud and many subsequent analysts did not need to see the patient because the meaning was in the words and in their tone and sequencing. The gaps are important, as is the breathing.

The history of the couch, much of it is word of mouth stuff, can provide a better understanding of what we can do using

Telehealth: listen to the words. Don't focus on what's not present; you may not have been attending to this much anyway!

**Jo Grimwade**

## ANNUAL GENERAL MEETING

The AGM is scheduled for Thursday 27th August, 2020. It will be held then unless social distancing restrictions are resumed. The after-dinner speaker is to be Sister Brigid Arthur of the Asylum- Seekers Resource Centre, who will bring us up to date on what has been happening to the children and their families as the political games play out.

Final decisions about the event will be featured in our next newsletter.

# Winston Rickards Memorial Oration 2020

The 2020 Winston Rickards Memorial Oration has been postponed until 2021. News of the new arrangements will be given in the MHYFVic newsletter.

## MEMBERSHIP SUBSCRIPTIONS

Annual membership of MHYFVic runs for the Financial Year. Only paid-up members are entitled to vote at our AGM, normally held in August each year. Friends and associates who are not paid-up will still receive our electronic newsletters and notices because it is our mission to promote improvements in mental health for the young and their families.

However, it is important to reflect upon the difference between paid-up and non paid-up members.

Membership subscriptions of $50 per annum enable the organisation to maintain its website, mailbox, telephone service and to undertake its administrative tasks. If you value the work that MHYFVic does, we need your financial as well as your ethical support.

Our mail address is PO Box 206, Parkville, Vic 3052. If you prefer to pay by Direct Funds Transfer, the BSB is 033 090 A/C Number 315188 with your name in the Reference tab. It would be appreciated if you could also send a confirmatory email to admin@mhyfvic.org

## OUR UPDATED WEBSITE

After much thought our website has been significantly revised to give casual visitors immediate information about what we do and what we stand for, whilst at the same time allowing members to go straight to specific sections such as Projects or Newsletters or Events, without having to navigate past reams of information.

Now that the main revision has been implemented we are working on tasks of development of Projects to give us the evidence base for our advocacy. There are quite a few items under development at the present time which are not yet reflected in the website but over the next few months we expect to see a burgeoning of activity.

Visit us on **mhyfvic.org**

## 2019 MHYF Vic Committee

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