‘If i knock on your door, will you let me in?’

Psychotherapy
and
Working Class Women

Trevithick, P. (1998) Psychotherapy and working class women in B. Seu and C. Heenan (eds) *Feminism and Psychotherapy: Reflections on Contemporary Theories and Practices*. London: Sage.

I often think of psychotherapy as a meal - an opportunity to be nourished. What this meal is made of will depend, to a large extent, on what is wanted, affordable and available - financially and emotionally - and whether we have the time, space and stomach to consume and digest all that is there. The final choice of eating house may be influenced by many factors - what is already known about the choice and range of food available, whether it has been recommended and by whom, its location and how easy it is to get there, how the food will be served, whether the menu is written in a language we can understand and will be adapted to meet individual taste, whether there is room for us and, most importantly, what the bill will be and whether we can afford it. Having money buys choice and the chance to be served quickly. It also buys the expectation that the money spent will purchase food of a particular quality.

Those who cannot ‘pay their way’ must seek out other alternatives. For this group, what food there is may involve long queues, be limited to one menu, and served in a way that makes it virtually unpalatable. As a result, whilst having the appearance of being a nourishing and satisfying meal, it may provide neither: too often, it is a handout and that fact is not disguised. The picture that comes to mind is of one group heading for an expensive restaurant of their choice while another much more hungry group shuffle to the single menu soup kitchens of the NHS, craving for something, anything to ‘fill the hole’ as quickly as possible. If there is no food available, or it is placed tantalisingly beyond their reach or too rich for an empty stomach to digest then they must, for lack of choice, do without.

Doing without is not new to working class people - it is almost a class characteristic. And so, in the absence of any real alternative, other ways of addressing these needs are sought in the hope that this will take away the pain - the emptiness, the fury and the unbearable desire for more. Some turn to cigarettes, alcohol, gambling, drugs, sugar and other addictions in the hope that these will help them cope and make life more bearable or pleasurable. Too often, these substances fail to live up to their promise and more of the same is sought - as if hope can be purchased in a packet of cigarettes or lasting comfort found in a bottle of booze. Inevitably, health and outlook begin to suffer and other more helpful options become less attractive or less possible.

Freud understood this pull towards ultimately unhelpful solutions among people weighed down by the burden of their suffering and hoped that one day psychoanalysis would be able to adapt its technique to meet the needs of what he called 'the poor man':

> Then clinics and consultation departments will be built, to which analytically trained physicians will be appointed so that the men who would otherwise give way to drink, the women who have nearly succumbed under their burden of privations, the children for whom there is no choice but running wild or neurosis, may be made by analysis able to resist and able to do something in the world. This treatment will be free. It may take a long time before the State regards this as an urgent duty . . . however, it must come.
>
> (Freud 1924: 401)

But addictions are dangerous in other ways. People who turn to these substances for comfort run the risk of being denied access to certain kinds of help, such as counselling or treatment programmes if they are not 'dry' or are found to be still 'using' drugs. In some organisations, the level of motivation required for people to access these services and resources is very high and effectively acts as a selection process, excluding those whose lives are too chaotic or whose motivation wavers. Too often, little or no account is taken of the factors within an individual's life that militate against being able to meet the expectations of help-giving agencies. For example, I know of several family therapy centres, funded within the National Health Service, where lateness or absenteeism is understood only in terms of low motivation. This often results in families being denied the help they need. Whilst it is important to acknowledge the frustration and difficulties experienced when clients or patients are absent or late, I would argue that this behaviour needs to be understood in its widest context and requires a more sophisticated and compassionate professional response than denying access to services.

This chapter raises a complex and controversial issue within psychotherapy which is to explore what changes need to occur for psychotherapy to be able to speak to the experiences of people who come from poor, deprived and disadvantaged sectors of the population. What part can psychotherapy properly play when an individual's emotional energy is being consumed in the everyday struggle for survival? My perspective is that psychotherapy is worryingly out of touch with the needs, the strengths and struggles of working class people. Guntrip acknowledged this concern in relation to psychoanalysis when he wrote:

> psychoanalysis will hold the attention of the public only insofar as it speaks truly to the human condition ... able to help others with their struggles to be real persons living meaningful lives' (Guntrip 1971: 44).

It is unclear how well psychoanalysis is doing in speaking 'to the human condition'. Nor is there any indication that psychoanalysis or psychotherapy has become any more accessible to people

from poorer sections of the working class than when Barbara Lerner wrote *Therapy in the Ghetto* twenty-five years ago:

> Therapists disagree ..... and disagree sharply, as to the how, why, what, when and where of treatment ..... but with regard to the who, there is a striking degree of consistency over time, across professions and between orientations. (Lerner 1972: 3)

This chapter takes as its starting point the view that too little is known within psychotherapy circles about the plight of working class people living in poverty. It attempts both to bridge this gap by illuminating some key issues in relation to the growing inequalities between rich and poor within our society, and to identify the implications for psychotherapy. Drawing on the work of Freud, Donald Winnicott and Barbara Dockar-Drysdale[1], it goes on to explore how psychotherapy can be made more accessible and helpful in relation to people from poorer sections of the working class. In order to illustrate these ideas in practice, a final section looks at how these theoretical influences informed the work of Womankind, a women and mental health project based in Bristol.

It is important to state that when I first drafted an outline for this chapter, it was my intention to focus solely on the therapeutic needs of working class women. However, as the work progressed I found myself being increasingly drawn toward a particular cross section of the working class, namely the experiences of people living in poverty - people whose lives are overshadowed by the presence of deprivation and disadvantage. And as I returned to my own childhood experiences and tentatively re-entered the world of poor people, I found myself caught up in the hardship and suffering of working class men as well as working class women. Once there, it felt heartless and wrong to ignore the suffering of men where this closely mirrored the experiences of women. I felt divided in my loyalties in a way often described by working class and black women. This chapter reflects this tension and my need to relate my feminist perspective not only to women but to the whole of humanity - to men and women, boys and girls.

It may be helpful here to define some of the terms and words used. I use the word psychoanalysis as both a theory of human behaviour and as a method of treatment, based on a recognition of the importance of the unconscious, transference and resistance:

> Any line of investigation, no matter what its direction, which recognises transference and resistance, and takes them as the starting point of its work may call itself psychoanalysis, though it arrives at results other than my own. (Freud 1914: 3)

The term psychoanalytic psychotherapy is used to denote the use of psychoanalytic concepts in ways which fall within a general Freudian theoretical framework but do not strictly adhere to the more traditional and established Freudian schools of thought, particularly those attributed to the

Institute of Psycho-Analysis. Psychotherapy is used quite broadly to indicate any form of 'talking cure'. It has been estimated that there may be as many as 400 different psychotherapies.

In order to understand the experience of working class people, it is important to identify which group of people are included within this category. Similarly, it is important to define what is meant by terms such as deprivation, disadvantage and poverty - and how these relate to one another. However, before doing so, a word of caution is needed. Whilst generalisations are valuable in providing an overall picture about the lives and experiences of working class and poor women and men, such generalisations can never properly capture all that is complex and unique about any one individual or group. For example, it is difficult to talk about the specific experiences of working class women because what can be said of the thoughts and feelings of this group can also be claimed by those who are not working class or female. Very different experiences can bring about similar feelings, and similar experiences can produce very different reactions and emotions. So much hinges on what has gone before and the meaning attributed to those events and experiences.

Who are the working class?

A great deal of confusion still exists about what we mean when we use the term social class and who it includes - 'Sociologists are not agreed. Some define class as status or prestige, others as power, or income, or wealth and property, or say that class is what people think their class is.' (Argyle 1994: 3). Some of this confusion can be a denial of the stark realities of class inequalities. On the other hand, some confusion is understandable given the changes that have occurred since the war both in the overall improvement in living standards for working class people and also in the emergence of an educated group of people whose cultural heritage is working class but whose lifestyle has all the appearances of being middle class. I fall within this category.

Interestingly, more subjective definitions create less confusion. For example, one survey revealed that roughly 95 per cent of those researched thought there was a class system in this country and could identify which class they belong to (Argyle 1994: 3). Although statistics vary, it is estimated that 46 per cent of British people describe themselves as working class, plus an additional group (1.5 per cent) who see themselves as 'upper working class', sometimes called the 'labour aristocracy'. This roughly corresponds with the Registrar General's six categories of social class which are based on occupation.[2] These statistics showed that 52 per cent of people fall between social classes III(mn) (skilled manual) and V (unskilled manual). Women's class has traditionally been identified in terms of a woman's husband's occupation and class. This creates enormous difficulties when attempting to identify the specific characteristics of working class women, and feminists have argued convincingly for the need to give women a separate 'class position that adequately reflects their total class situation' (Abbott and Sapsford 1987: 30). However, to date this confusion remains.

The working class is a class of great diversity in terms of race and ethnicity and other social and cultural differences and although not all working class people are poor, the vulnerability of this group of people to deprivation and disadvantage is very marked. Notions of deprivation and disadvantage help to identify those sections of the working class most vulnerable to poverty and its short and long term impact. This vulnerability affects women disproportionately, which is a point to which I return later.

Deprivation, disadvantage and poverty. The term deprivation involves a sense of loss - the loss of something good, desired or worthwhile. Deprivations are a part of life. Some losses are inevitable whilst others are deeply class bound. For example, in relation to bereavement in the 1970s, men and women in occupational class V (unskilled manual) had a two-and-a-half times greater chance of dying before they reached retirement age than men and women in occupational class I (professional) (Black Report 1988: 43). Or again, the rates of sickness - that is, loss of a sense of health or well-being - showed great inequalities: 'the gradient is the steeper for limiting long-standing illness, where the rates in the unskilled manual group are more than double those of the professional group for both men and women' (Black Report 1988: 223). These are but two examples: many more could be added.

In the case of multiple deprivations and social disadvantage the causes extend beyond the experience of loss into situations where individuals are effectively excluded from gaining access to certain rights, opportunities, experiences or resources:

> Deprivations of all kinds - material, physical, social or emotional - may happen to anyone in any social group. But the disadvantaged are those who are consistently exposed to the highest risks of being deprived. Put crudely, the disadvantaged are those whose deprivations occur not because they are foolish or unlucky but simply because they belong to a particular social group. (Brown 1983: 5)

For example, the loss of a job could be considered a deprivation because it involves a loss of income, status, social contact and so forth. This deprivation becomes disadvantage when being unemployed means being denied access to decent housing, education or health service provision as a result of poverty. Peter Townsend uses a different terminology to describe the same problems, preferring the term 'relatively deprived' to describe people who are excluded from participating in society - 'If they lack or are denied resources to obtain access to these conditions of life and so fulfil membership of society they may be said to be in poverty' (Townsend 1993: 36). The social group most vulnerable to deprivation and disadvantage is working class people of all races. Whilst certain family patterns can limit or restrict an individual's opportunity to move forward, it is the systematic poverty of opportunity for working class people that reveals deprivation and

disadvantage as a consequence of the unequitable way that society is structured rather than as a result of individual fecklessness or irresponsibility.

One of the most worrying changes in recent years relates to the growing gap between rich and poor in this and in other countries. For example, in 1988/9 over a third of the population were living in or on the margins of poverty support. Unemployment accounts for nearly one fifth of those in poverty, the total number of which rose by 80 per cent between 1989 and 1993 from 1.6 million to 3 million people, according to official figures (Oppenheim 1993 p. 52). Poverty affects different groups unevenly, and frequently affects the most vulnerable sectors of society such as older people, children, disabled people and women.

Women and poverty. Poverty is marked among women. Women in employment tend to be low paid and for those who are unemployed or not employed, welfare benefits are very low. Where couples are on the margins of poverty, it is mainly women who have responsibility for the household budget and, as a consequence, carry the stresses and strains inherent in trying to make ends meet on the little money they have. Women's unique relationship to the burden of poverty has been described as the 'feminization of poverty' (Pearce 1978) - a fact that is reflected in the British statistics on women's poverty.

For example, it is estimated that in 1989 approximately five million women in the United Kingdom were living in poverty. Of these, in 1990 nine out of ten lone parents were women which means that there were well over one million lone mothers. In terms of women's employment, in 1991 over six and a half million women were low paid - that is, women comprised 65 per cent of the total number of people on low wages. Of the four and a half million women working part-time, 79 per cent of them were low paid. In terms of earnings, in 1992, women's average gross hourly earnings including overtime came to only 80 per cent of men's earnings and in the same year, over 2 million women fell below the threshold for making national insurance contributions and, therefore, forfeited their right to national insurance benefits (Oppenheim 1993 p. 96. In relation to older women, of the ten and a half million elderly people in Britain in 1990, women were the majority numbering around two-thirds. Of these, in 1991 there were over three times as many women pensioners as men dependent on income support.

Women's unemployment is thought to fall somewhere between 33 per cent and 41 per cent of those unemployed (Oppenheim 1993: 95). With regard to black women, like their male counterparts the unemployment rates have always been higher, sometimes two or three times higher than the average for white people, although the gap is narrowing (Argyle 1994: 100). The conclusion that must be drawn from these figures is that 'for many women neither employment nor social security can keep them out of poverty' (Oppenheim 1993: 100). More generally, the statistics reveal that working class people experience more 'unfavourable events of a variety of kinds' (Argyle 1994: 275) such as loss of income, unemployment, difficult conditions of

employment, bad housing, debts, etc. These are termed 'environmental stresses' by Brown and Harris (1978).

The emotional consequences of poverty and disadvantage. Over the years there has been an attempt to link certain types of mental disorders to social class, and particularly to the impact of poverty. The most influential research in this field relates to the work of Brown and Harris who found that working class women in their study were two to three times more likely to become depressed than middle class women (Brown and Harris 1978). Other research shows that working class people are roughly five times more likely to be diagnosed as schizophrenic (Argyle 1994: 273) and that alcoholism and drug addiction are also more common among the working class (McLeod and Kessler 1990). In addition to the impact of poverty, the class related nature of some mental illnesses may come about because working class people often have fewer resources to fall back on, both externally in terms of social support and internally in terms of emotional resources.

I have explored the relationship between class, deprivation, disadvantage and poverty in order to highlight the range and depth of the hardship experienced by people living in poverty, particularly women, and the vulnerability of all working class people to these hardships should they ever 'fall on bad times' that is, should they ever reach a point where they have nothing to fall back on but their wits and their determination to survive. It is a fear that working class people live with and defend against on a daily basis with far-reaching consequences in terms of their capacity to seek and accept help, assuming that this help is available and of the right kind. The hard lives that poor people live was something Freud understood:

> we shall probably discover that the poor are even less ready to part with neuroses than the rich, because the hard life that awaits them when they recover has no attraction, and illness in them gives them more claim to the help of others. (Freud 1924: 402)

If this is the case, then it follows that any psychotherapy offered to 'poor people' will need to take account firstly of their 'hard life' and secondly, the difficulties that working class people may experience in letting go of their suffering, particularly when doing so risks being abandoned and neglected in terms of access to health care and welfare services. It is to these issues that this chapter now turns.

The therapeutic needs of working class people living in poverty

In his paper 'Turnings in the Way of Psycho-analytic Therapy'[3] published in 1924, Freud addresses the accessibility of psychoanalysis in relation to people from poorer sections of the population. This paper is important because it provides a foundation from which to explore how the central concepts of psychoanalysis - transference and resistance - can be related in detail to the

experiences of working class and poor people and to an analysis of the emotional impact of urban decay and neglect, discrimination and disadvantage**.**

Freud begins his paper by acknowledging the 'incompleteness of our understanding' and goes on to look more closely at the importance of working with resistances. He then turns his attention to what Ferenczi described as the 'activity' on the part of the analyst/therapist, stating that whilst working with 'unconscious and repressed material and uncovering resistances' (p.395) may be considered activity enough, for some patients/clients this may not be sufficient to create the 'situation most favourable to solution'. He notes that what can be achieved may be mediated by 'external circumstances' and suggests that in such circumstances it may be appropriate and justifiable for analysts/therapists to be more active and to intervene to lessen the impact of external influences. However, when introducing adaptations in technique the purpose and aim of psychoanalysis must always be kept in view. This is 'not to make everything as pleasant as possible for the patient' but to make 'him (sic) stronger for life and more capable of carrying out the actual tasks of his life' (p.398). The ultimate aim is 'the patient's restoration to health' (p.396). For people who are 'helpless and incapable', this might involve combining the analytic technique with the role of educator, teacher and mentor but these changes 'must always be done with great caution' (p.399).

Freud goes on to remind us of the changes that psychoanalysis has undergone and that the treatment of new diseases (hysteria, phobia) necessitated different techniques that 'went beyond former limits'. However, he notes that the therapeutic effects benefited 'but an handful of people' from the 'well-to-do classes' and did little to address the 'vast amount of misery in the world' (p.401). Yet for Freud 'the poor man has just as much right to help for his mind as he now has for the surgeon's means of saving life' but acknowledges that for psychoanalysis to reach this group will require 'for us to adapt our technique to the new conditions'. This includes finding 'the simplest and most natural expressions for our theoretical doctrines'. In a final paragraph, Freud returns to the theme of analysts/therapists addressing the influence of external factors and states that 'we may often only be able to achieve something if we combine aid for the mind with some material support'. He concludes that 'it is very probable, too, that the application of our therapy to numbers will compel us to alloy the pure gold of analysis plentifully with the copper of direct suggestion' (Freud 1924: 402).

I would argue that there has been very little commitment within psychoanalysis to explore and to relate Freud's adaptations in technique to the needs of working class and poor people. The following section describes the work of Womankind as one example of how psychotherapy, particularly psychoanalysis, could adapt its technique in order to meet the needs of working class and poor people.

Womankind

Womankind was set up in January 1986 as one of 16 pilot projects scattered throughout England whose purpose was to explore what role self help could play in meeting people's health and welfare needs. For Womankind, this initially involved setting up a range of different self help groups for women suffering from depression, tranquillizer addiction, agoraphobia and eating disorders. In time, it also included initiating assertiveness training and confidence building groups and counselling skills courses for Afro-Caribbean and Asian women. Although we were involved in setting up many self-help groups, most collapsed once the development worker ceased to be involved. As a result, when our major funding ended in 1989 it was decided to focus our limited funds on working with depressed women.

When Womankind began, we thought that feminism would answer all our questions. We hoped that by giving women a 'good experience', and by being committed and supportive to women suffering from 'mental health' problems, life would come together for them. However, after many years of optimistic endeavour it became increasingly clear that the feminist approach we were adopting was failing to address a whole range of needs that women were expressing. We were not being successful in our efforts to help and this was beginning to affect our confidence and sense of hope. This was partly because from the beginning Womankind tended to attract a very distressed group of women. This tendency was compounded with the closure of the large psychiatric hospitals and the introduction of Care in the Community legislation.

As the years rolled past, it became increasingly clear that we did not have the knowledge or skills to work effectively with the women who came to Womankind for help. This placed us at a cross-roads. Either we had effectively to exclude women suffering from 'severe' and 'enduring' depression so that we could redirect our services toward women who were not so distressed or we had to develop a new approach and body of knowledge. We decided on the latter. Our quest began by returning to feminist writing on women's mental health and psychotherapy and also psychoanalytic theory because it was here that we found feminists addressing issues of concern to us about the importance of early childhood experiences in relation to women's emotional development and what women needed from Womankind, or from us as groupworkers or counsellors, in order to recover, to grow and to move forward. These authors included Jessica Benjamin (1990; 1995), Teresa Brennan (1989), Cynthia Burack (1994), Nancy Chodorow (1978; 1989; 1994), Dorothy Dinnerstein (1978), Luise Eichenbaum and Susie Orbach (1982), Sheila Ernst and Marie Maguire (1987), Jane Flax (1981; 1991; 1993), Caroline Glendinning and Jane Millar (1992), Carol Gilligan (1982), Hilary Graham (1993). Judith Jordan (1991), Jean Baker Miller (1973, 1976), Juliet Mitchell (1974; 1984), Janet Sayer (1991) and Elizabeth Wright (1992).

These writings gave us an important theoretical framework but as groupworkers and counsellors they did not help us to understand how to respond in practice to the suffering women were describing in their internal and external lives, particularly when their distress was being triggered

by ongoing experiences of hardship and poverty - of deprivation (loss) and disadvantage (exclusion). What we needed was a theory and practice that could help us to understand what was happening to women and what we could say or do to make a difference. This we found in the writings of Winnicott and Dockar-Drysdale. For two years, Barbara Dockar-Drysdale acted as a consultant to Womankind and it was from these regular weekly meetings that I and other groupworkers learned a great deal about how to listen to women's conscious and unconscious communications. Time and again Mrs. Dockar-Drysdale would say 'but you're not listening to what is being said' and she was, of course, correct. Once we learned the art of listening, our work at Womankind began to change in unexpected ways.

The exploration I am about to describe ran from 1992 to 1995. During this period, Womankind ran three weekly closed depression groups each made up of nine women per group. In addition, we also provided individual counselling for a small number of women. Toward the end of the period described, we ran several waiting-list groups every month that women were invited to attend. Finally, several times a year we ran day workshops for social workers, community psychiatric nurses and other practitioners working with depressed men and women.

It may be valuable to give a snapshot of the women we worked with: greater detail is described elsewhere (Trevithick 1993; 1995). Toward the middle of the period described, we had regular contact with about 30 women on a weekly basis of which almost a quarter came from black (African-Caribbean) and other ethnic minority groups. Their age range spanned many years - from 22 to 65 years - of which over half were under thirty. Most of the women we worked with were mothers. Of these children, fourteen were under ten years old. Two babies were born in the period described.

Almost all the women we worked with were on benefit, which included a large cross-section on disability benefit of one kind or another. As indicated in the section on poverty, the lack of money and the social exclusion it produced left women feeling intensely lonely and isolated. As a result, the sense of despair and defeat that women carried was very marked and troubling. Over half had attempted suicide at some time in their lives and two women had close family members who actually committed suicide. Their psychiatric diagnoses varied greatly and because of their long histories of depression, can be summarised falling within the category of 'severe' and 'enduring' mental illness. Most women used the word depression to describe themselves and this was true of women who had some history of psychotic illness who constituted about a third of the total numbers attending our groups.

Although the majority of our initial referrals came from family doctors, social workers and other health workers professionals, our selection process was based primarily on self-referral. This involved women ringing the Womankind help-line which was open every morning. After this initial contact, a range of different pamphlets would be sent out explaining our work and how our

groups were organised. Although we would have liked to offer more individual counselling[4], we made it clear in our literature that we were only able to offer groupwork (for a detailed account of our particular approach see Trevithick 1995). For women who wanted one-to-one work, we provided information on where they could go for help. The names of women interested in attending a group were then placed on a waiting-list. One survey we undertook showed that early on in our work, the time period involved from the point of self-referral to women attending a group was on average two weeks. However, as the names on the waiting-list grew this swift response proved increasingly difficult to maintain. For example, at one time there were eighty names on the waiting-list which created an enormous dilemma because we did not have the resources to meet this need. Women who had been on the waiting-list the longest were usually the first to be invited to join one of the groups when a place become vacant. However, on occasion we were offered places to meet specific needs - for example, to balance the racial composition of a particular group. Although the attendance at our three groups was unusually high, it is important to stress that our selection procedure evolved because of our limited resources and was far from ideal. The emphasis we placed on self-referral had its limitations as well as its strengths.

Each depression group we ran had three groupworkers: two group leaders and a co-ordinator. The primary role of the group co-ordinator was to ensure that Womankind provided a setting that was 'good enough' for women to explore their thoughts and feelings. It was the task of the group leaders not to provide insights or interpretations except as a way of caring but to help women to find their own understandings and solutions based on the premise that it is 'the patient and only the patient who has the answers' (Winnicott 1987: 114).

The same concept of care, nurturance and holding described later in relation to women in our groups was also extended to ourselves as workers. This meant that we gave a high priority to using our theoretical framework as a basis from which to understand ourselves and our transference and counter-transference reactions. The emphasis we gave to peer support and supervision, which we attended once or twice a week, proved essential in helping us to understand and to work with women's anxieties, to avoid merging and to maintain boundaries. As practitioners, we had no formal qualifications in groupwork or counselling. Gaps in our knowledge were bridged by supervision and through attending counselling and groupwork training courses. Again, this had disadvantages but also the advantage of leaving us free to explore new ideas and ways of working because we had no allegiance to a particular approach.

Change, growth and emotional development

The starting point for our work came from Freud, Winnicott, Dockar-Drysdale and other writers who acknowledge the importance of early childhood experiences in the emotional development of the individual; the capacity of individuals to grow and to change throughout their lives; the existence of conscious, preconscious and unconscious states and motives that influence actions; the part played by the defence mechanism in mediating an individual's experience of themselves and

others; the importance of transference as a process by which people displace or transfer feelings derived from the past on to others and of the primary search and drive for relatedness within human beings.

From Winnicott, we also took as our starting point the notion that at the beginning of life, for emotional development and maturation to occur involves creating a facilitating environment, capable of being 'good enough' at adapting itself to meet the infant's changing needs. At first, this adaptation must be almost 100 per cent but in time can be gradually reduced once the baby moves towards independence. Successful adaptation means that the individual continues to develop 'an unbroken line of living growth' (Winnicott 1987: 291). Where the infant does not experience sufficient adaptation, this constitutes an impingement. The infant's reaction to impingements carry more importance than the impingements themselves. Reactions to impingements that are ongoing and unrepaired lead to failure situations occurring where at certain points emotional development becomes stuck or 'frozen'. An individual may continue to grow physically but not emotionally. Instead, emotional growth becomes 'delayed and perhaps distorted' (Winnicott 1965: 228) and the energy or emotional resources which would have been directed towards growth and emotional development have to be re-directed in order to react to the impingement and to deal with the hold-up it produces. This can set in motion a range of reactions as the individual protects his or her sense of self through establishing a false self, which has the task of protecting the true self from further violations. However, whilst this strategic separation from the true self ensures survival, this comes at a cost. It harbours a sense of futility and feeling that life is not worth living and carries a painful aloneness and grief at having to live life separated off from an important part of oneself.

When working with deprived and disadvantaged sectors of the population, these 'failure situations' may be being constantly revived in the present, catapulting people into the past. This can make it very difficult to differentiate between past and present since both are operating which may be one important reason why psychotherapists find it so difficult to work with working class and poor people. For example, people who have been neglected and uncared for in childhood may find these memories being revived when living in an environment of urban decay and neglect where their needs are constantly being ignored. This makes it important for practitioners and therapists to acknowledge and work with the impact of painful events located in the present as well as the impact of suffering experienced in the past. The pull among human beings to return to earlier 'points of failure' is profound. However, this can easily be confused and seen as people bringing suffering on themselves. The lines are difficult to draw between masochism, addictive behaviour and the pull to return to earlier painful experiences in order to bring about repair and recovery. Whatever drives this return to the past, it provides an important opportunity for recovery but this possibility can be severely limited or inhibited by resistances and the impact of negative external, environmental factors over which people may have little control.

The successful return to earlier failure situations cannot be achieved unless we can create a facilitative environment or favourable conditions. The purpose of this return or regression is not to bring about change on a one-off basis although this is important. Nor is it to create an unhealthy and disempowering dependency for its own sake. Its purpose is to bring about ongoing and lasting change through 'unfreezing' or freeing-up the developmental process that has become frozen or stuck in order to revive the innate capacity within human beings toward recovery, reparation, growth and development. Just as exposing a minor wound to the air can produce a spontaneous capacity in the body to heal itself, this theory states that emotional wounds can be healed in a similar way, but only if the body's natural emotional healing process has the capacity and energy to take on the task. The effectiveness of this approach can be seen in people feeling able and driven to take on new challenges and to make changes in their lives, motivated by a desire from within themselves, rather than in response to the demands of others.

One difficulty with this approach is that people whose thoughts and feelings are bound up in the struggle for survival - who feel vulnerable to threats within their external and/or internal world - often do not have the emotional reserves or energy needed to bring about change, no matter how much this is desired and needed. In this situation, what is needed is an injection of resources from outside - in the form of care and other nurturing experiences - in order to remedy this sense of depletion so that psychic energy can become free-flowing and self-generating. To see their inability to move forward as a sign of poor motivation is a gross simplification. The risks involved in change are many. It exposes people and situations in ways that can feel humiliating, threatening, frightening and overwhelming. This makes it important to attend to all factors that inhibit change and people's capacity to move forward - external as well as internal.

Creating 'favourable conditions'

Thus, to unfreezing the developmental process so that individual's have the capacity to change their lives involves creating favourable conditions. Organisations or projects may identify different favourable conditions but for Womankind these included:

1. creating a secure setting - a holding or facilitating environment (Winnicott)
2. demonstrating a capacity to care and to be reliable, consistent and concerned
3. allowing women to become dependent so that a partial or localised regression could occur from which women felt 'held' enough to address earlier traumas and painful experiences
4. providing adaptation to need
5. using transitional phenomena
6. attending to external, environmental factors

It is not possible to describe these concepts in detail beyond illustrating how each factor played a part in creating an environment which enabled 'the tendencies that are at work within the individual' to lead to emotional growth (Winnicott 1965: 228).

A 'setting that gives confidence' is the context within which some repairing and recovery can take place so that change, growth and emotional development become a possibility. In the case of Womankind, this took the form of re-organising the layout of the building so that it met women's collective and individual needs. For example, we encouraged women to decorate the project with objects that meant something to them. These symbolisations took different forms - some brought in photographs, paintings, figures, cushions, mugs, special teas whilst others re-arranged the furniture in ways that 'felt right' for them. Our purpose in using these symbols or transitional phenomena was not to be clever or indulgent or to make Womankind more homely but to set up a situation where every woman felt special and unique. By creating an atmosphere of predictability, built on our reliability, consistency and concern, our aim was to help women to feel less guarded so that energy normally spent on defending themselves could be directed at repairing some of the failures of the past. Unless women could be encouraged to relax and to feel secure and safe, their defences remained 'on guard', mobilised and ready to react at any time. It is for these reasons that the setting had to be protected in the ways described.

The importance of reliability, consistency and predictability cannot be overstated, particularly when working with people who have been failed or 'let down' a great deal in the past. In relation to our work at Womankind, this involved regularly analysing the quality of experience that the project provided. For example, we thought a great deal about the kind of welcome women received, ensuring that drinks and the correct biscuits were bought, that the kitchen was tidy and cleared of papers, that the groupwork room had the same favourite cushions and other comforting objects and that the same sense of care, concern, permanence and consistency existed for the

coffee period after their group. As groupworkers, central to the task in creating favourable conditions was to provide a holding environment where through our care in the form of 'adaptation, concern and reliability' (Winnicott 1986: 116) we could create the situation where the anxieties involved in change and 'sorting out' and 'working through difficult feelings and experiences could be 'held' long enough to enable the development of 'the drive towards cure, and towards self-cure if no help is available' (Winnicott 1965: 222).

In terms of attending to external, environmental factors this often involved trying to ease some of the financial pressure that women were experiencing. For example, we paid for a telephone to be installed for one of the young mothers we worked with who was severely isolated at home with her baby. In another situation where a mother was living in extreme poverty we regularly negotiated for essential services not to be cut off and whenever we could, we paid bills that were causing the greatest anguish. Again, the primary purpose of this work was not solely to ease the impact of poverty, although important, but to provide an adaptation to need as part of a planned therapeutic strategy based on the notion that 'cure at its root means care' (1986:112).

Regression

The concept of regression was central to our work at Womankind because it was through this process that change became possible. Indeed, it was our belief that the possibility of change, growth and development could only become possible through women feeling safe enough to allow themselves to become dependent on us, if only in a limited way. From this perspective, the current trend within health and welfare services to inhibit or to stifle people's dependency needs is completely counter-productive and anti-therapeutic and helps to explain why so many patients, clients and service users fail to make progress and to move forward. It is important that this anti-dependency trend is reviewed but not in a way that creates an unhealthy dependency, divorced from any planned therapeutic strategy and approach. As stated earlier, dependency should not be encouraged for its own sake because this could have the effect of immobilising or disempowering an individual even further, thereby creating a whole range of additional difficulties.

For Winnicott, a regression or 'organized return to early dependence' becomes possible where there is reliability in the therapeutic setting (Winnicott 1987: 286). This provides the individual with the opportunity to return to success and failure situations without having to organize the defences to protect the self from further violations. It is worth quoting Winnicott in full in relation to what he saw happening in the regression because of the clear way he sees the progression occurring:

> In practice there is a sequence of events:
>
> 1. The provision of a setting that gives confidence.
> 2. Regression of the patient to dependence, with due sense of the risk involved.

3. The patient feeling a new sense of self, and the self hitherto hidden becoming surrendered to the total ego. A new progression of the individual processes which had stopped.
4. An unfreezing of an environmental failure situation.
5. From the new position of ego strength, anger related to the early environmental failure, felt in the present and expressed.
6. Return from regression to dependence, in orderly progress towards independence.
7. Instinctual needs and wishes becoming realizable with genuine vitality and vigour.

All this repeated again and again. (Winnicott 1987: 287)

What I find valuable about this description is that it acknowledges the importance of anger as a part of the recovery process. Several times at Womankind I experienced women shifting from a feeling of devastation and defeat at being 'let down' to one of absolute rage and fury some time later. They felt very alive in their fury and described being surprised and pleased by their reactions. When thinking about the hardship experienced by people from poorer sections of the working class, anger at their predicament seems a wholly appropriate response and one that is far more fruitful than adding one more experience of defeat and failure to the ever growing list of hurtful experiences and disappointments. However, I know too that most working class people cannot 'find their anger' because it is not yet safe to do so - the favourable conditions are not yet in place. This is particularly true for those people living in areas of severe urban decay and neglect, where the odds against their making progress are enormous, despite the well-intentioned efforts of professionals working in these settings. Some of this difficulty is due to the fact that just as our services are fragmented, so too are our responses. As a result, in recent years there has been little attempt among professionals to attend to the sources of suffering, hardship, deprivation, disadvantage and poverty. Lerner describes this difficulty as 'treating malaria victims in a mosquito-infested swamp. Treating those afflicted is a humane, even a heroic endeavour, but a rather futile one unless there is a simultaneous effort to drain the swamp to prevent new infections' (Lerner 1972: 6). This criticism is even more damning for those psychotherapists who have positioned themselves in settings where they cannot see the swamp and never need be affected by its existence and the suffering it causes. Where this is the case, Lerner's description of psychotherapists as 'failing to meet their social responsibilities' holds weight (Lerner 1972: 5). However, this need not be the case.

The history of psychotherapy and psychoanalysis is one of change. In relation to the latter, this largely occurred in response to psychoanalysis opening its doors to new and different groups of people. Its reward was to gain new knowledge. For example, Freud originally thought that psychoanalytic treatment could only be effective with hysteria in adults but his work with phobic patients forced him to revise his views and to 'go beyond former limits' (Freud 1924: 399). So too did the work of analysts such as Klein and Winnicott in their work with psychotic patients,

children and adolescents. With the introduction of each new patient group, psychoanalysis has grown and changed. From this perspective, psychoanalysis has much to learn from working class and poor people because its theory and practice has for the most part been severely class bound, with the experiences and characteristics of middle-class people being viewed as typical to all human beings. Clearly, this is not the case.

The strength of psychotherapy, particularly psychoanalysis is, as Freud noted, its capacity to adapt its techniques to 'new conditions' - 'to alloy the pure gold of analysis plentifully with the copper of direct suggestion' (Freud). For Guntrip, this involves psychoanalysis continuing to evolve its theory and practice to a point where it can 'speak to the human condition ..... able to help others with their struggles to be real persons living meaningful lives' (Guntrip 1971: 44). Since the experiences of working class and poor people constitute an important cross-section of the 'human condition', I see enormous benefits to be gained if, when poor people come knocking on the door, psychoanalysis has the courage and heart to let them in.

Footnotes

[1] The late Donald Winnicott was a paediatrician, psycho-analyst and twice President of the British Psycho-Analytic Society. Barbara Dockar-Drysdale is a retired psychotherapist and the founder of the Mulberry Bush School for children needing residential psychotherapeutic care. She was for many years a Consultant Psychotherapist to the Cotswold Community for disturbed and deprived adolescent boys and consultant at Womankind.

[2] It may be helpful to identify the Registrar General's six socio-economic classes because these are used a great deal in official statistics, particularly health statistics and to highlight the inequalities between rich and poor. They are also useful in illuminating which group of people psychotherapists are most and least likely to work with.

The Registrar General's Classification of Occupation

Social Class		**Examples of occupation**
I	Professional	Accountant, clergyman, doctor
II	Intermediate	Teacher, farmer, nurse
IIINM	Skilled non-manual	Secretary, shop assistant, sales representative
IIIM	Skilled manual	Bus driver, electrician, miner (underground), cook
IV	Semi-skilled manual	Agricultural worker, assembly worker, postman
V	Unskilled manual	Laundry worker, office cleaner, labourer

Source: Hilary Graham (1993) ***Hardship and Health in Women's Lives*** **London: Harvester Wheatsheaf**

[3] This paper stands in contrast with Freud's better known paper on this subject entitled 'The Question of Lay Analysis' published in 1926.

[4] We would have liked to have been able to offer a more comprehensive range of services based on an assessment of women's needs and to have had the opportunity to assess, monitor and evaluate the effectiveness of our approach. This became a possibility in 1995 with the securing of new funding but this opportunity was dashed following a dispute within Womankind about how this funding should be spent. This resulted in the abrupt dismantling of our groupwork and counselling approach. Although our actions were later vindicated at an Industrial Tribunal, none of the five groupworkers involved in the exploration described in this chapter were ever allowed to return to Womankind in their previous capacities.

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Acknowledgements

I am deeply grateful for the encouragement I have had from my friends particularly Judy Carver, Robert French and Sue Pollock whose helpful comments and corrections have been invaluable. I would also like to thank Colleen Heenan and Bruna Seu for their patience and guidance in steering this chapter toward publication.

Biography

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Pamela Trevithick was born in Burnley, Lancashire in 1947. She was a founder member of Womankind, a Women and Mental Health Project where she worked for ten years as a groupworker and counsellor. She currently works as a part-time lecturer in social work at the University of Bristol and as a Project Leader at Barnado's 114 Child and Family Support Centre, working with young people and their families. She is currently writing a book commissioned by Gower on communication skills for social workers.

Index authors

10 Key words

1. Adaptation to need
2. Care-cure
3. Dependence
4. External factors
5. Facilitating environment
6. Favourable conditions
7. Holding
8. Regression
9. Reliability and consistency
10. Transitional phenomena

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