

## PRACTICE NOTES

### Specific Cases, Techniques and Approaches

---

# Reconnecting Past, Present and Future Lives: Therapy with a Young Person who Experienced Severe Childhood Privation\*

Carole Meech\*\* and Andrew Wood\*\*\*

---

*This case study describes therapy over a three year period with a young adopted person who presented as highly suicidal, with a childhood background characterised by severe privation and abuse. The paper describes the use of a visual Life line, designed to assist the young person in reconnecting and honouring different parts of her life. A flexible and client centred therapeutic approach is also described.*

---

## THE PICTURE NOW

Lianna presents as a well-groomed young woman of sixteen. She is usually in her school uniform but has, outside of school times, occasionally come in 'street clothes'. Over the last six months she has been wearing her long dark hair off her face and her 'street clothes' are often brightly coloured. Recently we celebrated her sixteenth birthday with a breakfast in a local cafe. This also marked a change in the appointment arrangements, with six monthly review times to occur from now on.

Lianna has been attending appointments within the clinic as arranged, with sessions varying from weekly in the early stages of therapy to two and three monthly over the last year. If she is unable to keep appointments, she will ring to organise another time.

Lianna's interests are varied. At the end of 1997, she was voted House Captain by her school peers and the teachers and she recently attended a camp that taught her the skills she would need to fulfil her duties. Her school performance has steadily improved over the last three years and she finished Year 10 with good performances in all her subjects.

In mid-1997, Lianna joined the Air Cadets. She has now completed advanced cadet training and continues to attend on a weekly basis, with associated camps being held regularly during the year. It is a testament to her growth and courage that she makes a commitment to this activity in the knowledge that her visual disability will prevent her pursuing a preferred career in the armed forces.

At the end of 1998, Lianna went on holiday interstate, staying with relatives. Whilst away, she developed a close friendship with a young man and in the course of their time together revealed some of her background and past traumas to him. This experience was a very positive one for her, her first experience of disclosure outside of the home and therapy situations.

## THE PICTURE THEN

Lianna was aged twelve and a half when we first met her and her family in late 1995. She had been referred to Southern CAMHS by her primary school, where she was in her final year. The school's concerns included her verbal and physical harassment of other students and frequent threats to staff and students that she would kill herself. On one occasion she took a knife to school. These behaviours had been escalating over a period of six months. The school staff were feeling overwhelmed by her and concerned that she had serious psychiatric problems.

Due to the serious nature of these presenting complaints, we decided that our family therapy team would see her and her family. One of the authors (AW) conducted the first interview, while CM and other team members were behind the screen.

---

\* This case study was presented at the 1997 national Family Therapy Conference, Adelaide, S.A.

\*\* Clinical Nurse, Child and Adolescent Mental Health Service (Southern), Marion Regional Team, PO Box 248, Oaklands Park, SA 5046.

\*\*\* Director of Hospital and Community Services, & Senior Clinical Social Worker, Child and Adolescent Mental Health Service (Southern), Flinders Medical Centre, Bedford Park SA 5042.

From the outset, Lianna was very difficult to engage and angry about seeing us. She sat slouched in her chair, her head down and face covered by a baseball cap. She was clearly suspicious of us all, uncomfortable with the screen and offered only the occasional mumbled 'yes' or 'no' to questions. The family consisted of parents Susan and Bob, both Australian born and in the work force; Peter (eighteen years old); Joshua (fourteen) and Rachel (twelve) all of whom had been adopted from overseas orphanages as younger children, as had Lianna. We learnt that over the preceding twelve months, Lianna had become increasingly withdrawn and moody at home, interspersed with very angry outbursts, particularly towards her mother and her sister. More recently, she had been 'baiting' her mother to the extent of asking her mother to hit her again after her mother lost patience and slapped her. Lianna had even rung the local welfare department asking for another family. In addition to these events, she had been cutting her hair off, her personal hygiene had deteriorated dramatically to the point where she hid soiled sanitary pads around the house (if she used them at all), she had been stealing food and hiding it around her bedroom, and she had developed the habit of sleeping on the floor and urinating next to her bed. Most of these behaviours had commenced soon after Lianna had begun menstruating twelve months before; the stealing and hiding of food, however, had been taking place since her adoption. Other than her apparent obsession with food, her parents recalled no particularly difficult or unusual behaviour before that point. Lianna's parents were clearly very distressed by the transformation in their daughter and were at a loss as to what to do to help her.

At this early point in the first interview, she was very agitated about being the subject of discussion and left the room. With her parents, we continued to develop an understanding of what was happening in her life. They had adopted Lianna from an overseas orphanage, selecting her in Australia from photographs of available children. She was classified as a special needs child, having been born with only one eye. A glass eye had been fitted soon after her arrival in Australia. She had been left at the orphanage at the age of three weeks by her birth mother and the identities of her birth mother and father were unknown. Thus, Lianna had spent all of her childhood up to the age of seven in the orphanage.

There is now a substantial and compelling research literature on the critical importance to an infant of a warm, loving attachment to a significant adult as a protective factor in the development of psychological adjustment in childhood and adulthood (Masten, Best and Garmezy, 1990; Werner, 1993). It became clear that Lianna did not have such a start in her infancy and early childhood.

Further, recent research on the effects of severe early privation amongst children up to the age of three adopted from Romanian orphanages by English and Canadian families has found that while many of these children showed rapid developmental catch-up, they commonly displayed later difficulty in forming relationships and maintaining social interactions, and they showed limited social awareness (Rutter and the English and Romanian

Adoptees Study Team, 1998; Rutter, Andersen-Wood, Beckett, Bredenkamp, Castle, Groothues, Kreppner, Keaveney, Lord and O'Connor and the English and Romanian Adoptees Study Team, 1999). While Lianna was not from Romania, she had spent her formative years in an environment characterised by abuse, privation and a lack of meaningful attachment relationships. She displayed a number of the characteristics Rutter observed in his studies. Interestingly, like the large majority of the Romanian adoptees, she appeared to have no obvious cognitive impairment.

Lianna was aware of the facts surrounding her adoption. She arrived in Australia malnourished, in poor physical condition and speaking no English. She spent much of the first few weeks crying and huddled in the corner. Over time, she regained her health and appeared to settle into her new family, learnt a new language and started school. In the years after the adoption, Lianna's parents became aware of other children from the same orphanage who had been adopted in Australia. They also learnt that numbers of these children had been physically and sexually abused in the orphanage. They had questioned Lianna about this, and while she admitted to regular physical punishment, she denied any sexual abuse, claiming that she had been 'left alone because she was ugly'.

There is considerable research evidence that abused children are more prone to developing negative self images and poor self esteem and can learn to be suspicious and hostile towards others, particularly strangers (Youngblade and Belsky, 1990; Fraser, 1997). Lianna certainly displayed some of these characteristics.

At the conclusion of the first interview, the team was clear that its usual brief family therapy approach would likely alienate this young person even more. It was felt that Lianna was attempting to deal with a profound set of issues including identity and safety, and that we had perhaps only one chance left to engage her in therapy. The parents were very keen that she receive some help. It was decided to offer Lianna the option of meeting with the authors together, without the team or her family. It was felt that a gender balanced co-therapy arrangement might be of benefit not only to her but also to us! We also decided that we would offer an additional component to our work with her, that of 'shooting some hoops' together (we had learnt she was keen on basketball and we had a basketball ring at one of our team buildings). We went to the waiting room and put this proposition to Lianna. She agreed to come back and see us, albeit reluctantly.

Before the next appointment, she took an overdose and spent a week in hospital (not under our care). The psychiatric opinion at the time was that while she was not overtly psychotic or depressed, she was clearly a risk to herself and had significant life stage and early childhood trauma issues to deal with. She was discharged back into treatment with us.

## **The Early Stages of Individual Therapy**

We realised very early on that this therapy would need to go slowly. In the early stages, Lianna presented as very

suspicious and secretive, with no eye contact and virtually no verbal responses. Without telling us in words, she was reminding us that positive relationships must be founded on trust and that we had to earn hers. For the first few months of weekly and fortnightly sessions, we rewarded her attendance and responsiveness with time playing basketball together at the end of the sessions. While trying to conceal it, Lianna's enjoyment of this activity was obvious, particularly when she demonstrated that her ball skills were greater than one of her therapists! She also began to respond well to praise of her physical prowess and competence, an emphasis we learnt from Milton Erickson (Haley, 1973). Soon after she started high school, she volunteered for an athletics carnival and one of the authors attended anonymously but with her knowledge, to cheer her on. More recently, we attended her Air Cadets' graduation parade. Our presence to help mark the importance of these events seemed to hold real significance for Lianna.

In sessions where she was very withdrawn and wouldn't speak much, we would talk together in her presence, much of this 'incidental' talk being stories and metaphors about other young people and speculation about what Lianna might be thinking or feeling. She learnt to correct us and began to add to the conversation. This therapy would have been extremely difficult for one therapist.

Over time, Lianna became more verbal. She continued to threaten suicide but in one session, posed a critical question, 'Why me?' It was clear that she was looking for answers to the distressed state she found herself in but was having enormous difficulty relating to her experience and finding the language to express it. We paid special attention to her suicide threats and worked with Lianna, her family and the school to ensure that a safety plan was in place. Neither of us had worked with a young person of this age who seemed so despairing.

By this time, we were deliberately structuring the sessions by way of an agenda, which Lianna became accustomed to writing on the whiteboard. The purpose of the agenda was to provide a focus for sessions and some predictability for Lianna and ourselves. The agenda items changed over the course of therapy, but basically consisted of a 'review of home', 'review of school', 'Lianna's business' (her opportunity to raise issues), 'Tricky questions' (our opportunity to ask pertinent and often challenging questions) and 'fun' (basketball or a game of cards). We began to routinely scale her satisfaction with home and school (Berg and de Shazer, 1993), a process that enabled her closer involvement in the therapy. While Lianna was not very talkative, she could commit herself to a cross on a scale.

We felt Lianna was more trusting of us, and in order to help her begin to take some control in her life and in the therapy and to provide her and us with some clear therapeutic goals, we decided to provide some options for her that she could accept or reject. Choice might help empower her further. Using the whiteboard, we posed several questions and asked Lianna to nominate one that interested her. These questions were 'What would Lianna like different in her life?', 'What sort of future would

Lianna like?'; 'How would Lianna know when she was ready to talk about her problems?' She nominated the first question as her choice. In the following session, she was unable to identify any answers to the question, so we speculated on half a dozen possibilities in front of her, wrote them on cards, asked her again to identify any others and then lay the cards in front of her. She picked up two cards: 'To be able to forget the past' and 'To be able to talk about my feelings'. Some gentle inquiries about her past indicated that this part of her life was virtually off limits, to her as well as to us. She appeared quite disassociated from her early childhood. She claimed not to remember much of her early life in the orphanage but on being asked, did admit that she was physically beaten. Our inquiry about sexual abuse led to a quick denial. We were sure that her traumatic past had caught up with her, triggered by identity and sexuality issues. However, it would be some time before the past was revisited in a comprehensive way.

It became apparent very early in the process that Lianna had virtually no language with which to relate to or describe her feelings, a feature not uncommon amongst children who have experienced severe institutionalised privation and abuse (Rutter, 1999). She was not able to name even basic feeling states. We assisted by again using a series of cards, writing down the feeling states (angry, happy, confused, ashamed, sad, embarrassed, trustful, and others). These cards were routinely used for some six months, enabling her not only to clearly relate feelings to events or experiences but also to honour the feelings and try and make sense of them. The cards were particularly useful when she disclosed to us that she felt confused about her sexual preference. Over time, she developed a repertoire of language for her feelings and came to rely less on the cards.

## Addressing Family and Wider System Issues

Throughout the first eighteen months of the individual therapy, Lianna continued to exhibit difficult and at times disturbing behaviour, including some brief experimentation with drugs and alcohol. An important focus for us was to address her transition to high school, which took place only four months after therapy started. All things considered, she coped reasonably well, despite difficulties making friends. She struggled with the academic work, due in part to the disruptions to her learning in late primary school. Of significance is that while she continued to talk of suicide to us from time to time for the first six to eight months, she did not make threats at high school. The school counsellor was aware of our involvement and could call on us if required.

Throughout the therapy and particularly in the first eighteen months, regular sessions were held with various family members. A number of whole family sessions focused on issues including sibling relationships, and management of behaviour and relationship difficulties. Regular review sessions were held with Lianna's mother, who took primary responsibility for parenting in the family. As happens in many families, she bore the brunt

of much of Lianna's anger and despair. This was particularly the case when she began to openly struggle with issues relating to her natural mother and being abandoned as a baby. Throughout the therapy, Lianna's mother was supportive of the process, encouraged her daughter to hang in there when the going was tough and overall, she managed Lianna and her behaviour in a sensible and matter-of-fact way. In particular, it was a great relief to Lianna that when she told her mother of her confusion about her sexuality, her mother gave her a very clear message that it did not matter to her, as long as Lianna could be happy.

## **Managing Suicidal Thoughts and Plans**

Safety is of primary importance in any therapeutic context and threats of suicide from Lianna were commonplace in the early stages of therapy. She had already made one attempt on her life which resulted in a hospital admission. While threats were made and she did engage in risk-taking behaviour, no further hospital admissions have been required during the three years of therapy to date. Of the many issues needed to be dealt with, suicidal thinking and behaviour in a young person is one of the most nerve-racking and challenging for therapists to manage. Finding a balance between taking the threats seriously, and not reinforcing suicidal behaviour with attention was a fine balance to achieve and one we agonised over during the course of the work with Lianna. Collaboration with Lianna's family, having safety precautions in place at home, and discussion of suicidal feelings and plans in sessions combined to ensure as many precautions as possible were taken to enhance Lianna's safety. It was at these times that she was very uncommunicative and so discussion, as on many other occasions, sometimes took the form of speculation and story telling between the two therapists, with Lianna acting more as an observer. As the therapy process continued, threats of suicide became less and less frequent and her confidence in her ability to manage despairing and depressing thoughts in a less dangerous way increased.

## **The Life Line: A Visual Tool in Therapy**

In this article it is inappropriate to reproduce the Life line Lianna has developed. However, developing the Life line is an interesting exercise and readers might like to take an opportunity to develop their own.

Take a (very!) long piece of paper and on it draw a line, marked off from birth to your current age. Make sure to extend the line to represent the years not yet reached. Contemplate the Life line and begin by marking off the important events that have occurred in your life. These might include: being born, starting school, moving house, getting a pet for the first time, a sibling accidentally setting fire to the shed, parents separating, starting a first job, first serious relationship, and so on. Once this is done, go back over the Life line and mark all the major achievements you have had during the course of your life. Start with learning how to walk and other major devel-

opmental tasks, which we all achieve but often forget about. Then answer the following questions:

Of which achievement(s) have you been most proud, and why?

Which is the achievement most acknowledged by those around you?

Which achievement were you most proud of but its importance was not apparent to others?

The use of a Life line is based upon the 'timeline' concept (Suddaby and Landau, 1998; Stanton, 1992). Its use in the therapy came about as a direct result of looking for a way to represent visually the journey Lianna had made over her lifetime. The original aim of the Life line was for her to be able to identify achievements and events in her life and to mark these on a chronological chart so she might be able to share these safely with others. The purpose of the Life line has since changed, with its focus incorporating other important issues. These have included aspects of Lianna's early years which, up to two years ago, she would refuse to acknowledge.

The Life line, now many metres long and laminated, has become a representation of the integration of her early experiences of life in an overseas orphanage with her life experiences, both positive and negative, since her adoption by an Australian family. Lianna has essentially been in charge of this process including all of the writing on the Life line, with the therapists guiding the process through the use of speculative and other questions about her life.

The process of using the Life line has not followed any deliberate order and particularly, no chronological order. Rather, Lianna has used it as a reflection of what issues are most important for her each time the Life line is employed.

Issues included on the Life line and addressed in therapy have included her birth name and birthday, her biological and adoptive parents, puberty and menstruation, having a glass eye, coming to Australia, moving from the 'baby's house' to the children's orphanage, being physically and sexually abused in the orphanage, moving on to high school, joining air cadets, and becoming House Captain. The fact that her Life line extends into the future, still to be chartered (and charted), gives her a sense of intrigue and anticipation about her future.

Lianna has allowed us to display her work on the Life line in public on two occasions: at the Family therapy Conference in Adelaide in 1997, and for CAMHS colleagues in late 1997. The Life line, as a dynamic process, continues to evolve, and thus appears different at each public showing.

The Life line has given Lianna an opportunity to share publicly with a diverse audience her story of survival and courage, her achievements and her traumas. As a way of promoting her story as a two way process, the audience in the two venues were encouraged to write their comments and thoughts to Lianna in a specially purchased and decorated book. This book was returned to her, unread by the therapists, and she read these comments in her own time at home. Whether to share these writings with the therapists was left for her to decide.

## DISCUSSION

The work with Lianna has highlighted a number of issues for us as therapists.

Milton Erickson (Rosen, 1975) reminds us that the therapeutic approach should be adapted to the client (rather than vice versa) and this was reflected in our work with Lianna over a long period of time. Flexibility and responsiveness to the client's issues and stage of development over the three years of therapy have been crucial. In this case, there have been a number and variety of therapeutic challenges, requiring different approaches. The therapy was informed by a number of therapeutic models, including systemic, solution focused, narrative, cognitive-behavioral, Ericksonian, provocative and psychoanalytic. Our guiding philosophy behind the selection of approach is a belief that people do have resources, strengths and resilience despite adverse life events and experiences. Success in using a range of approaches and techniques is dependent on the therapists' sound knowledge and clinical experience in the use of such models. There were many points in the therapy where a particular approach didn't work and, at those times, post-session discussion led to a change of direction. Co-working enabled the brainstorming and pooling of experience and personal resources, invaluable during the difficult times.

We were constantly reminded of the importance of proceeding at the client's pace. At times, Lianna's progress and willingness to engage around particular issues went at a snail's pace. At other times, particularly later in the therapy, we felt left behind as she spontaneously raised and addressed very difficult and sensitive issues.

We found the initial going in this case very difficult. Not only was Lianna uncommunicative but there was an enormous amount of pressure on us to 'do something'. This was a young person who gave all the signs that she didn't want to be there, who 'sacked' us part way through the therapy, and to whom occasionally we didn't feel we were offering much. There were times in the first twelve to eighteen months where we felt there was no therapeutic goal and that the sessions had begun to flounder. There were other instances where Lianna's behaviour and conversation were challenging and demanding.

We would venture to suggest that if only one therapist had been involved, the therapy might not have continued. The sessions could be very intense and stressful, particularly around the safety issues. Ethnicity and sexuality were also especially challenging. Having two therapists working together, having a gender balance between the therapists, and having the support of another therapist both during the sessions and outside of them was invaluable and, for us, a survival mechanism. It helped that we had worked together for a number of years and knew each other's work very well. It helped that our work was informed by the same models of therapy. It helped that our personal styles were similar. It helped that the organisation for which we work is open and accepting of different styles of therapy and ways of delivering therapeutic service. In the end though, we think we had luck on our side! We hung on in there even when we despaired about

apparent lack of progress. We maintained boundaries and continually modified our expectations and goals to match Lianna's. We kept the sessions in context and never lost our sense of humour, both in the sessions and outside. We often planned for the worst. We were mostly surprised!

Random events in clients' and therapists' lives can and do play an important part in the therapeutic process. The Life line, the visual tool that drew Lianna's experiences together in some coherent form, was used following a discussion with her about presenting her story to a wider audience at the Family Therapy Conference.

Our work with Lianna has also highlighted the importance of harnessing the resilience of those with whom we work (Garmezy, 1985). Like many of the children of the well known Hawaiian Kauai longitudinal study, Lianna has demonstrated how protective factors such as supportive family, school and community resources can promote good developmental outcomes, despite severe adversity early in life (Werner, 1992). It is also our firm belief that Lianna possesses considerable innate resilience that has helped her survive and flourish.

It is very rare for the authors to work together with a young person and their family regularly for over three years. However in retrospect, we believe that in this case, it has been a worthwhile investment of time and resources, despite the contemporary focus upon the need for brief intervention in a climate of high demand and scarce resources. We carefully calculated our total combined time on this case over three and a half years and found the total cost to be approximately the same as a nine day admission to an adolescent inpatient unit. While not discounting the value of admissions (indeed Lianna had had that one admission soon after we met her), as family therapists we believe that longer term therapy for young people with significant risk factors and symptoms is still a good investment, not only for their future but also for the health of the community. Lianna may well seek out further therapy as an adult as she tackles further developmental issues. We would likewise see this as a wise investment in her future.

## References

- Berg, I. and de Shazer, S., 1993. Making Numbers Talk: Language in Therapy. In S. Friedman (Ed.), *The New Language of Change: Constructive Collaboration in Psychotherapy*, NY, Guilford.
- Fraser, M., 1997. *Risk and Resilience in Childhood: An Ecological Perspective*, Washington, NASW Press.
- Garmezy, N., 1985. Stress Resistant Children: The Search for Protective Factors. In J. Stevenson (Ed.), *Recent Research in Developmental Psychopathology*, NY, Pergamon Press.
- Haley, J., 1973. *Uncommon Therapy: The Psychiatric Techniques of Milton Erickson*, MD, NY, Norton.
- Masten, A., Best, K. and Garmezy, N. 1990. Resilience and Development: Contributions from the Study of Children who Overcome Adversity, *Development and Psychopathology*, 2: 425-44.
- Rosen, A. (Ed.), 1975. *My Voice Will Go With You: The Teaching Tales of Milton Erickson*, NY, Norton.
- Rutter, M. and the English and Romanian Adoptees Study Team, 1998. Developmental Catch-up, and Deficit, following Adoption after Severe Global Early Privation, *Journal of Child Psychology and Psychiatry*, 39, 4: 465-476.
- Rutter, M., Andersen-Wood, L., Beckett, C., Bredencamp, D., Castle, J., Groothues, C., Kreppner, J., Keaveney, Lord C., O'Connor, T., and the English and Romanian Adoptees Study Team, 1999. Quasi-

- autistic Patterns following Severe Early Global Privation, *Journal of Child Psychology and Psychiatry*, 40, 4: 537–549.
- Suddaby, K. and Landau, J., 1998. Positive and Negative Timelines: A Technique for Restorying, *Family Process*, 37, 3: 287–298.
- Stanton, M. D., 1992. The Timeline and the ‘Why now?’ Question: A Technique and Rationale for Therapy, Training, Organisational Consultation and Research, *Journal of Marital and Family Therapy*, 18: 331–343.
- Werner, E., 1992. The Children of Kauai: Resiliency and Recovery in Adolescence and Adulthood, *Journal of Adolescent Health*, 13, 4: 262–268.
- Werner, E., 1993. Risk, Resilience and Recovery: Perspectives from the Kauai Longitudinal Study, *Development and Psychopathology*, 5: 503–515.
- Youngblade, L., and Belsky, J., 1990. Social and Emotional Consequences of Child Maltreatment. In R. Ammerman and M. Hersen (Eds), *Children at Risk: An Evaluation of Factors Contributing to Child Abuse and Neglect*, NY, Plenum.

### **Under The Influence**

I hear the dry cough at the gate  
And turn to wonder why it seems  
Children don't sicken any more  
As they did when I was young. Those winters  
Spent breathing under water  
Under the hot sea of bedclothes  
Under the flu ocean  
Under the shivering dark blue shapes of night  
Under the contempt of my touchless father  
And the patient care of my strong mother  
Who you never really knew  
Under the hacking dirt road of the throat  
Under the spell of the rooms  
In their Victorian darkness  
Under the bright dry eye of God.

So Many Rivers, So Much To Learn

**LYNDON WALKER**

3 Wingfield Street Footscray Vic 3011  
walkerl@ocean.com.au