Winnicott, Bowlby and Rogers: The Development Of The Self In Relation To Others

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Abstract:

This thesis explores the subject of homelessness from a psychoanalytic perspective and suggests that the key causal factor in the lives of people who are homeless is trauma in the early environment. The theories of Winnicott, Bowlby and Rogers are critically analysed and compared due to their focus on the significance of the relationship in development and the influence of the external environment. The thesis is divided into four chapters. The first chapter explores the backgrounds and political views of Winnicott, Bowlby and Rogers, their beliefs on the optimal conditions for development, the relationship between the inner psyche and the external environment, and their work with delinquent youths. They contend that every individual has the potential for healthy growth if provided with a nurturing environment and advocate for care of the most vulnerable in society. The second chapter examines the theorists' beliefs on the nature of trauma in the early environment and the impact of this on an individual's mental health. They suggest that impingements and compliance are detrimental to development and lead to defensive exclusion, fragmentation and a lack of self agency. The third chapter looks at Winnicott's, Bowlby's and Rogers' beliefs on the nature of the therapeutic relationship. They describe the ways that the therapist should provide a facilitating environment for the patient to enable them to establish an integrated sense of self. The fourth chapter considers the main themes in my therapeutic work with individuals who are homeless and whether the concepts of Winnicott, Bowlby and Rogers can be beneficially applied to this practical context. This thesis proposes that Rogers' core conditions are crucial to therapeutic work with people who are homeless, but in conjunction with psychoanalytic developmental theories to understand primitive defense strategies and contain transferential enactments. The contribution of this research in the field of psychoanalysis includes the consideration of the traumatic roots of homelessness and the application of Winnicott's, Bowlby's and Rogers' theories to therapeutic work with people who are homeless.

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Introduction:

Stuart Shorter, a homeless man, requested his biography to be written in reverse:

'*Do it the other way round. Make it more like a murder mystery. What murdered the boy I was? See? Write it backwards.*' (Shorter, quoted in Masters, 2006, p. 6)

Homelessness can be defined as 'not having a home', which includes rough sleeping, as well as not having permanent or secure housing, such as staying in a hostel or night shelter (Shelter, 2018). The notion of 'home' involves both physical and psychological elements, such as the provision of shelter, security, comfort, identity and belonging. Responses to homelessness have tended to focus on the physical aspects, rather than considering the complex intrapsychic and psychosocial dynamics, perhaps avoiding the emotional discomfort evoked by seeing a person asleep in a doorway. Campbell (2019b) proposes that considering homelessness from a psychodynamic perspective involves '*entering into the dark spaces of trauma*' and being amongst '*powerful and disturbing projections*.' (p.67) The literature on homelessness ranges across many disciplines: legal (Pickard, 2014), economic, (O'Flaherty, 2012), medical (Williams, 2014), sociological (Parsell, 2011), psychological (Maguire et al., 2014), biographies (Masters, 2006), and memoirs (Orwell, 1933). I have chosen to look at the subject of homelessness from a psychoanalytic perspective. Integral to psychoanalysis is the belief that an individual's identity is significantly influenced by the events of early childhood. In this research, I am proposing that the key contributing factor in the lives of individuals experiencing homelessness is trauma in the early environment.

It could be argued that many people suffer trauma in childhood but do not become homeless. Environmental factors, such as the area where a child lives, the school they attend, one positive relationship with an adult, and the way the trauma is responded to, will all influence longer term consequences (Holmes, 2014). Adshead (2019) observes that most people survive traumatic events, but perhaps it is the cost and quality of survival that differs. The individuals that I work with all have very different histories; yet, the common factor is the experience of trauma in early life and the lack of a secure attachment. This research is important as it helps the reader to understand the traumatic origins of homelessness. It also has potential to support and guide therapeutic interventions with individuals who are homeless.

I plan to explore the theories of Donald Winnicott, John Bowlby and Carl Rogers regarding the development of the self in relation to others. I have chosen these particular theorists due to their focus on the significance of the relationship in development and the impact of this on mental health. They propose that every individual has the potential for growth if provided with a facilitating environment upon which they can depend. Psychological health includes the capacities for awareness, integration, and interdependence. The other aspect of my research concerns the potential application of these theories to my therapeutic work with the homeless and whether they can help to conceptualise presenting issues and guide treatment.

The thesis has been divided into four chapters to critically analyse and compare Winnicott's, Bowlby's and Rogers' main theoretical ideas, alongside considering their relevance to my work with homeless people. Chapter one considers Winnicott's, Bowlby's and Rogers' backgrounds and political beliefs, the environment required for healthy development, views on the inner psyche and external events, and experiences of work with delinquent youths. Chapter two concerns the theorists' beliefs about the origins of trauma in the early environment and the detrimental influence on the infant's developing sense of self, such as the need to defensively exclude experiences. Chapter three examines the theorists' views on the nature of the therapeutic relationship, including the provision of a facilitating environment, working with transference, and the ability to engage in reciprocal relationships. Chapter four draws attention to the current psychotherapeutic literature on homelessness, the main themes in my work with people who are homeless and considers whether the theories of Winnicott, Bowlby and Rogers can be beneficially applied in this context.

I have undertaken a predominantly theoretical dissertation, using research methods which are literature based. I have chosen to not use actual case studies, due to the ethical issues involved. Instead, I have constructed composite case studies to illustrate the work, which are based on my experiences of working with homeless people. My research is based on original writings, secondary literature, as well as subsequent developments of these theories. I have found comparative literature on Winnicott and Bowlby, Bowlby and Rogers, and Winnicott and Rogers. I have been unable to find literature that compares all three theorists. I have utilised literature on psychotherapeutic work with homeless people, which references the work of Winnicott and Bowlby, but not Rogers. It is notable that Bowlby's

and Rogers' theories have been institutionalised through training programmes, such as psychoanalytic attachment based psychotherapy and person centred counselling. In contrast Winnicott's theories have not been formalised in this way, although the Squiggle Foundation aims to study and disseminate the works of Winnicott, with a particular emphasis on application.

The inclusion of Carl Rogers' theories in psychoanalytic research is unusual, given that he was not a psychoanalyst and not acknowledged by the psychoanalytic community. I propose that Rogers' concepts can be extremely beneficial when working with a marginalised group such as homeless people. At the start of my career, I found I was able to build trusting relationships with individuals labelled as chaotic heroin users, violent offenders and schizophrenics. I believe this was largely attributable to my expression of the core conditions of empathy, acceptance and genuineness. I still find that these conditions are fundamental in building a secure base with my clients. Yet, I am suggesting that the conditions are necessary, but not always sufficient when working with homeless people, as the therapist needs an awareness of internal working models, primitive defences and transferential enactments. In the opening quote, Shorter refers to his younger self as being 'murdered', demonstrating the way that early trauma can be experienced as an annihilation of the self. He requests that his story is told backwards, which has interesting parallels to the nature of psychotherapy itself, where we begin in the present and where the past is retold and reconstructed.

Chapter One:

The Influence of the Environment

Introduction:

Winnicott (1965/2007), Bowlby (1965) and Rogers (1959) all highlight the role of relationships in early development, yet they approach the subject from very different theoretical positions. This chapter will explore Winnicott's, Bowlby's and Rogers' backgrounds and political beliefs, their ideas about the optimal conditions for development, the nature of the relationship between the inner psyche and external events, and their experiences of work with delinquent youths. Winnicott and Bowlby share similarities in terms of their backgrounds, but differ in their positions on the relationship between the inner psyche and external events. Rogers rejected psychoanalytic techniques, establishing the person centred counselling movement and referring to the individuals he worked with as 'clients' rather than 'patients'. Yet, he shares with Winnicott and Bowlby the belief that empathic responsiveness in the early environment facilitates an individual to develop an integrated and autonomous sense of self. The conditions for healthy development are also the basis for psychotherapy; these conditions could be seen as particularly relevant for people who have experienced trauma in the early environment, such as individuals who are homeless.

Winnicott (1984/2000), Bowlby (1953/1971) and Rogers (1977) applied psychotherapeutic thinking to social and political issues, advocating for a more compassionate society which supports its vulnerable members. Similarly my work involves the utilisation of psychological thinking to the social issue of homelessness. Winnicott's, Bowlby's and Rogers' theories developed from their experiences of working with delinquent youths, children and families. They claimed that delinquent behaviour was caused by psychological problems originating in the early environment. I suggest that comparisons can be drawn between delinquent youths and homeless individuals, such as using primitive defenses to manage psychic pain and the need for an environment which can physically and emotionally contain them. Winnicott's, Bowlby's and Rogers' beliefs and experiences will be explored under the four headings: home is where we start from, the environmental factor, external events and inner psyche, and work with delinquent youths.

Home is where we start from:

Donald Winnicott, born 1896, was a British paediatrician and psychoanalyst (Phillips, 1988). John Bowlby, born 1907, was a British psychiatrist and psychoanalyst (Holmes, 2014). Carl Rogers, born 1902, was an American psychologist and psychotherapist (Thorne, 1995). In terms of backgrounds, Winnicott and Bowlby had many similarities, in contrast to Rogers, who grew up in the American Midwest on his parents' farm; Rogers initially went to university as an agricultural student, before transferring to theology, and then psychology (Kirschenbaum, 2007). Winnicott and Bowlby both studied medicine at Cambridge, showed an admiration for Darwin and Freud, had experienced analysis with Joan Riviere, but did not become part of the Kleinian group (Issroff, 2005). They both emphasised the importance of the mother-infant bond, and consequently were criticised for wanting to constrain women to the home (Holmes, 2014). Yet, Winnicott (1965) and Bowlby (1965) contend that the healthy development of an infant is not just reliant on the mother, but supported by the father, extended family, and society*:*

> The mother is able to fulfil this role if she feels secure; if she feels loved in her relation to the infant's father and to her family; and also feels accepted in the widening circles around the family which constitute society. (Winnicott, 1965/2006, pp. 3 – 4)

Winnicott and Bowlby knew of each other's work, whereas I have not found any literature indicating they were aware of Rogers' practice, or that he was aware of theirs. This could be attributed to the fact that Winnicott and Bowlby were members of the British Psychoanalytic Society, whereas Rogers did not train as a psychoanalyst and was based in the United States (Kirschenbaum, 2007).

Despite the similarities, there were significant differences in Winnicott's and Bowlby's theoretical stances and positions within the British Psychoanalytic Society. Bowlby's ideas were considered too divergent for psychoanalytic application, whereas Winnicott's, whilst not fully comprehended, were seen as more orthodox and significant (Issroff, 2005). Issroff (2005) has personal recollections of working with both men; she describes Winnicott as spontaneous, imaginative and playful, compared to Bowlby who was reserved, rational, and objective. According to Issroff (2005), Winnicott was not in favour of Bowlby's membership of the British Psychoanalytic Society and critical of his work. Winnicott (1954/1987, pp. 65-66) wrote directly to Bowlby to express his concerns that Bowlby's work, on the dangers of

small children's separation from their mothers, was being used to close day nurseries. Yet regardless of their differences, Bowlby and Winnicott worked together at the British Psychoanalytic Society; Bowlby acted as Deputy President to Winnicott from 1956 to 1961 (Holmes, 2014). Winnicott (1984/2000) later acknowledged, '*John Bowlby has done more than one man's share of drawing the world's attention to the sacredness of the early holding situation and the extreme difficulties that belong to the work of those who try to mend it*.' (pp. 225-6) Bowlby did not make many explicit references to Winnicott in his work, though when he retired from the Tavistock Institute, he claimed that Winnicott had been of great importance to him (Issroff, 2005). Bowlby declared, in an interview near the end of his life, '*I always held the view that Winnicott and I were singing the same tune. We were essentially giving the same message, but again he didn't like my theoretical ideas.*' (Bowlby, 1990, quoted in Hunter, 1991, p. 170)

Winnicott, Bowlby and Rogers wanted their ideas to be accessible to a wide audience and tried to disseminate their knowledge to the public (Issroff, 2005; Kirschenbaum, 2007). They shared an ideal of a more benevolent society. Bowlby was a committed Socialist, who believed the government should protect the functioning family and provide support for the vulnerable in society (Issroff, 2005). The World Health Organisation commissioned Bowlby (1953/1971) to produce a report on the mental health of homeless children in Europe, '*The proper care of children deprived of a normal home life can now be seen to be not merely an act of common humanity, but to be essential for the mental and social welfare of a community.*' (p. 239) Similarly, Winnicott believed society should support the family, but without being intrusive and controlling (Issroff, 2005). Winnicott (1986/1990) contended that it was ordinary good homes which provided the setting to establish an inherent democratic factor, '*a stable home not only enables children to find themselves and to find each other, but also makes them begin to qualify for membership of society in a wider sense*.' (pp. 248) Bowlby and Winnicott were both involved in the post war development of the Welfare State, the 1948 Children Act, and the expansion of psychiatry (Issroff, 2005). Despite his criticisms of Bowlby, Winnicott (1989/1992) did appreciate, '*the specific trend in Dr Bowlby which makes him drive on towards a translation of the psycho-analytic findings of the past half-century into social action.*' (p. 423) Rogers promoted the notion of democracy, not just in therapy, but in all relationships (Kirschenbaum, 2007). In later years, he utilised the person-centred approach for cross-cultural communication and conflict resolution (Kirschenbaum, 2007). In his book, '*On Personal Power: Inner Strength and Its Revolutionary Impact*', Rogers (1977) explores the potential of the person-centred

approach in resolving disputes in marriage, education, industry, intercultural tensions, and work with oppressed groups. The emphasis on society providing a facilitating environment, especially for the vulnerable and traumatised, provides a pertinent link to my work with homeless people.

The Environmental Factor:

Winnicott (1965/2007), Bowlby (1969/1997) and Rogers (1959) believe that infants have an innate tendency towards psychological growth and the capacity to achieve healthy development if the appropriate conditions are provided. Winnicott (1965/2007) contends that these conditions need to be present from the beginning of an infant's life, highlighting the role of the relationship prior to an infant developing an awareness of others. In contrast, Rogers (1959) suggests that an infant is not affected by the environment until they develop a conscious sense of self and are able to recognise they are different from others. Bowlby (1944), similarly, states it is only deprivation suffered after the age of six months that affects the child's capacity to invest emotionally in others, due to the emerging awareness of dependence on the mother. Prior to this, the infant is dominated by instinctual needs and impulses, which are experienced as more immediate, powerful and real than the person meeting these needs (Issroff, 2005). Bowlby (1944, p.112) highlights the need for more research into the first eighteen months of an infant's life to explore this further. Winnicott, Bowlby and Rogers contend that early development has crucial long term consequences for an individual's psychological health and ability to interact effectively with the world. They all agree that psychological health includes developing the capacities for empathy, awareness, integration and reciprocal relationships:

> a sign of health in the mind is the ability of one individual to enter imaginatively and accurately into the thoughts and feelings and hopes and fears of another person; also to allow the other person to do the same to us. (Winnicott, 1986/1990, p. 117)

Winnicott (1965/2007) famously declared, '*There is no such thing as an infant'*, which he clarified as meaning, '*whenever one finds an infant one finds maternal care, and without maternal care there would be no infant.*' (p. 39) Initially the infant is in a state of unintegration and absolute dependence, as he does not have a self which is separate from maternal care (Winnicott, 1965/2007). The infant must experience omnipotence and an

undisturbed '*continuity of being*' (Winnicott, 1965/2007, p. 47) for healthy ego development and the process of integration (Winnicott, 1958/1992). The '*good enough mother*' experiences a temporary state of '*primary maternal preoccupation*', where she identifies and merges with the infant (Winnicott, 1965/2007, p. 57, p. 85). This enables her to provide almost perfect adaption to the infant's needs, creating the illusion of omnipotence for him. Reliable holding of the infant must be present from the start, '*The term 'holding' is used here to denote not only the actual physical holding of the infant, but also the total environmental provision*' (Winnicott, 1965/2007, p. 43).

Physical and psychological 'holding' protects the infant from the impact of impingements or failures in the environment, until they are ready to be introduced at a manageable pace (Winnicott, 1965/2007). The mother provides the mirror-role for the infant's development, '*What does the baby see when he or she looks at the mother's face? I am suggesting that, ordinarily, what the baby sees is himself or herself.'* (Winnicott, 1971/1974, p. 131) The mother reflects back the infant's inner states in ways that are manageable and contained. The infant is viewed in a way that affirms his sense of self and existence as a whole, rather than a set of parts, '*When I look I am seen, so I exist.'* (Winnicott, 1971/1974, p. 134) In healthy development, the environment is introjected and the infant achieves '*unit status'*, feeling like an individual in his own right and having a sense of self located in his body (Winnicott, 1965/2007, p. 44). Winnicott states, *'the mental health of the individual is being laid down from the very beginning by the mother who provides what I have called a facilitating environment*' (Winnicott, 2002, p. 25).

Bowlby (1969/1997), like Winnicott, believes infants are dependent on the environment for protection and care. In contrast to Winnicott, Bowlby utilises the ethological concept of the attachment system to explain the nature of interactions between infants and caregivers. The attachment system is biologically driven, directing behavioural responses to increase the individual's ability to survive and reproduce. The attachment system monitors for events '*which indicate the presence of potential danger and stress (internal or external), and those concerning the whereabouts and accessibility of the attachment figure*.' (Bowlby, 1969/1997, p. 373) Danger or stress will trigger '*attachment behaviour***'**, defined as '*the output of a safety-regulating system*', which protects the infant from harm and increases a sense of security (Bowlby, 1969/1997, p.375). Similar to Winnicott's holding environment, the 'set goal' of attachment is protection, achieved through proximity to the caregiver (Holmes, 2014). Bowlby describes two types of attachment behaviour, 'signalling', such as

crying or grasping to bring the parent to the child, or 'approach', where the child moves physically closer to the parent. The care giver needs to be physically accessible and emotionally responsive, willing to '*act as comforter and protector*' (Bowlby, 1973/1998, p. 234). These reassuring responses reduce the infant's distress, allowing the attachment system to switch off (Bowlby, 1973/1998).

The term 'secure base' denotes an attachment figure who can be relied upon to provide comfort and protection when needed (Bowlby, 1988/2005). Children are only confident to explore unfamiliar territory if they can seek out their secure base at times of threat, illness, or separation. A child needs a secure base from which they can venture into the world, but which they can return to knowing they will be welcomed, comforted and nourished (Bowlby, 1988/2005). Bowlby agrees with Winnicott that a child will move away from his parents with growing independence, but the ability to return to them makes '*excursions'* part of healthy growth, rather than a disturbance (Winnicott, 1986/1990, p. 135). Bowlby (1988/2005) states, '*All of us, from the cradle to the grave, are happiest when life is organised as a series of excursions, long or short, from the secure base provided by our attachment figure(s).*' (p. 69) Bowlby's concept of a secure base can be seen as one of the most significant elements in work with people who are homeless, who appear to have lacked security in their early lives, resulting in the need to establish a sense of safety in the therapeutic relationship.

Rogers (1959), like Winnicott, states that from birth the infant has an inherent actualizing tendency, *'to develop all of its capacities in ways which serve to maintain or enhance the organism'* (p. 196). The actualizing tendency is a biological instinct to survive, as well as an inclination to adapt, grow and fulfil inherent possibilities (Bohart, 2007). This includes establishing the organism for optimal functioning and movement towards integration:

> the human infant is seen as having an inherent motivational system (which he shares in common with all living things) and a regulatory system (the valuing process) which by its "feedback" keeps the organism "on the beam" of satisfying his motivational needs. He lives in an environment which for theoretical purposes may be said to exist only in him, or to be of his creation. (Rogers, 1959, p. 222)

The young infant does not perceive themselves as being separate from the rest of the world, they do not distinguish between 'me' and 'not-me' experiences, which is like Winnicott's stage of absolute dependence (Cooper, 2007, p.79). Instinctively, the infant engages in an organismic valuing process, which has as its reference the actualizing tendency, '*Experiences which are perceived as maintaining or enhancing the organism are*

valued positively. Those which are perceived as negating such maintenance or enhancement are valued negatively.' (Rogers, 1959, p. 222) The organismic valuing process ensures satisfaction of the infant's needs and supports development. Rogers (1959) notes that during the development process, there is a transition to experiences becoming '*symbolised in an awareness of being'* (p. 223); the infant starts to experience himself as a 'self', who is individual and distinct from others. In contrast to Winnicott's emphasis on the significance of relationships from the beginning of life, Rogers' theory of actualization has been criticised for its description of an autonomous and individualistic development of self (Bohart, 2007). Rogers focuses on the infant's tendency to develop without acknowledging their dependence on others and the impact of relationships, where the infant may have their needs met to further or lesser extents.

Winnicott (1965/2007) contends that the infant moves through a transition from absolute to relative dependence. In relative dependence, the infant becomes aware of their dependence on maternal care through the process of disillusionment (Winnicott, 1965/2007). The good enough mother introduces '*graduated failure of adaption*' (Winnicott, 1958/1992, p. 246), where the infant's needs are not always predicted or met immediately. The infant realises the mother is separate, beyond omnipotent control, and develops a sense of independence through her slowly moving away (Grolnick, 1990). Winnicott (1965/2007) states, '*A further development is the capacity for object relationships. Here the infant changes from a relationship to a subjectively conceived object to a relationship to an object objectively perceived.*' (p. 45) The infant needs a combination of 'me' and 'not-me' experiences, whilst still being supported and contained in a reliable, safe, understanding environment (Grolnick, 1990).Transitional phenomena and objects, such as a '*bit of cloth*', help to facilitate the move from the subjective to the objective, from being merged to being separate from the mother (Winnicott, 1971/1974, p. 4).

Transitional objects provide a connection between the inner and outer words; it is the first 'not-me' object, which the infant discovers and creates its meaning from their imagination (Winnicott, 1971/1974). Winnicott states, '*The infant assumes rights over the object…It must never change, unless changed by the infant. It must survive instinctual loving, and also hating*' (Winnicott, 1971/1974, pp. 5-6). The object is not forgotten or internalised, but simply loses meaning; transitional phenomena become '*spread out over'* the cultural field (Winnicott, 1971/1974, p. 6). The third stage of development is described as towards independence, with emphasis on the continuing interplay between dependence and

interdependence (Winnicott, 1971/1974). Increasingly, the child has a capacity for autonomy, which results from internalised memories of caregiving and confidence in the facilitating environment (Davis & Wallbridge, 1981). The capacity for interdependence has particular relevance in work with homeless individuals, who appear to have lacked an environment upon which they could depend, hindering internalisation of self-care skills and the development of a competent sense of self (Williamson, 2018).

Bowlby (1973/1998), in contrast, believes the infant's brain seeks to make sense of experience to anticipate, manage, and negotiate it, as well as achieve set goals. This is accomplished through constructing a cognitive model of the environment, based on previous experiences of the world and envisioning ways it may function in the future. Bowlby (1973/1998) notes, '*In the working model of the world that anyone builds, a key feature is his notion of who his attachment figures are, where they may be found, and how they may be expected to respond.*' (p. 236) An individual's working model allows him to recognise patterns of interaction with the caregiver, so he can predict their future responses (Bowlby, 1973/1998). Infants develop beliefs about their own worthiness and acceptability, based on others' capacity to provide care and protection. These beliefs become a template for the future, *'adult personality is seen as a product of an individual's interactions with key figures during all his years of immaturity, especially of his interactions with attachment figures*.' (Bowlby, 1973/1998, p. 242) Secure attachment strategies develop when caregivers are consistently available and sensitively respond to the infant's communication; this leads to attunement between the caregiver and infant, which is comparable to Winnicott's notion of maternal responsiveness (Holmes, 2014). Bowlby (1969/1997) contends that an individual who has experienced reliable and responsive caregiving will approach the world with confidence, resilience, a sense of worth and a positive model to build future relationships, '*So deeply established are his expectations and so repeatedly have they been confirmed that, as an adult, he finds it difficult to imagine any other kind of world*.' (Bowlby, 1973/1998, p. 242)

Rogers (1959) proposes that with growing awareness, the infant begins to build a view of themselves as they experience the world and are evaluated by others, which becomes the self-concept. The self-concept is comprised of beliefs, providing a framework to organise and understand experience, as well as relate to others, which can be seen as equivalent to Bowlby's internal working models (Tolan, 2003). Rogers (1959) states, *'all perception (and I would add, all awareness) is transactional in nature, that it is a construction from our past*

experience and a hypothesis or prognosis for the future.' (p. 198) The awareness of self, or consciousness, also leads to the infant's emerging need for 'positive regard', which is seen as attitudes of *'warmth, liking, respect, sympathy, acceptance*' and '*making a positive difference in the experiential field of another*.' (Rogers, 1959, p. 208) The need for positive regard could be seen as equivalent to the need for attuned parenting, yet in a direct challenge to Winnicott and Bowlby, Rogers (1959) states, '*Some writers have looked upon the infant's need for love and affection as an inherent or instinctive need. Standal is probably on safer ground in regarding it as a learned need.*' (p. 208) The learned need for positive regard moves to an overriding concern for the child, even at the expense of experiences which favour the actualizing of the whole organism (Rogers, 1959).

Unconditional positive regard is to feel '*prized*' or '*accepted*' by another, where the individual feels valued as a whole person, irrespective of different values placed on specific behaviours (Rogers, 1959, p. 208). A child who experiences unconditional positive regard in relation to all of their self experiences is able to respond to their organismic needs. Rogers (1959), similar to Winnicott and Bowlby, emphasises the importance of an accepting mother, who acknowledges and values her child's emotions, facilitating integration. Positive regard must be experienced from others at first, but this leads to *'a positive attitude toward self which is no longer directly dependent on the attitudes of others*.'(Rogers, 1959, p. 209) A child who feels prized develops congruence, which is described as being '*integrated, whole, genuine*' (Rogers, 1959, p. 206) Rogers (1959) saw congruence as a state of psychological health and later developed this idea into his definition of the fully functioning person, '*Optimal psychological adjustment is thus synonymous with complete congruence of self and experience, or complete openness to experience*.' (p.206) Winnicott, Bowlby and Rogers share the belief that healthy development includes the capacity for integration and awareness, alongside the need for internalization of actual good experiences, which are Winnicott's good object, Bowlby's secure base, and Rogers' positive regard.

External Events and Inner Psyche:

Winnicott (1958/1992), Bowlby (1973/1998) and Rogers (1959) agree that external events influence the inner psyche, but hold different views on the nature of this interaction.

Winnicott believes there is a constant interaction between external events and the inner psyche, including innate instinctual drives, where they influence and shape each other. In contrast to Winnicott, Bowlby and Rogers emphasise the role of actual external events directly forming the inner psyche, dismissing the role of the unconscious and fantasy (Reeves, 2005). Bowlby's work was met with disdain by the British Psychoanalytic Society, criticised for the utilization of different disciplines, such as ethology, and the emphasis on the external environment, rather than the inner psyche (Fonagy, 2001; Holmes, 2014). Bowlby (1940) proposes that the external nature of care is fundamental to a child's mental health, stating, '*It seems to me to be as important for analysts to make a scientific study of early environment as it is for the nurseryman to make a scientific study of soil and atmosphere.*' (p. 155) An individual's internal world is an accurate reflection of their past or present experiences in the external world, '*If a child sees his mother as a very loving person, the chances are that his mother is a loving person. If he sees her as a very rejecting person, the chances are she is a very rejecting person.*' (Bowlby, Figlio, & Young, 1986, p. 43) Winnicott responded to Bowlby's papers with disparagement, believing that he dismissed the importance of the child's internal disposition and intra-psychic processes (Reeves, 2005). Winnicott (1989/1992) states, '*Dr Bowlby is talking as if there is no such thing as fantasy in early infancy…Unconscious conflict seems to have no place in Bowlby's psychology*' (p. 431). Winnicott (1989/1992) comments that Bowlby does not seem aware of the disillusionment process and transitional objects, thus neglecting the issue of infants who have not had the opportunity to become integrated at any stage.

Bowlby (1973/1998) believes that the actual experience of maternal provision influences the child's inner world, rather than innate instinctual dispositions. However, it could be seen as unfair to say that Bowlby is only interested in the external environment, as he develops the concept of internal working models, which explores concepts of distortion, denial, and suppression within the inner psyche (Issroff, 2005). According to Reeves (2005), Winnicott adopts a stance between Klein and Bowlby, believing it is the ways the infant subjectively responds to the type of care that is of most significance for analysts. Winnicott does not accept the instinct-dominated view of Klein that the infant's initial relationship with the mother is principally oral in nature (Reeves, 2005). Reeves (2005) notes, unlike Bowlby, Winnicott is not willing to diminish instinctual elements to promote the environmental factor. Winnicott (1958/1992) believes there is a constant interchange between the internal and external worlds:

> the inner reality is always being built up and enriched by instinctual experience in relation to external objects and by contributions from external objects (in so far as such contributions can be perceived); and the outer world is constantly being perceived and the individual's relationship to it being enriched because of the existence in him of a lively inner world. (p. 61)

Winnicott's contention with Bowlby seems to be that Bowlby's presentations of the internal world as a stage where the child's external conflicts are enacted is lacking, and that it would be better to view the psyche as a vessel in which character, dispositions, and behaviour merge with instinctual elements (Reeves, 2005).

In contrast to Winnicott and Bowlby, Rogers was not psychoanalytically trained and largely rejected psychoanalytic practices (Thorne, 1995). Rogers found a number of difficulties with psychoanalysis, including the emphasis on past repressed material and the minimization of the importance of the existing environment (Kirschenbaum, 2007). Rogers (1959), like Bowlby, believes it is a child's actual experiences of the environment which shapes the development of the self. All individuals are born with an inherent actualising tendency, for Rogers (1959), which can either be supported or constrained by the environment. Rogers (1980) uses an analogy of his family's winter supply of potatoes, which were kept in the basement but still grew towards the light, to illustrate the way that the directional tendency is apparent even in adverse circumstances:

> The conditions were unfavourable, but the potatoes would begin to sprout… Life would not give up, even if it could not flourish. In dealing with clients whose lives have been terribly warped, in working with men and women on the back wards of state hospitals, I often think of those potato sprouts. So unfavourable have been the conditions in which these people have developed that their lives often seem abnormal, twisted, scarcely human. Yet the directional tendency in them can be trusted. (Rogers, 1980, pp. 118-9)

Roger's, in this quote, can be interpreted as advocating for the potentiality of forgotten, damaged individuals. Winnicott, Bowlby and Rogers appear to share an optimistic view of people, which can be seen as especially useful for work with disturbed individuals, often considered beyond help, such as those who are homeless. Rogers does not view the self as a psychic mechanism that drives the organism, but rather as a conceptual map that the organism develops in order to help it manage and adapt (Bohart, 2007). Each person has a belief of who they are, dependent on thousands of past experiences, as well as future interactions (Rogers, 1959). Rogers' theory has been criticised for ignoring the fact there may be other determinants to behaviour, such as the unconscious libidinal and aggressive instincts (Thorne, 1995). Rogers notes in his experience of psychotherapy, he has not found man to be inherently hostile, destructive or antisocial, '*he is a basically trustworthy member*

of the human species, whose deepest characteristics tend toward development, differentiation, co-operative relationships' (Rogers, 1990/1998, pp. 404-5).

<u>Work with Delinquent Youths:</u>

Winnicott (1984/2000), Bowlby (1940) and Rogers (1939) worked with delinquent youths, which they claim had an impact on their understanding of the role of the environment in the development of the self. Winnicott's and Bowlby's work in residential environments can be seen as directly comparable to my work within a hostel for homeless people, which will be explored in chapter four. Winnicott, Bowlby and Rogers suggest that delinquency should be treated as a psychiatric problem, rather than through the criminal justice system; believing the disturbance to be a result of trauma, caused by problems in the relationship between parent and child. Winnicott and Bowlby claim there is a connection between loss of the mother in early childhood and the child's subsequent psychological problems and anti-social behaviour (Reeves, 2005). In 1939, they joined together with Emmanuel Miller to write to the British Medical Journal to declare the dangers of evacuating small children without their mothers, '*It can in fact amount to an emotional 'black-out', and can easily lead to the disturbance of the development of the personality which may persist throughout life.*' (Bowlby, Miller, Winnicott, in Winnicott, 1984/2000, p. 14) Rogers (1939) observes that a number of factors can influence a child's problematic behaviour, such as hereditary, family, and cultural. Similar to Winnicott and Bowlby, Rogers acknowledges that the family is the most significant influence and '*parental rejection*' is closely associated with the amount of problem behaviour the child is exhibiting and the degree to which it can be treated (Rogers, 1939, p.8). Rogers (1939) states, '*Furthermore the home that is broken, whether by death or by marital friction, produces more than its proportion of personality problems in children*' (p. 8). I am going to elaborate on the approaches of these three theorists with two accounts of clinical work with delinquents by Bowlby and Rogers, and an account of Winnicott's clinical consultancy with this pathology.

Bowlby, after graduating from Cambridge, gained employment at a progressive school for maladjusted children (Holmes, 2014). Bowlby (1986) notes his experiences with children at this school had an impact on his career, as they highlighted the potential links between

deprivation and delinquency. One influential encounter involved a withdrawn, detached, adolescent boy, who had been expelled from private school for repeated acts of theft:

> Those in charge attributed his condition to his never having been cared for during his early years by any one motherly person, a result of his illegitimate birth. Thus I was already alerted to a possible connection between prolonged deprivation and the development of a personality apparently incapable of making affectional bonds and, because immune to praise and blame, prone to repeated delinquencies (Bowlby, 1981, quoted in Holmes, 2014, p. 8)

Alongside studies in clinical medicine and psychiatry, Bowlby embarked on training at the British Psychoanalytic Society (Holmes, 2014). In 1936, he started working at the London Child Guidance Clinic as a child psychiatrist, with two psychoanalytically trained social workers, which emphasised to him, '*the real life experiences within the family*' (Bowlby, 1986, p. 37). According to Holmes (2014) these social workers introduced Bowlby to the idea of the transgenerational transmission of neurosis, in which children's problems are seen to be the result of their parent's unresolved childhood issues. Bowlby (1940) in his paper, 'The influence of the environment in the development of neuroses and neurotic character', identifies links between delinquency and rupture of the child's bond to his mother, and a correlation between the nature of separation and the severity of the child's maladjustment (Reeves, 2005). Bowlby (1940) states, '*Prolonged breaks during the first three years of life leave a characteristic impression on the child's personality…Since they are unable to make genuine emotional relations, the condition of a relationship at a given moment lacks all significance for them.*' (p. 158)

After the war, Bowlby (1944) in his paper, 'Forty Four Juvenile Thieves: Their Characters and Home Lives' presents an examination of forty four delinquent cases, connecting their symptoms to histories of maternal deprivation and separation. Bowlby describes a child, Florence, who had been separated from her mother in hospital for a prolonged period of time. Despite regular visits, Florence gradually lost interest in her parents and did not recognise them. Upon her return home, she was very upset, would not settle, and displayed affectionless characteristics including, *'lack of attachment to her parents…frequent wandering away, drifting heedlessly amongst the traffic…an irrational aggressiveness to other children and habitual pilfering from her mother and the neighbouring sweet-shops.' (*Bowlby, 1944, p. 112) Bowlby (1944) identifies five factors in the development of delinquent characters: genetic factors; early and prolonged separation from the mother; an ambivalent, hostile or anxious mother; a father who dislikes the child; traumatic experiences, such as illness and death of close relatives. In the majority of the cases, more

than one of these factors is present. Affectionless delinquents appear to lack emotions and are prone to persistent stealing and disruptive behaviour, '*A child separated from his mother comes to crave both for her love and for its accompanying symbols and this craving, if unsatisfied, later presents itself as stealing*.' (Bowlby, 1944, p. 121) Stealing is motivated by a desire to make up for something lost, but also by a desire to cause hurt and loss to others (Bowlby, 1994). The affectionless children lack the usual inhibition of libidinal and aggressive impulses; they are unable to form and maintain personal relationships, due to an inability to feel or express love (Bowlby, 1944). Bowlby (1944) contends:

> it may be concluded that the socially satisfactory behaviour of most adults is dependent on their having been brought up in circumstances, fortunately common, which have encouraged or at least permitted the satisfactory development of their capacity to make object-relationships. (p. 125)

Bowlby's subsequent work on attachment led him away from the subject of delinquency; however there has been research by others on the links between insecure attachment strategies and offending behaviour (Ansbro, 2008).

In 1928, Rogers accepted a position with the Child Study Department of the Rochester Society for the Prevention of Cruelty to Children (Thorne, 1995). Rogers worked with delinquent, maladjusted and highly deprived children, who were referred for psychological diagnosis and treatment (Kirschenbaum, 2007). The children presented with severe problems including stealing, lying, bed wetting, truancy, sadism, sex perversions, extreme withdrawal, aggressiveness, and incestuous behaviour. In a case study Rogers describes one of the boys he interviewed, called Dick; he was obsessed with knives, slept with a knife under his pillow, had night terrors, showed sadistic tendencies, cruelty to animals, and teased and pinched other children (Kirschenbaum, 2007). Rogers, like Bowlby, observes links between the boy's home environment and his behaviour:

> Her promiscuity engendered a deep jealously in Dick's father, and his fearful temper storms gave the boy the pattern for his behaviour. The father's cruelty was known throughout the rural neighbourhood, and his almost insane torture of some of the farm animals makes gruesome reading. More than once he threatened to kill his family, and his beatings terrorized the children. (Rogers, 1933, quoted in Kirschenbaum, 2007, p. 64)

Rogers (1939) found that numerous books explained the causes of the children's behaviour, but few described types of treatment for these issues. Consequently, Rogers formulated a new method of diagnosis to thoroughly comprehend the nature of the child's problem.

Rogers' approach considered external and internal factors that could influence the child's behaviour, including: heredity, physical health, mentality, self-insight, family emotional tone, economic and cultural dynamics, social experience, education and supervision. After diagnosis, a case conference would be called for the professionals involved and a treatment plan would be decided. Treatment consisted of three main options: changing the child's living situation, modifying the child's living situation, or direct therapy (Rogers, 1939). Rogers (1939) recommends that the following criteria should be carefully considered before a child's removal from the home: the cause of the child's behaviour, the family situation, the child's affection for the parents, the child's degree of security in the home, the possibility of change in the home, and the placement opportunities available.

Environmental treatment involved the child either being placed in a foster home, moved to another foster home, placed in an institution, or returned to the family home (Rogers, 1939). Rogers (1939) felt punitive and regimented institutions tended to exacerbate a child's emotional problems, rather than reduce them; though he was impressed by institutions that offered individualised treatment to the child and development of their initiative. The option of modifying the existing environment involved work with parents to change their attitudes (Rogers, 1939). Rogers (1939) discovered that for over half the children they assessed, the first step was to provide them with a totally new environment. Dick, the boy referred to in Rogers' case study, was moved to a foster home:

> In Dick's case, as with some of the other boys, the greatest contribution made by the foster home is that of consistent control. Rewards and punishment follow with certainty on the heels of good and bad behaviour. The child's universe comes to have a logic, a reasonableness, which was scarcely discernible in the riotous confusion and fear of the early home life. (Rogers, 1933, quoted in Kirschenbaum, 2007, p. 69)

Rogers (1939) noticed the children's problems would often disappear or drastically reduce in a healthy environment, so determined a child has the motivation to develop if provided with the right conditions. Rogers (1939) contends that there are four qualities shown by foster parents that produce a healthy environment for a child: creative imagination to understand the child's feelings, motivations and behaviours; a consistent viewpoint and discipline, which provides stability, management and reassurance; showing interest and affection, which is crucial for the child's sense of security; finding satisfaction in the child's growing abilities, where they are rewarded for achievement and allowed freedom to gain independence. During his time at Rochester, Rogers' interests moved to intensive psychotherapy, however he remained impressed with the power of environmental therapy,

'*most children, if given a reasonably normal environment which meets their own emotional, intellectual, and social needs, have within themselves sufficient drive toward health to respond and make a comfortable adjustment towards life.'* (Rogers, 1939, p. 274)

In 1939, Winnicott was given the position of Consultant Psychiatrist to an evacuation scheme (during the Second World War), where he was involved in work with anti-social children (Reeves, 2005). Winnicott (1984/2000) claims the significance of the environment was highlighted through observing the benefits of good quality therapeutic care provided in residential hostels for difficult children. Winnicott came to support the provision of small group hostels when a child's needs were not being met adequately at home; whereas Bowlby continued to view separation as harmful, controversially claiming that, '*young children thrive better in bad homes than in good institutions*' (Bowlby, 1953/1971, p. 78). In contrast to Bowlby and Rogers, Winnicott did not work directly with delinquent children, but offered consultation to the hostel wardens (Reeves, 2005). The difficult children had experienced unsettled or inadequate homes prior to evacuation (Winnicott, 1984/2000). Consequently, they did not need substitute homes, but required *'primary home experiences'*, which is, '*an environment adapted to the special needs of the infant and little child, without which the foundations of mental health cannot be laid down.*' (Winnicott, 1984/2000, pp. 57-8)

The aims of the hostel were to provide 'holding', in the form of emotional and physical stability (Winnicott, 1984/2000). The children would go through stages of testing the building and people, before settling down and joining the life of the group. The wardens adopted parental roles, offering reliable care, personal management, and control. Important attributes of the wardens included being considerate, genuine, spontaneous, and consistent. The maintenance of rules and order was crucial to preserve the hostel and the good things it represented, regardless of the children's actions (Winnicott, 1984/2000). Therapeutic hostel provision helped the children to work through developmental issues, so delinquent behaviour ceased:

> hostels for evacuees all over the country succeeded in preventing many children from reaching the courts, thereby saving immense sums of money as well as producing citizens instead of habitual offenders; and from our point of view as doctors, the important thing is that the children…have been recognised as ill. (Winnicott, 1984/2000, p. 76)

Winnicott (1984/2000) was concerned about the lack of provision for anti-social youths when hostels were closed after the war. He continued to offer consultation to residential institutions, such as the Cotswold Community, throughout his career (Bradley, 2018)**.**

Winnicott (1984/2000) believes there is a direct connection between the antisocial tendency and deprivation, stating, *'psychoanalysis needs Bowlby's emphasis on deprivation, if psychoanalysis is ever to come to terms with this special subject of the antisocial tendency.*' (p. 125) The term deprivation refers to any physical or psychological rupture that happens at a significant time during childhood, not just a physical absence or withdrawal of care (Reeves, 2005). Winnicott (1984/2000) distinguishes between concepts of 'privation' and 'deprivation':

> When there is an antisocial tendency there has been a true deprivation (not a simple privation); that is to say, there has been a loss of something good that has been positive in the child's experience up to a certain date, and that has been withdrawn; the withdrawal has extended over a period of time longer than that over which the child can keep the memory of the experience alive. (p. 124)

Winnicott (1984/2000) describes two trends in the antisocial tendency: stealing and destruction. In compulsive stealing, the child is expressing a belief, desire, and reclamation of the early lost object, the unavailable mother. In the act of destruction, the child is seeking the stability from society, which he could not find at home, to stand the strain of his impulsive behaviour (Winnicott, 1984/2000). In contrast to Bowlby, who regards the act of theft as the consequence of maternal separation and unstable lives, Winnicott wants to understand the symbolic meaning of the act of theft (Holmes, 2014). The antisocial tendency is seen as implying 'hope', it is a reaction or protest to the loss of a person who is loved, or the loss of security, which the individual wants to find again; antisocial children experience '*a drive that could be called object seeking*' (Winnicott, 1984/2000, p. 129). Winnicott (1984/2000) warns that if the moment of hope is not responded too, it will lead to the continuation of delinquency and involvement with the criminal justice system, such as borstals and prison. Many individuals who are homeless have spent time in prison; Felix and Wine (2001) note that prisons can be seen as providing structure and containment to the chaotic worlds of homeless people, describing how for one client prison became, '*the closest to home he could realise*' (p.23).

Barbara Dockar-Drysdale attempts to reconcile Bowlby's affectionless youth and Winnicott's anti-social tendency by introducing the concept of the '*frozen child*' (Reeves,

2005, p. 96). She prefers the term '*frozen*', as affectionless sounds final, whilst '*a thaw can follow a frost*' (Dockar-Drysdale, 1958/1993, quoted in Reeves, 2005). The frozen child is described similarly to the affectionless youth, appearing charming, friendly, generous and kind, but also manipulative, destructive, ruthless and apathetic to others (Bradley, 2018). The frozen child has experienced a lack of nurturing and containment at an early stage in infancy. The broken bond with the mother leads to the infant's inner world becoming frozen, as they unconsciously shut down to block out emotional pain. The disturbance occurs when the child is still dependent on the mother; the child adopts radical coping strategies, such as extreme withdrawal or destructive acting out, as attempts to gain control (Bradley, 2018).

The frozen child feels persecuted by the external world, struggles to internalise positive experiences, projects emotions, over-identifies, merges with others, and experiences difficulties maintaining boundaries (Bradley, 2018). The child has not experienced something good which has then been withdrawn; they suffer from privation rather than deprivation (Reeves, 2005). Dockar-Drysdale contends that it is the care giving adult who has to offer the belief of hope and a different outcome, in order for the child to thaw and believe in the possibility of change (Reeves, 2005). Comparisons can be drawn between the characteristics of delinquent youths and homeless individuals, including employing primitive defenses, difficulties maintaining relationships, appearing emotionally detached, and inhabiting positions of estrangement or merger. People experiencing homelessness may also require a 'holding environment', to work through their developmental problems, such as the hostel environment where I am based. I would agree with Dockar-Drysdale rather than Winnicott, in that I have to hold the belief of hope and change for the individuals that I work with, in order for them to believe this is possible.

Summary:

This chapter has examined and compared Winnicott's, Bowlby's and Rogers' beliefs on the conditions that will facilitate growth, the interaction between the environment and inner psyche, and their experiences of working with delinquent children. They share the belief that there is an instinctive tendency in an infant to develop, which is achieved through the provision of a facilitating environment. Winnicott, Bowlby and Rogers can be seen as having a hopeful view of human nature, which is particularly helpful when working with a complex

client group, often deemed as 'untreatable', such as people experiencing homelessness. Winnicott's and Bowlby's notions of good enough parenting, which includes mirroring, attunement, and reliability, can be seen as compatible with Rogers' conditions of empathy, acceptance, and congruence. Maternal attunement supports the infant to manage their emotions and affirms their sense of self, which leads to integration. Winnicott believes that maternal attunements create the illusion of omnipotence for the infant, and it is through graduated failures of adaption that the infant becomes aware of the mother and relates to her as an objective object (Walant, 1995). In contrast, Bowlby believes that maternal responsiveness creates confidence in the infant's ability to seek help and feel connected to the attachment figure (Walant, 1995). Rogers, similar to Bowlby, thinks that it is the prizing responses of the parent which help the child to develop positive regard and enables them to empathise with others. The theorists, early in their careers, discovered a connection between the role of the early environment and delinquent behaviour. I began my career working with homeless people, which similarly influenced my interest in the impact of the early environment. Many of the homeless clients on my caseload describe traumatic experiences in their early lives, delinquent behaviour in childhood such as theft and criminal damage, and are involved in criminal behaviour as adults. In the next chapter I will explore the theorists' views on the nature of trauma in the early environment and the ways this contributes to the development of psychological problems. The notion of trauma in development is central to this research, which proposes that this is the key contributory element in the lives of people who are homeless.

Chapter Two:

Trauma in the development of the self

Introduction:

Winnicott (1965/2007), Bowlby (1973/1998) and Rogers (1959) are agreed that when the optimal conditions for growth are not provided it is distressing and harmful for the infant. This chapter will examine the theorists' beliefs about what constitutes an insufficient facilitating environment and the ways that trauma impacts on an infant's developing sense of self and future mental health. The subject of trauma in development is being explored as this research proposes that early trauma is the most significant factor in the lives of people experiencing homelessness. Winnicott (1965/2007) argues that an insufficient facilitating environment in the stage of absolute dependence has the most catastrophic impact on an infant's development. In contrast, Bowlby (1944) and Rogers (1959) suggest it is only when the child becomes aware of others that an insufficient environment causes damage, failing to comment on the impact of dysfunction in early infancy.

Winnicott, Bowlby and Rogers recognise that trauma leads to denial and exclusion of particular emotions, causing fragmentation of the self. Winnicott (1965/2007) describes this as the individual having to suppress their true self and being unable to live creatively; Rogers (1959) believes this creates an individual who is incongruent and denies their organismic experiencing; Bowlby (1973/1998) states this manifests in multiple internal working models and insecure attachment patterns. In terms of the false self, which hides the true self, and the incongruent self, which disregards the organismic self, Winnicott and Rogers appear to be trying to talk about similar territory; yet the concepts of the true self and organismic self are fundamentally different, as the true self never communicates with the world, must remain separate, and can be known only to the self (Winnicott, 1965/2007). Winnicott's, Bowlby's and Rogers' views on dysfunction can be compared under three main headings: impingements, which concern the nature of the trauma; defences, which concern the infant's responses to trauma; and fragmentation, which concerns the impact on an individual's mental health. Contemporary developments of these theories will also be explored due to the relevance of trauma for individuals experiencing

homelessness.

Impingements:

Winnicott (1958/1992) believes that if there is an absence of a facilitating environment, impingements or failures have a detrimental impact on the infant's omnipotence and '*continuity of being'* (p. 245). An impingement is anything external that impacts upon the infant or an overwhelming inner impulse or need in the infant that goes unmet (Issroff, 2005). The infant is only capable of coping with impingements within the context of ego support from the mother, as the environment is predictable and the mother provides physical and psychological 'holding' (Winnicott, 1965/2007). A lack of ego support or protection means that the environment will impinge upon the infant in a way that is not within the infant's competence, so the infant has to react. The infant's reaction disturbs their '*continuity of personal existence*' (Winnicott, 1958/1992, p. 189), resulting in a temporary loss of identity and a severe sense of insecurity; the infant is unable to recover within an environment that has become adaptive (Davis & Wallbridge, 1981). Winnicott (1989/1992) states, *'Trauma is an impingement from the environment and from the individuals reaction to the impingement that occurs prior to the individual's development of the mechanisms that make the unpredictable predictable.'* (p. 198) Regular reactions to impingements have a detrimental impact on an infant's emotional development; they interfere with the tendency to become integrated, achieve 'in-dwelling' which is an intimate relationship between the psyche and body, and develop a sense of self with a past, present and future (Winnicott, 1958/1992). Winnicott (1958/1992) writes, *'an infant who has no one person to gather his bits together starts with a handicap in his own self-integrating task, and perhaps he cannot succeed, or at any rate maintain integration with confidence.*' (p. 150)

Winnicott (1965/2007) argues that an infant is an immature being, constantly '*on the brink of unthinkable anxiety'* (p. 57), defined as, *'(1) Going to pieces. (2) Falling for ever. (3) Having no relationship to the body. (4) Having no orientation*' (p. 58). A facilitating environment prevents an infant from experiencing such anxieties, whereas failure in holding exposes an infant to these experiences. Trauma implies that there has been a break in life's continuity, so primitive defences have to be employed to defend against a repetition of unthinkable anxiety (Winnicott, 1965/2007). Early environmental failure in the stage of

absolute dependence, where the infant has not yet experienced something good, is termed '*privation*' (Winnicott, 1965/2007, p. 226). The mother's face is not a mirror, but *'reflects her own mood or, worse still, the rigidity of her own defences'* (Winnicott, 1971/1974, p. 131), so the infant does not get back what they are giving and learns, '*my own personal needs must then be withdrawn otherwise my central self may suffer insult.*' (Winnicott, 1971/1974, p. 132)

Maternal failure can result from a mother having an inability to be preoccupied with her infant, or being too preoccupied (Winnicott, 1965/2007). It leads the infant, *'to take over and organize the caring for the psyche-soma*' (Winnicott, 1958/1992, p. 246), taking responsibility for the environment that has failed by becoming self-sufficient (Phillips, 1988). The psyche gets '*seduced*' into the mind, away from the relationship with the soma, leading to a pathological mind-psyche which disavows the body (Winnicott, 1958/1992, p.247). Winnicott believes the nature of the maternal failure influences the type of mental illness that develops; early and intense failures have the most devastating impact on the infant (Winnicott, 1965/2007). Symptoms of fragmentation, dissociation, and loss of contact with reality are the result of early environmental deficiency (Winnicott, 1965/2007). Individuals who are homeless often present with incoherent senses of self, distortions of reality, and estrangement between their minds and bodies, evident in self-harming behaviours; in chapter four, homeless individuals' difficulties with 'in-dwelling' will be explored more.

Winnicott's theory of trauma involves an introspective focus on the impact of the continuity of being; in contrast, Bowlby's observations on trauma are based on the external, objective influence of the environment (Issroff, 2005). Bowlby's (1944,1953/1971) previous research explores the connection between delinquency and broken infant-mother bonds, the impact of separation and loss on children in hospital, and the ways prolonged deprivation effects a child's physical and psychological development. Bowlby (1988/2005) contends an ethological approach explains the issue of separation anxiety, as humans respond with fear to certain situations, *'not because they carry a high risk of pain or danger, but because they signal an increase of risk.*' (p. 33) Situations that threaten the attachment bond trigger behaviours designed to protect it. In times of separation and loss, intense '*attachment behaviour*' is activated, such as crying, clinging and angry coercion (Bowlby, 1969/1997, p.375). In cases when separation is temporary, anger serves the following purposes, '*first, it may assist in overcoming such obstacles as there may be to reunion; second, it may*

discourage the loved person from going away again.' (Bowlby, 1973/1998, p. 286) Separation triggers protest and extreme physiological and psychological distress for the infant; yet, when the affectional bond is restored, distress is soothed and attachment behaviour ends. Bowlby (1973/1998) notes that in cases where the period of separation from the attachment figure is not extensive, children recover their attachment:

> it is common for a child to begin by treating the mother as if she were a stranger, but then, after an interval, usually of hours or days, to become intensely clinging, anxious lest he lose her again, and angry with her should he think he may. (Bowlby, 1988/2005, p. 37)

Bowlby (1980/1998) observes that infants, from the age of six months, show a distinct pattern of behaviour when they experience prolonged separation or loss of a primary attachment figure, *'there is a tendency to underestimate how intensely distressing and disabling loss usually is and for how long the distress, and often the disablement, commonly lasts.*' (p. 8) The infant's initial reaction is one of protest, such as loud crying, screaming, anger, and eagerly searching in an attempt to find the lost attachment figure (Bowlby, 1980/1998). Continuation of the loss or separation results in the infant entering the second stage which is despair. The infant is still preoccupied with the attachment figure and vigilant for her return, but begins to lose faith of this happening. This is a time of grief and mourning for the infant, with characteristics such as dejection, loss of appetite, and disturbed sleep. Bowlby (1980/1998) states, '*Ultimately the restless noisy demands cease: he becomes apathetic and withdrawn, a despair broken only perhaps by an intermittent and monotonous wail. He is in a state of unutterable misery.*' (p. 9) Continuation of the loss leads to the third stage of detachment and an absence of attachment behaviour, where in severe cases the child treats the mother as if she is a stranger (Bowlby 1980/1998). Emotional detachment results from a pathological defensive exclusion, where the attachment system, along with the range of feelings and behaviours it evokes, are unable to be aroused (Bowlby 1988/2005). Bowlby (1988/2005) notes that this deactivates the individual's behaviour that would '*enable them both to love and experience being loved.*' (pp. 38-9)

Bowlby (1973/1998) acknowledges the terms 'separation' and 'loss' imply that the subject's attachment figure is inaccessible either temporarily (separation) or permanently (loss). It is only when the attachment figure is responsive, as well as accessible, that they are seen as truly available. Bowlby (1973/1998), like Winnicott, believes the nature of loss can be psychological as well as physical, '*a mother can be physically present but 'emotionally'*

absent. What this means is that, although present in body, a mother may be unresponsive to her child's desire for mothering.' (p. 43) The term 'maternal deprivation' can be used to describe a child's separation from the mother, as well as when a mother is unable to provide her child with loving care (Bowlby, 1953/1971). Issues such as mental illness, chronic ill-health, unhappy marriage, or violence in the family can impact on an attachment figure's ability to be responsive (Bowlby, 1953/1971, 1988/2005). The traumatic impact of a caregiver being psychologically unavailable is of central significance to my work with homeless people. Most of my clients recount experiences with parents, who seemed dangerous, uncaring or preoccupied, which provoked feelings of fear, inadequacy and loneliness. The nature of the attachment relationship has a direct influence on the way the self and others are perceived:

> confidence in the availability of attachment figures, or a lack of it, is built up slowly during the years of immaturity – infancy, childhood, and adolescence- and that whatever expectations are developed during those years tend to persist relatively unchanged throughout the rest of life.' (Bowlby, 1973/1998, p. 235)

An individual who encounters rejection, hostility or indifference from attachment figures will view the world as unreliable and unsafe (Howe 2011). The connections between deprivation in the early environment, an insecure sense of self, and the experience of homelessness will be considered further in chapter four.

Rogers (1959), like Bowlby, emphasises the external environment as having a direct impact on an individual's sense of the self. The self-concept is based on interactions with others, especially the infant's relationship with their caregivers. Caregivers, who demonstrate conditional regard, teach the infant that they only have value if they behave in certain ways, which others have told them are deserving of love and respect (Thorne, 1995). Rogers (1959) states, '*A condition of worth arises when the positive regard of a significant other is conditional, when the individual feels that in some respects he is prized and in others not*.' (p. 209) The child's behaviour appears fixed and rigid, without flexibility and spontaneity, due to trying to adhere to significant others' values. Progressively, these attitudes are '*assimilated into his own self-regard complex*'; the individual behaves in accordance with the introjected values of others and can be described as having '*conditions of worth*' (Rogers, 1959, p.209). He will avoid or seek experiences because they are deemed as more or less worthy of positive regard, irrespective of whether they are organismically satisfying, '*Thus, a condition of worth, because it disturbs the valuing process, prevents the individual from functioning freely and with maximum effectiveness*.' (Rogers, 1959, p. 210) Conditions

of worth mean that the infant has to comply with the caregiver's needs, rather than their own, which results in them becoming estranged from their sense of self; as we will see further on, compliance to the mother's needs is also the origin of Winnicott's false self and Bowlby's insecure attachment patterns.

Rogers (1959), unlike Winnicott and Bowlby, does not primarily focus on the mother in his writings. Yet in the following excerpt he acknowledges the infant learns to view himself in the same way his mother views him and adapts his behaviour to gain love and approval from her:

> He develops a total gestalt as to the way he is regarded by his mother and each new experience of love or rejection tends to alter the whole gestalt…he comes to be guided in his behaviour not by the degree to which an experience maintains or enhances the organism, but by the likelihood of receiving maternal love. (p. 225)

Critical, ambiguous or inconsistent care givers leave the infant feeling extremely confused and anxious, trying to find ways of gaining love or affection (Thorne, 1995). The infant may discover ways to elicit praise and validation, but their self-regard is dependent upon its maintenance. The continuous pursuit of positive regard causes the individual to be dominated by a sense of inadequacy and dissociated from their organismic valuing process (Thorne, 1995). Rogers (1959) notes that individuals, who have received highly selective positive regard from significant others, find it difficult to maintain self-regard to any degree. The individual has little confidence in their own judgement and ability to make decisions or take satisfactory action (Rogers, 1959). They develop an external '*locus of evaluation'* (Rogers, 1959, p. 210), where the ability to appraise experiences is found in others, rather than within the individual himself. Internalised conditions of worth and an external locus of evaluation will prevent authentic living (Thorne, 1995). The individuals that I work with seem to have not been 'prized' by significant others, which has led them to feel worthless, confused and alienated. Some clients have learnt ways of eliciting superficial approval through being charming or amusing, whereas others struggle to obtain any kind of affection, resulting in repeated experiences of criticism, shame and rejection.

Defences:

Winnicott (1974), in his paper 'Fear of Breakdown', acknowledges that the term unthinkable anxieties is not sufficient, so renames these experiences '*primitive agonies*'. He describes

the primitive agonies as:

> 1. A return to an unintegrated state. (Defence: disintegration.)
> 2. Falling for ever. (Defence: self-holding.)
> 3. Loss of psychosomatic collusion, failure of indwelling. (Defence: depersonalization.)
> 4. Loss of sense of real. (Defence: exploitation of primary narcissism, etc.)
> 5. Loss of capacity to relate to objects. (Defence: autistic states, relating only to self phenomena.)'
>
> And so on. (Winnicott, 1974, p. 104)

A failure in the facilitating environment results in the infant suffering primitive agonies, where they feel annihilated, isolated, helpless, and like they do not exist (Winnicott, 1974). These feelings are extremely disturbing and intolerable, so the infant produces a defence organisation as a protective barrier against this; a high degree of false self is the product of an organised defence system. The infant does not consciously experience the early breakdown, due to the limited capacity of their immature ego structure; consequently, the breakdown is not consciously remembered (Winnicott, 1974). The individual defends against environmental failure by a, *'freezing of the failure situation*' (Winnicott, 1958/1992, p. 281). The unthinkable memories are frozen or put on hold, in the hope that there will be a new environment in the future that can make adequate adaption. The individual carries, *'an unconscious assumption (which can become a conscious hope) that opportunity will occur at a later date for a renewed experience in which the failure situation will be able to be unfrozen and re-experienced*' (Winnicott, 1958/1992, p. 281).

Winnicott (1974) states he is being deliberately vague using the term 'breakdown', which can have a variety of meanings. Ogden (2014) proposes that it could represent the initial breakdown of the mother infant bond; the infant distracts from the experience of primitive agony by employing a defence organisation, hence the experience is not remembered. Newman (2013) argues that Winnicott's description of environmental failure is not as detailed as his notion of the facilitating environment. Newman (2013) suggests that the mother's inability to contain the distress caused by the primitive agonies constitutes a second dimension of maternal failure and may lead to the infant internalising a persecutory bad object. I would agree with Newman that there are likely to be additional dimensions to maternal failure; my clients can appear overwhelmed by distressing emotions which they are unable to contain, and seem to have internalised the critical and dismissive voices of parents, which are enacted in self-harming, self-sabotaging and self-neglecting behaviours.

The fear of a future breakdown by patients, according to Winnicott (1974), is actually the

fear of a breakdown that has already happened, but which they are unable to remember. Winnicott (1974) contends that it is crucial for the patient to remember the breakdown, '*but it is not possible to remember something that has not yet happened, and this thing of the past has not happened yet because the patient was not there for it to happen to.*' (p. 105) The patient needs to be able to experience the breakdown in the present, in order to be able to integrate the experience within their ego structure (Winnicott, 1974). Winnicott (1965/2007) contends, *'The patient's fear of breakdown has one of its roots in the patient's need to remember the original breakdown. Memory can only come through re-experiencing'* (p. 139) The patient continues to search for the past event, that has occurred but is not remembered, and it disturbs the patient until it is remembered and experienced in the transference with the analyst:

> This past and future thing then becomes a matter of the here and now, and becomes experienced by the patient for the first time. This is the equivalent of remembering, and this outcome is the equivalent of the lifting of repression that occurs in the analysis of the psychoneurotic patient (classical Freudian analysis). (Winnicott, 1974, p. 105)

Winnicott (1974) refers to the primitive agonies as a universal phenomenon, which everyone has known and experienced to more or lesser degrees. Ogden (2014) proposes that emotional limitations, such as not being fully present in experiences, are demonstrative of such defense organisations; individuals will have a desire to find and integrate these experiences in order to feel complete. The need to integrate experiences to develop an authentic sense of self is a concept that has resonance in Bowlby's and Rogers' work as well**.** This notion could be seen as particularly relevant in work with homeless people who require a safe, reliable environment to integrate past traumatic experiences in order to build a more stable, coherent and resilient sense of self.

Bowlby (1973/1998), like Winnicott, believes that individuals produce psychic defences to cope with environmental failure, consisting of multiple working models of their attachment figures and themselves. Bowlby (1973/1998) notes, '*When multiple models of a single figure are operative they are likely to differ in regard to their origin, their dominance, and the extent to which the subject is aware of them*.' (p. 238) The model with the greatest influence on an individual, suffering from emotional disturbance, is the one developed in childhood, yet he may be moderately or completely unaware of this (Bowlby, 1973/1998). Multiple models create defensive processes, where disturbing emotions are excluded from memory for long periods or permanently (Bowlby, 1980/1998). Bowlby (1980/1998) states that

information that needs to be defensively excluded comes under two headings:

> (a)information that leads a child's attachment behaviour and feeling to be aroused intensely but to remain unassuaged, and perhaps even to be punished, and (b)information that he knows his parent(s) do not wish him to know about and would punish him for accepting as true. (p. 73)

Defensive exclusion may be '*adaptive*' in childhood, as the benefits of complying with a parent's demands may outweigh the costs, yet in adult life exclusion of the same information may become '*maladaptive*' (Bowlby, 1980/1998, p. 45). The existence of multiple models results in major disorders of personality such as narcissism, the false self, psychosis, or multiple personality (Bowlby, 1973/1998). Main (1991, cited in Wallin, 2007) proposes secure individuals can be described as having one integrated model of attachment, whereas insecure individuals experience multiple models, due to incoherent, conflicting or dissociated representations of attachment. Bowlby (1973/1998) states, '*The hypothesis of multiple models, one of which is highly influential but relatively or completely unconscious, is no more than a version, in different terms, of Freud's hypothesis of a dynamic unconscious.'* (p. 239)

The comparison between Bowlby's working models and Freud's unconscious continues to be an issue of debate in psychoanalysis. Eagle (2013) argues that Bowlby's working models involve representations of actual interactions and experiences; in contrast, Freud's unconscious consists of instinctual libidinal and aggressive drives, which need to be repressed. Juri (1999, cited in Marrone & Diamond, 2014) claims Bowlby's concept of 'defensive exclusion' refers to the same process as repression, which can be seen as equivalent to the notion of the unconscious; certain types of experience are not processed in an attempt to avoid psychic distress. Defensive exclusion filters information which is taken in, interferes with an individual's perception, and leads to a degree of splitting or dissociation of memories (Juri, 1999, cited in Marrone & Diamond, 2014). Holmes (2006) says that a child with an avoidant attachment may want to cuddle his mother when he is reunited with her, but knows from experience that such actions would be met with rejection; he may just loiter close to her, unable to express his emotions openly. In this way, supressing attachment needs and anger at being dismissed could be seen as similar to the Freudian concept of repression. The child may feel shame regarding his need for affection, leading to confidence issues, narcissistic traits, and hostility towards others who are vulnerable. The attachment behavioural unconscious is rooted in the survival of the vulnerable infant through protection provided by relationships. According to Holmes (2006),

the Freudian psychoanalytic unconscious is also rooted in vulnerability, yet survival and adaption is through self-deception rather than protection. However, self-deceit, such as denying needs for affection, may be adaptive for a child with an unavailable attachment figure (Holmes, 2006).

Rogers (1959) like Winnicott and Bowlby, believes that failures in the environment result in the individual having to exclude certain experiences from awareness. The introjection of beliefs, attitudes and judgements produces a discrepancy between the self-concept and the actual experience of the total organism. This is defined as '*incongruence*' or a lack of integration between the self and experience (Rogers, 1959). Self-experiences consistent with conditions of worth evoke feelings of positive self-regard, so these are accepted and integrated into the self-concept (Cooper, 2007). Experiences inconsistent with conditions of worth produce difficult or distressing feelings, so these are left at a 'pre-reflective' level; they are not symbolised accurately in conscious awareness or integrated into the self-concept (Cooper, 2007). Rogers (1959) states, '*It is an important specific instance of inaccurate symbolization, the individual valuing an experience positively or negatively, as if in relation to the criterion of the actualizing tendency, but not actually in relation to it.'* (p. 210)

According to Rogers (1959), when the self-concept includes distorted perceptions which do not accurately represent the individual's experience, and experiences include elements which the individual does not recognise as being part of their character, the result is a lack of integration. Rogers (1959) refers to this process of discrimination as '*subception'*, which is achieved through strategies of denial or distortion, in order to preserve the self-concept from threat:

> This process consists of the selective perception or distortion of the experience and/or the denial to awareness of the experience or some portion thereof, thus keeping the total perception of the experience consistent with the individual's self-structure, and consistent with his conditions of worth. (p. 227)

Experiences incongruent with the individual's concept of himself tend to be denied awareness regardless of their social acceptability, including feelings of love and confidence (Rogers, 1959). Bowlby and Rogers both identify that an individual may deny their need for affection, if they have been raised in an environment where it was detrimental to express such needs. Individuals who are homeless often exhibit both '*longing for'* and '*profound fear*' of dependency and intimacy, leading them to reject care, as having 'needs' can trigger

emotions of anger, shame and criticism (Williamson, 2018, p.245).

Fragmentation:

Winnicott (1965/2007) believes that the '*not good enough*' mother fails to sense and acknowledge her infant's needs and spontaneous gestures, instead substituting her own feelings in place of his (p.145). The infant is placed in a very difficult position, due to the potential for denial and exploitation of the true self. In response, the infant accepts the environmental demands and behaves compliantly for the mother, rather than expressing their own spontaneous feelings; this leads to the development of the false self, *'The False Self has one positive and very important function: to hide the True Self, which it does by compliance with environmental demands.'* (Winnicott, 1965/2007, pp. 146-7) The false self is seen to employ a defensive or protective role; one of Winnicott's patients describes this part as her '*Caretaker Self*' (Winnicott, 1965/2007, p. 142). Winnicott (1965/2007) suggests that the false self will be on a spectrum of degrees. In severe examples of the false self, there is an absence of spontaneity as the true self is so deeply hidden. The false self develops false relationships and as a result of introjections, may appear real as they imitate other people in their lives, like their father or aunt. The false self will result in a sense of feeling unreal, hopeless, and life not being worth living. In the most extreme degree, the false self is presented as real to others and not connected to the true self, which is completely hidden; however this is not sustainable in relationships, as there is something essential lacking in the person (Winnicott, 1965/2007). In my work with homeless individuals, who are dependent on substances, the 'addict' part could be seen as representing the false self, which protects a wounded inner core, but leaves it cut off and unable to live spontaneously.

A less extreme position involves the false self defending the true self, so the true self is recognised as a potential and able to have a secret existence (Winnicott, 1965/2007). Towards health, the false self seeks the conditions to allow the true self to develop. However, if this could not be found there would have to be suicide to end both selves so that the true self is not betrayed. Further towards health, the false self is built on identifications with the environment and people in it (Winnicott, 1965/2007). In the definition of health, the false self is described as '*the whole organization of the polite and*

mannered social attitude, a 'not wearing the heart on the sleeve', as might be said.' (Winnicott, 1965/2007, p. 143) The false self is required to function in society, but enables the true self to exist without compromising its integrity (Winnicott, 1965/2007). In health, the false self exists as a necessary boundary between the outside world and the inside, protecting the true self, rather than needing to supress it (Abram, 2004). Winnicott (1965/2007) notes that a particular risk arises when the mind becomes the location of the false self, causing dissociation between intellectual activity and psychosomatic existence. The individual achieves significant academic success, which causes others to not recognise the distress of the individual, who feels '*phoney*' the more they are successful (Winnicott, 1965/2007, p.144). Others develop high hopes of the individual and feel shocked when the individual is self-destructive, rather than fulfilling their potential (Winnicott, 1965/2007).

Bowlby (1988/2005), in contrast to Winnicott, contends that in the absence of attuned and responsive parenting, insecure attachment patterns develop. Ainsworth (1978, cited in Bowlby, 1969/1997), Bowlby's colleague, undertook research known as the 'Strange Situation', where mother-infant interaction was observed under various conditions in an unfamiliar environment. The 'Strange Situation' resulted in the discovery of three distinctive patterns of organised attachment behaviour: secure, avoidant, and ambivalent (Bowlby, 1969/1997). Avoidant attachment strategies develop when caregivers reject, deny, or attempt to control the infant's expression of attachment behaviour (Howe, 2011). The caregiver appears angry, irritated or upset if the child shows they have needs. Expressions of vulnerability, dependence and emotional demands cause the caregiver anxiety, which they defend against by dismissing and distancing (Howe, 2011). The best strategy for the infant to maintain closeness to the caregiver is to avoid expressing their needs:

> he tries to become emotionally self-sufficient and may later be diagnosed as narcissistic or as having a false self of the type described by Winnicott (1960). This pattern, in which conflict is more hidden, is the result of the individual's mother constantly rebuffing him when he approaches her for comfort or protection. (Bowlby, 1988/2005, p. 140)

Avoidant children learn to hide their feelings in order to be accepted, which leads to their emotions becoming over-regulated (Howe, 2011). There has to be a very high threshold of arousal before avoidant children display any attachment behaviour. Avoidant children dismiss negative emotions or needs, appearing reserved, compliant, self-sufficient and detached. They lack the capacity to reflect on emotions and feel anxious when others want to become intimate, due to fear of rejection. Avoidant children have a working model in which the self is viewed as self-reliant, but unloved and unlovable; whilst others are

believed to be rejecting, intrusive, and unavailable at times of distress (Howe, 2011).

Ambivalent attachment strategies develop when caregivers are insensitive and unreliable, due to being preoccupied with their own emotional needs for love and approval (Howe, 2011). In order to increase closeness to the caregiver or provoke a response, the infant will exaggerate their expression of need and distress. Ambivalent children have a low arousal level as their emotions are under-regulated, so a little stress will trigger intense shows of protest and demand. They adopt an angry or resistant approach, displaying whiney, needy and attention seeking behaviour, which is not easily soothed (Howe, 2011). Children are described as being 'ambivalent' as they desire the attention of their caregiver, but show anger due to its unreliability:

> Because of this uncertainty he is always prone to separation anxiety, tends to be clinging, and is anxious about exploring the world. This pattern, in which conflict is evident, is promoted by a parent being available and helpful on some occasions but not on others, and by separations and, as clinical findings show, by threats of abandonment used as a means of control. (Bowlby, 1988/2005, p. 140)

Ambivalent children are preoccupied with their emotions and the emotional availability of others (Howe, 2011). They are highly dependent on others, due to fearing abandonment; though others can feel exhausted or frustrated being subjected to unpredictable, coercive, demanding behaviour, and may withdraw. Ambivalent children fail to make connections between emotions and behaviour, often blaming others, whilst feeling deprived of affection. The ambivalent child's working model tends to view the self as unworthy, inadequate and dependent; whilst other people are believed to be uncaring, abandoning, and unpredictable (Howe, 2011).

Main (1990, cited in Wallin, 2007) discovered an undetected attachment pattern in the Baltimore infants many years after Ainsworth had completed her original studies. The infants, when reunited with the mother, back towards her, freeze, collapse to the floor, or appear in a trance like state. This behaviour only occurs for a brief period, and then the infant reverts to other patterns of attachment. These infants were classified as 'disorganised' with secure, avoidant or ambivalent strategies (Wallin, 2007). Disorganised attachment strategies develop when the caregiver is the source of the child's fear and distress, as well as being unable to respond to the child's needs (Howe, 2011). Bowlby (1988/2005) highlights research showing that disorganised attachment is found in infants, '*known to be physically abused and/or grossly neglected by the parent (Crittenden, 1985).*' (p.141) The parents have often suffered physical or sexual abuse as children, are suffering

from bipolar affective illness, or are preoccupied with mourning a parental figure lost during childhood (Bowlby, 1988/2005). The child's attachment system remains highly activated, as their arousal is unregulated by the attachment figure (Howe, 2011). The child is torn between conflicting instincts to approach and avoid, as they source of fear they need to escape is also supposed to be the source of safety (Howe, 2011).

In the case of disorganised attachment, any strategy employed fails to bring proximity, care or comfort, so the attachment behaviour lacks a coherent strategy (Howe, 2011). A child may move towards an attachment figure one moment and then turn away from them the next. The child's attachment behaviour becomes increasingly disorganised, alternating between avoidance, anger, apprehension or disinterest; in cases of severe trauma, children may appear physically and psychologically frozen. Dangerous and neglectful caregiving can detrimentally impact on a child's memory, perception, insight, and the development of an integrated sense of self. Disorganised children have an internal working model that views the self as fearful, isolated, neglected, harmful and bad; whilst others are believed to be unpredictable, unresponsive, rejecting, unsafe and helpless. Children who have suffered maltreatment do not feel safe when the caregiver is in control, so they try to manage the parent-infant interaction through compulsive self-reliance, caregiving, compliance, coercive or controlling behaviours (Howe, 2011). The disoragnised attachment style is particularly relevant to work with homeless people, who present with high levels of emotional arousal, mistrust of others, and fear of both intimacy and abandonment. Links have been made between the development of insecure attachment patterns and issues of substance misuse, homelessness, and psychopathology, such as personality disorders, which will be explored further in chapter four. It could be argued the insecure attachment patterns appear too prescriptive or simplistic, as most individuals will not fit neatly into categorical boxes. Yet, attachment styles can be seen to be on a spectrum and utilised as general principles; they may also help to guide the nature of therapeutic interactions, which will be considered in the next chapter.

Rogers (1959), like Winnicott, believes individuals who have grown up with conditions of worth will experience alienation from themselves by adulthood. Rogers (1959) states, '*It is thus because of the distorted perceptions arising from the conditions of worth that the individual departs from the integration which characterizes his infant state.'* (p. 226) The more alienated a person is from themselves, the higher the level of incongruence and psychological disturbance (Cooper, 2007). An individual, separated from their organismic

valuing process, lacks the capacity to fully understand or accept themselves, as they have to deny experiences which do not fit with their self-concept (Cooper, 2007). Rogers (1959) notes, *'Psychological maladjustments exist when the organism denies to awareness, or distorts in awareness, significant experiences, which consequently are not accurately symbolized or organised into the gestalt of the self-structure, thus creating an incongruence between self and experience.'* (p. 204) An incongruent individual is unable to identify whether an activity will be satisfying, as they have to alter their preferences based on other people's values (Rogers, 1959). Consequently, they will engage in banal activities, where they feel despondent and unhappy, or self-destructive behaviours. The individual is likely to regularly experience anxiety, tension and internal conflict, as their behaviour continues to be regulated by both the actualizing tendency and the self-actualizing tendency, which are at odds, '*Thus he can no longer live as a unified whole person, but various part functions now become characteristic.'* (Rogers, 1959, p. 226) Incongruence produces conflicting and incomprehensible behaviours, especially when subceived needs or feelings are so powerful that they are openly expressed (Cooper, 2007). The individual may experience a confusing sense of '*I am doing things which are not myself, which I cannot control*' (Rogers, 1951, p. 514), or that they are being controlled by an *'alien*' force within (Cooper, 2007, p.82). Alternatively, the person may have a lack of awareness of the disturbance, and the disturbance may not be perceived by others, especially if they benefit from the person's incongruence or self-deception (Thorne, 1995).

Rogers (1959) distinguishes between defensive and disorganised behaviours, which deny or distort perceptions of experience, to maintain a coherent self-concept. Defensive behaviours include those regarded as neurotic, such as, '*rationalization, compensation, fantasy, projection, compulsions, phobias, and the like*', as well as paranoid and catatonic states (Rogers, 1959, p. 228); disorganised behaviours include those considered irrational and acutely psychotic. In fantasy, a new symbolic world is created which enhances the self, whilst the actual experience is denied as it threatens the self-concept. In a situation where the organism has a strong need, which is inconsistent with the self-concept, the need is expressed in a distorted way. An individual, whose self-concept involves no 'bad' sexual thoughts, may express, '*I am pure, but you are trying to make me think filthy thoughts'* (Rogers, 1959, p. 228). This is a projection, as it involves expression of the organism's need for sexual satisfaction, but the need has to be denied for the behaviour to be perceived as consistent with the self-concept (Rogers, 1959).

An individual will not be able to maintain their self-concept through the process of defense if they experience a threat that is overwhelmingly and obviously incongruent with their self-concept (Rogers, 1959). Rogers (1959) notes the defense mechanism is unable to operate if the incongruence is impossible to deny or avoid, *'The process of defense being unsuccessful, the experience is accurately symbolized in awareness, and the gestalt of the self-structure is broken by this experience of the incongruence in awareness. A state of disorganization results.'* (p. 229) In a state of disorganisation, the individual fluctuates between behaving in ways that are consistent with their experiences, which previously had been distorted or denied, and at other times behaving in accordance with their self-concept (Rogers, 1959). This produces tension and confusion, as both the self-concept and experiences not included in the self-concept, are supplying feedback by which the organism regulates behaviour (Rogers, 1959). Defensive behaviours can be seen as similar to avoidant and ambivalent attachments, as they are strategies which maintain the dominant working model or self-concept; in the disorganised category, as in disorganised attachment, the dominant model breaks down and behaves inconsistently, due to overwhelming threat.

Contemporary Developments:

Winnicott's, Bowlby's and Rogers' ideas about the nature of dysfunction in the development of self have been built on by contemporary theorists. In terms of Winnicott's ideas, Orbach (2003) believes that the concept of the true and false self demonstrate the ways in which subjectivities are formed relationally and the different states of self that individuals may embody. According to Orbach (2003), the false self is no less real than the true self, as both are developed within the nature of relationship. The false self can be seen as a 'creative adaption' to what the child is being offered and the search for aspects of the self that can receive validation in the existing environment (Orbach, 2003). In this way, the false self can be seen as comparable to Rogers' self-concept and Bowlby's insecure attachment patterns, where validation is gained through compliance and adaption. Newman (2013) argues that in environmental trauma, the infant must continue to control the object in phantasy, as opposed to in health when the infant can give up the illusion of control and acknowledge the object is outside of the self. The infant's adaptation to the mother maintains the illusion of control and creates a form of connection, but it is a conditional acceptance, in that the individual may feel dropped if they fail to provide the necessary role for the parent. The false self provides the illusion of a good relationship and controls the awareness of the

harmful relationship, keeping the true self in a state of suppression (Newman, 2013). Mollon (1994) suggests that maternal failure, such as a lack of empathic mirroring and having to comply with maternal expectations, leads the infant to develop narcissistic disturbance, defined as a fragile sense of self. The infant lacks a sense of agency when they are unable to elicit meaningful responses from the mother, which triggers feelings of helplessness, inadequacy, and incoherence. Narcissistic vulnerability makes an individual extremely sensitive to feeling disregarded and prone to reactions of rage, depression, grandiosity and shame (Mollon, 1994).

Main's (2000) research, devising the Adult Attachment Interview, can be seen as further developing Bowlby's concept of internal working models. In the AAI, participants recollect the history of their relationship with their parents, to assess an individual's '*state of mind with respect to attachment'*. (Main, 2000, p. 1078) Main (2000) found, '*different patterns of mother-infant interaction must have led to the development not only of different behaviours, but also of different representational processes.*' (p. 1059) The internal working model not only influences emotions and behaviour, but attention, memory, language and cognition. Main (2000) introduced the concept of 'metacognition', which is the capacity to think about thinking; Fonagy (2001) extended the research on metacognition to include the individual's awareness of mental states in general, including the mental states of others, which he termed 'mentalization'. Mentalizing is central to secure attachment, as it supports the development of the representational system, enabling individuals to understand, interpret and predict the behaviours of others. Crucial to the development of mentalizing is affect regulation, where caregivers regulate the infant's emotions through attuned mirroring (Fonagy, 2001). Fonagy (2001) argues that certain psychopathology, including individuals with personality disorders who have been victims of childhood abuse, can be attributed to failures in attunement:

> This should be understood not simply as a deficit but as an adaption that has helped the child to attain some distance from a traumatizing situation. Although restriction of mentalization was originally adaptive, there is a clear and powerful link between this restricted capacity and later vulnerability to trauma. (p. 176)

The notion of mentalization is extremely significant for people experiencing homelessness, who appear to struggle to make sense of their own minds and the minds of others; this affects their capacity to regulate emotions, engage in reciprocal interactions, have a sense of self-agency, and process past traumatic experiences. Crittenden (2006) has built on attachment theory to create the Dynamic Maturational Model of attachment and adaption;

this distinguishes many atypical strategies rather than just disorganised, thus representing a gradation of processes rather than categorical absolutes.

Biermann-Ratjen (1998a), in the person centred counselling movement, proposes that there is an '*interpersonal need for unconditional positive regard'* (p. 115) from birth for a child to develop an integrated sense of self. A child who is shown a lack of positive regard or incongruence will experience this as a threat to the self and employ defensive strategies to minimise experiencing certain feelings. This will be exacerbated further if the parent responds according to their emotional experiences, neglecting to accurately identify the child's experience. Biermann-Ratjen (1998a), similar to Winnicott's fear of breakdown, states that if positive regard is not experienced and integrated into the self-concept, '*it will not be consciously experienced as such but disguised as fears of being obliterated or destroyed – as a threat to the person's very existence*.' (p.115) Emotional neglect, such as being left alone, will lead to a person feeling '*unable to live'* as they will *'experience no right to exist*' (p. 115). Intense emotions and close relationships may seem like an existential threat to an individual who has not experienced unconditional positive regard. In situations where the person is unable to defend against feelings of dependence on another person, they are likely to feel overwhelmed or destroyed by emotions which are alien and dangerous (Biermann-Ratjen, 1998a). Biermann-Ratjen (1998b) states that post-traumatic stress disorder can be seen as the result of a person not being able to integrate a self-experience. Symbolization of the traumatic experience often remains restricted to an image or physical sensation, as the feelings are unable to be tolerated or accepted. There is a conflict between efforts to become aware and integrate the experience, alongside efforts to defend the self-concept, leading to incongruence. The danger of traumatic experience is that it may lead to a permanent stagnation, where defending against experiences becomes routine and generalised (Biermann-Ratjen, 1998b).

<u>Summary:</u>

The second chapter has explored Winnicott's, Bowlby's and Rogers' views on the nature of trauma and the impact of this on an infant's development. The subject of trauma is of central significance to this research, which contends that traumatic experiences in early development are the key causal factor in the lives of individuals experiencing homelessness. The notions of impingements, primitive agonies and maternal deprivation are particularly

useful in understanding the impact of abuse and neglect, which many homeless people appear to have experienced. The absence of an attuned, reliable, accepting mother results in the infant having to comply with environmental demands, disturbing the development of an integrated, secure sense of self. Bowlby acknowledges that compliance is biologically adaptive and a survival strategy in childhood, but causes significant dysfunction later on. Similarly, Winnicott views the false self as protecting the true self by adapting to environmental demands, yet not just the demands of the mother but also the physical and psychological demands of existence; this compliance can lead to the estrangement and impoverishment of the true self.

Winnicott contends that trauma in the stage of absolute dependence is the most catastrophic, whereas Bowlby and Rogers fail to comment on trauma prior to the infant's awareness of others. Research in attachment theory and person centred theory now suggests that an infant, from the beginning of life, requires empathy, reliability, and cherishing from a genuine other (Gerhardt, 2004; Biermann-Ratjen, 1998a). Winnicott, Bowlby and Rogers agree that compliance will cause the infant to defensively exclude certain experiences from awareness, leading to fragmentation of the self. Winnicott and Rogers propose that the infant has to exclude emotions to comply with the parent's demands; whereas, Bowlby explores the impact of trauma on affect regulation, where emotions can be avoided, exaggerated, or unregulated. Many of clients that I work with have developed primitive defenses to manage psychic distress, such as aggression, projection, denial, and avoidance; emotional responses are often unpredictable and unregulated, ranging from dramatic outbursts to emotional detachment and dissociation. As a result, Bowlby's concept of affect regulation is particularly helpful in this work. In the next chapter, I will explore Winnicott's, Bowlby's and Rogers' views on the nature of the therapeutic relationship.

Chapter Three:

The Therapeutic Relationship

Introduction:

Winnicott (1958/1992), Bowlby (1988/2005) and Rogers (1959) believe that the optimal conditions for early development are also the essential conditions for psychotherapy. This chapter will examine their views on the nature of the therapeutic relationship and the ways this supports the natural growth tendencies of the patient. It is crucial for the therapist to provide a facilitating environment, demonstrating the qualities of an attuned, but human and real, mother, '*The patient makes use of the analyst's failures. Failures there must be, and indeed there is no attempt to give perfect adaption*.' (Winnicott, 1958/1992, p. 298) Howe (2011) and Holmes (2014) similarly propose that secure attachment relationships are not free from disruption, but have ways to manage rupture and repair. The theorists hold in common the belief that a nurturing therapeutic relationship enables integration, yet they differ in their views on the nature of interventions.

Winnicott (1971/1974) and Rogers (1959) believe in the therapist being non-directive, authentic, and spontaneous. In contrast, Bowlby (1988/2005) proposes that the therapist needs to help the patient to understand and revise their internal working models, which can be seen as more structured and agenda driven. Perhaps these stances reflect the different versions of the 'mother' that the theorists present, with Bowlby's mother being more able to set limits, whereas Winnicott's mother is more playful. Winnicott (1958/1992) and Bowlby (1988/2005) contend that a facilitating environment enables the patient to work through the transference and progress to use the therapist's interpretations; whereas Rogers (1959) believes the core conditions are necessary and sufficient for personality change. Rogers (1951) acknowledges that transference exists, but argues that it must not be focused on as a special phenomenon in therapy; he believes in a 'real' relationship between the therapist and client. I plan to explore the theorists' views on the nature of the therapeutic relationship under three main topics: the facilitating environment, transference, and use of an object.

The Facilitating Environment:

Winnicott's observations of the mother-infant relationship are his foundation for psychoanalytic treatment (Phillips, 1988). Winnicott (1959/1992) states, '*An analyst has to display all the patience and tolerance and reliability of a mother devoted to her infant*' (p. 202). The analyst provides a holding environment, equivalent to maternal care, supporting the natural developmental process of the individual (Winnicott, 1958/1992). Psychological disorders are caused by problems in development, so the aim of psychotherapy is simply, '*undoing the hitch, so that development may take place where formally it could not*' (Winnicott, 1986/1990, p. 103). Winnicott (1965/2007) contends that the analyst must provide sensitive adaption and attunement to the needs of the patient, responding to verbal and non-verbal communication:

> The glimpse of the baby's and child's seeing the self in the mother's face, and afterwards in a mirror, gives a way of looking at analysis…it is a long-term giving the patient back what the patient brings…if I do this well enough the patient will find his or her own self, and will be able to exist and to feel real. (Winnicott, 1971/1974, pp. 137-8)

In analysis, development must occur at the pace of the patient and interpretations are most useful if they originate from the patient (Winnicott, 1971/1974). Untimely interpretations destroy creativity and become traumatic in the maturational process, forcing compliance or rejection of the therapy (Winnicott, 1965/2007). It is not the act of interpretation itself that is beneficial, for Winnicott, but the patient's use of the interpretation (Phillips, 1988). Winnicott establishes a mode of treatment, based on the mutuality of relationship, as the analyst creates a setting which enables the patient to create their own interpretations (Phillips, 1988). Winnicott (1971/1974) notes, regrettably, he has prevented or delayed patient's progress due to his need to interpret, '*The principle is that it is the patient and only the patient who has the answers. We may or may not enable him or her to encompass what is known or become aware of it with acceptance.*' (Winnicott, 1971/1974, p. 102)

Winnicott (1958/1992) believes patients, who lack sufficient ego strength, require a phase of regression during treatment. The infant defends against early environmental deficiency by, '*a freezing of the failure situation*' (Winnicott, 1958/1992, p. 281); regression allows the individual to unfreeze and re-experience the failure situation in an environment that makes adequate adaption. The analytic setting facilitates regression due to its dependability, which the patient develops confidence in, *'The setting of analysis reproduces the early and earliest mothering techniques. It invites regression by reason of its reliability. The regression*

of a patient is an organised return to early dependence or double dependence.' (Winnicott, 1958/1992, p. 286) The patient must experience 'absolute dependence' on the analyst, so the analyst must become preoccupied with the patient, protecting them from unnecessary impingements (Spurling, 2008). Winnicott (1965/2007) notes, '*The analyst will need to remain orientated to external reality while in fact being identified with the patient, even merged in with the patient.*' (p. 163)

Normal analytic techniques, such as interpretation, speech and movement, are suspended during a regression, to provide ego support in an extensive way (Winnicott, 1958/1992). The patient may require 'holding' or 'management' of care, which involves environmental adaption, such as extended sessions, long periods of silence, or admission to hospital (Winnicott, 1958/1992). Regressed patients re-live aspects of their previous traumatic experiences during sessions with the therapist (Spurling, 2008). Winnicott (1958/1992) states, '*Whereas in the transference neurosis the past comes into the consulting-room, in this work it is more true to say that the present goes back into the past, and is the past*.' (pp. 297-8) Regression can vary from brief moments in sessions, to consuming a patient's life for a period of time:

> Whenever we understand a patient in a deep way and show that we do so by a correct and well timed interpretation we are in fact holding the patient, and taking part in a relationship in which the patient is in some degree regressed and dependent.' (Winnicott, 1958/1992, p. 261)

Environmental adaption can be seen as particularly important in work with people who are homeless, where fragile psychological states, defense strategies, and feelings of mistrust, shame and alienation have to be managed and contained; this idea will be explored further in chapter four.

Bowlby (1988/2005), like Winnicott, utilizes his beliefs about the infant-mother relationship to provide the framework for analytic psychotherapy. The therapist must provide a secure base, from which the patient is able to explore distressing and difficult parts of his life, both past and present:

> In providing his patient with a secure base from which to explore and express his thoughts and feelings the therapist's role is analogous to that of a mother who provides her child with a secure base from which to explore the world. (Bowlby, 1988/2005, p. 159)

Bowlby (1988/2005) notes the notion of a secure base is very similar to Winnicott's concept of 'holding' and Bion's theory of 'containment'. The therapist, like the mother, must accept

and respect his patient, and endeavour to be, '*reliable, attentive, empathic, and sympathetically responsive*' (Bowlby, 1988/2005, p. 172). The role of the therapist is to facilitate the patient's exploration of his experiences, resulting in less emphasis on interpretation. The patient has the answers and with support, he is able to discover the nature of his working models and revise them, so the therapist's task, '*is to provide the conditions in which self-healing can take place*' (Bowlby, 1988/2005, p. 172). The therapist must encourage the patient to lead the exploration of his inner world, but at times the therapist may need to guide the patient. The therapist may comment on subjects that are being avoided, or ask the patient to elaborate on certain memories. Bowlby (1988/2005) states, '*A therapist applying attachment theory sees his role as being one of providing the conditions in which his patient can explore his representational models of himself and his attachment figures with a view to reappraising and restructuring them.*' (p. 156) In this way, Bowlby's therapeutic approach can be seen as more directive than Winnicott's and Rogers' models. Bowlby, unlike Winnicott and Rogers, does not describe in detail the ways a therapist provides a secure base or give examples from his practice.

Bowlby (1988/2005) proposes that the tasks of therapy are related and a session may involve more than one task at a time; unless a therapist supports his patient to feel a degree of security, therapy is unable to commence. Wallin (2007) and Holmes (2014) agree with Bowlby's notion of the therapist providing a safe base for patients; yet, they explore whether the provision of a secure base is an initial step to facilitate interpretation, or a therapeutic component in itself. Wallin (2007) observes that different styles of attachment will require different responses from the therapist, '*with most patients the relationship is a significant part of therapy, for patients who are unresolved the therapeutic relationship is the therapy*.' (pp. 243-4) Wallin (2007) uses the AAI term 'unresolved', also known as 'unresolved disorganised state of mind', to refer to individuals presenting with disorganised attachment styles. Holmes (2014) similarly notes that patients who are severely damaged will require a significant amount of acceptance, empathy and environmental provision; they are likely to find just engaging in therapy challenging. In contrast, less damaged patients tend to accept the provision of the therapeutic environment, so the emphasis can be on the relationship with the therapist (Holmes, 2014). I agree with Wallin and Holmes that the secure base is especially significant in work with individuals presenting with disorganised attachment strategies, as dependency can provoke primitive feelings of fear and hostility. Categories of attachment may become relevant when considering therapeutic interventions for patients (Holmes, 2014). Disorganised patients may need a basic

supportive approach; ambivalent patients may require firm boundaries with encouragement to explore; avoidant patients may need an amicable relationship, where the therapist holds most of the patient's emotions. Holmes (2014) proposes there does not have to be a conflict between attachment and interpretation in psychotherapy. The therapist's attuned responses help the patient to form a secure base, which enables exploration, and the therapist's interpretations support the patient's narrative to develop and become more coherent. Holmes (2014) notes, '*we can identify three elements which go to make up the secure base phenomenon in therapy: attunement, fostering autobiographical competence, and affect regulation (Holmes, 2010).*' (p. 140)

Rogers (1957/1992), like Winnicott and Bowlby, bases his beliefs about the therapeutic relationship on the conditions required for healthy development. All individuals possess a natural tendency to reorganise their self-concept to become more congruent with their total experience, which can be supported through the therapeutic relationship. Rogers (1959) argues that, '*the reintegration or restoration of personality occurs always and only…in the presence of certain definable conditions*.' (p. 231) According to Rogers (1957/1992), there are six conditions which facilitate a client's growth, which are necessary but also sufficient. Once the conditions have been established, the client's process unfolds spontaneously and inevitably (Rogers, 1957/1992). The therapist does not need to employ any techniques or interventions, as the client knows the direction for healing to take place (Thorne, 1992/1995). The first condition specifies that psychological contact, or a minimal relationship, exists to some degree between two people (Rogers, 1957/1992). Contact is defined as '*that each makes some perceived difference in the experiential field of the other*' (Rogers, 1957/1992, p. 828). It is also sufficient if each person makes a '*subceived*' difference, though the person may not be consciously aware of the impact (Rogers, 1957/1992, p. 828). Rogers (1957/1992) states that it might be difficult to determine whether a catatonic patient can comprehend a therapist's presence as making a difference to him, but the patient may experience this at some organic level.

The second condition is '*the client, is in a state of incongruence, being vulnerable or anxious'* (Rogers, 1957/1992, p. 827). Incongruence refers to the discrepancy between a person's actual experience and their self-concept. A client with no awareness of their incongruence is vulnerable to the possibility of anxiety or disorganisation. In this case, an experience may arise suddenly or obviously, so that the incongruence is unable to be disowned; thus, the individual is vulnerable to such a possibility. A client, who vaguely

senses their incongruence, experiences a state of tension known as anxiety. The incongruence does not need to be acutely sensed, it may even be 'subceived', in that the individual experiences a threat to the self without awareness of the subject of the threat (Rogers, 1957/1992, p. 828). The third condition is '*the therapist, is congruent or integrated in the relationship*' (Rogers, 1957/1992, p. 827). The congruent therapist is real, genuine, and transparent; he does not deny any feelings but accepts them all, so his actual experience correlates with his awareness of himself (Rogers, 1957/1992). Congruence is a condition for the therapeutic relationship, as well as an example of psychological health and maturity (Rogers, 1959). Rogers' (1959) definition of a '*fully functioning person'* includes being completely congruent, non-defensive, open to all experience, able to respond creatively, and having a flexible and fluid gestalt (p. 234).

The fourth condition is that the therapist experiences '*unconditional positive regard for the client'* (Rogers, 1957/1992, p. 827). This is defined as a genuine acceptance of every aspect of the client's experience and all of their feelings. The fifth condition is that the therapist experiences an empathic understanding of the client's internal frame of reference, '*To sense the client's private world as if it were your own, but without ever losing the "as if" quality – this is empathy, and this seems essential to therapy*.' (Rogers, 1957/1992, p. 829) The sixth condition is that the therapist communicates empathic understanding and unconditional positive regard, which the client senses, to some extent (Rogers, 1957/1992). There has been debate in the person centred movement over whether the conditions are necessary and sufficient; some therapists contend that the conditions are necessary, but not sufficient, so should be supplemented with other interventions (Freire, 2007). The conditions of congruence, empathy and unconditional positive regard later became labelled as the core conditions (Wyatt, 2007). The conditions are a matter of degree and occur in moments in therapy, rather than being present the entire time (Rogers, 1959). The modelling of the conditions by the therapist helps the client to become more congruent, empathic and accepting of themselves, as well as towards others (Rogers, 1959). In this way, the provision of the conditions, similar to Bowlby's secure base or Winnicott's good objects, helps the client to feel safe, but also demonstrates a quality which the client can internalise. The experience of an accepting and compassionate other is particularly significant in work with people who are homeless, who have often been let down by unreliable and persecutory objects in their early environment.

Transference:

Winnicott (1958/1992) believes that transference enacted with the analyst can be best understood in terms of the infant-mother relationship. The patient, who experiences early environmental failure, will require regression to dependence in the analytic setting. In contrast, the patient, who manages to develop an intact ego, will find the past coming into the consulting room, '*the analyst's failure is being used and must be treated as a past failure, one that the patient can perceive and encompass, and be angry about now*.' (Winnicott, 1958/1992, p.298) Winnicott (1958/1992) in 'Hate in the Countertransference' emphasises the need for the analyst's awareness and management of his own fear and hate towards patients. Winnicott (1958/1992) controversially proposes that psychiatrists, as well as analysts, struggle with hateful feelings towards patients, resulting in brutal practices such as lobotomy and shock therapy. Winnicott (1958/1992) states, '*However much he loves his patients he cannot avoid hating them and fearing them, and the better he knows this the less will hate and fear be the motives determining what he does to his patients.*' (p. 195) A distinction is made between countertransference resulting from the analysts' unresolved issues, and objective countertransference, which is a justified reaction to the personality and behaviour of the patient (Winnicott, 1958/1992). Blum (1997) argues the notion of objective countertransference is paradoxical and questions whether a suspension of subjectivity is ever possible. The analyst's countertransference could demonstrate acting out, collusion or identification with a hateful patient (Blum, 1997).

Winnicott (1958/1992) states that mothers have hateful feelings towards their infants and provides a list of eighteen reasons for this; including the infant shows ruthlessness towards the mother, the baby '*treats her as scum, an unpaid servant, a slave*' (p. 201). The analysts' hate of the patient is comparable to the mother's hate of the infant; they both have to tolerate the strain, not act upon the hate, and receive no appreciation, '*When deeply regressed the patient cannot identify with the analyst or appreciate his point of view any more than the foetus or newly born infant can sympathize with the mother*.' (Winnicott, 1958/1992, p. 202) Winnicott (1958/1992) describes the case of a nine year old delinquent boy, who lived with him and his wife for three months of '*hell*' (p. 199), stating '*the boy's personality engendered hate in me*' (p. 200). Winnicott (1958/1992) says he never hit the boy, due to awareness of his feelings of countertransferential hate. During crises, Winnicott placed the boy outside the front door; the boy could ring a special bell to be readmitted to

the house, once his episode was over. Winnicott (1958/1992) informed the boy that his actions made him hate him:

> I think these words were important from the point of view of his progress, but they were mainly important in enabling me to tolerate the situation without letting out, without losing my temper and without every now and again murdering him. (p. 200)

The notion of hate in the countertransference is extremely applicable to work with homeless people, who evoke strong feelings of hostility and helplessness. Felix and Wine (2001) contend that treating homeless individuals relies on the ability of the therapist to remain attuned when confronted with intense emotions of hate and destruction.

Blum (1997) argues that Winnicott's response to the delinquent boy actually demonstrates denial of rage and acting out of the countertransference by the analyst; Winnicott placed the child outside in the cold, told him he hated him, and would not speak about the incident afterwards. Kahr (2011) claims that Winnicott highlights the importance of therapy and supervision for analysts, as well as the need for parents to have a support network:

> If we are to become the analysts of psychotic patients we must have reached down to very primitive things in ourselves, and this is but another example of the fact that the answer to many obscure problems of psycho-analytic practice lies in further analysis of the analyst. (Winnicott, 1958/1992, p. 196)

Ironically, Winnicott later became involved in the case of Masud Khan, who, according to Godley (2001), often practised abusively. Kahr (2011) notes there was no formal training in providing psychoanalysis to patients with symptoms of psychosis or borderline personality disorder when Winnicott was working. Consequently, Winnicott was a research analyst for such patients, covering new clinical ground to discover beneficial interventions. Patients often contacted Winnicott after unsuccessful treatments with other analysts and experienced significant safety and understanding with him (Kahr, 2011). Kahr (2011) states, '*Had Winnicott lived today, he would, in all likelihood, have offered food and shelter to the homeless mentally ill, overlooked by most people on the streets of many large cities*.' (pp. 202-3). This quote is extremely pertinent with the suggestion that Winnicott himself would have worked with individuals who are homeless.

Bowlby (1988/2005), like Winnicott, contends that the patient's early experiences with significant others are demonstrated in therapy in the form of transference. The patient is likely to perceive the therapist based on working models from experiences with attachment figures, rather than current experience. As a result, the patient's perception of the therapist

can be described as '*transference'* (Bowlby, 1973/1998, p. 239). The patient's feelings about the therapist reveal his beliefs and expectations of how an attachment figure would feel and behave towards him:

> When an analyst interprets the transference situation he is, among other things, calling the patient's attention to the nature and influence of those models and, by implication, inviting him to scrutinise their current validity and, perhaps also, to revise them. (Bowlby, 1973/1998, p. 239)

The task of the therapist is to help the patient to explore the ways he interacts with significant individuals in his life, including the therapist (Bowlby, 1988/2005). This involves reflecting on unconscious values and expectations, which influence emotions and behaviours, as well as beliefs about others. The therapist must help the patient to consider that his current beliefs are the product of experiences during childhood, especially with parents. This is often challenging, as the patient needs to consider intolerable or unimaginable emotions, and may experience reactions towards his parents or therapist which he finds undesirable. The patient's awareness and understanding of the transference enables him to reflect on the suitability of his working models and choose alternative models, which are more appropriate, '*By these means the therapist hopes to enable his patient to cease being slave to old unconscious stereotypes and to feel, think, and to act in new ways.*' (Bowlby, 1988/2005, p. 158)

Bowlby (1988/2005), like Winnicott and Rogers, proposes the therapist should be consistent, thoughtful, and empathic towards his patient. Some patients will display distrust, criticism, and anger towards the therapist, whereas others will express gratitude, admiration, and compliance. The therapist needs to be aware of misunderstandings or preconceptions that the patient may display and the earlier experiences from which these originate. Bowlby (1988/2005) suggests that if a therapist is confused or aggrieved by the way a patient is treating him, '*he is always wise to enquire when and from whom the patient may have learned that way of treating other people*.' (p. 164) Bowlby's notion of transference is very applicable in work with homeless people, where past trauma can result in feelings of persecution, abandonment, paranoia, or idealisation being projected onto those trying to offer help. The therapist who adopts an attachment based approach believes the patient's misconceptions are an appropriate outcome of their lived experience; whereas other psychoanalysts might '*see these same misperceptions and misunderstandings as the irrational offspring of autonomous and unconscious fantasy*.' (Bowlby, 1988/2005, p. 160) Bowlby is referring to his concern about the emphasis on

unconscious fantasy and neglect of actual events, associated with Freudian and Kleinian theories (Eagle, 2013). The patient's relationship with the therapist is not just the product of his history, but also established by the external environment in the way the therapist treats the patient (Bowlby, 1988/2005). The therapist has to endeavour to be aware of his participation in the relationship and the ways it may imitate the therapist's childhood. Bowlby termed this aspect of the therapy as countertransference:

> I want to emphasise not only the importance of the counter-transference but also that the focus of the therapy must always be on the interactions of patient and therapist in the here and now, and that the only reason to explore his past is for the light that it throws on his current ways of feeling and dealing with life. (Bowlby, 1988/2005, p. 160)

Rogers (1990/1998c) accepts transference exists in the therapeutic relationship, but, in contrast to Winnicott and Bowlby, does not believe it should be acknowledged or addressed. Emotions, which are directed towards the therapist, fall into two categories. The first consists of feelings which are an understandable response to the attitudes or behaviours of the therapist. The therapist may have a manner of superiority or offer incorrect interpretations, resulting in the client feeling demeaned, misunderstood, or coerced. Alternatively, the therapist's actions may generate positive feelings in the client, such as showing a deep understanding of the client or demonstrating concern for their comfort. The second group of emotions has little or no relationship to the therapist's behaviour. These feelings are genuinely '*transferred*' from their real origin to the therapist, thus they are '*projections*' (Rogers, 1990/1998c, p. 130). They can be triggered by the therapist, such as a physical resemblance to someone, but the intensity of feeling originates within the client. The true object of the emotion may be a parent, significant other, or a negative attitude towards the self, which the client is unable to accept. Rogers feels it is a '*grave mistake*' (Rogers, 1990/1998c, p. 134) to focus on transference feelings in therapy, as it fosters dependency and lengthens the process. It is not necessary to determine whether feelings are projections, as all emotions, transferential or not, should be responded to with the core conditions:

> In the therapeutic interaction, all of these attitudes – positive or negative, "transference" feelings, or therapist caused reactions – are best dealt with in the same way. If the therapist is sensitively understanding and genuinely acceptant and non-judgemental, therapy will move forward *through* these feelings. (Rogers, 1990/1998c, p. 130)

In contrast to the psychoanalytic emphasis on the transferential relationship, Rogers (1961/1997) believes in a 'real' relationship between the client and therapist. The therapist

needs to be a real, congruent person, genuinely accepting and prizing the client, as well as actually empathising with the client's situation. The client is in a relationship with a real person, which enables the client to become congruent and real:

> Being genuine also involves the willingness to be and to express, in my words and my behaviour, the various feelings and attitudes which exist in me. It is only in this way that the relationship can have *reality*… It is only by providing the genuine reality which is in me, that the other person can successfully seek for the reality in him…It seems extremely important to be *real*. (Rogers, 1961/1997, p. 33)

The congruent therapist is able to maintain a high level of self-awareness, understanding, and accept experiences as they occur (Thorne, 1992/1995). This involves an openness to inner experience, even if this jeopardises the therapist's self-concept; it is crucial that negative thoughts, emotions and values are acknowledged, in the same way as positive ones (Thorne, 1992/1995). The therapist must accept conflicting feelings, such as being afraid of the client, being preoccupied with their own problems or struggling to listen to the client (Rogers, 1957/1992). The therapist is only able to be completely open to the client's experience, if they are fully open to their own experience (Lietaer, 2001). Lietaer (2001) notes that in Rogers' later work, congruence is seen as having two facets; there is an inner quality where the therapist is '*openly being the feelings and attitudes that are flowing within at the moment'*, as well as an outer aspect, where the therapist is transparent to the client in the relationship, so the therapist's experience '*is available to awareness, can be lived in the relationship, and can be communicated, if appropriate*.' (Rogers, 1980, p. 115) Congruence involves two dimensions of existence, an individual's internal relationship to self, as well as their external relationship to others (Schmid, 2001).

Rogers (1961/1997) states that the concept of congruence means the therapist does not deny any emotions, acknowledges enduring feelings that exist in the relationship and is, '*able to communicate them if appropriate*.' (p. 61) It could be argued that congruence within the parameters of Rogers' definition is similar to the notion of countertransference in psychoanalysis, as they share the belief that the therapist's responses to the client may be useful in the work and the effectiveness of the therapist depends on their self-awareness (Wilkins, 1997). Yet, countertransference is seen as a reaction to the client and involves the unconscious, whereas congruence is a state of being in which the therapist is integrated in terms of their awareness and experience (Wilkins, 1997). Wilkins (1997) argues that empathy is more comparable to the notion of countertransference, as it involves being aware of thoughts and feelings provoked in the therapist by the client, which enables the therapist to gain a better understanding of the client's experiences. In being

congruent, the therapist may share their emotions with the client, especially if these are limiting the therapist's ability to be accepting and empathic (Rogers, 1957/1992). This disclosure could be seen as similar to Winnicott telling the delinquent boy that his behaviour made him hate him, as a way of managing the hate in the countertransference. The incongruent therapist will present in a contradictory manner, which may cause the client to feel distrustful and not explore disturbing issues (Rogers, 1961/1997). The therapist must be deeply involved in the experiential world of the client, not hiding behind a professional front or acting as a blank screen:

> With another person we recognise that what he is saying is almost certainly a front or a façade…With such a person we tend to be cautious and wary. It is not the kind of relationship in which defences can be dropped or in which significant learning and change can occur. (Rogers, 1967/1997, p. 283)

Many individuals who are homeless are highly observant and wary of others, so the ability to be real and authentic is fundamental in building trust with this client group. Yet, the disclosure of the therapist's feelings, that exist in the relationship, need to be expressed in a very sensitive way, as they can easily be experienced as impingements due to the client's fragile sense of self. Grafanaki (2001) argues that congruence is highly subjective, which had led to the concept being difficult to understand and research. There has been particular controversy over the idea of the therapist's self-disclosure and whether this provides permission for self-expression and acting out behaviour (Grafanaki, 2001).

Object Usage:

Winnicott (1971/1974) in his paper 'The Use of an Object' distinguishes between object relating and object usage, as an important process in development. An object in psychoanalysis is defined as, '*the thing in respect of which and through which the instinct seeks to attain its aim (i.e. a certain type of satisfaction). It may be a person or a part-object, a real object or a phantasied one.*' (Laplanche, 1998, p. 273) In object relating, the mother is perceived as an internal object, whereas in object usage, the mother becomes recognized as both an internal and external object. Winnicott (1971/1974) states, '*The development of a capacity to use an object is another example of the maturational process as something that depends on a facilitating environment*.' (p. 105) In early development, the object is within the subject's omnipotent control; the object is a '*bundle of projections*' and an extension of the subject (Winnicott, 1971/1974, p. 103) In object usage, the object

becomes an objective object, perceived as having an external, autonomous existence. The object can then be used for exchange, challenge, and growth, supporting creativity and self-expression. In object relating the subject is described as an '*isolate*', whereas in object usage the subject can engage fully with others in a shared reality:

> This thing that there is in between relating and use is the subject's placing of the object outside the area of the subject's omnipotent control, that is, the subject's perception of the object as an external phenomenon, not as a projective entity, in fact recognition of it as an entity in its own right. (Winnicott, 1971/1974, p. 105)

In order for the subject to transition to object usage the, *'subject destroys object'* (Winnicott 1971/1974, p. 105); the infant destroys the mother in unconscious fantasy, to place her outside of omnipotent control. The object, who survives destruction, as there may not be survival, becomes real and external. The subject can use the object that has survived and live in the world of objects (Winnicott, 1971/1974). Winnicott (1971/1974) states, '*From now on the subject says: 'Hullo Object!' 'I destroyed you.' 'I love you.' 'You have value for me because of your survival of my destruction of you*.' (pp. 105-6) Goldman (1998) notes this paper demonstrates the ways the internal and external worlds are discovered to be separate but interconnected. Ghent (1992) argues that this process could be seen as the beginnings of intersubjective experiences, where subjective realities are shared.

Winnicott (1971/1974) proposes that it is crucial for analysts to be concerned with the development of the capacity to use objects, as this is, '*the most irksome of all the early failures that come for mending*.' (Winnicott, 1971/1974, p. 105) Analysts must not offer interpretations in the phase of object relating, as it can interfere with the process and seem like self-defence, with the analyst imitating the patient's attacks. The analyst's interpretations will have no effect if the patient is unable, '*to place the analyst outside the area of subjective phenomena*' (Winnicott, 1971/1974, p. 102). The patient, who does not develop the capacity to use objects, will only ever be able to engage in a 'self-analysis', where the analyst is seen as a projection of the self. The analyst and the analytic setting will either survive or not survive the patient's destructive attacks. Destruction is the patient's attempt to place the analyst in the world, outside of omnipotent control:

> These attacks may be very difficult for the analyst to stand, especially when they are expressed in terms of delusion, or through manipulation which makes the analyst actually do things that are technically bad. (I refer to such a thing as being unreliable in moments when reliability is all that matters, as well as survival in terms of keeping alive and of absence of the quality of retaliation.) (Winnicott, 1971/1974, p. 108)

The term ‘destruction’ is not employed due to the subject’s need to destroy, but due to the object’s potential of not surviving. Winnicott notes that some analysts, like some mothers, may be good enough or not good enough to help the patient to transition to object usage. The destruction of the object does not involve anger or aggression; it is an act of discovery and creation, where there is joy at the object’s survival (Winnicott, 1971/1974). Abram (1996/2007) notes Winnicott distinguishes between healthy and pathological destruction. Healthy destruction occurs in unconscious fantasy, which demonstrates maturity and integration. Pathological destruction is acted out, revealing immaturity and an aggression which remains detached. Slochower‘s (1994) position is that in ‘holding’, the analyst's provision of emotional attunement protects the patient from the impact of the analyst's external existence. The attainment of object usage may involve gradual failures in adaption being combined with the holding experience. The discovery of the analyst's subjectivity, alongside the analyst’s toleration of being loved and hated as an external object, results in the capacity for object usage (Slochower, 1994).

Bowlby (1988/2005), like Winnicott, contends the therapist should support the patient’s transition to a more attuned and reciprocal way of relating, ‘*For a relationship between any two individuals to proceed harmoniously each must be aware of the other’s point-of-view, his goals, feelings and intentions, and each must so adjust his own behaviour that some alignment of goals is negotiated*.’ (pp. 147-8) People who are homeless can struggle to understand their own mind and the minds of others; therapeutic work with these clients involves helping them to strengthen these capacities. Bowlby (1988/2005) suggests the therapist must help the patient to communicate about parts of their experience, which have had to be denied, to develop a more accurate model of self. A child learns two main modes of behaviour based on interactions with parents and develops working models based on these (Bowlby 1988/2005). These models may be demonstrated towards the therapist, ‘*Not infrequently a patient shifts during the therapy from treating his therapist as though he was one or other of his parents to behaving towards him in the way one of his parents had treated him.*’ (Bowlby, 1988/2005, p. 163) The therapist must help the patient to comprehend that his feelings originate from past experiences, and although understandable, may not be beneficial for him currently. Bowlby (1988/2005) notes he has been criticised for developing an attitude that ‘*simply blames parents*’ (p. 165), despite acknowledging parents’ negligent behaviour is often a product of their own difficult childhoods and attempting to help parents recover from the impact of their own early experiences. He contends it is important for the therapist to accept the patient’s account of

their parents, whilst avoiding moral judgement, and encouraging the patient to consider the reasons that their parents had behaved in those ways:

> In raising these questions, it is always useful for the therapist to enquire of the patient what he knows of the childhood experiences that the parent in question may have had. Not infrequently this leads the patient to gain some understanding of how things developed and, from understanding, often to move on to a measure of forgiveness and reconciliation. (Bowlby, 1988/2005, p. 165)

In therapy a patient may continually describe terrible childhood experiences, but without any progress being made, even when the therapist shows acceptance of the patient's narrative (Bowlby, 1988/2005). Bowlby refers to research by Fraiberg and colleagues (1975, cited in Bowlby, 1988/2005), who worked with vulnerable mothers at risk of abusing their infants. The mothers told distressing accounts of abuse during their childhoods, including violent beatings and abandonment. Yet, they did not express any emotions, dismissed their experiences, and said they just wanted to forget them. One therapist responded by articulating the emotions any child would be likely to experience in such a situation, including feeling terrified, angry, despairing, and craving protection and comfort, '*In doing so the therapist not only showed an understanding of how the patient must have felt, but communicated in her manner that the expression of such feeling and desire would be met with a sympathetic and comforting response*.' (Bowlby, 1988/2005, p. 176) The empathic response enabled the mother to express her grief and distress, which she had never attempted to articulate (Bowlby, 1988/2005).

Bowlby (1988/2005) states the failure to express emotion is connected to an unconscious anxiety that this will cause negative consequences. Effective therapy, for Bowlby, requires the patient to not only talk about their experiences, but to express emotions. During early childhood emotional expression is the main form of communication, thus it becomes the foundation to build working models of the self and attachment figures, '*Small wonder therefore, if, in reviewing his attachment relationships during the course of psychotherapy and reconstructing his internal working models, it is the emotional communications between a patient and his therapist that play the crucial part*.' (Bowlby, 1988/2005, p. 177) Individuals experiencing homeless, similar to the mothers in Bowlby's account, often appear emotionally detached when speaking about traumatic experiences. Yet, many clients struggle to tolerate empathic responses from others, as they feel unbelievable, alien and uncomfortable. In my experience, it can take considerable time to establish a secure-enough relationship, in which empathic responses can start to be accepted by the client.

Rogers (1957/1992), like Bowlby and Winnicott, believes the therapist needs to facilitate the client's move towards an integrated way of relating, which includes empathic understanding. Empathy allows an individual to understand their own emotions, as well as the emotions of others, which supports communication and guides behaviour (Baughan & Merry, 2001). It is crucial for the therapist to demonstrate empathy as it is a healing agent, '*It is one of the most potent aspects of therapy, because it releases, it confirms, it brings even the most frightened client into the human race. If a person is understood, he or she belongs*.' (Rogers 1986, quoted in Haugh & Merry, 2001, p. 231) This quote is particularly relevant to homeless people who experience hostility, disinterest and neglect from others. Cockersell (2018) recounts a person who was homeless telling him that '*the only difference between me and the binliners is that somebody comes to collect them each day*' (p.15). Adshead (2019) notes that every year, at least one homeless person is murdered by people who seem to view them as '*a type of organic rubbish that does not count as human*.' (p. xvi)

Rogers (1961/1997) suggests the therapist should aim to perceive the client's internal frame of reference and underlying emotions, as well as communicate their understanding. It is crucial for the therapist to suspend evaluation, but possess a secure sense of self to not get lost in the client's world. The therapist must tentatively offer responses to quantify the accuracy of their understanding, correct misunderstandings, and discover deeper levels of meaning (Rogers 1961/1997). One of Rogers' clients commented, '*It was like Dr. Rogers was a magical mirror. I looked into the mirror to get a glimpse of the reality that I am*.' (Slack, 1985, quoted in Rogers, 1990/1998b, p. 128) A client who feels understood will connect with a wider range of experiences and then can integrate these into a revised self-concept (Cooper, 2007). Rogers states, '*The individuals' greater understanding of and prizing of themselves opens to them new facets of experience which become part of a more accurately based self-concept*.' (Rogers, 1980, p. 159) A client who receives empathic understanding will feel valued, as it is not possible to profoundly understand another's world without a level of esteem (Rogers, 1980). The process of being recognised by another is a form of affirmation, which is essential to the development of identity (Zinschitz, 2001). Comparable to Winnicott's notion of the attuned mother, Rogers (1980) holds that empathy enables an individual to exist:

> Laing (1965) has said that "the sense of identity requires the existence of another by whom one is known" (p.139). Buber has also spoken of our need to have our existence confirmed by another. Empathy gives that needed confirmation that one does exist as a separate, valued person with an identity. (p. 155)

Rogers (1959) proposes all human beings have a persistent need for positive regard, which is fundamental for psychological existence. The therapist must experience unconditional positive regard towards the client, which is described as a prizing, valuing or accepting attitude:

> The therapist is willing for the client to be whatever immediate feeling is going on – confusion, resentment, fear, anger, courage, love, or pride. Such caring on the part of the therapist is nonpossessive. The therapist prizes the client in a total rather than a conditional way. (Rogers, 1980, p. 116)

The therapist's prizing of a client can be compared to a parent's prizing of a child, the parent values and accepts the child, despite not approving of all of the child's behaviours (Rogers, 1959). Unconditional positive regard facilitates the client's trust, integration and acceptance (Thorne, 1992/1995). Rogers (1980) states, '*Caring is an attitude that is known to foster creativity – a nurturing climate in which delicate, tentative new thoughts and productive processes can emerge*.' (p. 160) The therapist experiences moments of unconditional positive regard towards his client, yet at other times he experiences a conditional regard, and potentially, although unlikely, a negative regard (Rogers, 1957/1992). Rogers (1961/1997) acknowledges the challenges of this condition, '*I have found that truly to accept another person and his feelings is by no means an easy thing, any more than is understanding. Can I really permit another person to feel hostile toward me?*' (p. 20)

Unconditional positive regard requires the ability to be non-defensive and receptive to the other's experience, but with a strong sense of self to survive without being, *'destroyed by his anger, taken over by his need for dependence, not enslaved by his love*' (Rogers, 1990/1998a, p. 121). The therapist is only able to experience unconditional positive regard towards the client, if they can experience unconditional positive self-regard, '*the curious paradox is that when I accept myself just as I am, then I can change.*' (Rogers, 1961/1997, p. 17) Bozarth (2007) notes there are differing views within person-centred therapies on the condition of unconditional positive regard; some view it as the most important condition, whereas others believe it is an unachievable task for the therapist and incompatible with congruence. In my work, I find acceptance to be the most challenging, as well as the most potent, condition. Individuals who are homeless will often enact hostile and helpless roles, unconsciously trying to provoke criticism, anger or rejection in new relationships; the

expression of acceptance can be seen as crucial in order not to replicate early experiences of abuse and abandonment.

Summary:

Chapter three has explored Winnicott’s, Bowlby’s and Rogers’ views on the nature of the therapeutic relationship. The theorists share the belief on the significance of the relationship and qualities of the ‘good-enough therapist’, who provides a facilitating environment. Winnicott and Rogers crucially highlight the importance of the therapist’s authenticity in the work and the dangers of compliance for both therapist and client. Winnicott, in his notion of object usage, explores the ways an individual discovers the internal and external worlds through destruction of the subjective object, enabling individuation as well as relational connection. It has been suggested that object usage could be seen as similar to the concept of intersubjectivity, in terms of the awareness of the interaction of subjective realities (Ghent, 1992). Bowlby and Rogers similarly believe that a securely attached or congruent individual develops an autonomous sense of self, as well as an ability to understand and connect with others. In attachment theory, the notion of 'mentalization', which is the ability to understand one’s own mental state, as well as the mental states of others, can be seen as comparable to object usage. These concepts are pertinent to my work, where clients often struggle with the ability to mentalize or revert to states of ‘*pre-mentalization*’ (Cockersell, 2019, p.119).

Winnicott differs in proposing that the process of ‘destruction’ occurs within the subject's inner psyche and the therapist’s role is to survive being destroyed. In contrast, Bowlby and Rogers view the process as a relational interaction, where the therapist’s empathic and accepting responses enable the client to better understand their own mind, as well as the minds of others. Rogers, in contrast to Winnicott and Bowlby, emphasizes the importance of congruence and the ‘real’ relationship, rather than the transferential. The concept of congruence, which includes the therapist’s reactions to the client and the use made of them, could be seen as equivalent to the notion of countertransference. Yet, countertransference involves the unconscious and is seen as a product of the analytic relationship, whereas congruence is a result of the therapist’s inner state and has to be perceived by the client for trust to develop (Wilkins 1997). In my work with the homeless,

there can be dynamics of both the real and transferential relationships; clients can be highly sensitive to whether others are being genuinely accepting towards them or not, whilst also provoking transferential re-enactments. Bowlby believes it is fundamental for patients to understand the relationship between their internal working models and early environmental experiences; this concept has been developed in attachment psychotherapy as the notion of 'autobiographical competence' (Holmes, 2014). In the next chapter, I will analyse the relevance of the theories on trauma and the therapeutic relationship to the practical context of my work with homeless individuals.

Chapter Four:

Themes in my work with people who are homeless

Introduction:

I work with a group of individuals who are defined as being homeless or having experienced homelessness. This chapter will explore the themes that arise in my work with this client group and consider whether the theories of Winnicott, Bowlby and Rogers can be usefully applied to conceptualise the presenting issues and guide therapeutic interactions. Historically various terms have been used to describe people without a permanent home, such as vagrant, vagabond, down-and-out, tramp, hobo, and bag lady. The term 'tramp' originally referred to skilled workers who moved around the country looking for work, but by the 1870s it was associated with unskilled labourers, reliant on the state for charitable assistance (Crowson, 2018). Lund (1996, cited in Pickard, 2014) claims that the modern concept of 'homelessness' did not exist before the twentieth century, for centuries vagrancy was associated with unemployment and punishable by law. The National Assistance Act of 1948 and Housing (Homeless Persons) Act of 1977 were significant as they focused on providing help and resources for people who were homeless (Pickard, 2014).

Homelessness tends to be seen as a housing issue, dismissing intrapsychic factors that shape profound disconnection and exclusion; perhaps due to the disturbing feelings of fear, shame and pain that homelessness can evoke in people (Campbell, 2019b). I have worked in various roles with individuals experiencing homeless for over nineteen years and have knowledge of both the physical and psychological issues that they experience. I am currently employed by a charitable housing association as a counsellor, working within a residential hostel for individuals who are homeless. Many of my clients are housed in the main hostel, others live in community shared houses, and some have gained independent housing through the organisation's resettlement scheme. The group of people defined as 'homeless' are not homogenous, consisting of numerous sub groups, such as offenders, drug and alcohol users, psychiatric patients, and care leavers (Cockersell, 2018). Individuals

can present with complex multiple needs, which contribute to the challenges in supporting them.

I have composed three case studies of Paul, Kelly and Bob to demonstrate aspects of my therapeutic work. The case studies are fictional but based on a composite of events that have happened to individuals I have worked with. They can be seen as typical narratives in the homeless community and representative of the trauma many individuals have experienced. The use of case studies in psychoanalytic writing is contentious due to issues around confidentiality, the prevention of harm to the patient, and impact on treatment (Goldberg, 1997; Gabbard, 2000; Kantrowitz, 2010). Case studies which employ disguises or change details have been criticised for being unreliable, invalid, and misleading (Michels, 2000). Yet, Kantrowitz (2010) suggests that composite case studies are successful when clients have similar characteristics and aspects of one case illustrate issues in others. It has been suggested that the aim of writing case studies is primarily about conveying new understanding or expressing, '*an authentic representation of states of feeling rather than a strict adherence to narrative truth.*' (Orbach, 2002, pp. 225-6) I contend that composite case studies are an effective way of illuminating the marginalised lives of people who are homeless, whilst maintaining privacy. I am going to explore the application of the theories to my work under the themes: the brick mother, traumatic impingements, the facilitating environment, and composite case studies. Firstly, I will explore the current literature regarding psychoanalytic psychotherapy with the homeless.

Current Literature:

Responses to homelessness in the United Kingdom have often been based upon political agendas and focused on physical resources, without acknowledgment of the psychological forces that create and maintain social exclusion (Adshead, 2019; Brown, 2019; Seager, 2011). Stuart Shorter, emotively expresses, '*Homelessness – it's not about not having a home. It's about something being seriously f(***)ing wrong.*' (Masters, 2005, p. 37) The homeless have tended to be seen as not 'suitable' or 'treatable' by mainstream mental health services or psychotherapy provision. Yet, research has illustrated that homelessness can be effectively addressed with awareness and treatment of underlying intrapsychic problems (Campbell, 2006/2019); there is a relationship between complex trauma, personality disorder and homelessness (Maguire et al., 2010); psychoanalytic theories can

offer ways of understanding and responding to difficulties of feeling settled, housed and contained (Brown, 2019). Gwen Adshead (2019) has written about the connection between insecure attachment styles and homelessness. According to Adshead (2019), 'home' is often perceived as a place of security, so homeless people can be seen as being both physically and psychologically insecure. Adshead (2019) notes that the majority of people who are chronically homeless are likely to have insecure attachment styles, particularly avoidant and disorganised. Research shows individuals who experience childhood adversity, particularly neglect and abuse, will be at a heightened risk of developing minds that are unstable, impacting on their abilities to create enduring social connections and inhabit an identity of their own. Adshead (2019) states, '*Professionals working with the homeless can therefore expect to be working with people with personality disorders, whose attachment security of mind has been profoundly disorganised by chronic repeated trauma and unresolved fear and distress.*' (p. xv)

Scanlon and Adlam (2006) propose that the development of a psychological skin, or home, is dependent on the presence of a secure relationship during infancy, where a child can learn that they are safely housed within their own skin and another's mind:

> In terms of attachment theory, 'the secure base' is another way of saying that in ordinary development the experience of 'home' is linked to the experience of one's self as being housed in others', usually parents', minds. The likely outcome of secure attachment during childhood is a mind with a 'lived-in' feel, which can be valued and looked after. (p. 11)

In contrast, children whose attachment figures have been the source of harm and fear are often traumatised by experiences of '*intrusion or abandonment*'; leaving them unable to develop the capacity to understand and process feelings of distress (Scanlon & Adlam, 2006, p.11). Scanlon and Adlam (2006) utilise the image of a house or building as a metaphor for the mind and body; they suggest that a person who experiences their internal psychic home as enduringly empty will also struggle to feel secure in the external space of a house. The homeless can be described as being '*psychologically unhoused*', or having a mind that is '*unhoused'*, as the inability to secure a physical home can mirror the absence of finding a psychological home in the mind of another during development (Adlam & Scanlon, 2006, p.10). Individuals, who have experienced intrusion or abandonment from attachment figures, will be caught between two extremes of fear and longing, wanting to avoid being inside anything, but also desperate to be known and inside the mind of others (Scanlon & Adlam, 2006).

Cockersell (2018), who developed the Lifeworks Psychotherapy service for the homeless charitable organisation St Mungo's, acknowledges links between adverse early life experiences, compound trauma, and homelessness. Cockersell (2018) describes the situation of a man, who had been rehoused 88 times,

> For him, homelessness was not primarily a housing issue: it was a product of his sense of relatedness and stability, or rather his sense of unrelatedness and instability, a sense that arose from specific experiences and relationships in his childhood compounded by later experiences and relationships as he grew up. (Cockersell, 2018, p. 17)

Saunders (2018), who established a psychotherapy service for homeless women at St Mungo's, refers to the ways that an understanding of trauma and attachment theory underpins the work, '*psychotherapy provision was guided by the understanding that the childhood environment within which women grew up failed them because it was neglectful and abusive and left them unable to trust and depend upon it safely*.' (p. 137) Brown (2019) also argues that difficulties gaining and maintaining housing in adult life can reflect issues in early environmental provision, such as deficient responses from significant others. According to Brown (2019), the un-housed mind is haunted by fear of the repetition of past trauma as future catastrophe, which is comparable to Winnicott's fear of breakdown. An individual, who has experienced trauma and loss in their early environment, may experience a new home as revisiting the nightmare of the past, *'home is haunted by 'un-dead' parts of the mind and fears of confrontation with an early damaged self.*' (Brown, 2019, p. 116) Brown (2019) suggests that homelessness can be seen as representing a solution to intolerable internal states and traumatic histories; it is a system of defences that hold the traumatised mind together, as well as a symptom of the traumatised inner psyche. Similarly, Kalsched (1996) argues that the inner psyche responds to overwhelming life events, such as trauma, by creating dissociative or primitive defences; these guard against further trauma through isolating the core self from reality. These defences can be maladaptive, but also miraculous and life-saving, providing both protective and persecutory guardianship of the core self (Kalsched, 1996).

The current literature on psychoanalysis and the homeless informs my research, such as the ways that individuals may feel physically and psychologically insecure as a result of not experiencing a nurturing environment in early life. However, there are differences between the psychoanalytic literature and my research, including my working environment and the use of Rogers' theories. The psychotherapy services at St Mungo's are not based in a residential environment; therapy is offered in locations such as offices, GP surgeries, and

day centres. Cockersell (2018) notes, '*Clients often prefer to be a certain distance from their 'homelessness-homes' (hostels, shelters etc.) it seems, to safely go to the wounded places that they can visit in therapy.*' (p. 86) In England, employing psychotherapists in a homeless service has not been common; therapists tend to go into services to deliver interventions, which results in treatment being '*complementary*' rather than an '*integrated*' part of the service (Cockersell, 2018, p. 94). In contrast, I am employed to work within a residential hostel as an integrated part of a housing organisation. I have found that creating a secure base, physically as well as psychologically, is crucial to the work with this client group. It could be argued that for individuals who present with extremely fragmented senses of self, it feels containing to be physically and psychologically accommodated in the same place. I will explore the benefits and challenges of working within a residential environment in the section entitled 'the brick mother'. The current literature refers to the importance of offering empathy and acceptance to a homeless client group, but does not acknowledge any particular theorists (Adshead, 2019; Cockersell, 2018). In contrast, my research focuses on the work of Rogers, alongside Winnicott and Bowlby. In my experience of work with homeless people, being genuinely accepting and consistently authentic is fundamental in building a trusting relationship and helping marginalised individuals feel connected to others. Rogers claims that the conditions are necessary and sufficient; yet, it could be argued that homeless clients require an accepting and compassionate therapeutic approach, but one which is founded upon a psychoanalytic understanding of developmental needs and transferential dynamics.

The Brick Mother:

The charitable housing association that I work for owns a residential hostel, which houses single men and women over the age of eighteen years. The hostel can be seen to function as a facilitating environment, in terms of providing shelter, food, and warmth, as well as twenty four hour support from the staff team. Winnicott (1984/2000, p.57) states that delinquent children need '*primary home experiences'* to support them to work through developmental issues. The physical provision of the institution, including the meals, bedspreads, and bricks of the building, is therapeutic in itself (Winnicott, 1984/2000). Henry Rey (1994) refers to the Maudsley Hospital as 'the brick mother', due to the importance of the hospital as a place of safety for patients, which offers continuity and

stability. The hostel could similarly be described as the brick mother or secure base for many homeless individuals, who return over the years at times of distress. A hostel can be seen to offer the solaces of a home, a substitute family of support workers, and relief from the dangers of rough sleeping (Campbell, 2019b). Yet, some individuals struggle with living in the hostel, resulting in defiance of the rules and sabotaging of tenancies. A reason for this could be negative associations with the concept of home, *'home is a dangerous place whose meaning is laden with anxiety, through trauma and memory, and whose form, in the shape of a house, is constantly sought, and constantly lost, abandoned or destroyed.'* (Campbell, 2019b, p. 58) Campbell (2019a) notes that individuals who have suffered abuse and neglect in infancy may experience disproportionate reactions to events associated with 'mother', such as being given a meal in a homeless shelter:

> In the absence of a capacity for discriminatory thinking to help process such reactions, deeply unconscious representations of the primary maternal or facilitating environment are likely to come to the fore without recognition of either their familiarity or what they represent in personal experience. (Campbell, 2019a, p. 29)

The hostel provides a stage for various transferential enactments amongst the clients and staff team. Haig (2013) observes that clients often present ambivalently with a longing to form relationships and be understood, as well as a need for distance and separation:

> Often, attachment is both strongly sought and fiercely feared (and resisted): the struggle between desperate neediness and angry rejection. Not enough stable ground has developed between, and the demands of reality almost always meet the emotional responses of pain, anger, humiliation and shame. (p. 8)

It is not uncommon for homeless clients, with fragmented senses of self, to exhibit primitive defences of projective identification, splitting and acting out. It can be difficult for the staff team to make sense of the clients' challenging behaviours, especially when they appear both helpless and hostile (Campbell, 2019b). Efforts by the staff to help clients are often resisted and refuted, leading to disappointment, anger and frustration. Housing staff may, *'unknowingly replicate something of the homeless person's history… making concrete and external the features of that individual's destructive internal object world*.' (Campbell, 2019b, p. 58) The hostel can be perceived as a family, community, or institution, due to the rules of the organisation. Winnicott (1984) notes that in hostels for delinquent youths, there is a phase of testing the building and people, to see the amount of damage that can be tolerated. The level of containment offered in the hostel has limits; the staff team are not permitted to restrain clients, clients can choose to leave, or they can be evicted for breaking the rules. On occasion, the relationship between the client and hostel breaks

down, potentially replicating early environmental failure. Yet, the organisation often re-accommodates individuals, which potentially leads to a mending of the failure.

The counselling service has benefitted from being based within the hostel and embraced by the organisation. Many clients, who experience the hostel as a secure base, have felt able to engage in counselling due to it being offered in a place that is familiar and supportive. Counselling can offer psychological containment in conjunction with the physical containment provided by the hostel. One client acknowledged that my job was to help her with her 'head', whilst the hostel staff helped her with practical issues like medication; she was able to bring her mind and body to be housed 'under one roof'. The therapeutic role provides support for the staff team, who can request consultations regarding clients' mental health issues. Yet, there are challenges of offering a therapeutic service in a non-therapeutic environment. There can be a conflict between the symbolic positions of the '*material provider (housing/body')* and the *'thinking process (psychotherapy/mind)*' (Campbell, 2019b, p. 59). Unconscious dynamics influence interactions between the hostel staff and myself; some of the team are idolising of the therapeutic position, believing that I will have the answers or 'sort out' any difficult client. In contrast, others are unreceptive or dismissive; suggestions of trying to understand a client's internal world have been experienced as critical, threatening or demanding. I have experienced feeling like an instrumental part of the organisation, as well as an outsider; my transferential experience of marginalisation could be seen to parallel many of my homeless clients' experiences. The use of clinical supervision and personal therapy to explore my own processes has been essential in managing these experiences.

Traumatic Impingements:

The clients in my caseload tend to describe childhoods lacking in physical and emotional safety, where themes of abuse, neglect, rejection and separation are common. Caregivers are recalled as unresponsive and unreliable, often having their own unresolved issues with mental health, addiction, domestic violence, divorce, and bereavement. In terms of Winnicott's theory, individuals who are homeless appear to have suffered significant

trauma in their early facilitating environment, where there was no one available to 'hold' them physically or psychologically, in conjunction with actual incidents of abuse and neglect. They have had to disconnect from aspects of their experience in order to comply with the environment, resulting in a fragmented sense of self. These individuals have developed working models, where others are perceived as dangerous and unreliable, and the self is seen as unlovable and insignificant. Self-blame tends to be common amongst these clients, who have developed beliefs that they are 'bad', 'worthless', and to blame for their early experiences (Saunders, 2018). Brown (2019) notes, '*Maltreated children become 'containers' for a perverse and malign emotional environment through a type of absorptive introjection, taking all that is rotten and corrupt into themselves*.' (p.47) Brown (2019) contends that through adopting the role of being the 'problem' in a dysfunctional system, the child is able to imagine that they are cared for by '*benign, blameless and nurturing objects or people*.' (p.47) Similarly, Cockersell (2018) contends that a child may need to deny the hostility of the environment, on which they are dependent, by blaming themselves. These difficult feelings need to be psychically disowned, resulting in the bad part of the inner world being projected onto others and external situations. The perception of the world as a harmful and neglectful place is often validated by actual experiences of maltreatment (Cockersell, 2018). Many individuals who are homeless have had early trauma compounded through repeated experiences of abuse, deprivation, violence, marginalisation and a lack of compassion from society.

Relationships, for homeless people, are often equated with feelings of harm and distress, resulting in rejection of help when it is offered, '*at the times when they seek care, the fearful attachment figure in their internal working model will come to the fore, displacing other supportive experiences of relationship.'* (Saunders, 2018, p. 138) The absence of a secure base is demonstrated in mistrust of others, high emotional arousal, primitive defences, an incoherent sense of self and an inability to regulate emotions. Abusive or neglectful caregivers tend to dismiss the child's emotions and present a reflection of their own overwhelmed states of mind; the child experiences being obliterated and not existing, comparable to Winnicott's primitive agonies (Holmes, 2006; Motz, 2019). In sessions, clients will say that they are frightened of their emotions, as they will consume or destroy them. One client said that when I looked at him, it was like the 'penance stare' of Ghost rider, a marvel comic character, who gazes into individual's souls (https://marvel.com). Ghost rider's stare causes the victim to feel all the pain they have caused to others or themselves, emotionally and physically, leaving them in a catatonic state

(https://marvel.com). It could be seen that these clients fear the breakdown that has already happened in the early facilitating environment (Winnicott, 1974). Individuals who are homeless can have intense reactions to seemingly trivial situations, such as having to wait to use the telephone in the office, the time of meals being changed, or not being able to use the washing machine after a certain time. These situations could provoke uncomfortable feelings of dependency. Howe (2005) notes, '*Their emotions explode in an infant-like and unregulated manner, producing powerful feelings of fear, rage, hostility and shame, triggered by events, however innocuous to the observer, that seem to echo old hurts and dangers*.' (p. 167) It could be argued that any impingement potentially replicates early failures, which were never mended, triggering the same intolerable, devastating emotions.

People who are homeless often present with a lack of integration between their minds and bodies. They can be seen to neglect and annihilate their bodies through rough sleeping, substance use, violence, accidents, prostitution, suicide, self-harm, lack of nutrition, and not accessing health care. Winnicott (1974) proposes that it is the mother's devoted care of the baby that enables the capacity for '*in-dwelling*' and '*psychosomatic collusion*' (Winnicott, 1974, p. 103). In situations where the infant has to comply with environmental demands, the pathological mind-psyche disavows the body (Winnicott, 1974). Brown (2019) contends that enduring patterns of somatic communication result from problems in early nurturing, where thoughtful and attuned responses were lacking, '*The individual's failure to care for his or her adult body repeats scenarios of early neglect or abuse that enduringly dominate the internal psychic landscape.*' (p. 43) It is common for homeless clients to present with bodily odour in the counselling room, through neglecting to wash, wearing unclean clothes, and incontinence. Clients can seem unaware of their odour and the impact of this on others. A client attended a counselling session covered in faeces after having a seizure; the smell was so overpowering that it caused me to severely retch, resulting in the session ending prematurely. Fonagy (1999, cited in Brown, 2019) notes that individuals who have suffered early trauma become, *'hypervigilant towards others but uncomprehending of their own states*.' (p. 44) Some clients will not have a shower unless prompted by the staff team and their rooms are found in unsanitary states. Clients are often told by the staff that they 'smell', but seem to struggle with any sense of agency in relation to this. One of my clients was found to be hoarding out of date food, including chocolate eclairs and salmon terrine, amongst clothes in his room. Another client reported that a chicken carcass, which he had found in a bin and taken to eat, was 'moving'. My initial concern was that he could

be experiencing a psychotic episode, but when the staff checked his room, they found that the reason for this was the carcass was full of maggots.

Insufficient facilitating environments cause individuals to create defensive processes to deal with disturbing emotions and traumatic memories (Bowlby, 1988/2005). The use of substances can be seen as a defense strategy, helping to regulate disorganised states of mind and anaesthetise tormented inner worlds. Many of the homeless clients that I work with have histories of substance misuse; they can be actively using substances such as alcohol, heroin or crack, engaging in a recovery programme, or maintaining abstinence. Individuals who have not been soothed by an attuned other will lack experiences of inner comfort and coherence, which can lead to the substitution of chemical connections for human ones. In this way, substance misuse can be understood and responded to as an attachment disorder (Khantzian, 2014; Flores, 2001; Walant, 1995). Khantzian (2014) states, '*When early attachments have been compromised, disrupted, traumatic, and neglectful, the human tendency is one of relational retreat and isolation and to attach to the inanimate dependencies of addictive substances and behaviours.*' (p. 42) Opiate users describe the effect of the drug as producing an intense comforting, soothing feeling, which could be seen to imitate the experience of the secure base (Holmes, 2006). In contrast to the secure base, the dependence on the substance remains external and leaves the individual as an isolate. In terms of Winnicott's theory of 'object usage', clients using substances present in a narcissistic stage of object relating, where others are dominated and manipulated to meet their needs. Flores (2001) refers to a saying from Alcoholics Anonymous *'we don't have relationships, we take hostages*.' (p. 64) Wright (2014) considers addiction in terms of attachment to a 'dead object', proposing that if the internal structure of the psyche was developed when there was an inadequate holding environment, the infant may have experienced relations with actual objects that felt dead.

A Secure Base:

The developmental theories of Winnicott, Bowlby and Rogers are particularly useful when working with homeless clients who present with deficient experiences of early relationships and fragmented senses of self. It is essential to offer a secure base, both physically and psychologically, where clients can feel accepted and understood. I have a designated

counselling room within the hostel, which has been decorated and furnished to create a comfortable space. It could be seen that the counselling room provides a form of physical 'holding', in the same way that the mother adapts an environment to her infant's needs. The consistency of the space helps to facilitate feelings of reliability, whilst the physical boundaries of the room help clients to feel contained. Bowlby (1988/2005) proposes that therapy cannot begin unless a patient feels a degree of security; the secure base must be established before challenge occurs (Holmes, 2006). Yet, building a secure base can be seen as the therapeutic work with homeless clients and confrontation as a part of that process. The act of engaging in counselling is challenging for these individuals, triggering attachment systems and defensive strategies. This is demonstrated in erratic attendance patterns, forgetting appointments, turning up late, and dipping in and out of therapy. Some clients find it difficult to stay in a session for more than ten minutes, whereas others find it difficult to leave. Clients have left midway through a session to make a drink, smoke a cigarette, or answer their mobile phones in sessions. These individuals yearn to be known in the mind of another, but fear harm and abandonment (Scanlon & Adlam, 2019). Saunders (2018) states that it is important that therapists are aware that clients may be fearful of therapeutic engagement and their fight or flight reflexes are likely to be activated:

> This understanding enables the psychotherapist to prepare herself for being experienced as frightening and for her to be mindful of how she communicates this to the client; this includes her tone of voice, body language and the words she uses. (p. 138)

In numerous aspects of my work with homeless people, I modify standard techniques due to the clients' developmental issues and the need to establish a secure base. Homeless clients can present with fragile ego strength, where they need to experience a sense of omnipotence. Winnicott proposes it is crucial to suspend interpretation in analysis when patients require a 'holding environment'. Initially, the focus needs to be on offering Rogers' core conditions, as many clients only seem to manage therapeutic contact when they experience being deeply accepted and understood. Other adaptions include being tolerant of chaotic patterns of engagement and making the service easily accessible; clients who indicate they want counselling are usually offered sessions. I also send text messages to remind clients' about their counselling appointments; the text has a practical function of reminding the client about the date, as well as providing psychological 'holding', demonstrating that I am keeping the client in mind outside of sessions. I have provided supporting letters for GPs, mental health teams, and benefits departments about mental health difficulties, when requested by clients. The letters have a practical purpose of

supporting the client to access resources, but also demonstrate that I have been able to understand their experiences. The letters could be seen as a form of 'management', dealing with impingements from the external world, such as the risk of welfare benefits being stopped. In working with homeless people, there is a need to balance environmental adaptability alongside limit setting, structure and boundaries. Many individuals who are homeless have had their physical and psychological boundaries violated and will enact these transferential dynamics in new relationships. Limit setting can be experienced as attacking and rejecting. Yet, impingements provide an opportunity for the therapist to repair the failure, and maintaining a boundary can help an individual to feel safe and contained. One client said that he felt safe knowing that he was not able to smoke crack with me in his sessions. In terms of limit setting, there can also be practical considerations, such as managing the waiting list, which has to be balanced against the adaption of tolerating missed appointments.

The clients on my caseload struggle to make meaningful connections between their emotions, thoughts and behaviour, and to engage in reciprocal interactions with others; they could be described as being in a '*pre-mentalization*' state at times (Cockersell, 2018, p. 119). They find it challenging to describe their histories, saying they do not remember the past, or recount incoherent, contradictory narratives. Accounts of experiences can seem extreme, exaggerated or unbelievable, such as, '*I beat up twenty men on my own'*. Timeframes and details of past events can change, such as '*my mother committed suicide in front of me'*, to '*I found my mother after she had committed suicide*.' Traumatic experiences can be denied, casually dropped into the conversation, or mentioned once but never returned to. Painful emotions can be avoided through talking about superficial topics, jumping from one topic to another, monologues, and the use of humour. Clients will often speak in idealized or generic ways saying, '*my childhood was fine'*, detached or dismissing styles, stating '*I had acid thrown in my face but it didn't really bother me*', or present incongruous responses such as laughing at their own pain or stating, '*I like being raped*'. Clients can appear emotionally detached, but project strong emotions onto the therapist, or have brief moments where they look vacant or frozen. The provision of mirroring, empathic attunement and acceptance as part of a facilitating environment, can support clients to integrate these dissociated parts of their experiences, develop a sense of self and build a coherent narrative. Holmes (2006) argues that psychotherapy should help a client to develop such capacities:

> reflexive function is related to autobiographical competence: to tell a story about oneself in relation to others, one has to be able to reflect on oneself – to see oneself, partially at least from the outside, and this in turn depends on the experience of maternal mirroring. The maternal mirror is the basis of the 'inner mirror' or representational world whose establishment is part of the task of psychotherapy. (p. 69)

Composite Case Studies:

1. 'Somewhere safe to break down'

Paul, a male in his late twenties, had a history of violence, alcohol dependency, and numerous custodial sentences. He told me that he had been raised by a violent, controlling father and an anxious, depressed mother. Paul's father was physically abusive towards his wife and son; Paul tried to protect his mother from his father's rages. He had been excluded from school for criminal damage and fighting; he started to regularly drink alcohol and smoke cannabis at thirteen years of age. Paul was having frequent aggressive outbursts in the hostel, which were threatening his tenancy, so the staff suggested that counselling may be helpful. In our first meeting, he made it clear that he was very sceptical of talking to me. He attended appointments on a sporadic basis, turning up late, requesting to leave early, or finding it difficult to leave. He spoke illusively in riddles, jumped around topics, or ranted at me, maintaining an emotional distance. He commented that I was very understanding and could 'get him to talk', but at other times dismissively remarked that he could not see a point in our sessions. Paul liked to offer to swap positions with me and become the therapist, asking me to tell him my problems. His dominating behaviour enabled him to experience the illusion of omnipotence in our relationship. He idealised or denigrated others, viewing the staff team as heroes or villains, and other residents as persecutors or victims, which mirrored his early relationships. Winnicott notes that patients who suffer significant disturbances in their early environment will be unable to place the analyst outside the area of subjective phenomena; Paul seemed unable to relate to me as a separate person, with my own feelings and thoughts. He experienced extreme frustration and anger when I did not agree with him, shouting '*you don't understand*' or '*it's all ruined now'*, before storming out. Holmes (2006) notes, '*In the transference, the therapist becomes both the longed for and abusive object – but because transferentially rather than actually so, one that is potentially transformational.*' (p. 94) My responses ranged from countertransferential hate, wanting to hurt or abandon him, to a strong desire to take care

for him. Paul evoked in me the unbearable feelings that he could not psychologically accommodate (Wallin, 2007). It was crucial to have awareness of these emotions to foster empathic understanding of Paul's narcissistic pathology.

In sessions, Paul would dramatically or abruptly bolt out of the counselling room, when he felt angry or distressed; my responses included feeling shocked and frustrated, unsure whether he would return the following week. Over time, I realised the importance of accepting and tolerating Paul's departures, texting him about his next appointment as usual. The ability of the care giver to withstand protest without retaliation or rejection, and help the child to re-establish the secure base following a separation, is the mark of secure attachment (Holmes, 2006). In one session, when Paul was beginning to look agitated, I suggested that feeling distressed in the presence of another, such as myself, made him feel very uncomfortable, as this had not been safe in the past. Expressions of emotional distress had angered his father and been dismissed by his mother, resulting in criticism and rejection. In prison and hostels, the importance of not showing your vulnerability had been reinforced. This '*transference-type interpretation*' (Holmes, 2006, p. 63) linked Paul's narrative of external events, his internal world, and his relationship with me. Paul ignored my interpretation, leaving me to wonder whether this had felt too intrusive or been premature for him. However, a few weeks later, he allowed himself to cry in front of me, before leaving the room. On another occasion, despite feeling low in mood and angry, he remained for the duration of the session and noticed he was feeling slightly better by the end. It could be seen that Paul gradually began to develop an external secure base in terms of our relationship. New experiences of others as accepting within the context of a safe attachment relationship can start to challenge old defensive models (Wallin, 2007). Unfortunately, Paul smashed a window in the hostel, after a difficult interaction with the staff team, which led to his eviction. I found Paul waiting outside the counselling room; he looked very upset and asked if he could speak to me before he left. Once in the counselling room, Paul said, '*I just needed somewhere safe to break down*'. He proceeded to deeply sob, his whole body shaking, tears streaming down his face. I sat silently with Paul, experiencing a sense of physically and emotionally holding him in that moment. In this last encounter, it felt extremely significant that Paul had been able to ask for help in a time of despair, express his distress without fear of rejection, and seek comfort from a safe other.

2. 'It's just the way it was'

Kelly, a woman in her thirties, had a history of domestic violence, heroin and crack use, and a transient lifestyle. She told me that her father had died when she was five years old and she could not remember him much. Her mother had a diagnosis of bi-polar and could be affectionate and fun at times, she told Kelly she was the only thing that kept her going; she also had angry outbursts where she shouted at Kelly and then disappeared for long periods of time. Kelly would be left with a 'nice' elderly male neighbour, who sexually abused her and said she would be taken into care if she told anyone. Kelly grew up in a disturbed environment, with no containment or mirroring, where her feelings were disregarded and annihilated. She found it difficult to concentrate at school, so hung out in the local park, where older men bought her alcohol and cigarettes. She would drink to the point of losing consciousness and was sexually assaulted at these times. She never reported the assaults as it was her word against theirs, she was drunk, and she probably deserved it. Kelly, as an adult, continued to be involved in abusive relationships, where she was beaten and raped; heroin and crack helped to numb her body and comfort her mind. Holmes (2006) states that drug and alcohol use, *'blots out pain physiologically, and provides a feeling of being held and divested of responsibility similar to that which is sought when attachment needs are activated and assuaged*.' (p. 100) Kelly was ambivalent about engaging in counselling and there were a number of referrals before she attended on a regular basis. Initially, she worried that she was 'wasting my time' and 'talking rubbish'; she was self-deprecating, frequently saying that she always got things wrong and was stupid. My countertransferential feelings included wanting to protect and care for her, but also finding her feelings of powerlessness overwhelming at times.

In sessions, Kelly and I seemed to have a good rapport, but she was often dismissive, hostile or rejecting of my empathic responses. She described disturbing incidents of violence, which I attempted to empathise with, and she would irritably respond, '*It's just the way it was*' or '*that's life*'. On one occasion, I acknowledged that my empathic reflections seemed unwelcome, and she told me that they didn't make sense or feel believable to her. Holmes (2006) notes that victims of abuse are often viewed as objects without feelings or memory, forced into denying their own experiences. I realised that I needed to tolerate and accept Kelly's beliefs that she was a bad person, who deserved to be hurt. She would often say that she missed being raped, as this confirmed her beliefs about herself. Kelly had supressed her emotions to survive and felt very fearful of connecting with these. It felt crucial to provide responses which were non-intrusive to enable her to connect with her inner world at her own pace. Gradually, Kelly developed trust in our relationship, even

declaring her ‘need’ to see me. She began to express disowned parts of herself, including feelings of anger, shame, and sadness, and demonstrated self-empathy, noticing the ways her childhood had ill equipped her for adult life. In the hostel, Kelly had an encounter, where she was ‘told off’ by a member of staff for using the washing machines after the allotted time. She attended the session but refused to speak to me, identifying with a rejecting maternal figure. I felt perplexed, unaware of any ruptures between us, but attempted to remain non-defensive. After some time, she told me about the incident; one moment resolutely stating that she deserved to be punished as she was bad, and the next moment angrily sobbing that she shouldn’t have been spoken to like that, feeling criticised and shamed. Kelly was able to express both parts of her experience within a secure relationship, which was containing and accepting. After the session, she requested a meeting with the manager of the hostel and the member of staff involved, where she asserted her feelings and discussed the incident further. In our next session, she said that she better understood where the staff member had been coming from and felt able to move on from the incident. Wallin (2007) notes, ‘*Our task is to co-create a relationship with our patients that allows them to make sense of their experience, to feel more “together”, and to relate to others more deeply and with greater satisfaction.*’ (p. 133)

3. ‘I’m still sitting on the floor now’

Bob, a man in his late forties, had a history of street homelessness, alcohol and heroin use, and severe self-neglect. Bob’s mother was a cruel alcoholic and his father was a passive, depressed, distant figure. Bob would be found routinely stealing and causing criminal damage in the local neighbourhood. He was taken into care at the age of ten years old and accommodated in a children’s home. After the care system, Bob had lived a very transient lifestyle for most of his adult life; he had recently been rehoused into his own flat after a successful period of living in the hostel. The staff had noticed that since moving out, he had periods of not eating or washing, cutting his legs and feet, and smashing up his flat. Brown (2019) notes, ‘*Endangering and then rescuing the body replays an affective climate in which feelings of dying and being revived were the child’s actual experience of ‘maternal’ care… the body becomes the site of highly ambivalent relating to the ‘maternal object’*.’ (p. 119) Bob was keen to engage in counselling, he seemed desperate to talk to someone. He adamantly told me that his past had no bearing on his life now and he wouldn’t blame his parents for his mistakes. He felt confused about his behaviour and described feeling very lonely and like he did not exist at times. Bob usually spent his sessions talking about day to day life, such as his interests in fishing, cars and problems with his benefits and housing. It

felt important to accept and understand his need to not talk about the past. Bob's emotions presented as volatile, ranging from laughing and joking, to angry and hopeless, to tearful and needy. He presented with two different selves, which he defined as the 'straight' and 'wasted' parts. The 'straight' self was amenable, jolly, and desperate to please people, due to a fear of abandonment. The intoxicated self was aggressive, destructive, and chaotic. The two parts of Bob appeared extremely dissociated; once recovered from a binge, he would dismiss his destructive behaviour as 'not a problem' and avoid the subject. My countertransferential responses included feeling frustrated and exhausted with his frequent crises and subsequent denial of these.

In one session, Bob explained that he did not have any seating in his lounge, as he had spent his loan for furniture on alcohol and drugs. He said that he was finding it increasingly uncomfortable to sit on a pillow on the floor to watch television. He shared that when he was a child, his mother would often fall asleep on the couch when she was drunk. I asked Bob where he had sat when his mother was on the sofa. Bob replied that he had sat on the floor and then remarked, '*I'm still sitting on the floor now*'. Bob suddenly became very tearful, saying he had never made the connection between his childhood and current behaviour. Winnicott notes, '*Changes come in an analysis when the traumatic factors enter the psycho-analytic material in the patient's own way, and within the patient's omnipotence.*' (Winnicott, 1965/2007, p. 37) Bob started to reveal memories from his past, including his mother leaving him alone in his cot for hours at a time; he said he would stop crying after a while, as he knew no one would come. Bob's difficulty with self-care represented the profound neglect he had experienced from his parents. He said that as a child he would climb down the drain pipe to run away from home, but as an adult he had replaced the drain pipe with alcohol and heroin. Bob was able to develop a more coherent narrative, through understanding the ways his early environment had contributed to feelings of worthlessness, shame, and isolation. Bob applied to work as a volunteer at a local conservation project and was looking forward to starting there. However, on the morning he was getting ready to leave, he started to experience doubts, such as, 'I will be rubbish at this', and 'no one will like me'. Bob said he remembered that we had explored the ways his behaviours could be self-sabotaging and realised the voice in his head sounded like his mother. He said he was conscious of two sides of himself having an argument, one part saying don't go and the other part saying he should do this. Bob said, surprisingly, he was able to disregard the part telling him not to go, and went on to experience an enjoyable day at the conservation project. Wallin (2007) notes, '*A mentalizing stance*

creates the potential for affective, cognitive, and behavioural flexibility, in large part because it allows us to envision multiple perspectives on any given experience, enhancing the likelihood that pre-existing models can be updated' (p. 136).

Summary:

The fourth chapter has explored the themes in my work with people who are homeless and the ways that the theories of Winnicott, Bowlby and Rogers can be applied to this practical context. Homelessness has often been approached from economic and political perspectives, without consideration of the intrapsychic factors underlying extreme disconnection from others and society. This research contends the trauma in the early environment is the causal factor in the lives of people who are homeless. Psychoanalytic theories can help to conceptualise the intrapsychic world of homeless individuals and help to manage transferential enactments; whilst the provision of Rogers' core conditions enables clients to engage in treatment and establish a secure base. I believe that Winnicott's concept of a 'holding environment' can be applied to the residential hostel where I work, which provides physical and psychological containment to individuals with fragile senses of self. The composite case studies illustrate the application of Winnicott's, Bowlby's and Rogers' theories to the understanding and treatment of individuals who are homeless, such as the importance of the secure base, integration of traumatic experiences, and developing a coherent narrative. They also demonstrate some of the challenges and successes presented to the therapist when working with this client group. The biggest challenges of working with homeless people include managing chaotic patterns of engagement, staying attuned when confronted with primitive defences, and entering into clients' disturbed worlds without losing one's own sense of self. The biggest rewards of working with people who are homeless include their willingness to trust me and form a connection, their commitment to counselling despite finding it challenging, and their courage to explore the shameful traumatised parts of themselves which have been long excluded. Similar to Rogers, I witness clients trying to grow in the most adverse of circumstances and have enormous admiration for this.

Conclusion:

In this research, Winnicott's, Bowlby's and Rogers' views on the influence of the early environment have been critically analysed and compared. They agree that the infant is dependent on caregivers, who can either offer the optimal conditions to facilitate development, or fail to provide these, disturbing the developmental process. The infant's instinctive tendency to grow is nurtured through a relationship with an attuned other, who offers protection, mirroring and containment. These interactions with the caregiver help to affirm and strengthen the infant's sense of self. The infant develops beliefs about their acceptability and value based on the nature of the caregiving they receive, so it is crucial they internalise actual good experiences. Paradoxically, the experience of dependence within a facilitating environment leads to the ability for autonomy, as well as meaningful connection, enabling individuals to participate in full and functioning lives. In contrast, an insufficient facilitating environment results in traumatic impingements and dysfunction in development. The infant is forced to comply with environmental demands, leading to defensive exclusion of experiences and fragmentation of the self. Defensive strategies prevent an individual from being able to live creatively, authentically and flexibly. The implication for psychotherapy is that it is through a nurturing relationship with the therapist that the client is able to develop a more coherent sense of self and reciprocal ways of relating.

There are marked differences in the theories of Winnicott, Bowlby and Rogers, including the role of the environment and the psychoanalytic unconscious. Winnicott believes in a constant interplay between the external and internal worlds, which are equally important in the formation of the self. In contrast, Bowlby emphasizes the impact of external events and the role of the biological attachment system, where fear and survival are the main motivators of behaviour. Rogers rejects the idea of the psychoanalytic unconscious and innate destructive drives, emphasising the impact of the environment on an individual's self-concept. Another point of divergence concerns the nature of maternal attunement and dependence in development. Winnicott highlights the importance of the mother-infant dyadic from birth; the infant develops an awareness of others by graduated failures of adaption in maternal care, leading to individuation. In contrast, Bowlby and Rogers suggest it is maternal responsiveness, which supports the infant to understand their own mind, as

well as the minds of others, and become autonomous. The theorists also vary in their approaches to therapeutic interactions. Winnicott and Bowlby contend a facilitating environment enables the patient to work through transferential enactments, leading to a more integrated sense of self. In contrast, Rogers thinks transference should not be focused on, emphasising the 'real' relationship between the therapist and client.

This thesis has shown that the theories of Winnicott, Bowlby and Rogers can be utilised in the practical context of therapeutic work with homeless individuals. The theorists propose there is a connection between an insufficient facilitating environment and the subsequent development of psychological problems, such as delinquent behaviour. Many homeless people report they have experienced a lack of reliable, attuned relationships in early life; resulting in difficulties internalising good objects, learning a capacity for self-care and developing an integrated sense of self. Homeless people can be seen as not only having difficulties with residing in an external home, but also struggling to reside comfortably in their intrapsychic world. The notions of impingements and attachment patterns can help to conceptualise a homeless person's experiences of deficient relationships and the development of adaptive defense strategies. Individuals who are homeless can be seen as having both a need for, as well as a fear of, dependence; as a result, the concepts of the secure base and facilitating environment are particularly relevant in supporting the developmental needs of these clients. I have found that homeless people are keen to engage in therapeutic treatment, when it is adapted to meet their developmental needs and informed by a relational approach.

Winnicott, Bowlby and Rogers believe in the inherent value and potential of every individual, when provided with the optimal conditions to grow. They extend therapeutic thinking to social issues, supporting the provision of care for the most vulnerable and disadvantaged in society, and contend that antisocial behaviour is a psychological problem which requires therapeutic treatment, not criminalisation. These notions strongly resonate with the beliefs that underpin my work, namely that every homeless individual has value and potential, and viewing homelessness as a developmental and relational issue, requiring psychotherapeutic interventions in conjunction with practical support. I contend that the key casual factor in the lives of people experiencing homelessness is trauma in their early environment. The theories of Winnicott, Bowlby and Rogers provide a comprehensive understanding of homeless peoples' developmental needs and help guide therapeutic practice. This research has directly benefitted the counselling that I offer to people who are homeless, deepening my understanding of primitive defenses and the importance of the

provision of a secure base. I contend that work with people who are homeless requires the provision of a genuinely accepting, empathic therapeutic relationship, upon which they can depend, alongside knowledge of psychoanalytic developmental theory to contain primitive defenses and transferential enactments.

References:

Abram, J. (2004). The survival of the object: Does Winnicott's work suggest a paradigm shift in psychoanalysis. PhD by published works – psychoanalysis. Middlesex University.

Abram, J. (Ed.). (1996/2007). *The language of Winnicott: A dictionary of Winnicott's use of words* (2nd ed.). Routledge. https://doi.org/ 10.4324/9780429482250

Adshead, G. (2019). 'Foreword: In and out of the mind'. In G. Brown (Ed.) *Psychoanalytic thinking on the unhoused* (pp. xiii-xxi). Routledge.

Ansbro, M. (2008). Using attachment theory with offenders. *The Journal of Community and Criminal Justice, 55*(3), 231-244. https://doi.org/ 10.1177/0264550508092812

Baughan, R., & Merry, T. (2001). Empathy: An evolutionary/biological perspective. In S. Haugh & T. Merry (Eds.), *Rogers' therapeutic conditions: Evolution, theory and practice volume 2: empathy* (pp.230-238). PCCS Books.

Biermann-Ratjen, E-M. (1998a). On the development of the person in relationships. In B. Thorne & C. Lambers (Eds.), *Person-centred therapy: A European perspective* (pp.106-118). Sage Publications.

Biermann-Ratjen, E-M. (1998b). Incongruence and Psychopathology. In B. Thorne, B. and C. Lambers (Eds.), *Person-centred Therapy: A European perspective* (pp.119-130). Sage Publications.

Blum, H.P. (1997). Clinical and developmental dimensions of hate. *Journal of the American Psychoanalytic Association*, *45*, 359-375.

Bohart, A. (2007). The Actualizing Person. In M. Cooper, M. O'Hara, P. Schmid & G. Wyatt (Eds.), *The handbook of person-centred psychotherapy and counselling* (pp.47-63). Palgrave Macmillan.

Bowlby, J. (1940). The influence of early environment in the development of neurosis and neurotic character. *International Journal of Psycho-Analysis*, *21*, 154-178.

Bowlby, J. (1944). Forty-four juvenile thieves: Their characters and home-life (II). *International Journal of Psycho-Analysis, 25*, 107-128.

Bowlby, J. (1953/1971). *Child care and the growth of love*. Penguin Books.

Bowlby, J. (1969/1997). *Attachment and loss volume 1: Attachment.* Pimlico.

Bowlby, J. (1973/1998). *Attachment and loss volume 2: Separation, anger and anxiety.* Pimlico.

Bowlby, J. (1980/1998). *Attachment and loss volume 3: Loss, sadness and depression*. Pimlico.

Bowlby, J., Figlio, K., & Young, R. (1986). An interview with John Bowlby on the origins and reception of his work*. Free Associations*, *1*(6), 36-64.

Bowlby, J. (1988/2005). *A Secure Base*. Routledge Classics.

Bozarth, J. (2007). Unconditional positive regard. In M. Cooper, M. O'Hara, P. Schmid & G. Wyatt (Eds.), *The handbook of person-centred psychotherapy and counselling* (pp.182-193). Palgrave Macmillan.

Bradley, C. (2018). *Revealing the inner world of traumatised children and young people.* Jessica Kingsley Publishers.

Bretherton, I. (1992). The origins of attachment theory: John Bowlby and Mary Ainsworth. *Developmental Psychology*, *28*(5), 759-775.

Brown, G. (Ed.) (2019). *Psychoanalytic thinking on the unhoused mind*. Routledge.

Campbell, J.M. (2019a). There's no place like home: On dwelling and unheimlichkeit. In G. Brown (Ed.), *Psychoanalytic thinking on the unhoused mind* (pp. 19-35). Routledge.

Campbell, J.M. (2019b). Homelessness and Containment. In G. Brown (Ed.), *Psychoanalytic thinking on the unhoused mind* (pp. 56-68). Routledge. (Reprinted from 'Homelessness and containment: A psychotherapy project with homeless people and workers in the homeless field'(2006) in *Psychoanalytic Psychotherapy*, *20*(3), 157-174. Taylor and Francis)

Cockersell, P. (Ed.) (2018). *Social exclusion, compound trauma and recovery: Applying psychology, psychotherapy and PIE to homelessness and complex needs*. Jessica Kingsley Publishers.

Cooper, M. (2007). Developmental and personality theory. In M. Cooper, M. O'Hara, P. Schmid & G. Wyatt (Eds.), *The handbook of person-centred psychotherapy and counselling* (pp. 77-92). Palgrave Macmillan.

Cornelius-White, J. (2007). Congruence. In M. Cooper, M. O'Hara, P. Schmid & G. Wyatt (Eds.), *The handbook of person-centred psychotherapy and counselling* (pp. 168-181). Palgrave Macmillan.

Crittenden, P. M. (2006). A dynamic-maturational model of attachment. *The Australian and New Zealand Journal of Family Therapy, 27*(2), 105–115. https://doi.org/10.1037/a0032102

Daehnert, C. (1998). The false self as a means of misidentification: A psychoanalytic case study. *Contemporary Psychoanalysis*, *34*, 251-271.

Davis, M., & Wallbridge, D. (1981). *Boundary and space: An introduction to the work of D.W. Winnicott*. Karnac.

Eagle, M. (2013). *Attachment and psychoanalysis: Theory, research, and clinical implications.* Guildford Press.

Flores, P.J. (2001). Addiction as an attachment disorder: Implications for group therapy. *International Journal of Group Psychotherapy*, *51*(1), 63-81.

Fonagy, P. (1999). Pathological attachments and therapeutic action. In G. Brown (Ed.), *Psychoanalytic thinking on the unhoused mind* (p.44). Routledge.

Fonagy, P. (2001). *Attachment theory and psychoanalysis*. Karnac.

Freire, E.S. (2007). Empathy. In M. Cooper, M. O'Hara, P. Schmid & G. Wyatt (Eds.), *The handbook of person-centred psychotherapy and counselling* (pp. 194-206). Palgrave Macmillan.

Gabbard, G.O. (2000). Disguise or consent: Problems and recommendations concerning the publication and presentation of clinical material. *International Journal of Psychoanalysis, 81*, 1071-1086.

Gerhardt, S. (2004/2010). *Why love matters: how affection shapes a baby's brain*. Routledge.

Ghent, E. (1992). Paradox and Process. *Psychoanalytic Dialogues*, *2*(2), 135-159.

Godley, W. (2001). Saving Masud Khan. *London Review of Books*, *23*(4), 3-7.

Goldberg, A. (1997). Writing Case Histories. *International Journal of Psychoanalysis, 78*, 435-438.

Goldman, D. (1998). Surviving as scientist and dreamer: Winnicott and "The Use of an Object". *Contemporary Psychoanalysis*, *34*(3), 359-367.

Grafanaki, S. (2001). What counselling research has taught us about the concept of congruence: Main discoveries and unresolved issues. In G. Wyatt (Ed.), *Rogers' therapeutic conditions: Evolution, theory and practice volume 1: Congruence* (pp. 18-35). PCCS Books.

Grolnick, S. (1990). *The work and play of Winnicott*. Jason Aronson.

Haigh, R. (2013). The quintessence of a therapeutic environment. *Therapeutic communities: The International Journal of Therapeutic Communities*, *34*(1), 6-15. https://doi.org/10.1108/09641861311330464

Haugh, S., & Merry, T. (Eds.). (2001) *Rogers' therapeutic conditions: Evolution, theory and practice volume 2: Empathy*. PCCS Books.

Holmes, J. (2006). *The search for the secure base: Attachment theory and psychotherapy*. Routledge.

Holmes, J. (2014). *John Bowlby and attachment theory* (2nd ed.). Routledge.

Howe, D., (2005). *Child abuse and neglect: Attachment, development and intervention*. Palgrave Macmillan.

Howe, D. (2011). *Attachment across the lifecourse: A brief introduction.* Palgrave Macmillan.

Hunter, V. (1991). John Bowlby: An Interview. *Psychoanalytic Review*, *78,* 159–175.

Issroff, J. (2005). *Donald Winnicott and John Bowlby: personal and professional perspectives*. Karnac.

Joseph, S. (2004). Client-centred therapy, post-traumatic stress disorder and post-traumatic growth: Theoretical perspectives and practical implications. *Psychology and Psychotherapy: Theory, Research and Practice, The British Psychological Society*, *77*, 101-119.

Kahr, B. (2011). Winnicott's "anni-horribiles": The biographical roots of "Hate in the counter-transference". *American Imago*, *68*(2), 173-211.

Kalsched, D. (1996). *The inner world of trauma: Archetypal defences and the personal spirit.* Routledge.

Kantrowitz, J.L. (2010). Using disguised clinical case material. *The American Counselling Association: Counselling and Values*, *54*, 117-134.

Karpf, A. (2013). From Donald Winnicott to the Naughty Step. BBC Radio 4 Archive. https://www.bbc.co.uk/programmes/b00hg8dq/topics/Donald_Winnicott

Khantzian, E.J. (2014). The self-medication hypothesis and attachment theory: Pathways for understanding and ameliorating addictive suffering; The twentieth John Bowlby Memorial Lecture. In R. Gill (Ed.), *Addictions from an attachment perspective: Do broken bonds and early trauma lead to addictive behaviours?* (pp.33-56). Karnac.

Kirschenbaum, H. (2007). *The life and works of Carl Rogers*. PCCS Books.

Kirschenbaum, H. & Henderson, V.L. (Eds.). (1990/1998). *The Carl Rogers reader.* Constable.

Laplanche, J. (1988). *The Language of Psychoanalysis*. Taylor & Francis Group. https://doi.org/10.4324/9780429482243

Lietaer, G. (2001). Being genuine as a therapist: congruence and transparency. In G. Wyatt (Ed.), Rogers' therapeutic conditions: Evolution, theory and practice volume 1: Congruence (pp.36-54) PCCS Books.

Little, M. (1985). Winnicott working in areas where psychotic anxieties predominate: A personal record. *Free Associations, 1*(3), 9-42.

Maguire, N., Johnson, R., Vostanis, P., Keats, H. (2010). Meeting the psychological and emotional needs of homeless people. National Mental Health Development Unit. University of Southampton Institutional Repository.

Main, M. (2000). The organised categories of infant, child and adult attachment: Flexible vs inflexible attention under attachment-related stress. *Journal of American Psychoanalytic Association, 48*(4), 1055-1095.

Marrone, M., & Diamond, N. (2014). *Attachment and interaction from Bowlby to current clinical theory and practice* (2nd ed.). Jessica Kingsley Publishers.

(the penance stare and ghost rider) (n.d.). Marvel.com/The Official Site for Marvel Movies. Retrieved from https://marvel.com

Masters, A. (2005/2006). *Stuart: a life backwards*. Harper Perennial.

Mearns, D. (2005/2011). Working with Dominic: A 'partial' drunk. In D. Mearns & M. Cooper (Eds.), *Working at relational depth in counselling and psychotherapy* (pp. 71-97). Sage.

Michels, R. (2000). The Case History. *Journal of the American Psychoanalytic Association*, *48*(2), 355-375.

Mollon, P. (1994). *The fragile self: The structure of narcissistic disturbance and its therapy*. Jason Aronson Inc.

Motz, A. (2019). Women: the hidden homeless. In G. Brown (Ed.), *Psychoanalytic thinking on the unhoused mind* (pp.69-79). Routledge.

Newman, K. M. (2013). A More Usable Winnicott. *Psychoanalytic Inquiry*, *33*, 59–68. https://doi.org/10.1080/07351690.2013.743805

O'flaherty, B. (2012). Individual homelessness: Entries, exits, and policy. *Journal of Housing Economics*, *21*(2), 77–100. https://doi.org/10.1016/j.jhe.2012.04.006

Ogden, T. (2014). Fear of Breakdown and the unlived life. *The International Journal of Psychoanalysis, 95*, 205-223. https://doi.org/10.1111/1745-8315.12148

Orbach, S. (2000/2002). *The impossibility of sex*. Touchstone.

Orbach, S. (2003). The false self and the false body. In B. Kahr (Ed.), *The legacy of Winnicott: Essays on infant and child mental health* (pp.124-34). Karnac.

Parsell, C. (2011). Homeless identities: enacted and ascribed1. *British Journal of Sociology*, *62*(3), 442–461. https://doi.org/10.1111/j.1468-4446.2011.01373.x

Phillips, A. (1988). *Winnicott*. Fontana Press.

Pickard, S. (2014). *Anti-Social Behaviour in Britain Victorian and Contemporary Perspectives* (1st ed.). Palgrave Macmillan UK. https://doi.org/10.1057/9781137399311

Reeves, C. (2005). Chapter two: Singing the same tune? In J. Issroff, *Donald Winnicott and John Bowlby: personal and professional perspectives* (pp. 71-100). Karnac.

Rey, H. (1994). *Universals of psychoanalysis in the treatment of psychotic and borderline states.* Free Association Books.

Rogers, C.R. (1939). *The clinical treatment of the problem child.* Houghton Mifflin Company.

Rogers, C.R. (1951). *Client-centred therapy: Its current practice, implications and theory.* Constable.

Rogers, C.R. (1957/1992). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting and Clinical Psychology*, *American Psychological Association*, *60*(6), 827-832.

Rogers, C.R. (1959). A theory of therapy, personality, and interpersonal relationships, as developed in the client-centred framework. In S. Kock (Ed.), *Psychology: A Study of a Science. Vol 3: Formulations of the Person and the Social Context* (pp. 184-256). McGraw Hill.

Rogers, C.R. (1961/1997). *On becoming a person: A therapist's view of psychotherapy*. Constable.

Rogers, C.R. (1977). *On personal power: inner strength and its revolutionary impact*. Constable.

Rogers, C.R. (1980). *A Way of Being.* Houghton Mifflin Company.

Rogers, C.R. (1990/1998a). The characteristics of a helping relationship. In H. Kirschenbaum & V.L. Henderson (Eds.), *The Carl Rogers Reader* (pp.108-126). Constable. (Reprinted from *Personnel and Guidance Journal*, *37*, 6-16, 1958, by the American Association for Counseling and Development)

Rogers, C.R. (1990/1998b). Reflection of feelings. In H. Kirschenbaum & V.L. Henderson (Eds.), *The Carl Rogers Reader* (pp.127-129). Constable. (Reprinted from *Person-Centred Review*, *1*(4), 375-377, 1986 by Sage publications)

Rogers, C.R. (1990/1998c). Transference. In H. Kirschenbaum & V.L. Henderson (Eds.), (1990/1998) *The Carl Rogers Reader* (pp.129-134). Constable. (Reprinted from "Comment on Shlien's article 'A Counter-Theory of Transference'" from *Person-Centred Review*, *2*(2),182-188, 1987 by Sage Publications)

Saunders, N. (2018). Psychotherapy with homeless women. In P. Cockersell (Ed.), (2018) *Social exclusion, compound trauma and recovery: Applying psychology, psychotherapy and PIE to homelessness and complex needs* (pp.134-148). Jessica Kinsley Publishers.

Scanlon, C., & Adlam, J. (2006). Housing 'unhoused minds': inter-personality disorder in the organisation?. *Housing, Care and Support*, *9*(3), 9–14. https://doi.org/10.1108/14608790200600018

Scanlon, C., & Adlam, J. (2019) Housing un-housed minds: Complex multiple exclusion and the cycle of rejection revisited. In G. Brown (Ed.), *Psychoanalytic thinking on the unhoused mind* (pp.1-18). Routledge.

Schmid, P.F. (2001). Authenticity: The person as his or her own author. Dialogical and ethical perspectives on therapy as an encounter relationship. And beyond. In G. Wyatt (Ed.), *Rogers' therapeutic conditions: Evolution, theory and practice volume 1: Congruence* (pp.213-228). PCCS Books.

Seager, M. (2011), Homelessness is more than houselessness: a psychologically-minded approach to inclusion and rough sleeping. *Mental Health and Social Inclusion*, *15*(4), 183-189. https://doi-org.ezproxy.mdx.ac.uk/10.1108/20428301111118682

(‘What is homelessness?’) Shelter, England. 3rd April 2018. Retrieved from https://england.shelter.org.uk/housing_advice/homelessness/rules/what_is_homelessness

Slochower, J.A. (1994). The evolution of object usage and the holding environment. *Contemporary Psychoanalysis*, *30*, 135-151.

Spurling, L.S. (2008). Is there still a place for the concept of ‘therapeutic regression’ in psychoanalysis?. *The International Journal of Psychoanalysis*, *89*(3), 523-540. https://doi.org/10.1111/j.1745-8315.2008.00058.x

Thorne, B. (1992/1995). *Carl Rogers.* Sage Publications.

Tolan, J. (2003). *Skills in Person-Centred Counselling and Psychotherapy.* Sage Publications.

Walant, K.B. (1995). *Creating the capacity for attachment: treating addictions and the alienated self.* Jason Aronson.

Wallin, D. (2007). *Attachment in Psychotherapy.* The Guildford Press.

Warner, M. (2012). A person-centred view of human nature, wellness, and psychopathology. In S. Joseph & R. Worsley (Eds.), *Person-centred psychopathology: A positive psychology of mental health* (pp.91-109). PCCS Books.

Wilkins, P. (1997). Congruence and Countertransference: similarities and differences. *Counselling Journal of the British Association for Counselling*, *8*, 36-41.

Williams, R. (2014). Homeless health. *Nursing Management*, *22*(8), 21–21. https://doi.org/10.7748/nm.22.8.21.s24

Williamson, E. (2018). The Dependency Paradox. In P. Cockersell (Ed.), *Social exclusion, compound trauma and recovery: Applying psychology, psychotherapy and PIE to homelessness and complex needs*. Jessica Kingsley Publishers.

Winnicott, D. W. (1954/1987). Letter to John Bowlby. In F. Rodman (Ed.), *The spontaneous gesture: Selected letters of D.W. Winnicott*, (pp. 65-66) Harvard University Press.

Winnicott, D. W. (1958/1992). *Through paediatrics to psychoanalysis.* Karnac Books.

Winnicott, D.W. (1964/1971). *The child, the family and the outside world.* Perseus Publishing.

Winnicott, D.W. (1965/2006). *The family and individual development.* Routledge Books.

Winnicott, D.W. (1965/2007). *The maturational processes and the facilitating environment*. Karnac Books.

Winnicott, D. W. (1971/1974). *Playing and Reality.* Routledge Books.

Winnicott, D. W. (1974). Fear of Breakdown. *The International Review of Psycho-Analysis, 1*, 103-107.

Winnicott, D. W (1984/2000). *Deprivation and delinquency.* (Eds.) C. Winnicott, R. Shepherd, & M. Davis. Brunner-Routledge.

Winnicott, D. W. (1986/1990). *Home is where we start from: Essays by a psychoanalyst.* (Eds.) C. Winnicott, R. Shepherd, & M. Davis. Penguin Books.

Winnicott, D. W. (1989/1992). *Psychoanalytic Explorations*. (Eds.) C. Winnicott, R. Shepherd, & M. Davis. Karnac Books.

Winnicott, D.W. (2002). *Winnicott on the child*. Perseus Publishing.

Wright, J. (2014). Addiction: treatment and its context. In R. Gill (Ed.), *Addictions from an attachment perspective: Do broken bonds and early trauma lead to addictive behaviours?* (pp. 11-32). Karnac.

Wyatt, G. (2007). Psychological Contact. In M. Cooper, M. O'Hara, P. Schmid & G. Wyatt (Eds.), *The handbook of person-centred psychotherapy and counselling* (pp.140-153) Palgrave Macmillan.

Zinschitz, E. (2001). Understanding what seems unintelligible. In S. Haugh & T. Merry (Eds.), *Rogers' therapeutic conditions: Evolution, theory and practice. volume 2: empathy* (pp. 192-205). PCCS Books.