Inhibition of anger in the child psychotherapist: Examining its effects on the therapeutic process

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Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgments), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Signed:_____

Date:_____

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Abstract

A modified systematic literature review was adopted as a research method to examine the impact on the therapeutic process of the therapist's inability to recognise anger in themselves. To gain a comprehensive understanding of the origins of anger and the basis for inhibition of anger different theoretical constructs are examined. The factors that influence the therapist's inhibition of anger are then explored. The findings revealed that the therapist might find it difficult to be aware of their anger, due to countertransference issues, culture and socialisation dynamics, and professional factors. These factors indicate that the therapist's failure to recognise anger in themselves has a negative impact on the relationship with the child and their family within the therapeutic process. These factors also highlight that an essential component in facilitating change in the therapeutic process is the therapist's awareness and recognition of their inhibited anger. Clinically, the findings from this study may help child psychotherapists to increase their awareness of their own history of anger inhibition, and its implications for the therapeutic process.

Chapter I: Introduction

The aim of this dissertation is to understand the effects on the therapeutic process, of the inhibition of anger in the child psychotherapist.

Anger may be one of the emotions that the child might bring to, or experience within, the child psychotherapeutic setting. Where this happens, according to Mayne and Ambrose (1999), the child psychotherapist's role is to help the child moderate their anger's intensity, duration and eventually frequency, and to facilitate appropriate expression. This then poses the question: what happens if the child psychotherapist is not able to facilitate the process? Dalenberg (2004), Parker Hall (2009) and Weiner (1998) found that a therapist's failure to recognise anger in themselves, and/or client, can result in therapy being unsuccessful.

In this chapter I will provide an explanation as to how I became interested in this topic, which will include my experience during training to become a child psychotherapist. I will also define terms relevant to the study such as: anger, inhibition and transference-countertransference relationship. I will conclude with an outline of the complete dissertation.

Background to my interest in the research topic

My interest in the inhibition of anger stems from my own cultural experiences. I grew up in Kosovo and for most of my life, it was a country under forced occupation by a hostile, ethnic group: the Serbians and the regime of Slobodan Milosevic. During Milosevic's regime my parents and many other Kosovars were removed from Government jobs which resulted in mass demonstrations and strikes. Education in the

Albanian language was abolished, and an unofficial parallel system of Albanian-language education was put in its place. I studied in a basement and in the garage of a private home during my four years of high school. Although we felt victimised and threatened, and our cultural freedom and civil rights were denied, we relied on our nation's leader who advocated non-violent resistance. As a result I learned how to inhibit my anger for my own safety and for the safety of my family.

In March 1999 the 'war' initiated by the Serbian army and police escalated in Kosovo. This resulted in Kosovar civilians being killed and many families, including my own, were forced to flee our homes at gunpoint and made homeless. In 1999 just after the war ended, my family and I came to New Zealand as refugees and have been living here ever since. From as long as I can remember, close family members and I had to make the best of our living situation and get on with the rest of our lives. This approach to life, within the context of fear, inhibits anger and to this day alerts me to think positively. As I moved on with my life in a new country, unconsciously I developed an approach of avoiding conflict and instead focused on things and situations that had a positive outcome. My analysis of this 'anger inhibition' approach, made me consider the question where this anger rests in me? It has also made me consider its impact on my decision to train as a child psychotherapist. This is in line with Henry, Sims, and Spray (1971, 1973) who indicate that one of the reasons one chooses to be a psychotherapist is to understand and help oneself and solve one's own emotional problems (cited in Farber, Manevich, Metzger, & Saypol, 2005, p. 1011).

When I commenced my training as a child psychotherapist the need to be aware of anger within the therapeutic context was regularly discussed, particularly during individual and group clinical supervision. During these sessions I became aware that, at times, I did not recognise inhibited anger in clients. This led me to look at my own understanding of the emotion of anger and how I dealt with it. I realised that at times, in

the therapeutic setting, my response to anger impacted on my ability to be fully emotionally available for the child. I further realised that if I had not make a decision to fully understand and consequently accept my own anger, this may have had a negative impact on my therapeutic relationship with my clients.

To further my investigation into this topic, I elected to conduct a modified systematic literature review as a research method, to examine the effects on the therapeutic process, of the child psychotherapist's inability to be aware of anger within themselves. Through the initial literature search more specific questions arose, and my interest in psychodynamic thinking around the meaning of anger grew. I was drawn to psychoanalytic understandings of the roots of anger; the factors that may impact on anger inhibition in the child psychotherapist, the effect they might have on the therapeutic process, and the implications for effective practice.

Defining terms

Fitzgibbons (1986) and Parker Hall (2009) postulate that anger can be triggered when others fail to meet one's need for love, praise and acceptance. Furthermore it is suggested that anger is likely to be experienced to some extent in all intimate human relationships (Digiuseppe & Tafrate, 2001; Weiner, 1998). Parker Hall (2009) asserts that in a relationship anger can help one succeed to meet their needs, and when needs cannot be negotiated, this might bring the end to the relationship. Therefore in this section I will start by reflecting on the meaning of anger. In the therapeutic setting the child psychotherapist might not be able to contain the child's needs due to the fact that she inhibits her own anger. Thus, inhibition is defined in the context of this dissertation. Finally, the basis of anger inhibition for the child psychotherapist in the therapeutic process, which might be evident in the transference-countertransference relationship with the child, will also be briefly described.

Anger

As a basis for discussion I began with the dictionary as my starting point of inquiry. In the Oxford Dictionary (2011), *anger* is described as a strong feeling of annoyance, displeasure or hostility. Researchers who have studied emotions described anger as an internal, mental and subjective feeling state, which has associates, conditions and psychological arousal patterns in both body and mind (Berkowitz & Harmon-Jones, 2004; Kassinove & Sukhodolsky, 1995; Norcross & Kobayashi, 1999; Weiner, 1998).

In psychodynamic terms, anger can be generated and occur as a conscious or unconscious process; whereas in cognitive-behavioural terms anger may be defined as behaviour, cognition and physiological arousal (Mayne & Ambrose, 1999). Two thousand years ago the Roman poet Horace described anger as 'madness', noting the similarities between "mad" and "angry" (Tavris, 1982). Tavris (1982) explains that this link is psychological as well as linguistic, because in many cultures an enraged individual and an insane individual are both regarded as being out of control and unable to take responsibility for their own actions. This way of thinking would equally be applied to my own culture. By contrast, Parker Hall (2009) represents anger in a positive light, describing it as a 'pure emotion' without implication that it must necessarily be acted upon. She stated that for both children and adults anger functions to regulate and repair the inevitable failures, insensitivities and ruptures that overwhelm even very close relationships.

Anger can be verbal, non verbal, physical, direct, repressed, suppressed, turned inward, bottled up, silent, sublimated, hot or cold, a communication or a defence (Weiner, 1998). Weiner (1998) found that anger overlaps or is related to many words, such as: rage, aggression, frustration, assertiveness, self-affirmation, destructiveness, grievance, grudge, hatred, revenge and fury. These descriptions all suit different

situations, different experiences or different feelings, but all have a common root: some degree of anger.

Although anger is a common word in the English language, defining the term is not straightforward. It is further complicated by researchers who use words such as anger, aggression, hostility and rage interchangeably. Even in the clinical setting there can also be a degree of misunderstanding as to whether someone is talking about anger. For example, Gaylin (1979) found that when adult clients talked about their anger they used words such as 'frustrated', 'agitated' or 'anxious'. In child psychotherapy, anger can at times be explained as a 'big feeling', a 'scary feeling' or 'tummy pain' etc. In the situation where the child psychotherapist may inhibit anger it is possible that she may miss the cues the child presents, or avoid them by unconsciously redirecting or distracting the child.

Inhibition

In this study my definition of inhibition is specifically discussed in the context of child psychotherapy. It refers to either a conscious or an unconscious process in which the child and/or the child psychotherapist, suppresses or represses anger; thus there is no awareness of anger or acknowledgment of anger. Historically the terms "repression" and "suppression" were first used by Sigmund Freud. In Freud's writing (1915), suppression was a specific mode of repression designed to eliminate emotion from consciousness; whereas repression describes the process that keeps material from consciousness.

According to the Oxford Dictionary (2011), *suppression* in psychoanalysis is the conscious inhibition of unacceptable memories, impulses or desires. Inhibited anger can also be unconscious, in which case the proper psychoanalytic term is *repression*. Repression describes an unconscious blocking of angry sensations from the

consciousness of the angered individual so that he is unaware that they are angry (Oxford Dictionaries, 2011). In psychoanalytic terms, inhibition refers to the inability to achieve a psychomotor act owing to unconscious psychic conflicts (Akhtar, 2009). For the purposes of this dissertation, inhibited anger as a term includes both the repression and suppression of anger.

In the psychotherapeutic process the child psychotherapist may unconsciously or consciously inhibit anger. The conscious containment of anger is appropriate to facilitate child's therapeutic process. The unconscious inhibition of anger is likely to impede the therapeutic process.

Transference-countertransference relationship

In the therapeutic process psychotherapy includes working with transference and countertransference. Countertransference is described as an emotional reaction to the child by the therapist, irrespective of empathy or trauma (Figley, 2002). According to Lanyado and Horne (1999), within the therapeutic relationship many aspects of ordinary development come to life, both as part of the child's on-going development during treatment, and as a result of past developmental conflicts being expressed within the transference relationships. As a response, the therapist might experience her own strong feelings about the child's traumatisation that may include anger similar to the child has experienced or is experiencing (Osofsky, 2007). According to Anastasopoulos and Tsiantis (1996), countertransference can have a powerful effect on psychotherapy either as a useful therapeutic tool in one's work with the child or as a hindrance with negative influence if the therapist is not aware of the origin of her own feelings. Thus, countertransference may interfere with the therapist's ability to understand the child and may adversely affect the therapeutic process.

I will elaborate further on the transference-countertransference relationship in Chapters IV and V.

Outline of the dissertation

This dissertation consists of six chapters:

- Chapter I has provided a context for the study, it has described the aim of the study, given definitions of anger, inhibition and the transference-countertransference relationships, and concludes with the outline of the following chapters;

- Chapter II discusses the methodology used to undertake the research;

- Chapter III examines the origins of anger in more depth, starting from the psychoanalytic perspectives of Sigmund Freud, Object Relations theory of Melanie Klein and Donald Winnicott, Attachment Theory will also be reviewed;

- Chapter IV examines the factors that may influence the anger inhibition in the child psychotherapist;

- Chapter V examines how this might impact on the therapeutic process, and looks at the steps the child psychotherapist may need to take to be aware of their anger, and how to make use of their awareness within the therapeutic context;

- Chapter VI provides a summary of the findings, discusses the significance of the study, identifies the limitations of the study, areas for future research, and concludes with final comments.

Note

In this dissertation I look at understanding anger inhibition from a psychodynamic perspective. However, as psychodynamic theory has its roots in psychoanalytic theory, terms such as psychoanalytic and psychodynamic are used interchangeably as authors have used them.

Throughout the dissertation I use the terms repression, suppression, non expression, turned inward, and bottled up to refer to inhibited anger as many authors have (e.g. Bowlby, 1973; Freud, 1915: Shaver, Mikulincer & Chun, 2008). Also, I use the pronoun "she" to refer to both male and female psychotherapists, when referring to a child or child's behaviour or emotions I will use the male pronoun to assist the flow of writing.

Chapter II: Methodology

Overview

The purpose of this study is to understand the effect of anger inhibition in the child psychotherapist on the therapeutic process. In this chapter I will discuss the concepts of qualitative research and evidence-based practice and the rationale for the methodology of choice for this study. I will then define the systematic research review and discuss the modified aspect of this study, and finally describe the process of the systematic review.

Qualitative research

According to Midgley (2007), qualitative research has its focus on the understanding of the human world rather than on calculation and statistical significance. Qualitative research explores subjective understandings of peoples' daily lives, and the experience felt from the individual's perspective (Avis, 2005; Hill, 2006; Pope & Mays, 2006). Midgley (2007) suggests that such a method is especially useful when the focus of the study is to understand the meanings which one employs to make sense of their experiences, and the use of such experiences to guide their actions.

Qualitative methodology seems to correspond with the focus of this study, which is to understand the impact of the child psychotherapist's inability to recognise anger in themselves and the effects of this on the therapeutic process. The themes extracted from the literature aim to understand the essence of why the therapist might inhibit anger and the factors that contribute to this, and the consequences this might have for the therapeutic process.

Evidence-Based Practice (EBP)

Evidence-based practice is a research methodology most commonly employed by healthcare professionals and policymakers, and typically relies on quantitative methods. The terms evidence-based medicine (EBM) and evidence-based practice (EBP), often seem to be used interchangeably, and on the whole EBP is believed to have originated from EBM. Sackett, Rosenberg, Gray, Haynes, and Richardson (1996) offer the following definition of EBM:

> Evidence-based medicine is the conscientious, explicit, and judicious use of current evidence in making decisions about the care of individual patients. The practice of evidence-base medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research. (p. 71)

Lockett (1997) explains that EBP combines the terminology of 'science and professional practice' with 'evidence-based' referring to the concepts of scientific rationality and practice, to individual practitioner behaviour (cited in Hamer, 2005, p. 4). As a process, EBP is about finding, appraising and applying scientific evidence to the treatment and management of healthcare (Hamer, 2005). According to Hamer (2005), it essentially exists to support the practitioner in decision making, in order to reduce the use of ineffective, inappropriate, costly and potentially dangerous practices.

On the other hand, Rosen and Proctor (2002) view EBP as the use of treatments, for which there is sufficient evidence to support their effectiveness, to achieve the desired outcome (cited in Roberts & Yeager, 2004, p. 5). One of the goals of EBP is to identify the study design before collecting the data, in order to provide the least biased answer to the question, which according to Dickson (2005) can be either qualitative or quantitative. Sackett et al. (1996) postulate that evidence-based medicine is not limited to randomised trials and meta-analyses; it also includes tracking down the best external evidence with which the clinical question can be answered. Thus, to ascertain the best external evidence within this study, a qualitative methodology, is best suited to a

research question which is focused on the emotional experience of the therapist, and meets the goals of EBP.

Modified Systematic Literature Review

As stated in the introduction my interest in this study is to understand the effects on the therapeutic process, of the child psychotherapist's inhibition of anger. Since my question seeks to examine the emotional experience of the therapist I have chosen a systematic review of relevant literature to answer it. This methodology attempts to identify, evaluate, select and synthesise all the evidence related to the particular subject or the single defined clinical question (Petticrew & Roberts, 2006). Systematic reviews have been regarded as one of the key sources of EBP and are considered to be a method for practice-based research (Roberts &Yeager, 2004). Droogan and Cullum (1998) noted that systematic reviews are the most reliable and valid method for summarising the accessible research findings of any particular topic, and are considered the root of evidence-based health care (cited in Sim & Write, 2000, p. 282).

According to Fonagy (1982), systematic literature reviews are often seen as the preferred research method in the field of psychotherapy. McLeod (2011) pointed out that qualitative research contributes new understandings regarding the power relationship between the therapist and the client. For the purpose of this study my focus on which information to include, has been modified. The information gathered is not limited to Randomised Controlled Trials (RCTs) or scientific quantitative data, the information is gathered from qualitative data. In view of the range of literature sourced, I consider my research to be a systematic literature review but it might equally be described as a modified qualitative literature review.

The process of the systematic literature review

In undertaking this modified systematic literature review I have employed the steps listed by Gilbody (2006):

Firstly, the question has been defined: 'examining the effects on the therapeutic process, of the inhibition of anger in the child psychotherapists'. This study looks at the factors that may result in anger inhibition in the therapist, in order to understand any potential implications for therapeutic process.

Secondly, I have undertaken a comprehensive, complicated process to locate studies. I found there was limited literature available that was directly applicable to the research question. I searched major electronic databases and library records and commenced my literature research using AUT's specialised databases such as Psych INFO. Two other major databases PEP (Psychoanalytic Electronic Publishing) and PsychARTICLES are automatically searched within PsychINFO. These databases provided the abstracts that I used to search for additional relevant articles for my dissertation topic. I separately searched the PEP database, PsychARTICLES and ProQuest Dissertation and Thesis. A literature search was conducted using keywords from the formulated question, such as: anger, child*, psychotherap*, child psychotherap*, child therap*, therapeutic process, and inhibition. In my initial search I found a number of books and articles on anger, but none specifically looked at the inhibition of anger in the child psychotherapist. As a result, keywords such as aggression, repression, suppression, frustration, rage and expression were included in the search for evidence. A detailed list of the search results is outlined in Appendix A (p. 80).

Books related to the research question were searched in the Auckland University of Technology (AUT) Library Catalogue and Auckland University (AU) Library Voyager. I purchased two books and an article and I followed the recommendations

made to me by my supervisor and outside resources with regards to books and articles to read and phrases and sources to search. I also followed up on references cited in my initial search results, which is where I found most of the articles used in this dissertation. I also manually searched for books related to the topic on the AUT library book shelves. A detailed list of the search results in outlined in Appendix A (p. 82).

The third step is the inclusion and exclusion criteria. Due to the limited literature looking specifically at the inhibition of anger in the child psychotherapist, I found it difficult to designate clear criteria and put definitive limits on what material to include or exclude. The articles and books sourced in this study come from several research disciplines that offered information relevant to the topic. My research includes literature related to anger, specifically looking at anger in the child psychotherapist and anger in the therapeutic setting. However, my reading not only incorporated articles that had a psychodynamic and developmental approach, but also articles and books from the field of psychology; research on emotions; a gestalt approach to child psychotherapy and an article by a family therapist. Due to the limited literature on child psychotherapist's inhibition of anger and/or child psychotherapist and anger, additional literature referring to psychotherapists in general, psychoanalysts, child therapists, play therapists, play specialists and child analysts have been reviewed. However, where appropriate this dissertation will be written from the child psychotherapy perspective. Furthermore, within this study, the word 'inhibition' signifies the non-expression, repression, suppression, anger turned inward and bottling up of anger; for this reason, where relevant articles and books using any of these words have been included.

It became necessary to exclude material relating to child psychotherapists who worked with adolescents, because the wealth of literature available relating to anger in adolescents, would have exceeded the word limitation of this dissertation. Articles that were not written in English were also excluded.

The fourth step includes extracting themes and synthesising results. Themes were extracted during the literature search according to their relevance to the research question. Hence, in this study I have summarised literature exploring the roots of anger from the psychoanalytic perspective of Sigmund Freud, object relations theories of Melanie Klein and Donald Winnicott, and Attachment theory. Chapter IV presents the synthesis of information in an attempt to understand the factors that influence the therapist's inhibition of anger. Chapter V evaluates further the results explored in Chapter IV, and how they impact on the therapeutic process. Additionally, the implications for effective practice are identified.

Ethical approval was not required to be obtained for this research because it does not include specific clinical material. Two examples included in Chapter V are obtained from literature, and the reactions of the therapist are hypothesised. However, throughout the dissertation I have drawn on my own experiences with children during my training, to make sense of findings, and consequently explore how they can be translated in a therapeutic setting.

Conclusion

This chapter has discussed the research method used for this dissertation by bringing together the concepts of qualitative research and evidence-based practice to illustrate its purpose. The systematic research review has been defined and the reason for adopting a modified systematic review, justified. The systematic process included in this dissertation was also described. The following chapter will begin the systematic review by summarising the literature in order to understand the inhibition of anger from a psychodynamic perspective.

Chapter III: A psychodynamic perspective on anger

Overview

In this chapter I will examine the origins of anger, and the basis for anger inhibition in the child psychotherapist from a psychodynamic perspective. I will start by looking at the psychoanalytic thinking of Sigmund Freud, and then move on to the school of object relations formulated by Melanie Klein and Donald Winnicott. Attachment Theory will also be reviewed.

Sigmund Freud

As stated in Chapter I, in any psychotherapeutic process, including child psychotherapy, anger may consciously or unconsciously be inhibited. Accordingly psychoanalytic theory may assist in understanding how the emotion of anger may exist beyond our normal awareness. Freud's theories provide the fundamentals of classic psychoanalytic understanding.

In Freud's reflections on emotions, he observed emotions to be the subjective experience of drives (Nichols & Zax, 1977). He explained that 'instincts' or 'drives' such as fear, love and anger were innate, universal and constantly felt. Regarding anger, Gay (1980) maintains that Freud theorised that anger was fundamental to man's nature, and that aggression was an innate part of human biological heritage. Tavris (1981) points out that while Freud emphasised the destructive, violent aspects of aggression, he did not pay much attention to anger in isolation. Emotions such as anger and rage were considered by Freud and many of his contemporaries, to be linked with the aggressive drive (Music, 2001; Spielberger, Reheiser, Owen, & Syndeman, 2004).

Freud (1915) originally viewed aggression as sadism, a component of the sexual instinct and the means to seduce the object of desire (Knafo & Moscovitz, 2006). Thus, he formulated his concepts of oral sadistic and anal sadistic complexes, which led to his own self-analysis and consequently the development of his theories of the Oedipus and Electra complexes. Alongside those theoretical constructs, Freud developed his well known stages of psychosexual development.[1] However, in this study I have chosen to focus on Freud's contribution to understanding anger through his 'instinct theory'. I will then look at understanding anger inhibition through Freud's ideas related to anxiety. In his work Freud also focused on the maladaptive psychological defences that block the appropriate expression of emotions, which will be considered in Chapter V. As indicated in the introduction, Freud's terms of repression and suppression have been used in this dissertation to define the concept of inhibition.

Instinct theory

Freud (1920) posited two instincts, the *life instinct* and the *death instinct*. These two instincts are useful to explain the inner conflict that might arise in the therapist when faced with anger within the therapeutic process. The life instinct, also known as Eros or Libido, is allied with positive emotions of love, cooperation, and other behaviours that support harmonious societies. The death instinct, also known as Thanatos, appears to be opposite to Eros, and its function serves to push a person towards extinction and a 'lifeless state'.

Freud (1933/1959) suggested that aggressive impulses, accompanied by hatred, anger and rage, result from the 'death instinct', and these emotions lead people to commit anti-social acts, from bullying through to murder (Speindlberger et al., 2004). In situations when the aggression (anger) could not be expressed towards external objects

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[1] For a list and discussion of Freud's psychosexual stages of development the reader is directed to the work of Sullvian (1963), Gertraud (2011) and Milton, Polmear, and Fabricious (2011).

(people) there was a possibility that it may be turned back against the self, resulting in depression or other psychosomatic manifestations (Speindlberger et al., 2004). When considering this psychological construct in relation to the therapist who repeatedly is unable to understand and reflect on her own anger and use it appropriately to help the child process his anxieties, the therapist might have no alternative but to inhibit anger which in turn may impact on her physical and psychological well-being.

Freud (1920) maintained that the instinctual life and death drives complemented each other in the personal and interpersonal lives of individuals. Arnold (1960) on the other hand asserts that we find conflict and disagreement between the two instincts. In order for the therapist to maintain a healthy emotional state when conflicts between two instincts arise within herself, she needs to have an awareness of her own intra-psychic process. However, if the conflict is typically defended against, and kept at an unconscious level, it is not able to be discharged healthily and needs to be brought to consciousness so that it can be understood and managed appropriately.

Understanding the inhibition of anger in response to anxiety

Plutchik (2000), a psychologist who has conducted extensive research about the understanding of emotions, determined that Freud saw anxiety as a consequence of repressed emotion, and that he eventually came to see anxiety not as the result of repression, but rather as the reason for it. In understanding the repression of emotions, or anger, the question of whether an emotion can be unconscious arises – that is, whether the therapist can experience anger and not be aware of it. In his book '*The Unconscious*' (1915), Freud states that:

> It is surely of the essence of an emotion that it should enter consciousness. So for emotion, feelings, and affects to be unconscious would be quite out of the question. But in psychoanalytic practice we are accustomed to speak of unconscious love, hate, anger etc...and find it impossible to avoid even the strong conjunction 'unconscious consciousness of guilt'...strictly

speaking...there are no unconscious affects in the sense in which there are unconscious ideas...(p. 177)

Freud (1915/1957) further suggested that an emotion, including anger, is primarily a form of energy that required some kind of direct or indirect expression. The undischarged emotions in a child or adult may result in them expressing those feelings in a masked form, for example, as somatic complaints or in dreams (Barish, 2009). Freud relied on dreams, free associations, slips of the tongue, postures, facial expressions and voice quality, to arrive at judgments about repressed emotions (Plutchik, 2000). Similarly, in child psychotherapy if a child frowns, withdraws, symbolically sets up a battle, throws toys on the ground or 'accidentally' destroys the toys etc., the therapist might infer that the child was expressing anger in an indirect way and address this appropriately. However, the therapist who inhibits anger could easily miss the indirectly expressed anger. The therapist's responses to these missed cues could result in the therapist indirectly showing anger, for example, by ending the session early or cancelling sessions with the child.

Melanie Klein

Melanie Klein (1882-1960) the founder of the theory of object relations, was the first theorist to use psychoanalysis to understand the inner world of infants and young children, and had much to say about human aggression and anger. In her observations of young children, Klein maintained that at the beginning of life the infant does not recognise the existence of 'the other' despite being totally dependent on someone else for his survival. Gradually the infant becomes aware of his dependence, and that he cannot provide for wants and needs (Klein & Riviere, 1964). In Klein's view, this resulted in primitive anxiety and aggression. Klein (1930/1935) posited that the infant's 'self' is from the beginning of life experienced as being constantly under threat from the aggressive drive (Fonagy, 2001).

In this section I link Klein's concept of aggression with the Freudian concepts of anxiety and the death instinct. I will also discuss the concept of the paranoid-schizoid and depressive positions. Finally I will briefly define projective identification as this has relevance to the dissertation question.

Anxiety and death instinct

Klein (1958) found that for the new born infant the life and death instincts are bound together but are different from each other; thus the infant finds himself in a constant struggle between an urge to destroy the object that does not provide for him and the desire to preserve the object he is reliant on for survival (Greenberg & Mitchell, 1983). This causes extreme anxiety in the infant due to fear of being persecuted or destroyed and the urge to survive, which in turn results in the infant experiencing persecutory anger towards the object. From a 'Kleinian' point of view, in order to ease this anxiety, the death instinct in the form of anger is turned outward to the mother and in phantasy[2] the infant wishes to harm her. However, this can become overwhelming for the infant's sense of self, and in order to ameliorate his anxiety, the infant employs the use of the harsh superego to protect himself from acting out anger and being rejected by the mother (Klein, 1989).

The paranoid–schizoid and the depressive position

Klein linked early development and one's mental state throughout life, describing this as the story of a shift between two positions: the paranoid-schizoid and the depressive positions.

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[2] In Klein's concept, of phantasy describes an experience that emanates from within and imagines what is without; it offers an unconscious commentary on instinctual life and links feelings to objects and creates a new amalgam: the world of imagination. Through its ability to phantasize the baby tests out, primitively 'thinks' about, its experiences of inside and outside (Mitchel, 1986)

In the paranoid-schizoid position the infant experiences his existence as all good or as all bad. Klein (1935) concludes that the ego comes to relate to the primary object of the mother's breast as 'split' into two parts: a 'good' pleasurable and 'ideal' part, and a 'bad', frustrating and 'persecutory' part. The mental mechanism of the infant in paranoid-schizoid position, according to Spillius (1988), is characterised by the use of splitting, projections, introjections, idealisation, denigration and denial.

According to Segal (1982) at a certain point, the split objects are brought together, or integrated in the infant's developing ego. This results in the infant moving into the depressive position. In the depressive position the infant learns to both love and hate the object (mother) and starts to phantasize that the loved 'good' object (mother) is being damaged by the attacks he has made, and continues to make, on the 'bad' object (mother), for they are one and the same (Spillius, 1988). The infant's main fear then is the destruction of the good object (mother). This realisation is extremely painful and gives rise to what Klein calls *depressive anxiety,* which replaces the destructive desires with guilt (Spillius, 1988).

Klein (1952) suggests that the paranoid-schizoid and depressive positions are never entirely overcome and the conflicts in adult life that evoke anxiety can bring about the recurrence of these two positions. In the child psychotherapy process, the therapist who inhibits anger when faced with the child's anger might consciously or unconsciously be afraid of the persecutory feelings that anger evokes in her. This may cause the therapist to revert to the paranoid-schizoid position by splitting, for example the good-therapist and bad-child, or vice versa. In order for the therapist to be able to understand her own anger and also be in touch with a child's anger, she needs to be functioning in the depressive position with the ability to repair her own feelings of anger as they arise.

Klein stresses the importance of repairing the damage done, both in phantasy and external reality, in response to the anger and aggressive impulses towards the mother, also known as the tasks of mourning and reparation. Klein makes it clear that the child's concern for the fate of the object is an expression of genuine love and regret, which develops along with the deep gratitude for the goodness that the child has received from the mother (Greenberg & Mitchell, 1983).

In order for the therapist who has a history of anger inhibition to regain the depressive state of being, and enter the process of reparation, assistance may be required through personal therapy. Unless the therapist is prepared to go through this process there is a potential fear of damage to the relationship with the child, which may lead to the premature end of therapy.

Projective identification

Klein (1975) saw *projective identification* as an unconscious infantile phantasy through which the infant is able to relocate his persecutory experiences by splitting them off from his self-representation and make them part of the image of the particular primary object, typically the mother (Ramchandani, 1989; St.Clair, 2000).

Within the therapeutic process the child strives to relieve some inner anxiety and/or sense of persecution, by externalising his anxiety through projective identification. Instead of feeling his anxiety, the child projects it into the therapist, who then vicariously feels the child's experience. The projective identification provides an understanding for the therapist of the child's primitive anxieties. Here the question arises as to whether the child psychotherapist is able to hold the child's anxiety. The problem lies in recognising, understanding and making sense of what is being communicated by the child, and ultimately conveying this understanding to the child so that he can better understand what is causing the anxiety and distress. Similarly, if the

child projects anger, the therapeutic task for the child psychotherapist is to understand what is being communicated by the child, so that this can be addressed within the context of the child's distress. Chapter IV will elaborate further on the possible factors that might impair the therapist's ability to accept and understand the child's projections in the therapeutic context.

Donald Winnicott

Winnicott drew upon the theories of both Freud and Klein, he also stressed the importance of the maternal environment and the emergence of the self. Winnicott (1964) determined that anger arose in response to frustration, and in his later writings he considered anger as a sign of hope, that through anger the child was able to react when his needs were not met (Winnicott, 1986).

Winnicott (1960a) asserted that what the psychotherapist does in the psychotherapy setting is an attempt to imitate the natural process that characterises the behaviour of any mother with her own infant. The behaviour of the mother, as regarded by Winnicott, is described through the process of 'holding' (1960a) which involves the whole routine of care throughout the day both emotional and physical, thereby providing a 'facilitating environment' (1963). This describes the environmental, or mother's adaption to the infant's needs, and the concept of a 'good-enough mother' (1960b) whereby the mother provides sufficiently for the child to get a good start in life. In other words, like to good-enough mother, the therapist needs to actively adapt her mind to the setting and the form of psychotherapeutic treatment, for the child (Lanyado, 1998). In response to the environmental adaptation, Winnicott suggested that the infant develops what he describes as the 'true self' and 'false self'. The true self experience allows the child to discover the environment and his sense of what is real, including the difference between 'me and not-me' and the difference of thoughts and needs.

Alternatively in the false self-state of being, the infant reacts compliantly to environmental demands and builds up a false set of relationships (St.Clair, 2001).

In the next section I will discuss Winnicott's concept of false self and how it might apply to the therapist, I will then look at Winnicott's theory of anger and aggression.

The false self and its relevance to child psychotherapy

The false self develops in the earlier stages of object relations when the mother is not able to adequately respond to the infant's needs (Winnicott, 1960b). This is shown by the mother intruding upon, abandoning and/or rejecting the infant's experiences. Consequently the infants experience maternal impingement and/or emotional withdrawal by the mother, and as a result adapts his own needs to accommodate the conscious and unconscious needs of those whom he is dependent upon. When functioning from the false self the child may experience himself as the passive victim of environmental and instinctual impingement (Winnicott, 1964).

In terms of the emotion of anger, Posner, Glickman, Taylor, Canfield and Francine (2001) suggest that when the mother is not able to receive and digest the child's anger and respond appropriately, the child may fear his own anger and in turn develop a false self. The false self may also develop when the environment places too high an expectation on the child for perfection. Or where anger, or any form of autonomous behaviour is not seen as acceptable by the parents.

The therapist with a history of growing up in a non-facilitating environment, and due to environmental demands, may have developed a false self herself. St. Clair (2000) explains that the presence of a false self, may result in the child feeling unreal, ineffective, and unable to be genuine in a relationship. In a study examining the impact of true and false self in the development of the psychotherapists, Eckler-Hart (1987)

found that when there is anxiety about the vulnerability of one's true self, the false self takes over for protection. According to Mitchel (1984), the false self has the defensive functioning of protecting and hiding the true self by dealing with external reality on a compliant and purely reactive basis (Eckler-Hart, 1987). The therapist who inhibits anger might not be able to adapt to the child's needs within the therapeutic process due to the anxiety it evokes. As a result the therapist may become overwhelmed and withdraw emotionally from the child, or conversely if the child comes to therapy with a false self presentation, the therapist may collude with the child defences.

Winnicott (1960b) expressed concern that when the false self becomes tied up in an individual who has an intellectual propensity, there is a strong tendency for the mind to become the location of the false self. Therefore the adult, or in this case the therapist, may attempt to solve personal problems by the use of the intellect. Consequently while the therapist focuses on the intellect she might not be able to maintain a good enough environment for the child to authentically connect to his emotions, which could result in any anger emanating from the child's true self being avoided or rejected. Winnicott (1960b) when discussing the intellectual false self postulated that this way of functioning easily deceives.

Aggression and anger

Throughout his writing Winnicott seems to have developed different ideas on describing the theory of aggression. Initially he proposed that aggression was shown in innate motility, starting from kicking in mother's womb, and when out of the womb by greedy sucking and chewing (Winnicott, 1939). He further maintained that at this early stage aggression shows no intention to hurt but is simply a form of instinctual love which increases during excitement and may be experienced as highly pleasurable. Winnicott (1950-5) wrote:

It is necessary to describe a theoretical stage of unconcern or ruthlessness in which the child can be said to exist as a person and to have purpose, yet to be unconcerned as to results. He does not yet appreciate the fact that what he destroys when excited is the same as that which he values in quiet intervals between excitements. His excited love includes an imaginative attack on the mother's body. Here is aggression as a part of love (p. 206).

Winnicott seems to suggest that the fate of the infant's aggression (anger) is determined by the facilitating environment, and the capacity of a 'good-enough mother' to tolerate this. In the child psychotherapeutic setting the therapist who inhibits anger might not be able to fully adapt to the child's needs, and consequently not able to maintain a 'good enough' environment. In relation to the research question it is useful to consider anger through the perspective of Winnicott's theory of aggression and how the non-facilitating environment might impact on the inhibition of anger.

According to Winnicott (1950-5), the infant with the experience of 'good-enough' mothering is able to combine aggression with pleasure. The 'good-enough' mother is able to contain and survive the child's aggression (Winnicott, 1960b). This experience allows the child to develop the true self. However, Winnicott (1964) suggested that as the 'good-enough' mother continues to survive the infant's attacks; the infant develops the feeling of guilt and a sense of concern for the mother. He further explained that this guilt is an important component of the desire to repair, to re-create and to give something pleasurable back to the mother. This concept can be seen as compatible to Klein's depressive position and reparation. The concept of making reparation is important within the therapeutic context because as Winnicott (1963) believed, the therapist must allow the child to express his anger and find a way of symbolically making reparation in the relationship with the therapist. However, the therapist who is unable to tolerate the child's anger, might not be able to provide the child with the environment where the reparative work can take place, leaving the child alone in dealing with his own anger.

In the therapeutic process, Winnicott (1971) postulated that the therapist needs to allow herself to be used by the child in such a way that allows her to survive the child's aggression and/or anger. Explaining that for the child, the fantasy of destructiveness and the impulse to destroy, are important components of the normal emotional and cognitive developmental processes of differentiating between the self and the 'other' (e.g. the mother) (Winnicott, 1969 cited in Nason, 1985, p. 175). When the object is experienced as surviving the destruction, the quality of permanence is achieved (Winnicott, 1971). This results in the object, the mother, or in this case the therapist, being loved and hated at the same time, of having its own entity and therefore being able to be used by the child. It is important to note that the child needs the object to survive his capacity for destruction in order for him to accept his anger and know that it will not destroy the 'other'. The therapist who inhibits anger might be experienced by the child as not being able to survive his anger.

Attachment Theory

Attachment theory was formulated by John Bowlby (Holmes, 2005). His theoretical model differs from those of Freud and Klein in that he postulated the understanding of the developmental origins of individual differences is located in a context of close relationships. Consequently the relationship between the therapist and the child in the psychotherapeutic setting is likely to have significance for the emotional development of the child. When considering the emotion of anger in the relationship Winnicott, like Bowlby, saw anger directed towards an attachment figure as a response to frustration (Bacciagaluppi, 1989).

From his observations during his time in the child guidance clinic, and in conjunction with the research undertaken by James Robertson, Bowlby was able to develop a theoretical model of anger and separation (Holmes, 2005). Bowlby (1988)

proposed that for the child the function of the anger was meant to be a signal to the parent to become available and provide comfort and support, thus soothing the child's distress, fear and anxiety associated with separation. He also determined that when separations are prolonged or repeated, or when the child is constantly threatened with abandonment, the child's ability to both experience and express anger might become dysfunctional. When the child is regularly threatened with abandonment, he might inhibit his anger in case it results in the loss of the parent in reality (Bowlby, 1973).

In the following section I will introduce the concept of Bowlby's secure base effect, I will also discuss attachment patterns as devised by Mary Ainsworth (Karen, 1994), adult attachment, and the therapist attachment style.

Secure base and attachment patterns

Bowlby (1973) introduced the notion of a secure base, whereby the child expects the attachment figure to be available, responsive and consistent, enabling the child to feel better about themselves (Davila & Levy, 2006). Within the therapeutic process the child psychotherapist may act as a secure base for the child, however, if the child has not had the experience of a secure base he is likely to feel insecure in this relationship.

Support for Bowlby's theory of attachment was provided by Mary Ainsworth and her colleagues (1978), who documented different patterns of attachment and secure base usage between children and their parents or caregivers. In order to do this, Ainsworth and her colleagues devised 'The Strange Situation' as a model to assess the attachment behaviour in young children.

From the findings in 'The Strange Situation' study Ainsworth and her colleagues (1978) determined that variations in the sensitivity and responsiveness of the mother to the child's distress and the child's needs on reunion resulted in different attachment

patterns of behaviour (Shirk & Russell, 1996). These patterns were termed secure,

insecure avoidant and insecure ambivalent. Later, Main and Solomon (1986) examined

a group of children that did not fit any of the three classifications suggested by

Ainsworth and colleagues (1978) (Main & Solomon, 1990). They classified a fourth

pattern as being disorganised or disorientated attachment.

Children in all four attachment categories experience anger and frustration at

being left, but it is how their caregivers responds to their distress, and how the child is

able to receive comfort and reassurance from their caregiver on reunion, that determines

how the child ultimately copes with this emotion.[3]

Adult attachment

Early attachment experiences appear to set the stage for attachment relationships

in later life by creating expectations about the consistency and responsiveness of others

(Bowlby, 1973; Mikulincer, Florian, & Tolmacz, 1990). Such expectations effect

interpersonal interactions in adulthood which include partners and friends.[4]

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[3] For example:
- Although the secure child exhibits distress at being left by his mother, he seeks out his mother on reunion, experiences relief and returns to play, if the child is angry then he is able to express his anger directly to the mother;
- the anxious/avoidant child reacts to the separation from his mother with less protest or distress, on reunion he ignores his mother acting as if he was indifferent to her presence, this child's anger is more likely to be expressed in an indirect way;
- the anxious/ambivalent child displays high levels of distress both on separation and reunion, and exhibits a mixed approach/rejection pattern of behaviour when his mother returns, and is not easily consoled, when angry this child can become chronically angry and express other emotions through anger (Potter-Efron, 2005).
- and the disorganised or disorientated child displays no constant pattern and shows unusual behaviour upon his mother's return, such as falling to the floor or turning in circles (Potter-Efron, 2005). When angry he will become overwhelmed with emotional flooding, and dissociate or become aggressive towards self or others.

[4] Adult attachment researchers have found that there is about 80% continuity between childhood attachment patters and adult attachment patters (Suess & Sroufe, 2005). For instance, securely attached adults have strong, secure base (Bowlby, 1973), and trust that their significant others will be available in times of need. In contrast, insecure adults who are either avoidant or ambivalent perceive their significant others as unavailable and are suspicious of whether they will be there for them in times of need (Mikulincer, Florian, & Tolmacz, 1990). When their attachment figures are not reliably available and supportive, they lose their sense of security; negative internal working models of self and/or others are then formed. It may suggest that above strategies for dealing with anger are likely to persist into adulthood.

Potter-Efron (2005) states that although similar in form and function, adult attachment is different from parental/infant bonding, because it involves reciprocity – an individual can be either caregiver or care receiver, or both. Adult attachment research has also shown that attachment styles can change depending on the subsequent life experiences of the individual (Mikulincer & Shaver, 2007).

The therapist's attachment style

The therapist's attachment style may interfere with her ability to manage her own anger and/or the child's anger. Bowlby (1973) found that the association between anger and attachment is strong in adults with insecure relationship histories. He found that individuals with a secure attachment style are able to cope effectively with negative emotions, whereas individuals with insecure attachment patterns may not acknowledge negative emotions. It is possible that some insecurely attached individuals may choose to become child psychotherapists.

Individuals with an avoidant style of attachment seem to be more likely to inhibit negative emotions such as anger. This has been supported by numerous studies that have examined the experience of anger and the attachment style of individuals and have noted that anger inhibition is associated with avoidant attachment (Mikulincer, 1998; Mikulincer, Florian, & Tolmacz, 1990; Mikulincer & Shaver, 2007; Mikulincer & Shaver, 2008; Shaver, Mikulincer & Chun, 2008). Therefore, in this part of the chapter, I will examine the implications of the avoidant attachment style and anger inhibition for the therapist within the therapeutic process. Due to the word limitation the inclusion of any discussion relating to the same implications for the therapist with ambivalent and/or disorganised attachment, will not be included as they are regarded as outside the scope of this dissertation.

Research suggests that individuals with an avoidant style of attachment tend to block or inhibit negative emotions such as anger because anger can activate unwanted, attachment-related needs, memories and behaviours (Main, 1981; Mikulincer & Shaver, 2008). Hence anger is kept out of consciousness. According to Cassidy (1994), anger implies emotional involvement in a relationship, and as such may intensify an avoidant person's commitment to self-reliance. This may be due to the fact that from childhood they have learned that distressed feelings are met with either rejection or punishment. Thus as suggested by Shaver, Mikulincer, and Chun (2008), individuals with an avoidant attachment style may be unable or unwilling to deal openly with the causes of painful emotions, regardless of the harmful effects on a relationship. Consequently the therapist with avoidant attachment style may not be able to acknowledge either their own, or another's anger, which may in turn result in ineffective therapy or harmful psychological implications for the client. This is also applicable in child psychotherapy and will be discussed further in Chapter V.

Furthermore, the fear of rejection for individuals with avoidant style and the need for an 'other's' love, may hold their anger in check, resulting in them presenting themselves as positive, competent and capable (Mikulincer, 1998; Shaver, Mikulincer & Chun, 2008). In the case of a therapist trying to project a positive image, she might inhibit any anger that may be evoked as a result of therapeutic process. There may then be a risk of this being acted out or otherwise expressed unintentionally outside of therapy setting.

Attachment theorists have also suggested that individuals with an insecure style of attachment may also have deficits in emotional regulation, and consequently may have difficulty in providing effective care (Collins, Ford, Guichard & Allard, 2006; Mikulincer & Shaver, 2007; Shaver & Hazan, 1988). Shaver, Mikulincer, and Chun (2008) found that anger is intensified for individuals with an avoidant style of

attachment. This emotion can trigger disruptive memories, especially when the person encounters other people's pain and suffering; resulting in attention being focussed inward rather than outward, toward what might be done for someone else. This is likely to be problematic within the therapeutic process where the child psychotherapist is expected to be a reliable emotional base.

If the therapist has not sufficiently addressed her own anger, she is left with only one option – to suppress her anger or distance herself from its effects (Shaver, Mikulincer & Chun, 2008). This process involves the denial or suppression of emotion-related thoughts and memories; diversion of attention away from emotion related material; suppression of emotion related action tendencies and the inhibition or masking of verbal and nonverbal expressions of emotion (Mikulincer & Shaver, 2007; Shaver, Mikulincer, & Chun, 2008).

An avoidant individual who expects to be punished or rejected when distressed may be less likely to ask for help because that may feel risky or uncomfortable. As a result a therapist with an avoidant attachment style, even one who has worked on her anger during training, might well be less likely to seek advice if unresolved anger was triggered in the therapeutic process. Consequently this may affect the relationship between the therapist and the child in the therapeutic setting.

It is worth noting however, according to Mikulincer and Shaver (2007), the therapist's attachment style may change if her circumstances change, which in turn could affect how the therapist deals with anger in the therapeutic process with the child at any given time.

Conclusion

In this chapter I looked at psychoanalytic and psychodynamic theories to understand the roots of anger and the basis for anger inhibition in the child

psychotherapist. Both Freud and Klein suggest that anxiety can be a reason for anger inhibition. Theorists seem to agree that the first relationship with the mother has a significant influence on how one deals with anger and the inhibition of anger, in relationships with others. The therapist who inhibits anger may have grown up having developed a false self and insecure attachment in relationships with the outside world. Anger inhibition in the therapist might impact on the therapeutic process which will be discussed in the next two chapters. The following chapter looks at factors that might impact on the therapist's anger inhibition.

Chapter IV: Inhibition of anger in the child psychotherapist

Overview

To further investigate the basis for anger inhibition I will explore the possible factors that may influence the child psychotherapist's inhibition of anger. This exploration will begin with the psychological construct of countertransference and will incorporate defining countertransference, addressing countertransference issues, explore anger in the context of countertransference and the consideration of countertransference when working with children and their families. I will then explore cultural and socialisation issues. In the final section I will address professional factors for example, stress, vicarious traumatisation, burnout and compassion fatigue.

Countertransference

In attempting to understand countertransference in the context of the therapeutic process it is important to look at transference. The terms 'transference' and 'countertransference' refer to the feelings that get evoked within the therapeutic relationship. These two concepts in essence are derived from Freud (1910-1957). Transference can be simply defined as the projection onto the therapist of the client's feelings and issues connected with significant others, for example parental figures.

Freud (1910) considered countertransference to be the therapist's unconscious reaction to the client's transference (Jacobs, 1999). He suggested that the therapist needed to recognize her countertransference and 'overcome it', because it may represent a blind spot which might impact on the therapeutic work (Jacobs, 1999; Sandler, Dave, & Holder, 1982). On the other hand, Heimann (1950), Racker (1968) and Kernberg

(1965) considered countertransference as all the therapist's responses (pathological or appropriate) as sources of the significant understanding of the client's on-going emotional process. This view maintained that countertransference needed to be understood by the therapist and used to help strengthen the therapeutic process. Heimann (1950) believed that countertransference provided information not only about what was evoked in the therapist, but also what was evoked in the client, and what was occurring within their relationship. Furthermore, Racker (1968) presented two types of countertransference: concordant (whereby the therapist felt the same as the client), and complementary (by which the therapist felt and took a role of what the client cast upon her).

On the other hand, Bion (1962) in his model of containment, introduced an explanation of countertransference as a basic mechanism of projective identification (cited in Anastasopoulos & Tsiantis, 2003, p. 6). Interpreting this model, the therapist needs to be able to accept feelings projected by the client and return them to the client in a modified and acceptable form. In terms of psychotherapy with a child it might not be possible for the therapist who inhibits anger, to contain the child's anger, which in turn leaves the child either unable to communicate his anger or to be left in an uncontained state if he expresses it. Joseph (1988) points out that although projective identification is a fantasy, it has a strong effect on the therapist (cited in Anastasopoulos & Tsiantis, 2003, p. 7). If the therapist is open and capable of recognising what she is experiencing, her countertransference feelings can be used to help to understand what is going on in the relationship with the child.

Countertransference as a therapeutic tool

Countertransference can be used as a tool within the therapeutic process to understand the child's anger, but it could be problematic if the therapist is not aware of

the origin of her own anger. The inhibition of anger can create difficulties, because it may stimulate conscious or unconscious experiences in the therapist, resulting in the re-enactment and the reliving of these experiences (Smith, Kleijn, Trijisburg, & Hutschemaekers, 2007; Wilson & Lindy, 1994). Anger evoked in the therapist may bring the familiar predicament of the need to inhibit the anger, because in reality it may make the therapist feel overly vulnerable and/or helpless within the therapeutic relationship.

Anger evoked in the therapist, according to Langos (1981, 1990), has a wider lens and may arise in response to many things, for example the therapist's family of origin; as a response to a child's transference and/or projections; as a response to the material presented by the child; or if the disturbance is within the therapist (Wilson & Lindy, 1994). Bonovitz (2009) found that the therapist's experiences and feelings from her childhood may be a distraction that could interfere with treatment. Furthermore, the therapist may also bring into the therapeutic setting, her own personality and habits, as a method of dealing with anger. Wilson and Lindy (1994) concur, suggesting that this may include personal beliefs, ideological systems, defensive styles, personality traits, education, and personal life experiences relevant to the therapeutic subject.

Teyber (2000) argues that frequently psychotherapists are drawn to clinical practice often by an unresolved need to rescue, or to solve their own childhood's emotional issues. Although Waksman (1986) suggested that when the child's conflicts, projections, or transference feelings touch in the therapist's own unresolved infantile longings, they may defend themselves by repressing those feelings. For example, a therapist who has learned to inhibit anger from her childhood may have longed to have had the opportunity to openly express anger towards her own parents, but this was not allowed. Hence, when the therapist is faced with a child who openly expresses anger, it may be overwhelming for the therapist, and consequently make it harder for her to

appropriately work with the child's anger, and to understand the extent of her own emotions. This may result in the therapist relying on unhelpful ways to manage the situation, such as drifting off and daydreaming, unexpectedly placing strict limits in the playroom, cancelling appointments, or ending sessions early. Where this happens the therapy is likely to end or be unsuccessful.

Bonovitz (2009) emphasised that working with countertransference involves developing the capacity to first recognise and tolerate what is being evoked in the countertransference with the aim of using it actively instead of dismissing it, or considering it as unrelated and therefore something to be avoided or kept apart from the work with the child. When a therapist inhibits anger she may be less likely to reflect on her own emotional reactions to the child or think through the meaning and implications of them and their relationship with the child.

Anger in countertransference

There are a number of reasons for experiencing anger as a countertransference reaction in a child psychotherapy setting. Osfosky (2007) found that a therapist's anger may be as a response to a child's disruptive behaviour or parents being inattentive to the child's needs or when a therapist's work is devalued. In these situations Osfosky (2007) found that therapists would be reluctant to acknowledge their anger. Furthermore, Dale (1997) and Parker Hall (2009) found that the therapist may get angry with the child who uses defences such as denial, repression and dissociation. With Parker Hall (2009) suggesting that as a result of using these defences, the child inhibits his own anger to the point of having no conscious awareness of it, and is therefore unlikely to acknowledge that he has difficulties in conveying his anger (Parker Hall, 2009). It seems likely that this child would need the therapist to be receptive to his conscious and unconscious needs, in order to be able to assist the child. However if the therapist inhibits her own

anger then she is unlikely to be sufficiently aware or able to use her countertransference feelings successfully in order to understand the child, and in turn may collude with the child's unhelpful defences. As with earlier examples, when there is this level of therapeutic misattunement, therapy is likely to terminate prematurely, resulting in a missed opportunity for the child to be provided with the space where he can grow emotionally.

Additionally, according to Piene, Auestad, Lange, and Leira (1983), the therapist may over identify with the child. They found that this type of countertransference can interfere with the integration of the split-off parts of the child's internal objects, because the therapist may take part in this splitting by only presenting the 'good therapist' during the therapeutic process as opposed to the 'whole therapist' who is inevitable going to transferentially fail the child at times. Giovacchini (1974) postulated that this reduces the therapist's ability to be empathetic and acknowledge the child's feelings (cited in Anastasopoulos & Tsianis, 2003, p. 4). If the therapist is unable to be authentic with the child, the child will not have the opportunity to resolve any unconscious struggles he is navigating with his own parents.

Winnicott (1949) seems to indicate that within the therapeutic context the child can evoke anger in the therapist, and that the therapist needs to be able to acknowledge and manage her own anger, and use this understanding to help the child. In providing a context for this assertion Winnicott (1949) stressed that it is developmentally essential for the baby to feel that mother's hate, in order to feel truly loved. Like the mother, the therapist must be aware of her own hate or anger and be able to tolerate it without expressing it or acting on it.

Bonovitz (2009) argues that in the child psychotherapeutic process, communicating countertransference with the child is quite different from doing the same with an adult, due to the child's less developed cognitive abilities. Furthermore

therapeutic communication with children is mainly non-verbal and occurs on a symbolic level, through play and action (Anastasopoulos & Tsianis, 2003; Piene et al., 1983). As a result the therapist needs to have the ability to accept the child's anger, and be able to take it into the account in order to understand what the child needs to convey.

Anastasopoulos and Tsianis (2003) argue that child psychotherapists try to avoid negative countertransference reactions due to the anxiety it causes. Marshall (1979) stated that this avoidance may be due to the fact that most child psychotherapists are parents themselves and tend to see their own children in the child they are working with. The parental-like responsibility and worry of losing or harming the child seems to be intensified when working with children rather than adults. Bonovitz (2009) considered this anxiety interfered with therapists allowing themselves to experience the full force of their feelings. Furthermore, McCarthy (1989) suggests that the therapist may resist their countertransference because they might be unwilling to identify their personal sources of anxiety that connect them with the child's intra-psychic life and family relationships (cited in Anastasopoulos & Tsianis, 2003, p. 10). The therapist's avoidance of countertransference reactions places the therapeutic work in danger, and may result in the child being referred to another therapist, which in turn may cause further trauma for the child (Bonovitz, 2009).

Countertransference when working with the child and their family

Countertransference for child psychotherapists might be more intensely felt due to the fact that when working with children the therapist needs to be more present and interactive with the child's external world, both inside and outside the therapy room, than with adult clients (Lanyado, 2004). For example, psychotherapy with children involves numerous relationships and as a result the therapist is a subject to countertransference reactions that may access her own experiences as a sibling, parent,

grandparent, student or friend during the process (Bonovitz, 2009). Thus Waksman (1986) suggested that the stresses of countertransference on the therapist are more severe when working with children due to the therapist needing to deal with her own unconscious conflict with the parents or caregivers, and figures or authority, as well as the nature of the child's material.

As mentioned above, countertransference may be influenced by the therapist's past, therefore where the therapist has not been able to work through her own difficulties in expressing anger towards her parents and other figures of authority, it is likely she will re-experience those feelings in relationships with any parents or caregivers she works with. This countertransferential conflict with the parents may be applied in support of the child against the parent, or in support of the parent against the child.

In accordance to the above, within the therapeutic context the therapist might identify with the child, accept the child's view of his parents, and be angry with the child's parents (Bernstain & Glenn, 1988). On the other hand, Bernstain and Glenn (1988) found that the therapist may want to please the parents and achieve a quick cure, gratifying their unrealistic expectations. As a result the therapist may become angry if the child fails to perform or improve.

Dale (1997) suggested that the therapist's countertransference response towards the parents when the child is subjected to cruelty and sadism may mirror the way the therapist was treated by her own parents in childhood. Anastasopolous and Tsiantis (1996) explain that in such cases the therapist may identify with the child, and unwittingly encourage the bad parent/good parent-therapist split, or might reject the family and classify the situation as untreatable. The therapist, who inhibits anger as a way of resisting her countertransference responses in relation to emerging aggressive

feelings, might need protection from her escalating anxiety in order to maintain the good parent-therapist role.

The impact of culture, gender and socialisation on the inhibition of anger

As I mentioned in Chapter I, I am a Pakeha[5], Kosovar woman, relatively non-religious with a Muslim background who grew up in a country under oppression. Why is this important to consider and comment upon? I believe it is important for any psychotherapist to consider their own gender, culture, and background in order to understand any blind spots and biases that might impede their work, including the inhibition of anger. For someone who has grown up in an occupied and oppressed country where to acknowledge anger would not only have been dangerous but also psychologically unbearable and in conflict with the cultural norms and beliefs. It is also important to consider whether any, or a combination of these factors, impact upon my work as a child psychotherapist.

In discussing child psychotherapy, Bromfield (2007) argues that cultural difference can make an impact very early in any work with the child and the family. The therapist needs to have the ability and willingness to enter another's world as in the development of any therapeutic relationship. To do so, the therapist needs to be aware of her own cultural influences and socialisation, and whether it affects the way she deals with emotions, which of course includes anger. Brems (2008) suggested that a problem in cultural countertransference might arise if the therapist had projected stereotypes into the family regardless of the child's symptoms.

Socialising influences, including cultural rules and gender roles, commence from the moment the child is born. In Western culture this is often signified by whether the infant is wrapped with a pink or blue blanket. In turn these cultural norms often

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[5] Pakeha is a Maori language term for New Zealanders who are of 'non-Maori' or 'non-Polynesian' heritage (Ranford, 2013)

modify the child's expression and experience of anger (Barish, 2009; Thomas, 2006).

For example, studies (Bacon & Ashmore, 1985; Brinbaum & Croll, 1984, Miller, 1983)

have shown that parents are more accepting of anger in their sons and even encourage

them to be aggressive (cited in Thomas, 2006, p. 71-95). Kassinove and Sukhodolsky

(1995) found that great maternal attention is given to boys' anger, whereas girls'

displays of anger are ignored, therefore boys are noticed, and in some ways expected, to

show anger (Chaplin & Aldao, 2013). As a consequence of this, girls might grow up

learning that experiencing and expressing anger is unladylike.

Anger is a universal and primary emotion, but according to Russell (1991), the

meaning of anger in each culture is constructed within the cultural beliefs about the

mind, the self, society and nature (cited in Thomas, 2006, p. 71). For example, anger

may be constructed differently in an individualist culture, in comparison to collectivist

cultures. Furthermore, different cultures assign different social roles to the emotion of

anger, thus determining how anger is expressed and, quite possibly, how it is

experienced by individuals. For example, in my culture anger is described as a change

in the nervous system, and when one shows anger the individual is considered to be out

of control.

Thomas (2006) argues that in many cultures anger is viewed as a negative

emotion and sometimes forbidden or taboo. Again, this has obvious implications for

child psychotherapists working in a multicultural society. In the case of a therapist who

comes from a culture where anger is seen as bad, or an emotion that one needs to be

ashamed of, the therapist may be more likely to inhibit anger. Consequently when anger

arises in the therapeutic context the therapist might become overwhelmed. This in turn,

might impact on her ability to understand and manage the child's anger, either by

facilitation or containment.

In terms of culture differences, the child psychotherapist may need to keep in mind the cross cultural differences of language, religious beliefs, trauma or social status when working with children. Every socialisation of anger is individual. For example, a child who grows up during a war or economic crisis is exposed to his parents' socialisation of anger of being victims of their circumstances and experienced hopeless anger, compared to the child raised in relative social harmony (Tomkins, 1991). It then follows that, when faced with the child of a different cultural experience, the background of the therapist it is likely to impact on her countertransference reactions.

Andreou (1999) states that the racial and cultural differences between the therapist and the child might activate very primitive defences between the child and the therapist, and/or the therapist and the parents or caregivers of the child. The therapist needs to be aware of her emotional reactions when working with children of a different culture. For example, the therapist needs to recognise whether she is getting angry with the parents because of cultural or religious reasons, or because of the way the child has been treated. When faced with a therapist of a different culture and/or skin colour, the child is likely to experience a transference reaction to the therapist in the same way the child, or the child's family, might have reacted to other members of the therapist's cultural background (Brems, 2008). It is possible that this may evoke anger in the therapist, but in these circumstances the therapist might suppress her own anger and use her countertransference to understand what is going on for the child, and to maintain the relationship with the child and the family. However, if the therapist is not able to accept her own anger due to cultural differences, then she is more likely to inhibit anger, which might impact on the relationship with the child or with the parents and will need to take appropriate steps to alleviate the situation.

To date, I have not found any studies that specifically examine gender differences and anger in child psychotherapists. Consequently I have looked at human

development studies on gender and expression of anger, to help me understand how these might impact on the therapist's inhibition of anger. I found that individuals from various ages and socio-economic backgrounds, perceived women to be more emotionally expressive than males (Bradley & Hall, 1993; cited in Reiser, 2001, p. 29). However, when it comes to the emotion of anger, according to Brodly and Hall (1993), there is a widely held belief that anger is more intensely expressed by males (cited in Reiser, 2001, p. 29). In Western society women are seen as nurturing and caring, while men are viewed as strong and are at times, expected to show anger. This view is shared by Bernard (1981) and Pollack (2000), who state that women are seen as helpful, agreeable, willing to comply and able to connect, whereas men are seen as tough, competitive and autonomous (cited in Englar-Carlson, Stevens, & Scholz, 2010, p. 225). Tavris (1982) argues that cultural norms allow males to respond with anger when they are provoked, but cultural definitions of femininity do not allow for women to be openly angry.

Reiser (2001) in her book concludes that there are no differences in how men and women experience, express and identify anger, but that women are less likely to express it because of the associated costs due to their culture or social status. As a result it is likely that a false stereotype regarding the expression of anger in men and women has developed. Whereas, Crawford et al. (1990, 1992) conclude that for men, anger is empowering, whereas for women, anger emerges out of feelings of frustration and powerlessness (cited in Eatough, Smith, & Shaw, 2008). Furthermore, Mayne and Ambrose (1999) in their investigation of anger in psychotherapy found that women are less likely to express anger outwardly and tend to turn it inward. Consequently women's anger tends to be experienced in indirect and often self-defeating ways (Thomas, 2006). Furthermore, inhibited anger tends to make women more likely to experience somatic symptoms such as stomach upsets, headaches, and dizziness (Mayne & Ambrose,

1999). It has also been identified that alcohol or 'over the counter' drugs are used to medicate these uncomfortable, anger-related symptoms (Mayne & Ambrose, 1999; Thomas, 2006).

While these findings make it more difficult to understand gender differences in the expression of anger, what has been learned is that while there seem to not be many differences in the way men and women feel or experience anger, the culture we come from and the environment we live in, determines how each gender expresses or inhibits anger. In New Zealand, like other Western societies, the profession of child psychotherapy tends to be dominated by women. For example, information gathered from The Psychotherapist Board of Aotearoa New Zealand (PBANZ) indicates that there are 49 registered child and adolescent psychotherapists, 48 of which are female and one, who is male. If women grow up learning to inhibit anger and feel powerless to express it, these feelings may be translated into their relationships with children through countertransference, which in turn might impact on the therapeutic process.

Professional factors

Tansey and Bruke (1989) found that countertransference can be a conscious and/or unconscious response, not only coming from past, but also from present conflicts, feelings, and life events. In the workplace, when the therapist is under stress she might not be able to acknowledge and reflect upon her own anger. Dale (1997) suggested that stress can eventuate when a therapist works with severely deprived or psychotic children because the therapist is bombarded by intrusive and invasive projections. In such situations, the therapist needs to be able to receive these primitive projections from the child, while at the same time being able to protect herself from being overwhelmed by them.

Nevertheless, Dale (1997) postulates that being on the receiving end of such powerful projections can both threaten the therapist's emotional stability and her capacity to think and reflect on what is happening in the relationship with the child. Under stress, the therapist is more likely to develop negative countertransference reaction towards the child (Anastasopolous & Tsianis, 2003). She is also likely to have a lower threshold for coping, and a lower ability to attend effectively to the child's needs (Farber, 1983). This may result in her not being able to recognize the child's anger or her own anger.

From my readings it seems evident that high levels of stress are likely to impact on the therapist's anger inhibition, and negatively impact on the quality of the therapeutic process by interfering with her emotional availability and the attention she should be devoting to the therapy. This can result in the limited success of the treatment, treatment failure, or premature termination. Furthermore, the stress of having to witness the repetition of extensive abuse or neglect of the child can become traumatic for the therapist (Dale, 1997). As a result the therapist may suffer from professional factors, which can be experienced by any health professional:

- Vicarious traumatisation: the therapist might feel post-traumatic symptoms similar to those of the trauma clients, such as: nausea, headaches, difficulty with sleep, emotional numbing, feelings of personal vulnerability, and intrusive thoughts (Osofsky, 2007);

- Burnout: defined as a state of physical, emotional and mental exhaustion caused by long term involvement in emotionally demanding situations (Figley, 2002);

- Compassion fatigue: when the therapist experiences caregiver burnout related to caring, empathy and emotional investment in helping those who suffer (Figley, 2002; Osofsky, 2007).

Conclusion

This chapter has explored the factors that might influence the therapist's inhibition of anger and how that might impact on, and interplay within, the therapeutic process with the child and the family. Countertransference can be problematic in cases when the therapist is not aware of her blind spots around anger. This can manifest, not only in the relationship with the child but also with the child's support system outside of therapy. The background and culture of the therapist can represent countertransference issues when working with the child and the family in a multicultural society. Finally, the therapist needs to be mindful of the stress that the work may cause and how that might impact on her emotional availability to the child as well as the effects on her own professional and personal wellbeing. In the following chapter I will address the function of the therapeutic relationship and the implications for effective practice.

Chapter V: Therapeutic implications of the inhibition of anger

Overview

The aim of this dissertation is to understand whether the inhibition of anger within the child psychotherapist impacts on the therapeutic process, and if so what may be the implications. As the therapeutic relationship is central to the therapeutic process it is important to consider this, therefore in this Chapter, I will define and discuss the function of the therapeutic relationship. I will also elaborate on how the inhibition of anger in the child psychotherapist may impact on the therapeutic relationship by discussing the defence mechanisms used by the therapist and the transference-countertransference relationship. In order to provide a context for this, I will give two examples of how the child might express anger, directly or indirectly, within the therapeutic environment and hypothesise as to how the therapist who inhibits anger, might or might not respond. Finally, I will discuss the implications for effective practice and the moderating factors that may ameliorate this.

The therapeutic relationship

In order to understand the function of the therapeutic relationship, I came across terms such as 'therapeutic alliance' and 'working alliance' during my literature review. The term 'therapeutic alliance' comes from Zetzel (1956), who theorised that a therapeutic alliance depends on the extent of the patients capacity to employ the healthy, functional parts of his ego in relationship with the analyst (cited in Saketopoulou, 1999, p. 330). Whereas, Greenson (1967) defined the term 'working alliance' as the emotional relationship established between the therapist and the client as they begin to work

together (cited in Saketopoulolu, 1999, p. 330). Norcross (2010) defined the therapeutic relationship as the feelings and attitudes that the therapist and the client have towards one another, and how these are articulated. The terms, 'therapeutic alliance', 'working alliance' and 'therapeutic relationship' differ somewhat in their descriptions, but all include the affective quality between the client and the therapist, an essential factor in a therapeutic relationship. Thus, in this Chapter the terms "relationship" and "alliance" are used interchangeably, in line with contemporary usage.

The centrality of therapeutic relationship in child psychotherapy is beautifully described by Lanyado and Horne (1999) as follows:

> The child comes to see the therapist with all manner of difficulties in his or her relationships with family and peers, and talks and plays around these themes, and yet in psychoanalytic work the most important insights which lead to deep change in the patient's relationships and internal world are gained from what is happening in the consulting room, in the 'here and now' of the meeting of two people, the therapist and the child (p. 55).

The assertion made by Lanyado and Horne (1999) is echoed throughout literature describing therapeutic alliances, typically postulating that the relationship between the therapist and the child lies at the heart of psychotherapeutic work, and that the therapeutic relationship is the most important component in determining treatment outcome (Clarkson, 2003; DeVet, Kim, Charlot-Swilley & Ireys, 2003; Digiuseppe, Linscott, & Jilton, 1996; Horvath, 2005; Lanyado & Horne, 1999; Parker Hall, 2009; Shirk & Saiz, 1992). Additionally, a study by Garcia and Weisz (2002) has shown that the problems with the therapeutic relationship, more than other factors, are associated with premature termination of therapy (cited in DeVet et al., 2003, p.277).

Trotter and Landreth (2003) explain that within the therapeutic process, the child needs to feel accepted, cherished and respected by the therapist in order for the child to have the confidence to express his anger. Osofsky (2007) suggests that when the child is able to expresses their personal struggle and to integrate his experience with anger, it can stimulate a conscious and unconscious re-enactment and reliving processes for the

therapist. The therapist's own difficulties with anger can undermine her capacity to meet the child's anger, which can impact on the therapeutic relationship and ultimately the therapeutic process. In order to facilitate the therapeutic process, Levenson & Herman (1991), suggested that the therapist needs to help the child expand what he initiated; concentrate on what the child is experiencing or expressing and not distract him; stay within the immediate experience and not disrupt an ongoing experimental process; and to expand on whatever the child has introduced rather than distract him by suggesting a game.

However, the therapist who struggles with expression of anger, and relies on inhibition of anger as a safety mechanism, may feel the need to protect the child from his valid experience by attempting to provide what the child feels deprived of, in an attempt to assuage the child's rage. On the other hand, for the child who is unable to overtly express his anger, the therapist might overly identify with the child and collude with the child's defences in order to protect herself from facing a difficult experience. In these cases the therapist might be relying on defences that are unhelpful to the child's needs, which in turn might not enable the child to experience his anger, and eventually lose the gains made from the therapeutic relationship.

The following section will elaborate on the defence mechanisms the therapist may adopt within the therapeutic context with the child, the transference-countertransference relationship, and the potential impact they may have on the therapeutic relationship.

Defence mechanisms

Freud came to believe that the various unconscious defence mechanisms were triggered by anxiety (Knafo & Moscovitz, 2006). In the case of the therapist who inhibits anger because it arouses anxiety, the presence of anger can trigger her to adopt

and/or apply a number of defence mechanisms within the therapeutic context with the child. Freud frequently referred to the defence of displacement, which he used to explain how the psyche manages in everyday life. When referring to interpersonal relationships, Freud considered displacement to be an unconscious defence mechanism where the mind redirects anger from the person felt to be dangerous to an object or person felt to be safe. In relating this concept to the psychotherapeutic process, it could be considered that anger evoked within the therapeutic relationship or the context of the psychotherapy process is inhibited in the therapeutic setting but may be displaced into the therapist's personal life.

In the therapeutic setting the therapist may also employ other defence mechanisms; for example denial, avoidance, or dissociation (Freud, 1936). This is more likely in cases where the therapist might be 'conditioned' out of experiencing anger to such an extent that she might have no conscious awareness of harbouring any anger. Alternatively, the therapist might fear acknowledging anger due to the fear of rejection, or the fear that her anger might escalate out of her control and she may act out her anger. In this case the therapist might employ the defence of reaction formation and become overly friendly with the child, or may use somatisation, resulting in the emotional impulse of anger being converted into physical symptoms such as headaches or stomach pains during session.

The transference-countertransference relationship

Within the therapeutic relationship the child has the opportunity to work through their transferential anxieties with the therapist. The transferential relationship for the child can manifest in either positive or negative transference and may oscillate during the course of therapy. A positive transference embodies those friendly, loving, trusting feeling which will facilitate a secure base experience, whereas a negative

transference contains feelings such as anger, hatred, rejection, envy and mistrust, which

gets projected onto the therapist (Lanyado & Horne, 1999).

It is by working through the transference that the child develops an

understanding of his experiences with important people in his life, and how those

experiences influence other aspects of his life, including interactions with others.

Ideally, the therapist would understand what gets evoked in the countertransference and

be able to work with the transferential anger projected by the child (Dalenberg, 2004).

However, if anger related anxieties are not resolved for the therapist, the chances are

that she is not going to be able to effectively assist the child when anger comes up in a

therapeutic setting (Corey, 2009). The therapist might fail to understand or acknowledge

the inhibited or overt anger in the child, by avoidance or fear of retaliation. This, in turn,

may then send the message to the child that the anger the child holds is dangerous and

cannot be tolerated by the therapist. Thus the therapeutic relationship fails to be

effective.

Lanyado and Horne (1999) argue that there are aspects of countertransference

that predominantly reflect the unconscious personal difficulties and blind spots of the

therapist, hence the need for lengthy and in depth, personal therapy to enable the

therapist to separate what belongs to the child and what to the therapist. As previously

discussed under the heading of 'countertransference issues' the therapist who inhibits

anger might not be able to see or understand her countertransference or be able to

understand the child's transference.

Clinical examples

Children come to therapy for many reasons and some of them might have issues

of unresolved anger. For example, children who have experienced interpersonal trauma

may have difficulties with anger, either expressing it for fear that it will become out of

control, or that there will be retaliation; and inhibiting it as a learned response to ensure their safety. In an attempt to illustrate how a child's anger may be observed within the therapeutic environment I will give two scenarios where a child might either express anger directly, or inhibit it. These examples have been chosen from literature; the first is of a child with a history of foster care placements and the second is of a child with what Winnicott (1960b) describes as a false self. Included in the scenarios are thoughts about how the therapist with inhibited anger might respond to the child's anger.

Example I: Child with history of foster care placements

The child who is placed in foster care may not express anger towards his biological parents who maltreated and/or neglected them, and who may still neglect him by not maintaining regular contact during his time in foster care, resulting in the child feeling rejected and abandoned. This anger may be repressed, or selectively unattended to, and frequently displaced or acted out while the child is in foster care (Archer, 2003). One form of acting out is behaving in a provocative manner towards the foster parents to see if they too will resort to the maladaptive, care-giving responses the child has suffered in the past which resulted in the child feeling rejected and uncared for (Hughes, 1997). The provocative behaviour by the child may bring him into therapy for assistance.

The child with the above history may show anger in the therapeutic setting testing whether the therapist is going to reject or mistreat him as other important people in their life have done. The important consideration in this scenario is whether the therapist who has learned to inhibit her own anger will be able to tolerate the direct expression of anger from the child. If the therapist is not able to tolerate, manage and validate the child's anger she may respond by choosing not to work with the child and

refer them to another therapist. This then may confirm to the child that he is bad, unmanageable and deserves to be sent away.

If on the other hand the therapist chooses to work with the child and the child expresses anger directly or indirectly within the therapeutic environment, the therapist might resort to terminating the session prematurely, leaving the child in a dysregulated state; or impose rigid and unhelpful limits in the room resulting in the child feeling overly restricted. The therapist might find herself dissociating and start to daydream, or might focus on the child's behaviour rather than the underlying cause of the anger. Consequently she may then resort to providing instructions to the caregivers requiring the reinforcement of strict rules and limits in the home environment in an attempt to change what may be regarded as conduct disorder or oppositional defiant disorder, rather than the natural response to the maltreatment he has received in the past. It is also possible that if the child attempts to tell the therapist about his angry feelings and the therapist is not be able to empathically respond to this, she may discount the child's experience and associated feeling by concentrating on the positive aspect of the child trying to talk about his anger, for example, "You are very brave for talking about angry feelings", rather than explore what that might be like for the child and the underlying cause of his anger.

Example II: Child with a 'false self' presentation

Winnicott (1960b) notes that the therapist may at times fail a child with a false self -presentation. The definition of false self is given in Chapter III (pp. 22-23). Winnicott indicates that when the child with symptoms of repressed anger is able to show anger in the therapeutic relationship, the treatment "has gone a long way". Anger may manifest in the transference when the child feels that he is failed by the therapist, which is a positive step for the child, because he is using the therapist to solve his past

real failures. This sort of situation was described by Winnicott (1965) (cited in

Gronlinck, 1990, p.139), as follows:

> ....that the patient can perceive and encompass, and be angry about now. The analyst needs to be able to make use of his failures in terms of their meaning for the patient, and he must if possible account for each failure even if this means a study of his unconscious countertransference" (p. 298).

Failures of adaptation by the therapist are of course inevitable, and as Winnicott

implies, whatever readiness the child may have to be angry needs to be facilitated,

including the therapist's mistakes or, in Winnicott's terms, the therapist's failures. If the

therapist can accept and make use of her own mistakes, then the child has a chance to

experience and accept his own anger as valid. However, the therapist who inhibits anger

may not be able to own her mistakes, and consequently not give the child the

opportunity to experience and understand his anger. The therapist may fail to empathise

with the child's experience, leaving the child feeling alone with his internal struggles,

resulting in the child's need to maintain his false self.

It is possible that in adulthood, a therapist, who may have repressed or denied

anger in her own childhood or believed that she has resolved it, may use traits of false

self to stay in a relationship with people. Therefore for the therapist, within the

therapeutic context, a child with a false self may trigger a painful re-emergence of the

way she has dealt or continues to deal with her own anger. In this case the therapist

might identify with the child's anger and/or collude with the child's defences.

Conversely the identification might make the therapist feel more vulnerable, resulting in

regression to her own childhood feelings of anxiety. This re-emergence can leave the

therapist feeling overwhelmed and indeed may have also failed to enable the child to

experience their true self.

Implications for effective practice and moderating factors

As previously mentioned personal psychotherapy and clinical supervision are regarded as important and essential requisites for all psychotherapists to enable reflective understanding and analysis of their countertransference reactions. Ideas discussed in Chapters III and IV, indicate that the therapist's inability to sufficiently allow the expression of anger in the therapeutic setting will limit the therapeutic assistance they can provide for the child. The reason for, and implications of this, have also been discussed, but essentially there is an overriding theme that the therapist's own inhibition of anger can lead to inhibition of accurate attunement to the child's distress and therapeutic needs. This could result in avoiding the child's feelings, or in over identifying with the child, resulting in enmeshed relationship with the child (Fussel & Bonney, 1990: Parker Hall, 2009; Teyber, 2000).

Teyber (2000) postulates that change can happen if the therapist makes a lifelong commitment to working with their own interpersonal and intrapersonal dynamics. Whereas therapists who are unwilling to work on persistent countertransference reactions are those most likely to have a negative therapeutic impact on their clients.

Personal psychotherapy

As mentioned in Chapter I the therapist may enter the profession of child psychotherapy with an unconscious motivation of addressing and resolving her own emotional struggles (Farber et al., 2005). Conversely, Parker Hall (2009) suggests that for a person who inhibits their own anger, either consciously or unconsciously, becoming a therapist provides them with an opportunity to work with others' anger rather than address their own.

It is suggested that personal therapy for the child psychotherapist starts with the training. According to Lanyado and Horne (1999), it is essential that the therapist should come to know her own internal world in depth and detail, recognise her own characteristic emotional responses and ways of relating to others. This does not mean that therapist should stop her own personal development once training is completed. In the psychotherapeutic setting the therapist may become subject to the same psychic disturbances as the child she is working with, hence it is essential to maintain an appropriate distance to ensure the therapist neither becomes enmeshed in the child's anger nor avoids the child's anger. If issues with anger are not resolved the chances are that the therapist is not going to be able to effectively assist the client when anger comes up in a therapeutic process (Sander, Kennedy & Tyson, 1990).

Clinical supervision

Clinical supervision introduces and reinforces for the therapist, that her own emotions and feelings are critical to understand her work with children and families (Osofsky, 2007). Clinical supervisors can help therapists recognise their blind spots, misattunements, and failures of empathic attunement that put the therapeutic process and outcome at risk. Supervision can also identify if the treatment is in trouble by discussing the therapist's limits and the child's needs, and assessing whether the child is responding to treatment (Lieberman & Von Horn, 2008; McConnaughly, 1987; Dale, 1997). This would be important in relation to the therapist who has potential to inhibit anger and is not aware when they are doing so, or how that is impacting on the child or the therapeutic process.

Furthermore, it is the supervisor who can assist the therapist in identifying cultural awareness by providing a culturally sensitive, supportive and challenging environment for the therapist (Drews, 2008). In addition Lieberman and Van Horn

(2008) suggest that through supervision the therapist can discuss whether the problems of the families she treats are impacting on the therapist's personal life in the form of intrusive thoughts, nightmares or uncharacteristic hyper vigilance, and as such can monitor the effectiveness of their self-care practices. If not addressed, these symptoms can lead to vicarious traumatisation and/or professional burnout.

Conclusion

In this chapter the context of the therapeutic relationship has been discussed together with the implication of therapist inhibition of anger in the therapeutic process. The defence mechanisms used by the therapist as a response to child's anger have been elaborated on, together with the transference-countertransference relationship. Two case scenarios have been provided to illustrate how the therapist might respond to direct or inhibited anger within the therapeutic environment. Finally, the need for continued personal psychotherapy and clinical supervision has been addressed. The following chapter gives the summary and conclusion of the whole dissertation.

Chapter VI: Summary and conclusion

Overview

In the final chapter I will review the findings of this study and discuss the

implications of these findings in the field of child psychotherapy. I will discuss the

limitations of the study, suggest ideas for future research, and address the significance

of this study. Lastly, I will present concluding remarks.

Summary of the findings

This study sought to gain an understanding as to whether the inhibition of anger

in the child psychotherapist impacts on the therapeutic process, and if so what may be

the implications of this.

Firstly, psychoanalytic theory, object relation theory and attachment theory offer

an approach to understanding anger based on an understanding of early childhood

development, and also by means of the relationship established between the primary

object (mother) and the infant.

From a psychoanalytic perspective, and from an object relations perspective, it

could be concluded that ruptures in the therapeutic process might occur when the

therapist experiences anxiety as a result of anger being evoked in the relationship with

the child. Freud saw anxiety as the reason for inhibition of anger, and argued that

repressed emotions, even if we are not consciously aware of them, might direct how we

are in relationship with others (Barish, 2009). Klein (1959) suggested that early

developmental positions such as the paranoid-schizoid and depressive positions are

never completely overcome, and that conflicts in adult life that evoke anxiety can bring

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about a recurrence of either of those two positions. In order for the therapist to be able to understand her own anger and also be in touch with a child's anger, she needs to be functioning in the depressive position, and contain and reflect on her own feelings of anger as they arise.

Winnicott, also coming from an object relations position, suggested that the infant's anger is determined by the facilitating environment and the capacity of the good enough mother to tolerate this. The therapist needs to adapt to the child in the psychotherapeutic setting in the same way as the mother adapts to her infant. However, the therapist who has developed a false self, due to her early developmental experience in a non-facilitating environment, might experience unbearable anxiety when anger is evoked in the therapeutic context (Winnicott, 1960b). As a result the therapist may become overwhelmed and withdraw emotionally from the child, or conversely if the child comes to therapy with a false self presentation the therapist may collude with child's defences. Consequently the therapist might not provide the child with the opportunity to experience and understand his anger. The therapist may fail to empathise with the child's experience, leaving the child feeling alone with his internal struggles, resulting in the child's need to maintain his false self-presentation.

A therapist with an avoidant style of attachment is less likely to acknowledge her client's anger, because according to Mikulincer and Chun (2008) she might be unable or unwilling to deal openly with the cause of painful emotions. It would be expected that if the therapist should find she had been unaware of the effect of her own anger in the therapeutic process, she would seek advice from her clinical supervisor or take it to personal therapy. However, as indicated in attachment theory (Bowlby, 1988) people with an insecure attachment, which may include psychotherapists, are less likely to ask for help. Research (Collins et al., 2006, Mikulincer & Shaver, 2007; Shaver & Hazan, 1988) also shows that avoidant styles of relating can affect the therapist's ability

to provide effective care. For example, addressing anger can cause the therapist to draw attention inward rather than outward. It would be reasonable therefore to assume that the therapist's attachment style can also enter into the equation in the development and maintenance of the therapeutic relationship. Thus the therapist needs to be aware of their own attachment patterns and consistently reflect on how they relate with each child they work with.

Countertransference reactions frequently have to do with the therapist's own unresolved issues. Winnicott (1949) suggests the child can evoke anger in the therapist, and that the therapist needs to be able to acknowledge and manage their own anger, and use this understanding to help the child. If the therapist inhibits her own anger, then she is unlikely to be sufficiently aware or able to use her countertransference feelings successfully in order to understand the child, and in turn may collude with child's unhelpful defences. Therapy is likely to terminate prematurely, resulting in a missed opportunity for the child to be provided with the opportunity where he can grow emotionally.

The therapist who struggles with expression of anger, and relies on inhibition of anger as a safety mechanism, may overly identify with the child who is unable to overtly express his anger. This in turn is likely to result in collusion with the child's defences in order to protect herself from facing the difficult experience; for example, avoidance, denial, displacement, reaction formation and somatisation.

The child psychotherapist needs to have an understanding and awareness of her own cultural influence in the way she feels, expresses or inhibits anger, and how cultural biases might impact on the therapeutic process. Bromfield (2007) argues that the cultural difference can make an impact very early in the work with the child and the family. This may be from gender expectations around expressing anger; for example, boys are expected to show anger (Thomas, 2006) and girls are expected to inhibit anger.

Adult research (Averill, 1983; Main & Ambrose, 1999; Tavris, 1989; Thomas, 1989, 2006) seems to imply that there is no gender-based difference in the way anger is expressed, although this does depend on the cultural context. Anger socialisation is likely to be different for each of us in terms of what environment we have grown up in and what we carry unconsciously when working with children and families from different country, religion and or race (Andreou, 1999; Brems, 2008; Bromfield, 2007; Tomkins, 1991). If the therapist inhibits anger due to cultural connotation of anger then the therapist's ability to understand and manage anger either by facilitation or containment is limited.

The therapist can be influenced by the current stress in her life, for example inner-personal conflicts, physical health and life events. These factors can impact on the therapist's wellbeing resulting in stress related responses which might induce the therapist reliance on inhibiting anger in the therapeutic process. Furthermore, the therapist might be bombarded by intrusive and invasive projections (Dale, 1997) which can cause stress; or witness a repetition of abuse or neglect on children, which can become both stressful and traumatic. In order to survive the stress the therapist might consciously and unconsciously inhibit anger. Further considerations are related to professional factors that might eventually impact on the therapeutic process with the child, such as: vicarious traumatisation, burnout or compassion fatigue.

Finally, the question remains for me, of how much the professional training, personal therapy and clinical supervision can assist the therapist to be aware of her blind spot around anger. Lanyado (2004) argues that the need for the therapist to continue to analyse her inner world, and examine the impact of the child's transference and/or projections in the countertransference, remain throughout the therapist's working life. Hence, the need for continued personal therapy and clinical supervision.

Limitations of the study

This dissertation is a qualitative study informed to some extent by the emotional/subjective experience of the therapist, thus the findings are likely to be different from those found in quantitative research. This can be considered a limitation of the study. The present study is mostly based on qualitative findings, case studies and expert opinions or theories, which provide an understanding of anger inhibition and propose answers to the research question. The study does not involve statistics; hence the findings lose the objectivity and generalisability that they would have in the quantitative study. Due to the limited time-frame for completing the study and the research method used I did not carry out observations of therapists and clients, or interview them about their experience of anger inhibition in the therapeutic process. I believe this would have enriched the validity of this study.

The research for this study was limited to studies written in English. Egger and Smith (1998) note that 'positive' findings are more likely to be published in English, whereas 'negative' findings are more likely to be published in the indigenous language (cited in Sim & Wright, 2000, p. 282). In this case I might have missed findings that may have been useful in understanding the cultural impact of anger inhibition.

Furthermore, the material gathered for this study looked at the experience of anger and the basis for inhibition of anger in infants, children and adults; however studies including adolescents had to be excluded due to word count limitations. I believe that the research including anger in adolescents would have enhanced the study, for the reason that adolescents might have a different understanding and experience of anger compared to children and/or adults. It is also likely that the therapist's countertransference response might be different with an adolescent compared to that with the child.

Recommendations for future research

The present study is a comprehensive examination of the therapist's inhibition of anger and its effects on the therapeutic process. This narrow focus on the therapist's inhibition of anger within the therapeutic process may enhance more specific understanding of the basis for anger inhibition and the factors that might influence anger inhibition in allied professions.

It may also assist the child psychotherapist, supervisors and trainers to have more awareness of the potential of the inhibition of anger, and ensure a better-informed support system is put in place during training and when practising as a child psychotherapist. This is particularly important for the trainees and therapists coming from a culture where anger is seen as bad or taboo, to ensure that when anger arises in therapeutic context they are aware of their own psychological defences. The situation is further complicated when the child is from a culture where anger is accepted and seen as necessary and/or a positive emotion. Conversely it is also important that child psychotherapists develop an understanding and sensitivity to working with a child who comes from a culture where anger isn't deemed acceptable and the associated fears that may accompany this.

The above points suggest there is much scope for further research in relation to cultural differences in anger inhibition and its impact on therapeutic process. In addition, I believe it would be useful to look at whether the socialisation of anger impacts on the perception and expectations of the therapist. In particular how clients express anger, depending on their gender, religion, and /or race.

A further area of useful research would be whether there is a difference between experienced therapists and trainee therapists, in their awareness of anger inhibition, and how countertransference responses are managed when anger gets evoked in the therapeutic process.

Significance of the study

Clinically, the findings of this study may help child psychotherapists (whether in training or experienced) increase their awareness of their own history of anger inhibition and of potential blind spots, and the impact this has on therapeutic process. The areas identified for future research I believe are relevant and if carried out would further enrich the field of child psychotherapy and benefit both the therapist and the client.

In addition to child psychotherapists, this study may benefit other mental health professionals, whether they are working with children, adolescents, adults or families. By increasing awareness of their own anger and any blind spots they may have due to cultural or social influences, they are more likely to consider the impact of this on the relationship they have with their clients, and take steps to ensure it does not adversely impact on the client.

Concluding remarks

The motivation for this study was the perceived limitation of literature and understanding of the effects of anger inhibition, specifically in relation to the child psychotherapist, and the impact this may have on the therapeutic process. In researching the topic, and as I gained more awareness of my own personal experience, I was able to use different theoretical constructs to gain a comprehensive understanding of the origins of anger and the basis for the inhibition of anger. From this I was able to hypothesise about the potential impact of anger inhibition on the therapeutic process.

This study has increased my curiosity about anger, the need to have a level of self-awareness, a questioning attitude towards my own anger and causes. This curiosity and the knowledge gained from this study will benefit not only my work with my clients, but also my relationships with parents, siblings, caregivers, and other support workers related to the child. I also hope this study will instigate further research in

relation to the issue of anger inhibition in the psychotherapist and its implications for

the therapeutic process, not only for the child psychotherapy but for psychotherapy with

all groups.

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Appendix A: List of search results

Data Base: PsychINFO Advance search

Key words:	Search results	Relevant
anger (and) psychotherapy*	1251	40
anger (and) inhibition (and) child*	363	6
anger (and) analyst	25	2
anger (and) therapeutic relation* (and) child*	38	4
inhibition	37091	
anger	19362	
inhibition (and) anger	279	
therapist (and) anger	5	1
attachment	24204	
attachment (and) anger	19522	
repression	5727	
repression (and) anger	150	9
repression (and) anger (and) child	30 (as above)	
repression (and) anger (and) psychotherapy*	21 (as above)	
repression (and) anger (and) therapeutic relation*	1 (as above)	
child psychotherap* (and) supervision	2	2
child psychotherao* (and) personal therapy	0	
trauma	42967	
child psychotherapy* (and) trauma	403	
personal (and) child psychotherap* (and) trauma	18	3
frustration	2	
frustration (and) inhibition	0	
aggression	39706	
aggression (and) inhibition (and) child	84	2
suppression (and) anger	375	

Data Base: PEP

Key words:	Search results	Relevant
anger (and) psychotherapy*	1000	1
inhibition of anger (and) child*	86	
inhibition of anger (and) therapy*	66	

inhibition of anger (and) therapeutic relation* 18

anger in psychotherapy* (or) anger in child psychotherapy* 10

child psychotherapy* (and) anger management 0

psychotherapy* (and) anger management 0

definition of anger 54 2

Data Base: PsychARTICLES

Key words:	Search results	Relevant
anger	1665	
attachment	17305	
anger (and) attachment	2075	
angry	9106	
attachment (and) angry	1181	
insecure	2412	
anger (and) attachment (and) angry (and) insecure	219	
adult	109662	
adult (and) anger (and) attachment (and) angry (and) insecure	163	5

Data Base: ProQuest Dissertation and Thesis (Full text)

Key words:	Search results	Relevant
anger (and) inhibition (and) psychotherapist	681	
anger (and) inhibition (and) psychotherapy	4337	

AUT Library Catalogue:

Key words:	Search results	Relevant
anger	429	2
anger (and) child psychotherapy	23	3
anger (and) child	75	
anger (and) therapeutic relationship	15	
anger (and) psychotherapy	65	
inhibition of anger	5	
anger (and) child psychotherapy (and) therapeutic relationship	2	
trauma (and) child (and) psychotherapy	80	4

trauma (and) child (and) anger	10	1
inhibition	164	5
inhibition (and) anger 5 (as above)	5(as above)	
inhibition (and) psychotherapy	5 (as above)	5(as above)
inhibition (and) emotion	11	3
inhibition (and) affect	13	3(as above)
child psychotherapy	695	6
child psychotherapy (and) supervision	679	2

Manual search AUT library Index words: anger and inhibition

Subject or Author	Search results	Relevant
Sigmund Freud	43 (shelf)	2
Melanie Klein	3 (shelf)	2
Child Psychotherapy	28 (shelf)	10
Donald Winnicott	28	6

Auckland University Voyager:

Subject	Search results	Relevant
anger	754	4
anger and child	59	17
anger and psychotherapist	4	2
anger and psychotherapy	32	5
inhibition	295	1
repression	435	
repression of emotion	4	
handbook of emotion	48	1
handbook of anger	19	

Items purchased:

Books

1. Barish, K. (2009). Emotions in child psychotherapy.

    New York, NY: Oxford University Press.

2. Parker Hall, S. (2009). Anger, rage and relationships: An empirical approach to anger

    management. London, England: Routledge Taylor & Francis Group.

Article

1. Bonovitz, C. (2009). Countertransference in child psychoanalytic psychotherapy: The emergence of analyst's childhood. Psychoanalytic Psychology, 26(3), 235-245.