If I work with the mother will the child get better?

Harry Potter says to Draco : 'Love blinds. We have both tried to give our sons not what they needed, but what we needed. We've been so busy trying to rewrite our own pasts, we've blighted their present.' (Rowling ,J.K., & al. P 279 (2016).

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Abstract: Children with Encopresis are hard to treat (1998). The two children described here, had been through various therapeutic approaches (psycho-dynamic and psychoeducational) without benefit. Rather than family work, the author chose to work directly with each of their mothers using Cognitive Analytic Therapy with the idea that if the mother develops an understanding of her relationship with her daughter, the child's symptom of encopresis might be relieved. The focus of the therapy unexpectedly was more upon the mother's understanding of her own childhood trauma.

The paper explores how the relational dynamics of the mother's childhood trauma is re-created in her relationship with her girl child and how therapeutic understanding for the mother, allows the mother-daughter relationship to change and the encopresis in the child to be relieved. There are no clear answers theoretically either to the mechanisms of transmission of the trauma from one generation or one body to another nor in the mechanism of therapeutic change that lead changes in the mother to enable changes in her daughter. This paper is an invitation to colleagues to further explore the complex relational processes involved.

Keywords: Encopresis, symptom, mother-daughter relationship, inter-generational transmission, co-embodied, abuse, family secret, cognitive analytic therapy.

THIS ARTICLE describes two therapies with mothers seeking help for their daughters who show symptoms of secondary encopresis. According to DSM5 (2013) encopresis 'is essentially a repeated passage of faeces into inappropriate places, such as on clothing or the floor'.

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While typically the passage is involuntary in nature, it can be intentional in some cases, linked to oppositional behaviour. The French meta-analysis by Boige and Missonier (1998) points to relational difficulties in families when a child shows a symptom of encopresis. The authors recommend that contextual, family and environmental factors should be taken into account in an integrative, psychosomatic therapeutic approach, linking organic and psychological elements, rather than dissociating them (1999). For other clinicians, Interactive Parent-Child Guidance has shown its effectiveness (2006).

The purpose of the present paper is not to describe different approaches and show their effectiveness. The two CAT therapies we have been conducting with the mothers of girls showing symptoms of encopresis, were offered after psychoeducational work with parents and children as well as psychotherapy for the children had failed.

In our out-patient clinic in Paris (CAMHS) there has been an acceptance that sometimes the child might be 'symptomatic', but it will be the parent who directly needs our attention if we are to help the child. It is with this idea in mind that both mothers were offered and accepted sixteen sessions of CAT's relational approach to therapy. CAT is an open and versatile model and has a lot to offer to parenting with its particular emphasis on 'the relational', especially the parent/child relationship and its flexibility, allowing the movement back and forth between the child and the parent if needed, as Jenaway (2007, 2013) and Varela (2016) have already shown in their work.

As we shall see, the mother's own abuse was a family secret, kept within the family – in a 'protective bubble', without ever revealing anything to a professional or anybody else. The child psychiatrist invited the mothers to engage in individual psychotherapy in order to work on their difficult relationship with their children. Both mothers could get very angry, but the anger was always shown in the relationship with their daughters and rarely with the older boy siblings.

In both cases, the mothers revealed their own history of abuse and their suffering during the first sessions of individual CAT therapy. The children were seen a few times by a child psychiatrist in order to 'keep an eye' on their 'toilet training' during the mothers' therapy. We also wanted to observe any effects on the child of the therapy with the mother. In both situations the first child in the family is a boy. The boys in both families are doing well and it is the girls who are both suffering with encopresis.

We began the therapies with a series of open questions. How might the symptom of encopresis in the child be linked with the expression of the mother's suffering? Was there a transmission of suffering and pain through their bodies? For instance, could there be the repetition of a damaging pattern of bonding such as an insecure attachment arising from the experience of sexual abuse suffered by the child's mother in her own childhood? If so, why is this mainly with the girl children? If the mothers were protectively controlling of their daughters were they then able to rebel and be oppositional to the mother in ways that the mother could not be with her abusive parents? In sum, could the symptom of encopresis in children sometimes be related to a traumatic life (sexual abuse by parent or grandparent in these cases) experience of the mother when she was herself a little girl? Were both mothers unconsciously trying to protect their daughters?

A second range of questions concerns the mechanisms of therapeutic change. If therapy with the mother is successful what is it that changes in the mother that indirectly relieves the encopresis in her daughter? With these issues in mind I share description of two therapies with a mother of a daughter with secondary encopresis.

I offered sixteen sessions of cognitive analytic therapy (CAT) to both mothers. I chose CAT, for its relational capacity to link the interpersonal and co-embodied relation between mother and child past and present. I didn't realize until later that it could also show the relationship across three generations. CAT as a brief model of therapy is an asset in our CAMHS setting as it helps us get off the symptom hook and work with the family relationships.

We have developed CAT as our practice in France in the context of a strong psychoanalytic tradition in which the neutrality of the therapist/analyst in the relationship to the patient is emphasized. In our work we advocate what is called '***désir sur le patient***' in French. This translates as a willingness on the part of the therapist to have hope for the patient, to get involved in the patient's struggle. The collaborative work in CAT gives shape and a safe voice to this '***désir***'.

In order to respect the confidentiality, names, locations and some of the details of the patient's history have been changed.

First therapy: Sophie in relation to her daughter Lucy

Sophie's parents never listened to her needs. Very early on in the CAT sessions, Sophie starts talking of 'bizarre physical contacts' with her father, where he invited her to come and do 'play fighting'. It remained difficult for us in therapy to call what had happened to Sophie by its proper name of 'sexual abuse'. She needed time to feel confident, especially as we unpacked the weight of secrecy she had been carrying for years without telling anybody. Her mother did not protect Sophie from her husband's unhealthy and abusive treatment.

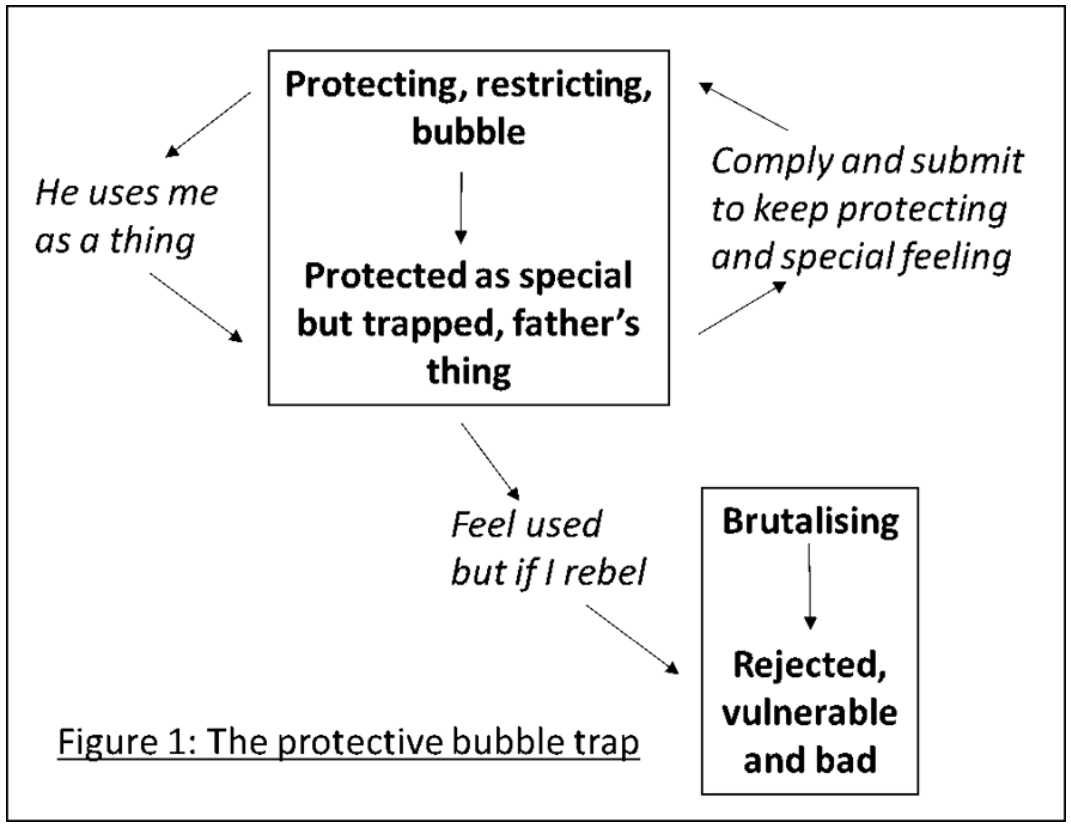

Figure 1: The protective bubble trap

As Sophie's therapist, I felt all the weight of these disclosures during the sessions, as if I were intruding into what had been kept secret for a long time, feeling the pain of this suffering, and holding her fear of what would happen 'if her father were to discover that she had disclosed this secret'.

After her parents divorced, Sophie was abandoned by her mother to the abusing father. She hardly ever saw her mother after the divorce and even when Sophie tried to commit suicide as a 'cry for help', her mother did not respond.

Sophie described how her father put her inside what she called a '*bulle de protection*' (tr. protective bubble), which turned out later as being a prison in which she was abused. When she rebels and refuses to be her 'father's thing', he becomes violent. Her dilemma was then in her words: 'either I am everything for him 'his thing', or if I rebel, he will become extremely violent, hurt me and reject me. And I will be nothing.'

The map of the 'protective bubble trap' helped us to contain her fears and anxiety as she understood gradually why she had not been able to escape this terrible trap. To calm herself, she would do relaxation exercises after the sessions and thus, put herself inside another 'protective bubble'. As she gradually felt safer in therapy, she stopped putting on this self- protective 'skin/coat'.

At the age of 16 years, Sophie tried to escape from this 'incestuous' relationship with her father by attempting to commit suicide. She described it as a 'call for help'. But nobody came to help her and when Sophie got back home it got worse. Sophie fled from the abusive home when she turned eighteen. But she had no qualification, no job and met in this context of vulnerability a man who repeats her father's abuse. She manages to escape from that abusing relationship, showing capacities of resilience and finds a man with whom she has a loving and stable relationship. He is the father of her two children. But Sophie carries the relational patterns of her abuse with her, causing her a lack of self-esteem and has an increasing number of panic attacks.

Sophie starts her first therapy after Lucy, her second child is born. Lucy as a girl child offers a mirror which re-activates the relational dynamics of her own unresolved sexual abuse. It is as if some of the repressed, unsolved conflicts, pain and suffering were popping up and abruptly forcing their way into the present.

Lucy triggers the reciprocal roles of her mother's childhood: over protectively controlling, to overly controlled. When Lucy is provocative and tries to control her, Sophie can feel her own anger growing. After the onset of anger, Sophie realizes her behaviour and feels guilty. She then wants to put her arms around Lucy and kiss her. This reminds Sophie of her childhood experience. After her father had hit her, he wanted to stroke her. We worked this out by mapping together what was happening in these particular moments and it helped her develop a compassionate observing reciprocal role in relation to herself.

As a child it was too dangerous for Sophie to show her anger. She learned to repress her feelings and cut off. This seems to be her core

problem, as she repeats the abusive configuration of reciprocal roles with Lucy. But Lucy has the possibility to rebel and this changes the outcome and the configuration of their relationships. In the process of naming this we were able to work more deeply on Sophie's childhood, where she could not rebel, as it was too dangerous. As an adult, she can change and, release herself from the 'compulsion to repeat' and find new exits.

The compulsion to repeat is one of Freud's earliest concepts appearing in a certain number of his writings. It is understood as a compulsion to resolve, connect with or escape from the relational character of the trauma. It fits well with the CAT understanding of the repetition of formative early relationships. J.D. Nasio, (2012) writes 'that which has not found a signification in our head, always comes back in our acting, whereas that which has found a signification, stops coming back.' In her troublesome interactions with her daughter Sophie was caught up in a pattern of reciprocation which she was compelled to repeat in search of a meaningful exit which never came.

Sophie feels controlled by her daughter Lucy's encopresis. Lucy seems to express with her symptom and in her body something of the mother's childhood trauma. Looking at trauma work, especially by Bessel van der Kolk (2014) and the way the Vagus Nerve reacts to trauma, there might be an explanation of the child's symptom in relation to the mother's sexual abuse, as an expression of co-embodied suffering.

In our work of mapping together, we identified moments where Lucy is opposing, refusing to do what her mother asks her to do, like getting ready for bed, cleaning up her toys, sitting on the toilet. Sophie, confronted with Lucy's anger, 'quits the scene', 'rejecting and abandoning' her daughter somehow, as she was herself abandoned as a child. Sophie's love towards her daughter appears conditional and demanding. There seems to be a repetition of Sophie's experience as a child. Sophie says that she wants to get rid of her anger through therapy and avoid spoiling her relationship to her children and especially to Lucy.

Sophie describes herself becoming a phantom or a fawn in dangerous situations, (figure 2) and we work on 'if I am a phantom, I cannot get caught and if I am a fawn I run away at the slightest noise'.

Reading the reformulation letter seemed to have a traumatic effect on Sophie. She is crying and says she is feeling dirty, oppressed, frightened, as if 'it had all come back', when she wanted to get rid of all these memories. Perhaps it is too exposing and she is not yet in the zone

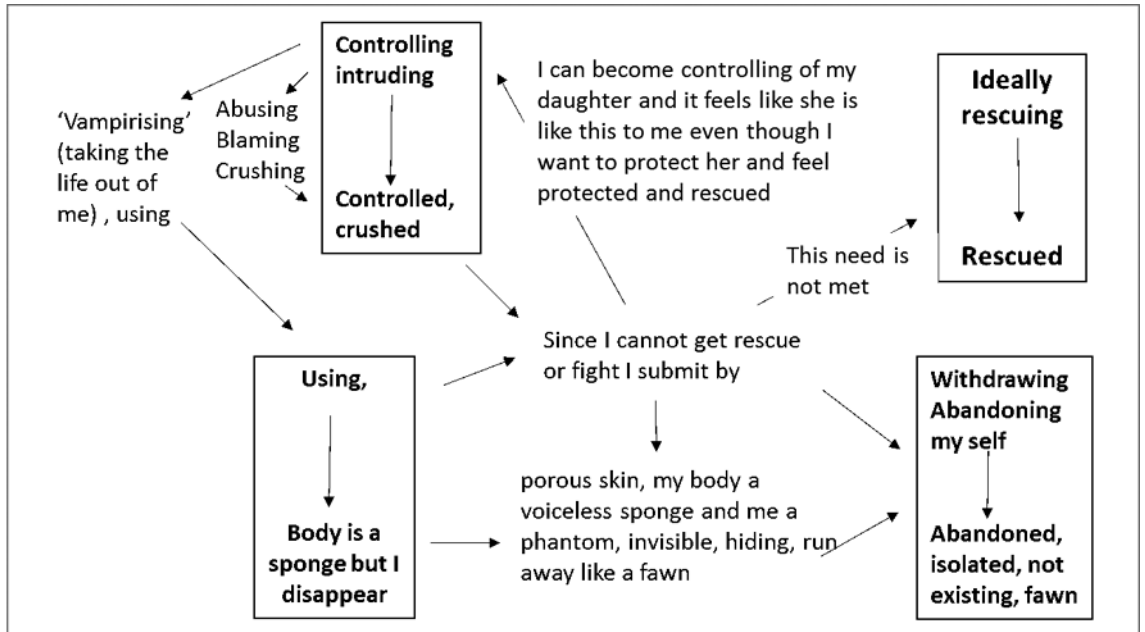

Figure 2: How the child's needs trigger the compulsive, unformulated, unconscious reciprocal role pattern arising from the mother's childhood abuse: for example when my daughter wants a cuddle it feels controlling and invasive and rekindles my body's memory of abuse. Since my body cannot hold her, she holds herself and I become invisible and she fights for care and I become angry and attacking which she copies.

to make use of it. At session eight, we explore Sophie's relationship with her father in a 'psychodramatic vignette'. She shakes and is afraid of what he could do to her. She becomes the little girl, a prey without any defence but as we talk, she realizes that she is no longer this little defenceless girl. We write a 'protective' sentence for her to take home, in order to fight this fantasy: 'Today, I can defend myself and nothing can happen to me'. Sophie also came to therapy with symptoms of somnambulism and nightmares which faded as the sessions went on. The decrease in these symptoms was for us an indicator of progress.

Sophie is gradually stepping out of the 'protective bubble' into a more open bubble with me in the therapeutic relationship. She can begin to look at what happened and how all this might be in relation to her

daughters' oppositional attitude which in turn makes Sophie feel controlled. More generally, this makes us reflect on how our defences can constitute a false protection to change and how we need a protective, secure environment in order to be able to change. As we get to the end of therapy, Sophie starts letting go. We can share her feelings of being 'abandoned' by me after such a 'short' period.

She felt able to acknowledge that she 'is an adult woman now and that her father can no longer harm her'. She has learned to stay with her daughter's anger and not run away 'like a fawn' and abandon her as her own mother did when she was a child.

Second therapy: Anabel in relation to her daughter Maya

Anabel came into therapy saying that she wanted to learn to 'manage her anger' which she was only expressing with her children. She did not want to behave like her mother who could be very impulsive, controlling, blaming and sometimes blackmailing her.

She explained: 'There was something that frightened me as a child and that I have not been able to digest'. Anabel described a 'merged relationship with her mother' and was kept inside a 'protective bubble', which oppressed her. All the family secrets were hidden in that same bubble. The protective bubble revealed itself as a false protection, filled with denial, anger and fear. It was where her mother imprisoned her. The only possible escape for her was cutting off.

The 'protective bubble' burst when Anabel was in her twenties, as her mother separated from her father and she was told that all five children, were from five different fathers. Nobody wanted to tell her why her father had been kicked out of the house. Years later, Anabel's father revealed to her that he had sexually abused her two stepsisters. He presented the abuse as a commonplace event to her and was never prosecuted.

The words 'anger, guilt and regret' are very important for Anabel as she talks about her past history. Guilt, because she did not cut the relationship with her father immediately. Regret, because she could never tell her mother all the wrong she did to her and because she could not blame her father any more for what he had done, as he started having signs of dementia.

Anabel's four year old daughter Maya suffers with encopresis. Anabel was wondering in the first session, whether there might be a 'family heritage of bottling up'. She describes a difficult relationship with her daughter, for example, when Maya does not dress quickly enough Anabel can get very angry. Anabel is aware of her difficulties to control her mood when Maya is opposing her and says. 'Either I control her or I am lost'. Gradually, we could understand and name the way she was working through her own trauma in relationship with her daughter. She was confident and seemed relieved to be able to talk about her past, even if it was painful to recall what had happened.

Anabel described nightmares: 'where she tried to find a light, but the switch did not work'. In other dreams she is forced to have sex with a very strong and big person. Anabel is unable to find links in reality, as she has no memories of any special events in her childhood. We wondered whether Anabel could have been abused at a very young age before she was even able to speak. We also talked about the atmosphere of insecurity in which she was living from a very young age, with an impulsive and insecure mother. Anabel realizes that she behaves with Maya in some ways like her mother was with her.

At her last session, as she sits down, Anabel looks at me and says: 'I wonder whether I have let go of things because Maya has been to the toilet for the last four days and has declared that: she is a big girl now, she can take care of her faeces and go to the toilet'.

After sixteen sessions, Anabel had recognised what caused her controlling and sometimes aggressive behaviour towards the children and especially in the relationship with her daughter. She had managed to stop and revise this behaviour and Maya had stopped retaining her faeces. But Anabel had felt also that she was still kept a prisoner inside the family bubble, not allowed to get out and talk about what had happened. Considering the overwhelming feelings of anxiety which she is describing at follow-up, we decide to add eight sessions.

These additional sessions allowed her to disclose slowly, respecting the needs of her '*temps psychique*' (her own emotional pace). Only when she is ready does Anabel talk about her mother's sexual behaviour of inviting her into her bed whilst she was masturbating. Recalling these painful events, makes Anabel still feel dirty and ashamed. At the same time, she acknowledges that talking and feeling heard now, makes all the weight she was carrying gradually vanish. The CAT framework of collaborative work with the diagrams helped to enable and hold what was being felt and said.

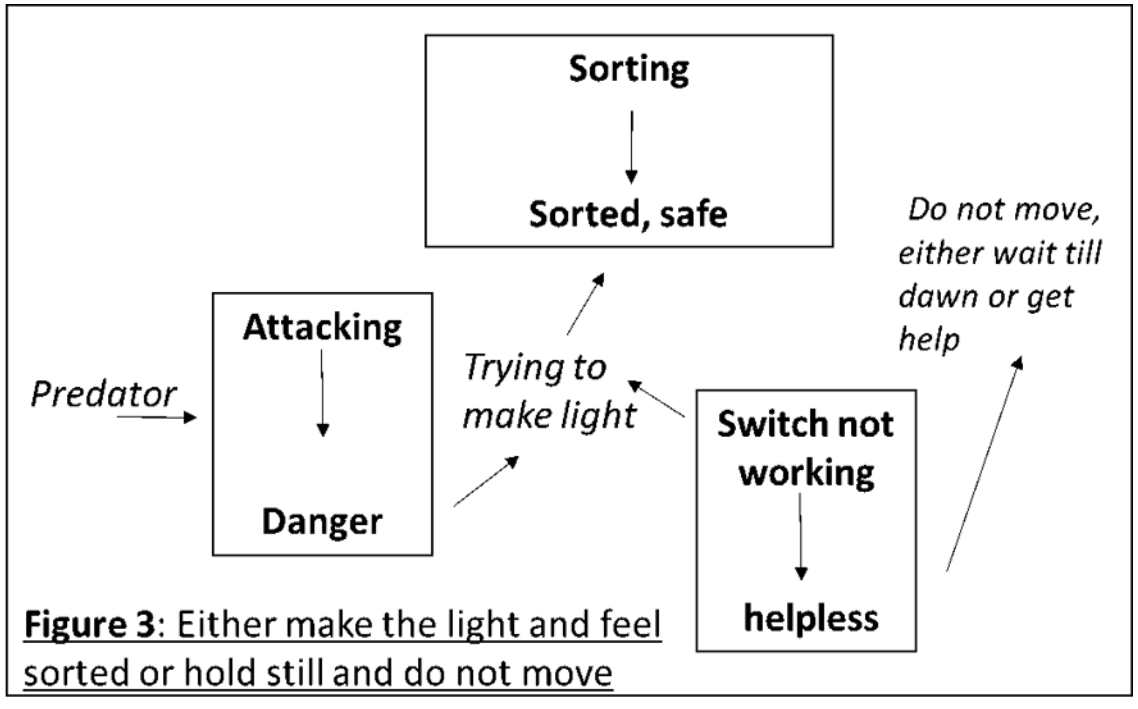

Figure 3: Either make the light and feel sorted or hold still and do not move

We also deal with nightmares. One she is having three or four times a week. In this nightmare Anabel reports. 'Being in the dark, lying down and having to switch on the light, searching for the button, finding it, but the button does not work.' This overwhelms her as she cannot 'make light'. She says. 'I do not move. I am petrified. I wait for daylight to come.' Another nightmare which she calls 'the attacking nightmare' goes as follows. 'I am supposed to put books into order on shelves… and there is a shelf where it says PREDATOR! As we map these nightmares (Figure 3) Anabel realizes that when she started feeling the onset of anxiety coming back, Maya was also showing symptoms on encopresis again. This diagram shows the importance of working relationally as there is constantly a mutual mother/child – child/mother influence. Could it be that Anabel was petrified by anxiety and fear of what could happen to her, so she would not move and Maya would pick up her anxiety and her bowels would stop moving? Could it be something of a co-embodied experience, with feelings deeply related between mother and child and a clenching of bodies defensively that is enmeshed in the transgenerational moments of aggression and opposition.

The additional sessions allowed Anabel to break out of the imprisoning family bubble. She started talking to her siblings about the events that had been forbidden to be spoken of by her mother, elder brother and elder sister. She felt rubbished as they attacked her for 'disloyal' behaviour, made her feel as if she had made up the terrible events. But she was capable of distancing herself from these attacks and stepped out of the family circle, having learned to redirect her anger to those who she felt deserved it.

At follow-up three months later, Anabel said that she had put everyone in his rightful place, that she had taken her own place and was no longer in her words 'the helpless baby in the high chair watching events', but she was 'a grown-up taking responsibility and deciding for herself.' She felt relieved and so were her daughter Maya's symptoms.

Discussion

Whilst writing this article I became more and more conscious of the way I am working with parents in order to help the child. All of a sudden I had an impression of multiple voices simultaneously interacting – mothers with their children – mothers with their inner child – mothers with their own parents. It has started a theoretical enquiry for me between CAT's reciprocal role concept, the psychoanalytic idea of the 'compulsion to repeat' (1920) and Nasio (2012) and Bessel van der Kolk's (2014) more biological and body focused approach.

The parents of these two mothers seemed to have changing self-states, going from uncontrollable anger to hugging, caressing and abusing. As adults Anabel and Sophia were left with inexpressible and inaccessible anger. They behave in a controlling way with their daughters Maya and Lucy and show angry reactions when the daughters are showing oppositional behaviours. They are petrified with fear when the situation gets out of control. Both mothers had one parent abusing and the other parent not protecting, ignoring, behaving as if nothing was wrong, like a silent 'watcher'.

Their daughters carry symptoms of encopresis with an indication that this is an expression of opposition to their mothers. Both parents are controlling in the therapy sessions and need their own 'psychic time' to 'let go' as in both cases it was forbidden as too dangerous to 'talk of what was going on'.

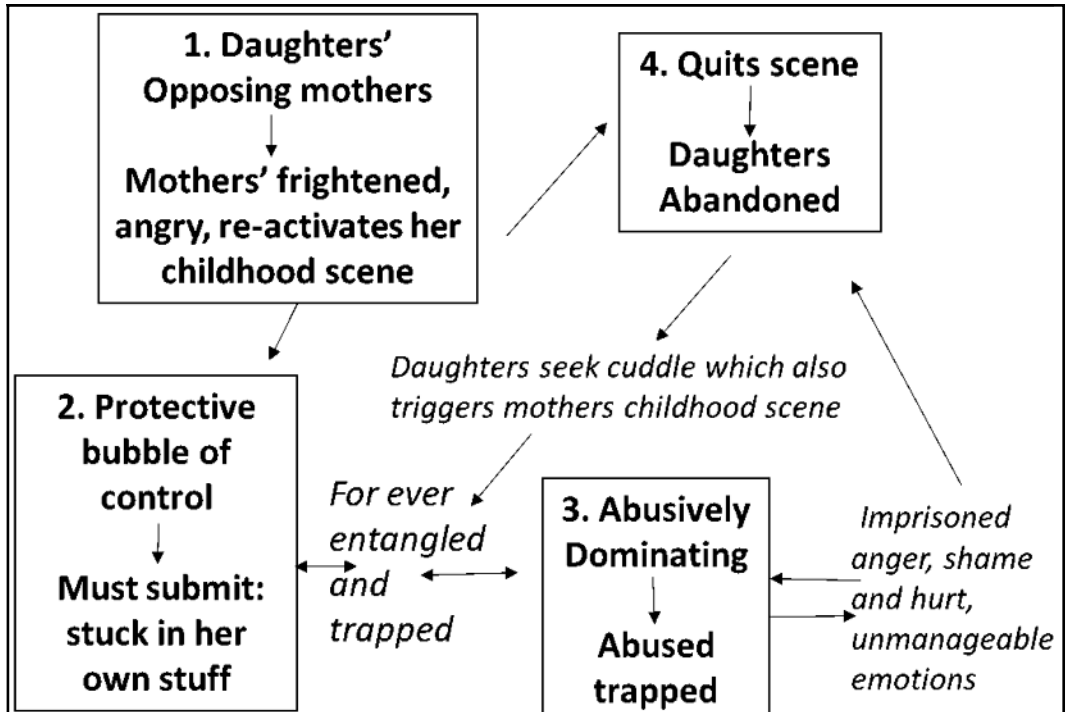

Figure 4: Mapping the compulsion to repeat using reciprocal roles

A conceptual map of the compulsion to repeat using reciprocal roles

I have tried to summarize in Figure 4 what could be at stake for the two mothers and how they need the help of being in dialogue with another (a third person) before they learn how to use the therapy.

The diagram attempts to summarize the concept of the compulsion to repeat in CAT terms. When the daughter is oppositional (1) in response to a protectively and controlling mother, the mothers' reciprocal roles are activated (2,3,4) of over protection entangled with abuse and control or domination followed by flight or quitting the scene. They are activated self to self and to the daughter and perhaps to the mother's body. Whether the daughters are oppositional or seeking a cuddle the mother's childhood pattern is equally triggered. Both mothers have grown up bottling

their angry inner child inside themselves. The expression of anger would have been too dangerous, maybe fatal. The mother is imprisoned '*dans son propre bazar*', 'in her own stuff' (Role 2 in the Figure 4) without a possible exit.

The compulsion to repeat their patterns by both mothers is painfully exposed when repeated with their own child who is free to react with opposing and rebelling behaviour rather than submit. This is an option which the mother never had and of which she cannot make sense or contain because in CAT terms the protective reciprocal role is entangled forever inside her with the abusive reciprocal role (2 and 3 in Figure 4). The repetition constantly brings back the mother's unmanageable anger as well as a feeling of helplessness of her inner child. This feeling seems to be mixed up with the daughter's oppositional feelings and when the child insists, the mother refuses. Because she feels stuck, she quits the scene (fawn, phantom) which then makes the child feel abandoned (4 in Figure 4).

Mapping together helped us hold a compassionate focus at points where the compulsion to repeat her reciprocal role procedure of running away was strongest. Two exits came alive in the session: one not to run away but stay with the mix of feelings and secondly to develop with me a shared reflective capacity. My way of mapping is to make scribble sketches beside her and then to offer her to take them away. Before the next session I have done a tidy version on my laptop which I share in print form. Once, when looking at the map and my tracing of the running away repetition when things get difficult, we noted she didn't run away at that point. In sharing and exploring their stories through CAT these two mothers were enabled to stay in therapy with me and not run away and hide. It was as if the mapping allowed the projection of terrible events out of the person's body onto a blank screen, enabling the freeing of imprisoned and cut off emotions. Through the words written on paper, it becomes possible to revisit the trauma, to understand what was happening and slowly step out of the compulsion to repeat by gradually letting go of the pain and the anger caused by the trauma and find exits to a healthier place.

These mothers try unconsciously to repair their own damage. But they are in conflict with what happened to them as children and their need to protectively control their daughters today. It is like a huge misunderstanding, where they 'say' to their daughters, 'Consciously I want to protect you, give you so much love but unconsciously I want to repair, through you, what happened to me'. Things get muddled up as

the parent has no awareness of wanting to repair her own trauma and the child does not understand why her parent is behaving in this way.

This interpersonal drama may also be enacted repeatedly through reciprocal 'body' memories between mother and daughter in ways which we cannot yet understand. I noticed that when both mothers were talking about their anger it showed up most in the region of the stomach. Both mothers were also talking about 'something that was stuck there and that they had not been able to get rid of'. Bessel van der Kolk's (2014) work on trauma makes me wonder about co-embodied transmission through the intestine. As the therapies went on, they could feel and express what was going on 'inside'. They seemed to be able to connect with the 'cut off feeling'. By the end of therapy, they were able to say that 'something had loosened', the knot of stuck anger was gone. Their two girls had started to go to the toilet. Although there must be a link between the mother's difficulties and the child's symptom, we are only at the stage of beginning to ask the right research questions before a possible wider and more focused study.

Conclusion

Encopresis as a symptom calls our attention towards a relational problem with the parent (1998, 1999). In these two examples, we might venture to argue that both children might have used encopresis as a symptom to show that 'something' in the relation with their mothers was not right. We might add that encopresis might have come into action as a way of controlling the mothers or of having some control of what was happening to them. As professionals we have to be careful not to get 'trapped' and only 'treat the symptom'. As D.W. Winnicott (1965) said 'there is no such thing as an infant'. We might expand that statement and say 'there is no such thing as a child's symptom'. In order to understand and help, we need to look into the family system and the relationships within it across the generations. The versatility of CAT's reciprocal role concept is very helpful in this respect. In work with children and their parents, there is always pressure to reduce the therapy journey to a problem solving one in relation to the child. I did not intend it to be a therapy for the mother but realized in the process that indeed it was. □

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