The serious business of play, playing and inter-play between patient and therapist.

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In this paper I will present some of Winnicott's ideas on the nature of play and its place in healthy development and psychotherapy. I will use key extracts from his paper *Playing: A theoretical statement* (1971)[1] and accompany these with material from my work to illustrate and reflect on my understanding. In the process of this presentation, there will also be links with other concepts formulated by Winnicott and those of Anna Freud and her colleagues and successors in the Contemporary Freudian group.

I think it is important to note the context of my work. I am retired from clinical practice now but the work you will hear about took place in my role as a Child Psychiatrist working within the UK National Health Service. I specialised in using psychoanalytic ideas and approaches to the problems which were brought to us by children, adolescents and their parents. Intensive psychoanalytic treatment was not available in the clinic or elsewhere in the Northwest of England. I was able to offer once or twice weekly psychotherapy and concurrent work with their parents to a small number of them, either with myself or with people seeking to gain some experience. My role in undergraduate and postgraduate education in medicine and mental health was an additional core part of my responsibilities.

The element of surprise

Winnicott saw play as central to the psychoanalytic psychotherapeutic process, emphasising the ability of the patient and the therapist to play:

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"Psychotherapy takes place in the overlap of two areas of playing, that of the patient and that of the therapist. Psychotherapy has to do with two people playing together. The corollary of this is that where playing is not possible then the work done by the therapist is directed towards bringing the patient from a state of not being able to play into a state of being able to play."[2]

My first illustration comes not from the therapy setting but from an assignment for medical students as part of their learning about communication with children.[3]

Example 1: Spontaneity

Students were given a brief introduction to an assignment to explore children's development and their experiences of being admitted to hospital. They were instructed to spend some unstructured time with a child in a clinic or in-patient setting. They were given guidance outlining how to introduce themselves and the importance of ensuring they allowed reasonable time, and suggestions were made about suitable materials to have with them.

The first student had seen a five-year-old boy. She already knew him as she had been present the previous evening when he had been admitted with a severe asthma attack. He was now almost completely recovered. He was an intelligent, precocious child whom people initially found charming but who had by this time irritated everyone with his intrusive behaviour and bossy attitude.

The student knew she had to prepare the assignment and despite some concern about the likelihood of him being uncooperative, she decided to approach him. She introduced herself politely as a medical student, but he totally ignored her. She thought she had nothing to lose so she spontaneously tried a different approach.

She said, 'I'm not really a medical student, I'm really a Native American woman and my pigtails have been cut off.'

The boy stopped in his tracks, captivated. He immediately told her he would draw the person who had done it. He developed the story, producing further drawings to say it was a monster who cut things off people. He went into great detail. The student and the child both took great pleasure in their time together as he spontaneously elaborated his story engaging without inhibition with this unintrusive, playful and facilitating young woman.

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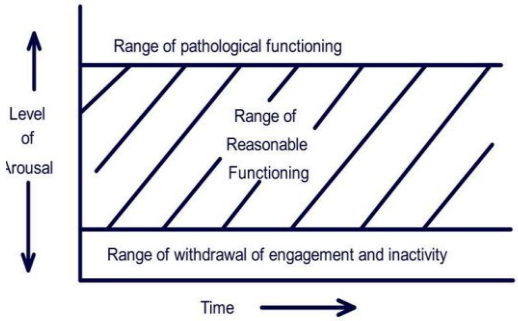
Although the interaction did not set out to be a therapeutic encounter, the student embodied what Winnicott's description emphasises. She was able to tolerate not knowing where the interaction would lead and to be spontaneous, and perhaps a little mischievous. This enabled him to enter into a world in which he could safely play with themes of dangerous vulnerability and achieve some degree of mastery. I thought this boy was able to process something of his experience of his asthma and his admission to hospital through the playful interaction with this student in what might possibly be described as a *therapeutic consultation*[4].

Unconscious Attunement

The student could not explain why she said what she did, but her attunement had enabled him to regain his ability to play.

This links with Meltzer's formulation of the therapist's role in identifying when the patient is operating in different states of mental functioning and in adapting their own responses[5]. When the patient is operating within their "Range of reasonable functioning", work can be focussed on the *modification* of underlying conflicts, for example by the use of interpretation. When the patient's functioning lies outside this range, the task is *modulation* of a therapist's responses with the aim of increasing the likelihood of return to that range.



The following example illustrates the move towards enabling engagement.

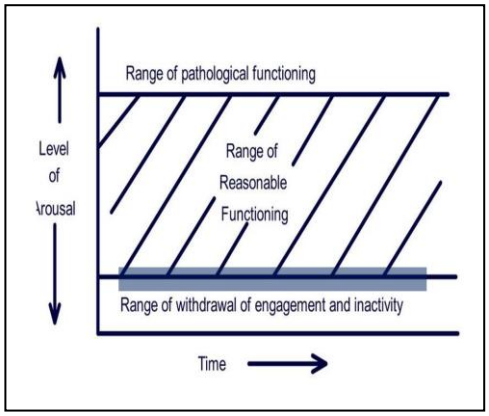
Example 2: re-awakening

Jenny[6] was 6 years old and had been born with a deficiency of her immune system. When emotional and behavioural difficulties arose, I was asked to see her.

Jenny responded positively to psychotherapy and there were improvements in the original symptoms. The work involved a complicated range of interactions with family and staff

beyond her formal psychotherapy sessions and when her physical health deteriorated dramatically my colleague who was working with the parents, and I needed to visit them all in hospital.

When we arrived on the hospital ward her parents were in tears. Jenny was lying in bed, not responding to anyone. A nurse was also there in attendance. I sat down next to her bed, but she did not respond to me. I sensed she was aware of my presence. Or perhaps I simply wanted to believe that she was.



My colleague and Jenny's parents went to another room. I was very conscious that it had seemed like a long time since Jenny and I had had proper contact. I thought I would try an indirect approach making use of the presence of the nurse to see if it was possible to communicate to Jenny through indirect means.

I asked the nurse if she knew much about my involvement. When she said that she did not, I suggested that I could explain it to her. I hoped it might re-engage Jenny through hearing our history together if, as I suspected, she was able to take in what I was saying. I summarized for the nurse the main events of our contact from the beginning up to the present situation.

At the end of this process Jenny still did not show any response so I re-joined my colleague who was with the family in another room. They were feeling devastated. They described the dramatic change in Jenny. It was what they had always feared. They thought she was about to die.

I thought she might actually want to die.

The family returned to Jenny while my colleague and I discussed things further. We then re-joined them. Jenny was sitting up in bed, taking her medicine and smiling. She had told her mother that she wanted to tell me about images of 'good and bad pages' she had been having – I thought these were what Jenny and I had talked about before as 'mind-pictures'. I spent some time alone with Jenny and asked her to draw them. Believing that the images

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could be understood as a mechanism for managing emotional turmoil and conflict, I made an explicit link between the visual images and the difficulty of talking about upset.

Tipping points

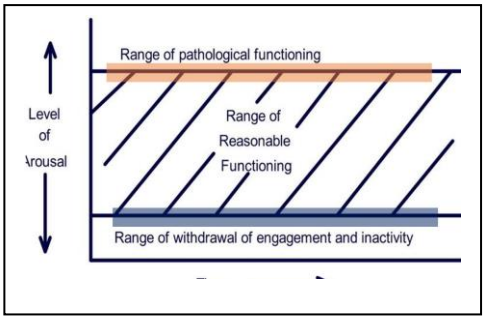
"Playing is inherently exciting and precarious. This characteristic derives not from instinctual arousal but from the precariousness that belongs to the interplay in the child's mind… of personal psychic reality and the experience of control of actual objects… The precariousness of play belongs to the fact that it is always on the theoretical line between the subjective and that which is objectively perceived."

Example 3: On edge

Kerry had complex relational difficulties in conjunction with learning difficulties and serious visual impairment. In psychotherapy sessions she was sometimes impulsive, disinhibited and aggressive: at other times she was thoughtfully engaged with me as someone whom she trusted and sometimes teased. This manifested as her sometimes being inquisitive and interested in my comments or enquiries but at other times being arrogantly dismissive of anything I might say or do. At more extreme times she could be bullying, threatening or violent towards me, wanting to hurt me, and being successful.

In one session she kept insisting that I should not talk. Previously, if I did not obey her it could lead to her hitting and hurting me, but in this session there was a quality of mischievous playfulness about her. As I observed her activity, I thought there were some important links which could be made between her activity and her underlying fears, wishes and conflicts. However, I thought that if I made any comment directly related to these, it would be likely to evoke at best an unhelpful rejection by her and perhaps even precipitate a physical assault on me. Neither of these would assist the therapeutic process.

However, I thought there could be therapeutic value in articulating something of what came to my mind during the process of watching her doing what she was doing in my presence. I felt that the comment needed would be a complicated balancing act which must not place too great a demand on her. It would inevitably challenge her because it meant me asserting my autonomy by actually speaking and having a mind of my own: this would mean her



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being faced with her lack of omnipotence. However, the fact that she could also be inquisitive indicated an interest in finding out about things, which implicitly demonstrated a capacity to tolerate not being omniscient and omnipotent.

After careful thought, I decided to simply say to her:

'I don't think you're going to want to know what I'm thinking about.'

Kerry was not only able to tolerate my comment, she also laughed and was able to listen and think with me about what her activity had brought to my mind about her.

The delicate balance of interplay between Kerry and I shows just how narrow a line we may walk in playing. I confronted Kerry with what was her own wishes and that I was a truly external object with a life of my own.

In this instance I judged the moment successfully and we moved from potential interpersonal conflict, through interplay, to intrapsychic conflict in which play could be a process of 'working on' and possibly 'working through' this conflict.

When is 'activity' play?

"I am making a significant distinction between the meanings of the noun 'play' and the verbal noun 'playing'."

At a psychoanalytic conference on the theme of play, I was surprised to hear the discussants starting to repeat a phrase 'the play of children who can't play'. The distinction I felt was being missed was between activity which might observably be children using physical objects we would usually call 'toys' as an activity and this process which Winnicott wants us to understand as being free from overwhelmingly inhibiting influences and through which impulse may be transformed into creative activity.

In presenting Kerry's material, I am making a distinction between times when Kerry's use of the toys, and of me, was sometimes driven by impulse rather than in the service of healthy social development as defined by relationships which move more towards mutuality and reciprocity. Another observer or commentator might have described her as 'playing with the toys' and perhaps 'playing with Dr Sutton'. My responses were aimed at engaging with her through respecting her sadistic impulses and fragility when faced with feelings of impotence whilst engaging also with her well-established, developmentally healthy, nosiness also known as 'scopophilic impulses'.[7]

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I had to avoid participating in enactment of 'predator and prey' by distinguishing between when she was 'toying with me', rather like a cat playing with a mouse, as opposed to playing and making 'good use' of me[8]. We were then able to move from my activity being one of *modulation* to operate with Kerry on potential *modification* of her internal world.

Setting the scene for health through play

"I want to draw attention away from the sequence psychoanalysis, psychotherapy, play material, playing, and to set this up again the other way round. In other words, it is play that is the universal, and that belongs to health: playing facilitates growth and therefore health; playing leads into group relationships; playing can be a form of communication in psychotherapy; and, lastly, psychoanalysis has been developed as a highly specialized form of playing in the service of communication with oneself and others."

Winnicott placed practitioners as contributors to health through recognition of the healthy processes which are available in the child and in those responsible for their care and taking a place alongside these. Our role as therapists may be more like the role of a catalyst in a chemical reaction rather than as an active agent.

Example 4: The spoon that broke the giraffe's back[9]

Helen was six years old and had suffered from idiopathic juvenile arthritis for three years. This is a serious chronic disease process which can affect not only joints but also other body systems. Helen had pain and stiffness in her joints and her eyes had also been affected. There was a danger of losing her sight without an operation. She required frequent blood tests, injections and medicines by mouth. Until recently she had been able to cope but this picture suddenly changed: she became extremely upset and fearful particularly when needles were involved. Preparation for her operation became extremely problematic. Helen had been told why she needed the operation, and she wanted it. However, she had been unable to tolerate attempts to proceed. It was at this point that psychiatric assistance was requested.

Helen willingly attended with her mother for an initial consultation which lasted about one and a half hours. As part of my usual introduction, I made it clear to Helen and her mother that if she was able to talk to me then I would listen but that she did not have to talk. For most of the time Helen kept very close to her mother, communicating mainly via her. Mother

explained the immediate crisis, the background, which included her and Helen's father separating, and details of Helen's development.

When I next saw them, Mother had continued thinking carefully about the issues that had arisen. She had reflected on Helen's earlier life. She said Helen had been an 'unsettled baby' and wondered if that was significant in terms of her physical health, perhaps indicative of symptoms of the arthritis which was later diagnosed. She had thought more about the changes which had gone on in the family and how difficult that might have been for Helen.

Meanwhile Helen occupied herself with the toys. She enacted what she thought should happen after the operation, specifically that her mother should be waiting for her in the recovery room drinking a cup of tea. She then used some bricks to make a tower, testing what made it more or less stable. She incorporated small animal figures into the tower, making the structure very precarious. Helen's absorption in this and her ways of ensuring that we took notice had her mother and I galvanised. Helen put a giraffe on top and the tower still remained standing. She put a teaspoon on the giraffe's back and the whole tower tumbled.

Mother simply said, 'It's the spoon that broke the giraffe's back.'

Although Mother used different words I Instantaneously mother knew that she was using an English metaphor: 'the straw that broke the camel's back'. "The straw that broke the camel's back" is in one way similar to the idea of 'the last drop of water' in the sense that there is no space for anything else, but it contains a sense of trauma: something is <u>fractured</u> rather than simply spilling out. Mother was summing up the present crisis – the eye operation left Helen feeling broken beyond repair. Mrs Y and I discussed this and explained to Helen what we meant. I explained further how I thought she was capitalising on the consultations to show us more about herself. I played with the idea that she was the teacher and we were her pupils: she was giving us lessons. I went on to describe how I was also a teacher and that I thought that the things we were doing would be very good for helping other doctors learn. I asked Helen and her mother for permission to use the material from our work together for teaching and writing.

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Helen had been able to capitalise on her own abilities and the presence of her mother and I to safely play and explore 'unsafety', a developmental achievement captured in Winnicott's concept 'The capacity to be alone'.

"…alone in the presence of someone. The child is now playing on the basis of the assumption that the person who loves and who is therefore reliable is available and continues to be available when remembered after being forgotten…"[10]

Playing with words

"… we must expect to find playing just as evident in the analyses of adults as it is in the case of our work with children. It manifests itself, for instance, in the choice of words, in the inflections of the voice, and indeed in the sense of humour."

My account of play and interplay is concerned with this process through childhood and adolescence during which we can see how words, spoken and written, may gradually take the place of the need for enactment. The final two patients take us further into the world of playing with words.

Example 5: When is play not playing?[11]

Word play

Six-year-old Dwayne arrived one day after a few weeks of therapy and obviously was unwell, sneezing and coughing. He told me he had a cold.

During the session he talked to me about going fishing with his grandfather and catching a fish; simultaneously he played at this by hanging a piece of string out of the window. Much later in the session, he repeated the pattern of hanging the string out of the window but then he made me touch it. It was a cold day and I noticed that the string was colder. At first I was puzzled about what it was he was communicating but then remembered noticing that when he had arrived he had a cold.

I said, 'You're showing me that you've caught a cold!'

Dwayne was very pleased that I had understood.

Word play - its limitations

Dwayne enjoyed playing with words most of the time, but he could find them challenging as well. He had tried to force me never to mention two things - the abuse he had suffered at

the hands of his father and the major surgery he had required during his first two years because he had been born with a severe deformity of his trachea and oesophagus.

At the beginning of a session, Dwayne had reacted strongly and angrily when I had referred to myself as a psychiatrist.
He said: 'Not one of those mad psychiatrists who makes people lie down on a couch.'
As the session drew towards the end, I thought it would be important to make some links about the material that had unfolded through the course of the whole session. Dwayne rapidly sensed that I was about to attempt some interpretative work. As I attempted to articulate what was in my mind, he gave a big sigh and said,
'Meaning ... has there always got to be a meaning to everything ... it's a game.'

I laughed with him, saying I understood what he was saying but I really was here to be his psychiatrist. I told him that I knew there were times when he found it annoying that I always thought about 'meanings', but, if I did not, then I would not have been able to help him in the way I had. With a slight sigh he simply said, 'Yes I know.'

Playing and not-playing by the rules.

Dwayne continued to progress inside and outside his therapy. Play became more robustly established as a means of working through conflicts rather than simply enacting them. But monitoring this and responding through containment and not being lured into counterproductive activity required careful thought as illustrated in this material.

Dwayne developed a theme of being a king and enlisted me to be his servant.
For a time, I fulfilled this role in the scenario, seeking his direction about what needed doing and found myself being treated very badly by King Dwayne. I felt this was significant in terms of his underlying struggle with persecutory mechanisms. However, because of the different developmental position which I felt now applied, i.e. that play could be a healthier medium for processing experience without it being 'simple enactment', I decided that I would use my assigned role to challenge his omnipotence.
Rather than using interpretation, I told him I wanted to resign my job as his servant because he wanted to make me do things by threatening me. I said that if I was going to live in fear because he was always giving me impossible things to do, then I didn't want to do the job: I

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had decided that I would only participate if I could negotiate a new job specification and contract.

Dwayne was surprised by my demands but readily agreed to change the rules of our relationship and the play then proceeded on this basis.

My interplay derived from viewing his playful activity changing to become an expression of sadism and subjugation. I understood this as an enactment, with roles reversed, of his experience with his own father and potentially an indication of identification with the aggressor which I felt needed to be commented upon to counter perverse relating.

Therapy *sans frontiere* and *sans* interpretation.

In a paper in which Winnicott described a child for whom therapy was not possible, he countered any tendency to idealise the place of interpretation, underlining his approach as one which sought to capitalise on health in the internal resources of the child and those caring for him:

"This child needed my personal help, but there are the many cases in which the psychotherapeutic session can be omitted, and the whole therapy can be carried out by the home. The loss is simply that the child fails to gain insight, and this is by no means always a serious loss."[12]

Winnicott also emphasised that the patient's personal and practical issues needed to be considered:

"There are, however, many varieties of psychotherapy, and these should depend for their existence not on the views of the practitioner but on the need of the patient or of the case. Let us say that where possible we advise psychoanalysis, but where this is not possible, or where there are arguments against, then an appropriate modification may be devised".[13]

The only term I have been able to formulate for this form of work is "Psychoanalytically-informed therapeutic case management".

Example 6: A case for psychoanalytically-informed therapeutic case management.

The following material presents work with Vanessa, a girl with whom I was in contact from when she was 11 years old until she was eighteen. [14],[15].

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The situation was one in which a regular process of psychotherapy was not possible. Liaison with the Paediatrician responsible for her physical health was a key component of my involvement alongside consultations with Vanessa & her parents. The principal focus of the clinical interplay between Vanessa and I will be communication by old-fashioned, hand-written letters exchanged via surface mail.

Vanessa had longstanding, variable symptoms which had been diagnosed previously as urinary tract infections and respiratory tract infections. She had been unwell for four years and had missed considerable schooling. I was asked to see her by a paediatrician who had been consulted for a further opinion.

When I first saw her, the immediate symptoms were pains in her ears and throat. There were no concerns about her general development. When I saw her on her own, Vanessa was amenable and pleasant. She did not feel there were any problems beyond her physical complaints and the impact of these on her life. She readily engaged in the consultation, but it did not develop a momentum of her spontaneously contributing or elaborating topics nor using any of the materials available for drawing or playing. I felt as though I needed to take the initiative and decided to see if 'Squiggles' would be useful.

Winnicott (1953: 108) developed the technique of using 'Squiggles' diagnostically and therapeutically.[16] He described it as 'a game in which I first make a squiggle and [the child] turns it into something, and then he makes a squiggle and I turn it into something'.

Vanessa took readily to the Squiggle game. As she elaborated on the squiggles I offered her, I asked if there was any story to go with the drawing. A pattern arose where the story she told came to a full stop at which point there was simply 'danger'. Vanessa was not anxious in talking about this.

The pattern of persisting physical symptoms continued without any indication of any underlying diagnosable physical condition and it felt as though there was no development or progress in my understanding of any psychological contributions to her problems but Vanessa and her parents valued my involvement. The most noticeable issue was how sleepy I became in my direct consultations with her. When I came to understand this as a *somatic countertransference*, the way became open for a different approach.

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Meeting Bert: The case of an illusive and elusive diagnosis.

I explained to Vanessa and her parents that neither I, nor the other doctors, had a good name for her illness. What we did know was that there was no indication of anything dangerous going on in her body. I suggested that as we could not provide a good name, she should think of one and we would use that as the diagnosis. Vanessa liked this idea and produced the missing diagnosis – 'Bert'.

She relished this approach and was able to play with the idea with me. I asked where Bert would live if he could not live in her ears or throat. After some consideration she spontaneously said, 'I need to find a place in my heart for him.'

I suggested that we needed to try and get to know Bert during the sessions and in letters during the gaps. We attempted to compile a life history of Bert, to work out what he might look like and even to 'introduce' him to Vanessa's still-cherished transitional object, Kenneth, a soft toy animal.

The material is from our correspondence over a number of years.

Dear Dr Sutton,

I don't know quite what to write but I will have a go at writing Bert's life first of all he was born or invented 6 years ago about when I was 7 he gave me sharp pains shooting across my chest, then later on about a year he gave me really bad pains on my tummy around my tummy around my bladder I think that's right. Then ever since he gave me cystitis or a bad throat and ears which were very sore and he has just been doing it ever since, only now he also makes me feel very tired and weak. I get tired very easily. When he isn't giving me sore ears or throat he is playing and having fun. I think when he gives me sore ears and throat he is rebelling! From staying in one place all the time ...

Vanessa had her thirteenth birthday just after this letter and I wrote to her three weeks later.

Dear Vanessa,

I'm not surprised you didn't quite know how to write about Bert, but I think you've made a very good start. I think it's a bit of a puzzle about whether he was born or whether he was invented. If he was invented maybe he didn't have two people – a Mummy and a Daddy who made him but only a single inventor. What do you think?

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I suppose if he was invented, he can stay inside someone, but if he is born, he's got to get outside. No wonder he's rebelling if he reckons he's really been born and not invented! ...

Eleven days later, Vanessa replied:

Dear Dr Sutton
I think Bert was invented but I also think he thinks he was born sometimes like when he rebels. I don't think he knows if he was born or invented. I only know he was created either by his Mum and Dad or by an inventor or even a professor.
Bert has been rebelling a bit lately. I have been off school for a week but I am going back by the end of the week. But I have been doing some school work today I did Italian and german. I had a lovely easter and got a lot of nice presents thank you…
See you soon,
Vanessa Smith

Three weeks later (1st April – April Fool's Day), Vanessa wrote again:

Dear Dr Sutton
I have decided that Bert was not born or invented but he was created out of one of my pains. What do you think about that!
I have also decided that Bert and Kenneth could probably meet, if they really try to find each other. If they did find each other I think they would both be jealous, Kenneth because Bert knows different stuff about me, like Kenneth only knows the outside of me whereas Bert knows the inside of me. This is all very confusing I know but when or if they find each other I think it will all fit into place (I hope!!)... ...Hope you had no April fools jokes?...

A week later, I responded.

Dear Vanessa
So, Bert was neither born nor invented but created out of one of your pains! What on earth does a creature like that look like? This is going to be extremely important to know because how on earth would Kenneth know what to look for if he did decide to go in search of him? The problem is that neither you, me, your Mum and Dad, nor any of the doctors in the hospital have ever actually seen him – so, how can we get a proper description? We are going to have to work on what the police would call 'an artist's impression'. It's more difficult

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for us though because we've only got your inside-feelings to go on and not your eye-sight or mine. I'd like you to write down what different bits of him feel like and then draw a picture of him. By the way, how do you know it's a 'he' not a 'she'? It's also clear that we mustn't rush Bert and Kenneth into a meeting – it sounds like they both want you all to themselves – one knows you inside: one knows you outside: it's going to take time for them to learn that they can both know you inside-out without losing you to anyone else. They are going to have to learn this from you and it's going to take time. So, they mustn't meet yet otherwise there will be fireworks! You'll need to work out how to teach them that it's safe to share (it might even be fun): can you start writing about it?
Best wishes,
Doctor Sutton

The pattern was one of fluctuating symptoms but with an overall sense of less severe recurrences and overall progress. Bert was a slippery character, difficult to pin down. In the spirit of characterising and locating him, I posed the question, 'Where is Bert when he's not living in your throat or ears?' The reply came by letter.
Dear Dr Sutton
I have decided that Bert should live in my big toe. I don't know why but it just seems to be a good place for him to go. Because if he does turn nasty all he could do is make me stub my toe or make me break my toe, it is quite small so he can't get into mischief but also quite big in some ways so he will have enough room to play in…

In my reply, I commented on the idea of Bert needing a place that was big enough, but not so big that he felt lonely or lost. I suggested we could try and make friends with him. Vanessa arrived for her next consultation on crutches. There had been an accident. She had dropped a mirror on her left foot. Walking awkwardly as a result, she had slipped, badly sprained her ankle. That was why she needed the crutches.

We then had the following exchange of letters.

Dear Dr Sutton
Bert has been in a very good mood recently. My ears and throat don't hurt that much recently but my foot isn't any better. I have had my foot in a pot for 2 weeks. I got it off on

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Monday. My foot is still very sore and swollen, I am still on crutches. I am also having physiotherapy at the moment (that is quite painful). So really Bert is being rather good at the moment, so is Kenneth. I have been to school....

I replied:

Dear Vanessa
I'm sorry to hear your foot is still hurting and that physio is difficult. Still, it seems to have kept Bert in one place, trapped underneath the plaster-cast. But I do feel sad for him trapped down there. You say he's been 'good'. I don't really think it's being 'good' or 'bad'. If you think about it, it must be pretty difficult being all on your own, in the dark with nobody who even knows what you look like let alone how you're feeling. Kenneth has a much easier life.
I think he needs someone to take proper notice of him and to go to great lengths to get to know him properly – just like Kenneth has. So, it's down to you Vanessa. You've got to be his 'Super-Hero', discovering him, shining some light on to him, then he can be seen and known. I reckon he'll be frightened at first then he'll find it a relief. I even have a suspicion that he might turn out to be something like Kenneth – maybe even his long-lost twin. So, Vanessa let's have the story of 'Vanessa the Intrepid Explorer seeks and finds Bert'. I think it will need to be a long story and probably needs words and pictures. Can you try and make a start on it before we next meet?.....
Best wishes
Doctor Sutton

Vanessa's physical symptoms decreased over time and she made good progress at school. We did not have much contact after a brief episode when she experienced conversion symptoms in contrast to the Medically Unexplained Symptoms which had been present before. it was possible to understand the changes in terms described developmentally by Anna Freud[17].

When she graduated from High School, she wrote to me:

Dear Dr Sutton
Why is it that when you should be happy and care free that almost depression glides over your whole life? I have got my results and now I am at the university of my choice, to do the course I have picked. I have a fantastic boyfriend and some brilliant mates. I am working and

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therefore earning money with great employers. But it seems as if there is something missing. I'm on autopilot and it seems like I'm not living my own life, physically it does with the tiredness after working for five hours, but mentally it is somebody else doing it. It's not me. I guess the truth is it's Bert, which makes me realise that I will be alright in a few days, and my bubbly personality will shine but in the meantime I will continue to operate under a dark cloud. The strongest feeling inside me at the moment is to escape, go away, think and most importantly relax, which I feel physically I haven't done in months, what with school, then work. The last I wrote to you I spoke about a feeling of control, well that has gone for the moment. I lost hold of it and am now dreaming about retrieving it. I am at works beck and call and the rest of the time I have to divide between Dave (my boyfriend) and my mates. Where am I supposed to find time to myself? ...

Whilst writing this letter I am listening to the Alanis Morrisette album, I don't know if you have ever heard any of her but personally I believe the lyrics are surprisingly relevant in reality and life as I am finding it. In one song called Perfect some of the lyrics are:

"Don't forget to keep that smile on your face. What's the problem ...why are you crying?"

I guess they apply to most people. I know I will get through this bleak period as I have survived the last years of my life. But hey a smile doesn't have to be present constantly on my face. It's weird, I can hardly remember what I wrote at the beginning of this letter. But what I do know is that I feel better for writing. In case you hadn't realised this is one of the first times I have been absolutely honest about my feelings to you. And as Bob Dylan sang in the first few lines of all along the watch tower

"There must be some way out of here. There's too much confusion. I can't get no relief"…

I replied:

Dear Vanessa

It was lovely to receive your letter. That may sound a bit strange when it was about feeling sad and empty. But it was a beautiful letter because of how clearly you explained what it is you are struggling with and how you keep hope alive at the same time as these other feelings – knowing 'Bert' is part of you even if it feels like someone else taking you over. Congratulations on your university place. I was wondering if you might like to meet once more, before you start there. That would give us a chance to talk about your letter and to think a bit about the future ...

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Vanessa replied:

Dear Dr Sutton

The sadness that was prevalent through my last letter is gradually disappearing as I knew it would. However this only began when I was honest with myself and to my parents – I'm not sure whether I want to go to university or not. At the moment there are plenty of choices however there are only two main ones. Go to university or train as a medical technician which is something I considered a while back. However I only have a couple of weeks to decide!! I think it would be a good idea to meet up again ... Vanessa

When we met, Vanessa's depression had lifted and she had made arrangements for university which left her feeling settled and looking forward to the future.

It is important to note that the application of psychoanalytic ideas and, in particular, the role of play, contributed not only to developmental progress but also to Vanessa gaining insight into her internal world despite 'psychoanalysis' not being available.

Concluding thoughts

Winnicott placed an importance on play as both an indicator of health and as a resource when problems arise. To capitalise on this, he emphasises the importance of the capacity for well-directed playfulness in therapists and its use in attuned interplay with patients. Winnicott was an expert on contending with paradox. Using our playfulness in the service of our patients is a serious business. It is not a license to act on impulse or indulge ourselves. It asks us to find a place for another apparent paradox, the therapeutic benefit of developing the skill of 'disciplined spontaneity'.

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[1] DWW (1971) Playing: a theoretical statement. Chapter 3 in *Playing & Reality* Aylesbury. Penguin Education
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[3] Sutton, A. (2013) Finding one's place Chapter 3 in *Paediatrics, Psychiatry & Psychoanalysis: through counter-transference to case management* London & New York. Routledge 47-51
[4] D. W. Winnicott (1971) *Therapeutic Consultations in Child Psychiatry*: London: Hogarth Press
[5] See Sutton A. (2013) Chapter 1. Developed from discussions with Peter Hollis and Dilys Daws in considering Meltzer D. (1967) *The Psycho-analytical Process* Perthshire. Clunie Press. Also see "Developmental Help" Edgcumbe R. (2000) *Anna Freud: a view of development, disturbance and therapeutic techniques.* London Philadelphia. Routledge.
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[7] Freud, S. (1905) *On Sexuality: three essays on the theory of sexuality and other works* Lectures 20 & 21 Volume 7 Pelican Freud Library
[8] See DWW 'The Use of an Object and Relating Through Identifications**.'** Originally published in *International Journal of Psychoanalysis*, 1969, *50*, 711–716, as 'The use of an object'. Republished with minor revisions in *Playing and reality* (pp. 86–94). London: Tavistock, 1971; and C. Winnicott, R. Shepherd, & M. Davis (Eds.), *Psycho-analytic explorations* (pp. 218–227). Cambridge, MA: Harvard University Press, 1989. Collected Works https://doi.org/10.1093/med:psych/9780190271404.003.0066
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[10] DWW (1958) The Capacity to be Alone Chapter 2 in *The Maturational Processes and the Facilitating Environment: Studies in the Theory of Emotional Development*. London: Hogarth Press and the Institute of Psychoanalysis, 1965
[11] AS (2001) Consent, latency and psychotherapy or 'What am I letting myself in for?' J Child Psychotherapy **27**:3 319-333
[12] DWW (1953) 'Symptom intolerance in Paediatrics' in *Through Paediatrics* to *Psycho-Analysis.* London: Hogarth Press and Institute of Psycho-Analysis (1982). 115
[13] Winnicott D.W, Varieties of Psychotherapy *Volume 6 Collected Works* 197–204 and chapter in Winnicott, R. Shepherd, & M. Davis (Eds.), *Deprivation and delinquency* (pp. 232–240). London: Tavistock, 1984. Also published in C. Winnicott, R. Shepherd, & M. Davis (Eds.), *Home is where we start from: Essays by a psychoanalyst* (pp. 101–111). Harmondsworth, UK: Penguin, 1986.
[14] AS (2000) Psychoanalytic Psychotherapy (2000) Volume **15:**1 1-19 Dependence and dependability: Wlnnicott in a culture of symptom intolerance
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[16] Winnicott (1953) 'Symptom intolerance in Paediatrics' in *Through Paediatrics to Psycho-Analysis*. London: Hogarth Press and Institute of Psycho-Analysis (1982). 108
[17] See Edgcumbe R. (2000) *Anna Freud: a view of development, disturbance and therapeutic techniques.* London Philadelphia. Routledge., for a summary.

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