Managing passivity

By Dr Odette T Reader

Have you at some time in your practice, felt as if you may be in some way supporting or reinforcing a client's passivity?

By definition, passivity, is the discounting of one's ability to solve problems (get better/move on/get one with life), (Schiff & Schiff, 1971 p. 35). The purpose of a clients 'passivity' is to maintain the childlike relationship as once experience by the infant with mother or caregiver.

In normal early childhood development, a 'symbiotic by nature' relationship exists between the mother/caregivers and the infant. This symbiosis is a normal condition of the oral stage in the development of an infant, and ensures the infant's survival during that time when the infant is completely dependent. (Schiff & Schiff, 1971 p. 34)

When an infant's support systems are available, viable, and in good working order and the growing infant's needs are met, the child grows with the capability to feel for itself, think for itself, and to solve problems for itself. Allan Schore (2000) has shown that this attachment relationship directly shapes the infant's right brain stress-coping mechanism.

It is also recognised by other child development authorities (Stern, 1985; Edme, 1988; Gildebrand, 2003; Allen, 2000; Hargaden & Sills, 2003) that the greatest promoter of growth lies in this early experience of intimacy that the infant experiences with the mother/caregivers, thus *shaping and developing the pre-frontal cortex in preparation for the child to function as an independent person who can solve problems in the world*.

Edme (1988). Stern, (1985) states that the first two years of life hold great importance for the infant with the laying down of neural pathways in the pre-frontal cortex (the areas activated when we experience empathy and soothing).

However, voids exist in the neural pathways in the cortex of infants who experience disturbances in the early symbiotic relationship with the mother/caregivers. The possibilities for these failures in attunement and/or, empathic failures, are immense, and are often precipitated by *e.g. separation, either through physical illness, mental illness, or abandonment; unresponsiveness of the mother/caregivers to the child – post-natal depression; neglect by the mother/caregivers, or over-protection by the mother/caregivers. (Schiff & Schiff P. 34)*

If the neural pathways in the cortex have not been adequately laid down, it is at times of stress, such as major illness, injury or loss that the unresponsive patients represent a re-enactment of the symbiotic relationship of childhood, *in an attempt to get taken care of (Schift & Schift, 1971 p. 35)* due to an inability to *self-soothe and self-nurture,* with passivity as the psychopathology.

Four passive behaviours

Doing nothing: the patient undertakes very little thinking for themselves, and places great emphasis on the 'fix' coming from 'others' (magic pain reliever, anti-depressant, physio). These clients often speak quietly, hesitantly or haltingly.

Over-adaptation: this behaviour is most often re-enforced as the patient is seen as 'doing everything' as a means of over-adapting to his situation. He fails to identify goals for himself in attempting to solve the problems, and often tries to achieve what he believes to be goals, but are someone else's goals.

Agitation: repetitive activities which are purposeless or non-goal directed, feels inadequate and fails to do things that would start to resolve the problem.

Incapacitation or violence: results when the energy built up in the body needs to be released. There is no thinking identified, and the patients accept no responsibility for their behaviour. Often the words a patient uses are 'I can't stand it!' as a reaction prior to an episode of incapacitation or act of violence.

It is quite common, as you will have probably noted in your current practice, for clients to cycle and re-cycle these four passive behaviours, even in very short periods of time. Being able to identify which passive behaviour your client is currently using allows you to cease re-enforcing the current passive behaviour and may allow your client to move on. This will at least help move the energy in the body, and may invite the client to start problem solving.

Moving the client on

Doing nothing: even if the client does not have the means to 'fix' themselves, participating in identifying the mechanism of injury *e.g. bending, twisting, sitting too long, etc* and seeking information about how he will manage his injury, can help this client move on.

Over-adaptation: as this is a cycle of 'lots of thinking/doing' suggesting the client look at 'cause and effect' with realistic goals identified by the client, can help this client move on, as it decreases the non-goal directed activities *e.g. if sit-ups are hurting your back what else will you do to strengthen your tummy muscles?*

Agitation: most clients do not stay in agitation for long periods of time as it requires great energy. In a clinical setting this may occur on an irregular basis. By directing the clients to carry out simple tasks in a firm professional voice e.g. *take some deep breaths; take a few sips of water; get yourself ready; settle yourself on the table.* Once the client is settled with less agitation, they will start to over-adapt and talk about what has caused the agitation.

Incapacitation or violence: this is the ultimate of all of the four passive behaviours as this client has given up any responsibility for thinking or problem solving. You will have probably noted the incidence of multiple injuries and/or re-aggravations in several clients. From this position, the client will revert to *Doing nothing.*

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