‘Coming into Being’

The process of developmental growth in a severely deprived child in intensive psychoanalytic psychotherapy

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Abstract

This thesis is a study of recovery, reparation and developmental progress in a severely deprived child in intensive psychoanalytic treatment. The methodology involved the detailed analysis of a single case study, using grounded theory. The study was designed to analyse the process of treatment and discover how the child made developmental progress. Implications for psychoanalytic technique in working with children who have endured severe deprivation is examined. Some of the key findings add to existing knowledge about psychotherapeutic theory and practice, particularly in relation to reverie, attunement and containment in the context of the child's experience of gaps and breaks in treatment.

Declaration

This thesis represents my own research and original work. It cannot be attributed to any other person or persons.

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We shall not cease from exploration
And the end of all our exploring
Will be to arrive where we started
And know the place for the first time
— T.S. Eliot, *Four Quartets*

Chapter 1

1.1 Introduction

Over 89,000 children in the UK are looked-after and, while attempts have been made to identify and provide wide-ranging therapeutic interventions to address their psychological needs, consistently poor outcomes across a range of social and emotional measures remain for these children. This study is aimed at investigation into what facilitated recovery, reparation and developmental progress within an intensive psychoanalytic treatment of a severely deprived latency child, looked-after in kinship care. I wanted to learn about the process of developmental progress and contribute to informing training for professionals providing therapeutic interventions for these children.

In the early 1970's psychoanalysts began to directly grapple with the effects of severe deprivation. In 1974, Henry described the 'double deprivation' she saw many of her deprived patients suffer. She states:

> *Firstly, the one inflicted upon him by external circumstances of which he had no control whatsoever, secondly the deprivation derived from internal sources: from his crippling defences and from the quality of his internal objects which provided him with so little support as to make him an orphan inwardly as well as outwardly.*
>
> (Henry, 1974, p. 15, 16)

The work of Boston and Szur (1983), in their study of children in care receiving psychotherapy, was highly influential in addressing the therapeutic needs of severely deprived children and in contributing to the modifying of psychoanalytic technique, to take account of deficit in psychological development. However,

thirty years on from this seminal study, psychoanalytic treatment provision for looked-after children remains limited, particularly in the region where the present study was undertaken. The notion prevails among professionals that a stable external environment is enough, in itself, to ensure the child's recovery and that unconscious enactments of earlier deprived experiences in present-day relationships, are not routinely taken into account during assessments, care and treatment plans for these children.

How can plans for looked-after children take more account of the link between traumatic experiences, associated with severe deprivation and the presence of unconscious dynamics enacted in the present? Can research investigation into what facilitated recovery, reparation and developmental growth in a severely deprived child, in the course of intensive psychoanalytic treatment, help to address the gap in the availability of psychoanalytic clinical services for severely deprived children? These are some of the questions and issues that motivated my research investigation into 'Coming into Being – developmental growth in a severely deprived child in intensive psychoanalytic psychotherapy.'

1.2 Professional background context

Working with severely deprived children of all ages has been a central component of my professional practice. Before becoming a trainee child and adolescent psychotherapist within a Child and Adolescent Mental Health Service (CAMHS), I worked for many years as a social worker within the context of a therapeutic team within Social Services, assessing and providing therapeutic interventions for children and families where there was risk of significant harm. Many of the children with whom I worked were placed within the care system, either in residential settings or foster homes, or were adopted.

My approach, prior to clinical training, was informed by play therapy interventions, which were aimed at helping children who were neglected, deprived and abused, to express their difficult thoughts and feelings and assist

their psychological growth. While therapeutic work with these very deprived children was helpful for those who could verbally express their feelings, I found the work bewildering and challenging with the more disturbed children, who could not play or symbolize and whose behaviour was difficult to manage.

However, even when they were able to engage in therapeutic work, I was persistently left with the sense that I had only attended on a superficial level, to the deep inner disturbances of these very deprived children. I had not understood that the strong feelings of helplessness and hopelessness many of these children evoked in me, and in the network around them, were linked to the children's unconscious communications of the devastating effects of psychological trauma, on their internal worlds.

Clinical training in psychoanalytic psychotherapy involved a profound shift in my therapeutic practice with severely deprived children. It enabled me to work within the transference and with projective processes and attend more deeply to the disturbances in these children. It also meant that I had a framework for assisting carers and others in the network, to make sense of the rejecting and destructive behaviours that are so often bewildering to those trying to respond to the needs of the severely deprived child.

1.3 Aim of the study

This study describes the therapeutic process, within the first year of a five year intensive treatment, of an 8 year old severely deprived girl in kinship care. It investigates the detail of interaction, describes the learning gained through this process and explores themes identified from a grounded theory analysis of the material. The research aims to generate knowledge and hypotheses about the process of psychoanalytic therapeutic intervention, that could be tested in further research.

This was my third training case during which, in the first year of treatment, the intensive supervision I received made it possible to manage the challenges of the

child's disturbed states of mind. My interest in studying this case stems from wanting to understand better the process involved in the child's progress from being in a terrified and overwhelmed state of mind at the beginning of treatment. I was also interested in the meaning of her intense use of me during prolonged periods of play.

The child's presentation shared many common features with other severely deprived children, in that the extent of deficit in her internal world affected her capacity to register emotions and to think about her experiences and needs. Her expectation of being forgotten about made it difficult for her to believe that she could be benignly held in anyone's mind and this linked to her lack of an inner sense of continuity, consistency and security.

Although there was clinical evidence of developmental progress in the child, I wanted to be able to articulate, in a more systematic and objective way, how this progress had occurred within the context of a therapeutic relationship. I also wanted to explore whether the findings from a single case study were relevant to therapeutic experience with other severely deprived children and, I hoped, that these would help augment the value of psychoanalytic psychotherapy for looked-after children, within Child and Adolescent Mental Health and Children's Services.

Chapter 2 - Literature review

2.1 Introduction

Up until the 1970's, little consideration was given to the emotional and therapeutic needs of looked-after children. Since then, there has been a growing wealth of literature relating to severely deprived children. This has encompassed theory and research from the fields of social work, developmental psychology, neurobiology and psychoanalytic psychotherapy. This review focuses predominantly on knowledge developed from a psychoanalytic perspective. Psychoanalytic theory offers ways of understanding the complex unconscious states of mind of these children. Findings from the data analysis in this single case study are informed by relevant psychoanalytic concepts, developed from clinical cases and single case research studies, on the process of psychoanalytic treatment of severely deprived children.

The search strategy for the Contexts section in this review focused on UK demographic information located from government databases; Department for Education (DfE), Department of Health (DH) and Department of Health and Personal Social Services. (DHSSPS) I searched government websites for demographic information specific to each of the four Nations.

For the sections on Contexts, Prevalence of Mental Health Difficulties in Looked-After Children, UK Policy Context and Provision of Therapeutic Interventions With Looked-After Children, I used PsycInfo and Google, submitting the key words 'looked-after', 'kinship care' and 'severely deprived children'. I also searched specific government websites for studies and reports; National Institute for Health and Clinical Excellence (NICE), Social Care Institute for Excellence (SCIE), British Association for Adoption and Fostering (BAAF), Centre for Excellence for Looked-After Children in Scotland (CELCIS) and Northern Ireland Assembly (NIA).

The following journals provided a major source of information on clinical practice and research: *Child Abuse and Neglect; Clinical Child Psychology and*

Psychiatry, Journal of Child Psychotherapy, Journal of Social Work Practice, Child-Care in Practice Northern Ireland, British Journal of Social Work Developmental Psychopathology and the *International Journal of Psychoanalysis.*

The vast array of literature available, on the needs of severely deprived children, made it difficult to select material to include in this review. I restricted the review of developments in psychoanalytic theory and technique to an investigation of available research evidence, informing psychotherapeutic interventions with this group of children.

2.2 Contexts

2.2(a) Kinship

In all child welfare systems, kinship care is an important practice. Over the past ten years in the UK, it has become more common for looked after children to be placed with friends or relatives. In 2001, around 1 in 10 looked after children were placed this way. By 2010, the number had increased to 1 in 5. There are now more children in kinship care than there are in residential care and it is fast catching up with numbers in foster care (Farmer & Moyers, 2009).

In Northern Ireland, where the present study was undertaken, Nandy, et al. (2011) found that, while kinship care had increased in the last 10 years, this region has the lowest rates compared to other UK nations. A striking feature of the findings in this study was that, unlike the rest of the UK, most children in kinship care in Northern Ireland are living with a sibling rather than with grandparents.

It is found that children placed with family and friends have the same high levels of need, as children placed with non-family foster carers. This is due to the fact that both sets of children are looked-after for similar reasons. The most common causes for family members and friends taking on the care of children are those related to neglect and abuse and parental factors, such as domestic violence,

alcohol or substance misuse, mental or physical illness or incapacity, separation or divorce, imprisonment, or death of a parent (DfE 2010). A recent major UK-wide study by Selwyn et al., (2013) found that increased numbers of children in kinship care is specifically related to three factors: changes in the nature of the family, increasing levels of drug and alcohol use and legislation which encourages the placement of children with family.

The aim and benefit of kinship care to the child is to offer permanency, by keeping them close to their own communities and families (Black, 2012). A study by Burgess, et al., (2008) on the experiences of young people in kinship care found that they felt life with their kinship carers was safer, more settled and predictable than when they stayed with their parents, especially where neglect, abuse or substance misuse had been a feature. It is thought that children in kinship care have more stability and that they also experience better life outcomes, when placed near or within their own family circles.

Winokur, et al. (2008) compared children in kinship care and foster care in the UK on matched child welfare outcomes and found there to be less mental ill health, stigma and trauma in children cared for in a kinship placement. Life outcomes for children looked after in non-kinship fostering placements were found, in the study, to be generally lower than for children who are placed with relatives or friends.

Farmer and Moyers (2009) found that kinship care placements tended to have longer duration than those where the carers were unrelated to the looked after child. Kinship carers were found to persist more often with difficult placements, long after unrelated foster carers would have given up.

2.2(b) Prevalence of mental health difficulties in looked-after children

It is widely known that children and young people living in care, including those placed in kinship care, are one of the most vulnerable groups in society and are at high risk for a range of mental health difficulties. Consistent evidence shows

that, throughout the UK, the rate of emotional, social and behavioural problems found in children and adolescents who are looked after, is substantially higher than that of children and adolescents living with their birth families (Rutter, 2000; Meltzer, Corbin, Gatward, Goodman & Ford, 2003; Scott and Hill, 2006 and Pecora, White, Jackon & Wiggins, 2009).

A study by Cousins (2010) of 165 young people between the ages of 10 and 15, living in care in Northern Ireland, compared the level of mental health difficulties in looked after children in Northern Ireland to those living in England and Scotland. It was found that 70% of these young people scored within the abnormal and borderline ranges of the Strengths and Difficulties Questionnaire (SDQ) total difficulties score, indicating 'high risk' for meeting the criteria for a psychiatric diagnosis. The prevalence of psychological co-morbidity in the Northern Ireland looked-after population was found to be higher than in the rest of the UK. It is suggested that this finding is a legacy of the province's history of civil conflict (Kelleher, 2003; O'Reilly and Stevenson, 2003 in Cousins, 2010).

2.2(c) UK policy

The National Service Framework for Children, Young People and Maternity Services establishes clear standards for promoting the health and wellbeing of children and young people, including those living in 'special circumstances', such as being looked-after (DfES and DoH, 2004). The White Paper *Care Matters* (HM Government, 2006) makes specific reference to ways in which the emotional and behavioural health of looked after children can be supported; for example, through increasing placement stability and better training and support for foster carers. However, there remains a shortage of therapeutic services for children in care, despite available specialist mental health teams for looked-after children (CAMHS Review, 2008; GB. Parliament. HoC. Children, Schools and Families Select Committee, 2009).

In Northern Ireland, attempts to address the needs of looked-after children in kinship care culminated in the publication of statutory *Minimum Kinship Care Standards* by the Department of Health and Social Services and Public Safety (DHSPPS 2012). Standard 5, 'Support for Looked-After Children in Kinship Care', outlines the requirement to 'pay general attention to the child's health and well-being, including emotional/mental well-being'. How this translates into provision for the therapeutic needs of looked-after children remains to be seen. Therapeutic provision in Northern Ireland has largely been restricted to specialist teams, where clinical practice is based on a generic consultative model to foster-carers and residential care staff. Direct therapeutic work with children is not routinely offered. Moreover, unless a looked-after child is diagnosed with a mental health disorder, it has become increasingly unlikely that they are offered therapeutic provision from within Northern Ireland-based CAMH Service.

2.2(d) NICE Guidelines

Changing polices in the UK; developments in legislation and different approaches to provision of care for looked after children has not prevented the continued presence, in these children, of high levels of mental health problems, severe enough to prevent optimal functioning (Forde et al., 2007; Sempik, 2008). This situation is compounded by increasing reliance on guidelines from the National Institute of Clinical Excellence (NICE) to inform commissioning priorities for therapeutic provision.

In Northern Ireland, NICE guidelines are closely adhered to by commissioners at the Health and Social Care Board. This has resulted in no strategic investment in child psychotherapy provision by commissioners or Trusts, either within core CAMHS or in any other part of Children's Services. The scant child psychotherapy service that does exist historically arose from ad hoc arrangements in separate locations, in which individual managers were persuaded by individuals to support secondment on an individual basis for child psychotherapy training, within their own Trust. Decisions to support individuals to train in child psychotherapy were made in the context of where finance happened

to be available, rather than on the basis of commitment to overall strategic investment in child psychotherapy service provision. This situation is compounded by commissioners in Northern Ireland perceiving child psychotherapy as having no evidence base because of its relative absence in NICE guidelines, except for the inclusion, alongside CBT, of short-term psychotherapy recommended by NICE for depression (Trowell, J. et al., 2003).

It is highly problematic that, within the context of reference to NICE Guidelines, there is an assumption that 'lack of evidence' is equated with lack of effectiveness. Challenges to this position are on-going and a number of work streams on New Ways of Working (2011) for Psychological Therapists, highlight the debate around perceived over-investment in a narrow field of therapeutic provision, based on available evidence-based practice. Workstream 1, though mainly focused by its authors, Turpin and Fonagy (2011), on provision of therapeutic mental health services for adults, raises issues on commissioning of evidence-based services, which are also relevant to implications for the provision of therapeutic services for children. They highlight the problematic reliance on NICE Guidelines and the perceived privileging of CBT. This is linked to the 'choice agenda' and questions about whether commissioning of therapeutic services reliant on certain forms of evidence is, in reality, enabling proper choices of therapies with the most frequently mentioned treatments being equated with the most effective (Turpin & Fonagy, 2011).

The problematic nature of NICE's adoption of Random Control Trials (RCT's) as the standard for determining therapeutic effectiveness, is the assumption that only evidence-based practice (i.e. RCT trials aimed at determining efficacy of interventions), should be the standard included in NICE which commissioners will inevitably follow. Fonagy and Turpin argue for NICE to support the 'rigorous collection of practice based evidence' (PBE) to inform NICE recommendations. They highlight the value of inclusion in NICE of the more process-oriented research which has sought to identify so-called 'non-specific' factors, such as:

therapist characteristics, the quality of the therapeutic alliance and the match between therapist and client in determining clinical outcomes.

Moreover, emphasis on RCT's providing the evidence base informing NICE guidelines on commissioning is problematic for CAMHS provision, since many of these trials are of cases not typically seen in CAMHS i.e. those with co-morbidity and those who are suicidal or present as high risk. It is for this reason that The National *CAMHS Review* (2008) *Children and young people in mind: the final report of the National CAMHS Review,* recommends services to develop practice-based evidence, monitored by routine outcome measures developed by the CAMHS Outcomes Research Consortium (CORC), (Waggett and Morris, 2011).

Further funded research is recommended for those therapies that have a relatively weak evidence-base, so that there can be 'a level playing field in research investment within mental health' (Fonagy and Turpin, 2011). The rationale for qualitative methodologies being given equal status to RCT trials is that they are more likely to capture what actually happens in a psychoanalytic psychotherapy treatment, from which inferences can be made about how any observed changes may have come about (Midgley, 2004).

2.2(e) Provision of therapeutic interventions for severely deprived children

Policy driven recommendations, for the commissioning of interventions to meet the therapeutic needs of looked-after children, are predominately derived from NICE guidelines. The main interventions recommended are: individual CBT and family therapy for a range of mental health problems. Additionally, in relation specifically to depression in adolescence, 30 weeks of psychodynamic therapy is recommended. Where looked-after children meet the criteria for conduct disorder, 'multi-systemic therapy', for looked-after children and their foster-carers, is recommended by both NICE and the Department for Education (DfE, 2013). Support for the 'team around the child' referred to in NICE (2010) as 'reflective

practice', was informed by psychoanalytic approaches to work with the networks around looked-after children, as outlined by Sprince in the form of a consultation document submitted to NICE (2009).

Multi-systemic Therapy is recommended for adolescents between the ages of 11 and 17 at risk of, or already in, out-of home placements who present with serious clinical problems such as substance misuse, violence or emotional disturbance. It is a community-based, intensive, family-driven treatment for antisocial/delinquent behaviour in young people. The intervention is multifaceted and focuses on empowering parents/carers to solve current and future problems. The MST 'client' is the entire ecology of the young person - family, peers, school and neighbourhood.

Psychoanalytic approaches, involving specialist psychoanalytic consultancy to networks around looked after children, place emphasis on supporting caring systems and networks to contain the child's disturbance. It is also believed to provide the consistency and continuity of care to help the child recover from earlier psychological damage. Caring systems - fostering, adoption, residential homes, as viewed from within a psychoanalytic frame, are seen as substitute 'family systems' and are, therefore, thought to be the arena within which the looked-after child unconsciously re-enacts a 'breakdown' similar to that of the family of origin. Such enactments are thought to lead to multiple placements and further emotional disturbance to both children and carers. Sprince outlines specialist consultancy as intervening in this process by helping to identify, understand and neutralize the trauma to avoid breakdown (NICE, 2009).

An increasingly popular therapeutic intervention with looked-after children, derived more from multidisciplinary participation in widespread training events rather than official policy recommendations, is Dyadic Developmental Psychotherapy (DDP), designed by Becker-Weidman & Hughes (2008). This approach is used extensively in the UK and in Northern Ireland for children with complex trauma and attachment disorders. The work derives from attachment theory and, in particular, from the work of Bowlby (1988) on attachment, Stern

(1985) on attunement of parents to infants' communication of their emotional needs and Tronick (1986), who referred to the process of repeated communicative mismatch and repair.

Dyadic developmental therapy is reportedly aimed at the creation of a 'playful, accepting, curious and empathic' environment, in which the therapist attunes to the child's 'subjective experiences' and reflects this back to the child through eye contact, facial expressions, gestures and movements, voice tone, timing and touch. The process is described as involving the 'co-regulation' of emotional affect and the 'co-construction' of an alternative autobiographical narrative with the children. The active presence of the primary caregiver is usually recommended, but not essential. (Hughes, 2004).

Reservations with this approach are articulated by Trowell (2004), who identifies the need to take into consideration that foster-carers may have their own unmet attachment needs from childhood, which may significantly inhibit their ability to be honest with the professionals aiming to help the children in their care. She points out that the use of facial expressions, in attempts at attunement, is problematic and notes that 'although the therapist may look and feel sad, the young person may see this as a provocation - either hit out, or the therapist may be perceived to be triumphant (the facial expression may be misread)' (p. 281). Trowell goes on to emphasize the value of many of Hughes's ideas for clinical work, but provides the following caution:

> *experienced, well-trained clinicians can, with supervision, take these ideas forward into their clinical practice. But the ideas in (Hughes's 2004 paper) do not provide a sufficient basis for a treatment manual, and are not to be followed uncritically.*
>
> (Trowell, 2004 p 281)

Increasingly, mental health problems in looked-after children have necessitated direct involvement of CAMHS, requiring child psychotherapists to work across the interface of social services and CAMHS. This has resulted in specialist CAMHS and social services in England jointly providing and delivering services for

looked-after children (Lindsey, 2006). Hunter's work with severely deprived looked-after children influenced provision of psychoanalytic psychotherapy, within social services departments in England (Hunter, 2003).

2.3 Child psychotherapy and severely deprived children

The psychoanalytic treatment of severely deprived children requires attention to both how infant minds develop, in the context of maternal deprivation and to related technical issues. Early studies by psychoanalysts such as Bowlby (1952) and Winnicott (1964) illuminated the devastating effects of maternal deprivation on the developing mind of the infant and child. Further developments in psychoanalytic theory and practice, enabled increasing understanding of states of mind characteristics of children who have suffered maternal deprivation. An important feature of such deprivation is the effect on the infant's capacity to symbolize his experiences.

Early generations of child psychotherapists believed that children who were severely deprived were not treatable within a psychoanalytic frame. Reservations related to the belief that poor ego structure in many of these children, meant that the use of traditional psychoanalytic interpretation of their unconscious processes would, at best, not reach them and, at worst, increase their anxiety. Despite their reservations, however, child psychotherapists in the 1970's did begin to work with these children.

Boston (1972) describes work with a violent and demanding six and a half year old boy from a Children's Home, who defended himself against the pain of dependency through omnipotent denial. Newbolt (1971) worked with a seven and a half year old looked-after girl, who portrayed her experience of deprivation and abandonment by repeatedly burying the doll she depicted as never playing. Henry (1974) describes work with a 14 year old, severely deprived boy, whom she identified as having 'crippling defences' and fragile internal objects which afforded him little support, making him 'an orphan inwardly as well as outwardly'. (Henry, 1974 p. 16). Miller (1980) describes work with a severely deprived child

who made everyone feel 'a useless failure' (Miller, 1980 p. 58). The shallowness of the child's lack of capacity to play, think or feel at the beginning of treatment, is understood by Millar as evidence of severe deprivation. Berse (1980) reported her work with a 9 year old severely deprived child who had been abandoned at birth by his mother. Corresponding to common experiences in such children, Berse describes the child's repeated fear of 'being dropped' (p. 50) and refers to the intensity of feelings stirred in the counter-transference by this child, depicted as passionately struggling to survive the trauma and deprivation of his infancy.

The culmination of this work resulted in the pioneering study of psychoanalytic work with severely deprived children, by a group of child psychotherapists within the Tavistock Workshop (1980). Case studies from the workshop were published as a collection, entitled *Psychotherapy with Severely Deprived Children,* edited by Boston and Szur (1983). This book has since become seminal reading for those working with severely deprived children.

2.3(a) Findings from the Tavistock Workshop

The Tavistock Workshop closely examined clinical experiences with 80 severely deprived and traumatized children, referred because their behaviour alarmed their carers and felt unbearable to them. Some children had endured traumatic experiences. It was noted that very often, despite difficult behaviour, the children were felt to be capable of being reached emotionally.

Common themes from the findings of the workshop centre on the defences used by these children and the powerful feelings stirred in the therapists. Frequent defences include 'splitting' good and bad in order, it is thought, to preserve the good and avoid becoming overwhelmed by persecutory feelings, linked in anxious states of mind to bad experiences/people. Other common defences in the children were omnipotence as a defence against helplessness and hyper or manic activity, to avoid thinking. It was found that assisting these children to make developmental progress required technical adjustments to treatment approaches.

A major recurring theme from the workshop study was that severely deprived children had a lack of expectation of any continuity. Certain recurring questions were found to be typical. For example: 'Will I be seeing you till the next lady comes?' 'Will I be passed on to someone else?' One young adolescent girl is reported not to have bothered telling her therapist that she would have to miss a session, because she thought the therapist was like the dentist and wouldn't notice if she didn't come to a session. Many of the severely deprived children were described as having little idea of an adult's continued concern and attention.

Another common theme related to anxiety about there not being enough time. References to 'thousands of years' were reported to be a source of pain for the therapist, who questioned whether such a limited amount of therapy could ever be enough for children who have been so deprived. Other striking themes to evolve in the play included falling and being dropped, which were understood as concrete enactments of having been dropped or got rid of, resulting in feelings associated with being un-held emotionally. The sense of being dropped was also thought to be reflected in the children's frequent appearance of scruffiness and, at times, by actual soiling.

Often, with these deprived children, the therapist had to endure the force of intense projections, while the children attempted to manage unbearable feelings associated with their deprivation, through reversing their experience. This took the form of inflicting psychological and, sometimes, actual physical pain. An additional problem in work with these children was found to be linked to disruption of sessions by irregular attendance, which repeated the numerous separation traumas already experienced.

A major outcome of the Tavistock Workshop was the discovery of the need for adjustments in psychoanalytic technique, to take account of deficit in maternal containment and responsiveness. In particular, work with these children highlighted the problematic nature of traditional analytic interpretations, aimed at uncovering the underlying meaning of behaviour. While such interpretations

were usually helpful for children whose internal world was sufficiently structured, they often had the effect of increasing anxiety in severely deprived and traumatized children.

2.3(b) Psychoanalytic work with severely deprived children

The successful treatment of severely deprived children, highlighted by the Tavistock Workshop, inspired child psychotherapists to forge ahead with regular provision of psychoanalytic treatment for these children. From this work, increasing insights were gained into the impact of developmental deficit and manifestations of disruptions to psychic functioning in these children.

Hunter (1986) describes psychotherapy work with a four year old, severely deprived and sexually abused girl, who catastrophically lost both her parents through their arrest and imprisonment for prostituting her older sister. The child's internal world was dominated by confusion and chaos that she tried to manage through pseudo-independence, which oscillated with sudden bouts of crying. Hunter's work with severely deprived children was gathered together in the form of case studies published under the title *Psychotherapy with Young People In Care: Lost and Found* (2001). This work was influential in drawing attention to the need for psychoanalytic provision for looked-after children in CAMH services. Since then, increasing evidence demonstrates that many children, referred to CAMHS, are living in environments where they have been maltreated and where parents have a history of drug and alcohol misuse and/or domestic violence, which has necessitated care arrangements for these children (Meltzer, et al., 2004).

Alvarez (1997) describes her work with a 10 year old boy, abused by his mother in early childhood. The mother suffered manic depressive psychosis and abandoned the boy abruptly when he was 18 months old. Developmental deficit in the child manifested in a need for potency, which was expressed in omnipotent desire. Hindle (2000) illustrates psychoanalytic work with a 10 year old boy, who had been physically abused by his mother and spent six years in various foster

homes. The child displayed profound confusion between self and object. This was expressed in his desperate search for the unreachable mother in his mind. Canham (2004) describes work with a 9 year old severely deprived boy, whose perverse functioning and violent impulses were concretely expressed in the form of physical attacking of the therapist and the room. Rustin (2004) describes different presentations of two severely deprived boys. One boy had a faint grip on life and hope, while the other was manifestly terrorized and terrifying in his aggressive onslaughts. These examples of psychoanalytic work with severely deprived children provide a flavour of the richness and complexity of the work and are by no means exhaustive.

In a later section on technical developments, I shall elaborate on the technical adjustments highlighted by these authors as imperative, in accommodating the developmental deficits endured by severely deprived and traumatized children.

2.3(c) Theoretical considerations in work with severely deprived children

Early forms of psychoanalytic treatment were based on Freud's thinking that insight, gained through the uncovering of past experiences, was the key to the resolution of psychological suffering (Freud, 1920). Klein developed Freud's thinking by postulating that the unconscious life of the infant was dominated, from the beginning, by instinctual phantasy, linked to objects. Her observations, through play, of aggressive fantasies of hate, envy and greed in very young, very ill children, led to her postulating a model of the human psyche.

She described the development of mental states and thinking as derived from sources of destructiveness, projected onto the 'hated' object (or primary carer), producing persecutory experiences in the infant. In parallel to this, sources of love are also projected and, in this side of the split, the object becomes idealized. Klein referred to this process as the 'paranoid-schizoid position', which is characterized by extreme splitting, projective identification and idealization. It is a process which, she believed, dominated the first half of the first year of an infant's

life. In the paranoid-schizoid position, states of persecution and idealization alternate between an idealized good object and persecutory bad one and are linked to the presence and absence of the object.

Klein held that, within the spatial dimension of early development, self and object are experienced as being comprised of bodily parts such as breast, face and hands. Whole object functioning is considered a developmental achievement, signalling movement towards what Klein referred to as the 'depressive position'. In this state of mind, the infant realizes that the frustrating breast that fails to instantly gratify, due to the normal rhythm of object absence, is the same one, which also satisfies. This development results in increased integration of hating and loving feelings, leading to shifts from self-preservation to concern for the object, with all the loss and guilt that this entails. The gradual internalization of an object that loves and protects the self, leads to an internal world in which increased ego integration and the establishment of internal object constancy are the basic sources of inner strength, buffering the infant from actual separations, disappointments and frustrations (Klein, 1946).

2.3(c) i <u>Projective identification</u>

Developments in psychoanalytic theory, through the work of Klein (1937) and object relations theory, paved the way for explorations of the interpersonal nature of psychoanalytic treatment. In elucidating the complexity of projective processes in the developing mind of the infant, her work formed the basis of our understanding of how psychoanalytic treatment could bring about psychic change. Of particular importance to clinical work and later developments in work with severely deprived children, was her notion of projective identification (Klein 1946). Klein held that projective identification is a defensive process in normal infantile states of mind, whereby parts of the personality of the infant are split off and expelled into the object, which then becomes identified with the unwantedaspects of the infant. This is thought to occur in phantasy and without the real mother being affected.

2.3(c) ii Counter-transference

Klein's view of projective identification, as limited to unconscious phantasy, was later extended through the work of Heimann and others, to include the incorporation of the analyst's identification with the phantasy. The basis of this theoretical development is linked to increasing recognition of counter-transference responses in the analyst, providing important insights into unconscious processes in the patient. Heimann wrote:

> *... the analyst's unconscious understands that of his patient. This rapport on the deep level comes to the surface in the form of feelings, which the analyst notices in response to his patient, 'in his counter-transference'. This is the most dynamic way in which his patient's voice reaches him.*
>
> (Heimann, 1950 p 81)

Both Freud and Klein believed that counter-transference feelings, stirred up in the analyst during treatment, interfered with interpretative work and needed to be overcome, through personal analysis. Heimann's alternative view of counter-transference, as 'an instrument of research into the patient's unconscious' (p. 81), formed the foundation for later adjustments to psychoanalytic technique with severely deprived children.

2.3(c) iii Container-contained model

Bion's container-contained model of the mind extended Klein's concept of projective identification, as an evacuative function (Bion 1962). This work laid the foundation for shifts in psychoanalytic approaches to working with severely deprived children. Bion held that, via the process of projective identification in normal development, the infant communicates his emotional and mental states to the mother in a powerful pre-verbal way. The mother receives her infant's projections of fluctuating anxious states with which, via her reverie, she identifies, digests and then transforms through her capacity for containment. Through this process, the mother renders anxious states bearable for the infant. Without

containment, Bion contends, the infant is left in a terrifying state of 'nameless dread' against which many defences may be employed.

Bion's emphasis, on the interplay between communications of infant distress being inseparable from the containing qualities of the maternal function, enabled extensions to our understanding of how minds grow. His notion of the maternal container at the centre of the growth of mind had a profound influence on psychoanalytic thinking and in later clinical interventions with severely deprived children. It provided a context for understanding the need for patients to have experience of containment and transformation of their unwanted, projected aspects of experience to be held in the mind of the therapist, before they are returned in digested form.

2.3(c) iv Introjection and identification

Identification, through the process of introjection, has been extensively written about in the psychoanalytic literature, beginning with Freud (1914), through to developments in Kleinian theory and clinical practice. In normal development, identification is essential to the building up and sustaining of a sense of self. The infant, from the beginning of life, needs to introject and assimilate the containing availability and mirroring presence of mother. Where the mother is pre-occupied with her own states of mind and, as a result, is unresponsive to the baby's need for mirroring of his experience, the child's sense of identity can be seriously compromised (Winnicott, 1967). The baby, in this condition, experiences the mother as unreachable and, in a fundamental sense, unavailable. Rhode suggests that it is the right balance between the child and mother's 'internal occupant' which allows primary identification that is imitation of the developmental kind – to take place (Rhode, 2005 p. 61).

2.4 Trauma and borderline states in severely deprived children.

Many severely deprived children display characteristics of borderline states, including experiences of profound confusion between a fragile self, experienced having little integration and an object felt to be unreachable. This is combined

with a terror of separation, experienced as terrible expulsion (Rey, 1994 p. 26-7). Rey describes the person in a borderline state as 'an emotional prisoner, craving love but prevented from loving' due to fearing too much that they will destroy the love they need (Rey, 1994 p 8). Meltzer elaborated on the clinical manifestations of borderline states in his depiction of the internal 'claustrum'. He explains that profound confusion in the mind is defensively managed, by means of a kind of psychic invasion into the inner world of the maternal body and this inevitably causes a sense of claustrophobia (Meltzer, 1992).

The reality that all looked-after children are traumatized by experiences of rupture to their primary relationships is supported by substantial convergence of findings from psychoanalytic, developmental, attachment and neurobiological research on the effects of trauma. Freud referred to trauma as a flooding of the psychic system, evoking helplessness and leading to defensive dissociation (Freud 1920). Garland suggested that children who are traumatized live in a heightened state of anxious watchfulness. Winnicott described it as causing catastrophic disruptions to 'going-on-being' (Winnicott, 1965). He sums up the effects of trauma with his description:

> *Trauma means the breaking of the continuity of the line of an individual's existence. It is only on a continuity of existing that the sense of self, of feeling real, and of being, can eventually be established as a feature of the individual personality.*
>
> (Winnicott, 1986 p. 22)

In the field of neuroscience, Pally's (2007) research highlighted the effects of trauma on memory systems, whereby excessively high levels of emotional arousal can impair encoding of information and cause disconnection between states of consciousness. The implicit memory may result in 'symptoms' of trauma, such as emotions and somatic experiences, without the conscious recall of trauma. This concurs with clinical experience of working with severely deprived and traumatised children (Balbernie, 2001; Emmanuel, 2004), whereby experiences from the past, disconnected from conscious memory reactivated in

the present, are experienced as happening in the 'here and now' (Pally, 2007). This finding is highly relevant to the fragmentary states of mind in the child in this study.

Explicit processing of trauma is thought to be enabled by the analyst's facilitation of links between traumatic symptoms and past experiences of trauma, so that experiences can be remembered more in context and not reactivated as though felt to be in the present (Pally, 2007). Freud originally stressed that the activation of emotionally–linked representations of experiences with others occurs entirely unconsciously and appears in the transference relationship. In his classic 1914 paper 'Remembering, repeating and working through'; Freud observed that the patient will repeat experiences which he cannot remember, in the form of 'acting-out' in the immediate interaction with the analyst.

Fonagy (1999 p.3) noted: 'As psychoanalysts, we know that patients cannot possibly remember why they behave as they do…. The only way we can know what goes on in our patients' mind, what might have happened to them, is how they are with us in the transference.' Schore describes trauma derived from relational sources as having a catastrophic effect on introjective and projective processes. He says:

> *The ultimate endpoint of experiencing catastrophic states of relational-induced trauma in early life is a progressive impairment of the ability to adjust, take defensive action, or act on one's own behalf, and, most*
>
> *importantly, a blocking of the capacity to register affect and pain.*
>
> (Schore, 2001 p. 232)

There has been much clinical and theoretical debate in psychoanalysis about how to clinically respond to borderline and traumatized states. In considering these states in severely deprived children, Alvarez, among others, focused attention on the need to consider and differentiate between projective processes

that lean towards integration, as distinct from repetitive activity that is anti-development. She contends:

> *Splitting and projective identification can be seen to be in the service of development rather than a defence because they enable new introjections to take place under conditions that should be described as protective rather than defensive.*
>
> (Alvarez, 2012 p. 86)

Psychoanalysts describe in different ways the roots of borderline and traumatized states, linked to the effects of deficit in maternal responsiveness and containment. Bion (1962) describes 'nameless dread', Winnicott (1962) depicts 'unthinkable anxiety' and Bick (1968) refers to the infant's fears of falling and falling apart. Many severely deprived children with borderline presentations have little ego and are gripped by a cruel, depriving superego. Alvarez contends that these children require the kind of response from the therapist that nurtures development through an emphasis on a good object and a good self. Increasing understanding of the characteristics of mental functioning and defences, employed by severely deprived children, has informed shifts in psychoanalytic technique in working with these children.

2.5 Technical considerations in work with severely deprived children

Freud discovered that, when therapist and patient are together, patients develop what he called a 'transference neurosis'. This, he thought, referred to a set of attitudes, affects, fantasies and assumptions about the therapist that express central unconscious organizing themes and conflicts, originating from intrinsic forces and drives central to psychological development in childhood (Freud, 1920). He believed that insight gained through the uncovering of past experiences was the key to the resolution of psychological suffering. He held that change required attention to the emotional experience of the patient, expressed and resolved through the immediacy of the transference (Freud, 1905). Klein (1952) later built upon Freud's work by postulating unconscious phantasy and infantile mechanisms of defence against anxiety, as central to the

interplay between the external and internal world. Klein emphasized the centrality of analyzing the negative transference as the only possible way of penetrating what she referred to as the deepest layers of the mind (Klein, 1952).

Bion's work on thinking and maternal containment had a profound influence on psychoanalytic thinking and on extending, and even shifting, the notion of psychic conflict being at the root of psychological problems, to consideration of the impact of deficit in the maternal function. Increasing experiences with severely deprived children led to child psychotherapists discovering the need to adjust and extend their repertoire of traditional psychoanalytic techniques, in order that these children could be reached and helped.

2.5(a) Developments in psychoanalytic technique

Hunter's book *Psychotherapy With Children in Care* (2001) addresses the central technical issue of the need for the therapist to bear the helplessness and despair evoked by working with severely deprived, traumatized children. Hindle (2000) describes work with a severely deprived boy who flaunted the boundaries of the room, by running outside to climb trees when he had 'had enough', evoking in the therapist feelings of shock, disorientation and worry about his safety. Hindle realized that the child seemed to be engaged in a search (for mother) and needed his therapist to 'join him' in his enactment, through 'searching' for him outside the building. Hindle became the narrator of his story, talking out loud about a mother who left, without thinking about him and his needs and how he needed to be outside, high up, and independent. Hindle's attunement and containment of the child facilitated his capacity for recognizing his longing and need for mother.

Canham (2004) describes the challenging experience, when evacuation of unmanageable feeling states in severely deprived children are physically enacted, through attacking the therapist and the room. He suggests that the terrifying feelings of having been abused are often brought into the therapy in concrete ways 'for examination of the dynamic relationship between abuser and

abused' (Canham, 2004 p.145). Canham describes psychoanalytic psychotherapy with a 9 year old boy who was profoundly emotionally neglected and abused from infancy, removed permanently at two and adopted at 3 years. He provides rich detail of his means of reaching this very disturbed boy, through the use of counter-transference, which involved Canham being put through something of the helpless terror the boy experienced in infancy. Canham insists that this helplessness must be genuinely experienced by the therapist, in order to speak 'with conviction' to the child about these experiences. He stresses the technical need for differentiation, between violence which is driven by a desperate need to communicate violent experiences in the child's past, and violence driven by perverse parts of the patient. Canham demonstrates how able the child was to develop symbolic functioning, as a result of having both his 'infantile experiences understood and his perverse tyranny withstood' (Canham, 2004 p. 153).

Rustin (2004) describes her struggle to 'get through' to two very deprived looked-after boys and explores the different technical implications of their differing presentations. In one case, the therapist is required to survive the terror and aggression thrust upon her and, in the second case, stay alive with a shut down boy whose faint grip on life and hope was hard to bear. Rustin captures how the traditional techniques of psychoanalysis were modified by the clinical imperative to respond outside her 'cherished ways of working' (Rustin, 2004 p. 279). Thus, Rustin movingly describes her technical dilemmas when, for example, she provided soil for a plant cutting that may or may not have survived and, also, when she became a 'furniture removal' participant in the child's need to connect to the ordinary omnipotence in re-designing a world shattered by abuse.

Increasing attention to projective identification meant greater focus on the importance of counter-transference on waiting, on the needs of the children to have a new experience, and on recognition of their defences against unbearable pain. Joseph (1983) suggests that projective identification may, in some cases, need to be held by the therapist sometimes for a long time, even when

projections have been metabolized, before returning these, in the form of interpretation, to the patient. Kenrick (2009 p. 29) points out that this is even more crucial with very deprived children, who have not had the experience of an object capable of containment of 'communicative projective identification', but rather one preoccupied with their own external or internal difficulties.

Drawing on Alvarez's work, Kenrick discusses the need, in work with severely deprived children, for 'different levels of interpretation for different patients at different times' (Kenrick, 2005 p. 27). Thus, developmental deficit in these children may often mean the therapist providing less interpretation, particularly in the initial stages of treatment and more containment of projected states of mind, to facilitate the most effective therapeutic process.

Music (2009) argues that psychoanalytic technique has tended to over-emphasize interpretation of defensive systems, at the expense of facilitating the positive. Drawing on findings from developmental psychology and neuroscience, as well as his own clinical practice, Music highlights the need for children, deprived of experiences of pleasure or joy, to have opportunity to experience playful exchanges with the therapist, in order to nurture developmental possibilities. He writes:

> *We need to help our patients manage difficult feelings, and this may be our main skill, but what we have possibly under-theorised is how we can also increase a patient's sense of agency, enjoyment and aliveness through a way of being which is not merely helping them process difficulty*
>
> *nor being a blank screen. For these patients, blank screens can breed more blankness, which is certainly not what they need.*
>
> (Music, 2009 p. 152)

Moreover, Kenrick (2005) suggests that severely deprived children may need the therapist's help to register that there is an emotional state worth exploring.

2.5 (b) Technical considerations in relation to play with severely deprived children

In examining case studies from 2000 onwards, I discovered that developments in psychoanalytic technique with severely deprived children seemed, increasingly, to depict the importance of certain functions of play. In addition to play being a medium for communication of internal states via projective identification, it seems that play, in itself, (in the presence of the other and involving the other), is increasingly portrayed as being the means through which developmental growth can occur. The following selection of case examples highlights what I see as reference, by the authors, to the importance of play within the context of psychoanalytic treatment.

Jackson (2004) describes intensive psychotherapy with a multiply traumatized five year old girl, Yasmin. He shows how, through play, the gradual dismantling of the child's defences was facilitated, enabling uncertainty and anxiety to be tolerated and curiosity to evolve. Jackson describes the technical dilemmas when working with Yasmin, where words and interpretations were insufficient to reach her. In particular, he explores how the child's violent and traumatic experiences, enacted in the transference, were 'unpacked' through Jackson's catching and processing moments, where the child needed amplification of her affect. Moreover, he shows convincingly that his engaging in play enactments with Yasmin (and stresses that the child needed him to play the games and talk later about how he understood them), enabled her to move from 'survival' states of mind to the capacity to symbolize. Such games as 'babies' or 'operations', where Jackson acted as a 'kind of narrator', 'facilitated the first steps of registering, processing and thinking about experiences for which there had been no words' (Jackson, 2004, p. 60).

Marsoni (2006) refers to the need to be a witness to and narrator of the violent acting out, through play, by Luke, a child traumatized in infancy. Using Alvarez's notion of a 'grammar of description', as opposed to a 'grammar of explanation', Marsoni describes the child's need for her to be available to experience, on his

behalf, the evacuation of an un-processable ‘up-side down world’, involving murderous attacks and endless gory violence in horror fights, enacted in play.

Strati (2010), describes psychoanalytic work with two and a half year old Phoebe, who had witnessed her mother killing her father. She discovered that attempts to understand the child’s distress and verbalize her affect were fruitless, due to the child’s dissociative defence against feelings, which evoked in the counter-transference a paralyzing state of helplessness and mindlessness. Strati discovered that she had to find alternative ways of both reaching Phoebe and of containing the child’s unconscious triggers of the traumatic experience, which seemed to be felt at a physical level and which were expressed in the form of a deadening dissociation. She gives an example of adapting her psychoanalytic interpretative technique, by creating an ‘intermediate, yet transitional space’, which was a playful environment within which the child’s feelings could be explored. For example, Strati describes the ‘paradoxical manner of gathering pieces of paper to create a game’ whereby, after counting 1..2..3, she threw the pieces in the air and sang while watching the papers fall on their heads, with Phoebe joining in. Strati refers to this being akin to Stern’s idea of a ‘moment of meeting’ and that this ‘spontaneous gesture’ ignited a ‘fleeting encounter with the lively infant’ (Strati, 2010 p.22) in Phoebe and represented an alternative to a premature verbalizing of dead affect in her.

Alvarez explores one of the main technical dilemmas for psychoanalytic treatment of severely deprived children who lack 'imaginative capacities'. She says:

> *....when simply to describe the patient’s pleasure in a phantasy and when to link it with transference meanings. There are moments when a Winnicottian respect for the play itself is important and when a too premature transference interpretation would interfere with the very process of formulation the child is trying to achieve. But there are other moments when a comment which links the play and the relationship to the therapist*

may underline the experience and place it on firmer and more lasting ground.

(Alvarez, 1992 p 125 –126)

2.5(c) The work of Anne Alvarez

The work of Alvarez (1983, 1992, 1996, 1997, 2000, 2012) draws attention to the impact of deficit in severely deprived children. She thinks that one of the main problems for many of these children is their failure to achieve healthy projective identification, due to deficits in ego functioning and that it is their lack of integration, rather than disintegration, which is central to their problems. She suggests that there was a need to develop a model of mind which incorporated understanding; that severely deprived children may not have developed 'defences' in any ordinary sense and that to do so should, in certain circumstances, be viewed as developmental achievements. She usefully distinguishes between projective processes that are excessive and those that are too weak and inadequate, due to experience being non-located and the capacity for thinking underdeveloped (Alvarez, 1996).

Alvarez addresses the implications of Bion's theoretical ideas on projective identification, maternal reverie and containment, by postulating the need for an expansion to the function of projective identification, to take account of the degree of deficit in the patient's internal world. Alvarez argues that many severely deprived children lack motivation and desire and often need the therapist to function as an enlivening object. Extending the notion of the therapist's mind as container for unwanted and unbearable experiences in the child, Alvarez recommends the inclusion, in the container, of 'pleasure' in the playful presence of the object, as fundamental to the development of 'vitality'. She says:

….containment of hope, exuberance, delight and joy would seem to be just as important to development and thinking as much as is the

containment of anxiety and frustration.

(Alvarez, 1992 p. 76)

Alvarez elaborates upon Joseph's (1984) idea that some patients need the analyst to hold the projection for lengthy periods of time. She suggests that the gradual uncovering and exploration of a 'disappointing or fragile parental object', whose weakness may have been denied, needs more description and less explanation. She recommends the technical 'move from a grammar of explanation to a grammar of description' (Alvarez, 2000 p. 9). She refers to Steiner (1993) raising this issue in his emphasis on the containing function of the therapist, when he wrote about analyst-centred versus patient-centred interpretations.

Deficit in capacity for projective and introjective processes impacts on the child's ability to develop a range of psychological functions, linked to capacities for identification and internalization. Alvarez suggests that facilitating these capacities in severely deprived children requires the therapist to be vigilant to signs of curiosity and desire in the deprived child, and identify possibilities for the unfolding and registering of 'anticipatory identifications' (Alvarez, 2000). The child who has experienced inadequate or non-existent identifications needs to develop these, argues Alvarez, through gradual movement towards introjective processes (Alvarez, 2000).

Linked to the technical shift towards facilitating developmental progress in the child, Alvarez thinks it necessary to take into account the difference between a desire for omnipotence and a need for potency (Alvarez, 1997). In illustrating this point, she gives an example of work with a 10 year old boy and describes her response when he was painting large strokes on the page. She spoke to him about his desire to be able to paint like 'the painters upstairs' one of whom he had met in the hallway, earlier. His response, 'Yes I do, I do want to, but I *do* work, this is what I *do*, you see!' challenged Alvarez to re-think her usual view of this being an omnipotent, defensive identification and more like a communication of a desperate need to be seen as being capable of being, or becoming like, a

potent and reparative father. Alvarez believes that he may have experienced her interpretation as a 'crushing reminder of lifelong impotence and maybe lifelong humiliation' (Alvarez, 1997 p. 759). Alvarez goes on to wonder how much of a difference it would have made to the support of his ego, if she had said 'Well, I think I should notice that you can paint too, not so differently from those fellows upstairs!'? Alvarez suggests that the therapist needs to assist developmental progress in the severely deprived child by facilitating introjections, through what she refers to as an 'enlivening' function.

2.5(d) Developmental function of the therapist

Alvarez's view on the therapist having a developmental function, providing more than containment of anxious states in the infant, seems to converge with Hurry's (1992) idea of the therapist as 'developmental object'. Hurry contends that, when the child has experienced deprivation, he carries hope that the therapist will 'contradict transference expectations' by becoming an 'appropriate developmental object' (Hurry, 1992 p. 47). The developmental object in Hurry's work is internalized alongside existing object-relationships. However, Crehan (2011) in her doctoral research, raises an important question about how this process is conceptualized as differentiated from 're-experiencing and working through in the transference relationship' (Crehan, 2011 p. 21). The reason this question is important, as Crehan points out, is that the answer to it has implications for technique in relation to whether, for instance, the therapist participates in or interprets play. In my view, the two are not mutually exclusive. I suggest that a bifocal approach could be considered, in which the therapist simultaneously attends to deficit in the child's developmental needs throughout engagement in play, while interpreting disturbances in internal representations manifest in the transference. However, as Crehan also points out, the important question remains as to whether established internal object relationships are altered by the internalization of a new developmental object.

Williams (1998) postulates that the containing presence of the therapist, which is enabled by her 'internal connectedness', allows the therapist's attention to the child to be sustained. This process, which Lanyado (2004) also explores in the context of the 'presence of the therapist', facilitates introjection of a 'connectedness' that becomes internalized and takes shape. Lanyado contends that change in the child's internal representations comes about from connections to the 'present' moment because, paradoxically, 'only the present and future matter'. Lanyado emphasizes the personal characteristics of the therapist as having an influence on the quality of these 'present moments' and whether and how these are introjected by the child.

Lanyado draws on the work of Stern et al., (1998), placing the personal characteristics of the therapist at the centre of change in the internal world of the child. In findings from studies of change in the therapeutic encounter within the perspective of developmental psychology, Stern, et.al, conclude that:

> *Whereas interpretation is traditionally viewed as the nodal event acting with and upon the transference relationship, and changing it by altering the intrapyschic environment, we view 'moments of meeting' as the nodal event acting upon the 'shared implicit relationship' and changing it by alerting implicit knowledge that is both intrapsychic and interpersonal. Both of these complementary processes are mutative.*
>
> (Stern, et al., 1998 p. 918)

Stern and his colleagues contend that transference interpretation is only one aspect involved in the process of change and that it is the development of repeated experiences of attunement between therapist and patient, leading to 'moments of meeting', that are the basis of change in the internal world of the patient.

2.6 Working with the Network

It is considered essential in the provision of intensive psychoanalytic psychotherapy with looked-after children, to have on-going meetings with those

in the network around the child. The purpose of these meetings is to 'create a therapeutic network' (Sprince, 2000 p 414) so that the child's presentation and behaviour are explored and understood within a psychodynamic frame, attending to the inner world of the child. The development of psychodynamic thinking about the child and the ways in which the child's projections affect each member of the network, provides crucial containment and essential support to the psychoanalytic work.

Sprince highlights that projections from looked-after children are so powerful that there can be 'an overwhelming wish to deny the level of damage in these children' resulting in the belief 'that all that was needed was a good experience in a normal family' (Sprince, 2000, p 417).

Sprince further suggests that field social workers, like foster-carers, take on cases that flood them with feelings that are difficult to understand and that they are expected to work with, in relative isolation. Often, splits occur in the network around looked-after children, particularly in the context of trying to understand and respond to the turmoil of abused and deprived children, who find it difficult to use the good experience provided by foster carers or staff in children's homes. Often, it is the case that severely deprived children will be compelled to destroy the very situation of good enough parenting that they so desperately need.

2.7 Child psychotherapy process research

The complexity of psychoanalytic work, in relation to the intricacies of the transference counter-transference relationship at the core of treatment, presents significant challenges to the child psychotherapist/researcher. Thus, there has been traditional reliance on developing theory and technique through clinical, single case studies. However, there is a steady increase in process research in child psychotherapy, incorporating developmental progress in severely deprived children receiving psychoanalytic treatment. A large scale study by Boston, Lush and Grainger (1991) was designed to test the hypothesis of the Tavistock

Workshop, that psychotherapy can modify the internal images of abandoning and rejecting parents. The researchers wanted to obtain more systematic evidence relevant to this hypothesis, with the use of a prospective design and an evaluation of all children; not just a selected number entering psychotherapy in a given period. This study also aimed to develop an empirically-driven method for evaluating psychoanalytic psychotherapy with children in general. The researchers used selected categories that were felt to capture all aspects of functioning in which changes could be noted. These are: (1) changes in the structure of the inner world and internal parental images; (2) perception of self and self-esteem; (3) toleration of mental pain; (4) capacity to think, learn, play and symbolise; (5) access to imagination and phantasy; (6) relationships, depth of relationships and concern for others, and (7) types of anxieties.

Improved outcomes for most of the children in the study were found in all categories. Unfortunately, this study did not meet the criteria for inclusion within the evidence base of NICE guidelines. However, it adds to our increasing understanding of theory and technique in work with severely deprived children.

A study by Hodges, et al. (2004) examines the impact of maltreatment and neglect on the psychological development of children. The researchers used 'The Story Stem Assessment Profile' to investigate the effects of abuse on children's representations and any changes following adoptive placement. The post-adoption findings show development of aspects of new and more positive inner-representations in the children. The researchers link these findings to 'the natural history of change in attachments after adoption placement' (Midgley, et al., 2009 p. 204). I include this study, as it is interesting to consider the findings, in relation to the present study of developmental progress in a severely deprived child and what aspects of the therapeutic relationship might be relevant in facilitating this process. The study draws attention to what is referred to by Hodges, et al, as 'development recovery' which is linked, in the findings, to experiences of new and positive relationships (Hodges, et al., 2009 p. 204). However, while new internal representations such as helpful adults were found in

the children after one year, no decrease in representations of adults as aggressive or rejecting was evident.

In considering these findings, Crehan (2011), in her doctoral research, which I discuss in more detail later, wonders if there could be differentiation between therapeutic outcomes for 'developmental therapy' compared to psychoanalytic psychotherapy. She asks an important question: 'Does developmental therapy concentrate on the building up of new representations and does work in the transference focus on the transformation of existing representations?' (Crehan, 2011 p. 22). This is an interesting question, which pertains to the present study in relation to the possibility that work in the transference and the creation of new representations may both be involved and essential to developmental progress in a severely deprived child. Intuitively, it seems to make sense that attending to existing internal representations creates space for new representations, which may further facilitate transformation of existing internal representations. This seems to imply a linear process, whereby work in the transference needs to happen first before new representations are possible. This may be the case, but given the complexity of developmental growth under any circumstance, transferential forces and developmental imperatives are likely to be in constant interaction from the beginning of treatment. These questions and explorations highlight the need for continued research into unravelling the complexity of mental processes where deficit is a predominant condition.

Philps (2003) explores emotional development in psychoanalytic psychotherapy with looked after children, through studying the fine-grained transference and counter-transference processes, as well as levels of interpretation in psychoanalytic treatment. She found evidence of a gradual decrease in paranoid-schizoid functioning and an increase in depressive functioning within the sessions themselves.

While there continues to be gaps in child psychotherapy research and evidence for treatment with severely deprived children, findings are steadily accumulating, assisted by the now yearly contributions of doctorate research projects.

Research into change processes help to support and refine the work, as well as challenge theory and its application to work with severely deprived children. I describe a number of doctoral research findings from single case studies, which are relevant to the present study.

2.7(a) Findings from Doctoral process research studies

Weir-Jeffrey (2011) studied the process of recovery from deprivation and trauma. She discovered three phases in the treatment, involving development from psychic fragmentation to the second phase of beginning to internalize the therapist as a good enough object, to the third phase, characterized by the capacity for thought, insight, reflective function, toleration of mental pain and integration. Two important dimensions to the findings are highlighted, which relate firstly to time and secondly to the non-linear aspect of developmental progress. In relation to time, findings from the study indicate that therapy needs to be sustained for a period of at least two years before evidence of progress can be observed. In her comparative study, as part of the research of relevant case studies from the *Journal of Child Psychotherapy,* she noted that many of the case studies show how severely deprived children often take in excess of a year before there is evidence of development. In relation to the second dimension, a non-linear cycle through the phases between the fragmentary and more contained states of mind was found. This supports evidence from clinical experience of developmental progress in severely deprived children.

Ryan (2011) studied therapeutic change in a deprived boy in long-term foster care. Through an examination of what interfered with the child's capacity to think and learn from experience and what factors in a therapeutic relationship assisted growth in these areas, Ryan found that development of curiosity in the child was stimulated more than anything by the therapist's capacity to engage emotionally. This was achieved through her use of counter-transference to, firstly, guide containing responses to projected disturbing feelings in the child of 'hatred, envy, fear and rejection' (Ryan, 2011 p. 158) and, secondly, by conveying her capacity

to receive his projected states of mind via her tone and inflection, as well as her joining the child in play.

Crehan (2011) studied the transference relationship within an intensive treatment of a severely deprived child and found that the work required attending to both positive and negative transference, in order that loving feelings could more readily be managed. She also found that, in the treatment of a severely deprived child, the therapist as 'receptacle for projective processes' and 'container' of these, was more predominant than was the therapist as 'transference object' (Crehan, 2011 p. 89). Crehan highlights the importance of play as a medium for communicating disturbed states of mind and for facilitating the establishing of a greater degree of object constancy. She refers to play as also representing an opportunity to experience 'having fun together' (Crehan, 2011 p 71). However, I think that there is a question of whether 'having fun together' is no more than a valuable experience in itself or whether the 'together' and 'fun' elements in the exchange are essential to the growth of much more than object constancy. I contend that 'having fun together' is linked to the process of facilitation of introjections.

Scott (2010) investigated therapeutic and developmental process in a boy traumatized in infancy. Her findings support the central role of therapist as container. She draws on child development research and on the work of Bateman and Fonaghy (206) on mentalization, to help explain her findings on some of the activity of the therapist, essentially involving facilitating the child's experience and understanding that others have minds with thoughts and motivations. Scott highlighted the usefulness of her findings to the provision of consultation to foster carers, enabling them to understand better the defence mechanisms with which severely deprived children relate to others. Scott's inclusion and examination of her own thinking process in the treatment, captures the functional connection between the qualities required of the therapist and developmental growth in the child's mind. Indeed, Ryan makes reference to the extension of the frame of her research to include systematic tracking of the

process activity in the mind of the therapist. Ryan (2011) highlights that it is not common practice, in qualitative case study research, to include the activities of the mind of the therapist and that, instead, case studies tend to focus primarily on the internal world of the patient.

2.8 Summary

Increasing research evidence on the processes involved in internal change in severely deprived children in psychoanalytic treatment, highlights ever-increasing fine-grained discoveries of the impact of severe deprivation and the technical requirements for assisting developmental growth in these children. The dynamics of transference and counter-transference continue to lie at the heart of treatment and change processes, while psychoanalytic technique increasingly nudges towards non-interpretative means of reaching these children.

Child psychotherapists respond to the needs of severely deprived children by increasingly taking into account deficits in capacity for reflection and symbolization, linked to fragmentary states of mind. Music (2009) highlights findings from research on child development and neuroscience, confirming and adding to psychoanalytic understanding of the fragmentary internal states of children who have experienced severe neglect and trauma. The therapist's role as receptacle and container of these states is consistently revealed in clinical case studies and case study research, as a central process in the work of facilitating developmental progress in these children.

Also linked to the therapist's role is the importance of counter-transference, as a crucial guide in assisting understanding of the internal states in severely deprived children and in informing therapeutic responses and technique. The complexity and delicacy of such responses is effectively captured by Hoxter, who writes:

> *We can never observe emotional injury; we can only observe the adaptations and maladaptations, which each individual utilizes in attempts to cope with pain. The pain remains unseen, our only perceptual organ for it is that most sensitive of instruments, our own capacity for emotional*

> *response. By maintaining our sensitivity without being overwhelmed or resorting to withdrawal or attribution of blame, we may then be better able to provide the answer which brings relief: the experience of a relationship with someone who can be relied upon to attend to suffering with both receptivity and strength.*
>
> (Hoxter, 1883 p. 132)

Increased understanding of the therapeutic needs of severely deprived children has been assisted by shifts in psychoanalytic technique, from the use of interpretation to uncover masked repressed material (Freud) or hidden aggression in patients (Klein), to their use within the context of containment and transformation (Bion, 1962). Kenrick highlights that current technique with severely deprived children aims to:

> *build up our interpretations quite slowly: perhaps from a description of what is happening in the play, then as much at a time as the child can manage, bringing it into the transference, and only then making links to internal phantasies or external past known facts in the child's life, what Alvarez calls 'minimal dose' links.*
>
> (Kenrick, 2005 p. 29)

The wealth of knowledge, expertise and demonstrably effective psychoanalytic work with severely deprived children remains a challenge to illustrate, as evidence-based practice. Policy drivers tend to emphasize RCT's as the 'gold standard' research, which has implications for certain process-based research not meeting criteria for inclusion in NICE Guidelines. However, increasingly, there appears to be a registering of the need to understand therapeutic change processes in greater depth. Child psychotherapists, as clinicians and researchers, are well placed to make contribution to discovery and illustration of the complexity of therapeutic process, facilitating developmental growth in severely deprived children.

Chapter 3 - Research Methodology

3.1 Research and psychoanalysis

Psychoanalysis was created as a new paradigm by Freud (1895) and has been central to the evolution of enquiry into the formations of the mind. The very backbone of psychoanalysis is that internal worlds and, particularly the unconscious part of the internal world, do not lend themselves to discovery through traditional interview and questionnaire methodology. The assumption that participants in research provide an unproblematic account of their experience, when what is being explored can often be unconscious, challenges the notion of 'narrative truth' put forward by Spence (1982). Indeed, Green (2000) argues that patients do not tell us stories, but sometimes use stories to say something else. Hollway (2001) points out that, if we are to accept psychoanalytic theories of mind, such as the inability to think being linked to mental distress or pain (Bion, 1962) and that paranoid-schizoid defences (Klein, 1946) exist as states of mind that defend against external reality, then the power of reason and the empiricist's belief in the reliability of sense perception and observation, through recording interviewee descriptions, is likely to be unreliable.

The essence of psychoanalytic theory of mind draws attention to the reasons and contexts within which respondents and interviewees may not reflect accurate responses. It points to the importance of defences against anxiety and the need to interpret the meaning of the information provided. This contradicts the assumptions of traditional research methodology with its emphasis in research on people's descriptions and expressions, which are believed to be relatively unmediated by mental processes such as anxiety, desire or projective identification.

The debate about whether psychoanalytic enquiry can be pursued within a research paradigm links with rationalist notions of objectivity. In the absence of inclusion of emotions, which is core to what is being inquired into, research outcomes may reflect a process of learning about, rather than learning from,

experience. Bion (1962) called 'learning about', an intellectual acidity, as opposed to 'learning from experience', which engages the emotions and thus gets to the core of what is being inquired into. Bion's idea of the container-contained relation provides an explanation for the emotional development of human capacity for thought. This is not worked out from the perspective of a rational subject, but from understanding unconscious dynamics which take place in the early mother-baby interactional dynamic, whereby the mother functions as a container and the baby's projections are contained. The implication of Bion's thinking is the presence of an underlying psychological organisation. He describes the earliest and normal forms of communication as highly dependant on projective identification, which revolves around the emotional knowing and sharing of states of mind.

Proponents of psychoanalytic research highlight the richness of child psychotherapy's theoretical base, evolving from in-depth examination and reflection on clinical material. Fonagy (2005) points out that the inadequacy of available research methodology is mistakenly viewed as reflecting weakness in the psychotherapy method. The challenge, then, is to evolve research methods that properly reveal complex developmental processes; which will create ever-increasing understanding, leading to the development of theory, practice and technique. With its emphasis on object relations, psychoanalysis pays close attention to relations among subjects and objects. In this regard, it is not bound by linear causality, which has tended to characterise the focus of conventional scientific paradigms.

In presenting an argument for qualitative methodology in psychoanalytic research, Rustin (2002) refers to 'Complexity Theory' developing out of the recognition of the need for paradigms to more effectively investigate the significance of complex self-organising systems, that change from one ordered systemic state to another and, in particular, discover what contingencies bring about such change. The assumptions of constancy, determinism and equilibrium, which underlay previously conventional scientific paradigms, are

replaced by the idea of evolution, partial uncertainty, and disequilibrium. This, Rustin suggests, is compatible with psychoanalytic assumptions about the nature of uncertainty and unpredictability in human nature, which also assumes that individuals have potential worlds, as yet undiscovered, that can be imagined and realized through the process of psychoanalysis.

3.2 Single case study research

The study of single cases has long been a tradition within psychoanalysis. Beginning with Freud in the late 19th century, the case study has been used to generate understanding of mental phenomena. By outlining precise accounts of his psychoanalytic work with patients, Freud attempted to establish the case history as a method of research. In 1895 he published four detailed accounts of his cases in *Studies in Hysteria*. Thirty years later, Freud remained firmly of the view that clinical practice is, in itself, research. He stated:

> *In psychoanalysis there has existed from the very first an inseparable bond between cure and research . . . Our analytic procedure is the only one in which this precious conjunction is assured. It is only by carrying on our analytic pastoral work that we can deepen our dawning comprehension of the human mind.*
>
> (Freud, 1927, p. 256)

In this statement, Freud conveyed the conviction that the therapeutic session itself provides a valid form of data for analysis and, as such, is a form of scientific research. From the 1930's onwards, psychoanalytic theory and practice was considerably influenced by the work of child analysts such as Klein, A. Freud and Winnicott, all of whom published detailed accounts of their work, including their formulations and reflections linked to their observations and experiences in the clinical setting, as these unfolded in each session. Such accounts of the process involved in patient-therapist interactions as those in Klein's *Narrative of a Child Analysis* (1961) provided the explanatory means for tracking theoretical and technical developments in her psychoanalytic clinical work. Indeed, clinical cases

have been central to the development of psychoanalytic ideas and techniques. Rustin states:

> *Since its invention as a new paradigm by Sigmund Freud psychoanalysis has evolved as a productive research programme. Its primary research method has been clinical; its main laboratory has been the consulting room. Its theories and classifications (of developmental patterns, psychic structures, psychopathologies) have continued to develop, as psychoanalysts take account of new clinical evidence. The main purpose of this gathering of knowledge has been to inform clinicians in their practice*.
>
> (Rustin, 2009, p. 36)

3.3 Single case study method

In recent years, the case study is increasingly used as data in formal research, enabling development of opportunities to apply and develop qualitative methods for studying therapeutic process and change. Midgley highlights the growing number of studies that demonstrate single case studies, as legitimate methods for examining causal influences and mechanisms that are serving to 'bridge the gap between research and clinical practice' (Midgley, 2006, p. 126).

The validity of case study research continues to be debated about the reliability of case notes as data. Fonagy (2003) argues that important components of clinical interactions can never be reliably available from self-reporting case notes. Moreover, single case study research is perceived as restricted in objectivity, linked to the phenomenon of holding differing theoretical and technical perspectives on the same material, which is believed to cause the data to have limited reliability and, therefore, is thought to be of little research value. Moreover, Midgley (2006) argues that, even where credibility of single case study findings arise from reliable analysis of basic case study data, there will always remain the problem of 'generalizability', in that the clinical facts of one case may not be representative of other cases, even where similarities exist among them.

Turpin (2001) argues that the 'limited generalizability' (p.105) of the single case study can be overcome through cumulative single case study research, providing opportunity to compare the relevance of previous findings to aspects that can be generalized. Weir-Jeffrey (2011) creatively attempted to address the limitation of the single case study by a comparative analysis of the findings from her doctoral single case study of a severely deprived child, with a selection of single case studies on severely deprived children, from the *Journal of Child Psychotherapy.*

3.4 Process research

The object of study for child psychotherapists is the unconscious inner world of the child, discovered in its unfolding within the transference counter-transference relationship. Interactions between patient and therapist emerge and evolve in spontaneous and unpredictable ways, within the boundaries and consistency of the clinical setting. In practice, these interactions are subject to close observation, intuition and reflection, linked to underlying psychoanalytic concepts that resonate and are described by some as emerging into 'clinical facts' (Tuckett, 1994; Caper, 1994).

Ahumada (1994) states:

> *The emergence of facts in a given clinical setting depends less on the analyst's theories than on his ability to build an intuitional and observational field for his patient and himself, on keeping to his neutrality, on his intuitive and observational capacities, and on whatever counter transference insights he is capable of.*
>
> (Ahumada, 1994, p. 950)

The application of specifically chosen research methods (in the present case study, the use of grounded theory methodology) to a systematic analysis of clinical data enables validation of 'clinical facts'. The case study research method, argue Rice and Greenberg (1984), requires the tapping of therapists' rich clinical experience and knowledge to produce a systematic description of patterns they observed.

Over many decades, qualitative research in psychology and social science has evolved and expanded into a range of methods that overlap and are built upon each other. One reason for this expansion relates to developments in clinical practice – for example, modifications in psychoanalytic technique have been required when working with severely deprived children, who may not be able to make use of interpretation aimed at insight alone.

Discovery of aspects of psychoanalytic treatment that lead to change has required the breaking down of global outcome into a series of smaller, interrelated changes to examine the therapeutic process; that is, how the therapist's interventions and patient's responses contribute to, or explain, these smaller changes. Thus there is an increasing shift from studying outcome to a focus on the process of change.

In the process of identifying my research methodology, I considered Interpretative Phenomenological Analysis (IPA) Reid et al. (2005). This approach has an idiographic focus that stresses the study of the uniqueness in each person, in terms of his or her own organization and not in comparison to others. I thought that this research methodology would be relevant, given that the present study is of a single case. However, I decided against this method as I thought it might restrict learning about processes that could be generalized, to clinical understanding of how psychoanalytic treatment can facilitate developmental progress and recovery in severely deprived looked-after children.

I also considered context analysis and thematic analysis. Context analysis refers to a method of sociological analysis associated with Scheflen (1963), whereby it is assumed that all verbal and non-verbal behaviour has no meaning, other than in the context of a relationship (Kendon, 1990, p.16). However, the methodology used in context analysis is 'trend analysis' which is less suitable to a single case study. Thematic analysis emphasizes pinpointing, examining and recording patterns or themes within data. Although this is the most common form of analysis in qualitative research

Greg (2012), I decided to use a form of grounded theory because, compared to thematic analysis, the methodology is more clearly outlined in the literature. There are, however, areas of overlap between them.

Although I had knowledge of the outcome of treatment, in that the child did make progress, I wanted to find out how this had come about and thought that, by examining what may have facilitated her recovery and developmental progress, I might discover, more precisely and objectively, what facilitated this growth. I decided to study selected sessions from the first year of treatment, in order to capture a baseline of the child's state of mind and of the therapeutic process at the beginning of treatment, from where developments in the child and in the therapeutic dynamics could be tracked.

I wanted to use a methodology that could most usefully be applied to examining what facilitated recovery, reparation and developmental growth in the child.

3.5 Grounded theory methodology

The research method used in this thesis is a modified form of grounded theory, which is a methodology originally conceived by Glaser and Strauss in 1978. It involves the generating of theory in the context of 'discovery' rather than validation. The central method and principles outlined by proponents of Grounded Theory, is that data is examined systematically without a preconceived hypothesis, which forces the researcher to attend closely to what happens in the empirical world being studied. The process is inductive—the data comes first, and then the theory arises from it. The study begins with data collection, followed by data analysis using codes from where concepts, themes and categories emerge. The focus is on unravelling the elements of experience and letting the theory grow out of the process. Identification of emergent themes allows further questions and hypotheses to be generated, as well as conveying the descriptive detail and depth of interactions and relationships.

The aim of grounded theory study is not to validate relationships between concepts nor those developed from empirical data. Instead, the criteria in

grounded theory study include ‘fit’ and ‘relevance’ (Glaser and Strauss, 1967). Fit has to do with how closely concepts fit with the events from the material they are representing and this is related to how thoroughly the constant comparison of events to concepts was done. Relevance deals with the real-life context of participants in their naturalistic setting.

In the empirical world of the psychoanalytic clinical setting, the unfolding of material via free association, play, and the reporting of dreams is closely attended to by the observational mind of the analyst, who draws on a whole range of psychoanalytic thinking, developed over many decades. Like the psychoanalytic attitude in the clinical setting, the researcher using grounded theory maintains an open mind and allows the data to inform the discovery of theory. It is thus a methodology compatible with the key tenets of psychoanalytic theory and practice. Rooted in empirical scientific methodology, another key tenet of grounded theory is the separation of data collection and data analysis.

The method proceeds with the study of data through an initial line-by-line ‘open coding’ from which categories will emerge. This ensures relevance, by generating codes that fit with the area under study. Coding stimulates conceptual ideas recorded as memos and ensures congruence with the data, which then enables the researcher to follow the direction of the emerging categories. Data can be ‘fractured’ in different ways to add to understanding about categories, their properties and inter-relationships. There is a continual progression from data to coding and the material is constantly combed for findings, through a process of ‘constant comparison’ back to initial codes, until all the data is ‘saturated’ and no new conceptual detail can be added. However, saturation may be a matter of degree. New ideas emerging in the sorting process are recorded in new memos (Glaser, 1998). Constant comparison is used to uncover underlying themes, ideas and categories in the material.

For this study, I used a modified form of grounded theory. There are different ways of applying grounded theory methodology. Among others, Bryant and

Charmaz (2007) have written about this, while Bursnall points to the modification of grounded theory methodology as being essentially pragmatic:

> *… every researcher, equipped with the basic premises of grounded theory methodology, goes on to develop their own variation of grounded theory technique, adapted to the context and purposes of the study and the individual's mind-set.*
>
> (Bursnall, 2004, p 81)

I undertook an initial open coding of the material. Particular themes emerged from an initial coding and these related to the child's presentation and responses to the therapist and the therapist's responses to the child. The codes identified were then subjected to a focused coding, from which emerged categories related to reparation, recovery and developmental progress in the child. (See Appendix 1 for an example of a coded session)

3.6 Sources of Data

This study contains three sources of clinical data:

3.6 (a) Primary data - clinical material

The primary data used for this research was gathered retrospectively and consisted of detailed session notes from the first year of an intensive treatment. Initially, 54 fortnightly selected detailed clinical notes were chosen for the study. However, for reasons which are explained in the data selection section, this number was reduced to eight selected sessions.

3.6 (b) Secondary data – supervision notes

Supervision notes were used to provide some degree of triangulation and objective perspective. Supervision comments were added to the coding of the data and used to identify and verify emerging categories. Monthly recordings of network meetings were also examined.

3.6 (c) Tertiary data – reports from external sources

Independent professional assessment reports on the patient's history and cognitive and behavioural functioning, prior to assessment, were used to verify the child's presentation. I also used looked-after child reports from a colleague undertaking parallel parent-work.

3.7 Data Selection and Rationale

I decided to examine the first year of treatment as it was felt that, for a project of this nature, studying five years of treatment would not be manageable. I considered that reparation, recovery and developmental progress may be cumulative and that, by studying her final treatment year, there might be greater evidence of more in-depth developmental progress, compared to that in the first year of treatment.

Initially, I decided to study fortnightly Friday and Monday sessions, as I thought this might enable the tracking of changes in the child's presentation and states of mind while, at the same time, capture any significant features or patterns in the child's reactions to gaps and breaks and whether there were any identifiable changes in her reactions over time.

Within a psychoanalytic frame, breaks in treatment are attended to in recognition of their significant association with absence, loss and separation. The child's experiences of the regular and usually planned absence of the therapist, as a result of gaps between sessions and longer breaks, are deemed to be crucial in the growth of thinking and personality.

However, the study of such a large amount of data, even in the first year, proved unmanageable. I thought it useful, nonetheless, to use an impression I had gained by reading and re-reading all the session notes of the first year, that there were a number of sessions in the first term in which the child presented in extremely turbulent states of mind and, that these seemed to occur at certain

points in the first term. I wanted to investigate the meaning and context for these extreme states of mind in the child and how she recovered from them.

When I examined the timing of these sessions, I discovered that they were associated with specific gaps in treatment. I decided, therefore, to study sessions around breaks. I selected detailed recordings of four paired clinical sessions, in the first year of five years treatment. These were paired in relation to both planned and unplanned breaks.

I thought that, by investigating the beginning phase of treatment through to the end of the first year, I might be able to track and identify changes in the child's presentation and states of mind and how these had come about. In particular I wanted to understand more precisely what facilitated recovery, reparation and developmental growth in the child.

The four paired breaks in the first year of treatment were; (1) First and third treatment sessions, which followed a planned two week gap between assessment and treatment. (2) Sessions before and after an unplanned break in mid-term. (3) Sessions immediately before and after the planned first major break at the end of the first term. (4) Sessions immediately before and after an unplanned break involving the child's move to a children's home towards the end of the first year of treatment.

This study is an analysis of work already undertaken and, therefore, the clinical data stands independent of the research aims**.** The objectivity problem derived from close connection between researcher and material researched is, to some extent, addressed in this study by a number of factors; process notes were written in detail immediately following each session and these were closely read, in supervision, on a weekly basis. As well as using the supervisor's comments to validate my experience of treatment, I included these for coding. The process notes were not written for intended research and, therefore, the data gathered was not influenced by this study. The chosen process notes were also read and discussed by the academic supervisors of

the project and this added to the validity and reliability of the analysis and findings. In addition, a number of colleagues also read and commented on the process notes.

3.8 Triangulation

The problems derived from the case study which are related to intrinsic biases have to some extent been addressed in this study, by combining multiple sources of information on the patient and her states of mind. This method of using multiple sources of information has been described as ‘triangulation’, by Denzin (1970). I used independent reports from other professionals on the patient's history and cognitive and behavioural functioning, prior to assessment.

I also used on-going case conference review reports to assist in triangulating the data. Process notes from monthly network meetings involving all professionals working with the child and family, including the school, were also used, as was the regular case notes written by a colleague undertaking parallel parent-work.

There is always the danger, in this form of research, to grasp at possible theoretic concepts which would explain the phenomena. It was an on-going struggle to prevent premature and theory-led conclusions. This issue is highlighted by Anderson, who suggests that it is 'both difficult and important' to avoid preconceptions and retain an open 'but not empty mind' (Anderson, 2006, p 334).

This project was conducted following qualification and further years of clinical practice, which brought a greater degree of confidence in analyzing the data from a fresh perspective.

3.9 Reflexivity

The root meaning of the word reflexivity is ‘to bend back upon oneself’. In adopting a research mind, reflexivity represents the thoughtful, self-aware analysis of the inter-subjective dynamics between researcher and the researched. The grounded theory researcher maintains an open mind and

allows the data to inform the discovery of theory. In this way, emergent findings are highly representative of natural phenomena, and evolving theories are not forced to fit into preconceived theoretical ideas from the literature.

Though the analytic researcher brings with her prior knowledge and clinical experience, which has stimulated an interest in the particular area of study, the researcher approaches the work without a hypotheses. However, Charmaz (1993) argues that background assumptions and interests sensitize the researcher to look for certain issues and processes in his or her data. For example, background assumptions based on knowledge of the depth and breadth of case study reports on work with severely deprived children, as well as my training and experience, inevitably sensitized me, as researcher, to some of the clinical challenges encountered in working with these children. I knew, for example, that severely deprived children are likely to resort to the use of evacuation as a way of attempting to manage overwhelming feelings. My research interest was in discovering and identifying how this actually took place in the therapeutic process, by investigating the detail of the interaction between therapist and child.

Categories that emerge do not, argues Charmaz, 'leap out at the researcher' as Glaser and Strauss (1967) implied. Rather, she said, the categories reflect the interaction between the observer and observed. Moreover, the particular perspective and discipline from which the researcher approaches his/her studies, acts as a point of reference for developing ideas and specific concepts through the research process, as systematic study of data is undertaken.

I found it necessary to steep myself in every detail of the chosen material, which I read and re-read as new concepts emerged. I found that writing memos, revisiting questions about the data, consulting the literature, re-writing and revising the draft, did not occur in a systematic, linear sequence. Insights at later stages propelled me back to the data for a fresh look. Though this process was exciting and creative, it also required of me and my supervisors, patience and

tolerance for ambiguity. Discussion with supervisors and colleagues was essential to the process of examining and re-examining the material, during an intense period of organising and re-organising the material as themes and categories emerged. Thus, the experience of disorientation and confusion, intrinsic to the reflexive approach in grounded theory studies, is an inevitable part of the process of commitment to discovery and identification of new categories, which eventually bring order and meaning to complex human interactions.

Process research provides the means to investigate the underlying mechanisms of change, through exploration of key psychoanalytic concepts and practice. This can lead to improved psychological outcomes for clinical services, by finding out what works for whom. It was hoped that the findings from this study could be generalised to assist those working therapeutically with severely deprived children.

Chapter 4 - Data Analysis and Findings

In this Chapter, I present findings from the analysis of the clinical data, which constitutes the main body of evidence for recovery, reparation and developmental progress in the child over the course of the first year of psychoanalytic treatment.

The following section provides a contextual description of the child's circumstances and reasons for referral.

4.2 Introduction to the Clinical Case

4.2 (a) Referral

Lucy, at 7 years, was referred for psychotherapy by the local Social Services team responsible for looked-after children. The child had received some months of cognitive behavioural therapy prior to being referred for psychotherapy. It was reported that she found it difficult to engage in a structured approach and it was thought that a psychoanalytic approach, which attended to what appeared deeper-rooted anxieties, might help contain her more.

Lucy was described as demanding of one-to-one attention at home, at all times, from her aunt. She frequently erupted into rage when her aunt gave attention to any of the other children. This was particularly acute when Lucy's aunt attended to her own daughter, Lucy's cousin, who is the same age as Lucy. Lucy's aunt and uncle were increasingly despairing of their capacity to continue to care for her and, at the same time, deeply upset that she might require admission to non-relation care. Their upset was exacerbated by the fact that, given the extent of her violent and disruptive behaviour, both inside and outside the home, Social Services were considering a specialist therapeutic placement located a long distance away from the kinship home.

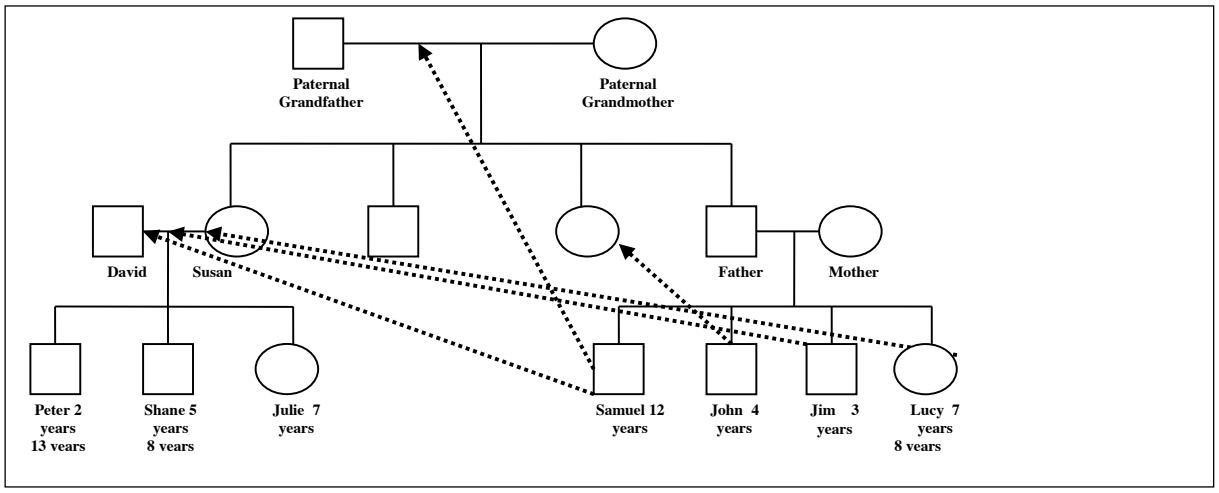
Following a period of assessment, Lucy commenced thrice-weekly psychotherapy at the start of the academic year in September. Because of the extent of her difficult behaviours, she missed out on a significant part of her

education and the decision by the Educational Board was that she should repeat Year 4. Lucy was 8 years old when she commenced treatment lasting 5 years, until she was aged 13 years.

4.2 (b) Note about the therapist

At the time of the referral, I worried about my own capacity to offer Lucy psychotherapy treatment, given her high levels of disturbance and my inexperience as a trainee. I also worried whether she was able to use psychotherapy. However, this was my third intensive case working with severely deprived children, one of whom was very disturbed and had been violent in the early part of treatment. I felt that, along with current on-going supervision, I could also rely on internalized previous supervision experiences which taught me ways of reaching severely deprived and disturbed children.

Genogram[2]



4.3 Family background

Lucy is the youngest in a family of three older brothers. Her mother suffered

[1] Names and some personal details of my patient have been changed to preserve anonymity.
[2] The ages given of the children are at referral

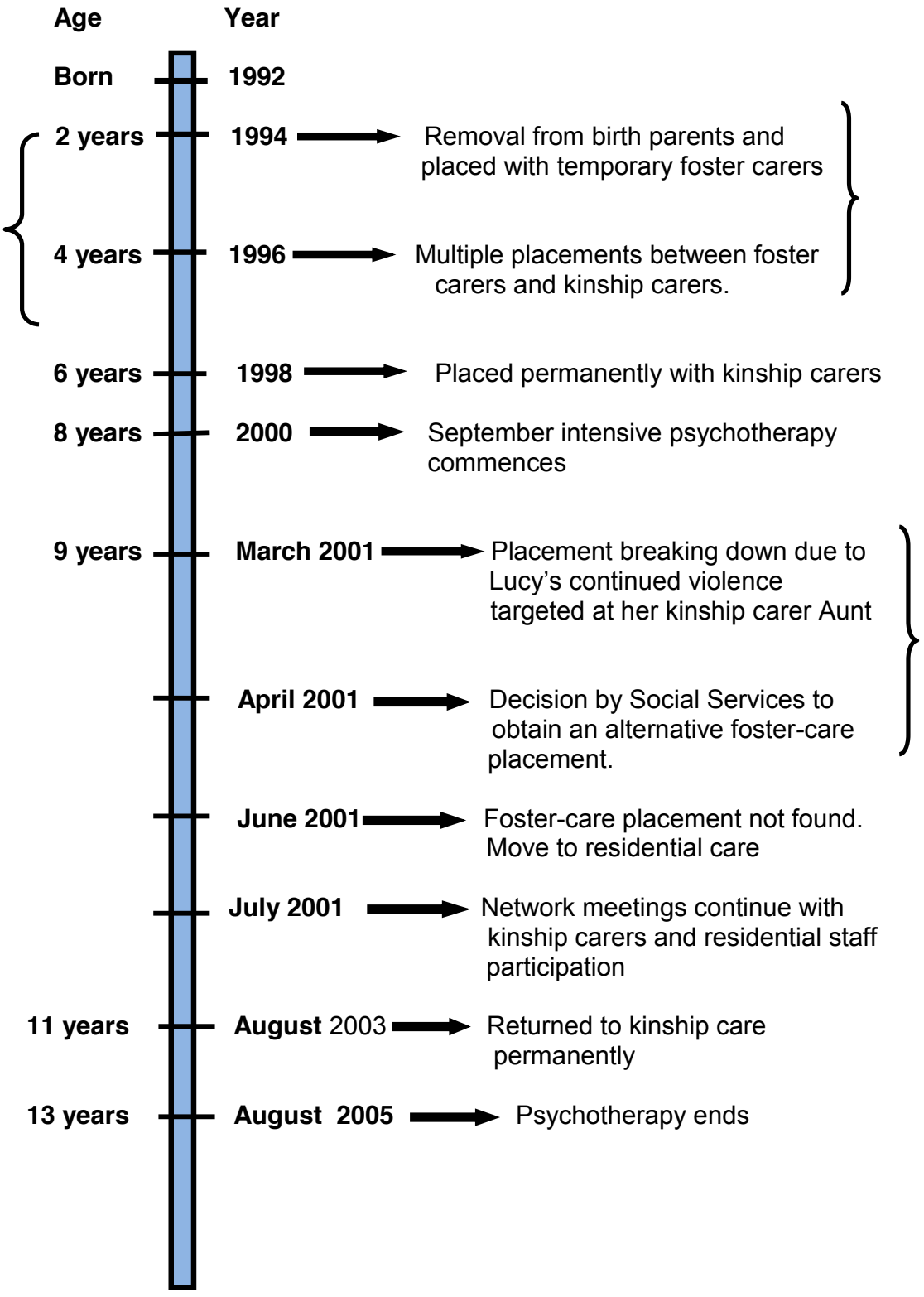
severe depression and was frequently admitted to psychiatric hospital throughout Lucy's early life. Lucy's father also suffered mental health problems. Both parents struggled to parent their children and shared care arrangements were put in place when Lucy was an infant. These involved the use of various foster care and kinship care placements, which became more frequent when the mental health of both parents increasingly deteriorated.

Following on-going neglect, Lucy and her three brothers were eventually taken into full-time care when Lucy was 3 years old. Lucy and two of her brothers were placed in the full-time care of her paternal aunt and uncle who had three children of their own, one of whom was the same age as Lucy and two were younger. The eldest sibling was placed with paternal grandparents. Following the children being received into care, Lucy's parents separated. Contact between Lucy and her mother was severed due to the detrimental effect upon Lucy, of her mother's uncontained emotional states of distress during contact. Lucy was frequently observed to sit in a frozen state, in response to her mother's persistent expressed wails of anguish. Lucy's father was prevented from seeing her when it was discovered that, during periods of overnight contact, he willfully failed to manage both his own and Lucy's diabetic condition. As a result, both father and daughter suffered frequent hypoglycemia and were regularly hospitalized.

When Lucy was 7 years old, she disclosed to her aunt that her brother, who was 5 years older and living with the same aunt, had been sexually abusing her for a number of years. He denied the on-going assault and was subsequently removed from the care of his aunt and placed with his grandparents, who did not believe that the sexual abuse had happened. This disbelief created a divide between Lucy's aunt and grandparents and contact between them was strained and infrequent. Social Services took the decision to prevent contact between Lucy and her brother. Lucy's difficult behaviour, prior to disclosure, was reported to have intensified following her brother's move. She became increasingly violent, both in the home mainly towards her aunt and cousin and in the school setting, where she regularly lashed out at staff and children. Lucy's teachers

were increasingly worried about whether they could continue to hold her in mainstream school.

Timeline of significant points in Lucy's relational history and external events across the treatment period: 1996-8



As can been seen from the timeline, during the course of the first year of treatment the significant external event of the kinship placement breaking down was due to the child's intensity of violence against her aunt. Initially, a foster placement was sought for the child but, because of the extent of her violence, a suitable placement could not be found and the child moved to a children's home for the duration of two years. This was a very difficult time for the child's kinship family.

The emotional strain on the family, of Lucy's violence, was exacerbated by the perplexing contradiction between the child's increasingly contained state of mind within school and in the therapeutic context, and her violence towards her aunt. The child's aunt blamed herself for the child's violence towards her, even though there were no obvious reasons for the child's continued aggression.

Because Lucy's aunt felt intensely guilty for Lucy's continued violence, she withdrew from network meetings following the child's move to residential care, believing that she had been a 'failure' to Lucy. However, members of the network managed to persuade her to continue to attend monthly process meetings for the two years duration of the child's placement in residential care. Initially, the child's aunt expressed discomfort in her first encounters with residential staff attending network meetings. However, the sense of there being an established shared commitment in trying to understand the complexity of the child's contradictory presentations helped to contain the aunt's tendency to feel guilt and shame about her niece’s violence towards her.

Residential staff felt empathy with the child's aunt as, after the 'honeymoon' period of the child settling in to residential care, they too were subject to the child's violence for a few months in her placement. However, her violence did subside and as a network, we wondered whether the child's violence towards her aunt derived from the child's unconscious experience of her aunt as a bad maternal object. This is a theme which will be explored in more detail in the next Chapter.

4.4 Data analysis and preliminary findings

I approached this study with the knowledge that the child expressed turmoil at the beginning phase of treatment. I also knew that there was a positive treatment outcome, in that the child did make progress. However, I wanted to investigate the evidence for this progress and to explore what facilitated reparation, recovery and developmental progress in the child.

From a preliminary first reading of all the clinical sessions in the first year, I noted that there were two sessions in the first term which stood out, in relation to the child's presentation of extreme turmoil. I then noted that these sessions occurred, in the first instance, following a gap between assessment and treatment and, in the second instance, following an unplanned cancellation of a session at mid-term. I wanted to study, in detail, the child's turbulent state of mind in these sessions and what facilitated shifts in her state as it seemed, from reading the material, that the child was in a calmer state of mind by the end of each session.

I was also curious to investigate the possible meaning in the stark contrast between her seemingly stable presentation over a three-week period of once weekly assessment and her tumultuous presentation in the first treatment session, two weeks later. Moreover, following the turbulence of the first treatment session, the child seemed to settle into therapy without further extreme expression of turmoil, until I unexpectedly had to cancel a session mid-way through the term, due to illness. Her reaction following this cancelled session was reminiscent of her turbulent state in the first treatment session.

The preliminary findings of the child's turbulent presentation in two sessions in the first term, which, as mentioned, immediately followed planned and unplanned breaks respectively, informed the decision to investigate evidence for what facilitated repair, recovery and developmental progress in the child, in the context of planned and unplanned breaks. Eight sessions across the first year of treatment were paired in relation to their occurrences before and after planned

and unplanned breaks. The first of these - the first and last session of the first week of treatment - were chosen to provide a baseline understanding of the child's state of mind, behaviour and interaction with the therapist at the beginning of treatment. The second paired sessions chosen for the study were the two consecutive sessions following the unplanned cancellation of Session 20, which occurred mid-way through the first term of the first year of treatment.

When I was thinking about how to select sessions to study what facilitated repair, recovery and developmental progress in the child and, while reading through each session in the first term, I recalled that the child's entry into Session 21, which followed the unplanned cancellation of Session 20, was similar to the turbulent state with which she presented in the first treatment session, but this time it seemed even more extreme. My sense of shock and feelings of being overwhelmed in this session were also resonant with the first treatment session. Moreover, there was a striking similarity in the child's relatively stable state of mind during the three-week assessment period and between Session 2 and Session 19. I also noted, as in the first session, that the child was calmer by the end of session twenty one and I wanted to investigate the evidence for what had facilitated this shift.

As well as studying the session following the unplanned cancelled session, I thought it important to study Session 22, which immediately followed the tumultuous Session 21. I wanted to examine whether aspects of her turmoil persisted into the next session and how she may have reacted, in the aftermath of the turmoil she had experienced and expressed in the previous session. Given that her extreme turmoil in Sessions 1 and 21, seemed to coincide with a planned and an unplanned break, respectively, I thought it important to try and examine in detail, her experience of breaks (both planned and unplanned) over the course of the first year of treatment. I noted, from a preliminary reading of the sessions, that the child did not seem to have any further extreme reactions to breaks, both planned and unplanned. I wanted to investigate what it may have been, in relation to breaks in the first term, which seemed to have had an

emotionally catastrophic effect on the child and what might have facilitated her capacity to manage further planned and unplanned breaks over the course of the year.

Therefore, two further sets of sessions were paired in relation to a planned and unplanned break respectively. The first of these, Sessions 45 and 46, were paired in relation to the first major two-week planned break at Christmas. From my preliminary reading of the recorded sessions, the child did not seem to react with any overt turmoil to the Christmas break.

The second set, Sessions 99 and 105, were paired in relation to their occurrence before and after an abrupt and unplanned break, towards the end of the first year of treatment. This break had abruptly been decided by Social Services, on the basis of the belief that the child needed a break from therapy to enable a 'settling in' period, following her move to a children's home. A preliminary read of these sessions indicated that the child did not seem to react to this significant two-week unplanned and abrupt break, in the overt catastrophic way that she had reacted following an unplanned cancelled session midway through the first term. This was all the more striking as this break was of two weeks duration, compared to the abrupt cancellation of one session that had occurred mid-way through the first treatment term.

4.5 Summary of rationale for data selection

There are, perhaps, numerous ways in which an investigation could have been approached into what facilitated repair, recovery and developmental progress in a severely deprived child in psychoanalytic treatment. The decision to study what might have facilitated this, in relation to planned and unplanned breaks, was derived from noticing, from a preliminary read of the material, what appeared to be the child's striking reactions in two sessions in the first term, which seemed associated with gaps in treatment. I considered that this focus on paired sessions may leave out other important features that could arise from studying randomly

selected material. However, the broad research question about what facilitated repair, recovery and developmental growth in the child requires the focus of study to be on the fine-grained detail of the child's shifting states of mind, in conjunction with examining her interaction with, and response to, the therapist. This means that, while it is interesting to study the child's reaction to breaks, particularly as these were striking in some incidences, this study is not merely about the child's reaction to breaks, but about how repair, recovery and developmental progress might have occurred in the child, in the context of psychoanalytic treatment over the course of the first year.

4.6 How the data was analysed

For the purpose of ease of presentation and discussion of Data Analysis and Findings, I refer to Sessions as 'Data Sets'. In this section, I outline, in detail, the analysis of Session 1, Data Set 1. The categories emerging in this Data Set provided the baseline evidence for the child's state of mind at the beginning of treatment. This enabled an examination of comparative evidence from all the Data Sets for recovery, reparation and developmental progress in the child as treatment progressed.

4.6 (a) Initial open coding - Data set 1

Following the preliminary findings and selection of data sets, I looked for codes which related to the child's state of mind. I also examined the material for codes related to the therapist's experiences and responses to the child. While it is difficult to evidence any internally driven capacities in the child that could explain the shifts in her states of mind, I thought that the detail of the child's responses to the therapist's interventions might provide some evidence for what may have facilitated the child’s shift from her tumultuous state of mind in Data Set 1. I therefore examined the therapist's activities and interventions, in conjunction with the child's responses and reactions.

4.6 (a) i Codes related to the child's states of mind in Data Set 1

When I began the initial coding of the first selected session, which was the first treatment session, I remembered how overwhelming the child's tumultuous and violent reaction to the therapist was. I wondered how it happened that, by the end of the first session, the child was much calmer and, indeed, appeared to engage in conversation with the therapist; this was in stark contrast to her turbulent presentation at the beginning of the session. The following initial codes related to the child were extracted:*

> *violence, turmoil, terror, screaming, thrashing, self-protection, pulling away, throwing, scattering, falling apart, rejecting, emptying, safety, danger, caring, knowing, not-knowing, suspicious, questioning, curiosity, understanding, gathering, calm.*

Some of these codes related to the child's concrete expression of her tumultuous emotional state, such as her violent throwing of items from her box around the room and at the therapist, as well as pulling dangerously on the wire. Other concrete expressions of turmoil included screaming, pulling away from the therapist and emptying her box. The child's symbolic expression of a more stable state of mind towards the end of the session included physically caring for the baby dolls and gathering up items that she had earlier thrown around the room.

Some of the codes, which relate to the child's emotional state, include certain aspects identified at the time in supervision. Thus, it was recorded that the therapist thought the child was in a state of rage. However, through supervision and reflection on the material, the therapist realised that the child was terrified and that her behaviours suggested that she was in a state of turmoil. The code, *falling apart*, is identified as a global state of mind in the child.

The child's terror seemed evident in activities linked to self-protection, such as

*See Appendix 1 for all 8 coded sessions.

pulling away from the therapist. The story she told about the *'bad baby sitter'* indicated *suspicion* about the therapist and whether she, the child, was being left with a '*bad sitter'*. This linked to what appeared to be the child's suspicion about whether the therapist could be trusted as a benign figure. This is indicated in her questions about whether the therapist had any children and who looked after them. In relation to a more benign state in the child linked to curiosity, this seemed to be expressed in her communication of *knowing* what babies needed, as well as being *caring* towards babies, as when she was physically caring for the baby dolls.

I found that I could group the initial codes into the following conceptual dual themes, which captured the child's conflicting and shifting states of mind in Data Set 1:

turmoil/terror/calmness
throwing/playing
emptying/gathering
safety/danger
curiosity/suspicion
caring/rejecting
knowing/not knowing

From these themes, categories developed in relation to the child's states of mind. These are represented in Table 1, page 67.

Table 1 - Categories from Data Set 1

Child's states of mind
Fragmentation throwing, screaming, violence, emptying, terror, turmoil
Protective/Defensive pulling away from therapist placing chair in front of herself. suspicious of the therapist. **Interestedness/Relatedness** curious about babies and how they communicate and what they need. curious about therapist's qualities of knowing. **Symbolic Play** feeding and nursing the baby doll.

In order to make sense of the shifts in the child's state of mind from turmoil to curiosity and relative calmness by the end of Data Set 1, it was important to examine these shifts in the context of the child's responses to the nature and quality of the therapist's responses to the child. Codes, related to the therapist's experience and responses to the child, were then identified.

4.6 (a) ii Codes related to the Therapist's experience and activities in Data Set 1

The following codes which relate to the therapist's activities and responses to the child were extracted from Data Set 1:

> *worry*, *hopelessness, helplessness, reflecting, concrete soothing, naming, narrating and gathering, boundary-giving, making sense of the child's anxiety, linking the child's thoughts, feelings and actions to anxiety and defences against anxiety.*

The codes, *worry, hopelessness* and *helplessness,* represent the therapist's sense of being overwhelmed by the child's turmoil. The code *'concrete soothing'* relates to the therapist's attempt to soothe the child's state of turmoil by stroking her back. This seems to have a calming effect on the child. The *naming* code represents the therapist's spontaneous attempt to engage the child in a form of play, with the intention of calming her, when she is throwing items from her box around the room. This seems to have a soothing effect on the child.

As well as naming the items the child throws around the room, the therapist later gathers the same items, which appears to also represent an emotional gathering. When the child seems in a calmer state of mind, the therapist is noted to actively make sense of the child's presentation of anxious states, by linking the child's thoughts, feelings and actions to worries and concerns the child conveys in her anxious questioning of the therapist. The therapist also concretely protects the child from harm by stopping her pulling dangerously on the wire.

The main themes emerging from the coding of the therapist's experience

and activities in Data Set 1 are:

> *boundary-giving, soothing, emotional responsiveness, gathering* and *linking*.

Categories identified from the main themes in relation to the therapist's experiences and activities in Data Set 1, were found to correspond with familiar psychoanalytic technique and practice. These are:

- Counter transference
- Thinking/Mentalising
- Interpretation

The therapist's experience and activities are represented in Table 2, page 70.

Table 2 Categories from Data Set 1

Therapist's experience and activities

Countertransference

- anxiety about child's violence.
- worry about the depth of the child's turmoil.
- helpless to calm the child at first.
- hopeless that the child can be contained.
- intrigued by child's curiosity.
- relieved when the child is calm.
- emotionally moved by child's insight into what babies need.

Thinking/mentalising

- thinking about how the child experiences the therapist as a bad presence.
- thinking about the child's experience of the gap between assessment and treatment as catastrophic.
- first hand experience of reports of the child's violence and turmoil in the external world – home and school.

Interpretation

- giving meaning to the child's behaviour and experiences
- giving the child an experience of the therapist's receptivity to the child's fears and suspicion of the therapist

4.6 (b) Coding of Data Sets 2-8

The coding of Data Sets 2 to 8 proceeded in the same way as for Data Set 1, from an initial coding, followed by focused coding. The codes and themes, which emerged in these Data Sets, were found to be relevant to categories identified in Data Set 1 and subsequently placed within each relevant category. Two additional codes, *trips to the toilet* and *eating,* were identified in Data Sets 2-7 and these were placed in the category *Protective/ Defensive.* The category, *symbolic play,* which emerged in Data Set 1, was found to incrementally increase in intensity, from Data Set 2 to Data Set 8. The nature of the child's symbolic play in Data Set 2 was found to shift by Data Set 4, to the child's exclusive involvement of the therapist in intensive play. The thematic play activities with the therapist shifted as treatment progressed. In the early phase of play, especially in the first and second terms, the following themes in the child's play were identified:

- nurturing/cruel games, involving mother and baby.
- sadistic games involving doctor and patient and teacher and pupil.
- version of hide and seek in which the child doesn't allow the therapist to find her.

Themes identified in the child's play activities with the therapist towards the end of the first year of treatment, involved a shift from the child's preoccupation with cruel games, in which she was often tyrannical towards the therapist and in which the therapist was made to suffer, to the child's symbolic play being more benign in relation to representing self and object. For example, by Data Set 8, the child uses the therapist in symbolic play as a 'nurturing' mother.

Another finding was the qualitative shift in relation to the nature of the child's fragmentary state of mind, following a planned Christmas break at the end of the first term, in Data Set 6. Her fragmentary state of mind, on return from the break, appeared to manifest more in confusion and disorientation

than in terror and turmoil. Thus, fragmentation seemed expressed in the child's uncertainty about where the consulting room was and whether she had come back on the right date. This is in contrast to the extreme turmoil she expressed in Data Set 1, following the two-week gap between assessment and treatment and, similarly, in Data Set 3, which occurred following an unplanned and abrupt cancellation of the session. This had occurred immediately prior to Data Set 3. Before and after the planned Christmas break in Data Sets 5 and 6, a sub-category, *overcoming,* within the category 'Interpretation' is identified. This relates to the therapist's emphasis on the child managing the break and on her attempts to overcome her difficult emotional experiences during the break.

The fragmentary state of confusion and disorientation evident in Data Set 6, was further identified in Data Set 7. This session occurred, prior to an unplanned and abrupt break instigated by Social Services, at a time when the placement was breaking down. In Data Set 7, *fragmentation* manifests as '*slurred and mumbled speech'*. The child was not consciously aware by this stage that she was moving from her kinship placement to the children's home. In Data Set 8, which followed two weeks unplanned break directed by Social Services, there is no manifest fragmentation. This is indicated in the child's capacity to directly communicate her thoughts, feelings and experiences and engage in symbolic play, which had the quality of healthy self-representation, rather than sadism and tyranny. This shift appears to indicate that some repair, reparation and developmental progress had occurred. Detailed evidence for what might have facilitated this progress in the child is given in a later section on Findings.

The finding that the child's shifting states of mind seemed linked to aspects of the therapist's responses to the child, led to further examination of the interaction between therapist and child. It was found that the therapist's responses to the child seemed to feature variation. While my psychoanalytic training sensitized me to the use of certain clinical tools, such as counter-transference and interpretation, I found that not all the therapist's interpretative responses to the child contained what may be referred to as the tool of classical interpretation, which is to interpret

defences in order to uncover and resolve anxiety and inner conflict. This led to further examination of the nature of the therapist's responses to the child.

It was found that the therapist's interpretative activity seemed linked to the therapist's consideration of what the child could tolerate, given her fragmented and turbulent state of mind, which likely originated in grave deficits in self and object, as a result of severe deprivation. However, this link was not explicitly referred to by the therapist within the recording of the material. It emerged in this study, from an analysis of the specific nature, context and frequency of different types of interpretations given.

An examination of the qualitative nature of interpretations used by the therapist brought to mind Steiner's distinction between analyst-centred and patient-centred interpretations (Steiner 1993). Steiner distinguishes between these two types of interpretation in addressing the technical problem, where the patient is defended against or not able to use, an approach from the analyst that helps him understand himself but, at the same time, wants and needs to be understood.

He helpfully elaborates upon the patient's wish to be understood as being either consciously experienced or unconsciously communicated. It is imperative, Steiner argues, that the therapist, in such cases, is able to *'recognize and cope with what the patient has projected and with his own counter-transference reactions to it'* (Steiner, 1993 p 132). Steiner suggests that, instead of containment being made possible by the analyst retaining the projected elements from the patient, interpretations which focus on the mind of the patient, i.e. 'patient-centred interpretations', are likely to be experienced by the patient in circumstances where understanding of his own mind is defended against, as 'pushing the projected elements back into him'. (Steiner, 1993 p 133).

However, I found that not all the therapist's interpretations fitted into these two forms of interpretation. The discovery that the therapist used different forms of interpretation at different times, led to further examination of the interaction

between therapist and child. It was found that narrative interpretation was more prevalent in the therapist's responses to the child and this was particularly evident in relation to the therapist's involvement and responses to the child's symbolic play. In order to highlight and distinguish between the different forms of interpretation within the commentary and data, I inserted the numbers (1) (2) (3) beside each identified form of interpretation and colour-coded these as follows:*

(1) denotes analyst-centred interpretations.
(2) denotes patient-centred interpretations.
(3) denotes narrative interpretations.

The numbers corresponding with the identified interpretation were inserted into the data to clearly differentiate one form of interpretation from another*. I thought that the number and colour-coded system would help to identify the presence of different qualities in the therapist's interpretative responses to the child, so that these could be further analysed in relation to their aim and meaning, in the context of the child's states of mind.

The function and meaning of the use of different forms of interpretation will be explored in the next section, using illustrative clinical material from the sessions studied.

It was found that the degree of repair, recovery and developmental progress evidenced in the data did not occur in all areas of her life, as would be expected from the progress she made in treatment. Indeed, at the same time as the child made progress in treatment, her state of mind deteriorated at home and this necessitated her move to a children's home, toward the end of the first year of treatment. This was due to the escalation of her turmoil and violence in her kinship care placement, particularly towards her aunt. The containment provided in the well-attended monthly network meetings throughout the year did not seem

* See Appendix 1 for colour-coded examples of different forms of interpretation.

to contain this escalation of violence. This is discussed in the findings section, with reference to literature in this area.

Table 3 displays occurring incidences of clinical material over the course of the first year of treatment. These are represented by the emergent categories:

> **Child's States of Mind:** Fragmentation, Protective/Defensive, Interestingness/Relatedness
>
> **Therapist's Activities:** Analyst-Centred Interpretations, Patient-Centred interpretations, Narrative Interpretations, Elaborating Interpretations, Overcoming Interpretations.
>
> **Play Activities with the Therapist:**

In relation to therapist's activities, I included in the table only the therapist's interpretative activity, as I thought that the therapist's counter-transference, thinking and mentalizing, as well as containment, could be represented as subsumed under each sub-category of Interpretation, given that each interpretation contains counter-transference, thinking and mentalizing experiences and that the aim of containment is also embedded in interpretative activity. Evidence for each category in the clinical material, derived from the data analysis, will be illustrated in the Findings Chapter.

I inserted an additional column to the table, calibrating the incidences of the child's violence towards her aunt. The numbers of these incidences were taken from Social Services case conference and review reports, corroborated by reports from the child's aunt in network meetings and in the parent-work reports. The inclusion in the table of the child's violent incidences towards her aunt enabled visual highlighting of the contrast of escalating violence with the occurring categories. The contrast between the other occurring categories, for instance 'defensive/protective' and 'play activities with the therapist', is particularly stark in comparison to the child's escalating violence towards her aunt. Up until Data Set 3 there were 28 reported incidences of the child's

violence against her aunt. By Data Set 5 there were 63 and, immediately before the child was moved to residential care, (Data Set 7) the total occurrences of violence against her aunt since treatment began, was estimated at 208. These incidences included the child's attempts to tear off her aunt's clothes.

Table 3

Occurring categories over a 12 months period of psychoanalytic treatment.

	Child's state of mind - Fragmentation.	Child's state of mind - Protective/Defensive.	Child's state of mind - Interestedness/Relatedness.	Therapist's activities - Analyst-centred interpretations.	Therapist's activities -Patient-centred interpretations.	Therapist's activities - Narrative interpretations.	Therapist's activities - Overcoming interpretations.	Play activities	Play activities with the therapist.	Child's violent acts in kinship care.
Data Set 1 Session 1	8	4	4	3	7	3	0	4	0	
Data Set 2 Session 3	2	16	3	2	7	7	0	4	0	
Data Set 3 Session 21	12	6	2	0	1	3	0	7	0	28
Data Set 4 Session 22	1	5	2	1	3	5	0	9	1	
Data Set 5 Session 45	2	3	1	2	4	9	2	21	21	63
Data Set 6 Session 46	1	17	7	4	4	13	1	31	30	
Data Set 7 Session 99	1	15	5	7	1	3	0	11	11	208
Data Set 8 Session 105	0	5	4	1	9	5	1	20	20	0

There are a number of notable patterns highlighted in the table. First and most strikingly, as mentioned, is the increase in the child's violent acts towards her aunt. As can be seen, by the time of Data Set 8, when the child had been in residential care for two weeks, these violent acts towards her aunt diminished. This was the case even though the child had contact with her aunt during this time. However, after the first two-week period in residential care, the child became violent on occasion; this reduced to zero after three months. This reduction may be linked to the child's greater capacity to tolerate a less intensive experience in a residential care setting, compared to the intimate demands of family life. I will discuss this in more detail in the Findings section, with reference to findings from the Literature.

Another notable pattern is in relation to Fragmentation. Data Sets 1 and 3, under the category 'Fragmentation', contain the highest number of occurrences (for example screaming and throwing) related to the child's fragmentation, which contrasts with Data Set 8, Session 105, in which there are zero occurrences of fragmentation. An increased number of fragmentation occurrences are found in Data Set 3, compared to Data Set 1 and this may be linked to the possibility that the unplanned cancelled session may have had an even greater impact, given the intensity of her growing attachment to the therapist and the therapeutic setting. It is an important finding of the paradox that the child was able to make progress within a one-to-one therapeutic relationship and, at the same time, was finding the intimacy of family life increasingly intolerable. However, as outlined, the child's tolerance of the therapeutic relationship was found to be linked to the therapist's considerable technical adjustments to psychoanalytic technique, which involved 1) facilitation of the child's use of play as displacement and, at certain times, 2) greater analyst-centred and narrative-type interpretations.

Another interesting pattern is in the category Protective/Defensive, whereby clinical occurrences were notably higher in Data Sets 2, 6 and 7, compared to other Data Sets. The possible reason for this in Data Set 2 may be related to the child's experience of containment in Data Set 1, whereby the child in Data Set 2,

was able to make use of more protective/defensive means of communicating her distress. However, this does not explain why there wasn't a similar increase following Data Set 3, when the child's fragmentation was most extreme. Compared to 16 occurrences in Data Set 2, there are only 5 in Data Set 4. This may be linked to an increase, at this stage, of the child's capacity for symbolic play, which perhaps provided a form of containment through displacement.

The reasons for higher protective/defensive occurrences in Data Set 6, compared to others data sets, seem to relate to the child's more evolved defensive means of managing the two-week break at Christmas, compared to her previous dissolution into an extreme, fragmented state in Data Sets 1 and 3. In relation to the comparatively high proportion of defensive and protective occurrences in Data Set 7, this seems related to the child's greater capacity for a more evolved protective/defensive state of mind in managing the breakdown of her placement at this time.

In conjunction with the higher protective/defensive occurrences in Data Set 6, the highest occurrence of narrative interpretations and play activities with the therapist also occurs in Data Set 6. This may be linked to the child's increasing capacity to use symbolic play as possible 'displacement' (Hurry 1988) in the service of development in self and object.

A striking increase from Data Set 3 is noteable from the table in the number of patient-centred interpretation occurrences by Data Set 8 i.e. 9. Although there is a similar number of patient-centred interpretation occurrences, i.e. 7 in Data Sets 1 and 2, there is a significant drop in Data Set 3 to the occurrence of 1. In Data Set 4 there are 3 patient-centred interpretation occurrences, while Data Sets 5 and 6 have 4 occurrences. The comparison between Data Sets 1 and 2 and Data Set 8 seems related to different processes. Thus in Data Sets 1 and 2, it appears that the therapist used patient-centred interpretations as a traditional tool in helping the child gain understanding into her own mind. However, it is evident from the findings that this interpretative tool did not match the child's capacity to

primarily use this form of interpretation at this early phase in treatment. This appears to be due to the deficits in self and object as a result of her severe deprivation. Therefore the increase in the use of patient-centred interpretations by Data Set 8, seems to reflect the child's greater capacity to use this form of interpretation and this appears linked to developmental progress in the child.

4.7 Data Analysis of network meetings

Network meetings were an important support to treatment. In this section, I give a detailed summary of the thematic context of discussions which took place in the monthly network meetings and identify core themes from this material.

Network meetings initially comprised of Lucy's aunt and uncle, their link foster-care social worker, field social worker, senior social worker, classroom assistant, schoolteacher, headmaster, parent worker and me.

In the first term, we struggled to make sense of the contrast between Lucy's improvement in presentation and behaviour in school and her continued targeting of her aunt with violence, hostility and rejection on the one hand and, on the other, clinging desperately to her. At the meetings, we thought about how Lucy and her aunt seemed locked into a complex dynamic and wondered how to understand this. We thought about Aunt's limited time and energy, which may have reduced her capacity to give Lucy the attention she needed and wondered whether this had compounded Lucy's associated experiences of severe deprivation. The network team also considered whether these possible associations were linked to how Lucy may have experienced her aunt not knowing that she was being sexually abused while in her care. Perhaps, in Lucy's mind, her aunt being oblivious to Lucy's brother's sexual abuse of her was evidence that her aunt, like her mother, was so preoccupied that she did not care.

Lucy's aunt thought that the demands on her time and attention as a mother of three and, in addition, a carer for her niece and nephew, placed limits on her

capacity to meet Lucy's emotional needs resulting in an escalation of Lucy's desperation, which was increasingly expressed through aggressive and violent outbursts. Lucy's aunt was also consumed with guilt that the abuse of Lucy by her older brother had occurred in her home without her knowledge. It was acknowledged by Lucy's aunt that her guilt feelings may, in themselves, have caused her to unwittingly turn away from Lucy.

As a group, we were intrigued and bewildered by the sense in which Lucy seemed locked into an intensely negative reaction to her aunt. We wondered if Lucy confused her aunt in her mind with the depriving and un-protective mother, which seemed to make sense to all in the network as compounded by the sexual abuse Lucy suffered from her older brother, when both were in the care of her aunt.

As a network, we felt that releasing Lucy and her aunt via an alternative placement from what had become a dangerously destructive repetitive cycle of intense distress and violence, might assist Lucy relate more to her aunt as an aunt, rather than as a possible receptacle for negative maternal transference. This form of thinking helped Lucy's aunt feel less guilty and persecuted by Lucy's violence and, indeed, ultimately assisted her to retain her place in network meetings for the duration of Lucy's treatment, including during Lucy's return from residential care to her aunt's care, two years after being placed there and three years from the commencement of treatment.

When Lucy was transferred to residential care, her aunt wanted to withdraw from network meetings, as she feared judgment from others for perceived failure to hold on to Lucy. However, the network group had, by the time Lucy was received into residential care, established itself as a strong support to Lucy's kinship carers and to the treatment itself. Thus, far from judgment, Lucy's aunt experienced the group as empathic, supportive and committed to understanding the splits in Lucy's mind. This 'thinking' attitude in the network enabled Lucy's aunt to overcome her fear of judgment and, indeed, resolve her tendency to judge herself. She remained an active and valued member of network meetings

throughout Lucy's placement in residential care. Key staff from the residential home joined the monthly network meetings and their presence reinforced the sense in which there was a collective commitment to both trying to understand the inner world of Lucy and to supporting the treatment itself.

When Lucy was successfully and permanently returned to her aunt's care, after two years in residential care, Lucy's aunt wrote a letter to the therapist, in which she expressed her immense gratitude for the support and encouragement she had received to stay with the network meeting process and conveyed her pleasure in Lucy and her rediscovering each other as aunt and niece.

The outcome of regular discussion among members was the development of a shared understanding and acceptance of the need for Lucy to move to a children's home. However, I was left with unanswered questions about how to understand the stark contrast between Lucy's increasingly stable presentation in school and in treatment, compared to her continued and even escalating violence at home, particularly towards her aunt. Indeed, it is expected that progress in psychoanalytic treatment usually results in greater cohesion of self- object representations. In Lucy's case, progress was not evident in all areas of her life and I wanted to explore possible reasons for this.

The main themes identified from an analysis of network meetings in the first year of treatment include:

1. Child's self-deprivation.
2. Child's violence - specifically against Aunt.
3. Child's functioning developmentally at a much younger age.
4. Child's move to a children's home.

The core category identified from these themes is:

- The child's fragmented state of mind in kinship care.

4.8 Concluding reflections on the methodology and data analysis.

Before going on to the next section, I will address some of the questions related to the grounded theory and what is understood as evidence in relation to this method.

I approached the data with the knowledge that the child made progress. I knew that, at certain times in the first term of treatment, the child's behaviour was extremely turbulent in sessions and that this shifted in the treatment over the course of the first term. I wanted to investigate evidence for the nature of this shift, in the context of the therapeutic process. I thought that an examination of clinical processes might also help shed some light on the conundrum of the stark contrast between the child's developing progress in treatment and in school and her continued turbulence and violence in her kinship placement, which eventually led to its breakdown.

A version of grounded theory used to analyze the data in this study gives explicit recognition that the data collection and analysis was informed by previous experience and knowledge of psychoanalytic treatment. This is not idiosyncratic to this study and, indeed, it is well known that all data collection and analysis are 'theory-laden' in scientific observation, in that they are informed by previous experience and knowledge which assists the extraction of concepts from the data (Charmaz, 2007).

Chapter 5 - Discussion of Findings from Clinical Data

In the following section, I present the findings from the clinical data, which has been analysed and forms the central part of this research project. The first section explores categories identified from the clinical data relating to the child's states of mind and these are: 1) Fragmentary states of mind, 2) Defensive/Protective, 3) Relatedness, 4) Symbolic Play. The second section examines categories identified in relation to the therapist's experience and activities and these are: 1) Counter transference, 2) Thinking/Mentalizing, 3) Interpretation. I hope to demonstrate development of theoretical and practical understanding of what facilitated repair, recovery and developmental progress in the child.

5.1 Child's States of Mind

5.1(a) Fragmentation

The nature of the child's fragmentary states of mind shifted in the course of treatment in the first year, from terror and turmoil, particularly evident in Data Sets 1 and 3, to states of disorientation and confusion, particularly evident in Data Sets 5 and 7.

5.1 (a) i Terror and Turmoil

In Session 1, Data Set 1, Lucy was carried into the room by her aunt and uncle, in what I thought at the time was a state of extreme rage. I was shocked by Lucy's extreme demeanor and felt worried about whether I could contain her in the room. Reflection on her state of mind in supervision helped me to understand that Lucy had been in a state of terror and that my visceral sense of shock and helplessness was crucial information about the intensity of Lucy's inner turmoil. In the first half of this session she wailed in agony and, as she thrashed around the room, I sensed that she was gripped by a terrifying inner falling apart.

> *Feeling overwhelmed by the ferocity of her turmoil, I was barely able to contain her flailing movements and found myself intuitively stroking her back in an attempt to soothe her. After a few minutes of allowing me to*

stroke her back, which seemed to reduce her need to scream loudly, she began groaning and suddenly pulled away from me. She thrashed around the floor violently, and started to scream again. After a few moments, she suddenly and rapidly began to scramble across the floor and my heart sank, thinking of what she might do next. She grabbed at items in her box and threw them around the room and at me.

Data Set 1, Session1 (Monday)

In this session, Lucy appeared to be in a state of fragmentation, which was manifest in both her expressions of terror, through screaming and in throwing items around the room and at me.

Following the turbulent state of Lucy's mind in Data Set 1, she settled into thrice weekly treatment for a period of seven weeks until Data Set 3, which occurred immediately after an unexpected cancellation of Session 20, due to my illness. In this session, I was shocked at seeing Lucy in an extremely turbulent state of mind, given that she had been relatively contained in the seven weeks prior to Data Set 3. Her turbulent state of mind in this session was reminiscent of Data Set 1, but this time, she seemed even more terrified. She was carried into the session by three people, Aunt, Uncle and Older Cousin, while she screamed in agony. I was startled by the contrast between Lucy's extreme turbulence in this session, compared to her capacity to be contained in the therapeutic space for a prolonged period of time since Data Set 1. It seemed that the cancelled session had a catastrophic effect on her mind, something like a rupture; yet there had been no obvious reactions to weekend breaks during the period between Data Set 1 and Session 21. While a reading of the sessions during this period gave an impression of there being no striking similar catastrophic reactions to weekend breaks, an analysis of all the sessions during that period of time would need to be undertaken to find out whether there were patterned anxious responses to the weekend breaks.

When in the room in Data Set 3, Lucy wailed unrelentingly, while lobbing the entire contents of her box at me. While stroking her back seemed to help soothe

her in the first treatment session when she was in a state of extreme turmoil, this time she 'elbowed' me off. Her terror and fury in this session seemed more unrelenting than in the first.

> *She suddenly grabbed the metal bin and with a look of fury, leaned back to maximize the force of intention to lob the bin towards me. I managed to stop her and she began scratching and scraping bits of peeling paint off the wall. She scurried over to her box and started to lift things out of it, the giraffe and pens and threw them at me. I was becoming increasingly worried and helpless. I tried to stop her and she started to thump and kick me. I held her arms, but she persisted and then turned to her box.*
>
> Data Set 3, Session 23 (Monday)

In this session, compared to Data Set 1, Lucy was more violent towards me, both in directing her aim when throwing items from her box and in physically attacking me. I recorded at the time my sense of increasing helplessness and worry about how Lucy could be contained. What did it mean that Lucy specifically expressed her terror and fury at me directly rather than towards the room as she had done in Data Set 1? Did this indicate evidence that, by this stage, she had internalized an experience of consistently being thought about and now felt gravely abandoned by me? Did this trigger a reminder of her mother's frequent abandonment of her?

5.1 (a) ii <u>Disorientation and Confusion</u>

The nature of the child's state of fragmentation shifted over the course of the term, from terror and turmoil to disorientation and confusion. This is evidenced in findings from Data Set 6, which followed the first major two-week break in treatment. Lucy was somewhat confused and disorientated before entering the room and, when in the room, expressed uncertainty and suspicion.

> *As Lucy approached the therapy room she hesitated, glanced at me and said in an uncertain tone, 'In here' then looked at me with suspicion, smiled in a strained way and said, 'You've changed your hair'. Even though I knew I had not changed my hair, I was immediately disoriented.*

Lucy followed this half-accusation with,'Aunt Susan thought you weren't back today'.

Data Set 6, Session 47 (Monday)

In her approach to the therapy room, Lucy palpably conveyed her state of uncertainty and disorientation about where the room was located and, at the same time, looked at me with suspicion about whether I had changed my hair. This suspicion continued to manifest in Lucy's expression of suspicion about whether I was expected to return from the break on that day. This suspicion and uncertainty occurred even though my return date had been carefully highlighted in both the calendar chart that I had given Lucy prior to the break, and with my giving the dates in written form to Lucy's aunt and uncle.

Lucy's state of fragmentation in the form of disorientation and confusion was evidently conveyed in this encounter, in her seemingly fragile sense of the continuity and reliability of the sessions in time and space. Canham (in Briggs, 2012) refers to the impact of early severe deprivation on the infant: He says infants in such circumstances, *'consequently do not introject an object that is attentive to their development-neither past nor future'* (Briggs, 2012, p 62). Canham goes on to suggest that severe deprivation impacts upon subsequent development.

'this piling up of unresolved anxieties and preoccupations gives rise to much confusion in terms of order and sequence and, consequently, of time itself'.

(Briggs, 2012, p 63)

The nature of the child's fragmentation in Data Set 6 was markedly different from the manifest extreme turmoil in the child, in both the first treatment session Data Set 1, which followed the gap between assessment and treatment and in Data Set 3, following an unplanned cancellation of Session 20. This indicated that, while the break was disturbing for Lucy, it seemed less catastrophic to her. This less turbulent, but more confused state of mind in reaction to the two-week break, seemed evidence of development in Lucy of some capacity to manage the break.

However, Lucy's experience of my absence gave rise to anxiety about whether I remembered the game we had played before the break. This seems to be relevant to the problem of time, outlined by Canham. He says that the impact of severe neglect *'often leaves the children feeling that no one has time for them'* (Briggs, 2012, p 62). Lucy seemed to communicate such a belief symbolically through play, which is illustrated in the following excerpt;

> *'We're going to play the animal game', she announces. 'Do you remember the animal game?' she asks, a little anxiously.....She puts the baby hippo on the top ledge of the door. 'It's the baby hippo, he's shy,he's not quite sure if you remember him', Lucy says.*
>
> Data Set 6, Session 47 (Monday)

It is evident from Data Set 6 that Lucy's state of mind following the two-week break contained uncertainty, disorientation, suspicion and insecurity. This is, however, a notable shift in term of the nature of Lucy's previous propensity to extreme states of fragmentation following gaps and breaks. While in Data Sets 1 and 3, fragmentation in Lucy manifested in terror and turmoil, in Data Set 6, fragmentation seemed to manifest in uncertainty and disorientation. This is indicated through Lucy's use of play as displacement (Hurry, 1998), in which she expressed doubt about whether I remembered her.

The play also seemed to contain hope that I did remember her, indicating the presence of a more evolved state of mind in Lucy; one in which she had perhaps internalized a more reliable object. O'Shaughnessy refers to the '*crucial advance'* in development, when the child is able to *'think of the real missing good breast'* and to preserve the good object, even though the child in phantasy experiences the therapist, in absence, as starving him to death. (O'Shaughnessy, 1964, p 35).

In Data Set 7, Lucy's state of mind was manifestly more fragmented than it had been for some time. Neither of us consciously knew in this session that Lucy would shortly move to a children's home, accompanied by a two week break

instigated by Social Services and that this was to be the final session before the break. Lucy's placement at home was breaking down at this point, with an escalation of her violence towards her aunt. I discuss this situation and its contrast with her therapeutic and developmental progress in a later section.

One of the indications of Lucy's fragmentation in Data Set 7, was in the moments of mismatch in our connection, which occurred a number of times in the session. At one point Lucy went to the toilet, just after I had misheard her say something about lunch. I felt rather confused and a little disoriented and wondered to her about the meaning of the mis-communication,

> *....'I was thinking about how confused I'm meant to be, misunderstanding what you were saying'. I said.*

Data Set 7, Session 99 (Monday)

Another example in this session of Lucy's fragmentation was in the spilling out of her aggression rather than this being displaced in play, when I had earlier misheard her at the beginning of the session. In reaction to mishearing her, she came over and 'smacked' me a little bit too hard on the head while she correspondingly said, 'bad girl', accompanied by an explanation that this was *'for not hearing me properly*'. I reported in the session notes that *'I felt strangely guilty, as though I had reprimanded her'.* My countertransference experience, which appeared to take account of the quality of Lucy's fragmented state of mind, seemed to have informed my response which was to offer Lucy an analyst-centred interpretation;

> *I sai,d that not being here on Monday might mean that she feels I'm to blame.*

Data Set 7, Session 99 (Monday)

5.2 Defensive/Protective

Many of Lucy's defences against anxious states of mind were expressed in concrete ways. In the early phase of treatment, particularly in Data Sets 1 and 3, Lucy conveyed a need to concretely protect and defend herself against what appeared to be her catastrophic feelings of terror. These feelings seemed evoked by what appeared to be the child's experience of me as persecuting her with my absences, first in the gap between assessment and treatment prior to Data Set 1, and in the abrupt cancellation of Session 20.

In Data Set 1, concrete defences included evacuation of unbearable fragmentary states of mind through screaming, throwing and scrambling across the room away from the therapist by whom, a short time earlier, she had allowed herself to be soothed.

Lucy gradually becomes still and moves the chair in front of her.

Data Set 1, Session 1 (Monday)

Lucy's capacity to enable the therapist to comfort her in her state of terror and turmoil was short-lived in Data Set 1. It seemed that, immediately following an experience of the therapist as a source of comfort, there was a shift to her experiencing me as a persecutor, against whom Lucy felt she had to concretely protect herself. This is evidenced in her defensively placing the chair between herself and the therapist.

In contrast to Data Set 1, where Lucy allowed me to soothe her momentarily, in Data Set 3, she *'elbowed me off'* when I tried to stroke her back as before and scurried across the room away from me. The child's experience of the therapist on her return seemed dominated by a catastrophic reaction to the cancelled session. There appears little expectation or belief that I could be helpful and comforting to her in her state of turmoil.

In Data Set 3, Lucy rejected the therapist's attempt to soothe her.

I put my hand on her back as I'd done before and which had soothed her eventually, but this time, she aggressively pushes me off. She seems to sink into the floor and then grabs the bin and is about to throw it.....

Data Set 3, Session 21 (Monday)

The child's rejection of the therapist may represent not only the belief that the therapist could not be relied upon, but that the child's only means of managing overwhelming internal persecution was to reverse the experience, so that it was the therapist who experienced rejection. Moreover, the child's physical attack on the therapist is further evidence of the child's evacuation of unbearably felt persecution. It may also represent a form of defence, referred to by Anna Freud as *'identification with the aggressor'* (A Freud 1936).

It seems, however, that Lucy not only identified with the aggressor, but needed me to know what it was like for her to feel abandoned and helpless. Canham refers to the child's need to bring feelings of terror associated with being abused into the therapy in concrete ways, such as putting the therapist through an experience of being abused, so that this *'dynamic relationship between abuser and abused*' can be thought about (Canham, 2004, p.145). I would suggest that similar feelings of terror are experienced in children who have been severely neglected and deprived. Canham stresses the need for therapists to be able to genuinely suffer the helplessness that these children evoke.

In a similar way, Alvarez describes the process of the child's use of a certain form of projective identification, whereby the therapist is being made to suffer something of the experience the child has endured in his/her severe deprivation. Building on the work of Joseph (1978), who suggested that projections may need to be held in the therapist sometimes for a long time, Alvarez suggests that severely deprived children often need the therapist to suffer so as to *'put one's fear at a distance*' (Alvarez, 2012, p.82). This form of projective identification, she argues, develops trust in the object's capacity to withstand and understand the child's desperation and turmoil. This leads to the potential, she says, for

transformation and, particularly, for the enabling of *'new introjections'* (Alvarez, 2012).

Lucy's concrete defensive activity, which, from the findings, seemed related to managing her state of anxieties about both the quality and reliability of her object, was found to take various forms throughout the first year of treatment. As well as her defensive/protective reaction to my presence, in the aftermath of my absence as described, other concrete defensive activities, in lesser states of fragmentation, involved frequent trips to the toilet and the bringing in of food to eat in sessions. Apart from Data Sets 1, and 3, Lucy brought in food and went to the toilet, sometimes more than once, in each session in Data Sets 2, 4, 5, 6, 7 and 8.

In the sessions following the turbulence of Lucy's state of mind In Data Set 1, she was somewhat subdued and I found myself at the time dreading the Monday of the second week of treatment, expecting there to be a reaction in Lucy to the first weekend break. However, to my relief, Lucy seemed to settle quickly into the rhythm of thrice weekly sessions and, from a preliminary reading of all the sessions in the first year of treatment, this settling in seemed to occur without further incidence of extreme catastrophic reaction to breaks. From the findings, she seemed to have developed defensive and protective ways of managing gaps and breaks, as well as managing the intensity of the analytic setting. This activity took the form of bringing food into sessions, which seemed to provide comfort to her. She also engaged in frequent trips to the toilet, when reference was made to gaps and breaks. These defensive activities will now be discussed.

5.2 (a) Consuming food as defensive activity

The following are six extracts from Data Sets 2 - 8, which illustrate the child's persistent bringing in and eating of food. While the focus of this study is on the selected data, I noted from a reading of all the sessions in the first year that, apart from Data Sets 2 and 4, the child brought food into every session.

.....She sits down at the small table and takes out her sandwich and munches on it contentedly, turning around and grinning as though wanting me to know how much she is enjoying her food.

Data Set 2, Session 3 (Friday)

.....She nods slightly and, taking out her apple, she starts to munch on it. She becomes absorbed in eating her apple, looking out the window until she has finished it.....She moves to the bin when she has consumed the apple to its core and places it in the bin, pausing for a moment.

Data Set 4, Session 22 (Wednesday)

Lucy sits opposite me and carefully opens her crisps and munches on them..... and eats her crisps in a way which feels endless and I will her to finish. She moves to her box when she has finished her crisps, discarding the wrapper in the bin.

Data Set 5, Session 45 (Friday)

Lucy looks at me with slight suspicion and uncertainty, I thought. She opens the crisps she was clutching and starts to munch on them.

Data Set 6, Session 46 (Monday)

Lucy munched on her lunch and said something, which I thought was that she'd nearly, finished her lunch and I repeated this back to her. She gave an agitated expression accompanied by a smile and said ' No, did you think I said I'd nearly finished my lunch? I said I normally have my lunch finished by now'.

Data Set 7, Session 99 (Wednesday)

She looked at me expectantly, I thought, as she started to munch on the crisps she had brought.

Data Set 8, Session 105 (Monday)

It is noted that the child ate the food she brought in at the beginning of each session and this seems to indicate her need to manage feelings associated with separation from the therapist between sessions. In particular, the consuming of food may relate to her attempt to soothe persecutory anxieties related to the

absence of her therapist between sessions. Perhaps food also represented a form of self-reliance, in which the child was forced to make concrete provision in the face of fear that she would not get her needs met by the therapist.

5.2 (b) Trips to the toilet

From an examination of the findings of the interaction between child and therapist, it appears evident that Lucy seemed to use the toilet as a form of evacuation of difficult thoughts and feelings, usually evoked when I made a link to an underlying anxiety in her.

From a reading of all the sessions in the first year of treatment, I calibrated Lucy's use of the toilet and found that she went to the toilet in all sessions, except in Data Sets 1, 3 and 8. The similarity found in these three Data Sets is that the sessions took place following gaps in treatment. It may be significant that these gaps in two of the Data Sets 3 and 8, were unplanned and abrupt. However, the contrast between Data Sets 1 and 3 and Data Set 8 is that Lucy was in a state of extreme turmoil in Data Sets 1 and 3, compared to Data Set 8 which followed the two-week unplanned and abrupt break instigated by Social Services towards the end of the first year.

There appears less evacuation of unbearable anxieties in Data Set 8, which also seems to correspond with an even spread of occurring categories in this Data Set compared to other Data Sets with an absence of the occurring category, Fragmentation. This seems evidence of some reparation, recovery and developmental progress in the child.

The following are excerpts from each Data Set in the session where Lucy went to the toilet.

> .....*She suddenly announces that she needs to go to the toilet and is out of the door as the thought comes to me about her anxiety about the 'gap' between sessions*.
>
> Data Set 2, Session 3 (Friday)

Lucy abruptly went to the toilet immediately after I referred to there being two days in-between sessions when she referred to it as one day. This seems to indicate that even the thought of gaps between sessions appears unpalatable to Lucy.

In Data Set 4, Lucy let me know that she was building a robot with Lego. In response;

> *.....I said out loud that I was thinking about robots not having any feelings. Lucy suddenly said she needed the toilet and left the room. She was away for longer than usual and, on her return, said that she was going to put the robot in the box to 'keep it together'.*

Data Set 4, Session 22 (Wednesday)

My reference to robots not having any feelings seemed to ignite anxiety in Lucy and she abruptly went to the toilet. Perhaps she feared that I might want to probe into her feelings.

In Data Set 5, Lucy went to the toilet immediately after she had symbolically performed sadistic injury to my senses.

> *.....'Then my ears and nose are also to be cut off and', I say,' I am to know what it is like to suffer, not move, not see and not hear anything. I am to just suffer and suffer'. Lucy announces that she needs the toilet and is away in a flash, leaving me bereft and feeling disintegrated.*

Data Set 5, Session 45 (Friday)

Lucy's anxiety in this excerpt seems to relate to her fear of her own aggression and destruction of me, which she attempts to rid herself of, through evacuation.

In Data Set 6, Lucy abruptly left to go to the toilet when I made a link between the chart I gave her, prior to the break, getting messed up during the break and her feelings about the break.

> *.....Lucy finishes her crisps, which takes about a minute and says that she needs the toilet. She puts her crisp bag on the chair and leaves. I think*

about her needing to get rid of the link I made between the chart being messed up and the break.

Data Set 6, Session 46 (Monday)

It seems that Lucy reacted defensively by going to the toilet to evacuate the link I made between feelings about the break spilling out and the chart getting messed up**.**

In Data Set 7, which occurred prior to the abrupt two-week break instigated by Social Services, Lucy presented in a somewhat fragmented state of mind. This manifested in her 'playful' aggression towards me, which was followed by a mismatch in our communication, whereby I misheard her say that she had finished her lunch, to which Lucy seemed to respond with a rush to the door to go to the toilet.

Lucy suddenly got down from the worktop and rushed to the door, opening it and going out, but then put her head round the door and said, 'did you wonder where I was going just now? I'm going to the toilet'. I wondered inwardly about the mismatch in our connection today.

Data Set 7, Session 99, (Wednesday)

Lucy, it seemed, evacuated the discomfort of an experience where I had misheard her. However, correspondingly and strikingly, for the first time, she conveyed an interest not only in what I might have been thinking, but also seemed to expect that I was wondering about her. I discuss this development in Lucy more fully in the next section.

5.3 Relatedness

In this section, I present evidence from analysis of the clinical data, for the quality of the child's capacity for relatedness at the beginning phase of treatment. This was characterized by oscillations between curiosity and suspicion. The shift in the quality of the child's relatedness over time is associated with developmental progress in Lucy, and I discuss more fully the evidence for this development in a later section.

From the beginning of my encounters with Lucy, including during the assessment period, her capacity for relatedness was evident. Due to the focus on the findings in this section, I will not refer to the detail of the assessment process, as these sessions were not analysed in this study. It is nonetheless important to convey my overall impression during the assessment, that Lucy seemed to have capacity for certain relatedness and it was this quality in her which informed my decision to offer her intensive psychoanalytic treatment, as I thought she could make use of this approach.

5.3 (a) Curiosity, Interest and Suspicion

From the beginning of treatment, even in the midst of Lucy's turmoil, there were signs of her capacity for interest in and relatedness to the therapist.

In Data Set 1, Lucy paused with momentary curiosity when I named the items she was violently throwing around the room.

> *.....she looked at me with some bewilderment and a seeming flash of interest. There was a momentary sense of calm.*
>
> Data Set 1, Session 1 (Monday)

Lucy's tumultuous state of mind in this session eventually shifted to curiosity, which was evident in her series of questions;

> *'Why do babies not like cold milk?' 'Do you live here?' and 'Who looks after your children?'*
>
> Data Set 1, Session 1 (Monday)

Lucy asked these questions while crouched under the table, behind a chair she had placed in front of her and between us, so that I could hear, but not see her. The nature of the questions seemed related to her curiosity about the qualities of her object. O'Shaughnessy (1981) states;

> *Can the analyst receive primitive projected states and know what they are? Children do research on the analyst's capacity for reverie and bring material for the purpose of testing whether he can think, notice, remember,*

tell the difference between truth and lies, and emotionally understand - as opposed to verbally, mechanically, or from books?....

(O'Shaughnessy, 1981, p 187)

A shift seemed to occur in Lucy's tumultuous state of mind within Session 1, Data Set 1, whereby there was a loosening of her concrete defences.

After a moment of quiet, Lucy asked if she could come out from under the table.

Data Set 1, Session 1 (Monday)

When Lucy came out from under the table, her encounter with me demonstrated the quality of curiosity and interest she had in the states of mind of infants, as well as having ideas about how these should be addressed.

'Babies can't tell you what's wrong with them, they just have to cry' – she said..... 'You could hardly say they are bad if they don't know what's wrong'.

Data Set 1, Session 1 (Monday)

Lucy went on to describe a programme that she had watched, about a very bad babysitter and then asked me *.....'Do you have children?'* She subsequently told me directly that she didn't have contact with her mother. The content of this prolonged encounter between Lucy and me is evidence that the child was both curious and suspicious of the quality of the therapist's capacity to understand and contain her.

Her intense interest in my qualities as an object was a predominant feature of the nature of Lucy's relatedness. This manifested mainly in Lucy's intense involvement of me in play, the nature of which I will illustrate in a later section on 'Symbolic Play'.

In Data Set 2, Session 3, Lucy expressed confusion between the categories fish and turkey. Seemingly in response to my differentiating these, she told me about a '*nightmare'* she had recently had, in which she and I were on a boat *'rescuing*

each other'. She described that, in the dream, she was *'bitten by a shark and fell into the waterfall*' which, she said became '*frozen*' as *'lightning struck'*. It seems that my capacity to 'know' the difference between turkey and fish deepened Lucy's relatedness to me in the form of telling me about the dream.

Moreover, in the same session, Lucy expressed curiosity about what I did with the contents of the bin. This seemed to convey her anxiety about what I did with her projected unbearable and unwanted internal experiences and whether I could manage these.

In Data Set 4, which occurred after her turmoil in Data Set 3, Lucy attempted to make 'a person' with the Playdoh. This turned out to have only one eye and seemed to symbolize Lucy's struggle to see and believe that she could be seen in a benign, helpful way. Later, in the same session, Lucy wanted to play hide-and-seek with a version she created, which involved my not being allowed to find her but, instead, she 'appeared'. This seemed to represent Lucy's belief that I could not be relied upon to reach her and, therefore, a belief that she had to rely on herself.

5.3 (b) Deepening of exploration of self and object

The nature of Lucy's capacity for relatedness shifted in the course of the year, from oscillations between curiosity and suspicion, to ever deepening exploration of the qualities of self and object.

Following the first major break in treatment, while Lucy presented in a somewhat fragmented state of confusion and disorientation in Data Set 6, as illustrated earlier, she also conveyed curiosity about my activities outside the session. In the following excerpt, Lucy had commented on not seeing her cousin very much, reasoning that her cousin *'has been very busy*'. When I wondered to Lucy about her *'thoughts about me being busy during the break'* she said:

'*I saw you with a green box; what was that for*'?

Data Set 6, Session 46 (Monday)

I registered inwardly that Lucy must have arrived early for her session and had seen me, through the window, transporting another child's box before Lucy's session began. When I commented on her having thoughts and feelings about what I am doing outside the sessions and who else I am with, Lucy told me about the '*fight*' she had had with her cousin during the break and how the chart I had given her got *'all messed up'* because her cousin had *'thrown water over it'*.

She later told me about a bruise she got on her leg when she hit it against the cupboard *'in a bad mood'* but then conveyed a sense of pride when she declared, *'I've stopped biting and kicking, though!'* Lucy's capacity for relatedness is not only evident in this session, but appears more developed in quality. I will discuss the development in Lucy's capacity for relatedness in greater detail in the section on Developmental Progress.

5.4 Symbolic Play

The concreteness of the child's defensive state of mind seemed to shift in its extreme nature over the course of the year, in conjunction with Lucy's developing capacity for symbolic play. It was found that the availability and facilitation of a transitional play space seemed linked to enabling Lucy to use the therapist as an object with whom to explore feelings of confusion, terror, hate, love, desire, excitement and joy. The evolution of Lucy's capacity for symbolic play appears linked to the deepening of her capacity to internalize the therapist's consistency and reliability. Some of the more benign feelings associated with curiosity and vitality such as excitement, joy and humour were evidently under-developed in Lucy.

The nature and themes in Lucy's symbolic play have been identified from an analysis of the data as having three distinct functions, which are: 1) Use of play to evacuate and communicate unbearable states of mind; 2) Play as displacement; 3) Play as facilitating internalization of a new object.

It was found that Lucy increasingly used the therapist as a playmate, which appears to be further linked to the development of her capacity for symbolic play. I will describe this in more detail in a later section.

5.4 (a) Use of play to evacuate and communicate unbearable states of mind

While Lucy's play in the first term had an evacuative purpose, it also functioned as a communication of her state of mind, which was fraught with sadism and tyranny. This manifested in the child through play enactments, where the therapist was repeatedly made to suffer. As is illustrated in a later section, the child's developmental progress was found to be associated with containment of her projective identification. However, the child's use of play appeared to be the means through which this containment occurred. This is evidenced in what seems to be an interconnection between the child's need to explore difficult states of mind through play as displacement, in conjunction with the use of a form of interpretation by the therapist, of the meaning of the play. The findings, in relation to the nature and quality of interpretation, are discussed in a later section.

In Data Set 3, which followed a cancelled session, Lucy had been in an extreme state of turmoil, which she eventually enacted within the play arena.

> *Lucy abruptly grabs one of the police cars and then another one and runs them along the ground...and sets the ambulance and police car opposite each other on either side of the chair and bangs them together, head on. ....'They're baddies' she quips. She takes out a figure and says that he is the policeman and then takes out another figure and bashes them against each other, looking at me and grinning a little sadistically, I thought.....She gathers three figures and suddenly they are dumped, tilted out and one of them is run over by the ambulance.*
>
> Data Set 3, Session 21 (Monday)

Lucy appeared to use play here to communicate and evacuate her experience of my unplanned absence the previous Friday, which seemed to feel like a crash to

her. In her mind, I was felt to be a “baddie” who was not reliable, helpful or trustworthy.

In the following excerpt from Data Set 5, which is the final session before the two-week planned break at Christmas, Lucy engaged the therapist in a version of hide and seek within which was a sadistic theme.

> ‘*...I'm going to hide the baby's bottle first and then it's your turn....’the bottle's full of milk but you don't know if it's nice or not'. I say, 'I'm to be worried and afraid of what's* going *to become of me. Will I get nice yummy milk or will it be horrible?’*
>
> Data Set 5, Session 45 (Friday)

In this excerpt, Lucy appeared to respond to the therapist's comment about the break being hard to make sense of, by symbolically communicating her experience of the therapist's break as tantalizing and cruel. Thus, it seemed that the child experienced the therapist as offering something nurturing on the one hand, perhaps in the rhythmic reliability of ongoing sessions, while on the other, the break appears to be experienced by the child as being made to ingest something toxic. This conflicting experience of the therapist is not only symbolized through the play, but is also being worked through with the use of play as displacement. Hurry (1998) suggests that children often require the therapist's engagement in their play in order

> *'to carry those externalized aspects of the child's self which cannot be integrated within it, or to enact the role of feared or longed-for inner objects'.*
>
> (Hurry, 1998, p 58)

However, even while participating in play, the therapist, argues Hurry, needs to be able to reflect on the play and to decide if and when interpretation of the play and its transference meaning is needed. (Hurry, 1998 p 58)

When it came to my turn to hide the bottle in Data Set 5, I commented on Lucy wanting me to be the cruel therapist who hides milk and she, in turn, doesn't

know whether the milk is '*nice*' or not. Lucy seemed to be trying to manage her feelings of fear associated with the break, by evacuating these in the form of projective identification, communicated and symbolized through play.

> *....(Lucy) says I am to think the poisonous water is good and I am to drink it.....and begins her tyrannical procedures, which are that my arms and legs are to be cut off (motioning with her plastic knife on my arms and legs) then my eyes are to be torn out and, again, she motions across my eyes. Then my ears and nose are to be cut off...*

Data Set 5, Session 45 (Friday)

Lucy's communication and evacuation of her difficult feelings about the impending break, associated with separation anxiety in her, is expressed sadistically in identification with the aggressor through the medium of play.

However, Lucy often went to the toilet following particularly intense moments of play, especially when she had been cruel in play towards the therapist. The following excerpt immediately follows Lucy cutting off my ears and nose, I narrate:

> *'.....I was to suffer and suffer'. Lucy smirked with sadistic delight..... she announced that she needed the toilet and was away in a flash, leaving me bereft and in pieces. When Lucy came back I said that I thought she really needed me to know about not being able to move, to be trapped and not to see or hear. (I was thinking about her sexual abuse by her brother and also an image of her as a baby in her cot abandoned for hours on end).*

Data Set 5, Session 45 (Monday)

Lucy, it seemed, needed me to suffer, and in this way, it seemed in this excerpt, I understood that *'badness needs to stay out there'* (Alvarez, 2012 p 94). It is important, Canham argues, to be able to differentiate between the child's need to communicate experiences of extreme violations in the child's past and violence driven by perverse sadism in the child. In the case of the above enactment, it appeared that, while Lucy seemed to need to evacuate anxiety about her

tyrannical and aggressive impulses by going to the toilet, she also seemed to need to reverse her experiences so that I was to suffer tyranny and cruelty.

Canham describes how able a child is to develop symbolic functioning, as a result of having both his '*infantile experiences understood and his perverse tyranny withstoo*d' (Canham, 2004, p.153). Alvarez refers to the need for a severely deprived child to have *'phantasies of justice and revenge'*, which she says '*may enable desperate and needed projections to occur and be contained.* (Alvarez, 2012, p 94).

5.4 (b) Play as displacement

The findings illustrate that through play as displacement, in the context of use of the object as 'play-mate', it appears the child was enabled to work through developmental deficits and associated trauma.

In Data Set 4, Lucy introduced the game of 'Hide and Seek'. In this phase of treatment she repetitively arranged the game so that I was able to look for her but, rather than my being allowed to find her, she instead 'appeared', accompanied by the exclamation, 'here I am!' Lucy seemed to be expressing symbolically, anxieties about whether I was capable of finding her and of holding her in mind.

In Data Set 6, which occurs after the first major planned two-week break at Christmas, the child created a 'school game' in which she symbolically expressed her sadistic anger with me.

> '*Pretend you're a bad pupil', she instructs. With an aggressive voice, Lucy says, 'you're full of pee and pooh! In response I say, 'I think I am to know that you haven't quite forgiven me for going away and that I'm stinky and bad'. 'Pretend you have to drink the pee', she says....*
>
> Data Set 6, Session 46 (Monday)

In this excerpt, Lucy powerfully communicated, via play displacement, that her experience of my returning from the break was felt to be a 'bad presence',

(O'Shaughnessy 1964). In identification with the aggressor, (A Freud, 1936) she symbolically saw me as a *'bad pupil full of pee and pooh'* and forced me to symbolically *'drink the pee'*. This identification could also be seen as a reversal of her experience of the break, in which my leaving her evoked an experience whereby she felt full of 'pee and pooh'. This reminds me of a recent paper by Rustin (2016), where she comments on O'Shaughnessy's paper, 'The Absent Object' (1964) and highlights O'Shaughnessy's attention, in her work with a 12 year old, to the bodily experience of *'urine which floods into him when the child feels left'* (Rustin, 2016, p 219). Rustin highlights the power of *'bodily metaphor and references*' in the work in achieving '*precision*' *'about being in touch with infantile aspects of our patients*'. She goes on to warn of *'the risk of watering down the impact of our understanding through staying away from bodily metaphor and references*'. (Rustin, 2016, p 219)

The theme of the therapist being a 'bad presence' (in displacement) continued in Data Set 6, with my being instructed to 'get things wrong'.

> *....'.Right, you have to get things wrong; what's this?' (holding up the giraffe). 'You say elephant, but first put your hand up', she instructs. Lucy roars at me that I am a stupid girl and will go to detention for 3 days.*
>
> Data Set 6, Session 46 (Monday)

Lucy here seemed to convey her experience of the therapist as a 'bad presence' by reversing her experience of my leaving her for 3 sessions per week over two weeks, by making me suffer a 3 day detention for getting 3 questions wrong. The significance of '3' in her mind seems strikingly symbolic of the '3' sessions that she had missed. The ‘earnest’ play in this excerpt conveyed something of the quality of a necessary transitional space (Winnicott 1971) within which Lucy, it seemed, could explore in a more symbolic way, the nature of her own aggression and sadism and test out how willing the therapist could be to receive and suffer aggressive and sadistic enactments.

In Data Set 7, Lucy expressed, through play displacement, her experience of the catastrophic breakdown of her placement. In the following excerpt Lucy involved me in the play about a gravely ill baby.

> *.....she made a 'makeshift clipboard ' and drew lines to show 'blood pressure levels'. I was to be the baby's mother who watched and cried when she, the baby, had to get an injection. The parents then suddenly seemed to disappear and she, the baby, had no one to care for her and had to be looked after by the nurses, who kept giving her injections.*

Data Set 7, Session 99 (Wednesday)

In this session, neither Lucy nor I realized that Social Services were soon to announce an abrupt two-week break in her treatment because, it was decided, she needed this amount of time to transition from her kinship care placement to a children's home. It is evident in this session that Lucy used play as displacement to express an experience felt to be akin to dying. The theme of a gravely ill baby whose parents leave her and who subsequently dies, powerfully conveys the catastrophic anxieties about the loss of her placement. However, unlike in Data Sets 1 and 3, where overwhelming feelings in Lucy are intensely evacuated via massive projective identification, this time she is able to symbolize her catastrophic feelings.

In Data Set 8, Lucy returned to treatment after a two-week unplanned break in a surprisingly relatively contained state of mind. She initially spoke in a straightforward, direct way about being in a children's home. However, her communication about how she felt about the breakdown of her placement and also about being in a children's home seemed difficult and she used play as symbolic communication of her experience. She announced that we were to:

> *'play a game; you're my mummy..... I'm Jason and I'm asleep' (she lay on the floor) 'no, actually this is my bed' and she climbed into the cupboard. She instructed me to close the doors and then to come and waken her up for school. When I did this she instructed me again to*

waken her at lunch-time and then at dinner-time and I was to have a worried conversation with Jason's Daddy about him not eating.....'

Data Set 8, Session 105 (Monday)

Through play as displacement, Lucy was able to communicate her experience of the breakdown of her placement by depicting 'Jason' as not having a bed to sleep in. It is interesting to wonder what Lucy was symbolically conveying about her experience, by having 'Jason' sleep so much of the time. Perhaps it represented a form of defensive retreat from the emotional impact of losing her kinship placement. However, as well as perhaps conveying the compulsion to put to sleep her difficult experiences, there is indication that Lucy also wanted me to help keep her alive to her experiences, which seemed to be communicated via her instructions, in the play, that I should *'waken Jason up'* for school and at mealtimes. She also seemed to expect me to worry about her, as indicated in her instruction in the play that I have *'a worried conversation with Jason's Daddy about him not eating'*.

5.4 (c) Play as facilitating internalization of a 'new object'

In this section, I describe evidence for how play facilitated, in the child, the internalization of a new object. It is important to highlight the distinction found between what I illustrate in a later section; which is, that certain forms of interpretation facilitated the child's progress and how the play itself was a necessary facilitator of the internalization of a new object. In addition to the working through via play as displacement of her deficits and internalized traumatic experiences of neglect, deprivation and abuse, the child was also found to explore many developmental themes through the play.

From the beginning of treatment, Lucy seemed, at times, able to introject and identify with a more benign experience of me. In Data Set 1, in an acute state of turmoil and terror, the child pushed away the doll I had put beside her. Following my comment on her need for shelter and protection when she was under the

table with the chair in front of her, Lucy appeared in a somewhat calmer state of mind and approached the dolls.

> *.....she reached out to the doll she had pushed aside (earlier) and placed it loosely in her arms. She looked over at her box. I pulled the box closer to her and she took out another doll and a doll's blanket.....she leaned down towards the two dolls and slid off her chair to lift them and covered them with blankets. She then lifted the doll's bottle out of her box and fed them, one after another and covered them both with a blanket.*

Data Set 1, Session 1 (Monday)

In this excerpt, Lucy seemed to have introjected my earlier capacity to contain her recovery from the manifest turmoil of an acutely fragmented state of mind. This introjection appears evident in her identification with a caring mother who soothed and looked after her baby.

In Data Set 2, Lucy described a dream in which she and I fell over and needed to be rescued. As she relayed the dream, she challenged the premise in the dream that she is required to look after me, rather than the other way around.

> *'The fishermen said that you were supposed to look after me and I was supposed to look after you? Well, that's strange; that's not supposed to happen' and with animated gestures, points to me saying, 'You're the one that's supposed to look after me!'*

Data Set 2, Session 3 (Friday)

There is indication in this excerpt that, even at this early phase of treatment, Lucy had introjected an expectation of a different kind of object, whose responsibility it was to protect her. Lucy's introjection of the quality of a containing other is further indicated shortly after her relaying of the dream, when she took out the animals from her box and *'declared they needed a bath'.* When I commented on the baby horses being thought about in response to Lucy saying that they were *'having fun'*, she commented that they were being *'cared about'*. It seemed evident, perhaps based on her recent experience of my helping her recover from

her extreme state of turmoil in Data Set 1, that Lucy had internalized and identified with a containing object.

Indication of Lucy's internalization of a 'new object' appears to be evidenced in her symbolic play, both before and after the first major break in the first term of treatment. In Data Set 5, Lucy seemed to respond to my emphasis on her managing the break through the use of hide and seek, which appeared to assist her internalization of an expectation of my return.

On my return from the break, in Data Set 6, Lucy appeared to have internalized my capacity to suffer being a *'stinky, poisoned, poohy, stupid and bad therapist'*, which seemed to evoke a deeper connection to the painful origin of her abandonment by her mother. This is evidenced in her creation of a song;

> *'The first day of school the baby was born. The second day of school, the baby cried, the third day of school the baby got fed and the fifth day of school the baby was left and the sixth day of school the baby died'.....Lucy sings more passionately this time...'Mum is leaving, Mum is leaving, she is bad, she is bad. Mum is a stupid pig.'*
>
> Data Set 6, Session 46 (Monday)

Lucy's creation of a song which contained the narrative of a mother who abandons her child, to which the latter responded with hatred, is profoundly poignant. It seemed to require me to bear witness to her experience of catastrophic beginnings as an infant and to tolerate the hatred this experience engendered in Lucy.

5.5 Summary of the Use of Play

Lucy increasingly used the therapist in symbolic play to express and work through cumulative trauma. The play, and the therapist's engagement in play as well as my narration and interpretation of the play's meaning, appeared not only to provide containment for Lucy, but also to facilitate repair, recovery and developmental progress in her. Winnicott emphasized the importance of the process of play itself, in which psychological transformations can take place,

referring to play as 'serious business' (Winnicott, 1971). Moreover, from the findings, I contend that the nature and quality of the therapeutic stance of the therapist, imbued by my wondering and receptive witnessing, was also crucial to the child's progress. The next section provides evidence using detailed examples from the clinical data of the findings of the impact on the child's recovery, of the therapist's responses to the child and interventions with her.

5.6 Therapist's experiences and activities.

In this section, I present the categories identified from an analysis of the data, in relation to the therapist's experiences and activities. These are: 1) Counter transference; 2) Thinking and, 3) Interpretation. It was found that the containing qualities of the therapist were a feature of all three categories. Thus, it was found that containment of the child's states of mind, as well as the facilitation of her developmental progress, was related to aspects of the therapist's use of her countertransference. This was also true of the containing function of the therapist's use of her thinking about the child. I have therefore added the category 'Containment' to the category of 'Countertransference', as they are interlinked.

I have also combined the categories 'Thinking' and 'Interpretation', in presenting the evidence from the data for these aspects of the therapist's activities, as they are so often interlinked. The findings illustrate that the various forms of interpretation, used by the therapist, were intertwined with the aim of containment of her fragmentary states of mind. It was also found that the narrative and analyst-centred forms of interpretation seemed aimed, not just at containment of the child's turmoil and fragmentary states of mind, but also appeared to facilitate internalization of a 'new developmental object'.

Hurry (1998) refers to Tahka's (1993) distinction between three strands in the patient's use of the analyst, with one important strand being that of 'New (developmental) object' (Hurry, 1998, p 45). Tahka describes the process of analysis as being one in which, through the transference, an opportunity is

provided for the patient to experience the analyst as acting differently from their original objects. This raises the question, which I addressed in the Literature review (p 32), about whether existing internal objects are transformed by a 'new developmental object', or whether 'new' experiences are internalized and co-exist with already established ones.

Alvarez (2012) and Music (in Briggs, 2012) in different ways address this conundrum in relation to neglected and severely deprived children. Both refer to the need for children to experience being enjoyed and contend that this represents a new experience, which becomes internalized by the child. The facilitation of this process might mean either the therapist initiating play and/or engaging in play with the child. In relation to initiating play, this is evident in Data Set 1, when I first moved the dolls near the child while she was frozen under the table behind the chair and then, later, when I 'named' the items she was throwing around the room. This latter activity seemed akin to the 'descriptive level' of therapeutic work referred to by Alvarez, where she says:

> *'naming and describing experience, I believe, has to have priority over locating it'.*
>
> (Alvarez, 2012, p 16-17)

Thus, the transference, countertransference process in which the child discovered a 'new developmental object', was found to occur predominantly within the play arena.

5.6 (a) Countertransference and Containment

Throughout the treatment, it was found that my countertransference experience was essential to understanding and containing the child's communications of her anxieties and turmoil, which were associated with extreme deprivation and abuse leading to deficits in her development.

In Data Set 1, it was found that the therapist seemed to use her experience of worry and helplessness at the extreme nature of the child's turmoil, to provide

physical comforting, through stroking the child's back, which provided some momentary containment for the child. In the process recording of this same session, I described my 'desperation' in my countertransference response to the child's aggression, which seemed to lead me to spontaneously attempt to engage the child in a simple form of play, by naming the items that the child was throwing around the room.

> ..,,*With a sense of desperation and urgency, I started to name the items as Lucy threw each one, 'car', 'pen', 'doll', 'lego', 'pen', 'crayon', 'girl', 'granny'.....This appeared to have a momentary calming effect on her and she looked at me with some bewilderment and a seeming flash of interest. There was a brief sense of calm. When most of the contents of her box had been emptied out, Lucy began screaming again and tipped the box over.*
>
> Data Set 1, Session1 (Monday)

The therapist's attempts to both playfully engage the child, while at the same time contain her turmoil, seemed to momentarily ignite the child's curiosity. As mentioned in an earlier section, this *'flash of interest'* from the child was the first indication, in the session, of the child's capacity for relatedness.

Having withstood the child's extreme state of turmoil, I recorded at the time that there was a shift in me from helplessness to hopefulness and relief that the child seemed in a calmer state of mind. Canham (2004) describes the helplessness of the therapist when evacuations by severely deprived children of unmanageable feeling states are physically enacted, through attacking the therapist and the room. He suggests that the therapist must genuinely experience this helplessness, in order to understand the helpless terror of the child and be able, with conviction, to speak about this experience with the child.

In Data Set 3, the ferocity of Lucy's turmoil was acted out in violence towards me and towards the room. I note in the record that I was becoming increasingly worried and helpless as I tried to stop her kicking and thumping me.

...she then tried to peel the paint off the wall....I said that she was really, really, upset and that it was very important we try and sort out what's making her so angry and upset....

Data Set 3, Session 21 (Monday)

The child's state of fragmentation in Data Set 3, is palpably expressed in her scratching and peeling bits of paint off the wall. When I comment on how upset she was and on how this needed to be thought about and understood, her violent onslaughts ceased and it seemed that she immediately sought protective refuge under the table, albeit still pulling dangerously on the wire. My withstanding of the child's violence, while also retaining thinking about the meaning of this, seemed to have a containing effect on her.

Intense feelings of helplessness and worry about Lucy's capacity to manage breaks from treatment, evoked dread in me, coming up to the two-week break at Christmas. Thus, in the final session before the break, I worried beforehand whether Lucy would be in a fragmentary state of mind. She, however, came easily with me from the waiting room. When in the room, in Data Set 4, Lucy enacted intense tyranny towards me in play and, seemingly satisfied by my capacity earlier in the Session, to withstand her cruelty, Lucy further enacted aggression towards me.

She goes over to her Lego box and starts to build with the Lego. She declares it is a gun and points it at me. She hands me the "gun" and tells me to shoot her. I don't take the gun and say that she wants me to be cruel to her.

Data Set 5, Session 45 (Monday)

When I didn't play along with her request for me to 'shoot' her with the lego gun, Lucy immediately said, *'Hide and Seek*". Thus, Lucy's request to play hide and seek seems to represent the development of a more benign experience of the therapist, linked to the growing sense of relatedness in her. It seems that Lucy's compulsion to repeat experiences of infantile violations, through inviting an enactment by the therapist, albeit in play, seemed to have a containing effect on

her and may have provided an experience of a 'new developmental object', which contradicted 'transference expectations' (Hurry, 1998). Hurry contends that, when the child has experienced deprivation, he carries hope that the therapist will 'contradict transference expectations' by becoming an 'appropriate developmental object'. (Hurry, 1992, p. 47).

5.6 (b) Thinking, Interpretation and Containment

I have added containment to this category as, similar to countertransference, containment of the child is embedded in the therapist's thinking and metabolizing of her states of mind. Thus, the nature of my thinking within the therapeutic relationship with Lucy seemed to take account of both her extreme states of mind and her corresponding need for containment. At the same time, I appear from the findings, to be mindful of the deficits in her development and of the need for developmental repair and recovery in her.

It seems therefore, that my thinking about the child's terrified and fragmented state of mind was derived from my attention to countertransference in the context of the child's defensive and communicative use of projective identification. Lucy, it seemed, needed to experience an object capable of waiting, thinking and containing her projected states of mind at certain times, rather than immediately providing interpretation, particularly of the patient-centred kind.

In Data Set 1, my interpretative responses to Lucy's fragmented and tumultuous state of mind were evenly balanced between analyst and patient-centred interpretations, with evidence of a slightly lesser narrative form of interpretation. This latter form of narrative gains momentum as treatment progresses, with what appears to be Lucy's need to explore and examine self and object through displacement in play. This is illustrated and discussed in the section on Narrative Interpretation.

In relation to the use of interpretation, there are four forms of interpretation identified in the data. These are 1) analyst-centred interpretation denoted in the

data as (1); 2) patient-centred interpretation denoted in the data as (2); 3) narrative interpretation denoted in the data as (3) and 4) overcoming interpretation denoted in the data as (4)*. From an analysis of the data and, specifically, calibration of types of interpretation (see Table 3 p. 19), there appears to be a steady increase of 'narrative interpretation' between Data Sets 1 and 6. In comparison, narrative interpretations in Data Sets 7 and 8 are less than in Data Sets 6 and 4. This seems related to the child's increased ability to communicate more directly about her feelings and outside life. Indeed, this corresponds with a significant increase in the child's relatedness in Data Sets 6 and 7.

Also, correspondingly, analyst-centred interpretations are found to increase up to Data Set 5, from where they begin to decrease, with a significant increase in patient-centred interpretations from Data Set 6 by comparison. This could be linked to the child's greater capacity to tolerate thinking about self and other.

In the next section, I give examples from the clinical material of the identified different forms of interpretation.

5.6 (b) i Analyst-centred interpretation

While Steiner (1994) suggests that elements of both patient-centred and analyst-centred interpretations are usually combined, he distinguishes between them in relation to their aim. Analyst-centred interpretations are aimed at containing the patient's projections to eventually enable him to use insight-focused interpretations of the patient-centred kind. At times, in the early part of treatment, analyst-centred interpretations seemed to provide sufficient containment for Lucy to enable evocation in her of curiosity about the therapist. I suggest that this process links to Lucy's introjection of a 'new developmental object' and that this led to repair, recovery and developmental progress, which I discuss more fully in a later section.

*See coded sessions in Appendix ii

In Data Set 2, Lucy recounted the scary dream, in which we both fell out of the boat and were supposed to look after each other, I interpreted Lucy's worry about whether I could look after her and not collapse. This seemed to ignite her curiosity, as well as evoke in her the desire to '*care*' for the animals by giving them a bath. Although this interpretation combined elements of both patient and analyst-centred interpretation, my emphasis on the qualities of the object, rather than on Lucy's anxieties, seemed to enable Lucy to identify with a thinking, 'caring' object.

In Data Set 4, which followed the session in which Lucy had been in a tumultuous state of mind, she attempted to put together with playdoh, the shape of a person. Using the form of an analyst-centred interpretation, I said:

> '*I wonder whether you need me to know you are putting yourself and me back together again, but that perhaps there was a worry that my head might be wobbly after all the battering; a worry that I might not be able to cope'.*
>
> Data Set 4, Session 22 (Monday)

In approaching the first major break in treatment, which took place at Christmas, I worried that Lucy would become fragmented again and arrive in a state of turmoil on the last day of term. However, I was surprised to discover in Data Set 5,that Lucy, instead, used play intensively to express through displacement, her experience of me as ruthlessly cruel in leaving her. Initially, she sat *'opposite me....and I sensed her eyes penetrating me with hostile curiosity'.*

A short time later, when Lucy had finished eating the crisps she had brought into the session, she began cutting out round shapes from the Playdoh and sticking them together, apparently aimlessly. I tried to make sense of this aimlessness by narrating what I sensed was the child's experience of the break. Thus, I commented, '*It's hard to make sense of the break, us being apart',* to which the child responded by announcing that she wanted to play hide and seek.

> *'I'm going to hide the baby's bottle first and then it's your turn; close your eyes'. I close my eyes while Lucy makes her way around the room and*

finally tells me to look. Lucy says, *'the bottle's full of milk but you don't know if it's nice or not'. I say, 'I'm to be worried and afraid of what's going to become of me, will I get nice yummy milk or will it be horrible and make me sick?'*

Data Set 5, Session 45 (Monday)

I find the bottle and then Lucy tells me it's my turn to hide it. I don't look for the bottle, refusing to enact being the aggressor against Lucy's victim and, instead, I say,

'Oh dear, the milk is to be hidden from Lucy and she doesn't know whether it's nice or not nice and I'm to be a cruel, not nice mummy therapist that hides the milk from Lucy, who doesn't even know if the hidden milk will be good for her or not'.

Data Set 5, Session 45 (Monday)

At first Lucy was identified with the aggressor (A. Freud 1936), in that she is the tantalizing object who makes the therapist suffer the uncertainty of whether the milk is good or not. It seemed that Lucy needed the therapist to endure '*worry*' and '*fear*' that the needed milk might be toxic. This endurance is expressed in the therapist's willingness to be subjected to the child's sadistic play, while providing an analyst-centred narrative of its meaning. When Lucy reversed the positions in the play and instructed the therapist to hide the bottle for Lucy to find, the therapist interpreted, rather than complied with, the child's instruction for an enactment of cruelty by the therapist towards the child.

As well as considerations of when not to engage in an invited play enactment, it seems that there is also a very important technical distinction, to be understood in relation to the meaning and purpose of play enactments in which the therapist is involved. The question of when to engage in play and when to solely interpret the play, has been debated many times in the literature. Alvarez highlights that a crucial function of play is the enabling of the child to formulate their experience. She says:

> *There are moments when a Winnicottian respect for the play itself is important and when a too premature transference interpretation would interfere with the very process of formulation the child is trying to achieve.*
>
> (Alvarez, 1992, p 125 –126)

Later in Data Set 5, following Lucy's tyrannical play wherein my ears and nose were symbolically cut off, I said:

> '*I am to know what it is like to suffer, not move, not see and not hear anything. I am to just suffer and suffer'.*
>
> Data Set 5, Session 45 (Friday)

Lucy went to the toilet immediately after my analyst-centred interpretation, perhaps worried about her own aggression. I noted at the time that I was feeling *'bereft and disintegrated'*. When Lucy came back from her trip to the toilet,

> *I say that I thought she really needed me to know about not being able to move, to be trapped and to not see or hear.*
>
> Data Set 5, Session 45 (Friday)

In the session following the break, after I made a patient-centred interpretation of feelings spilling out during the break, Lucy's defensive response was to declare that she didn't miss me at all. I seemed to take this to mean that Lucy found the patient-centred interpretation unbearable, which then appeared to prompt me to give more of an analyst-centred interpretative response. Thus, I said; *'maybe I'm to be silly for suggesting such a thing'*. It seems that my willingness to allow Lucy to have dismissed me and thereby convert the earlier patient-centred interpretation into more of an analyst-centred one, enabled Lucy to more directly convey a worry about whether I remembered her. This worry was displaced through a question about whether I remembered the animal game and seemed to prompt me to lean towards an emphasis on a patient-centred interpretation about there being 'a worry' (not naming it to be *her* worry) about being forgotten. I said:

'I think there is a worry that when I take a break, you and our time together and what we do, gets dropped from my mind'.

Data Set 6, Session 46 (Monday)

5.6 (b) ii Patient-centred Interpretation

Steiner suggested that containment is less effective if interpretations or explanations are given to the patient who is in a borderline paranoid-schizoid state of mind, about what he is thinking and feeling (Steiner, 2004). Given, he says, that the patient has projected unwanted elements of his experience into the therapist; these elements need to remain in the analyst's mind where they can be rendered meaningful.

In Data Set 1, when Lucy was in a more contained state of mind, she became more directly interested in the quality of her object. This is indicated in her quick succession of questions: *'Why do babies not like cold milk?' 'Do you live here?' and 'Who looks after your children?'*. When I took up her question about babies not liking cold milk and made an interpretative link with *her* not liking cold milk, she reacted with an expression of disgust and stated that she *'did not like cold potatoes'*. Lucy's response to this more patient-centred interpretation had a disorientating effect on me and was, perhaps, an indication of her intolerance at this time, of this form of interpretation. This may have influenced me thereafter, in what is evidenced in the data analysis, as a less frequent use of 'patient-centred' interpretations between Data Sets 3 and 5 compared to 'analyst-centred' interpretations.

However, later in Data Set 1, following Lucy's caring for the dolls,

I said she had a thought about the doll babies needing a blanket and to be fed.

Data Set 1, Session 1 (Monday)

This form of interpretation, contained narrative and patient-centred elements, and led to Lucy's pronouncement; *'Babies can't tell you what's wrong with them; they*

just have to cry'. This seemed to enable me to judge that Lucy was able, in this moment, to make use of a patient-centred interpretation. Thus, I said:

> *'The baby part of you can only cry with distress and rage and can't say what's wrong'*

Data Set 1, Session 1 (Monday)

Moreover, later in the session, Lucy's persistent curious state of mind seemed to enable me to link her questions to a transference interpretation which included a patient-centred aspect. This was aimed at uncovering and processing her anxiety and suspicion about my qualities. Thus I said:

> *'You have an idea that I have children and you worry about who is looking after them and maybe whether I can look after you; whether I will know that babies don't like cold milk and if I will know what you don't like.'*

Data Set 1, Session 1 (Monday)

Lucy pressed me on the question of whether I had children and this enabled me to further use a patient-centred interpretation, which gave meaning to her worry about whether I had space in my mind for her.

In Data Set 3, Lucy was in a state of abject turmoil in the first part of this session. When she was in a more contained state of mind, I said:

> '*I was thinking about what made you so angry and upset and I thought it might be to do with my cancelling the session so suddenly on Friday'.*

Data Set 3, Session 21 (Monday)

This interpretation enabled Lucy to talk directly about it 'being harder at home'. Following a sequence of play, in which Lucy is *'cleansing me of poison'*, I said:

> '*You have an idea that I have poison in me that you need to take out so that you can be sure I can be trusted'. She says that I am to think the poisonous water is food and I am to drink it. I say that I am to be cruelly*

tricked into thinking I am getting something which is good for me when it is poisonous. I am to suffer and suffer.

Data Set 5, Session 45 (Friday)

In this excerpt, while leaning towards an analyst-centred interpretation of Lucy's underlying anxiety about malign qualities in her object, I include analyst-centred and narrative aspects in my interpretation. This seemed to provide Lucy with an experience of her persecutory anxieties and aggression being received and understood. Moreover, this form of containment seemed to have a lingering effect as evidenced in her more contained state of mind in the session immediately following the two-week break at Christmas.

Following the Christmas break, the contrast in her state of mind compared to that in Data Sets 1 and 3, was striking. My use of patient-centred interpretations in this session was also more than double those in Data Sets 3. This seemed to indicate Lucy's more receptive state of mind to thinking about self and object. Thus, in Data Set 6, when Lucy asked tentatively if I remembered the animal game, I interpreted her *'worry that when I take a break, you and our time together and what we do, gets dropped from my mind'*. Lucy's capacity to receive this patient-centred interpretation, immediately following the break, about her anxiety during the break, was evidence of her developmental progress.

Later in the school game, I was not permitted to get any of Lucy's questions right and her punishment, which was that I had to *' go to detention for 3 days',* seems a striking symbolic communication, given that her treatment was three times a week. She seemed to be conveying, in this communication, her experience of the break as being like a detention for her. In response to Lucy's 'punishment', I gathered up Lucy's hostile enactments from the play and, using a combined analyst and patient-centred interpretation, said:

'Maybe I've to be put through lots of tests to see if I can manage being a stinky, poisoned, poohy, stupid and bad therapist/pupil before you can believe that I might be able to help you sort out difficult feelings'.

Data Set 6, Session 46 (Monday)

Lucy's response to this interpretation was an invitation for me *'to play the piano and I will sing'* and this seemed to indicate that she had introjected an experience of a new type of object, which was capable of withstanding her distress, hatred and fury about the break. O'Shaughnessy's question of how the patient uses the therapist's absence seems relevant here. She says:

> *Can he preserve, and use, under the strain of the absence of his therapist, the insight – the thoughts – he gains in her presence? In phantasy the object is attacked by various methods for its hostility, neglect, or selfishness in being absent and attending on itself or enjoying itself with others who are preferred. More basic, however, than such envious and jealous perplexities, is the feeling that the absent breast has left him to die.*
>
> (O'Shaughnessy, 1964, p 36)

Steiner suggests that both analyst and patient-centred interpretations are necessary and that the shift from one to the other depends upon the therapist's capacity to listen carefully to the patient's reactions to the therapist's interpretation. He emphasizes the impossibility of patient-centred interpretations when the patient is functioning at a more primitive level and when containment in the case takes priority over insight. (Steiner, 1994).

5.6 (b) iii <u>Narrative Interpretation</u>

Narrative interpretations seem to be based on the therapist attending to the child's use of play to formulate her experience via displacement. This seemed to occur both in relation to narrating the play and to mirroring the child's communication through a form of elaboration. Narrative interpretations, contained within which are either patient-centred and analyst-centred elements or a combination of both, are found to occur throughout the Data Sets, reaching their highest peak in Data Set 6, which was the first session following the two-week break after Christmas.

In Data Set 3, while still in a state of turmoil, Lucy managed to engage in a form of symbolic play which conveyed her inner hopelessness and despair. I narrated her play:

> *She sets the ambulance and police car opposite each other on either side of the chair and bangs them together, head on..... I say, 'the helpful police and helpful ambulance are not so helpful; they drive into each other.' 'They're baddies,' she quips. She takes out a figure and says that he is the policeman and then takes out another figure and bashes them against each other and looks at me, grinning a little sadistically, I thought. 'Everyone is to be a baddy and to hurt and destroy each other,' I say.*
>
> Data Set 3, Session 21 (Monday)

Lucy responded to my narrative interpretation by elaborating upon her communication of experience of despair and hopelessness, through a deepening of her symbolic representation. Thus, her declaration, *'they're baddies'* followed by informing me that one of the figures she had taken out of her box was a '*policeman'*, indicated that Lucy had used my narrating of her symbolic play to convey important themes about unhelpful and destructive experiences of internal objects.

It is significant that in Data Set 6, narrative interpretations were found to have the highest occurrence compared to other Data Sets. This may be related to Lucy's intense need to use play as displacement in an attempt to manage my return from the break, in which, as mentioned, she appeared to experience me as a malign presence.

In this session, Lucy conveyed anxiety via displacement, that I may have forgotten the 'animal game'. This communication was followed by depicting the *'baby hippo*' as fearing that I might have '*forgotten*' him. I simply narrated the hippo's fear without relating this interpretatively to her anxiety.

Similarly, I later narrated a very moving song Lucy created, which conveyed the terrible predicament of a severely deprived infant. Lucy sang:

'*The first day of school the baby was born. The second day of school, the baby cried, the third day of school the baby got fed and the fifth day of school the baby was left and the sixth day of school the baby dies'. I say that things started off alright for the baby, but got worse and worse as time went on'.*

Data Set 6, Session 46 (Monday)

This song movingly communicated the child's catastrophic experiences of deprivation. This reminds me of O'Shaughnessy's reference to the child's experience of separation as being left to die (O'Shaughnessy, 1964, p26). However, given the child's actual experience of severe deprivation, it seems evident that separation, as experienced by the child, is akin to starving to death.

In this context, it seemed that any form of either analyst-centred or patient-centred interpretation of Lucy's infantile self, contained in the song she created, may have interfered with her need to first explore her experiences of severe deprivation as an infant through symbolic play, before any linkage to her own experience could be tolerated. It wasn't until after she elaborated upon the song, by identifying that it was the mother who left the baby, that I ventured a patient-centred interpretation in the form of narration. Lucy sang:

'Mum is leaving, Mum is leaving, she is bad, she is bad.....Mum is stupid, she goes away, she's a stupid pig, she learns and comes back, comes back, and then she cries'. . I say Lucy 'needed me to know about a Mum being a stupid pig for leaving'.

Data Set 6, Session 46 (Monday)

This song appears to be a fusion of Lucy's internalized experience of a Mum who abandoned her and who cried all the time in Lucy's presence, with her experience of my return from the break. This fusion seems to be represented further by her experience of me as a persecutory presence, as indicated earlier in relation to my being *'full of pee and pooh'*, with a Mum who 'cries'. This also recalled what her real mother did, in that she cried extensively during contact visits with Lucy.

5.6 (b) iii <u>Overcoming Interpretations</u>

There were 4 overcoming-type interpretations identified in Data Set 5, and Data Set 6, which were before and after the Christmas two-week break. There was also an overcoming interpretation in Data Set 8, which followed the two-week break instigated by Social Services. Below are examples of 'overcoming' interpretations.

In Data Set 5, during a game of hide and seek, I narrate the child's anxieties by using a combination of patient and analyst-centred interpretation, contained within which is an overcoming interpretation aimed at helping the child manage the break. I say:

> *'There is so much to think and know about, especially about the break coming up. You need to know that it might seem that I am hiding, but that I will be back after the break and you will find me and we will find each other again'. While taking my turn to hide the bottle, I say: 'you need to know that I will be found and that you too can also be found'.*

Data Set 5, Session 45 (Friday)

This form of 'overcoming' type of interpretation, which focuses on the therapist and child 'finding' each other after the break is something Alvarez (2000) draws attention to, in raising the issue of technical approaches in working with severely deprived children. She says that these children require the therapist to put emphasis on their return, rather than on their leaving. She highlights the fact that severely deprived children are more accustomed to losses and separations than they are to the available presence of their objects. Therefore, emphasizing the return of the object can be more containing than a focus on the defences against loss in the child, where there is an already despairing state of mind.

In Data Set 6, Lucy was keen to tell me about difficult things that happened during the break and how she managed.

> *Lucy says: 'I've stopped biting and kicking though!' in a tone that indicates she is pleased with herself. 'I'm to know that you were*

able to manage some things but not others and you need me to know you're pleased with yourself for that'.

Data Set 6, Session 46 (Monday)

It is indicated in this excerpt that Lucy had internalized an experience and expectation of my interest in her and that she had used the 'overcoming' interpretation in Data Set 5 to help sustain her.

It seems evident that, in Lucy's case, her extreme reaction to gaps and breaks needed a certain technical approach which encouraged her ability to believe that she could overcome her despair, by holding on to the thought of my return.

5.7 Summary of use of interpretation

The findings indicate that different forms of interpretation were used in different ways, and that this assisted facilitation of reparation, recovery and developmental progress in Lucy. It was found that analyst-centred interpretations were used as a form of containment of Lucy's states of fragmentation, while narrative forms of Interpretation seemed to be linked to the development of Lucy's capacity for symbolic play. Thus, interpretation in its various forms enabled Lucy to both communicate and work through important psychological imperatives.

In thinking about the function of interpretation linked to developmental progress, Lanyado emphasizes the importance of the qualities of the presence of the therapist. She draws on the work of Stern et al. (1998), who place the personal characteristics of the therapist at the centre of change in the internal world of the child. Thus, in findings from studies of change in the therapeutic encounter within the perspective of developmental psychology, Stern, et al. conclude that:

Whereas interpretation is traditionally viewed as the nodal event acting with and upon the transference relationship, and changing it by altering the intrapyschic environment, we view 'moments of meeting' as the nodal event acting upon the 'shared implicit relationship' and changing it

> *by alerting implicit knowledge that is both intrapsychic and interpersonal. Both of these complementary processes are mutative.*
>
> (Stern, et al., 1998, p. 918)

Stern and his colleagues contend that transference interpretation is only one aspect involved in the process of change and that it is the development of repeated experiences of attunement between therapist and patient, leading to 'moments of meeting', that are the basis of change in the internal world of the patient (Stern, et al.,1988). It is important to consider that the narrative forms of interpretation perhaps facilitated 'moments of meeting' in Lucy's treatment, enabling her to introject experiences of my thinking about her and trying to understand her.

Kenrick highlights that current technique with severely deprived children aims to:

> *build up our interpretations quite slowly: perhaps from a description of what is happening in the play, then as much at a time as the child can manage, bringing it into the transference, and only then making links to internal phantasies or external past known facts in the child's life, what Alvarez calls 'minimal dose' links.*
>
> (Kenrick, 2005, p. 29)

Adam Phillips suggests that a good interpretation, like a transitional object, cannot be given to a patient; it can only be offered and found meaningful (Phillips, 1988, p. 115).

5.8 Reflections on the therapist's responses to the work

The intensity of my feelings in response to Lucy's shifting states of mind ranged from fear, helplessness and bewilderment to curiosity and intense fondness. I found it comforting at the time to refer to 'Some feelings aroused in working with severely deprived children' (Boston & Szur, 1984 p.125) and to be reminded, in particular, how daunting a task it is for such children to 'come to terms' with severe loss, when they have 'little initial capacity to feel or think about their inner

suffering' (p. 125). It also helped me to intuitively grasp Lucy's need for me to 'tip-toe up to the pain'. (Meltzer in Boston and Szur, 1984, p.130). It felt that Lucy's intense involvement of me in play enactments seemed to enable the gathering of the transference through the quality of particular interpretations, where her states of mind and the relationship between us, could be explored.

5.9 Repair, Recovery and Developmental progress

In this section, I draw attention to particular features of repair, recovery and developmental progress in the child, evidenced from the findings and illustrated in the clinical material in this study. These include features such as the child's engagement in ordinary play and development of her capacity for perspective-taking, sense of humour and development in her awareness of time. I discuss evidence for a particular quality of interestedness, which developed in the child. I also illustrate particular aspects of development in her symbolic play.

In Data Set 5, which is the last session of the first term, Lucy played hide and seek in an ordinary way. Whereas before, she had arranged the game of hide-and-seek so that she 'appeared' rather than allowed herself to be 'found' by me, in contrast, in Data Set 5, she engaged in the ordinary rules of the game. Thus, she expressed triumph in my finding it difficult to locate the object *she* had hidden, as well as taking delight in finding the object I had hidden.

In Data Set 7, Lucy initiated a 'racing up the corridor' game and, although there was a slight manic quality to this game, there was also an ordinary excitement in her capacity to be fast. Correspondingly, in the external world, Lucy's unexpected developing capacity at sport was beginning to be recognized. Indeed, one year on from the time of this session, she was selected for the local football team and travelled with her team to different regions to compete in tournaments.

Also in Data Set 7, for the first time, Lucy had a thought that contained a perspective on what I might have been thinking. Thus, as Lucy left the room to go to the toilet, she swung her head around the door and said;

'Did you wonder where I was going just now? I'm going to the toilet'.

Data Set 7, Session 99 (Wednesday)

In the third term of treatment, Lucy seemed to have internalized a sense of time boundaries and often, at the end of sessions, she played a game, which she initiated and in which she involved me, of counting down the last two minutes. Canham (1999) highlights the fact that, for many looked-after children, their neglected, disrupted and fragmented experiences mean that they often do not experience the normal rhythms of life, in terms of day to day care. This, he suggests, leads to confusion in order and sequence, which has a serious effect on these children's capacity to develop a concept of time and even to be able to tell the actual time.

In reference to themes from various writers exploring the concept of time representing development achievement, Perelberg suggests,

> T*he realization of the passage of time is an achievement in the process of development that requires a capacity to both recognize the other and be able to separate from the primary objects. It inserts the individual in the process of exchange with the other.*

(Perelberg, 2008, p23)

From the findings, reparation, recovery and developmental progress are evident by Data Set 8. Prior to this session as previously mentioned, there had been a two-week gap in sessions, during which time I was unable to persuade Social Services to retain her intensive treatment, while they insisted on the belief that she needed a settling in period. When I went to pick her up for the session, Lucy straightforwardly declared that she was 'in a children's home'. The sense in which the therapy room had become a place of reliable importance to her was expressed in her easy sliding into a familiar groove, when she declared that she would '*sit in my usual place'*.

Lucy's response on her return to therapy following this unplanned break indicated that she had internalized my availability and reliability and that this had sustained her through the difficult move from her kinship placement to a children's home. O'Shaughnessy describes the major developmental task of the child is to sustain the experience of the good breast gained in the therapist's presence while the therapist is absent. (O'Shaughnessy, 1964).

Lucy was surprisingly forthcoming and contained about being moved to the children's home. Though she sounded "*cheerful*" when talking about her new environment being "*okay*", she nevertheless communicated the shock and distress about her move when she described, "*falling out of bed*". Though defensive, in an 'overcoming' sense, Lucy was also thoughtful and contained in her engagement with me about her move to the children's home.

Lucy's developmental progress is further indicated in her expressed relief at re-discovering the water tap, which she turned on while agreeing with me that she was *'glad to be back'*. I decided not to draw attention to other levels of meaning in relation to the tap, as I thought Lucy needed me to help her orient herself back into the room and with me.

> *Lucy filled up the empty crisp bag with water, saying, 'Remember I used to do this'. 'Yes', I said. 'Can you hold this?' she enquired, handing me the filled up bag and saying that she wanted to sellotape the top of it. I thought of her creating a container for water inside the bag.*

Data Set 8, Session103 (Monday)

It is evident here that Lucy experienced me as container, (the bag filled with water and sellotaped at the top) and holder of memory about her, in the therapeutic space.

Later in Data Set 8,

> *Lucy sat down opposite me and said, 'Is that a dress you have on? No, it's a top and a dress', she observed and then got down to look closely at the bottom of my skirt. 'What are they?' she asked, 'Shells', 'Are they*

real?' 'Yes', 'I see you have some on your top. You look different', she said. 'You think I look different at the moment and things are different for you', I said. 'You're not living where you had been with your aunt and uncle since the last time I saw you'.

Data Set 8, Session 103 (Monday)

In this excerpt, Lucy studied me carefully and thought I was 'different'. It seemed that feelings and experiences associated with a different life in the children's home, needed to be located in me first. However, she also seemed to establish my presence through studying my clothes, which appeared to evoke thought in her of a poignant game, conveying her desire for containment.

'We're going to play a game; you're my mummy'. Lucy crouched in the chair saying she might doze, 'Remember I did that the last time.' 'You're remembering a nice feeling when you were here before of being curled up and sleepy and feeling sick,' I said.

Data Set 8, Session 103 (Monday)

Lucy's idea for a game in which I was identified as her "*Mummy*" evoked a memory in her, of dozing in the chair in one session when she was feeling unwell. She related to the therapist as a container and holder of memory and conveyed a deep understanding of the shared memories between us, of her experiences before she went into the children's home. This seemed to enable her to connect to the need to *'tell me the story'* through play, of being in a children's home. Her protective defence, early in the session, when she described the home as being '*okay*' gave way in the game to her conveying of anxiety about living in the children's home and the traumatic loss of her kinship placement. Lucy's 'play' with the bottle (as described in an earlier section) seemed to represent her belief that she was to blame for the loss of the placement.

However, she also conveyed that she had not lost her developmental achievements and proudly announced in the session that she was '*getting good with telling the time*'.

5.9 (a) Symbolic Play, Counter-transference, Interpretation an Developmental Progress

The content and quality of Lucy's symbolic play developed over time and was evidently linked to her states of mind and the shifts in these. This is evident in her movement from hopelessness and despair in unreliable, cruel and dangerous objects, as evidenced in Data Set 1, in which Lucy '*bashes*' the police car and ambulance together, to the emergence of humour in the second term. Thus, in Data Set 6, after the therapist narrates Lucy's declaration of the therapist being *'a bad pupil full of pee and pooh'*, she '*invites*' the therapist to join her playing music. It seems evident that the therapist's willingness to accept the child's aggression in that moment, rather than interpret it as a defensive reaction to the break, appeared containing for Lucy. This seemed to create in her a more creative space for playfulness, intermingled with her use of the play to communicate profound sorrow about a neglectful mother.

It seems that Lucy's capacity to manage breaks had significantly improved by the second term and the trepidation I felt, on my return from the two-week Christmas break, was eased on discovering that her reaction was one of disorientation, rather than catastrophe. From the findings, it is indicated that development in Lucy's more benign expectation of my availability, continued to oscillate with suspicion of me. It seemed, at times, that she needed me to be more like a benign developmental object[6] and, at other times, Lucy seemed to reverse her difficult experiences and make me suffer. She seemed to need me to have some idea what it was like for her to feel lost and bewildered. It felt important during

[6]Hurry suggest that analytic work represents the opportunity for a 'new beginning' and that, alongside a transference object, the child uses the psychoanalytic therapist as a 'developmental' object. The transference, she contends, is 'accompanied by an unconscious wish for change alongside the defensive need to repeat, thereby…carrying hope that the analyst will act as developmental rather than as transference object' (Hurry, 1998 p 47).

these times that I actually felt lost, helpless and even, at times, stupid when, for instance, Lucy gave me impossible guessing tasks, which evoked in me feelings of stupidity and helplessness. At other times, Lucy seemed to need me to benignly wait and wonder what she was making or creating with materials from her box.

Increasingly, in the second term of the work, I felt moved by Lucy's struggle to overcome her deprivation and I felt like I was a gatherer and narrator of the fragments of her past and present experiences of trauma, bewilderment and curiosity. Her growth in playfulness filled me at times with an ordinary sense of joy, while her need for me to suffer felt, at times, painful and overwhelming.

As the third term progressed, Lucy's connection to benign feelings seemed to develop, along with a belief in the presence of benign qualities in her therapist. Moreover, Lucy was increasingly able to communicate her experiences more directly. Thus, even after a two-week enforced and unplanned break, during which she moved to residential care, Lucy managed this difficult time without experiencing it as a catastrophe. Moreover, she was able to convey straightforwardly her experience of the move and of the missed sessions.

Lucy's growing ability to manage loss and endings developed into repetitive play themes, which seemed to emerge as an imperative for managing her experience of sessions coming to an end. These involved various games, including synchronized counting down to the end, which we did rhythmically together while following the second hand on the clock in the room. Hide and seek games were also a regular feature, which Lucy began to introduce 10 minutes before the end of each session.

From terrified and fragmented beginnings, Lucy gradually developed her capacity to manage breaks. Increasingly her creativity, humour and ability to think seemed to come alive as the year progressed, with themes in her play shifting from danger to nurture. The growing intensity of Lucy's use of me to play out her internal struggles and strive for mastery, was profoundly moving at times. From

the findings, it is evident that I felt the need much of the time to rely on intuition in playful responses to her. However, it is also evident that I felt the need to be careful not to collude with her more perverse and sadistic states of mind. This was challenging at times and it seemed important to allow myself to be the receptacle for her cruel and sadistic enactments and not accede to demands that I respond sadistically and cruelly to her, but instead talk about how she *wanted* me to be cruel. The evidence indicates that Lucy seemed to need her therapist to suffer, so that someone else experienced some of what her suffering was like and could talk with conviction about this. The danger of collusion with her perverse states seemed to lie in her compulsion to invite me to treat her badly and thereby repeat bad experiences she had had to endure as a younger child.

5.9 (b) Being interested and interesting

Gathering of the transference by absorbing and containing Lucy's turmoil and being willing to suffer her 'playful' onslaughts, evolved into a growing expectation that I wait and wonder. The qualitative dimension of this state of waiting and wondering in the therapist seemed linked to an expectation of the therapist's interest *in* her, which appeared to correspond with the therapist's 'interestingness' *to* her.

For example, in Data Set 3, when she had become more settled following the tumultuous early phase of the session, she declared, with a quality of expectation of the therapist's interest; '*Look, I'm still in my pyjamas'*, which was an acknowledgement that she knew that the therapist was aware that she was so distressed and violent at home that she had been unable to change into her clothes before coming to the session.

On Lucy's return after Christmas, which was the first major break in treatment, she seemed to have an expectation of the therapist's interest in her. This is indicated in her telling the therapist of a turbulent incident that had occurred with her cousin the day before. This was the first time Lucy communicated her experience in a direct way.

'I was in really bad form yesterday', Lucy said. She went on to explain that she and her cousin Julie had had a fight. Lucy said, 'Julie threw water over your chart so I threw water over her'. Then, in a pleading tone, she declared, 'She started it, or maybe me, sometimes it's Julie and sometimes it's me'.

Data Set 5, Session 47 (Monday)

This is an example of Lucy needing the therapist to absorb her narrative, in an 'interested' way, without in this moment interpreting a link with the break. It seemed to enable Lucy to further convey her experience, by telling the therapist that she had a big bruise on her leg. She explained:

'I hit it against the cupboard when I was in a bad mood and broke the door'. I say, 'When I was away, hurtful things happened and you didn't feel you could manage at times'. 'I've stopped biting and kicking though', she said, in a tone indicating that she was pleased with herself. I say, 'I'm to know that you were able to manage some things'. With a tone of forlorn sadness: I'm back in my own room and there is only a chest of drawers in it'. I say, 'Oh, that's difficult, because you were glad to be back sharing a room with Julie and now, during the break, you are back in the room you hate'.

Data Set 6, Session 46 (Monday)

Her description of breaking the door and causing herself more hurt seemed a poignant recognition of her unbearable states of mind. It also seemed to represent her expectation of the therapist's interest in her achievement in stopping biting and kicking. It seemed apparent that Lucy needed the therapist's 'interested' state of mind in recognizing her struggle to 'overcome', as opposed to 'defend' against the persecution felt by my absence. Alvarez highlights the need, in certain circumstances with severely deprived children, to recognize and identify the child's attempts to overcome their difficulties. She suggests that this form of interested recognition must be differentiated from collusion with the child's omnipotent defence. (Alvarez, 2000).

Though evidence of curiosity in Lucy was present in the first term, by Data Set 8, her awakening to the world around her was clear, poignant and moving. The

quality of her questions contained an enthusiasm and aliveness that also seemed to indicate that she had internalized an interested and interesting object, one with whom she could identify and who could join in her discovery. It appeared that what was in the beginning, intersubjective, became intrasubjective (Stern, 1985). In referring to Brendel's (2001) work on the features of the conductor Furtwangler's greatest strength as being "the great connector, the grand master of transition", Alvarez quotes Brendel as asking:

> *What makes Furtwangler's transitions so memorable?…They are not patchwork, inserted to link two ideas of a different nature. They grow out of something and lead into something. They are areas of transformation.*
>
> (Brendel, 2001, p. 325 in Alvarez, 2012, p. 41-42)

"Time present and time past
Are both perhaps present in time future,
And time future contained in time past"
— T.S. Eliot *Four Quartets*

Chapter 6 - Discussion

It is clear in this study that the child's experience of severe deprivation and abuse produced deficits in her capacity to contain and process her emotional states. These deficits appeared to affect the child's ability to tolerate gaps in contact with the therapist, particularly in the first half of the first term. Thus, the gap between assessment and treatment, as well as an unplanned cancellation of a session mid-way through the first term, evoked catastrophic emotional states in the child, which manifested in terror, turmoil and violence towards the therapist and the room.

It was found in this study that repair, recovery and developmental progress in the child was facilitated by certain aspects of the therapist's responses to the child's states of mind. Thus, the child's movement from terror and turmoil in reaction to gaps in treatment, to less catastrophic states of fragmentation was associated with the therapist's predominant use of particular forms of interpretation, in the context of intense engagement in the child's play. These forms of interpretation, which were guided by countertransference experiences, involved the therapist narrating her experience of the child's projective identification and observations of the child's play activities, predominantly more than directly interpreting the child's defences. These forms were identified from the data analysis as *analyst-centred* and *narrative interpretations*.

A further finding was that the two main forms of interpretation discovered in this study occurred predominantly in the play arena, in which the child used play as displacement and in which the child intensely engaged the therapist as a 'play-mate'. The child's use of play as displacement, in conjunction with the therapist's predominant therapist-focused and narrative-type interpretative responses within

the play, appeared to enable the child at different times to evacuate, communicate and examine self and object at a safe distance.

The predominant way in which Lucy seemed to manage inner turmoil when this was at its most extreme, was through evacuation of what were felt to be unbearable experiences. Evacuative states of mind in severely deprived children have implications for psychoanalytic assessment and treatment approaches to working with these children.

6.1 Developmental progress

It seems, from the findings, that developmental progress in Lucy is evident in her shift from evacuative states of mind, particularly in the first term, to greater capacity for thinking, reflection and symbolizing. Lucy's evacuative states were manifest in defensive concrete and mental activity, which are understood as forms of projective identification. For example, at times she evacuated tumultuous and overwhelming states of mind through violence towards me, towards her box and towards the room. At other times, Lucy concretely evacuated painful connections to feelings, especially those associated with dependency needs and experiences of separation, through frequent trips to the toilet and by bringing in food to sessions. These occurred most often at the beginning of sessions. Canham refers to 'every beginning and every end' being 'tinged' with anxiety related to early experiences of abandonment, separation and loss (Canham in Briggs 2012). Although Canham is referring to children in residential care, his observations are also relevant to the child in this study during the first year of treatment.

Detailed examination of the material through grounded theory method provides evidence that these concrete activities were defensive, in that they occurred during moments when a difficult thought or feeling was stirred in Lucy. She used projective identification extensively in communicating her inner states and struggles. Increasingly, play and engagement of the therapist in play, functioned as an arena for the expression of projected states of turmoil and fragmentation in

the child. It also seemed to function in facilitating healthy forms of projective identification. This may be linked to the child's need to be understood and enjoyed, which appears associated with the child's developing experience of the interestingness of her object, introjected over time.

Projective Identification was first outlined by Klein (1946) as a defensive function in the infant in dealing with aggressive and paranoid anxieties. She described different types of projective identification, which include evacuation of unwanted anxious parts of the self, or invasion of others, for the purpose of control or destruction. In relation to this latter form of projective identification used for invasive purposes, it seemed that the intensity of Lucy's use of me in play during which I was frequently controlled, while she was often destructive, might concur with Klein's view of this representing an invading of others for the purpose of control or destruction. However, my experience and understanding of Lucy's invasion and control of me was that it was linked to her need to investigate the robustness of her object.

O'Shaughnessy (1988) raises this issue in highlighting that the focus of analysis for a long time may be an 'anxiety ridden research into the analyst's mind rather than into his own' (O'Shaughnessy, 1981 p187). However, it seemed that Lucy also needed to repair, not only destructive attacks on her object, but to explore and repair developmental deficits in self.

The finding of the predominant use of narrative-type and analyst-centred, rather than patient-centred interpretations at particular times was linked to what was tolerable to the child at those times. Thus, it seemed that the child needed, for prolonged periods of time, the focus of analysis to be on what the therapist could tolerate experiencing and witnessing. It is also important, as referred to earlier, to consider that the child had a need to internalize not only a robust, containing object, but a live and present one, imbued with the qualities of being interested in and interesting to her.

6.1(a) Qualitative shifts in the child's use of projective identification

Shifts in Lucy's tumultuous state of mind corresponded with qualitative shifts in her use of projective identification. For instance, as a form of evacuation, she used it more extensively in the first term when her terror and anxiety was at its height. As Lucy's unbearable states lessened and became more manageable, her use of projective identification had more of a communicative purpose though she still remained, at times, compelled to evacuate unprocessed thoughts and feelings.

However, it is important to highlight that, though Lucy's use of projective identification changed over time, from having an evacuation purpose to a more communicative aim, even in her most extreme state of 'unthinkable anxiety' (Winnicott 1971), she was nevertheless communicating her extreme muddle between self and object. This state of mind conveyed via projective identification in the early phase of treatment had a palpable impact, in the form of intense confusion in each of us and in the relationship between us, indicating a muddle between self and object. The counter-transference experience of intense confusion, helplessness and fear, which were evoked in me via projective identification, was essential to the process of understanding and containing Lucy's highly anxious and turbulent state of mind.

I concur with Joseph's view of projective identification as having a communicative function, even when it has different aims or intentions. She writes:

> *By definition projective identification means the putting of parts of the self into an object. If the analyst on the receiving end is really open to what is going on and able to be aware of what he is experiencing, this can be a powerful method of gaining understanding. Indeed, much of our current appreciation of the richness of the notion of counter-transference stems from it.*
>
> (Joseph, 1984 p 170)

Bion (1962) developed Klein's definition of projective identification with his suggestion that its purpose in infancy is to communicate anxious states of mind. This view is relevant to understanding the process of work with Lucy and how she was enabled to make developmental progress.

6.2 Psychoanalytic technique

As outlined in the Literature Review, psychoanalytic technique in analytic work with severely deprived children has shifted to take account of developmental deficit. This has meant a shift in work with severely deprived and highly disturbed children, from direct interpretation of unconscious conflicts and anxieties, to the therapist receiving and holding these sometimes for long periods of time. From the findings, I discovered that Lucy needed me to be able to absorb and suffer, rather than directly interpret, the intense force of her oscillations between evacuatory and exploratory projections. It meant that my responses to her did not often take the form of traditional interpretation. This was less to do with 'knowing' that interpretations might amount to what Joseph (1985) refers to as making 'pseudo-sense of the incomprehensible' and more to do with the support of supervision, in trusting that meaning would emerge from experiencing Lucy's projective identification.

6.4(b) interpretations

From the findings, it is evident that the forms of interpretation, used by the therapist over the course of the first year of treatment, seemed to be influenced by oscillations in Lucy's states of mind, corresponding to her tolerance for thinking about her own mind and how these manifested in the dynamic transference to the therapist.

By providing interpretative linking *within* the play, it appeared that Lucy was more able to tolerate my thinking, which enabled her to explore and investigate the qualities of her object. By being a receptive 'play-mate', carrying out the instructions she gave me in play, while waiting, watching and absorbing the projected states she needed to locate in me, Lucy seemed more able to tolerate

my interpretative linking, mainly, at certains points in treatment, in the form of analyst-centred and narrative-type interpretations.

6.2(a) Container-contained therapeutic model

The process of the therapist's receptivity to evacuative states of mind is derived from Bion's depiction of the container-contained model of the mind, which refers to the on-going projective and introjective processes involved in the mother-baby relationship (Bion 1962). In ordinary infantile states of mind, anxiety is communicated by the infant to the mother, through projective identification. The mother, through her heightened sensitivity to her infant's emotional states, receives, and transforms her infant's unbearable anxious states through thinking and containment of these, which enables the infant to make sense of his experiences. Deficit in this form of maternal receptivity is likely to interfere with the child's capacity to learn to think and process feelings. The child in this study experienced severe deficits in maternal care in infancy, which had catastrophic consequences for her psychological development.

Bion contended that in optimal care giving situations, the infant's anxious states are received and absorbed through maternal reverie, and metabolized through containment and thinking, making the thoughts bearable to the infant. This has far-reaching implications for psychoanalytic practice and, indeed, for all forms of clinical intervention with severely deprived children. As this study demonstrates, Lucy's evacuative states of mind were received and held by the therapist, without returning them to her in the form of traditional psychoanalytic interpretation.

6.2 (b) Countertransference

The findings of this study confirm that my countertransference experiences of Lucy's projective identification were crucial, in both understanding her states of mind and in facilitating her developmental progress. The dynamic process, whereby the therapist experiences the patient's projective identification, was described by Heinmann (1950) as countertransference. She suggested that

countertransference enables the most effective form of ‘research’ and insight into the patient’s unconscious states of mind.

From the findings, Lucy, it seemed, needed to put me through many experiences of confusion, stupidity and uncertainty, as well as subjecting me to sadistic cruelty. From the evidence, the purpose of receiving Lucy's projective identification, in the form of her identification with the aggressor (A Freud 1936), seemed to be that her experiences of severe deprivation and abuse and their manifest outcome, needed to be fully and deeply understood.

Evidence from an analysis of the therapist-child interaction suggests that the child needed the therapist to convey her experience of the child's projective identification, in a palatable form to the child. Interpretative words about the meaning of the child's communication of her state of mind without the therapist's experience of these states may have been less effective and, indeed, may even have escalated her turmoil. This is evident in Data Set 1, where it is reported that,

> *'With a sense of desperation and urgency, I start to name the items as Lucy throws each one, 'car', pen', 'doll', ‘lego’.....’*
>
> Data Set 1, Session 1

As well as clearly conveying a sense of being overwhelmed, this is evidence of the therapist's attempt to contain the child's turmoil by introducing a type of precursor to symbolic play, to which the child responds with a *'momentary flash of interest'*.

Lucy’s need for me to experience in the counter transference, her projections of helplessness, terror and turmoil, concurs with Kenrick’s description of the process of containment and adjustment in technique, in work with deprived children. She states:

> *Bion with his interactive and developmental model, has helped us to think of the containing mind of the therapist bringing reverie and alpha function to the material of the session in such a way as to enable the therapist,*

having introjected the patient's projections, to interpret and return them in a modified way.

Kenrick (2005 p 26)

From the evidence, it is indicated that Lucy seemed to require me to receive and hold her evacuative states, sometimes for long periods of time without returning these, even in metabolized form. This was facilitated by a therapeutic stance, based on the recognition that her psychological problems were related to deficits in her capacity for emotional regulation and thinking. For example, in Data Set 3, I had to endure knowing about Lucy's feelings of persecution and despair, without interpreting her turmoil. There were no helpful figures in Lucy's play and my willingness to tolerate her despair as indicated in my comment, '*everyone is to be a baddie*', seemed to have a containing effect on Lucy, enabling her to connect to concern as indicated in her response, '*they're hurt'*.

The findings of a narrative approach in responding to Lucy's communications of turmoil and despair brought to mind the emphasis Alvarez places, when working with severe deficit in children. She refers to the need for less interpretation, particularly in the early phase of treatment and more exploring of the quality of the child's experience, which she refers to as a 'descriptive level' of intervention aimed at exploring 'what is' i.e. the 'whatness" and 'isness' of experience. (Alvarez 2012). From the findings, it seems clear that an exploration of Lucy's tumultuous and despairing experiences seemed to need me to not only explore these, through observing and making sense of the child's projected experiences, but also by experiencing turmoil and despair via countertransference experience of her projective identification.

6.2(c) <u>Attunement and reverie</u>

The notion of maternal attunement was developed by Winnicott, who referred to this being integral to 'maternal preoccupation' in the first months of a baby's life, whereby the mother is instinctively primed to respond to her child's every need. The sense of my 'preoccupation' with Lucy's states of mind which she conveyed

in her verbal and non-verbal communications, felt particularly intense in the first year of treatment. I felt in this early phase of treatment as though I were with an infant, calling her into psychological being.

Bion (1962) referred to the process of maternal sensitivities to infant states of mind as a form of reverie. Lanyado used Bion's idea of reverie to develop the notion of therapeutic reverie. She writes:

> *..the musing in the therapist's mind about what is going on in the patient's mind and the total therapeutic process…observations, projective identification with the patient and containment of the patient's projections, as well as the therapist's personal and professional associations…is the process that Bion (1962) describes, of the therapist turning unmetabolised beta elements into thinkable thoughts through the use of the therapist's reverie.*
>
> (Lanyado 2004 p 11)

Like the mother, who receives and metabolizes her infant's anxious and attacking states of mind before returning these in digested form, the findings indicate that I used my reverie to process and make sense of the child's evacuative states. Over time, Lucy's repeated experience of my absorbing, recognizing and narrating her reversal of experiences of deprivation and cruelty, seemed to have a transformative effect which is indicated in the reparation, recovery and developmental progress evident in Lucy by the third term of treatment.

Many experiences with Lucy in the first term were like gathering fragments of shrapnel. I found it difficult, when examining material in the context of this research, to capture this experience and observed myself gravitate during second and third stage coding, towards music as a metaphor for gathering my experiences with Lucy. In particular, I thought of the orchestra 'tuning' before a concert begins and the 'cacophony' of dissonant sounds that are harsh, meaningless and unrelated to each other.

Markman (2011) used 'dissonance' in recognition of the difficulty in symbolizing, through language, the isolation and insecurity that result from uncertainty and

fragmentation. It seems that I sensed the need for intuitive tolerance and gathering of the unpredictable emergence many times, of different jarring moments within Lucy and between us. For example, in Data Set 3, intense feelings of confusion and disorientation were evoked in me, in response to Lucy's confusion of the categories fish and turkey.

Lucy seemed to need me to survive her intense and, at times, highly disturbing projections by absorbing and containing these, akin to Bion's (1962) description of the processes of reverie and containment. However, Lucy also needed me to remain actively alert to developmental imperatives in her. This was difficult to achieve as, often the child's oscillations between curiosity, envy and omnipotence were rapid, random and unpredictable. I was frequently filled with intense confusion and disorientation, unable to think and relying mostly on the belief that, out of the chaos and dissonance, meaning would emerge. I was very reliant on supervision to help me metabolize these difficult, dissonant experiences.

6.3 Play and developmental progress

It was found that, as Lucy's evacuative states of mind lessened, her capacity to communicate her inner turbulent and anxious states through play, significantly increased. Research in child development demonstrates the crucial role of adult responsiveness in the emergence of the capacity to symbolize and to make use of play for adaptive and creative purposes.

> *Play is not just about imagination but about the possibility or the defeat of intimacy.*
>
> (Wolf and Slade, 1994 p 7)

In discussing the contribution of Winnicott's work to the psychoanalytic treatment of children, Slade said:

> *We tend to think of our work as uncovering meaning, but I think that by learning to play we are helping children to make meaning.*
>
> (Slade, 1994 p 82).

Winnicott referred to the function of play as facilitating the development of individuation and separation, while Andre Green commented that

> *Analytic technique is directed towards bringing about the capacity for play with transitional objects. The essential feature is no longer interpreting, but enabling the subject to live out creative experiences of a new category of objects'*
>
> (Green, 1978, p. 176).

Desmarais points out that regressive play may serve to repeat an anxiety-provoking situation in order to master it or, in omnipotence, reinvent it. This view concurs with the findings whereby Lucy seemed to need to intensely play out cruel, neglectful and, at times, loving experiences towards and with me.

Marans et al. suggest that high levels of disorganization and destruction in play, indicate the function of play as,

> *a domain in which fantasies and conflicts can move from the internal to the external realm, at once owned and disowned, on a stage set in suspended reality.*
>
> (Marans et al., 1993 p 17)

Where play is very disturbed, it may be difficult for parents, carers and even professionals, to enjoy, participate in, or even witness what takes place during play. There is little research into how parents and carers cope with play when its characteristics are represented by the need to play out intense frustration and anxiety, as was the case with Lucy.

In 1983, Hoxter and others raised the issue of how difficult it is to bear witness, in play enactments within the therapeutic relationship, to the pain of children who have been severely deprived. She states:

> *For therapists working with previously maltreated children, whose play may often serve to express pain and anger, full awareness of the child's loss and suffering is very often nearly as intolerable to us as it is to the child, and like the child, we are tempted to use many ways of distancing ourselves.*
>
> (Hoxter, 1983 p 126)

Moreover, it can be even more difficult to tolerate the child's play enactments of cruelty and aggression when the therapist is required, by the child, to be involved in the play and to be on the receiving end of cruelty and tyranny, as was the case with Lucy.

6.3 (a) The child's use of the therapist in play

The findings show that Lucy seemed to need to involve me intensively in her play. In its early phases, this took the form of tyrannical behaviour towards me within the play arena. This seemed a manageable way for Lucy to explore how willing and able I was to withstand her tyranny and sadism by receiving, absorbing and metabolizing her projections within the play.

The therapist's engagement in play raises an important technical issue, which child psychotherapists have grappled with for many years. The question of how far to engage in play with children and when to interpret the play, has been the source of much thought over the years. Joseph suggests that the therapist needs to play long enough to understand the child's communications and give understanding through interpretation, which she sees as the 'basic aim in analytic work'. She stresses the danger of enactment on the part of the therapist by engaging too much in play, which she believed serves as collusion in the avoidance of the child's deeper anxieties (Joseph 1998 p 363).

The findings indicate that, contrary to Joseph's view of play as a form of enactment on the part of the therapist, Lucy appeared to need me to be both observer and participator in her play. It seemed that the play enabled her to use me as a 'play-mate' with whom she could explore the qualities of and relationship

between self and object. This function of the therapist as 'play-mate' may be particularly important in relation to the therapeutic needs of severely deprived children. However, the findings indicate that my function was not simply to play but also to narrate the meaning of the play and interpret its transference meaning, using analyst-centred interpretations at times when Lucy was less able to tolerate thinking about her own mind and its defences.

Additionally, from the findings, it appears evident that the play and my involvement in it seemed a necessary medium through which Lucy was enabled to introject a benign, interested and interesting object. Moreover, there seemed a connection between my willingness to be the receptacle of her cruelty and the development of her capacity to use my thinking and understanding of her states of mind and their shifts, through the use of narrative and analyst-centred forms of interpretation, which seemed to be linked to the enabling of a gradual increase of Lucy's capacity to use more patient-centred interpretation.

6.4 Further thoughts on technique

From the findings, it appears that Lucy's explorations and investigations into her own mind and the mind of her therapist seemed to occur through the medium of play enactments, which evolved over time and which she required me to both observe and engage in. It is evident that the qualities of my presence, in relation to involvement in these play enactments, seemed influenced by attunement to Lucy's oscillating and extreme states of mind. In particular, Lucy's ascribed role to me as her 'play-mate', seemed linked to her need to explore self and object through the use of play as displacement. Given the degree to which Lucy's play and my involvement in her play occurred during a significant proportion of the therapeutic hour, it may be considered that the child's use of play and my willingness to engage in it, was an important contributing factor in facilitating the child's recovery, reparation and developmental progress. In particular, play seemed to be the arena in which the facilitation of the slow build up of ideas about her mind and my mind was made tolerable to the child.

6.4 (a) Narrating the child's play

It seemed that Lucy needed me to bear witness to, experience and narrate all forms of her play, including her violent and sadistic play. Over time, she came to expect me to 'wait and wonder', which often manifested in her expectation that I comment on her play with curiosity and interest.

I found myself waiting, watching and absorbing Lucy's states of mind and narrating what was happening in the play activity. In this way it appeared that I conveyed to her my thinking of the meaning of her communications and what she unconsciously needed me to know and understand about her internal experiences.

Mendes de Almeida (2002) (in Alvarez, 2012) referred to early work with severely deprived children which involved the therapist identifying experience in the form of 'relating to a mind to be'. Alvarez quotes Mendes de Almeida;

> *With these children we often find ourselves 'thinking aloud' as if 'broadcasting' for us and for them what we are observing, notice, what is surprising or intriguing to us, as well as what seems, through our observing eyes, to be surprising and intriguing them. We share with them, in the very core of our relationship, the emergence and building up of thoughts, from impulsive discharges of discomfort to possibly more elaborated experiences of containment and transformation of needs and intentions to be communicated.*
>
> (Alvarez 2012 p 139)

By watching, waiting and wondering in the context of narrating her play, it seems that I provided Lucy with a certain quality of 'presence' associated with being in an 'interested', receptive and thinking state of mind. This appears linked with the child's development of interest in her own mind and in the mind of the therapist. It concurs with what Lanyado (2004) refers to as the 'presence of the object' and with Alvarez's exploration of the process of new introjections of an 'interested' other (Alvarez 2012).

6.4 (c) Facilitating introjective processes

From the findings, it appeared that the quality of receptive waiting and wondering, while narrating and at certain times giving mainly analyst-centred and narrative interpretations of Lucy's play, seemed to facilitate introjective processes. In exploring the 'problem of facilitating new introjections' Alvarez (2012) suggests that 'introjections' is the least studied of all processes within psychoanalysis and yet, she says, the capacity for introjections (in the severely deprived child) is developed through

> *new experiences of relief, pleasure, or the interestingness and receptivity of one's objects –we might want to emphasize the' taking in' – rather than 'working through'.*
>
> (Alvarez 2012, p 9)

It seemed Lucy's emerging expectation that I was an interested and interesting object to her, was directly linked with her growing experience of the quality of my presence and involvement with her in play, which seemed introjected incrementally over time.

As well as the experience of an 'interested other', which Lucy appeared to internalize over time, 'new' experiences for her included my constant returns after each session, weekends and three major breaks in the first year of treatment, with one being an unplanned break. These experiences seemed to have become internalized and formed a major part of her development in containment and capacity for thinking. Alavarez (2012) writes:

> *When the child is used to a daily diet of negative states, new experiences of a therapist's return, constancy, reliability, durability can be actively alerting, interesting and thought-provoking. These experiences take place in the presence of an object. When these states can be digested, they may promote mental development and learning.*
>
> (Alvarez 2012 p. 75)

The process of introjecting new experiences facilitated over time by the quality of the presence of the object, is also I believe, associated with the experience of being ‘wondered with’ and links with what Stern (1983) referred to as the ‘slow momentous discovery’ of connectedness. The process of discovery and introjection of the object’s presence is also alluded to in Meltzer’s reference to Diomira Petrelli’s patient Francesco who, in astonishment, looked at his therapist and murmured ‘Are you a woman - or a flower?’ An example of Lucy’s sudden realisation of the quality of my presence and her connection to me, is in Data Set 6, which followed the first major planned break in treatment. There occurred in this session a moment in which Lucy expressed heartfelt surprise, conveyed in a tone of affectionate laughter, at my willingness to improvise the 'twanging' of a guitar to accompany her singing of a profound song about a Mum who abandons her child. This 'moment of meeting' seemed to represent the child's connection to an experience of discovery of the interestingness of her object, which, as a result of my reliable, interested presence, she appeared to have introjected over the course of the first term. It is significant that this moment occurred in the first session following the first major break in treatment. Lucy's presentation here was starkly different to previous gaps in contact with the therapist in the first term, in which she presented in extremely tumultuous states of mind.

6.5 Summary and conclusion

It seems clear from the findings that recovery, reparation and developmental progress in Lucy was facilitated by a therapeutic stance, based on recognition that her psychological problems were related to deficits in her capacity for emotional regulation and thinking.

The technical implications for therapeutic approaches to problems related to deficit, challenges the centrality in all cases of psychoanalytical interpretation as a technique, designed to uncover conflict and anxiety, manifest in the transference. Severely deprived children often do not have the capacity to use this form of interpretation and, indeed, it has been shown that they can respond adversely to such uncovering interpretations.

In discussing the technical implications of deficit and the need to attend to the developmental imperative in the severely deprived child, Alvarez brings together views from some of the most influential psychoanalytic thinkers. She states:

> *First, as Anna Freud says, 'build the house' (because if you haven't yet built the house, you can't throw somebody out of it) first, as Klein says,'introject the good breast", first as Bion says, 'you have to have an adequate container', first as Bowlby says, 'have a secure base'"*.
>
> (Alvarez 1992 p 117)

Analysis of the material revealed the extent to which my responses to Lucy had the quality of an observational, narrative approach with interpretations given predominantly *within* the play. This approach seemed to derive from reverie and countertransference experiences, which guided understanding of Lucy's need for containment of her unbearable, fragmented states of mind, while being alert to her developmental needs. Both elements are interrelated, in that Lucy's capacity for introjection of the qualities associated with my presence seemed connected to her experience of having her unbearable, fragmented states received and held in mind for long periods of time. The medium through which the processes of containment and introjection of Lucy's states of mind and developmental needs occurred, was her creation of and apparent need for my involvement in her play enactments.

Guided by countertransference and reverie, my approach to making sense of and commenting on her play, took the form of mainly analyst-centred and narrative-type interpretations. An example from Data Set 3 is of Lucy who, in an extremely fragmented state of mind, sadistically bashed the policeman and ambulance together, to which I commented on the normally helpful figures hurting each other. My willingness to tolerate and narrate the impact of her frightened, frightening and despairing state of mind where there were no benign figures, had a calming effect on Lucy, whose state of mind in that moment was understood and accepted.

An approach involving acceptance of Lucy's need to communicate, explore and examine self and object through play as displacement, seemed to facilitate a growing reliance by Lucy on my capacity to withstand her sadism and despair. As previously mentioned, though Lucy's tyrannical and sadistic states of mind were found to be conveyed via displacement, the impact on the therapist in relation to being made to suffer was in evidence from the findings. In addition, Lucy increasingly came to need me to be able to be on the receiving end of her sadism and hatred via play displacement, without fear of my retaliation or direct interpretation of her aggression towards me. In referring to the function of displacement, Horne writes:

> *It has long been a feature in psychoanalytic work with children to take issues up in the displacement, especially when the child's anxiety is too great to enable a transference interpretation to be made or when words have for the child a concrete reality…Displacement is especially effective with younger children… [it] allows high emotions to be explored in a safe, removed arena.*
>
> (Horne 2006 p 229)

Lucy's recovery and developmental growth appeared dependent for prolonged periods of time, upon my willingness to suffer the indignity of being humiliated and treated with utter contempt and cruelty at times. In referring to the need to attend to developmental deficits in severely deprived children, Alvarez writes of the child's need for revenge and justice (Alvarez 2000 p 7-8). It seemed that Lucy needed not only that I suffer, in order to know what her suffering felt like, she may also have needed to take revenge for the suffering she had been put through and, thereby, make it someone else's turn to suffer.

Analysis of the data identified developmental progress in the form of changes, both in the way Lucy related to me and in the changing nature and quality of her internal objects. Her reaction to separation had notably shifted over time, from terror and turmoil to confusion and disorientation by the second term. Moreover, by the end of the first year, Lucy responded in a thoughtful, contained way to separation as when, for example, there had been an unplanned break of two

weeks, which was instigated by Social Services when she moved from kinship to residential care. It was evident that Lucy had internalized the belief (and, I contend, the expectation) that I held her in mind when she communicated confidently that she had received my letter during the same break. This internalization also seemed to have had a transformative effect upon Lucy's anxieties about dependency. Thus, she openly acknowledged how she had missed her sessions and me during the break.

Of the analytic state of mind Meltzer writes:

> *It is clear that the task of the analytic attitude involves several elements: to receive the material, content and behaviour; to contain the projection of mental pain; to think about the transference situation; and finally to communicate the analyst's understanding, be it ever so tentative, from moment to moment.*
>
> (Meltzer 1967 p 82-83)

From the findings in this study, I add to Meltzer's 'task of the analytic attitude' a further task with severely deprived children. This involves acceptance, with certain children in extreme fragmented states at certain times, of their need to use play as displacement and to use the therapist as 'play-mate', while maintaining the task of 'communicating the analyst's understanding' through a narrative approach, imbued with narrative and analyst-centred forms of interpretation at times when the child is unable to tolerate thinking about their own minds.

6.6 Contributions to knowledge

This study draws on a significant body of knowledge built up over many decades of clinical work with children. It is an analysis of a single case study using grounded theory, which explored the process of recovery, reparation and developmental progress in a severely deprived child. While the findings confirm those from existing research and clinical studies, particularly in relation to the technical adjustments required in work with severely deprived children, some aspects of the findings represent a new discovery that contributes to the body of

knowledge. This relates primarily to the use, quality and function of play, as it evolved in the context of the child's need to explore self and object, which was seemingly only tolerable to her via her use of play as displacement.

The use of the therapist in play corresponds with the infant's use of the mother to discover themselves and their objects. Moreover, from the findings, the child's intense use of me in play and the quality of my engagement with the child in play – i.e., watching, waiting, absorbing, narrating, while providing analyst-focused interpretations, seemed to correspond with incremental developmental progress in her.

An important additional finding is that the child continued to make developmental progress which was evident in both the psychoanalytic treatment setting and at school, while concurrently presenting in her kinship placement, with extremely turbulent states of mind, manifesting in escalating violence towards her aunt. The situation necessitated her move to residential care towards the end of the first year of treatment. This important finding indicates that certain children, at certain times, may need a lesser form of intensity of family life. Indeed, Canham (in Briggs 2012) highlights that, for many severely deprived children, a substitute family life may be too intimate to manage.

It was reported regularly in network meetings that Lucy found it extremely difficult to manage relationships within the family unit. While the child's period within residential care is not covered in this study, it is important to provide some comment on the continued progress the child made in treatment for a further four years beyond the first year. Two of these years, the second and third of treatment, were concurrent with her placement in residential care. Network meetings continued during this period of time, which provided essential support to the staff in helping them think with Lucy about the major loss and separation issues which necessitated her move to residential care. The continued presence of her kinship carers, along with residential staff in network meetings during this two year period of residential care, seemed essential to the successful return of Lucy to her kinship family.

6.7 Conclusions and recommendations

My intention in undertaking this study was to investigate, in detail, what facilitated recovery, reparation and developmental progress in a severely deprived child in intensive psychoanalytic treatment. That she made significant progress was evident and clearly illustrated by the fact that, after a difficult move from her kinship placement to residential care one year into her treatment, she returned to the care of her aunt and uncle after two years, where she remained in a stable state of mind. It is indicated from the findings that on-going work with the network had contributed to the success of treatment insofar as the child made progress. The significant aspect of this work was the capacity of Lucy's aunt and uncle to continue to participate in network meetings, despite their enormous feelings of guilt and fear of being judged, especially by the residential staff who became part of the network monthly meetings when Lucy moved to residential care. Indeed, network meetings had the quality o, an 'extended family' thinking together about Lucy's state of mind and how to respond to her.

By analyzing the data using a version of grounded theory, categories and themes in the work emerged which helped me to systematically track the detail of the therapeutic relationship, revealing the growth and change in Lucy and in her relationship with me. Even though I knew during the work that Lucy involved me in play, an analysis of the data revealed the intensity of this involvement and the significance of play in the therapeutic relationship and in relation to developmental progress in Lucy. I refer to 'play' even in its most primitive sense as when, for example, in Lucy's evacuative terror-ridden and tumultuous states of mind, her primitive play of 'bashing' things together and my narrating of this, provided her with an experience of my being able to tolerate and think about her states of turmoil.

From the findings, it appears Lucy required certain qualities in me, which she needed to access at different times. For instance, the categories, which emerged from the data analysis, show that Lucy often needed me to receptively watch and wait with a willingness to absorb and suffer her projective identification. The

function of this waiting, watching, absorbing and suffering seemed to be associated with Lucy's need for an attuned, containing object in a state of mind akin to 'maternal preoccupation' with all the intensity that this entailed.

At the same time as receiving and containing Lucy's primitive projective identifications, Lucy seemed to need me to have the quality of attentive responsiveness within the play. This quality represented more than the quality of containment. It relates to the quality of being 'interested' and 'interesting' as an object. It is associated with introjection of the qualities of 'aliveness', which seems to concur with Alvarez's contention that the presence of the object is as much a spur to developmental growth as is the object's absence.

Given that Lucy's extreme turmoil was manifest so early on in treatment, it may be the case that, since she suffered extreme neglect in infancy, this manifest turmoil may have masked a more underlying deadness in her which, without conscious intention, was helped overcome by my rather immediate encouragement of the child to 'play'.* Music describes his work with a very deadened boy and, in what seemed to be a 'moment of meeting' (Stern 1985) between them, Music describes spontaneously bouncing his leg when the child bounced his, to which in response, the child 'awkwardly smiled' (Music in Briggs 2012, p 202). This seemed similar to the 'moment of meeting' between Lucy and me, represented by her 'flash of interest' when I was naming the items that she was throwing around the room*.

This leads me to contend that children, who have been severely deprived, inevitably suffer significant deficit in psychological functioning and require a quality of presence in the therapist which combines the features of watching, absorbing, waiting and enlivening. It seems that the child's capacity to introject new experiences relied on this qualitative presence of the therapist.

*See Data Set 1 Session 1 where, in placing the box near the child, I convey the message of encouragement to the child to play. See also in the same session where I spontaneously 'playfully' name each item the child is throwing around the room.

The ‘presence’ of the therapist may entail being actively engaged in the child’s play, while simultaneously narrating it. This approach to Lucy’s play seemed to provide the context within which she was enabled to explore the capacity of her object to withstand extreme projective identification which, having a containing effect, enabled her to introject and eventually internalize repeated experiences of an interested object who became increasingly ‘interesting’ to her.

6.8 Concluding thoughts

There have been several important issues that have arisen in the course of this study, which have been the source of much debate within the child psychotherapy community over many years: 1) use of interpretation in problems relating to developmental deficit. 2) play and its purpose and function in the context of psychoanalytic work. 3) the different functions of the presence and absence of the therapist, particularly in relation to working with deficit.

I do not claim to have reached a definitive position on any or all of these issues in my own practice, as a result of this study. What I do believe is that where a child is severely deprived, ‘patient-centred’ (Steiner 1993) interpretation of the negative transference is likely to be counter-productive when the child is in a distressed state and when she is more preoccupied with the qualities of her object rather than being interested in her own state of mind. I found that my patient was only able to tolerate her displaced aggression and sadism, when this was formulated either as an analyst-centred or narrative interpretation. These forms of interpretative approach to her play activities seemed to lead to ever-increasing ego-strength and produced the required developmental progress, without the use of direct interpretation of her anxieties and hostilities.

It also appears that, crucial to Lucy’s progress was her experience of inducing suffering in ‘someone else’ of the cruelty, sadism and humiliation she had suffered in infancy. This served not only a communicative function, in that my suffering gave me an insight into her suffering, but also enabled her to express a form of revenge, in the belief that it was someone else’s turn to suffer. However,

Alvarez cautions about the danger of collusion with perverse sadism (Alvarez 2012). Therefore, importance of supervision cannot be over-emphasized in helping to differentiate between a developmental imperative and an invitation, by the child, for the therapist to engage in perverse play.

6.9 Clinical recommendations

The treatment of Lucy took place three-times weekly over a five-year period. The clinical data was drawn from the first year of treatment and, even though this represents a fraction of the overall treatment, the findings demonstrate the efficacy of intensive treatment for bringing about the required depth of change. There is no doubt that the commitment of Lucy's kinship carers and the staff at the children's home in attending meetings, was crucial in supporting treatment and in influencing the process of the eventual reuniting of Lucy with her aunt and uncle.

Canham (in Briggs, 2012) and others have recommended that, for some children whose internal worlds are extremely disturbed as a result of severe deprivation often associated with ruptures to their early relationships, residential placement may be best suited to their needs for a period of time, while these children undertake psychoanalytic treatment. The findings from this study significantly show that the intensity of family life was too much for Lucy and that she responded well to being placed in a residential setting for a two year period, while she continued to make developmental progress in psychoanalytic treatment.

Although the breakdown of her kinship placement was distressing for all in the network and especially for Lucy and her kinship family, there also seemed a collective hope and even belief that the move was ultimately a positive one. No-one in the network could foresee just how positive the move would prove to be, in that Lucy and her aunt gradually reclaimed their relationship during the two years Lucy lived in residential care, until her eventual and permanent return to her kinship family, where she remained.

Network meetings had the quality as previously mentioned, of an extended family struggling to understand the child's internal world. The meetings provided much needed containment for members' experiences of Lucy's projective identification. It was very interesting to observe psychoanalytically-informed thinking develop in members of the network over the course of treatment, which I believe was an integral part of their experience of containment. Findings from this study highlight the crucial need for parallel work with parents and/or the network of carers involved with the child undertaking intensive treatment.

7.0 Research recommendations

There are three recommendations that arise from the course of this study that require further investigation of work with severely deprived children, which could inform further clinical recommendation.

- The function of play with severely disturbed children. A study which focuses on the nature of the child's play within a psychoanalytic frame investigating the child's use of play, in conjunction with the therapist's responses – i.e. comparing whether there are any significant differences, in relation to the impact on the child between interpretations given within the play and interpretations provided outside the play.

- An investigation of the process of introjection of the presence of the object in relation to developmental progress.

- An investigation of the 'developmental progress' of the network where a child is undertaking intensive treatment.

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Appendix 1

Information and Consent Form

Information and consent Form

The aim of this research

This study will explore the therapeutic relationship to understand better how the child can develop from being in a state of intense anxiety and terror, to a greater sense of emotional stability over time.

How the research will be done

A systematic investigation of case notes written in detail over a one year period of intensive three times weekly five year treatment, will be carried out under supervision.

What are the possible benefits?

It is hoped this research will add to the growing body of evidence for the effectiveness of psychoanalytic treatment for children with severe emotional problems.

Will I be able to look at the findings of the research?

At the end of the study I will offer a meeting to share the detail of my findings with you if you wish to.

Will the information about me and my family remain confidential?

All personal details will be treated as strictly confidential. When it comes to writing up the research for report or publication, personal details will be disguised.

Signed: ----------

Appendix 2

UREC Form

SCHOOL OF HEALTH, SPORT AND BIOSCIENCE
Dean: Professor Neville Punchard PhD FIBMS FHEA
uel.ac.uk/hsb

School Office

Mrs Deidre Meehan
8b North Parade
Belfast
BT7 2GG

15 September 2014

Dear Mrs Meehan

University of East London/The Tavistock and Portman NHS Foundation Trust: research ethics

Study Title: ***Coming into being' - the process of developmental growth in a severely deprived child in intensive psychoanalytic psychotherapy***

I am writing to inform you that the University Research Ethics Committee (UREC) has received your documents, which you submitted to the Chair of UREC, Professor Neville Punchard. Please take this letter as written confirmation that your study has been dealt with appropriately by the Tavistock Committee and ethical approval was granted.

For the avoidance of any doubt, or misunderstanding, please note that the content of this letter extends only to those matters relating to the granting of ethical clearance. Any other outstanding matters, if not yet resolved, will be dealt with entirely separately as they fall entirely outside the remit of our University Research Ethics Committee.

If you are in any doubt about whether, or not, there are any other outstanding matters you should contact Mr William Bannister at the Tavistock and Portman NHS Foundation Trust (e-mail WBannister@tavi-port.nhs.uk).

Yours sincerely

Professor Neville Punchard
Chair of the University Research Ethics Committee (UREC)

c.c. Mr Malcolm Allen, Dean of Postgraduate Studies, Tavistock and Portman NHS Foundation Trust
Mr Will Bannister, Associate Director, Education and Training, Tavistock and Portman NHS Foundation Trust
Professor John J Joughin, Vice-Chancellor, University of East London
Professor Neville Punchard, Chair of the University of East London Research Ethics Committee
Mr David G Woodhouse, Associate Head of Governance and Legal Services

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Appendix 3

The Sessions

Data Set One - Treatment Session One Monday 6th September 2004

Background context to the session

The following session is the first in Lucy's treatment. It occurred on a Monday, two weeks after completion of the assessment. Lucy arrived into the session in a state of extreme turmoil and what seemed, at first, to be rage. I realised through discussion in supervision that this was more an expression of Lucy's terror. Lucy's intense anxiety and violence had subsided by the end of the session.

Comments on the right hand column are denoted as follows:

CS denotes Clinical Supervisor

AS denotes Academic Supervisor

Lucy is carried into the building and the therapy room by her aunt and uncle. She looks rageful and I feel very anxious and worried about how I will physically contain her in the room. Lucy's aunt and uncle depart quickly, to Lucy's screams of "noooo". I place myself on the floor and try to remain calm (at least on the outside, as inside I am feeling very worried). I am barely able to contain her flailing movements and find myself intuitively stroking her back in an attempt to soothe her state of turmoil. After a few minutes of allowing me to stroke her back, which seems to reduce her need to scream loudly. She begins to groan. Lucy pulls away from the door and from me, and thrashes around the floor violently, screaming. After a few moments, she suddenly and rapidly begins to scramble across the floor and my heart sinks, thinking of what she might do next. She grabs at items in her box and throws them around the room and at me. With a sense of desperation and urgency, I	**Open coding** **Codes related to the child** violence terror screaming turmoil pulls away from therapist. violently thrashing around. throwing items around the room violently.	**Open coding** **Codes related to the therapist** anxious worried gets beside her on the floor to calm her. concrete soothing by stroking the child's back worried about the ferocity of Lucy's state of mind	**Focused coding** **Emergent Themes related to the child.** turmoil/terror/ calmness throwing/emptying/ gathering safety/danger curiosity/suspicion knowing/not knowing rejecting/caring **Emergent themes related to the therapist** • sense of hopelessness/ helplessnesss • concrete soothing • concrete and emotional gathering • boundary-giving • naming • narrating • making sense of the child's anxiety through linking the child's thoughts, feelings and actions.	**Categories emergent from themes:** **Child's states of mind**: **Fragmentation** throwing screaming violence emptying **Protective/ Defensive** pulling away from the therapist placing chair in front of her. suspicious of the therapist **Interestedness/ Relatedness** curious about babies curious about the therapist's qualities of knowing. caring for the baby doll.	**Supervisors comments** **CS:** Was the gap between assessment and treatment felt to be catastrophic?

start to name the items as Lucy throws each one, 'car', 'pen', 'doll', 'lego', 'crayon', 'girl'.....(3) This seems to have a momentary calming effect on her and she looks at me with some bewilderment and, I think, a flash of interest. When most of the contents of her box have been emptied out, Lucy begins screaming again and tips the box over. Lucy's screaming and violence seem endless and, while there are moments of hope that she could be soothed and contained, for the majority of time I am filled with helplessness. However, Lucy gradually becomes still and moves under the table placing the chair in front of her. I think of the ferocity of her entry into the first session of her thrice-weekly treatment and how none of what I am experiencing was in evidence during the assessment period. Now I understand the concerns her aunt, uncle and her teachers have about her extreme state of mind. I wonder about the two week gap between assessment and treatment which appears to be having a catastrophic effect on Lucy. She seems to experience me as very bad presence	child in a momentary calmer state child conveys momentary interest. screaming. tips over the box. calmer state of mind- puts chair in front of her, between herself and therapist.	worried, feeling desperate - spontaneously names the items being thrown. hopelessness helplessness reflecting on the contrast in the child's state of mind between the assessment and this first session. linking the gap between assessment and treatment as activating the child's extreme reaction to therapist as a 'bad presence'		**Interpretation** - Giving meaning to the child's experiences through various forms of Interpretation denoted in the data by numbers (1)(2)(3) Therapist-centred interpretation(1) - - receiving the patient's projections and translating this into what the child needs the therapist to experience. Patient-centred interpretation(2) - translating the child's experience into relational meaning. Narrative interpretation(3) - displacement of the child's experience to the third person and elements of symbolic play.	**CS**: Concrete evacuation of terror. **CS**: This move under the table and placing of the chair in front of her seemed an attempt to gain concrete containment while also enables her to keep the therapist out. **AS:** Seeking concrete containment, from which then she could explore therapist's capacities for understanding and emotional availability.

indeed. I place the baby doll beside her, under the table and she throws it to the side. She grabs the telephone wire and pulls and pulls and I grow concerned that she will electrocute herself. I tell her that I cannot let her do this, as I have to keep her safe. She stops pulling at the wire and wraps it around the chair. I say that the table is her shelter and that she wants to make sure the chair will protect her too (2) She reaches out to the doll she had pushed aside and places it loosely in her arms. She looks over at her box. I pull the box closer to her and she takes out another doll and a doll's blanket. 'Why do babies not like cold milk?'. I am taken aback and intrigued by Lucy's direct question in the aftermath of violence and turmoil. I wonder to her about not liking cold milk and immediately feel disoriented when she sticks her tongue out and says with disgust that she hates cold potatoes. I feel a mixture of worry, exhaustion, and relief and hope that Lucy can be reached and contained, even though she has been in an extreme state.

throws the baby doll away pulls on the dangerous wire stops pulling wire. reaches out and cares for the doll she threw away earlier. reaches into the toy box and takes out a doll and blanket. asks question about babies not liking 'cold milk'	places the baby doll beside the child. worried about the child in danger stops her from pulling the wire. comments on child's need to protect herself. puts the toy box closer to the child surprised, interested and intrigued by Lucy's question about what babies need. feels disoriented by Lucy's expression of disgust. worried, anxious and relieved, exhausted.			**AS:** Caring for the doll. **CS:** The child appears to be responding to her terror and turmoil being contained. **CS:** Child's curiosity is combined with protest about an experience of having to digest something noxious both inside and outside her therapy.

After a moment of quiet, Lucy asks if she can come out from under the table. I wonder inwardly about her asking and say that she needs me to know she wants to come out from under the table. (2) She pushes the chair in front of her forward and climbs out. She stands briefly in the centre of the room, as though not quite sure what to do. She seems to have a thought and then quickly moves to the table and sits down on the chair beside her box. She leans down towards the two dolls and slides off her chair to lift them and cover them both with blankets. She then lifts the dolls' bottle out of her box and feeds them one after another and covers them with a blanket when she has finished. This all happens so quickly. I say that she had a thought about the doll babies needing a blanket and to be fed. (3) 'Babies can't tell you what's wrong with them they just have to cry' – she says. I feel taken aback and moved by the straightforwardness of her comment. I say 'the baby part of you can only cry with distress and rage and can't say what's wrong'. (2) She replies,

child comes out from under the table. caring for the baby dolls. conveys understanding that babies communicate their needs through crying.	thinking about the meaning of the child asking if she could come out from under the table hopeful the child could be reached and contained. narrates the child's thought about babies needing food and warmth. inwardly emotionally moved by the child's insight and communication about what babies need. interpreting the baby part of the child.			

You could hardly say they are bad if they don't know what's wrong'. 'Isn't it the same for you when you cry and hit out?'(2) I say. 'I can't help myself', Lucy responds, quickly followed by a succession of questions, 'why do babies not like cold milk?' 'do you live here?', and 'who looks after your children?' Lucy momentarily nurses the baby doll in her arms. I feel moved by Lucy's assertion that babies don't like cold milk and think about her deprivation. "You have an idea that I have children and a worry about who is looking after them (2) and maybe also whether I can look after you, whether I will know that babies don't like cold milk and if I will I know what you don't like"? (1) Lucy then tells me about a programme called 'the very odd parents who leave their child with a very bad babysitter who is very bad to him' I say 'I think you are worried that if I have children I might leave them with a cruel babysitter' (1) 'Do you have	questions an idea about being 'bad' for crying when babies don't know what's wrong with them. conveys understanding that her extreme reactions are bewilding to her. questions therapist. caring for the baby doll. conveys story about a t.v. programme in which 'odd' parents leave their child with a very bad babysitter.	linking the child's thought with her 'hitting out' when she is upset. therapist moved by the child's awareness of what babies don't like. interprets the child's worry about the care of the therapist's children.(2) Interprets the child's concern about whether the therapist can look after her (1) interprets the child's concern about the therapist using a very bad babysitter.			**CS:** Child curious about what the therapist is made of. The child is also suspicious that the therapist might be a 'bad babysitter' with whom she is 'dumped' and by whom she feels abandoned. Her concern is also about who will look after the therapist's children, which conveys an anxiety that the therapist is a neglectful mother. **CS:** In the midst of her anxiety about the qualities of the therapist's maternal capacity, Lucy is nevertheless able to at least momentarily identify with the therapist's soothing of her when she nursed the baby doll in her arms.

children?' she insists. 'I think you are very curious about what other children I have in mind (2) and whether there is space in my mind for you. (1) It feels odd to you being here and being so upset'. (2) After a few moments of silence, she says, "When I used to see my Mum we used to upset each other and now I don't see her because it's best, but I see my Dad though, and that's okay'. I say that there are so many big feelings and worries to sort out (3). In a further moment of silence, we both look around the room, which is strewn with all the items from her box. I suggest that we gather everything up and put them back in her box for next time. We spend the final few moments gathering everything up and placing them back in her box. I heave an inward sigh of relief that we have both survived.

conveys direct information about why she doesn't see her Mum. gathers up items and puts in her box.	therapist interprets the child's experience of it feeling odd and upsetting to be in therapeutic setting. conveys to the child the need to sort out big feelings and worries suggests the gathering of all the strewn items around the room. gathers up items and puts in the child's box heaves an inward sign of relief thinking about how they have both survived the turmoil.			AS: This is a comment about reality - realistic.

Data Set 2, Session 3 Friday 10th September 2004

Background context

This session occurred on the Friday of the first week of treatment. Due to the extreme nature of her disturbed state of mind in the first treatment session, I approached the session with worry. Even though she had been contained in the previous, second session, I thought that Lucy might react to the weekend break in a similar, disturbed way as she had done in the first session.

Comments on the right hand column are denoted as follows:

CS denotes Clinical Supervisor

AS denotes Academic Supervisor

As we begin walking up the corridor, Lucy smiles, looks down at my skirt and says 'nice skirt' As we approach the room she tells me that she has decided to take her lunch with her. She sits down at the small table and takes out her sandwich and munches on it contentedly, turning around and grinning, as though wanting me to know how much she is enjoying her food. 'You want me to know how glad you are that you brought your lunch today'. (3) 'Is a turkey a fish?' she suddenly asks. I feel a little thrown and, gathering my thoughts, I wonder out loud that she thought they were the same and her maybe asking questions about what is different and what is the same. (2) She says that she thought they were the same and points to the sandwich; (the turkey part is wedged between the two pieces of bread, as though it was obvious that a turkey is a fish). I feel thrown again and say that I thought she really wondered what I knew and also if I could tell what is the same and what is different. (1) She takes out her banana and drinks some juice. After a little while she turns to me and says that she had a dream about a waterfall and says that it would be very scary to go over a

Initial Coding	**Initial Coding**	**Focused Coding**	**Categories emerging from themes**	**Supervisors comments**
Codes related to the child	**Codes related to the therapist**	**Emergent themes related to the child**	**Child's states of mind:**	
noticing and commenting on therapist's clothes		curiosity/confusion suspicion/desire / noticing eating/toileting conveying information/ symbolising	**Framentation** -confusing categories.	**CS:** She is either defensively bringing in her own supplies in the belief that the therapist cannot be relied upon, or she wants a pleasurable experience in the presence of another.
bringing in food and eating it.			**Protective/ Defensive**	
desiring to be noticed by therapist.	Therapist narrates the child's desire for her feelings to be known.	**Emergent themes related to the therapist** - thinking - linking - narrating, interpreting - wondering, - gathering, - boundary-making.	- bringing in food to eat. - curious about what the therapist does with the contents of the bin. - goes to the toilet on two occasions.	
confusing categories	Therapist disorientated by the child's confusion.		**Interestingness/ Relatedness/ Integrated**	
cannot differentiate the categories.	Therapist interprets the child's experience of confusion and curiosity.		- desiring to be noticed by the therapist. - noticing the therapist's clothes. - tells therapist about her frightening dream and about past nightmares. - explains her confusion about her overwhelming states of mind. - expresses awareness of the function of responsibility of the adult to look after the child. - expresses	**AS:** After a transference interpretation about the therapist's capacity to differentiate, she tells the therapist about a dream, deepening her contact with the therapist.
eats food and drinks	Therapist disorientated again.			
	Therapist interprets the child's curiosity			

waterfall. 'We were on a boat and rescuing each other and I got bitten by a shark and fell into the waterfall and it got frozen because the lightning struck - I used to have nightmares all the time when I first came to live with Susan and David* (aunt and uncle). It was always about Mummy and me and they used to scare me and I would wake up crying but I don't have those dreams anymore'. I think of the frozen waterfall. She finishes off her drink and puts her debris from the lunch into the bin. 'Why can't you just let the bin fill up to the top and then empty it' she says. I am really curious about her focus on the bin (she referred to the "new bag" in the bin last session). I wonder what to make of it. I say that perhaps she wonders about others who come into the room and put things in the bin. (2) Ignoring me, she sits down and rummages in her box, taking out black paper and some chalk.	talks about a scary dream Tells the therapist about other nightmares in the past. child curious about the bin and why it keeps getting emptied	. . Therapist thinking about the frozen waterfall in the dream. Therapist curious about the child's focus on the bin. Therapist interprets the child's curiosity about the bin in relation to others who come in to the room.		**Symbolic thinking and expression** - draws a boat on a river. - cares for the doll baby. - child narrates the feelings of the animals in relation to the theme of being left out.	**AS:** I thought of liquifying and falling - two anxieties described in Psychotherapy with Severely Deprived Children. **AS**: I thought this pointed to a question about how internal rubbish can be processed, disposed of.

I'm still wondering about the bin and thinking that maybe, in fantasy, she feels that she could be included in other sessions by seeing/observing what has been placed in the bin prior to her session. I'm not sure and decide not to say anything at this point. She starts to draw what looks like a boat on a river. When she finishes drawing, in an absorbed way, she takes out the previous boat picture she had done and smiles, pleased, touching it and saying that it has worked; that it is dry I say, 'You had an idea about wanting the chalk to dry in this way and it worked out'. (3) 'because'.....she says....."if you leave it for a day it dries' 'And you've left it for two days, because there has been one day in-between our last session on Wednesday and this session today'. (3) I say. Lucy does not obviously or overtly respond, remaining quiet a little longer. She	Child draws a boat on a river. Child refers to the picture she did during last session	Therapist thinking and wondering about the child's curiosity. Therapist narrates the child's thinking. Therapist introduces the sequence of time.		**Therapist's experience and activities** **Countertransference:** - disorientation: - emotionally moved by the child caring for the animals. **Thinking/mentalising** - introduces the concept of time. -thinking about the meaning of the child's dream -thinking about the meaning of the child going to the toilet.	**AS:** Drawing - symbolic communication. **CS:** Child conveys pleasure in the wet paper being dry. Wet and dry, the child was left in a mess after her brother sexually abused her.

suddenly announces that she needs to go to the toilet and is out of the door as the thought comes to me of her anxiety about the 'gap' between sessions. I wonder how to talk to her about this. When she returns, I say that she had wanted to go to the toilet after I talked about the gap between our sessions. (2) Ignoring me, she says that she is going to do the same with the other picture and prepares the green paper, taking two sheets and soaking them under the running water, squeezing them and running them over the page as she had done before. 'When I'm very cross...."she suddenly says, 'it's hard for me to just calm down, because I don't know what's wrong with me you see'. 'Yes and sometimes the things you do and what you draw can help us come to know what's wrong.'(2) 'There's a bit in the dream I didn't tell you about and that is that you fell over and then I fell over and this boat (pointing to the one she has just drawn) comes to rescue us'. I say: 'Perhaps the scary thing also is that I fall over as well as you; that there's no-one to protect you'. (3) 'Remember I was telling you that one of the fishermen

Child goes to toilet Child plays with the paper and water. Child suddenly explains how she feels and acts when angry and how confusing this is to her. Child elaborates on the dream with the therapist falling over and the need for her and the therapist to be rescued.	Therapist thinking about the meaning of the child going to the toilet. Therapist makes link between the child going to the toilet and her anxiety about gaps between sessions. Therapist elaborates on the child's communication, by linking it to the function of therapy. Therapist narrates the child's worry about the therapist falling over.		**<u>Containing:</u>** - shows interest in the child's feelings and desires. - tunes into the child's worries and confusions. **<u>Interpretation:</u>** Various forms of Interpretation: each denoted in the data by numbers (1) (2) (3) - Therapist-centred interpretation(1) - Patient-centred interpretation(2) - Narrative interpretation(3) - Elaborating interpretations (4)	**<u>AS:</u>** Concrete evacuation - in response to the gap? **<u>AS:</u>** Direct communication. **<u>AS:</u>** Catastrophic anxiety - here the therapist may be in the child's mind in the same relationship she had with her mother who was unable to protect her.

said that you were supposed to look after me and I was supposed to look after you? Well, that's strange; that's not supposed to happen,' and (with animated gestures) points to me, saying, 'you're the one 'that's supposed to look after me'. 'Yes and I suppose the scary thing is having the thought that maybe you're not too sure how it is in here and whether I can look after you or will collapse and not be able to?'. (1) 'What is that cord for?' she suddenly interrupts, pointing to the telephone cord on the floor. 'It's a telephone cord'. I say simply. She takes out the animals from her box, declaring that they need a bath and fills the sink with water. First she baths the horse and dries it and says that the baby horses are having fun, but need to come out. 'The horse and baby horses are all being thought about, that they need a bath'. (3) I say…'cared about', she emphasises and, in this moment, in her earnest speaking to me, I feel very moved. Suddenly, she puts the animals away, having looked at the clock and realised that we have15 minutes left (I have been telling her when it is 10 minutes before our time is up). She says that she will bath the rest	Child questions the validity in the dream of the child and therapist looking after each other and states that it is the therapist who is supposed to do the looking-after. child expresses curiosity about the cord. Child baths the animals. Child states that animals are being cared about.	Therapist interprets the child's worry that the therapist won't be able to look after her. Therapist narrates the child thinking about the animals. Therapist feels moved by the child's experience of caring for the animals.		**AS:** Direct communication which links to the child's expectation of a different type of adult - one who should protect her. **AS:** Caring - here she is taking on the role of the carer.

‘tomorrow’ and I say that she is giving herself plenty of time to tidy things away, and was reminding me before I reminded her, what the time was. I also say that it is hard to think that she won’t be coming tomorrow, but that she will be coming again on Monday. (2) As I say this, I think of the left-out animals. ‘The cheetah is angry because he didn’t get a bath’ she says. ‘Yes, I was thinking about how the other animals feel about being left out’ (3), I say ‘He’s just eaten one of the animals because he is so cross. He really gets very, very angry’ said Lucy ‘about being left out’ I added. (3) She tidies away quickly and sits down opposite me, grinning and then suddenly says that she needs the toilet. She is away until near the end. When she comes back, I start to say that sometimes worrying thoughts… (2) – she interrupts me, saying something about the digger outside. I attempt again to interpret her going to the toile twice, as being about	Child has an idea of a future time in therapy. Child narrates the anger of the cheetah for not getting a bath. Child conveys how angry the animals feel about getting left out. Child goes to the toilet.	Therapist clarifies when the child will be coming back by interpreting hard feelings about the gap - Therapist narrates her wondering how the animals feel about being left out Therapist attempts to interpret the child's left-out feelings being evacuated in the toilet.			**CS:** Does she feel the therapist wants her to clean up because it's too much? **AS:** Does this link also to the difficulties she was having in her aunt's home?

anxious thoughts being left at the end of our session and she interrupts me again in a defensive way, more typical of a younger child.(2) It is time to finish and I say that I will see her on Monday.

*Not their real names.

	Attempts again to interpret the link between anxiety and the child's trip to the toilet.			

Data Set Three - Session 21 Monday 25th October 2004 (This followed an unplanned cancelled session the previous Friday due to my illness)

Background context

In this session, Lucy is carried in screaming and wailing in terror, in the same way that she had entered her first treatment session. I instantly thought of my absence the previous Friday and immediately felt worried, but more certain this time that, while she looked rageful and behaved violently, she was, in fact, terrified.

Comments on the right hand column are denoted as follows:

CS denotes clinical supervisor's comments on the material

AS denotes academic supervisor's comments on the material

	Initial Coding **Codes relating to the child**	Initial Coding **Codes relating to the therapist**	Focused Coding **Emergent themes related to the child**	Categories emerging from themes **Child's state of mind in her external home life:**	Supervisors comments
Susan (Lucy's aunt and carer) phones before the session to let me know, before she brings Lucy, that things are still really bad and have been like this all weekend. She has been violent towards her aunt. Things were particularly bad the previous day until 11.00pm last night and Lucy was getting up at 5.00am. Her blood sugar levels were 25 and they should be 5. Aunt Susan thinks that she is eating stuff she's stashed away. Susan feels this happens on a regular basis. She felt it was important that Lucy comes to her session today and that her husband and cousin were both available today to carry her in. They arrive 15 minutes after the session was due to begin and David (husband) carries her in. She is wailing and struggling, red-faced and tears streaming. David delivers her on to a chair and quickly leaves. I get down on the floor and sit with my back to the door. Lucy is roaring and wailing, simultaneously. I put my hand on her back as I'd	Aunt conveys child in a very disturbed state. turmoil screaming wailing	receiving worrying information from the child's aunt. tries to provide concrete soothing	turmoil/violence symbolic sadistic and violent play/ concern for the 'hurt figures' curiosity/confusion about her own state of mind. expecting therapist's interest in her. wanting to go to the toilet.	**Fragmentation** stashing and eating food dangerous to her diabetic condition. violence against Aunt. **Child's state of mind in the session:** **Fragmentation** screaming wailing violence towards therapist throwing items around the room and at the therapist pulling dangerously on the wire. using scissors dangerously by stabbing at the chair. **Protective/Defensive** pushing away the therapist wanting to go to the toilet	**CS:** Diabetic risk. Congenital diabetes permeates. **CS:** Relationship between food and nourishment perverted by Dad giving her bad things to eat. **CS:** The child is terrified.

done before, which had soothed her eventually, but this time, she aggressively pushes me off. She seems to sink into the floor and then grabs the bin and is about to throw it with force at me (a metal bin) and I firmly say that no, I won't let her do this and peel it from her gripping fingers. She tries this a couple of times and then tries to peel the paint off the wall and some plaster with it and I stop her. – She scurries over to her box and starts to lift things out of it, the giraffe, then pens and throws them at me. I am becoming increasingly worried and helpless. I try to stop her and she starts to thump and kick me. I tell her firmly 'no', holding her arms, but she persists and then turns to her box. I say that she is really, really upset and that it is very important that we try and sort out what's making her so angry and upset, but that I will stop her hurting me and	pushing away therapist attempted violence violent throwing of items at therapist. violence towards therapist	boundary-making worried and helpless boundary-making therapist narrates how upset the child is and conveys that her feelings and behaviour have meaning. boundary-making	Emergent themes related to the therapist - sense of worry and helplessness -relief the child can symbolize. - concrete soothing - concrete and emotional gathering - boundary-giving - narrating the child's play - witnessing sadistic play - making sense of the child's anxiety through linking the child's thoughts, feelings and actions.	Symbolic Play Themes of: - sadism - violence - concern - hopelessness Relatedness/ Interestingness - concerned about the 'hurt' figures. - conveying expectation of the therapist's interest in her. - conveying uncertainty about the reasons for her turbulent state of mind. - awareness that her turbulent state of mind seems linked to home life being hard.	**CS:** Child is reversing things in relation to the cancelled session - she is rejecting the therapist. **CS:** Child feels violently projected into by the cancelled session. **CS**: Congential diabetes through umbilical cord.

hurting herself. She seems to suddenly stop the very destructive behaviour and aggressively climbs under large table and grabs hold of the cable wire and pulls and pulls at it very hard. I reach over and again say, 'no', firmly, that it is too dangerous and that I can't let her do this. I go back to my seat and am breathing very fast, as though I have just run up a mountain; yet there is a little more calm and I sense that we are over the worst again. Lucy abruptly grabs one of the police cars and then another one and runs them along the ground. She takes out scissors and I sense danger. She stabs at the chair with the scissors and I go over and take them away, saying that I need to keep her safe. She seems to accept this and moves the chair in front of her, out a little bit and sets the ambulance and police car opposite each other on either side of the chair and bangs	suddenly stops violent activity. repeatedly pulls on the wire. little more calm using scissors dangerously accepts boundary. creates barrier with chair. symbolic violent play	boundary-making boundary-making			**AS:** Symbolic expression of being out of control. **CS:** Child feeling dangerously cut up by the cancelled session.

them together, head on. She looks at me, for a reaction, I think. I say, 'the helpful police and helpful ambulance are not so helpful, they drive into each other'. (3) 'They're baddies,' she quips. She takes out a figure and says that he is the policeman and then takes out another figure and bashes them against each other. She looks at me, grinning a little sadistically, I think. 'Everyone is to be a baddy and to hurt and destroy each other' I say. (3) 'They're hurt', she suddenly says, as she gathers up three figures and puts them lying down in the ambulance truck and I have a momentary feeling of relief and think of the three exhausted and upset people waiting for her in the waiting room. I think that there is some concern in Lucy about that, too. Suddenly the three are dumped, tilted out and one of them is run over by the ambulance. She looks at me and grins a little and I feel I am being made to witness the grotesque.

symbolic sadistic play child concerned about the 'hurt' figures. sadistic play suddenly returns.	narrating the child's play narrates the child's play. momentary relief at child's concern sense of helpless despair about the child's sadist play.		**Therapist's experience and activities** **Countertransference:** Weary/concerned despairing/curious relieved uncomfortable witnessing of sadistic play. **Thinking/mentalising** indicating her behaviour has meaning **Containment** receives the child's violent projections without reacting. concretely tries to soothe the child	**CS:** World crashed at the sudden cancellation of the session. **CS:** Internal objects crashing. **CS:** Symbolic of the three sessions and one crashed last week.

I say, that at first I was to have hope that the hurt people would be helped by the ambulance men, but then they were to be hurt again. (3) She puts all the figures in the box and places the two ambulances and two police cars side by side at the edge of the large table and I have a sinking feeling that they're going to be tipped over the edge. I say that I was thinking about what made Lucy so angry and upset and say that I thought it might be to do with my cancelling the session so suddenly on Friday. (2) Lucy looks at me and says, 'I don't know', matter-of-factly. 'It's harder being at home' she suddenly says. She goes over to the sink, bringing a tub with her. As she turns the tap, she says suddenly that she needs to go to the toilet. I say that I was just about to say we have 10 minutes left and wonder if she could perhaps wait until the end of the session. She looks a bit hesitant and then says 'okay', turning back to the sink. She takes a green towel out of the dispenser and, as	symbolic play of hopelessness Child conveys uncertainty about the reason for her turbulent state of mind. Child indicates it is hard living at home. wants to go to the toilet	narrates being made to witness sadistic play. Therapist links Lucy's expressed turmoil with the therapist's cancelled session. boundary-making.		**<u>Interpretation</u>** Various forms of Interpretation: each denoted in the data by the numbers (1) (2) (3) Therapist-centred interpretation(1) Patient-centred interpretation(2) Narrative interpretation(3)	

she does so, she turns to me, saying cheerily 'I'm still in my pyjamas'. 'Yes, I noticed', I say. She fills the tub and I feel a little weary, concerned and very curious about her shifting states of mind and how relieved I feel at having eventually been able to contain her. I also feel a little despairing. I grow a little concerned about the mess of the room and, as we are approaching the end of the session, I wonder out loud about the need to tidy up and ask if we could gather everything up together. She nods her head and then asks me to put the things in her box. I begin to do so and she joins me, wondering why I didn't put the scrunched up paper towels in the bin. (She usually keeps these in her box). I am a little taken aback and blurt, 'Oh, I didn't know you wanted the green paper towels put in the bin' – 'Oh, it's okay, 'she says. She puts the rest of the stuff in her box, putting the used green	direct communication about being in her pyjamas with an expected interest from the therapist. Lucy joins the therapist tidying up.	therapist conveys noticing that she was still in her pyjamas weary, concerned, despairing, curious and relieved. concerned about the mess of the room suggests tidying up the mess together.			**CS:** Gathering up the mess. **CS:** 'Blurting' out countertransference and how things spill out of the child concretely.

towels in the bin. As she approaches the door, she asks me to let her aunt know that she has gone to the toilet. I walk to where Aunt Susan, David and cousin Jane are sitting. They look worn-out and fed-up. However, Susan jumps up to greet me and asks, 'Was she alright? We heard her screaming but then it seemed to stop'. I say 'yes' and also that she had gone to the toilet. I say that I think the sudden cancelled session might have upset her. Just then, Lucy arrives and she looks a little sheepish. David gets up to put her shoes on and I say my goodbyes, feeling a little anxious that there had been an encounter with her carers following her session, which doesn't usually happen.

Data Set Four - Treatment Session 22 Wednesday 27th October 2004

Background context

This session occurred after the session following the unplanned cancelled session, in which Lucy was carried in just as she had been in the first session, in a state of turmoil. While in the session, Lucy had eventually calmed down and was able to express her turmoil through symbolic play, I wasn't sure whether this would be sustained to the next session. I therefore approached this session with anxiety about whether Lucy would remain contained, or whether her state of mind was in turmoil again.

Comments on the right hand column are denoted as follows:

CS denotes clinical supervisor's comments.
AS denotes academic supervisor's comments.

	Initial Coding **Codes related to the child**	Initial Coding **Codes related to the therapist**	Focused Coding **Emergent themes related to the child**	**Categories emergent from themes**	**Supervisors comments**
Lucy looks exhausted and rather sheepish when I go to pick her up from the waiting room. I sense her worry but I also notice that she seems to be brazening it out! Immediately on entering the room, she looks out of the window to see, in the distance, the building work underway. She says, 'They're doing really well with that building; the roof is on and it looks fixed up'. I say, 'I think you are telling me you hope things are fixed here too'. (2) She nods slightly and, taking out her apple, starts to munch on it. She becomes absorbed in eating her apple, looking out the window until she has finished it. I don't comment on Lucy eating the apple, just watch and wait, feeling a little afraid of 'upsetting the apple cart', given that she was in such turmoil the session before. She moves to the bin when she has consumed the apple to its core and places it in the bin, pausing for a moment.	child comments on the building outside being fixed up eats food.	Senses the child's worry about her violence and turmoil in the previous session Makes an interpretative link between the child's thought about the outside building being fixed and her hope that things are fixed between herself and therapist. feeling trapped, cautious and afraid of 'upsetting the apple cart' by saying anything at this point.	- curiosity - noticing - eating - gathering up - symbolic play - robot, alien - hide and seek **Emergent themes related to the therapist** - narrating - introduces the child to her own thinking.	**Child's state of mind:** **Protective/defensive** - eats food - deflects attention to building outside getting 'fixed'. **Relatedness/ interestingness** - notices building work outside - notices the playdoh has gone hard. - initiates gathering up items from her box. **Symbolic Play** -makes: a person, an alien a robot. - creates her own version of hide and seek where she 'appears' rather than is 'found'	

She goes over to her box and takes out the Playdoh, which she had not put back into its container and it has therefore gone hard. 'It's gone all hard,' she comments. Before I have the chance to translate her comment into something to do with the hard playdoh being neglected and the soft playdoh being cared for, she says, 'I need a softer piece' and starts rummaging in her box. I say, 'some playdoh has been left to go hard while the other playdoh stays soft because it was in the container'. (3) She seems to have an idea about making a person with the Playdoh. She is absorbed in making the torso, competently rolling some Playdoh into a ball and positioning it firmly on the table. Next, she rolls four pieces of playdoh into snail-like shapes and sticks them on to the torso for arms and legs. For what I assume is going to be the head, she rolls a piece of Playdoh into quite a large ball, about the same size as the torso. I wonder	child notices with some surprise that the playdoh has gone hard. symbolic play making a person.	makes sense to the child of why the playdoh has gone hard, linking this with being left outside its container. .		**Therapist's experience and activities:** **Countertransference:** - sensing the child's worry about damage done to the therapist in the previous tumultuous session. - feelings of entrapment and worry about the child's previous state of mind. **Thinking/mentalising:** - about the meaning of the child's play. - about the Aunt not knowing the child was being sexually abused. - about the child's neglect in infancy	**CS:** Child surprised the playdoh has gone hard. Realisation of neglect.

inwardly if she has noticed the disproportionate size of the head compared to the torso. She places the 'head' on top of the torso and it looks insecure and wobbly. I say that I wonder whether she needs me to know that she is putting herself and me back together again, but that perhaps there is a worry that my head might be wobbly after all the battering; a worry that I might not be able to cope. (2) Lucy scrunches up the figure and rolls it into a ball. She announces that she is going to make an alien. She rolls the playdoh into one large ball and takes a piece out of it, rolls it again and rolls the little piece into a ball. She places it at the top, in the centre and says that it has only one eye. I say that maybe she is wondering what I might be able to see and that, perhaps she thinks I have only one eye and maybe the other eye can't or doesn't want to see (1). I am thinking inwardly about her	the playdoh figure becomes an 'alien' with one eye.	therapist notices the disproportionate size of the head on the torso and how insecure it is. She wonders if child has noticed. Therapist interprets the child's worry about the therapist's head being wobbly because of the turmoil in the previous session. Therapist interprets the one-eyed alien, in relation to the child's worry about the therapist not being able to see.		**<u>Interpretation</u>** **Narrative Interpretation:** of symbolic play. of the child's activity of building something. of therapist's own thinking about robots not having feelings. of child's creation of a version of the hide and seek game. **<u>Analyst-Centred Interpretation</u>** of link between external fixing (of the building) and internal repair in the child and therapeutic relationship. - of child's worry about whether the therapist's head is wobbly because of the turmoil in the previous session. - of child's worry about what the therapist is able to see.	

experience of her aunt not seeing that she was being sexually abused by her brother. I also think about the turning of a blind eye to her neglect in infancy. Without any obvious response to my interpretation, Lucy turns her attention to the Lego and starts to put it together. I wonder what she is making and think of how much she is trying, in this session, to put things together. I say out loud, 'You're building something'. (3) 'A robot,' she replies. She carefully and quietly builds what is shaping up to look like a robot. I say out loud that I was thinking about robots not having any feelings. (3) Lucy suddenly says that she needs to go to the toilet and leaves the room. She is away for longer than usual and, on her return, says that she is going to put the robot in the box to 'keep it together'. I say that she has an idea that the robot might fall apart if it wasn't kept safely in her box and that maybe she worries, too, that I might fall	symbolic play with Lego, building a robot. Child suddenly goes to the toilet. Child wants to keep the robot together in her box.	Therapist thinking about the child's sexual abuse and Aunt not seeing this. Therapist thinking about the child's neglect in infancy. Therapist thinking of the repeated theme of the child's attempts to put things together. Therapist narrates the child's activity of building something. Therapist narrates her own thinking about robots not having any feelings. Therapist interprets the child's anxiety about therapist's robustness			

apart. I add that I had been thinking about her going to the toilet and being away for quite a while and I wonder if maybe she has to be a bit like the robot and needs to get rid of feelings. (2) 'Hide and Seek' she exclaims, ignoring my interpretation and climbs into the cupboard, closing the door. 'We have 10 minutes left', I say, as I get up from my seat and look around the room, saying out loud: 'Are you under the chair? No! Are you under the table? No! Are you in the cupboard?' (I open the top cupboard) 'No!' Lucy flings open the door, saying, 'Here I am!' Lucy repetitively arranges the hide and seek game so that I don't find her, but rather, she appears. 'I don't find you, you appear,' I say (3). Lucy is climbing out of the cupboard as I say out loud that I am to look for her but not allowed to find her. (3) I wonder inwardly what it means that I am not allowed to find her.	Wants to play game of Hide and Seek. Game arranged by Lucy so that she 'appears' rather than is 'found'	Therapist links the building of the robot, who has no feelings, with her impulse to evacuate her feelings by going to the toilet Therapist narrates the child's arrangement of the game, whereby she appears rather than is found. Therapist wondering inwardly about the meaning of Lucy not allowing herself to be found.			**AS:** Pushing he therapist out and at the same time wanting to be found. **CS:** Child afraid of what the therapist will find and what she will find in the therapist.

'Time to tidy up,' Lucy exclaims. She hurries to her box and puts the Playdoh back in its container, whereas, before, she left the playdoh she had been playing with open in the box, so that it went hard. 'You are making sure the Playdoh doesn't go hard this time' I say and add that she is 'making sure everything is back in your box, until next time'. (3)

Child initiates the gathering up of the items from her box.	Therapist narrates the child's initiative of gathering up.			

Data Set 5 - Treatment Session 45 Friday 17th December 2004

Background context

This session is the last session of the term before the two-week Christmas break. I was relieved that there was no overt turmoil, but worried about how she would manage the break.

Lucy is keen to tell me, on the way up to the room, about being sick and missing the previous session. I sense anxiety and wonder in her. I respond that we could think about this when we get to the therapy room. Lucy sits opposite me and carefully opens her crisps and munches on them. I sense her eyes penetrating me with hostile curiosity. 'You were sick and weren't able to be here on Wednesday'. (3). She seems to ignore me and eats her crisps in a way that feels endless and I will her to finish. She moves to her box when she has finished her crisps, discarding the wrapper in the bin. She takes out the Playdoh and, placing it on the table without putting the board underneath, she cuts into the Playdoh with her plastic knife and scrapes the wooden table. I sense her defiant hostility. I say that I wonder if Lucy needed to make a mark to	**Initial Coding** **Codes related to the Child** Child keen to comment before getting to the therapy room, on being sick the previous session. eats food Playdoh play. under-current of aggression	**Initial Coding** **Codes related to the therapist** boundary-making Therapist takes up in a narrative form, the child's earlier reference to being sick. Therapist interprets Lucy's need to be kept in mind.	**Focused Coding** **Emergent themes related to the child** hostile/curious eating/toilet symbolic play: • aggression towards the therapist. • hide and seek • masochism - invites therapist to be cruel • sadism towards therapist **Emergent themes related to the therapist** - linking, - thinking - narrating - wondering	**Categories emergent from the themes** **Child's state of mind** **Fragmentation** - aimless play - spilling out before the session begins. **Defensive/Protective** - toilet - eating **Relatedness/ Interestingness** - conveys directly information about her family's religious beliefs about Christmas. - has expectation of the therapist's willingness to engage in play. **Symbolic play** - conveying with the play doh, a sense of meaningless - sadistic play - tyrannical play - hide and seek - aggressive play	**Supervisors comments**

make sure I would keep her in mind when she isn't here over the break. (2) She cuts out round shapes and sticks them together aimlessly. I say that I thought it was hard to make sense of the break, our being apart and Christmas being strange to her (2). 'We don't believe in Christmas,' (on religious grounds) she says. Yes, I know and so many people around you, in school and everywhere, all talking about Christmas and how strange this must feel'. (2) 'I want to play hide and seek', she announces. 'I'm going to hide the baby's bottle first and then it's your turn; close your eyes'. I close my eyes while Lucy makes her way around the room and finally tells me to look. 'The bottle's full of milk, but you don't know if it's nice or not'. I say, 'I'm to be worried and afraid of what's going to become of me; will I get nice yummy milk or will it be horrible and make me sick?"(3)

aimless putting together of shapes.	interprets the link between child's aimless play with confused feelings associated with the up-coming break.		**Interpretation** - narrative interpretations related to the child's symbolic playing of sadism and tyranny towards the therapist.	
hide and seek.	therapist narrates the child's possible feelings about Christmas festivities.			
sadistic play about the therapist ingesting something horrible.	narrates the sadistic play towards the therapist			

I find the bottle and then it's my turn to hide it. 'Oh dear,' I say, 'the milk is to be hidden from Lucy and she doesn't know whether it's nice or not nice and I'm to be the cruel, not nice mummy therapist that hides the milk from Lucy, who doesn't even know if the hidden milk will be good for her or not'. (3) Lucy finds the milk bottle and announces immediately: 'Let's play hospitals'. She jumps on the chair and bounces, toddler-like, looking at me. I have a sense of dread when she announces the hospital game. She collects a couple of plastic cups and a teapot from her box and goes to the sink and fills the teapot with water. She soaks a couple of felt tipped pens in the water so that the water turns to a brownish colour and she announces that it's poison. She pours the water from the teapot into the two cups and brings over the overflowing cups and sets them down

wants therapist to be cruel and sadistic. hospital play. sadistic play involving the therapist ingesting poison	narrates the sadistic play targeted at the child. therapist feels a sense of dread about the hospital game			

beside me. She gathers some green paper and puts these on the floor and sets the cups on the paper. She says that I am to go through much pain in order to be cleansed. I say that she has an idea that I have poison in me that she needs to take out so that she can be sure I can be trusted. (3) She says that I am to think the poisonous water is food and I am to drink it. I say that I am to be cruelly tricked into thinking I am getting something that is good for me when it is poisonous. 'I am to suffer and suffer', (3) I say. Lucy smirks with sadistic delight as she begins her tyrannical procedures, which are that my arms and legs are to be cut off (motioning with her plastic knife on my arms and legs) then my eyes are to be torn out and again, she motions across my eyes. Then my ears and nose are to be cut off and I say I am to know what it is like to suffer, not move, not see and not hear anything. I am to just suffer and suffer. (3) Lucy announces that she needs	sadistic and tyrannical play involving symbolic dismembering of the therapist and removing all the therapist's physical senses	narrates the sadistic play and links it to the child's need to discover whether the therapist can be trusted. Therapist narrates the sadistic play where she is made to suffer. narrates being made to suffer terrible powerlessness.			

to go to the toilet and is away in a flash, leaving me bereft and disintegrated. When Lucy comes back I say that I thought she really needed me to know about not being able to move, to be trapped and to not see or hear (1) (I am thinking about her sexual abuse by her brother and also have an image of her as a baby in her cot abandoned for hours on end). Seeming satisfied that I could think about what she was doing to me and not fall apart, she says that now I am to be injected with the poison. She takes my arm and pushes her finger into it to "inject" me with the poison and then pours water over my hand. She tells me that the poison will help me. I say that I think she really needs me to know and understand what it is like for her to have to inject herself every day with something she is told will help keep her alive, but which must feel like poison. (2) (I am so aware that so many of her experiences of neglect and

goes to the toilet	narrates being made to suffer terrible entrapment. Therapist thinking of Lucy being trapped in a sexually abusive relationship with her brother and also about her as an abandoned baby. Therapist interprets the injections of poison as the child's need for the therapist to know she feels the injections she gets every day are like poison.			

sexual abuse are mixed up with being diabetic). She goes over to her Lego box and starts to build with the Lego. She declares that it is a gun and points it at me. She hands me the “gun” and tells me to shoot her. I don’t take the gun and say that she wants me to be cruel to her. (1) ‘Hide and seek’, she declares. 'We are to play hide and seek' (3), I say. ‘My turn first,’ she says. She gets the bottle and tells me to close my eyes while she finds a hiding place. While my eyes are closed I say out loud that there is so much to think and know about, especially about the break coming up. (3) She needs to know that it might seem that I am hiding, but that I will be back after the break; that she will find me andwe will find each other again. (4) I look for the bottle and, after a number of failed attempts (at which Lucy is delighted) I eventually find

symbolic play of aggression towards therapist. hid and seek.	Therapist thinking about how the child's experiences of being diabetic, early neglect and sexual abuse are confusingly intermingled in her mind. therapist links hide and seek game with the break.			

the bottle and then it is my turn to hide it. I say that she found and that she too can also be found. (4) She finds the bottle (which I hide in her box) quite quickly and is triumphant. 'You're delighted to find the bottle so quickly'. (3) Lucy and I tidy up together before the end of the session.	tidying and gathering up.	therapist emphasizing her return from the break. narrates the child's delight. tidying and gathering up.			

Data Set 6 - Treatment Session 46, Monday 3rd January 2015 (first session back after the Christmas break)

Background context

This session took place after the first major two-week break in treatment. Given Lucy's reaction to the two-week break between assessment and treatment, I anticipated that she would return in a state of terror and turmoil. I approached this session with anxiety and anticipation that she would need to be carried in again.

Comments on the right hand column denote the following:

CS denotes clinical supervisor's comments on the material.

As we approach the therapy room, Lucy glances round at me and says, 'In here?' in an uncertain tone. I nod slightly and, having looked at me closely by this stage, she says (before we enter the room, smiling a strained sort of smile) 'You've changed your hair'. I am feeling a little bombarded and we both sit down opposite each other at the same time. Lucy looks at me with slight suspicion and uncertainty, I thought. She opens the crisps she was clutching and starts to munch on them. This gives me some relief and space to gather my thoughts. 'Aunt thought maybe you weren't back today; not until 10th', she says. 'Things seem a little muddled today'. You were uncertain if the room is still the same one as before the break and also whether I am the same as before. You think I look different', I say (3) Lucy says, 'I saw Geraldine on Saturday', (cousin who helped to carry Lucy into sessions last term

Initial Coding	**Initial Coding**	**Focused Coding**	**Categories emergent from themes**	**Supervisors comments**
Child uncertain about the room.		**Emergent themes related to the child**	**Child's State of Mind**	
Child thinks the therapist has changed her hair	Therapist feeling bombarded.	remembering/ forgetting. feelings spilling out. noticing/disorientation suspicion/ uncertainty ingesting food/ expelling, toilet confusion/direct communication about external events at home	**Fragmentation** -disorientation -suspicion -uncertainty -confusion -feelings spilling out in the external world. -worry about whether the therapist remembers the game played before the break.	
Child looks suspicious and uncertain.				
eats food.				
confused about the timings of the break.		**Themes related to the Therapist.**	**Defensive/ Protective**	
Child directly communicates about meeting the cousin who helped carry her in on two occasions when the child was in turmoil.	Therapist comments on the child's muddle by narrating the child's uncertainties.	narrating interpreting receiving absorbing	-ingesting - eats -expelling - toilet -denial of missing therapist during the break.	

and who seems to have distanced herself from Lucy) 'You haven't seen Geraldine for quite a long time'. I say. Lucy nods a little and rolls her eyes slightly, in the way I've come to associate with anxiety. I ask her where Geraldine has been and she says ‘she has been very busy'. 'Perhaps you have some thoughts about me being busy during the break', I say (2). 'I saw you with a green box, what was that for?' Lucy says. I register inwardly that she must have seen me through the window before the session, with a green box. 'You are curious about what I do and maybe who else I'm with when I'm not with you', I say (2). 'I was in really bad form yesterday' she says. She goes on to explain that she and her cousin Jane had had a fight and that she herself had started it, or maybe, she thought, Lucy had started it and that sometimes she starts a fight and sometimes Jane starts a fight. Lucy

Child comments on seeing the therapist with a box before the session.	Therapist senses the child's anxiety about not having seen her cousin for a long time. Therapist links the child not seeing her cousin with the break from therapy. Therapist interprets the child's curiosity about who else the therapist sees.		**Relatedness/ Interestingness** -child expects therapist to be interested in her external life. -relating events in external life. -remembering. -notices with surprise that the therapist is playing along. **Symbolic Play** -sadistic/aggressive/ tyrannical play. -working through feelings about maternal neglect.	

explains: 'Jane threw water all over your chart. She threw water over me first and then I threw water over her' I say that the chart I had given her before the break got all messed up, maybe a bit like feelings spilling out about me being away. (3) 'I didn't miss you at all!' she says in a patronizing tone. 'Maybe I'm to feel silly for suggesting such a thing!' I say. (1) Lucy finishes her crisps, which takes about a minute and says she needs to go to the toilet. She sets her crisp bag on the chair and leaves. I think about her needing to get rid of the link I made between the chart being messed up and the break. Lucy comes back and says: "I've a big bruise on my leg. I hit it against the cupboard when I was in a bad mood and broke the door'. I respond, 'You're telling me that when I was away, hurtful things happened (3) and you didn't feel you could manage at times'. (2) Lucy says: 'I've stopped biting and kicking though!' in a tone that	child comments on her own state of mind the previous day, elaborating upon this by talking about a 'fight' she had with her cousin relating to the therapy chart getting messed up. Child proclaims she did not miss the therapist during the break. child goes to toilet. Child conveys she has a bruise on her leg. Child conveys how she managed to stop biting and kicking during the break.	Therapist interprets the chart getting messed up with the child's feelings spilling out about the break. Therapist takes on the child's projection of the therapist being silly. Therapist thinking about the link between the interpretation she made about the chart being messed up and spilling out feelings break. Therapist interprets the child's relaying of her bruise with feelings seeming overwhelming during the break.		**Therapist's experience and activities** **Counter transference** - feelings of bombardment - feelings of helplessly the subject of sadistic play. **Thinking/ Mentalizing** - narrating - linking - sensing the child does not want the therapist to see her vulnerability. -pausing the play to think.	**CS:** Perhaps the child in fantasy believes she broke the door because of her fury about the break and also her worry about her violence.

indicates she is pleased with herself. 'I'm to know that you were able to manage some things but not others and you need me to know you're pleased with yourself for that'. (2) 'I'm back in my own room again, but there is only a chest of drawers in it', Lucy says. 'Hmm, that's difficult, because you were glad to be back sharing a room with Jane and, during the break, you are back in the room you hate', I say. (3) 'We're going to play the animal game', she announces. 'Do you remember the animal game?' she asks, a little anxiously. 'I think there's a worry that when I take a break, that you and our time together and what we do, gets dropped from my mind', I say. (1) Lucy gets out the animals and

Child conveys she is back in her own room with the consolation that there is one piece of furniture in it. Animal game Worries whether the therapist remembers the animal game.	therapist interprets the child's need for her to know she managed some things. Therapist narrates the child's need for the therapist to acknowledge she is pleased with herself. Therapist narrates the child's disappointment about being back in her own room Therapist interprets the child's worry about whether the child and her activities are remembered by the therapist.		**Containment** - sensing the child's anxiety about missing her cousin. - playing with the child. **Interpretation** - analyst-centred (1) - patient-centred (2) - narrative (3)	

opens the cupboard door and climbs in, bumping her head. She holds the door closed for a few moments and is quiet. I sense that she feels a little awkward and vulnerable. She puts the baby hippo on the top ledge of the door. 'It's the baby hippo, he's shy, he's not quite sure if you remember him', Lucy says. 'He thinks I might have forgotten him', (3) I say. Speaking as the baby hippo, Lucy says 'Hello', in a baby voice. 'Hello', I reply with a tone of enthusiasm. 'What's your name?' says Lucy, pretending to be the baby hippo. 'I think I will have to remind the baby hippo my name is Deirdre', I say (3). 'My name's David' she replies and goes on to explain, 'he's just a bit shy'. Lucy brings up the giraffe to rest at the top of the door. In a tyrannical tone, Lucy informs me that if I keep her son, the giraffe, talking for too long, I'll be sent to my room. Next

Theme of the animal game - forgetting and remembering	narrates the symbolic play about forgetting. Narrates the theme of forgetting and being forgotten about			

Next comes the son of the giraffe and his name is David too. I'm instructed to be surprised and even a little bit alarmed. 'They all forget their names, they all think they're called David, they just can't remember' Lucy says. 'So not only might they think I've forgotten them, they forget their own names!' I say (3). Lucy puts on a deep voice and brings up the large elephant. 'Hello, I'm 180 years old' she says. 'Gosh, you've lived a long time' I say (3). Lucy takes the elephant back and starts to climb out from the cupboard. 'Don't look at me in case I bump my head again' she instructs. I wonder about her not wanting me to see her vulnerability. Lucy climbs out and says excitedly, hardly catching her breath, 'Let's play the school game!' I tell Lucy I want to just think for a while, about the animal game. 'You think and I'll go

symbolic play around the theme of forgetting. child wants to play school game	narrates the play about animals thinking the therapist has forgotten them. narrates the theme of remembering. wondering about the child not wanting her vulnerability to be seen. pauses the play to think.			

playing!' Lucy fills up her crisp bag with water and cuts it at the bottom so the water leaks out into a glass cup she has placed underneath. 'Oh, it hasn't turned out the way I thought, it's all over the place', she exclaims, with a look of anxiety. I say, 'You had an idea that the water could be poured from one container to another, but it spilled and maybe there's a worry that when I go away, feelings spill out'. (3) She turns around so that she has her back to me and I am not sure what she is doing, until she turns around with a glass full of coloured water which looks like urine. 'Pretend you're a bad pupil' she instructs. Putting on an aggressive voice, Lucy says; 'you're full of pee and pooh! In response, I say, 'I think I am to know that you haven't quite forgiven me for going away and that I'm stinky and bad'. (1) 'Pretend you have to drink the pee'. I say, 'I've to be a bad, bad therapist/pupil who gets poisoned.

crisp bag filled up with water leaks. sadistic, aggressive school game.	narrates the child's attempt at playing out an idea of moving water from one container to another and links this via an interpretation about the child's feelings spilling out. Therapist links child's sadistic play towards the therapist with the child's feelings about the break			

I'm to know what it's like to feel helpless and be given bad stuff to drink'. (3) 'Right, are you ready to play the game?' Lucy orders. 'Right, you have to get things wrong, what's this? (holding up the giraffe). 'You say 'elephant', but first put your hand up', she instructs. I comply and Lucy roars at me that I am a stupid girl and will have to go to detention for 3 days. I get it wrong for three more questions and then, on the final question, I am allowed to get it right. I say, 'maybe I've to be put through lots of tests to see if I can manage being a stinky, poisoned, poohy, stupid and bad therapist/ pupil before you believe I might be able to help you sort out difficult feelings'. (1) Lucy responds with, 'I want you to play the piano and I will sing'. She instructs me and conducts herself, at first a little self-consciously and then relaxes into singing a made up song; *'the first day of school the baby was born. The second*

tyrannical play in which the therapist is assigned as stupid and is punished with detention.	Therapist narrates the child's sadistic play towards the therapist.			**CS**: Links to the 3 therapy sessions of the week and the break feeling like a form of detention.
symbolic playing of music and singing, whereby the child makes up a very sad song about a mother who started meeting her baby's needs but then neglected her and the baby dies.	Therapist interprets the child's 'testing' of the therapist as an attempt to find out how robust the therapist is.			

day of school, the baby cried, the third day of school the baby got fed and the fifth day of school the baby was left and the sixth day of school the baby died'. I say, 'things started off alright for the baby, but got worse and worse as time went on.' (3) 'Now I want you to play the trumpet' she instructs. Lucy sings more passionately this time and some of the words I can't make out. The words I recognize are; *'Mum is leaving, Mum is leaving, she is bad, she is bad. Mum is a stupid pig.* I say Lucy 'needed me to know about a Mum being a stupid pig for leaving'. (3) Seemingly ignoring my interpretation, Lucy says, 'Mr Healey is very good at music; he plays the guitar. Now I want you to play the guitar'. She instructs me to 'twang' the (imaginary) guitar more forcefully, in long movements across the strings at certain times when she gets

child elaborates on the song about being abandoned by a 'bad mummy'	Therapist narrates the horrific story in the made-up song. Therapist narrates the story and interprets the child's need for the therapist to know the story of the 'stupid pig mummy'			

louder, which I do in synchronicity. At one point, she laughs and looks at me with a sense, I think, of surprise at my willingness to play with her. I tell Lucy that there are 10 minutes left and, after momentarily acknowledging what I have said, she continues with the song; '*Mum is stupid, she goes away, she's a stupid pig, she learns and comes back, comes back, and then she cries'.* Lucy repeats this over and over and I interrupt her, saying that we need to tidy up. She stops and smiles at me, starts to tidy up and asks me to help her. I say that she feels glad I joined her in the song and to know she was singing about a stupid, useless mum'. (3) 'Oh there's no time for hide-and-seek. See you on Wednesday then', she says, as she leaves the room with a satisfied grin on her face.	Child surprised by the therapist's willingness to play along. Child continues to sing with more passion about a 'stupid pig mummy who goes and comes and 'cries'	therapist notices the child's joyous surprise at the therapist's willingness to play. Therapist interprets the child's satisfaction in the therapist participating and understanding that in the child's mind is a 'stupid, useless mum'			

Data Set 7 - Treatment Session 99, Wednesday 8th June 2005

Background context

This session occurred before an unplanned two week-break, which Social Services had insisted on, as part of the decision to move Lucy to a children's home. A foster care placement had been sought in the previous couple of months, but was unsuccessful and the move had been arranged rather suddenly; there had been no time to work this through in therapy.

Comments included in this coded session on the right hand column are denoted as follows:

CS denotes clinical supervisor's comments.

AC denotes academic supervisor's comments.

When I go to pick Lucy up, her escort (a family friend) is with her and stands up to come with her, saying that she wants to have a word with me. I say that it is best she ring me later to discuss anything, as it is important that the session begins on time. The family friend seems a little taken aback and says that she wanted to let me know that Lucy's blood sugars are up. Lucy looks at me and begins giggling a little manically and says, 'Race you!' and begins running up the corridor. I haven't registered immediately that she has said 'race you' until she says, 'I'm faster than you'. This all seems to happen so quickly. When we get to the room, Lucy immediately climbs on top of the worktop and kicks off her shoes. She says something I can't make out and when I ask if she could repeat it,

Initial Coding	**Initial Coding**	**Focused Coding**	**Categories emergent from themes**	**Supervisors comments**
Child's state of mind and behaviour Child's escort informs therapist of her unstable physical condition Child is playful in an ordinary way. child's verbalization hard to make out.	Therapist's thinking, experience and activities Therapist aware of the sense of mania in the child. Therapist cannot make out what the child is saying.	**Themes related to the child** - ordinary play - verbalization difficult to make out at the beginning of session. - tyranny - shows concern - ingesting food - perspective-taking - expelling - toilet. - making her own connections - symbolic play - interested/ awareness of time. - concrete expression of hurt. - pride in athletic achievements. - direct communication about being diabetic.	**Child's state of mind and activities/ responses** **Fragmentation** -slurred and mumbled speech **Defensive/ Protective** - eating - toilet - symbolic changing of the gravely ill baby to a happy, jolly and lively baby. - countdown to the end of the session	**CS:** The unmanageable worry about Lucy and her medical condition extends beyond the family to friends. **AS**: Is the child's deteriorating external situation mirrored in her inner deterioration.

she says, 'are you deaf?' then gets down, saying 'bad girl' and comes over and smacks me, not too hard, on the head and then repeats this. I say that she is to stop now. She immediately does and goes back to the worktop, climbing up with her back to me saying 'sorry, I didn't mean to hit you so hard'. I feel strangely guilty, as though I had reprimanded her. I say that not being here on Monday might mean she feels I'm to blame. (1) Lucy says that Susan had a headache and Julie (cousin) was sick and there was no-one to bring her. I say that it is hard when she is unable to come to the session because there is no-one to bring her and that she may be annoyed with me about that. (1) Lucy munches on her lunch and says something, which is, I think, that she's nearly finished her lunch and I repeat this back to her. She adopts an agitated expression, accompanied by a

Child apologises for hitting the therapist 'too hard' eating food.	Therapist gives child a boundary around her physically hitting out 'in play'. Therapist interprets the child's hitting too hard as the therapist to blame for the child not being brought to her session, due to an escort not being available.	**Themes related to the therapist** - boundary-making - interpretations - counter-transference and interpreting the c-t - thinking - linking - joining in the play - playing out assigned roles in symbolic play	**Symbolic Play** - tyrannical - mother abandoning baby. - gravely ill baby. **Relatedness/ Interestingness** - ordinary playfulness - ordinary communication - remorseful - perceives the therapist's thinking. - conveys self-awareness. - explains her own emotional state.	**CS**: The child's internal experience is one of confusion and disorientation. Who is to blame for her distress?

a smile and says, ‘no, did you think I said I'd nearly finished my lunch? I said, I normally have my lunch finished by now.' She suddenly gets down from the worktop and rushes to the door, opening it and going out but then puts her head round the door and says, 'Did you wonder where I was going just now? I'm going to the toilet'. I wonder inwardly about the mismatch in our connection today. Lucy comes back after a few minutes and finishes her lunch. She seems to look me up and down and I think of how fragile her connection can be. I say that I was thinking how confused I'm meant to be, that I misunderstood what she was saying. (1) 'Susan rang the	child realises the therapist misunderstands what she said and clarifies what she said to the therapist Child perceives the therapist wondering where she was going. Child goes to the toilet. Eats food.	Therapist wondering inwardly about the mismatch in communication. Therapist thinking of the child's fragility. Therapist interprets that she is meant to feel confused.		**developmental progress** -internalization - making her own links - introjection - awareness of time - perspective-taking - self-awareness **<u>Therapist's experience and activities</u>** **<u>Counter transference</u>** - sense of things being manic -feelings of guilt related to 'reprimanding her - mishearing what the child is saying. - inwardly feeling angry that the child is being left behind while her kinship family go on holiday.	

hospital yesterday as my blood sugars were dangerous. I'm making myself sick. I'm doing it to myself because I get soooooooooo...' Lucy imitated the roar and stance of a lion, closing her knuckles together and raising up her arms. 'I get really, really annoyed'. I said that I wondered what happened when she got really, really annoyed and that maybe this happens when she gets really frightened. (2) 'It's not that, it's when someone really annoys me. When is the last Saturday in June, is it the week after next? I say that it is and wonder what brought that to mind. Susan and the family are going away, ugh, ugh and I don't know who I'm going to. Whoever it is will have to know that school will be finished. 'Why are you not going too?' (I blurted out) 'Why do you think?' Lucy said in a tone of 'are you stupid!' 'It's a boat and in case I (roars like a lion) again. People get sick on the boat, you know, and they probably just get sick	Child explains how she makes herself sick by not complying with her medical condition. She links this in her mind with angry feelings. Child disputes the therapist's interpretation of fear and confirms that it is anger as a result of others annoying her. Child links not going away with her family to getting angry.	Therapist re-interprets the child's belief in the danger of her own anger by converting the feeling to fear.		-feeling moved and sympathetic for the child. -feeling impressed by the child's athletic prowess. -feeling horrified by the content of the child's made up story about a child who died. **<u>Thinking/Mentalising</u>** - thinking about the mis-match in communication between herself and the child. -thinking about how fragile the child's internal connections can be.	

over the edge'. I said. 'it's very difficult you're not going with Susan and the family'(3) 'Can you cut that?' (apple) Lucy said. I am surprised, as she normally eats the apple. I ask why she wants it cut and she pleadingly says that it is because her back teeth hurt and that all I have to do is go to the kitchen and get a knife and cut it. I wonder to her if she could manage and she tries to eat it. For the first three bites she says 'ouch' in what seems feigned then eats the rest easily. I say 'Maybe you need me to know that things might be too much and there is too much hurt'. (2) She says that (the family friend) came today because she, Lucy, had been 'very difficult this morning' and didn't want to come to see me because it was 'boring'! I say that I thought she really needed me to feel rejected and useless, especially for not being able to do something to get her here on Monday'. (1) 'Remember

Child expresses hurt feelings through conveying a concrete hurting of her teeth when eating an apple. Child explains she was difficult and this was why the family friend escorted her to the session adding that she didn't want to come to see the therapist as it was 'boring'.	Therapist narrates the child's difficult feelings about not going with the family on holiday. Therapist interprets the child's hurt feelings. Therapist interprets the child's contempt with the therapist by linking it to the child's anger and upset about not being at her session on the previous Monday.		**Containment** - providing a boundary to the child when she hits the therapist. - showing interest in her perspective-taking. - being impressed by her athleticism. -willingness to be involved in the child's play. - bearing witness to the horror of the child's story about a gravely ill baby who dies. **Interpretation** analyst-centred (1) patient-centred (2) narrative (3)	

on Friday, you put your chair here for me to lie down on and you sat on that chair? I'm sorry about Friday, I did it to myself. I slept for a few hours in the afternoon and then went to the shops with Susan. I had a bad nightmare, the first one in ages, about my mummy, but I don't want to tell you, it's too scary. I'll tell you one bit, but it gets scarier, so I won't tell you the rest'. With a manic sort of grin Lucy says that, in her dream, she fell off the roof. She immediately gets up and goes over to her box, showing surprise that the doll baby is wrapped up in the makeshift cot she made a few weeks ago. She says that she doesn't remember the baby being like this and takes out the 'cradle', sets it on the table and makes a makeshift clipboard, drawing lines to show 'blood pressure levels'. I am to be the baby's mother, who watches	Child conveys remembering the therapist being caring the previous Friday when she was sick and relates her awareness of causing herself to be sick. Child relays a bad nightmare she had about her Mother. Child shows surprise that the doll baby she had looked after is still wrapped up in a makeshift cot. Symbolic play in which I am assigned the role of mother who watches her baby having to get injections and then abandons her.				

and cries when the baby has to get an injection and then, suddenly, the baby's parents seem to disappear and she, the baby, has no-one and has to be looked after by the nurses who keep giving her injections. I say that I am to feel helpless about the baby and not being able to help the baby. (1) 'You know I get lots of injections'. Lucy suddenly says. 'I know, and that must be really hard'. Lucy gets up and leaves the 'injection' on the worktop and then asks me how many years are in 15 months. When I tell her, she drops down on the floor in a very impressive stunt-like performance. I spontaneously express being impressed and she does it again. This is followed by Lucy telling me her team came second in the relay; she shows me the bruises on her leg, saying that	For the first time the child communicates directly about the injections she has to take. First time interested in the sequence of time. Conveying pride in her athletic achievements.	Therapist interprets the child's need for her to feel helpless about the baby. acknowledges the reality of her diabetic condition.	.		**CS:** The child is connecting more deeply to her original trauma of being un-mothered.

she got these while scrambling through the tube. She asks me (much like a small child would) if she was fast, demonstrating her speed, sprinting across the room. After I am suitably impressed, she becomes the baby, climbing up on my knee, putting her face close to mine, giggling. Though this is overtly intrusive, I don't feel uncomfortably intruded upon. She rolls about the floor, giggling and wanting me to tickle her feet and then she is in hospital and I am instructed to talk to another doctor, in her presence and while she is asleep, about how gravely ill she is and how the drip keeps coming out and how, in the end, she dies. I feel quite horrified and conscious that we have only a few minutes of the session left. I had said earlier that there were 10 minutes to go and she doesn't show her usual concern about this, as though my saying it has passed	Child demonstrating new-found confidence in her athletic prowess. symbolic play as a baby gravely ill.	Therapist conveys being impressed by the child's athletic skill. Therapist conveying her thinking about her feelings in relation to the child's physical closeness. Therapist conveys an inward sense of horror about having to witness the grave illness of the baby.			

unnoticed. I say that I am to feel shocked and distressed about not being able to help the baby live. (3) She says, 'now I'm a happy, jolly, lively baby' and starts to babble and roll contentedly. I say that maybe she wanted me to worry but also to have joy and hope that the baby can be alive and happy. (3) Lucy starts to tidy up, asking me to help her and requests (as she has been doing) that we have a 15 to 0 countdown, while looking at the movement of the second hand on the clock.		Therapist interprets how she is to be shocked about not being able to help the baby live.			
	Child changes the baby's state of mind to being happy, jolly and lively.	Therapist interprets the child's wish for the therapist to have hope that the baby can live and be happy.			
	Child requests countdown from 15 seconds to the end of the session.	At child's request, therapist joins in the countdown.			

Data Set 8 - Treatment Session 105, Monday 27th June 2005

Background context

This session occurred after a two-week break, which Social Services decided was in Lucy's best interests. The rationale given was that she needed time to settle in to the Children's Home where she had been moved on Friday 11th June. Though the transition had been decided two months previously, the timing of the move was rather sudden and I was not part of the decision-making regarding the cancellation of her treatment sessions for a two-week period. I wrote to Lucy during this time to let her know that I was thinking about her and that she would be returning soon to her sessions. I approached this session with worry about Lucy's state of mind. I anticipated that she would be angry with me for not managing to get her to her sessions. Though she was well engaged in her treatment by this stage, I worried that she might regress to a turbulent state of mind, given the gap in treatment and her transition to the Children's Home.

Comments on the right hand column are denoted as follows:

CS denotes clinical supervisor's comments on the material.
AS denotes academic supervisor's comments

When I pick Lucy up at reception, I am aware of my relief and feel that I see a mixture of relief and anxiety in Lucy's demeanor. As she comes with me, she immediately says, 'I'm in a children's home'. I nod and she excitedly asks, 'How did you know?' stopping to wait for my reply. I suggest that we go on into the room and talk about it there. We do so and she approaches her usual place to sit, turning to me, smiling a little, I think, with relief, saying that she is going to sit in her 'usual place'. I feel relieved and so glad to see her. She looks at me expectantly, I think, as she starts to munch on the crisps she has brought. I say, in an emphasized tone, 'It's been ages since you were here and how difficult it's been to get you here'. 'I got your letter,' she says, smiling. 'So you knew I was thinking about you'. 'Who told you what was happening?' she enquires. I say that Sharon (social worker) told me that she

Initial Coding **Child's state of mind and behaviour**	**Initial Coding** **Therapist's thinking, experience and activities.**	**Focused Coding** **Themes related to the child**	**Categories emergent from themes** **Child's state of mind and activities:** **Protective/ Defensive**	**Supervisors comments**
Child communicates directly about being in a children's home. Child expresses excitement about the therapist knowing she is in a children's home. Child expresses familiarity with room Eating food. Child conveys she got the therapist's letter Child curious about the therapist's knowing.	Therapist conveying an inward relief. Therapist intuitively senses relief and anxiety in the child. Therapist gives the child a boundary. Therapist perceives the child looking expectantly at her. Therapist speaks directly about how difficult it was to arrange for the child to come to her therapy. Therapist links the child's conveying about the letter with being held in mind.	Direct communication of external circumstances Holding therapist and therapy room in mind. eating food Child able to think about therapist holding her in mind. child has expectation of therapist's help	- eating - gives up on the sellotape **Relatedness/ Interestingness** - direct conveying of information about outside world. - expresses excitement at the therapist knowing. - expects the therapist to help. -examines the therapist's clothes. - conveying she got the therapist's letter. - perceives the therapist looking different	**CS:** The child has internalized the therapist's holding her in mind.

was going to be leaving Susan and David's and moving to the children's home. Lucy nods in acknowledgement. 'I had hoped you would be able to come to your sessions but it was thought you needed time to settle in'. Lucy says, 'Were you here all alone waiting for me?' I feel moved and say, 'You need to know you were in my mind and that I was waiting for you to come back to your sessions'. (2) Lucy says, 'Susan has been to see me a couple of times and she and Shane (Lucy's younger brother) are coming to see me today; you see Susan goes on holiday tomorrow'. In response I say, 'You are glad that even though Susan cannot look after you any more, she still cares about you and thinks about you and comes to see you'. (2) Lucy nods. Silence falls and Lucy munches on her crisps. 'What's

Child has in mind the therapist having her in mind. Child directly communicates about her relationships outside.	Therapist directly explains to the child why it was difficult to get her to therapy during the past two weeks. Therapist narrates the child's experience of being held in mind. Therapist narrates the child's experiences of relief about her aunt's continued care under the circumstances.	child's curiosity child's concern for therapist symbolic play of 'blame' for being lost symbolic play spilling out. Awareness of time Difficult I-Spy game	- child has in mind the therapist has her in mind. - child holding comforting memories of the therapist's caring. **<u>Symbolic Play</u>** - therapist assigned the role of 'mummy' - enactment of a child sleeping endlessly and not eating. - child enacts being the therapist's baby. - infantile curiosity - baby bottle gets lost - blames the 'bad' bottle for getting lost. - child narrating her 'conversation' with her 'bottle'. - 'I Spy' game.	

it like where you are living?' I ask. 'It's okay; its like a home, but with lots of people. I fell out of bed the other night. I woke up with my duvet over me. I was on the floor.' 'It must feel strange, a new place, new bed' I say. Lucy finishes off her crisps and starts to turn the tap. 'I haven't seen this for ages,' she says, smiling with relief'. 'You are glad to be back and be able to turn the tap when you want to; back to our familiar room'. (2) Lucy fills up the empty crisp bag with water saying, 'Remember I used to do this?' 'Yes', I said. 'Can you hold this?' she enquires, handing me the filled up bag, saying that she wants to sellotape the top of it. I think of her creating a container for water inside the bag. I hold the bag of water while Lucy tells me to be careful it doesn't spill on me, while she struggles with the

Child explains what living in a children's home is like. Child conveys relief in being back in the therapy room. Lucy conveys a sense of being held in mind by the therapist. Child expects the therapist to help. Child expressing concern about the water spilling on the therapist.	Therapist conveys ordinary curiosity about the child's experiences of living in a children's home. Therapist narrates the child's feelings of gladness and relief at being back in the therapy room. Therapist thinking of the child's symbolic attempt to create a container.	**Themes related to the therapist** narrates interpretative linking engaging in play. Quality of the narrating includes an overcoming (rather than an uncovering of defences). identification? as a result of introjection (of therapist's narrative style)	**Developmental progress:** Introjection and Internalization: • thinking • rememberin g • holding therapist and room in mind. Awareness of time. **Therapist's experience and activities** **Counter transference** - feeling a mixture of relief and excitement. - feeling moved by the child's wondering if I had been alone waiting for her.	

sellotape, which had been in a mess for some time. She eventually hands me the sellotape, asking me to sort it out while she holds the bag. I struggle with the sellotape, which had been stripped off in chunks and lumps, leaving no smooth section to peel off. Lucy gives out an omph! noise and says that the bag is torn. The water I can see, is seeping out and she announces that she doesn't need the sellotape any more and instructs me to put it back in the box. I ask her if she wants me to continue sorting out the sellotape and she says 'No!' quite insistently and takes the sellotape from me and puts it roughly (as she usually does) back in the box and sits down opposite me. 'Is that a dress you have on?' she asks. 'No, it's a top and a dress' and gets down	After struggling, the child asks for help with the sellotape, which is in a mess. Child disgruntled about the water spilling from the bag. Gives up on the sellotape. Child notices and is curious about and examines the therapist's clothes.			**<u>Thinking/Mentalising</u>** - I thought of her creating a container with the crisp bag. **<u>Containment</u>** - giving a boundary about engaging outside the session. - playing with the child. **<u>Interpretation</u>** analyst-centred patient-centred narrative overcoming	**<u>AS</u>**: reference to the therapist as a container and holder of memory who remembers her before this time.

from the worktop to have a closer look at my skirt. 'What are they?' 'Shells'. 'Are they real?' 'Yes,' 'I see you have some on your top. You look different', she observes. 'You think I look different today; things are different for you, you're not living where you have been with your aunt and uncle since the last time I saw you', I say. (2) 'We're going to play a game; you're my mummy' (she crouches in the chair, saying that she might doze). 'Remember I did this last time'. 'You're remembering a nice feeling, when you were here before, of being curled up and sleepy even though you were sick'. (2) 'I'm Jason and I'm asleep (she lies on the floor). 'No actually, this is my bed' and she climbs into the cupboard. She instructs me to close the doors and then to come and waken her up for school. When I do this, she instructs me again to	Child perceives the therapist looking different. Symbolic play - therapist assigned the role of Mummy. Child holding comforting memories of the therapist's caring for her.	Therapist links the child's perception of the therapist looking different, with the child moving to a children's home. Therapist narrates the substance of the child's memory.			

waken her at lunch-time and then dinner-time and I am to have a worried conversation with Jason's Daddy about him not eating. In the play, this goes on through the next day, then for a week, followed by the whole summer, until Jason finally wakens up. I say that Lucy is telling me that maybe she wants to sleep through everything that's happening at the moment. (2) Lucy, as 'Jason', comes out of the cupboard and gets the bottle of water she had brought into the session and says 'I'm your baby this time and I don't know where my bed is and that's why I am asleep on the floor' she explains. I say she is telling me about how difficult it is to know where she is and what's happening. (2) Lucy starts to point (accompanied by a baby's voice) to name	symbolic enactment of a child sleeping endlessly and not eating. Child enacts being the therapist's baby who doesn't know where she is or what's happening.	Therapist interprets the meaning of the symbolic play as the child wanting to sleep through the difficult transition to the children's home. Therapist narrates the child's worries, especially about not knowing what's happening.			**CS:** The child's interest in what the therapist is wearing, to curling up sleeping, is showing an internal place of fantasy where she wishes she could just curl up and sleep.

things in the room - door, light, cupboard, chair - for me to name and I say, 'You must have been so unsure about where I was and where your therapy was and if the room was still the same. Now you are remembering, you have come back again and the room and I are still here'. (2) Lucy says 'lost, bottle lost'. I am to retrieve it for her. I say, 'You are telling me about losing your home and your family, but also finding them again. You will see your aunt and uncle and cousins and brother. (4) She lets the bottle repeatedly slip from her mouth while she says 'bad bottle' and smacks it. She tells me that she is having a conversation with her bottle, telling the bottle it was bad for getting lost and not staying in her mouth. I say, 'It is so difficult to sort out how all this happened and that someone	Symbolic enactment of infantile curiosity. Symbolic enactment of the baby bottle getting lost. Child converts loss into blame - the bottle is 'bad' for getting lost. Child narrates to the therapist about having a 'conversation' with her 'bottle'.	Therapist narrates the child's turmoil re her home situation and her loss of therapy for two weeks. Therapist interprets the child's enactment of the lost bottle as a communication of her loss of her home and family.			

must be to blame'.(3) 'Bad bottle' she repeats. Lucy then gets up and tells me we have 10 minutes left and counts down every minute, until a few minutes before the end. She says that she is getting good with telling the time. I say that she is keeping a close eye on the time to really make sure she knows when our time together stops, so that she is prepared for the ending and can tell me when it's time to stop. (2) Lucy wants to play an 'I Spy' game, which she makes very difficult for me to get right. I say, 'I am to know what its like to feel confused and find it difficult to know what is going on'. (1)

Child counts down the time	Therapist interprets the theme of loss with confusion about how this happened and that someone must be to blame.			
	Therapist interprets the child's need to prepare herself for the ending of the session by keeping a close eye on the time.			
Child initiates the 'I-Spy' game, but makes it difficult for the therapist to get it right.	Therapist conveys that the child wants her to struggle.			