

A baby mouse in a tiny boat.

In psychotherapy treatment can the experience of premature birth be considered significant in understanding the internal world of a child?

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All names and place details in this document have been changed to protect confidentiality

Abstract

This thesis discusses the potential impact a premature birth can have on a child's internal world. This was explored using a single case study of a girl who was born at 25 weeks gestation.

There are ten sampled individual psychotherapy sessions and one initial meeting in order to research this question using grounded theory and thematic analysis. Themes that arose from this material, in connection with infant prematurity, include babies and growing up; incubators and hospitals; psychotherapy and play; animals, insect and reptiles; and finally the importance of the beginnings, endings and holiday breaks in the psychotherapy.

The implications of the possible trauma of a premature birth for both the parents and the young girl are thought about in detail. My analysis of the material indicated that this had a profound effect on Poppy and her family. The question of whether Poppy's memory of her premature birth and early experiences were internalized by her at birth, or whether this was projected into her by her parents, concluded that it was likely to have been a combination of these two factors.

Key words

Special Care Baby Unit (SCBU), premature birth, incubators, attachment, separation, grounded theory and thematic analysis.

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1. Introduction

1.1 Introduction

Whilst training as a Child and Adolescent Psychotherapist in a CAMHS clinic I noticed that there were a high number of children referred for psychotherapy who had been born prematurely. I was interested in this fact and felt it would be worth investigating why this should be the case. I therefore decided to undertake research using the case study material of one child I worked with who was born premature (I will go into detail shortly about the case study).

My background prior to qualifying as a Child and Adolescent Psychotherapist was in social work. I had always wanted to work therapeutically with children and had been advised to undertake the social work training as a way into this. After several years working in a social care office, in the child and family team, I was able to take up a position in a voluntary agency as a project social worker undertaking play therapy work with children (I had a play therapy qualification). In this post I obtained consultation from a Child and Adolescent Psychotherapist for my individual work and this led to me undertaking the M7 psychoanalytical observational studies course. I had no intentions of applying for the child psychotherapy clinical training, however, once on the M7 I wanted to continue to learn more and the trainee post became available. Prior to undertaking the clinical training I wrote my M7 MA dissertation on endings in therapeutic work and this was called "Painful goodbyes with positive outcomes". I felt strongly that endings were an important part of the therapeutic process and needed to be considered in detail. The MA then led me to think about further areas of study and I became interested in infant prematurity.

Premature infants survival rates have increased over the years with medical intervention and technology. A premature birth is considered to be an infant that is born before thirty-seven weeks. A classification of being a more extreme premature birth would be if this infant has been

born before twenty-eight weeks gestation (World Health Organisation 2014). The Office for National Statistics (2013) based on 2011 figures indicates an increase in survival rates of premature infants.

The infant mortality rate for pre-term babies (between 24 and 36 weeks) born in 2011 was 25.4 deaths per 1,000 live births, 11% lower than the rate for pre-term babies born in 2006 (28.6 deaths per 1,000 live births) (The Office for National Statistics 2013).

The majority of research undertaken in this field considers the effect a premature birth has on the infant's first few years of life and the early developing relationships. The process of reciprocity, that is the two-way interactions between infant and parent can be interrupted, although in some cases temporarily, by the difficulties which arise from a premature birth, *"...mothers of premature infants are, at least initially, confronted with an infant with whom it is difficult to interact"* (Macey, Harmon, Easterbrooks 1987 p847).

The research suggested the outcome for infants who were born premature can be dependant on a number of factors such as: very low birth weight and/or those born at a gestational age of less than thirty two weeks; medical complications; and the family's environmental and social situation (Macey, Harmon, Easterbrooks 1987).

Thinking about the family led me to consider another aspect to my research and this was trauma. For some families having a premature infant is a traumatic experience that can affect early relationships. It is also possible for trauma to remain present for many years to come (Garland 2005).

I had extensive clinical data, in the form of process notes, regarding the child that is the subject of this thesis, that I felt indicated a question about whether her premature birth was impacting her internal world as I was aware this had been present in the clinical material. I therefore

considered this would be a suitable source of data on which to base my research using a qualitative approach and, in particular, grounded theory for the analysis of the sessions. Grounded Theory was developed by Glaser and Strauss (1967) as a research tool and this allows the use of clinical material that the clinician has already gathered, perhaps over a long period, to analyse themes found in the work to assist the researcher in making hypotheses. *“Clinical research using Grounded Theory produces theory that is grounded in the data and can provide explanations, prediction and applications directly applicable to the clinical setting” (Anderson 2006 p330).*

I will now move on to introduce Poppy, the child who is the subject of this thesis. I look at the environmental factors and family circumstances that may have impacted her internal world compounding the birth experiences.

1.2 Introduction to Poppy

When Poppy first came to see me, she was eight years old. She would carry her cot blanket with her and spoke in a very tiny voice giving the impression of a much younger child. On ending her psychotherapy at ten years old, she had longish hair that she liked to temporarily dye. Poppy was very fashion conscious and often pointed out the clothes and accessories she wore. Wearing the up-to-date fashion and sometimes make-up made her look older than her years yet emotionally she remained quite infantile.

The referral for psychotherapy was due to Poppy’s extreme aggression. Her parents described Poppy as being “violent”. Poppy would hit out at her mother regularly with some force leaving bruises. She had temper tantrums where she would fling herself on the floor kicking and screaming. Her parents were afraid of her outbursts and anxious she could erupt at any time.

Poppy lived at home with her mother, father and her older sister. Her father was a musician and worked some evenings. He suffered from a bad back and was registered as disabled. Her mother did not work due to the difficulties she experienced with her own anxiety and panic attacks. Towards the end of my work with Poppy I learnt that her father had mental health difficulties as a teenager. At one point Poppy's sister also attended CAMHS.

I was aware from reading her file that Poppy had been born at twenty-five weeks gestation and had been in the Special Care Baby Unit (SCBU) for three and a half months and Poppy had a cerebral bleed. Both her parents had experienced mental health difficulties and this could have been a factor in how they coped with the shock of having a premature baby.

I became very interested in the potential impact of Poppy's premature birth right from the beginning of my contact with her family. It was very striking that the trauma of having an infant born so early was so raw and alive in both the parents and Poppy's mind in terms of what they spoke about and the symbolic material which related to this.

The way Poppy related to me, particularly using the transference relationship and my countertransference feelings, helped me to investigate what kind of internal objects she had developed since birth. In both psychoanalytic and attachment theory it is considered that the infant actively takes in (internalises) his/her relationship with caregivers. I wondered how much a premature birth emotionally affected the internal world of the child and in particular what may be taken in through the incubator experience. My supervision notes and the review meetings with carers and other professionals helped to enhance this investigation along with the literature on this subject.

1.3 Background Information

When reading Poppy's files I noticed that the CAMHS team had known her since she was four years old. Mr. and Mrs. Abbott (Poppy's parents) had experienced enormous amounts of stress from her aggressive behaviour where she got herself into extreme rages that were mainly directed towards her mother. She was referred on by our service to a local project that visits the family at home and sees the child at school/nursery. This service has a Clinical Psychologist and support workers in their team. They specifically work on helping to modify any difficult behaviour helping the parents and the child.

However, when Poppy was five, the family returned to the CAMHS services as they continued to experience difficulties with Poppy's behaviour. Poppy had appointments with a Consultant Child and Adolescent Psychiatrist. He tried to help the parents in thinking about how to manage what the family described as "violent" episodes from Poppy towards her mother. Medication of various sorts was tried but to no avail. The impact of Poppy's premature birth was considered to be potentially significant by the professionals who came into contact with her.

When Poppy was eight years old a new Consultant Child and Adolescent Psychiatrist referred her for psychotherapy. The parents were referred for parent counselling and were also offered regular appointments with a Clinical Psychologist to help them think about how to manage Poppy's behaviour.

1.4 Presenting Difficulties

Poppy attended a local primary school and appeared to manage relatively well in the school environment. She had been able to make friends and did not require extra help within the school setting. Her teacher told me Poppy had exhibited her "extreme behaviour" on a

couple of occasions when she first started school but, once this had been dealt with by the teaching staff, Poppy calmed down and her behaviour at school was said to be “good”. The teacher reported that Poppy found separations from her mother difficult and would cling to the teacher on parting from her mother, however, as soon as she had gone Poppy seemed to “switch off as if nothing had happened”.

When I first met Mr. and Mrs. Abbott I noticed they exhibited a high level of anxiety, particularly with regard to Poppy and seemed desperate for someone to “fix her”. They described to me how “aggressive” and “destructive” she was. Mrs. Abbott wanted to show me bruises on her arms from the latest attack from Poppy and explained they had telephoned the Police to get help with her behaviour on a number of occasions. They spoke of how Mrs. Abbott restrained her and Mr. Abbott explained he could not do this due to his bad back. Mr. Abbott wanted Poppy diagnosed with ADHD (Attention Deficit Hyperactivity Disorder) and to be given medication. Mr. and Mrs. Abbott became defensive when I asked about Poppy’s early birth history. Mr. Abbott told me they had gone over this with other people but they did tell me several weeks later how “sensitive” Poppy was as a baby; particularly with regard to sound and that this was the case even now. When asked about the point when the rages started Mr. and Mrs. Abbott told me Poppy had “always been this way”. Mrs. Abbott told me how Poppy used to smear her faeces around the home as a baby and that she had, “always been difficult”. I found myself feeling very apprehensive about meeting Poppy after speaking with her parents. It felt as if I was going to be meeting a “monster” child. I felt fearful about the level of aggression that might come my way from Poppy.

1.5 Family Appointments and Assessing Poppy for Psychotherapy

Prior to taking Poppy into treatment the Clinical Psychologist and I undertook monthly family sessions for a period of five months. The purpose of this was to assess if individual psychotherapy was appropriate and whether her parents could show sufficient capacity for change within the relationship with their daughter. Within these appointments Poppy was able to choose what she played with and I made interpretations based on her symbolic play. The Psychologist supported Poppy's parents and occasionally spoke with them about Poppy's behaviour if they raised this. We also had a few sessions towards the end of the five months where Poppy got used to being with me on her own whilst her parents went to a different room with the Psychologist. During one of the family appointments, where I had some of the time on my own with Poppy, she asked me if my colleague and I were going to take care of her now as her mummy and daddy found this hard. I felt the Clinical Psychologist and I formed a strong couple in Poppy's mind that she sensed could contain her.

Over this period of time Poppy demonstrated an ability to convey her internal states symbolically. Her parents were able to show their interest in what Poppy was doing and this was a hopeful sign that there was potential for change. I therefore agreed to take Poppy into weekly treatment.

Initially, in the family sessions, Poppy was eager to present to me the gentle, tender part of her and the more ferocious, aggressive part was well defended and hidden. I noticed Poppy was unable to express her feelings directly and used an infantile means of communicating by pushing her feelings into others. This is an unconscious and primitive means of communicating which meant Poppy required an adult to regulate for her just as you would a very small infant. This could link to

the high levels of anxiety the parents' experienced as Poppy gave them so much of her own anxiety and fears.

1.6 Individual Psychotherapy with Poppy

In my first individual appointment with Poppy she greeted me with a hug. She seemed to latch on to me in a desperate kind of way, possibly to cope with the separation anxiety she experienced. She could not wait to tell me what was on her mind and began doing this as soon as I collected her from the waiting area. Separations were clearly difficult and painful for Poppy. She had many ways of coping with this, for example, in addition to latching on to me she would bring a cot blanket with her to the appointments as a comforter.

I started to become aware of how calm I needed to be in order for Poppy not to become too excited, as if this happened it felt like she had no internal mechanism for stopping her behaviour escalating. In the countertransference I felt Poppy wanted help to contain and regulate these emotions rather than allowing them to get out of control. I felt concern for her when she became like this, but instead of responding anxiously, as perhaps her parents did, I remained composed and my voice and words appeared to contain her. A good example of this was when on one occasion Poppy was in the waiting area, she became agitated and had one of her outbursts. I was called upon to help and witnessed her thrashing around on the floor screaming as if in a terrible temper tantrum. At the same time her father was pacing the floor, clearly anxious and frustrated, as he was feeling powerless. Her mother remained impassive. I suggested to her parents that we go into one of the private rooms away from public view. I told Poppy this and she screamed abuse at me but followed when I led the parents to the room. She continued to act in an aggressive and confrontational manner and I spoke quietly to her parents and said when Poppy was ready she could come and talk with us. I helped her parents to re-focus their attention in

such a manner that Poppy no longer felt an immediate return of her own projected hostility. I showed her mum a child's book that was in the room and spoke about the story. Poppy then began to listen and appeared interested in the conversation and after several minutes she came to look at the book with us and stopped her aggressive behaviour. This indicated to me that if Poppy's parents felt supported and contained they could do the same for Poppy.

Frustration could not be tolerated by Poppy. If something did not happen instantly she would give up. I could see the potential for such frustration to quickly turn to rage and that she needed help to build up her internal strength to manage frustrations in life.

I found Poppy could become internally destructive and squash the needy, vulnerable part of her and then quickly elevate herself to be the one in charge. However, behind this behaviour she felt anxious. She collapsed internally when her controlling did not work and this was one cause of her fury. Poppy also gave me the impression that adults were there to be got around. This was the trickier part of her that needed a great deal of attention as she needed help to relinquish her omnipotent control of adult authority. Throughout the psychotherapy I drew attention to this in a gentle but firm way.

I soon realised Poppy needed more than once weekly psychotherapy. This was partly due to her separation anxiety and also because of the level of her emotional disturbance. After discussion with her parents and my supervisor I increased her psychotherapy, five months into treatment, to twice weekly.

Poppy made good use of her psychotherapy and was able to symbolically represent how things were for her, mainly by using her artwork but also via play. She was desperate for someone to

understand how she felt, particularly in relation to the fact she was born premature.

As my work progressed it seemed that Poppy had a narrative, which suggested she felt her parents had abandoned her in hospital when she was an infant and that she had nearly died. Poppy told me she had been shown a video of herself in the SCBU. When I checked this out with her parents they confirmed they had shown her the video when she was seven years old, prior to the commencement of psychotherapy.

I think the video of herself in SCBU must have been hard for Poppy to process and clearly she had anxieties about this. This seemed to have left her with deep resentment towards her parents for the experience she had endured. She no longer had unconscious memories about this event; her phantasies were made into reality. Machines and bright lights surround infants in SCBU. It can be difficult to see their little bodies for all the equipment, which is wired up to them. Poppy would have seen this image, which would have been a painful awareness of how her parents could not physically hold or tend to her.

1.7 Poppy's Progress

It gradually seemed that when I received Poppy's anger she felt more emotionally held. She experienced the fact that her anger would not be returned and that I was not afraid of her. Enabling this to happen in psychotherapy meant that Poppy became internally calm within the appointments and she felt emotionally contained during the time she was with me. The analysis of the detailed transcripts indicate that if more of the negative transference had been addressed by the therapist in a robust way, Poppy may have made more progress with her behaviour at home. At different points in the psychotherapy treatment some of Poppy's difficult behaviour improved at home but this never lasted and she could quickly revert to the old ways of relating. I felt this

was, in part, due to how very sensitive she was to changes at home. For instance, when her sister was unwell in hospital she became very disturbed and her anxiety about this translated to rage. If her parents were feeling particularly anxious about something Poppy would respond to this too. Poppy needed consistent and firm handling from her parents, yet they seemed to remain fearful of doing this, or they would go to the other extreme and become very physical by restraining her. Unfortunately Mr. and Mrs. Abbott did not regularly engage with the parent support work, offered by the Clinical Psychologist, which was aimed at looking at ways of managing Poppy. However, they did engage well with their own weekly parent counselling.

The psychotherapy helped Poppy to feel more understood. Her symbolic play enabled me to make sensitive interpretations that clearly gave her the message that I understood what she was conveying. This seemed to offer Poppy some relief. She became more able to regulate her emotions and gradually Poppy developed an emotional literacy enabling her to name her feelings.

Psychotherapy opened up communication channels between Poppy and her parents, particularly with regard to her behaviour. Different techniques, developed by Poppy in her psychotherapy, were shared with her parents with Poppy's permission. Poppy became more able to think about her behaviour.

The separation anxiety she struggled with improved considerably over the course of her treatment. Putting into words her feelings regarding separations and transitions helped Poppy to think about this and eventually to respond differently.

In this thesis I examine in detail, by analyzing ten individual psychotherapy sessions and the initial meeting with Poppy and her

parents, whether her premature birth could be evidenced in the clinical material.

In the next chapter I give an overview of the literature that is pertinent to this research. This includes the experience for the infant in SCBU. The possible trauma for the family and infant is discussed. The psychoanalytical concepts that guided my work with Poppy are included. The literature review also references the different impact studies that I found regarding prematurity. I pay particular attention to the long-term emotional impacts being born premature can have in some circumstances.

The chapter on research methodology considers how psychoanalytical work can be viewed as research and the historical components of this. Infant observation and research is discussed as this relates back to the material connected to Poppy being born premature. I then look in detail at the findings and analysis from my research.

The findings chapter is separated into the themes that emerged from the analysis of the material. They included discussions on: babies and growing up; hospitals and incubators; psychotherapy and play; animals, insects and reptiles; beginnings, endings and breaks in psychotherapy; and the role of the therapist. I end with a summary and conclusion of this paper.

2. Literature Review

2.1 Introduction

This chapter reviews the current literature on children born premature. I start my literature review looking at the documented experience of infants in a Special Care Baby Unit (SCBU). Infants undergo intrusive procedures and are subjected to particular artificial environmental stimuli that they usually do not endure if they are born full-term.

I then look at the potential trauma to the infant and the family, moving on to discuss the internalisation of traumatic experiences. Winnicott (1949) comments on the significance of trauma related to the birth history of patients and how this can be researched via psychotherapy. He also stated the importance of observing newborn infants and the assessments made by neurologists too.

I consider the potential effect on the infant of being in an incubator in terms of the security of the attachment relationship. This involves a physical separation of the infant from the parent and for medical staff to intervene to care for the infant and, in effect, keep them alive.

There is much written about infants being born premature but few articles have been written on the potential emotional affect this can have on a child's internal world. I therefore feel this thesis could potentially add to our knowledge and thinking in this field. I found four articles focussing on this subject, three in The Journal of Child Psychotherapy and one in The International Journal of Infant Observation and its Applications. I will look at all of these articles in more detail later in this chapter.

I discuss the use of psychoanalytical concepts within Poppy's psychotherapy and the relevance of this to her premature birth. I also found some impact studies that looked at children who had been born premature. There was a potential link with the security of their

attachment relationships and the possibility for developing psychiatric disorders later in childhood. There is also evidence to suggest children could be at greater risk of abuse if they are born premature.

2.2 Premature Infants

In researching the experience of infants born premature I felt it was important to think about infants who are born full-term in order to consider the potential differences. What can be expected in terms of development and psychic growth in an infant who has had the whole nine months in utero? Certainly having less time to develop in the womb is likely to cause difficulties for the infant and this is the reason why most premature babies require intensive support in incubators.

The Wyly (1995) paper is helpful in distinguishing the physical development of the full-term infant with that of the infant born prematurely. Wyly describes how the full-term infant has developed regular and organized behaviours that she terms as “states”, in particular with sleep and alertness. “States” are patterns of behaviours that the infant goes through during a 24-hour period. In full-term infants Brazelton (1973) named six states that I have briefly described as follows; quiet, active, drowsy, quiet alert, active alert and crying. Understanding and tuning into infant states help parents to respond accordingly and is the first way a parent can help to promote self-regulating behaviours. However, those infants born premature, in particular between 23-27 weeks, do not follow this pattern of behaviours due to their lack of development. This means reading infants rhythms and attuning to them becomes much harder for parents as the infants state behaviours are more disorganised. The full-term infant has body organs, which are ready to function whereas the premature infant’s organs are immature. For example, this can result in infants having: breathing problems, as their lungs have not fully developed; possible brain damage; difficulties with maintaining body temperature; and

jaundice (Wyly 1995). Negri's infant observations compare the full-term infant's behaviour with the premature infant. The premature infant is, "...less alert, reactive and socially responsive" (Negri 1994 p85).

In terms of understanding the infant's development prior to their birth Piontelli (1989) studied twins in the womb using ultrasound and, once they were born, using infant observation. This gave us insight into the infant as she could see that even though the twins shared the same womb they still had their own unique temperaments and behaviours. This behaviour, observed in the womb, continued once the infants were born, suggesting that personality is developing prior to birth (Piontelli 1989). The premature infant is forced into the world having not had the same time as a full-term infant to develop such personalities and behaviours and has to continue to do this after birth but in the false environment of the incubator. This may go on to impact their early development and possibly their personality.

2.3 Pain Observed in Premature Infants

Cohen (1995) writes about her observations of premature infants in the intensive care unit. She gives moving accounts of the difficulties and pain they endure. She describes the complex equipment surrounding and attached to the infants, with bright lights and very warm temperatures. Some have equipment in their mouths to help them breathe and feeding is often intravenous. The infants have frequent blood tests throughout the day and they begin to anticipate this intrusive and painful procedure. Cohen describes this with her observations of infants who begin to "squirm" and "thrash" around when the medical staff approach them. Her paper gives a shocking sense of the fragility and near death experience that these infants and their families go through.

Field's (1990) paper described the levels of stress experienced by premature infants in the SCBU. In order to assess cortisol levels, heart rates and respiration in the infants were measured. This indicated that the continual, often painful, medical procedures, the high level of noise and bright lights contributed to stress levels. It concluded, *"...intensive care procedures and neonatal assessments appear to be stressful for the preterm neonate, as manifested by distress behaviour and altered physiological, adrenocortical, and growth hormone activity"* (Field 1990 p61).

The effects of pain in infancy have been recorded using behavioural and psychological indicators. In particular, the painful procedures premature infants in the SCBU experience. It has been concluded from monitoring stress and pain in the infant that, *"Acute episodic pain may cause early neurologic injury. Repeated and prolonged exposure to pain may alter subsequent psychokinetic development as well as affect long-term neurodevelopment, behavioural and social-emotional outcome"* (Bouza H 2009 p722).

Therefore I can conclude, from these studies, that enduring pain in infancy can have a profound effect on a child's overall development.

2.4 Parents' Experience

In terms of the parents' experience of SCBU Cohen (1995) stated that the infant is often not felt to belong to them but to the nursing staff. Usually in a full-term healthy infant negotiation, particularly with the mother, is required to hold and look at their infant. In an intensive care unit she says, *"...the baby is lying in the incubator open to the eyes of anyone..."* (Cohen 1995:279). Having a premature infant can arouse anxieties in parents. Their own mortality as well as the infant's comes into focus. Negri speaks of how personal death anxieties become

difficult to separate out from the infant. Sometimes this is so extreme that the parents are fearful of being near the incubator (Negri 1974).

An early birth is often accompanied by intense feelings of anxiety, guilt and grief. Parents may feel overwhelmed by a rollercoaster of emotions as their baby's condition worsens or improves. Some parents will distance themselves emotionally from their baby, fearing the baby might die (Nyly 1995 p153).

In order to help the parents and the infant McFayden (1994) discusses the particular skills of the child psychotherapist and how valuable their ability to observe premature infants and contain their projections can be. The child psychotherapist helps to process the parents' and staff's experience and put words and meaning to this. She also recommends the following, *"Approaches to infants as real people, who feel pain and are startled by sudden events, will help them to build on their fragile and early sense of integration rather than to disintegrate both physiologically and emotionally"* (McFayden 1994 p162).

When reading Cohen (2003) I was interested in her description of the environment of the locked SCBU as this felt like it was separate from the rest of the hospital. *"There is a sense that what is inside is fragile and that what is outside is dangerous"* (Cohen 2003 p1). Poppy's parents may well have been reminded of this experience at CAMHS. The clinic, where I saw Poppy and her parents, was also a place that had security doors that were locked and could only be accessed by the therapist's security card. This felt as if yet again they needed their child in a locked, safe and protected environment.

Although Reid (2003) focused on mothers who experienced the death of an infant and the impact of this on those born after this loss, I felt it had some relevance in thinking about Poppy. Her parents were told she might not survive and they prepared themselves for her death. When I was in the family sessions I felt in the countertransference that there

were feelings of walking on eggshells, fearful at any moment a catastrophe would happen with Poppy. It was almost as if there could be a life and death situation within the clinical room. Reid noticed that the mother and infant “...appeared to be haunted by the loss and to have internalized or projectively identified with an ambivalent maternal object whose mind was filled with death” (Reid 2003 p209).

Frances Tustin (1981b) discussed how psychotic states in children can be traced back to difficulties with a premature or badly managed psychological birth. This paper considers the internal states of infants. It is not solely about those who are born premature, it is connected to infants whose developmental stages have been “telescoped” leading to later confused and disorganised development. In normal development she tells us that the infant continues to be, “...sheltered in what might be termed the “womb” of the mother’s mind just as much as, prior to his physical birth, he was sheltered within the womb of her body” (Tustin 1981b p183). I think this could also relate to the experience of a premature infant who is forced into an early psychological birth before they are ready. The parents may be in shock and traumatised by the event and therefore less able to offer a mind which can “shelter” their newborn. This led me to think about trauma in relation to premature infants.

2.5 Trauma and Impact on the Family

A premature birth can be a traumatic event for parents. Most parents expect a nine-month period to psychologically and physically prepare for their infant. Suddenly this preparation time is taken away from them and in addition to this they are often faced with the reality of whether their infant will survive or not. They may also have fears that their infant will be left disabled.

Garland (2005) has written extensively about trauma and developed much of Freud's understanding on this subject. She thinks of trauma as an internal wound, something that gets deep inside and can trigger past traumas and anxieties. I was particularly struck by her description of how trauma can remain as an open wound, *"...for some people the support of family and friends is not enough and a traumatic event remains an open wound, deeply pre-occupying to the wounded and often very perplexing and taxing for the unwounded"*(Garland 2005 p246). If the trauma is not worked through it may remain a source of difficulty which is liable to be acted out, albeit unconsciously, in response to external events. This made me think about what support is offered to families who experience the traumatic event of the premature birth of their infant? From the literature I have read it suggests that group work is often offered to support parents and also educative help is on offer too in terms of understanding the infant. Some support focused on helping parents to learn to understand and attune more to their infant while others offered support to have closer physical contact with their child. In some cases further follow up support was offered at home to the family (McFadyen1994). Some families can be comforted and supported by their extended family and friends and recover from this experience. For others this may not be the case. Having a premature infant could also compound previous traumas in the parents' lives.

Freud (1917) stated that mourning was the normal response to loss and this was not only experienced due to death but could link to other areas of our lives where we feel loss. The parent's hopes and expectations for the birth and the possibility that the infant may not be healthy or be left with a disability may be experienced as a loss.

Many infants find themselves in a life and death situation, and the reality is that they may not survive. This was certainly the case for Poppy, as her parents were told she might not survive.

Lemma and Levy (2004) highlighted how an individual's response to trauma tells us something about their internal objects. They identify four themes which can impact on an individual's ability to respond: if their attachment relationships feel under attack; an inability to mourn; the type of identification the person has with their internal objects; and the individual being unable to reflect on their experiences due to an impairment of symbolic functioning. For instance, more than one individual may experience the same traumatic event, but dependant on each person's internal world and internal objects will influence how they cope with this. *"If the event is overwhelmingly catastrophic, then the more hostile and destructive aspects of that internal relationship come to life. The individual may experience his suffering as something 'bad' being done to him..."* (Lemma, Levy 2004 p2).

Therefore, when considering how parents cope, we need to take into account not only the external circumstances but the individual's internal resources too. Poppy's parents both had mental health difficulties and this may have impacted on their ability to manage the shock of a premature birth.

Tracey et al (1995) describe the impact for the mother when their infant is in an incubator rather than still in their womb and how this can interrupt the forming of a secure attachment relationship and impact on the mother's internal world.

A mother with an infant in neonatal intensive care lives in constant fear of her infant's death, her baby is in a machine instead of in her womb, sometimes for weeks or months, her baby feeds with milk not suckled from her breast, but expressed through a machine, she has no continuing sensory contact with her infant to involve or reward her, she is recovering from the trauma of an early birth (often by caesarean section). We suggest such events interrupt her attunement with her infant and negatively affect her inner world. We demonstrate through this case presentation and

discussion that this trauma initially causes 'affectless shock'. As she awakens from this, the mother is in turmoil and dread, her feelings are primitively chaotic. Her loss of control of events leaves her powerless; defining herself as a mother is a constant challenge. The machine is the life-giver, not her; the ward staff are the caretakers. However brief this period in intensive care may be, in the mind of the new mother it is forever (Tracey et al 1995 pp43, 44).

In contrast, Sjezer and Barbier (2000) question the idea that a premature birth is traumatic. Instead they say that the family circumstances and history determines the level of trauma. However, they do not illustrate in detail what this refers to. Ideas are shared about how nursing staff can support and minimise trauma in the family by advising them how to respond to their infant. "Mother-Kangaroo" units were set up moving the professional nursing team to the mother and infant within the hospital without the need for SCBU. This is only possible if there are no medical complications with the infant and therefore the premature birth is not seen as extreme. The idea is that the mother can remain in the hospital and be with their infant but with extra support from the "Mother-Kangaroo" team. This prevents the physical separation between mother and infant as this is often considered to be stressful for both of them. This was only possible in the less severe cases of prematurity, it was certainly not possible for Poppy.

The general consensus in the literature I read was that a premature birth is traumatic for the infant and the family. In terms of outcomes for premature infants Negri (1994) comments on the importance of assessing the psychological and social environment of the parents as this can have an impact on how they manage.

2.6 Internalisation of Traumatic Experiences

I questioned whether an infant has the capacity to internalize their experience of a premature birth and, if so, symbolically represent this in their play? There is evidence to suggest this is the case. In 1924 Rank identified how the trauma of birth can be seen within psychoanalysis. He felt that the ending of analysis triggered early trauma connected to the patient's birth. He said, "... *the patient attempts to repeat in a quite obtrusive way the process of birth*" (Rank 1924 p241).

Winnicott (1949) discussed birth trauma and how it was important to consider this in the analysis of patients. He spoke about how the trauma of the birth affects the infant's sense of "*going on being*". He goes on to say if the significance of this birth is so great it continues to effect the child's development.

...I do find in my analytic and other work that there is evidence that the personal birth experience is significant and is held as a memory material....In many child analysis birth play is important. In such play the material might have been derived from what has been found out by the patient about birth, through stories and direct information and observation. The feeling one gets is, however, that the child's body knows about being born (Winnicott 1949 p177 and p180).

He goes on to say that if the birth has been normal it may not present itself so obviously in analysis and that there may be other more pressing matters that the patient needs the therapists help with. However, if the birth has been traumatic he was clear that this material requires careful interpretation by the therapist (Winnicott 1949). When considering trauma Cohen (2003) says,

"I think that the experience of the babies is traumatic: they are often in pain, they cannot be picked up by their mother for the first few weeks, they are not living at home but in a high-tech unit" (Cohen 2003 p7).

In terms of anxiety, Klein said that infants experience this from birth. The infant is born into an environment that is unfamiliar and, with the loss of the womb, can experience hostile and persecutory feelings. “*The new-born infant suffers from persecutory anxiety aroused by the process of birth and by the loss of the intrauterine situation*” (Klein 1952 d p95).

Klein stressed how the infant, in phantasy, makes aggressive attacks on the object. The infant can then have phantasies that their own hostile projections will come back to them. Klein described this as “persecutory anxiety”. She also discussed environmental factors that could affect the development of the infant. She suggested how the infant managed internal processes might be dependent on how sensitively the mother responded to them. This was based on observations of mothers with their infants whereby if the mother handled the infant’s anxieties calmly it was likely this would ease the anxiety in the infant, whereas an anxious mother could increase the infant’s anxieties (Klein 1952 d).

In the case of a premature infant it is really hard for a mother to respond to their infant’s anxiety partly due to not being able to physically hold them. They may also be filled with their own anxiety about whether their baby will survive.

We can derive from the above authors the importance of the birth experience and its significance in our memories. This could be both unconsciously through the body and consciously from discussions with our family about birth. If the birth is complicated, sudden and/or premature this could result in traumatic memories.

Gaensbauer (2002) states how early memory, particularly in regard to trauma, can be re-enacted often by external stimuli many years later. He gives several examples of infants who, during their pre-verbal years,

experienced trauma and were later able to indicate some memory of this in later childhood via symbolic play and in adulthood too. One example was of the report of a young adult who expressed to his parent that whenever he was feeling stressed his heels were painful. He later found out that as an infant he had experienced frequent heel prick tests. In terms of symbolic play he also described the play of a 23 months old child who at nine months had been involved in a car accident. The child played out the car accident sequence he had been involved in using the toys. He therefore concluded that the clinical data, reinforced by research findings, indicated, "...*preverbal children, even in the first year of life, can establish and retain some form of internal representation of a traumatic event over significant periods of time*" (Gaensbauer 2002 p261). He concludes that therapists and those caring for the child are important in helping them overcome the trauma and in aiding the child's understanding of this. He says, "*Children should not have to cope with the memories, whatever their form, on their own*" (Gaensbauer 2002 p273).

From a neuroscience perspective Solms (2002) tells us about the process of memory in terms of three areas, "*The acquiring of new information is called encoding, retaining the information is described as storage, and bringing the information back to mind is retrieval*" (Solms 2002 p140). He describes how memories are "consolidated" by the brain and how older memories can become "entrenched" over time. In terms of childhood memories he argues that in the first two years of life they are stored as "bodily memories" and as such cannot be recalled explicitly. He suggests that if faced with such recollections in psychotherapy it must be regarded as "reconstruction". Solms also refers to traumatic memories and how they are frequently not encoded in episodic form, which means they will be harder to recall. He suggests that around the fifth year of life it is possible for memories to be

repressed but they can still have an impact on the child's cognition and behaviour (Solms 2002).

Therefore a young child will not have a conscious memory of their birth but they could have an unconscious one that manifests itself in a feeling in the body or in terms of their behaviour. I wondered if Poppy's aggression, in the form of outburst where she threw herself around on the floor kicking and screaming, was connected to her early experiences. By doing this she created a space around her body and maybe this was done when she was feeling intruded upon and frustrated in some way. This may be similar to a feeling she had in her body when she was in the SCBU. This behaviour could also link to her insecure attachment so that when she was not feeling emotionally contained she reacted in an uncontained and aggressive way. I will discuss attachment security later in this chapter.

Music (2011) explains that if there is stress in pregnancy the hormone cortisol is increased and may have an effect on the developing infant. Furthermore higher amounts of cortisol can be present within children who he said, "*are fearful or subjected to on-going trauma or anxiety*" (Music 2011 p89).

Parsons and Deremen (1999) tell us their thoughts on aggression and how this links to a lack of introjection of a protective internal object.

...violence is the most primitive (physical) response to a perceived threat to the integrity of the psychological self. The ultimate danger the violent individual defends himself against is the experience of helplessness in the absence of a protective internal object. This, for him, spells annihilation. Because of failures in his earliest nurturing, the violent individual lacks an adequately flexible protective membrane, which could allow him to register anxiety as a signal of impending threat and mobilise appropriate defences. He has developed instead a rigid protective barrier (more like an impenetrable fortress) (Parsons and Deremen 1999 p330).

Returning to think about the function of the brain in the child, different parts of this have more elasticity than others, therefore learning can continue in childhood and adulthood. The sub cortical limbic circuits linked to the infant's developing emotions have less plasticity. It is therefore possible that emotional development in infancy could have a long lasting effect on emotions. However, through the process of psychotherapy, attending to the emotional needs of the child can help to process emotional experiences and change the child's responses (Pally 2000).

I shall now move on to discuss the four journal papers I found that linked the child's premature birth with their internal world.

2.7 Journal Articles Relating to Infant Prematurity

Three key papers for my research were from the Journal of Child Psychotherapy and one from the International Journal of Infant Observation and its Applications. The first paper I will discuss is entitled "*Psychic links and traumatic events: Some implications of premature birth*" (Cathy Urwin 1998). The referral was based on the presenting information about this little boy's struggle to manage his parents' separation and divorce. However, as the work progressed this highlighted the difficulties he experienced due to being born three months premature. Urwin tells us how a premature birth can put too many demands on parents and how the infant can be so traumatised by the intrusive procedures that they endure in hospital, even though these are also so crucial for their survival. When speaking about the trauma experienced by this child Cathy Urwin tells us,

First, for various reasons, in a traumatic situation, those upon whom the child may usually rely, the parents, may be least available to provide support, as they are likely to have been involved themselves: they may be dead, injured or overwhelmed by pain and distress. Second, grappling with the impact of trauma highlights the significance of the capacity to contain anxiety

available to the child and family. In these cases where individual psychotherapy is recommended, this often reveals what one might describe as primary problems in containment contributing to particular children's vulnerability (Urwin 1998:62).

The psychotherapy undertaken with Urwin illustrates the need for a psychotherapist to contain the primitive anxieties experienced by the child and the difficulties parents may have in doing this due to their involvement in the trauma and because of their own needs. In some respects I felt Poppy's parents had difficulty processing the trauma of her birth, coupled with their own mental health needs, and this meant they struggled to contain Poppy.

Urwin concludes that having a premature baby is stressful for parents. Psychotherapy allowed this little boy to feel more contained and express his emotions in order for him to feel more integrated. It was interesting to note that, like Poppy, his psychotherapy ended prematurely.

The second paper is entitled, "*Shall I dare to come alive: Long term effects of painful beginnings*" (Blessing 2006). In this paper Blessing makes links to a young person's eating disorder right back to her experiences as a premature infant. She tells us how the process of the infant being in SCBU can interrupt the parents' thinking and reverie around the infant.

Blessing points out how the experience of being in SCBU often means the sensitive parenting infants need is compromised by the painful procedures they require. This can mean the usual processes of splitting good and bad objects are not as clearly defined. Satisfaction and pain can become confused and infants born premature can have difficulties in containment.

Until the functions of a containing object are introjected there is no sense of internal and external spaces, and confusion of identity abound. The who's who and what's what are blurred, leaving the borders between self and other, phantasy and reality insufficiently delineated. Such difficult beginnings creates vulnerabilities in the baby and parents... (Blessing 2006 p55).

Miller's (1980) paper discusses her work with a young girl who was in the care of social services and was entitled, "*Psychotherapy with severely deprived children: Eileen*". The child, she named as Eileen, was one of twins born premature and needed to be in an incubator in SCBU. Even though Eileen was fourteen at the start of her treatment Miller could still see the signs, in her appearance, of her premature birth as she looked undernourished and appeared small for her age. I was captured by her comment of Eileen when she made links to her experience in the incubator.

...Eileen could purchase a temporary state of ease, glueing eye to glass, word to ear, paper to paper, herself to me. But of course the me she glued herself to was not alive. The focus on looking through the glass at the distant garden below makes me think of the baby Eileen who was bottle-fed by so many different people. I would guess that she stared at the glass bottle and its contents and did not dare to look into the face above which changed so often. One might even go further back to the incubated baby who sees everything through the glass, and who, lacking other sorts of holding, might develop a particular dependence of looking at something as a means of focusing itself (Miller L 1980 p60).

Miller goes on to discuss the type of feeding experience Eileen might have had as a premature infant. Miller thought it is likely she would have been tube-fed and she described how it seemed as if Eileen had never experienced feeding with a mother who could focus solely on her and that Eileen could introject. The fact that Eileen was a child in care and had experienced deprivation was the main focus of this paper. However, many links were made in the clinical material to her premature start in life.

The fourth paper was called, “*Thomas looking for George: a premature twin emerging from the effects of early trauma*” (Carling 2003). Carling describes psychotherapy with a three year old boy who was one of twins born premature. He was referred to Carling due to behavioural disturbances that presented themselves in the form of head banging.

I was struck by the author’s description of the incoherent narrative the parents gave of the birth of the twins. This reminded me of Poppy’s parents and how they found it hard to describe Poppy’s birth history to me, possibly due to the trauma of this experience.

As in the other journal articles, containment was a crucial function for the child psychotherapist to maintain for this child. This was due to his mother being too traumatized by the experience of his birth and how fragile he was. Carling makes connections with the child’s head banging and their birth experience.

...having been literally dragged from his mother, to be placed alone in a glass bubble, exposed to glaring light and a cacophony of harsh sounds, helplessly dependant on a myriad of tubes restricting his movements. It would equally be possible to speculate that initially, at least, the banging may have been a means of reassuring himself of his own continued existence (Carling 2003 p336).

All articles indicated the need to process the premature birth in psychotherapy with the child. They also show how traumatic a premature birth can be for the parents too.

It is possible there are more papers within the journals that contain details of children who are born premature and whose clinical material can be connected to their birth. However, these papers do not stand out in a literature search as prematurity is not mentioned in the title.

I will now move on to think about the possible impact on attachment relationships and separations due to the infant being hospitalised.

2.8 Attachment and Separations (and the impact of hospitalisation)

A secure attachment relationship is fundamental to a child's healthy development and their ability to emotionally function and relate to others. The securely attached child learns to regulate their emotions, make relationships with others and explore the world around them. For a secure attachment to develop reciprocity (Stern 1977) between the child and carer is regarded as essential. For example, when the infant cries the parent tends to the child and tries to understand what the cry tells them; whether it be a nappy change, a feed or the need for a cuddle and soothing words. This all gives the infant a sense that their parent is trying to help regulate and understand their emotions.

When a young child has a secure attachment they will seek out their caregiver when they feel frightened and return to exploring the world through play once they are comforted. However, an insecurely attached child will not follow this pattern of behaviour (Holmes 2010).

In terms of recognizing the importance of children's behaviour and emotions, in regard to attachment and separation, John Bowlby was one of the first to research this (1969, 1973, and 1980). When thinking about attachment we also refer back to the "Strange Situation" which was a procedure developed by Ainsworth (1971) to assess the types of attachment behaviour we might see in children. Children were observed during separation and reunion with their carers. She classified different attachment categories based on the quality and nature of the interaction between parent and child as being secure, insecure-ambivalent, insecure-avoidant and insecure-disorganised.

Forming a secure attachment relationship is also crucial for the development of thought. Hobson (2002) developed the “theory of mind” where he stated that the child’s mind couldn’t properly develop without reciprocity, as they need interactions with carers to develop their capacity to think. The emotional connections that can be made if another mind is available to think about the child and consider and respond to their feelings promote the child’s development in this area (Hobson 2002). Therefore the reciprocal relationship between a child and a responsive carer helps the child to feel more contained, to develop a secure attachment relationship and increases their cognitive (thinking) development.

In terms of the parents being able to respond sensitively we need to consider how in SCBU parents might feel the hospital staff are more equipped to deal with their infant. This can effect the parent’s confidence in their abilities and they may feel envy about the way the staff handle the infant with ease. Furthermore the rhythm of the attachment relationship can be disrupted if the parents are not stimulated enough by their infant’s behaviour and responses (Stern 1977). Music (2011) talks about premature babies,

As babies they tend to be more distractible, harder to soothe and more demanding.... Prematurity is linked with high stress levels in pregnancy, and mothers who are highly stressed during pregnancy might also be stressed after the birth and less able to interact easily with their babies (Music 2011 pp36-37).

When considering the interaction between infant and carer Wyly (1995) discusses the possible impact on the attachment relationship. She uses the American term NICU that stands for Neonatal Intensive Care Unit.

Interactions may be influenced by the infant’s capabilities and medical condition. The NICU environment may affect an infant’s temperament and functioning as an effective social partner. Parents’ social behaviours are also affected by the NICU experience. They must try to initiate social beginnings within the

context of bright lights, noise and lack of privacy, and the stress associated with a premature birth can alter parents' interactions with their infant (Wyly 1995 p151).

Over and above difficulties of attachment discussed above, I also considered how the infant in SCBU manages separation from their parents. The Robertsons' films (1970) highlighted the trauma experienced by young children due to separation from their carers whilst in hospital and this has changed the way this is handled in current practice. James and Joyce Robertson also noticed the impact separation had for the child on their attachment relationships. When children were separated for long periods from their family, they exhibited signs of 'protest, despair and detachment' and they observed that this had a lasting impact on their emotional development and attachment relationships.

In terms of a baby who is born premature and in an incubator, even if the parent can remain in hospital with the infant they are still separated physically. For Poppy this might have initially impacted on her attachment relationship with her parents. Mr. and Mrs. Abbott had been told that their daughter might not survive and so they may have prepared themselves for a potential loss, possibly withdrawing from becoming too emotionally close with Poppy.

Poppy was described as "aggressive" and "violent" by her parents. When I asked how long she had been like this her parents told me since birth. Her mother would often come into the clinic with several bruises on her arms and legs that she said was a result of Poppy lashing out at her in temper. This had a feeling of someone describing domestic violence rather than talking about a young child who was having a temper tantrum. This could also be a symptom of Poppy's insecure attachment. If she did not feel contained and secure internally she possibly became frightened and would react in this way.

In a paper by Bowlby (1947) he states how aggression, in part, is normal but can become pathological too. He speaks of the causes of anger being due to separation from mother and that in turn creates frustration and insecurity in the child. He also says ambivalent parenting and parent's dislike of the child can all create such problems. Poppy's aggression could be seen as a defence against anxiety that might stem from her early childhood experiences.

Fraiberg (1982) noticed this behaviour in children and thought about it as a defense against anxiety. She speaks about a little boy who was aggressive towards his mother. She felt she was witnessing a child who was in a "disintegrative state." She stated that his fighting was being used; *"...against the danger of helplessness and dissolution of the self, feelings which accompany extreme danger. The disintegrated state that I have described.... must constitute an extreme danger in themselves"* (Fraiberg 1982 p626).

In terms of psychotherapy the forming of the relationship with the therapist and the child can increase the understanding of the child's attachment patterns and help with difficulties they may have in this regard. Research on attachment and psychotherapy is joined together by Holmes (2001 p33), *"It is about empathy and responsiveness, but it is also about the separateness of the therapist...and the ways in which patients cope with the rhythm of attachment and parting that is integral to the therapeutic relationship"*.

In infancy the experience of loss and separation can be felt at the breast, particularly when the child begins weaning. The child in therapy can experience a similar relationship as at times these primitive emotional processes are felt in relation to separation. *"The central emotional tasks are those of weaning and separation, ones which will*

be forever internally worked and re-worked, whether in life generally or, for some, in the particular setting of the consulting room” (Waddell 2002 p61-62).

The holiday breaks, over the course of the therapy, bring up feelings connected with separation that can be worked on with the child. When the child is more able to tolerate separations and hold onto the “good object” when it is not there then progress has been made. When we look at the clinical material we can see how Poppy struggled with separations and how much progress she was able to make through the course of her therapy in this regard.

2.9 The Relevance of Psychoanalytical Concepts in Working with Children Who Are Born Premature

I begin this section discussing splitting, projection, containment, introjection and the Oedipus Complex. I then think about the transference and countertransference as they are essential skills used by the psychotherapist. I considered these technical concepts in terms of their relevance to my work with Poppy.

2.9.1 The process of splitting and projection

Klein (1946) described how the infant often splits their good and bad objects and also projects their own ‘good/bad’ feelings into others. This process she termed “splitting”. This primitive, infantile form of communication is essential for the later development of emotional expression (Shore 1994). In time the splitting lessens and the infant sees their objects more as whole objects that have good and bad aspects. This is a sign that they are reaching the depressive position in which we might see the child showing some concern towards their objects, as they fear their projections have done some damage to them.

The role of the parent is crucial in terms of containing the projected emotions and split off parts of the self. If the infant has not experienced this containment then splitting can become excessive.

Klein (1946) explained how excessive splitting and projection of the aggressive parts of the self could lead to feelings of persecution in relation to the persons whom this is directed. Later in her work Klein provided a clear summary of her theory of splitting.

I have laid particular emphasis on the importance of the earliest splitting processes. If love and hate and the good and bad objects, can be split in a successful way (which means not so deeply as to inhibit integration, and yet enough to counteract sufficiently the infant's anxiety), the foundation is laid for a growing capacity to distinguish between good and bad. This enables him during the period of depressive position to synthesize in some measure the various aspects of the object. I suggested the capacity for such successful primal splitting depends largely on initial persecutory anxiety not being excessive (which in turn depends on internal factors and to some extent external ones) (Klein 1961p249).

Klein mentions internal resources and external factors in terms of whether successful splitting occurs. Is it therefore possible to consider that some infants in SCBU may have developed excessive persecutory anxiety due to the experience of intrusive medical procedures?

Poppy was reported to be very aggressive towards her mother and this impacted on their relationship. Internally the feeling of attack from within the self can lead to persecutory anxiety. In order to manage this feeling it can result in the child projecting or splitting off such aggression into another. If we think about Poppy's earliest experiences in the incubator, enduring painful and intrusive procedures, excessive lights and sounds, this could have resulted in her feeling very persecuted and intruded upon. The psychotherapy treatment can help children to internalize a 'good object' in order that they can better manage their experiences. Klein (1957) tells us this is potentially possible but this cannot change

any difficult experiences from the past. However, internalizing the therapist as a 'good object' can help the child.

I will now think about the processes of containment and introjection.

2.9.2 Containment and introjection

Bion (1962) described how containment of the child's expressed and projected emotions are a vital function the mother undertakes with her infant. Whilst in the incubator the main care of the infant is undertaken by the hospital staff. This means the emotional containment of the infant might be harder for the carer.

Projective identification is a form of communication and sometimes a defence to overwhelming feelings from the infant, hence their unconscious desire for others to feel the pain rather than themselves. The mother digests these emotions and eventually gives them back to the infant in a more manageable form and this process is similar to the therapist and the child in therapy.

The idea is that the infant will, through projective identification, insert into the mother's mind a state of anxiety and terror which he is unable to make sense of and which is felt to be intolerable (especially the fear of death). Mother's reverie is a process of making sense of it for the infant...Through introjection of a receptive, understanding mother the infant can develop his own capacity for reflection on his own state of mind (Hinshelwood 1991 p420).

As the child begins to introject, that is take in, the capacity of a carer's reflective mind his projections lessen. He begins to feel more contained. For the child whose carers have not been able to contain them or digest their feelings, perhaps due to the experience of trauma, psychotherapy can help in this regard.

“Parents who have been through the trauma of the birth of a premature baby may well label their infant as vulnerable and this may be the way they relate to the child for years to come. Not surprisingly, parents who themselves feel vulnerable find it difficult to contain their vulnerable premature baby” (Kerbekian 1995 p 56).

The next important psychoanalytical concept I will discuss is the Oedipal Complex.

2.9.3 Oedipus Complex

An important concept in psychoanalytical theory is the Oedipus Complex. This is part of development in children. The Oedipus Complex is seen when the child, in phantasy, desires for himself or herself one parent at the exclusion of the other. Melanie Klein argued that the infant experiences this during the first year of life (Segal 1989). Progress in this area is seen when the child is able to move from latching onto the two-person relationship to managing with a three-person relationship. It is important to help the child to manage separations from the parents and this in turn can help them move towards the depressive position. The depressive position is when the child begins to integrate both the ‘good’ and the ‘bad’ parts of his/her objects. He therefore experiences them more as whole objects and can become concerned and fearful that his/her projections may have in some way hurt others. *“Recognizing the parental couple confronts him with a good contained-container relationship from which he is excluded. It confronts him with separateness and separation as part of the working through of the depressive position” (Segal 1989 p8).*

Being able to tolerate separateness from the parental couple can also lead to an ability to adopt a third position where the child can act as observer. They have the opportunity to think about themselves with others and to have their own thoughts whilst also being aware of others’ viewpoints (Britton 1989).

Poppy seemed to struggle with her feelings in this regard and found separations difficult from her mother. It was as if she could not hold two objects in mind let alone three. There was also clinical material that included three but this was often felt to be stuck or in conflict. As the therapy progressed I helped Poppy with her separations from her mother. This in turn aided her in keeping three in mind, therapist, mum and herself. Poppy then began to think about other children who came to see the therapist and this was a hopeful sign that she could consider the therapist as relating to more than one person.

A triangular relationship between the child, parent and therapist occurs as part of the therapeutic process. The child becomes aware of the therapist having a relationship with the parent from which she/he is excluded. The parent has to bear their exclusion from the child's therapy too. At times this can result in the parent sabotaging the treatment if this feeling is intolerable (Givion, Bar 2014). Poppy's parents found it hard to continue with the therapy after my colleague, who was undertaking parent work with them, went on maternity leave. Although Mr. and Mrs. Abbott continued with their own weekly parent counselling they seemed to build up a resentment of Poppy continuing the psychotherapy without their parent worker. I also wondered how it might have felt for them knowing the parent worker was pregnant and that she had her baby at full-term. They may well have felt envy about this given Poppy was born so premature. It was shortly after my colleague returned from maternity leave that the parents decided to end Poppy's psychotherapy.

There would also be a triangular relationship within SCBU with the staff, infant and parents. Parents have to cope with the fact their infant requires nursing care from the staff in SCBU whilst they watch.

“For the parents the experience is also traumatic: they cannot take charge of their babies, they cannot begin the process of finding their way to bring up their child, to claim it as theirs; they have to stand by, impotent and in public. It is traumatic for staff to bear witness to all this pain. So there is a triangle between babies, parents, and the staff which is fraught with difficulty” (Cohen 2003 p7).

The sensitivities associated with early life experiences are re-encountered in transference and countertransference exchanges. It is the use of the transference and countertransference phenomena in psychoanalytical work that I now turn to.

Transference and Countertransference

It was Sigmund Freud (1905) who first spoke of the transference relationship with his patient he called “Dora”. Dora was an eighteen year old girl who was diagnosed with “hysteria” and felt suicidal. She had been kissed by an adult family friend, “Herr K” and seemed disturbed by this. Freud became aware of the transference in relation to this patient but at the time saw this as being something to be wary of. He began to understand that he could represent people from the patient’s experiences and feelings related to that person could be transferred to the analyst in the present. *“...a whole series of psychological experiences are revived, not as belonging to the past, but as applying to the physician at the present moment” (Freud 1905 p116).*

Freud gradually saw the benefits of using the transference to work through and resolve particular emotions and conflicts related to current and past relationships in his patients. Freud (1905) said, *“If the theory of analytic technique is gone into, it becomes evident that transference is an inevitable necessity” (Freud 1905 p116).* In conclusion, Freud considered the transference to be extremely important in accessing the unconscious clinical material in his patients.

Melanie Klein (1952) developed the idea of the transference particularly in relation to her work with children. Klein spoke of how the infantile transference feelings could also be accessed within the therapeutic relationship. Klein introduced the idea of the “total transference” (Klein M 1952) linking past and present relationships and internal objects to the transference. Betty Joseph (1985) continued to develop the concept of the “total transference”. When describing the transference she tells us, *“My stress will be on the idea of transference as a framework, in which something is always going on, where there is always movement and activity”* (Joseph 1985 p447).

Transference can of course be both positive and negative. It is my experience that most of the work in psychotherapy is necessarily undertaken in the negative transference. However, sometimes this can be challenging to take up with certain patients. I found this in my work with Poppy. There was a sense of frustration for the therapist that Poppy tried to keep her therapy “good” and split off from anything deemed “bad”. The benefit of undertaking this research and the writing of this thesis has afforded me the opportunity to consider in greater depth how some of the trickier and aggressive aspects of Poppy, at the time, were not fully addressed by the trainee psychotherapist. On reflection I feel this was due to the infantile and deprived content and presentation of Poppy in her therapy. This kept the therapist focused on that aspect of her and indeed in this thesis too. In the countertransference the therapist was drawn into a nurturing maternal transference, as there was a feeling of needing to nurture Poppy. In contrast the paternal transference function was primarily focused on providing containment and management of boundaries. There was a weakness in confronting the more destructive elements in Poppy’s presentation. This mirrored Poppy’s experience with her parents.

When considering the countertransference we can think of this in terms of the therapist's own feelings in relation with their patient's transference. Using the countertransference can help to understand the patient's own unconscious feelings and deepen the understanding of the transference,

When describing countertransference Salzberger-Wittenburg says it is,

"...the reaction set off in the worker as a result of being receptive to the client's transferred feelings. These emotions, in so far as they correctly mirror the client's, are a most helpful guide to understanding. Often, they give us a clue to the feelings which have remained unexpressed" (Salzberger-Wittenburg 1970 p18).

The years of personal analysis, that forms part of the training for Child and Adolescent Psychotherapists and continues post-training, prepares the therapist to be open to and understand the countertransference. This enables the psychotherapist to ensure the countertransference is not confused with his or her own personal feelings.

I now move on to describe several impact studies that have been undertaken in relation to children who have been born premature.

2.10 Impact Studies

What are the possible long-term emotional impacts of being born premature? A nineteen-year prospective study on premature and full-term infants was undertaken focussing on the mother and child relationship (Tideman, Nilsson, Smith and Stjernqvist 2002). This study's aim was to consider the emotional impact on the mother/child relationship due to the premature birth. Previous long-term impact studies have concentrated on cognitive and neurological problems related to prematurity. This study talks about the difficulties in interacting with premature infants and how this can effect developing

relationships. They noticed how the attachment relationships with premature infants and in later childhood were less secure. More emotion was expressed between the mother and her premature child than those born at full-term. Their study indicated that premature children are more likely to be vulnerable emotionally in relation to attachment and separation in adolescence and adulthood.

Macey, Harmon and Eastbrooks (1987) researched infant prematurity and its effect on attachment relationships and they concluded that being born premature did not have an impact on the attachment of the infant. However, they did find other areas of potential concern. The premature infant can be viewed as disabled and fragile by the parents throughout childhood even though they may be developing healthily. This could then lead to parents reacting differently to their child, perhaps in a more protective way. They also highlight the high numbers of children born premature who come to the attention of Social Care due to neglect and abuse. They go on to say, *"...the birth of a preterm infant does have an impact on the family. The premature infant may be at greater risk for abuse or may elicit over protectiveness from parents. Extreme reactions on either side will place infants at risk of psychosocial problems"* (Macey, Harmon and Easterbrooks 1987 p849).

In terms of increased risk of abuse it has been evidenced that children who have been born premature could be at more risk of abuse than those that were born at full-term. This is indicated due to the early separation between mother and child and, consequently, a potentially poor relationship that might develop as result. The difficulties with feeding and caring for the premature infant has a bearing on this, as does the stress endured by the parent in tending to their infant in SCBU (Corby 2000).

A study was also conducted to look at children's mental health when they were five years old whose history was of being born very premature between 22 – 27 weeks (Poppy was born at 25 weeks gestation). This concluded that these children had an increased risk of developing mental health problems, for example, in relation to behaviour, inattention, and hyperactivity and in terms of their interactions with their peers (Elgen et al 2012).

Another article looked at psychiatric outcomes for children aged seven who were born premature in comparison to those children born full-term. This concluded that very premature children (born before 32 weeks) had a higher rate of psychiatric diagnosis. The most common diagnosis was anxiety disorders, in particular separation anxiety and specific phobias (Treyvaud et al 2013). Poppy struggled with anxiety in general but specifically her separation anxiety.

From research in 2004 it was found that there were higher rates of depression amongst adolescents who were born premature (Patton et al 2004). A comparison study of children born premature (before 26 weeks) and those born at full-term found that the premature group had a higher rate of psychiatric disorders such as ADHD, anxiety and depression (Johnson et al 2010).

The impact studies have indicated an increased risk of mental health disorders, attachment and separation difficulties and abuse as a result of being born premature.

2.11 Literature Summary

To summarise, this literature review has highlighted the fact that there are very few papers written about psychotherapy with children that focus on the potential impact a premature birth might have had on the child's internal world. More has been written about infants in Special

Care Baby Units (SCBU) and their experience in the incubator. This indicated the often painful and intrusive procedures infants in SCBU endure. Their environment, where the lighting and level of noise is constant, has been shown to have an effect on them. Evidence, from research, has suggested infants in these conditions can feel stressed.

I looked at the trauma and impact on the family from having a premature infant. This seemed to be dependant on how supported the family were and how able they were at talking about their experiences. It was also dependant on the parents' own internal resources. I then considered whether an infant has the capacity to internalise their birth experiences. I looked at whether this could then be represented in their symbolic play. Winnicott (1949) stated that this could be held as 'memory material' that comes from what the child has been told about their birth but also held within their body. Gaensbauer (2002) gave several examples of the way in which trauma is repeated within therapy and that even very young children can recall traumatic events.

I moved on to think about attachment and separation. I specifically considered how the experience of being in an incubator, in hospital, could affect the security of attachment relationships. In Poppy's case it was evident she had separation anxiety and this could link to her early experiences and insecure attachment.

I discussed my use of psychoanalytical concepts that guided my understanding of Poppy's material during my work with her. I specifically considered the use of splitting, projection, containment, integration, the Oedipus Complex, the transference and countertransference.

Towards the end of this literature review I looked at several impact studies of children who were born premature. Overall this indicated

difficulties with separation and with the security of their attachment relationships. There were also studies that suggested there were a high number of infants who were born premature that later came to the attention of CAMHS and that had a higher rate of psychiatric disorders in comparison with children who were born at full- term.

The literature review has highlighted the importance of considering the impact and possible trauma a premature birth has on the child and the family. The need to offer parents' support to emotionally process this trauma and help them understand their premature infant is crucial. The importance of being able to allow the child to process their early experiences, if they were traumatic, is also crucial for some children who continue to experience difficulties in childhood.

3. Research Methodology

3.1 Introduction

In this chapter I focus on research methodology. I begin with thinking about how psychoanalysis and research come together to help us understand our patients. The historical perspective of research in the psychoanalytical field can be linked back to Freud's early work and this is discussed. As I am researching a child's emotional experience of premature birth I felt it fitting to make connections back to infant observation and its use in research for psychoanalysis.

In terms of the type of approach undertaken, qualitative research is the most appropriate for psychoanalytical investigation as it centers on individuals own experiences and looks to analyse this in more depth than quantitative research can. It seeks insight into the material for research rather than to produce statistical data. It has no set questions but focuses on individual's perceptions and experiences and their context in order to arrive at an understanding in more depth.

Discussing the use of qualitative research Charmaz (2014) says,

...we can add new pieces to the research puzzle or conjure entire new puzzles while we gather data, and that can even occur late in the analysis. The flexibility of qualitative research permits you to follow leads that emerge (Charmaz 2014 p25).

My research is using a qualitative approach. I gathered data from process recordings of psychotherapy sessions and then analysed them using a single case study approach. Grounded theory and thematic analysis were used. Ethical considerations, that were relevant in this work, are discussed. I describe how I analyzed the data and discuss the validity of this research.

3.2 An Historical Perspective of Psychoanalysis and Research

Sigmund Freud (1927) discovered new theories and formulations of the human mind could be developed via the therapeutic relationship with his patients. In his consulting room he noticed how unconscious processes emerged and he discovered and formulated ideas such as the transference. He used this term to explain how the patients used him to stand for relationships with people from their past and present.

In modern day practice psychoanalytical work still seeks to understand the unconscious. The unconscious can be understood with the help of the patient's dreams. The psychoanalyst or psychotherapist tries to help the patient unpack their dream and the associations and feelings in connection with this before analyzing the content. The analyst makes interpretations based on the patient's use of free associations (when the patient is encouraged to talk about whatever is on their mind). With children their symbolic play is interpreted and is similar to free association in adults. The analyst also uses their observations of the patient and, of course, the transference and countertransference.

In terms of research, traditionally the usual approach was experimental and methodical. However, Freud did not consider this was appropriate for psychoanalysis and explained how his unique methodology meant that analysis and research worked together within the consulting room.

In psychoanalysis there has existed from the very first an inseparable bond between cure and research. Knowledge brought therapeutic success. It was impossible to treat a patient without learning something new; it was impossible to gain fresh insight without perceiving its beneficent results (Freud S 1927 p256).

Freud was aware of the importance of using observational skills with children. "Little Hans" (Freud S 1909) was a young boy who was said to have had a phobia of animals and his parents turned to Freud for

help. Using the observations from the parents and the reports of the boy's dreams, Freud made sense of the boy's fears and linked this to a growing awareness of his sexuality. "Little Hans" is an example of how observations of children increased Freud's understanding. He later used such observations to evidence his earlier theory of infantile sexuality and the Oedipus Complex (Freud S 1905).

I will now return to thinking more about infant observations and how they have influenced psychoanalytical discoveries with patients. Klein used her clinical experience and the observational research from others, to evidence her theories regarding infantile anxiety and the development of object-relations (Klein 1952 d).

Burlingham and Anna Freud (1943) developed methods of observing children in the nurseries they set up in Hampstead. They were particularly interested in ensuring the more deprived children had a place in nursery. Anna Freud and Burlingham wanted to assess the level of the child's difficulties in order that they could help them. The nursery staff collected information from observations of the child in terms of their behavior in nursery. Anna Freud also observed their behaviour on separating from their carers and how the children interacted with the nursery staff. The other criteria for observations were to see how they interacted with peers and the toy equipment and also the general boundaries set in the nursery. These observations were then discussed in weekly meetings to think about the action the staff needed to take to support the child (Freud A 1988).

Bick (1964) established the formal method of infant observation at the Tavistock Centre in 1948. Observational skills remain essential for Child and Adolescent Psychotherapy trainees today, and this is considered very important for undertaking clinical work. Detailed recording of

observations are emphasized to the students as being crucial in helping to understand the infant's developing mind.

The early years of life can indicate early patterns of emotional development. Stern (2000) understood the importance of infant/mother observations and he described how they increased our knowledge of infants.

...infancy researchers and psychoanalysts have much to tell one another, not to confirm or disconfirm notions within each domain, but to stimulate, inspire, and provide the wider knowledge base against which the concepts of each discourse will find their plausibility and general intellectual interest" (Stern 2000 p90).

To summarize, psychoanalytical thinking and infant observation can come together to increase our knowledge and understanding of psychoanalytical ideas. I will now describe the use of the single case study in research.

3.3 The Single Case Study

New psychoanalytical theories and techniques continue to be discovered through clinical work. The single case study approach has often been the way of developing and illustrating new psychoanalytical ideas.

As well as providing 'evidence' or 'clarification' of certain theoretical ideas already held, case studies can also lead to the emergence of new ideas. As a form of learning they give us the opportunity to integrate our own clinical experience with theoretical concepts; and as a form of teaching they can allow others to get a sense of what goes on in the private space of a clinical treatment... (Midgley 2006 p125)

Returning to thinking about the clinical setting there are conditions within the consulting room that could be likened to a research laboratory (Michael Rustin 1997). An important factor in psychoanalytical work is that patients are seen in the same setting, at the same time and day

each week. These controlled conditions allow changes to be noticed in the patient and also avoids any distraction from the environment.

The setting for psychoanalytical thinking is not only important for this work but in terms of research too. Understanding the unconscious can be undertaken if the environment and therapist offers consistency and attunement to the patient's emotions. Any differences that occur can then be observed within this set of conditions. The therapist can then observe any changes in the patient's appearance and their communication, interactions and play.

If we now think about single case studies it would be only right to point out that it can often be difficult to compare and contrast single case studies, as no two cases are exactly the same. The case study is unique to the individual who you are basing the study on. However, this can have benefits to the overall understanding in psychotherapy, for instance, there will be other patients who are born premature who we are working with, and this research might give some insight into the possible dilemmas and links made with other such children.

Midgley (2006 pp124-125) says of the case study method,

When it comes to the history of child psychoanalysis and psychotherapy, there is no doubting the centrality of the clinical case study. The very first work in this field, Little Hans, was written in the form of a case study; many of the major developments within child analysis have been introduced through the narrative account of a particular child and his or her treatment; and the case study is central to all child psychotherapy trainings...

In using the single case study approach I also wish to mention Edna O'Shaugnessey's (1994) paper, "What is a clinical fact?" This paper helped me to consider the psychoanalytical material presented to us by our patients and how this can be considered a fact in terms of research, she says,

A claim of fact has two essentials. When I make a claim of fact, I make a truth claim, and I imply a readiness to submit my claim to verification...First of all when I make a truth claim, I do not claim to know the truth, or all the truth, but only a truth (O'Shaugnessey 1994 p942).

With this paper O'Shaugnessey addresses the idea of how the notes of an analytical session can be used as a research tool in psychoanalysis. Poppy's session material is factual in that it is a true representation of her session and what she said and did. This is a clinical fact. The interpretations made by the therapist may/may not be accurate and only by the child's behaviour/play can we tell if the interpretation is helpful for the child. It is my experience that children let you know if your interpretations are wrong rather than when they are right. Therefore interpretations are based on the clinical material and may/may not be correct but the child's material is a truth and the understanding of this by the therapist is open for verification.

On a final note about the single case study approach, Midgley states this is,

... a legitimate method within social science research, which needs to be assessed by criteria appropriate to its own methods, not by those deriving from experimental research...single case studies are often the most relevant way of studying causal influences and mechanisms; that they are a good basis on which to move towards a gradually wider level of understanding; that they are often more clinically meaningful; and they therefore play an important role in helping to bridge the gap between research and clinical practice (Midgley 2006 p126).

3.4 Data Selection and Collection

Psychotherapy produces considerable data regarding each analytical session. In the case of Poppy, the young girl who is the subject of this research, she attended weekly for the first term and then twice weekly. The total period of her psychotherapy was two years. Therefore there was a great deal of material in the form of process notes in connection

with Poppy's treatment. Patterns emerged gradually through Poppy's material and interpretations were made that verified the therapist's hypotheses at the time.

The data I collected consisted of all the session notes for the period of Poppy's therapy. Secondary data is that which is available to the researcher but is not part of the sampled sessions that are analysed. The secondary data was in the form of supervision notes from the small group seminars I attended at the Tavistock Centre during my clinical training as a Child Psychotherapist. I regularly took Poppy to this group and I also took her to my individual service supervision. The other data includes reported details of Poppy's history and current difficulties from her parents. It also includes my own observations of Poppy both within treatment and her interactions with her parents whilst in the waiting room and during family sessions. I used much of this kind of material in my outline of the case in the Introduction.

In order to have a broad spectrum of data over the course of the two years of therapy I randomly selected session material every two to four months. I made sure I had the first initial meeting and the first individual session and one nearer the end too. This resulted in me having ten sampled sessions and one initial appointment. I then made columns to place the detailed session material in. On one side of the column was the transcript and on the other were the codes.

In terms of my skills in writing process notes from psychotherapy sessions, this has been developed in my training as a child and adolescent psychotherapist. The method of observing infants, taught at the Tavistock Centre, prepared me for writing detailed notes and observing infants closely in readiness for using these skills in clinical work with children. The infant observation method does contribute to psychoanalytical research. In the infant observation setting data is

ordered and organized over a two-year period. Process notes are kept of every weekly observation and samples of these are shared within seminar groups at regular intervals so the student can begin to consider unconscious processes emerging in the infant. Susan Isaacs states that infant observation has in fact developed certain methods, which offer principles for psychoanalytical research.

These principles bring them into closer line with clinical studies and this forms a valuable link between observational methods and analytical technique. They are (a) attention to details; (b) observation of context; (c) study of genetic continuity (Isaacs 2003 p148).

In terms of data collection, analysis of material and using grounded theory, Anderson (2006) provides a diagram that explains the different stages. This begins with gathering your material and from this finding categories and looking at the properties of these categories. Hypotheses begin to emerge and substantive theory can be formed. This can then lead to formal theory.

Grounded theory methods consist of systematic, yet flexible, guidelines for collecting and analyzing qualitative data to construct theories from the data themselves...Grounded theory begins with inductive data, invokes iterative strategies of going back and forth between data and analysis, uses comparative methods, and keeps you interacting and involved with your data and emerging analysis (Charmaz 2014 p1).

When analyzing my material I continually went back to this and relooked at it to see if further codes could be found. By adopting this method I began to see new ideas emerge from the material.

I now move on to ethical matters and how this relates to my thesis.

3.5 Ethical Considerations

Research is defined as any form of disciplined enquiry that aims to contribute to a body of knowledge or theory. 'Research ethics' refers to the moral principles guiding research from its inception through to completion and publication of results (The British Psychological Society 2010 p5).

It is very important, before embarking on research of this nature, to obtain ethical approval from the family or young person. Towards the end of my work with Poppy, I spoke with her parents about my area of research that I would like to undertake and obtained verbal permission to use Poppy's case notes and the initial meeting with her and the family as part of my research. I gave the family time to reflect upon this request, even though they said yes immediately. The parents were given a detailed sheet outlining the proposed research (see appendix one). I spoke with them again after treatment had ended and gave them the opportunity to decline but again they agreed to me undertaking this research and signed a document outlined by the Tavistock consenting to this (see example sheet in appendix two).

My research proposal, the University of East London (UEL) form and the ethical approval signed by the parents were sent to the UEL ethics review board. The Tavistock Centre told me verbally that this had been approved. I attach the copy of the original front sheet of the document that was sent to UEL and someone at the Tavistock Centre had written on this "approved" (see appendix three). However, I had not received written confirmation of this approval from UEL. My supervisors made investigations into this and I now have a letter from the University Research Ethics Committee that states if I had applied at the time this would have been approved (see appendix four). It is very disappointing that they could not find the original approval.

Continuing to think about the importance of behaving ethically for research The British Psychological Society (2010) states,

There are numerous reasons for behaving ethically. Participants in psychological research should have confidence in the investigators. Good psychological research is only possible if there is mutual respect and trust between investigators and participants (The British Psychological Society 2010 p4).

All names of the family, child and clinic where I am based have been changed in this document to provide confidentiality. This is vital in terms of protecting the child and family's personal details. This is in line with the Association of Child Psychotherapists ethical guidelines.

The codes of ethics that relate to research are important to follow in order to protect the family and young person's rights.

Codes of ethics are formulated to regulate the relations of researcher to the people and fields they intend to study. Principles of research ethics ask that researchers avoid harming participants involved in the process by respecting and taking into account their needs and interests (Flick 2009 p36).

The moral principles for undertaking research developed by the British Psychological Society are as follows, "*Respect for the autonomy and dignity of persons. Scientific value. Social responsibility. Maximizing benefit and minimizing harm*" (The British Psychological Society 2010 p7).

In practice these principles offer a good guide to ensuring research is undertaken in a respectful and non-judgmental way. Research that values individual's personal experience indicates to others the need for them to do the same. I was mindful that I should discuss Poppy's material sensitively and without coming to sweeping conclusions that might cause more distress if the material were to ever be read by Poppy or her parents.

3.6 Grounded Theory and Analysis of the Data

Glaser and Strauss (1967) developed grounded theory for qualitative research. Information is collected via observations, audio material and transcripts. The material is then analyzed and gradually patterns begin to emerge through the gathered data. This data can then be used to formulate hypotheses (Michael Rustin 2007). Janet Anderson's 2006 paper describes how well this approach fits together, "*Well-suited partners: psychoanalytical research and grounded theory*". When explaining the use of grounded theory Anderson says,

The purpose of the methodology is to generate theory using an inductive approach. It is about theory generation not proof. The researcher approaches the work without a hypothesis. The raw qualitative data is studied and coded. From the codes, categories will emerge. Data can be 'fractured' in different ways to add understanding about categories, their properties and inter-relationships...Throughout the process findings are checked against the data by a process called the 'constant comparative model', a way of combing through the material to extract as much detail as possible. This permits the researcher to check emerging hypothesis, which leads to the development of substantive theory. Substantive theory may have relevance beyond the field studied, in which case further abstraction may lead to the formation of formal theory (Anderson 2006 p330).

In commencing the analysis of my data I first read through all of my session notes and highlighted themes or sections that were pertinent to my research question. This was a period when I had two years without any supervision at all. Once I had my current supervisors I learnt that analysis of the data needed to be undertaken in a more systematic way taking samples of the session materials at regular intervals not just selecting sessions that appeared relevant. I had to read more papers relating to research and to try and become more of a researcher.

With this in mind I set about looking at the material in a different way. I used samples of the sessions taking them at regular intervals over the

course of the two-year therapy. I analysed sessions between two to four months apart to give a broad view of the work.

I used the first initial meeting with Poppy and her family and her first individual psychotherapy session and the sampling ensured I had enough material from the middle of the work and at the end. Using this sampling of the material I spaced out the sessions resulting in a total of ten individual sessions and one initial appointment being analyzed.

In my research I increasingly saw the importance of looking at the data systematically in order that new information could be found as well as finding possible links that could be made to Poppy's premature birth. Once the 11 sessions were systematically selected I then did line-by-line analysis of the material. I did this using columns (see appendix five). On one side was the session material, or in research terms the transcript, and on the other side was the line-by-line analysis of the session.

As I continued my analysis of the transcripts I began to see material that repeated. Line-by-line coding helped me to see the themes and patterns emerging from Poppy's psychotherapy. I repeatedly looked at these transcripts with my supervisors to see if further themes and codes could be found from the material.

Detailed observations of people, actions, and settings revealing their everyday life as well as visibly compelling and consequential scenes and action lend themselves to line-by-line coding. Generalized observations afford you little substance to code. Line-by-line coding encourages you to see otherwise undetected patterns in everyday life. Line-by-line coding enables you to take compelling events apart and analyze what constitutes them and how they occurred (Charmaz p125).

This method of analyzing the data helped me to see new areas of my research. From this I could begin to see themes emerge. This leads me on to the next section on thematic analysis.

3.7 Thematic Analysis

Through the use of grounded theory themes began to emerge and this led my research into the realms of thematic analysis of the material. From the transcript material my coding developed and I could then see themes. These were not always linked to my research question but to Poppy's overall presentation and my understanding of her. I was then later able to analyze the themes further and make analytical links to her premature birth. *"Thematic analysis is a method for identifying, analyzing, and reporting patterns (themes) within data. It minimally organizes and describes your data set in (rich) detail"* (Braun and Clarke 2006 p83).

Analyzing the thematic content of a child's play is a scientific approach within research and can tell us much about the child's internal world. Marans et al (1991) used thematic analysis to understand a child's play. They concentrated on the general content and themes of the play. They then coded the sessions based on the themes that emerged looking at how often they occurred. As they described it:

Clinical observation of the actions and language during play provides crucial information about sources of anxiety and attendant defensive activities. The analyst focuses on the specific themes in play, while simultaneously attending to other domains such as accompanying affects and changes or disruptions in the play. It is out of the synthesis of the observations from many domains that hypotheses are generated about the child's developmental status and the dominant concerns and intrapsychic conflicts (Marans S et al 1991 p1016).

I therefore began to divide the research material into specific themes. This gave me themes where I could really begin to see patterns

emerging and from which I could begin to make links to Poppy's premature birth. The following diagram depicts the themes that emerged from my transcripts and coding.

Diagram A

Diagram depicting the themes emerging from the data



Reading all of the data and the coding I had undertaken did bring to mind some themes linked to Poppy's premature birth. There was a lot of discussion and play about babies and baby animals. A theme of wanting to grow up versus staying infantile emerged. Direct links were made by Poppy to her birth and themes began to emerge around hospitals. It was evident that Poppy struggled with transitions and separation anxiety and so I looked carefully at the beginnings and endings of sessions and those sessions around an analytical break. Poppy frequently spoke about or played with animals. She identified with animals such as the panther and kitten. I also focused on the role played by the psychotherapist. A section on psychotherapy and play aided further understanding of the themes emerging from the material.

On reflection, after completion of my research, I did think about why the more aggressive and trickier aspects of Poppy did not get picked up in the coding and themes as this might have been an interesting aspect of the research and could have linked to her experiences in SCBU. The research method was conducted systematically and rigorously, however, those aspects of Poppy did not come across strongly in the coding in the 10 sessions and one initial meeting with her family. When coding it was the material that was repeated and consistently present in those sampled sessions that became the codes and therefore part of the research. My research question was looking for particular aspects linked to infant prematurity and this was evident in my coding, which resulted in the main themes being presented.

My next section is thinking about the validity of my research and how I reflected upon my work with Poppy.

3.8 Validity of Research

It is important to consider how valid this research is in terms of whether this can be a thesis that can contribute to, and add to, the body of knowledge regarding infants who are born premature.

I have used a single case study and so the evidence for my findings is based on one child's experiences. However, although this cannot be applied to every child who is born premature, there may be some overlaps with other children's experiences.

In terms of how valid the process notes from the sessions are, we need to think about how reliable they are given it is from the therapist's memory. On this point I refer back to the extensive training I have undertaken at the Tavistock Centre in observing infants/children and writing up detailed notes verbatim of what is said and what is observed

during each session. This training ensures the psychotherapist's skills in recalling in detail are enhanced and are as accurate as possible.

Midgley (2006) tells us how the single case study can aid understanding of patients.

...single case studies, when systematically replicated with other individuals, can help us not only to understand what aspects of the original study's findings are transferable, but also those that are not. When a different result is found, one must try and work out what is specific to this second case which makes the results different to the first study, and in this way one's understanding is gradually enriched and one's understanding refined (Midgley 2006 p138).

I must also consider how subjective I was, or was not, as a researcher in this field. I could not be completely objective as I had already been involved therapeutically with the child that was the subject of this research, and had an idea of the material I was going to be analyzing. However, my past experience of working therapeutically with this child had to be suspended during the research so that I could look afresh at her material with a researcher's eye rather than as her therapist. This was helped by the fact that I had ended my work with Poppy several years before. In selecting randomly sampled sessions I discovered new ideas and impressions not thought about at the time of my work. For instance, I had not considered the possibility that the parents' trauma about her birth could have been projected into Poppy.

The supervision I had in connection with my thesis helped me to reflect on the psychotherapy material and find the codes to form the categories of this research. I was then able to reflect on this work using the third position of observer to the material rather than contributor to this.

Flick (2009) tells us about the importance of the qualitative method of research and how the researchers' subjectivity and ability to reflect on

the data is important in this field. For child and adolescent psychotherapists this would include the use of their countertransference too.

Unlike quantitative research, qualitative methods take the researcher's communication with the field and its members as an explicit part of knowledge instead of deeming it an intervening variable. The subjectivity of the researcher and of those being studied becomes part of the research process. Researchers' reflections on their actions and observations in the field, their impressions, irritations, feelings, and so on, become data in their own right, forming part of the interpretation... (Flick 2009 p16).

3.9 Summary and Conclusions

During Sigmund Freud's time psychoanalytical practice and research was a new phenomenon. Freud helped us to see that research and treatment could work together to increase our understanding. The single case study approach continues to be an important method of research in psychoanalytical thinking.

Infant observations have also been seen as critical data to inform our understanding.

There is no doubt that extra analytical observations (although questionable because of the way they were conducted, the kind of babies or children who were observed, etc) played a certain role in confirming and refining, at times, Freud's and the first child analyst's observations and hypothesis concerning the chronology of the development of the internal life of the baby and the child (Steiner R 2000 p10).

In the past and present discoveries in the clinical setting have sometimes been aided by infant observations. Therefore thinking about Poppy's early birth history and making links to the material she presented in her sessions illustrates how those early experiences may have an influence on current presentations. Although I did not observe Poppy as an infant in SCBU, I did get some indication of her early

history from the psychotherapy sessions. This may have been through Poppy being told about this and shown a video of herself as an infant by her parents, or it could have been a 'bodily memory' that Winnicott (1949) spoke about.

This chapter has evidenced the type of research I undertook using process notes from psychotherapy sessions over a period of two years. Sampling was undertaken allowing for a broad overview of Poppy's psychotherapy over the time she was attending. The material was analyzed using a line-by-line analysis to help to look at this in greater depth. From this, codes were found and themes emerged. The single case study approach, grounded theory and thematic analysis are now the most common used in psychotherapy for qualitative research. Ethical considerations were addressed that were relevant to this study.

4. Findings and Analysis

4.1 Introduction

This chapter is the result of detailed analysis of ten sampled individual psychotherapy sessions and one initial appointment with the child and her parents. As I analysed, in detail, the clinical material using a grounded theory approach and thematic analysis, consistent themes began to emerge. I have organised this chapter into those themes. Of course if I had been able to analyse all of Poppy's notes over the two years of psychotherapy additional themes may have emerged. For instance the therapist was aware of the trickier part of Poppy from her two years of work with her and this was the reason this was mentioned in the background details. However, this was not consistently present in the 10 sessions and introductory appointment that was analysed as the subject of this thesis.

The first theme I will discuss is the symbolic material connected to babies. There were also thoughts about growing up and needing to leave the baby years behind. However, this came across as an internal conflict for Poppy that she was trying to resolve.

Poppy also talked about her time in the Special Care Baby Unit (SCBU) and this was one indication of her need to process this experience. She also thought about hospitals and she even thought the clinic was a hospital at one point.

Another theme I discuss is Poppy's play. Poppy engaged well in the therapy and her play was imaginative and symbolic. I felt this was an important section of the findings chapter as her play gave insight into Poppy's internal world and helped her to work through her difficulties and anxieties. Her play and discussions frequently focused on animals, insects and reptiles and so this is another theme that emerged from the material.

The role of the therapist is also considered in the findings chapter. The essential tools of the transference and countertransference were important to think about as this enabled the psychotherapist to make connections to Poppy's internal struggles and the material that linked to her premature birth.

Finally, the difficulties Poppy experienced with separations were analysed by focusing on the beginnings, endings and holiday breaks in the sessions.

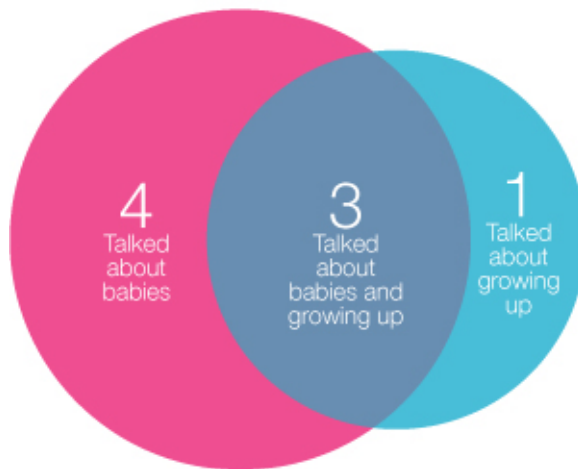
4.2 Babies and Growing Up

4.2.1 Babies

Poppy made lots of references to babies or baby animals during her psychotherapy whilst also referring to her desire to "grow up". Poppy was eight years old at the start of her psychotherapy yet she presented as being much younger than her years. She carried a cot blanket with her that seemed to represent a transitional object and she needed to hold the therapist's hand to manage the transitions from the waiting area to the clinic room. Diagram B illustrates both the number of times Poppy spoke about babies in contrast to her desire to "grow up" and how this was often spoken about at the same time, as if describing an internal conflict.

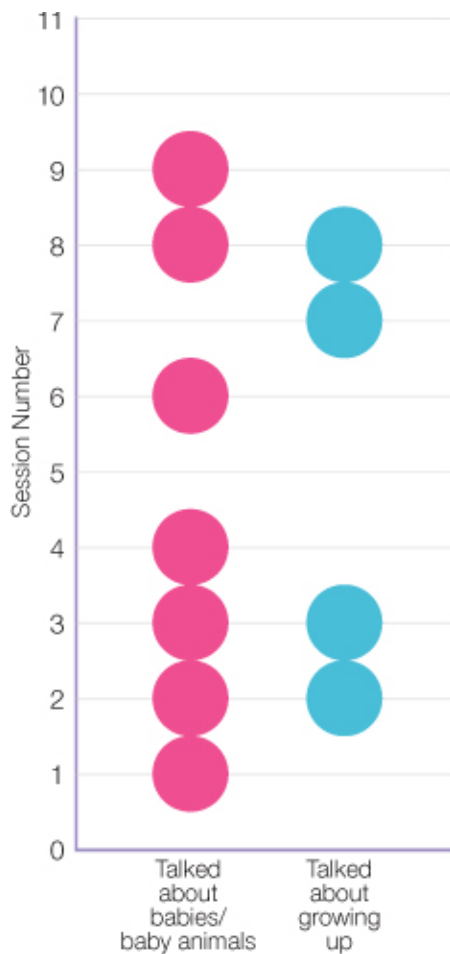
Diagram B

Sessions that show how often Poppy talked about babies and growing up in the sampled material



Poppy seemed emotionally immature, and did not want her baby years left behind, but also wanted to grow up and be bigger than her years. One paper I found suggested that children who were born premature showed greater problems with transition to adolescence and to adulthood (Allen, Cristofalo, Kim 2010). Perhaps this is due to these children needing longer in an infantile state as they missed out on time in the womb. This was certainly the case for Poppy in terms of her early childhood and moving into latency. The diagram shows that Poppy focused more on babies/infantile states than growing up. Given her premature birth it is not surprising, in some ways, that being able to grow up and develop was a struggle she had. Being born at twenty-five weeks gestation was very premature and being in an incubator for three and a half months is a long time.

Diagram C
Changes made over the course of therapy in thinking about infantile/growing up states



In diagram C we can see the change over the course of the therapy that Poppy made in thinking about infantile states. There was a reduction in speaking about babies as the sessions progressed and, alongside this, further thinking about growing up. This indicated that, to a certain extent, Poppy was beginning to process her early years.

The baby animals Poppy spoke of were usually kittens or wolf cubs. She often went from a domesticated animal to one that was wild, such as the panther or wolf. This was indicative of the contrast in her personality. On the one hand she could be sweet and gentle seeming to be vulnerable and fragile. On the other she could be strong, forthright and, according to her parents, aggressive. The aggressive part of

Poppy was played out using her identification with wild animals. This gave the therapist a glimpse into the 'untamed' parts of Poppy. Poppy seemed surprised that in the transference I did not fight her back or become afraid of her when she played out her aggression. I believe this was the reason she did not become physically aggressive towards me in the room.

The next extract is the appointment when I met Poppy with her parents. Prior to meeting Poppy I had seen her parents on two separate occasions. These meetings and descriptions of Poppy from her parents had led me to believe I would be meeting a "monster" like child and so I already felt fearful as to how I would manage this little girl in individual therapy. However, when I did meet Poppy, I saw a very infantile young girl who appeared anxious and fearful herself. In this first meeting Poppy had brought a caterpillar that became central to the discussions during this appointment.

***Initial appointment with Poppy and her family
(1st sampled session of 11)***

Poppy arrived with a very tiny caterpillar on a leaf... Poppy, "I saw the egg and the tiny caterpillar which is a baby". I recall feeling this little caterpillar was in a very vulnerable position and I was really worried we would not make it with this little life all the way to the clinic room (as it is a long walk). In the counter-transference I was like a parent who was responsible for a very premature infant who I felt might not survive and how alarming and distressing this was to experience. I recall feeling very relieved when we made it to the room.

Later...Poppy drew a picture of the caterpillar and in doing so nearly squashed it with her hand...Her father placed the caterpillar near him and said, "I want it to survive the session". There was a feeling of being on the edge of my seat during this point as, although we had made it to

the room, yet again the caterpillar was in danger of being harmed so no one could really relax.

In this very first meeting the therapist was told that the caterpillar was a “baby” taken from its mother and was precariously held by another (Poppy). Her father managed to move the caterpillar and prevent it from being squashed. He spoke of wanting the caterpillar to “survive” the session. There seemed to be an idea around babies potentially not surviving and this could link to Poppy’s own birth experiences. This was very striking material. It felt as if the family were unconsciously constructing a narrative around the trauma of Poppy’s premature birth.

The next extracts are examples of Poppy thinking about babies and younger stages in her life. Two months into treatment Poppy was bringing more and more material related to babies. Some aspects of this had a worrying, desperate feel to it as we see in the next session.

2 months into treatment (3rd sampled session of 11)

In the middle of her session Poppy began to draw a kitten with lots of hair. She told me she was going to watch Pirates of the Caribbean 3 tonight. She explained she had been upset when she watched the first one because there was a baby crawling around crying for its mummy. The therapist was shocked that Poppy recalled this detail of the film and her focus on the baby crying for its mummy. In the transference the therapist felt she was to feel like a parent who had left a baby crying and abandoned. Poppy told me the kitten cried for its mummy. I suggested there was a kitten part of her that maybe missed her mummy. Poppy said, “And the sessions”.

Later...Poppy finished her picture and said it was a kitten for the therapist and she would call it “Mee Mee. Mee Mee cried for you”.

Therapist spoke of “Mee Mee” needing time in the sessions for her and she was crying out to be helped.

It felt as if Poppy was letting the therapist know there was a baby part of her that needed some help and attention. The material often suggested there was a baby or baby animal that was crying for its mother as if the baby felt abandoned. This could be linked to her time in the SCBU when she was in an incubator. This may be an unconscious memory for Poppy or a memory based on information given to her by parents about her early life. The extracts show her desire to let the therapist know there is a baby Poppy that is crying out to be helped. The kitten was not only crying for its mother but also a therapist too.

Six months into treatment Poppy began to recall her first days at school and some painful memories of being bullied.

6 months into treatment (4th sampled session of 11)

After settling into her session...Poppy said she had not used clay for a long time. Therapist wondered when she had last used clay and Poppy said it had been in her first year at school. When the therapist asked what this had been like for her she said she had been frightened and unsure of the other children...Poppy also said she had been worried about bullies too.

Using the clay triggered memories for Poppy of when she first started school. She was able to recall her fears and worries from this time. The therapist began to get a picture of a child who conveyed feelings of vulnerability and fragility, yet in reality Poppy could also be the bully with her parents. In the next extract Poppy had thoughts about babies and biting.

12 months into treatment (6th sampled session of 11)

At the end of the session...Poppy was washing her hands and told me, "Babies do that when they bite (she made a biting action with her hands) and they bite down on wet towels in their mouths".

The comment made about babies biting down on wet towels is an unusual one. As the therapist did not open this up for discussion with Poppy she was not sure if she could have been referring to the SCBU video she had seen or whether this was something she had seen from a friend's baby who could have been teething. Perhaps she was letting the therapist know that babies could be aggressive and bite. The theme of babies continued and in her session some 19 months on in treatment babies are very much on her mind.

19 months into treatment (8th sampled session of 11)

In the middle of her session... Poppy went to the chalkboard and chalked a shape from the top of the board coming down like a pregnant mother's tummy. She wrote inside this shape "tummy" and some initials. Therapist asked about this. She told her the initials stood for a friend's baby that she thought she would be seeing soon.

It was interesting that Poppy drew a pregnant mother's tummy placing the initials of the baby inside. It seemed that Poppy had a fascination with the pregnancy and the womb experience. Maybe this linked with queries about her own birth. The friend's baby was already born and she had seen this baby before yet she still thought about him inside a mummy's tummy. In her session 23 months into treatment Poppy speaks about a wolf cub.

23 months into treatment (9th sampled session of 11)

In the middle of the session Poppy drew a wolf cub with the chalks. Therapist suggested she was thinking of something wild and she told her this was only a cub.

Poppy tried to explain to the therapist the fact that being a cub suggests it is less dangerous. Therefore babies are vulnerable, dependent and non-aggressive but, as we know, babies are capable of biting and feeling aggressive too.

4.2.2 Growing up

In stark contrast to Poppy thinking about babies, at other times she thought about being grown up. The reality was that Poppy was born too early before she had fully grown as a baby in the womb and therefore needed to be in an incubator. I wondered whether her struggle to move from infancy to childhood years was, in part, due to this.

In terms of her sessions she demonstrated this struggle when at times she attended the sessions with makeup on and would speak about her desires to have her mother's or her sister's shoes on. Poppy's desire to "grow up" went from babyhood to teenage years with no latency years in between. She had aspirations to be an artist and wanted to think about a time when she would be older, however, she still needed her hand held like a much younger child.

Poppy would often want items on the higher paper or paint shelves. She was also interested in the lift and the floors that were above our ground floor level. This felt symbolic of her desire and interest in being bigger and older than her years. At times this could feel rather omnipotent. One example of this was her standing on the chair above the therapist as if to take charge and be the grown up.

1st Individual session (2nd sampled session of 11)

In the middle of her session Poppy reached for some pink tissue paper and tells the therapist when she grows up she will be an artist.

2 months into treatment (3rd sampled session of 11)

After settling into her session Poppy began looking on the very high paper shelves for blue card. I spoke about her wanting to go to the grown up shelves yet the blue card was on the lower shelf. Poppy laughed and said she was taller than the therapist as she was standing on the chair.

In the next session her desire for being grown up was spoken about alongside a feeling of loss about her baby self. Poppy arrived wearing a great deal of make-up and the therapist felt shocked and repulsed by this.

19 months into treatment (8th sampled session of 11)

Poppy was wearing heavy eye makeup and blusher that was down just one side of her face. In the countertransference the therapist felt like she wanted to reject Poppy, as she felt disgusted by the way she looked. It was as if she was showing the therapist a different more horrifying part of her. In the transference to the therapist Poppy was communicating how her internal objects saw her as a "child monster".

Towards the beginning of the session...Poppy spoke about her boots and the kind of boots her mummy had with high heels. She told the therapist, "I would really like to have them but I have to wait for mummy to grow out of them. My sister has got some too I want". Therapist spoke about her wanting to grow up before she was ready to.

Poppy then spoke of when she was a baby and had a lovely jacket with snow leopard type fur and she had grown out of this but it was so

“snuggly”. She went on to say that her baby pyjamas were baggy but nice and they were too small now.

The session above is an example of one of the many times Poppy attended wearing heavy eye makeup and blusher, attempting to be older than her years and more like a teenager. It felt as if Poppy was showing her therapist the more perverse and disturbing side of her. The therapist (still in training at the time) had not felt confident to challenge this aspect of Poppy when she presented like this.

Poppy had a desire to be like her sister or her mother and have their boots as if wanting to walk in their footsteps even though she was nine years old. However, she still spoke about her baby clothes suggesting she had grown out of them but she said this with some regret in her voice. It was as if she felt torn; aware she needed to be allowing herself to grow up, yet still yearning for her baby years.

This conflict within Poppy remained throughout her therapy. She wanted to grow and develop but the baby her was desperate to be recognized. As she began to feel the baby Poppy being nurtured in her psychotherapy this in turn helped her to ‘grow’. In her session 15 months into treatment she drew a flower and Poppy spoke of it standing for the following, *“Well a flower grows and it stands for all the sessions and how they help me grow”*.

I will discuss the findings of babies and growing up at the end of the next section on incubators and hospitals.

4.3 Incubators and Hospitals (nurses and doctors)

A frequent topic of Poppy’s conversation was hospitals and thinking about nurses and doctors. In fact, thoughts about hospitals never seemed far from her mind. At times there were direct links made to her

premature birth by Poppy and the therapist. There was a preoccupation for Poppy with her birth and this could be due to her parents sharing information with her regarding this in video form several months prior to her commencing psychotherapy. Perhaps her parents thought Poppy would understand why she was behaving in such an aggressive way with them if she saw her SCBU video. However, Poppy presented as emotionally immature and as a result of this I felt she struggled to process this information.

Poppy's session material, at times, felt symbolic of her birth history. The therapist had spent five months of monthly family appointments prior to the individual sessions and it seemed that the parents had Poppy's premature birth unconsciously in their minds. I say unconsciously as it was only occasionally that they mentioned this directly. In fact when the therapist first met the parents on their own they were reluctant to discuss Poppy's birth history and in the countertransference it felt as if they were feeling defensive about this. However, during the family appointments, they used evocative words and references that left the therapist feeling this was linked to their thoughts about her birth. In one appointment her father spoke of being used to being in a clinic and how they had been getting help ever since Poppy was born. So it is not surprising that this long period of getting to know the family left the therapist with Poppy's premature birth on her mind too.

Once Poppy started her individual work the therapist gradually made links to her premature birth when she saw this in her symbolic play. These interpretations were felt as a relief to Poppy. The links made by the therapist came after Poppy spoke about this directly in her 6th individual session. (This is not one of the 11 sampled sessions but it felt important to mention it. This session comes between the 2nd and 3rd sampled sessions). *Poppy was playing with a toy kitten, mouse and girl figure. She then found her string and wanted to attach this to the plug in*

the sink and then to the kitten. The therapist had suggested maybe this was like the umbilical cord that attaches the baby to the mummy. Poppy had replied "Or attaches a kitten to an incubator". It was evident from this comment that Poppy was fully aware of her birth history and time spent in SCBU. In some ways it was sad that her first thought was an attachment to an incubator rather than to a mummy. In the countertransference the therapist was startled by this blunt link Poppy made to the incubator. However, this alerted the therapist to make interpretations and links to Poppy's premature birth when they later arose in the course of her therapy.

I will now move on to discuss the sampled clinical material. In Poppy's first individual session there was a family of animals that needed saving in a "lifeboat". The baby mouse had his own separate boat to be rescued in. This felt symbolic of Poppy's premature birth and the need for an incubator like a small separate boat.

1st individual session (2nd sampled session of 11)

Poppy had been trying to make a paper boat...Poppy wondered if the boat would float. Therapist had suggested she could try this and Poppy questioned if the sink was big enough but filled it with water. She placed the family of horses, a giraffe and some play people in the boat...

The boat began to sink so the therapist helped her bale the water out and Poppy found a plastic container to use instead and named this as a "lifeboat". She transferred the animals and play people into this container. She placed a baby mouse in a separate plastic container naming this as a "tiny boat". The therapist suggested this play was about how to survive, like surviving her first session without her family.

The play changed and the lifeboat became a speedboat. The people started to dive into the water and Poppy used her ruler to become a diving board.

Poppy's play with the animals and boat gave a sense of a family who needed some help as the boat sank. This then became a lifeboat that rescued them and the baby mouse was singled out in its own boat. Therefore, it was as if the mouse had a special boat to be rescued in. In the countertransference this felt symbolic of a baby who needed extra care and its own boat or incubator in order to survive the experience in the water. When the play changed to a speedboat this may have been symbolically representing how quickly Poppy moved from a thoughtful reflective position to one of defending against the sensitivities being explored. She became carried away by heightened excited and destructive acts.

The next session is the initial appointment where I first met Poppy. It was clear she had been thinking about nurses and hospitals prior to attending the appointment.

***Initial meeting with Poppy and her family
(1st sampled session of 11)***

At the end of the session...Mum told us Poppy had thought my colleague and I were two nurses who were going to operate on her today. Poppy said she did not want her blood pressure taken. My colleague spoke about this being an appointment to think about her feelings and behaviour rather than a doctor's appointment.

It was interesting that Poppy thought, in her first appointment, that she was going to be seen by nurses. Her phantasy was of needing to be helped by hospital staff for her difficulties. This seemed connected to her experience as an infant but could also be due to her having

appointments previously in CAMHS with the Consultant Child and Adolescent Psychiatrist. The therapist found herself feeling irritated with the parents that they had not told her about Poppy's anxieties about having her blood pressure being taken at the start of the session rather than saying this at the end so this could not be processed. Perhaps here I was picking up in the transference how the parents might have felt not knowing what procedures were going to be undertaken with their daughter when she was in SCBU.

Although in her sixth session (not one of the sampled sessions) Poppy had been the first to mention incubators when thinking of a baby kitten, the therapist did not interpret Poppy's symbolic material to her premature birth until two months after commencement of treatment which is illustrated in the next session. The therapist linked the kitten in the box crying for its mother to Poppy's prematurity. In response to the therapist putting this into words Poppy appeared relieved to talk about her own experiences.

2 months into treatment (3rd sampled session of 11)

Middle of the session...Poppy told the therapist, "I nearly died when I was in an incubator. Mummy had gone from the hospital and the nurses and doctors had put things on my chest to stay alive". (The therapist was felt in the transference to be like a parent who had abandoned their baby and left her to die). Therapist spoke about the nurses and doctors who had been there to help her. Poppy hugged the therapist and told her not to cry (she was not crying). Therapist spoke of Poppy wanting her to feel the shock and sadness of the little baby Poppy today.

This felt like a very vivid description of her time in SCBU and it was only when I was told in a review meeting that parents had shown her the video of herself in the incubator that I could make sense of how real this experience felt for Poppy as she had seen this with her own eyes. In the

session above I sensed her immense distress about her time in the incubator, as if in her imagination she had felt alone and abandoned by her parents (although this was not the case in reality).

In the next session she heard a noise and this made her think of hospitals. Poppy was very sensitive to any loud or unusual sounds.

12 months into treatment (6th sampled session of 11)

Towards the end...Poppy heard a noise and asked what this was. Therapist asked what Poppy thought this was as she considered, in the countertransference, that this seemed linked to a possible infantile fear. Poppy, "Maybe there is an oxygen tank upstairs. Is it a hospital upstairs? Maybe there is someone with a bad back up there".

When she heard a noise in the building she immediately thought this was connected to a hospital. She imagined there was a person with an oxygen tank or that had a bad back. Her dad had back problems so the therapist wondered if this was why she was thinking about someone with this condition. Although the therapist dispelled the idea of the clinic being a hospital Poppy still returned to thinking about and making links to hospitals in her mind.

**4.3.1 Discussion of the material
(babies and growing up / incubators and hospitals)**

This section illustrates how much Poppy thought about her birth history and that she was aware of her difficulties as a baby. I felt that Poppy was trying to process the information she had been given and was using her psychotherapy to do this. This felt like it was both conscious and unconscious material from Poppy. There was often a baby or baby animal that needed to be cared for and who was crying for its mother. In the countertransference there was a feeling of a baby who had been abandoned that linked with Poppy feeling she was "left" in SCBU.

When the therapist made links to her time in SCBU there was a feeling of relief from Poppy that she was understood and could speak about this. There seemed to be a real desire in Poppy for the baby her to be looked after as if she was feeling, in her phantasy, that this had not been the case during her early years.

The question for me was whether Poppy's preoccupation with her birth history was in her mind due to her parents projecting this into her, as they were struggling with the trauma of having a premature infant. Or was it there in Poppy's own mind, or possibly a combination of the two?

In the countertransference it often seemed as if the baby animals were standing for Poppy's early years experiences in SCBU. Poppy was consciously aware of her birth history. Two months after the commencement of psychotherapy the parents, in a review, informed the therapist they had shown Poppy a detailed video of her time in SCBU and they had done this several months prior to her starting treatment. This could suggest that the trauma of Poppy's premature birth may have been projected into her and not just internalised from her own early unconscious feelings and memories.

The family appeared to have formed a narrative of their experiences of Poppy's premature birth, and the trauma of this seemed to have been internalised by them. In the first family session her father uses the words "survive the session" when referring to the baby caterpillar who was nearly squashed by Poppy. This evoked a feeling in the countertransference of babies who struggle to survive. Even before her father became concerned about the caterpillar, I recall feeling very anxious that this little life (caterpillar) would not make it to the clinic room. It was as if I had become in touch with Poppy's parents feelings of fear that their premature infant might die. Garland spoke of how a trauma can continue to be acted out if it has not been worked through

and this felt as if it could be the case for Poppy's family (Garland 2005 p24).

In the majority of her sessions Poppy chose to think and play about babies. However, the discussions and symbolic material connected to a baby being in an incubator was present in the first two to three months but then did not continue after this point. I wondered if this was due to her feeling, to a certain extent, that this had been processed more for her in the therapy and was understood by the therapist. Thoughts and memories of noises and hospitals did continue further into the treatment.

The baby in Poppy's play often got singled out and needed separate support and help such as the tiny boat that seemed to stand for an incubator. This might suggest Poppy trying to work through her birth experiences and as we now know she was consciously aware of her premature birth. Winnicott spoke about the "memory material" that was held by the child about their birth. In some respects he felt the child obtained this from their parents but he also felt the child held this as an unconscious bodily experience too (Winnicott 1949).

In terms of when Poppy wanted to feel more grown up she went to the extreme and wore makeup and had a desire for being in bigger shoes or boots. There seemed to be no mid-way point between the adolescent and the baby stages in Poppy's mind. There appeared to be an internal conflict for Poppy, as she wanted to remain a baby at the same time as wanting to grow up. As the sessions progressed she spoke more about growing up and gradually less about babyhood. This indicated some progress in this area. However, I was concerned and shocked about how extreme Poppy's make-up was. Poppy also spoke to me, on one occasion, about her wish to change her eye colour using special lenses so that she could look like a wolf. In hindsight I felt Poppy was

highlighting to me the extreme and perverse part of her personality and it would have helped to have worked on this more in the transference.

The next section illustrates Poppy's psychotherapy and play.

4.4 Psychotherapy and Play

Analysis of the contents of Poppy's play was undertaken in order to understand her internal world and emotional experiences. Play can often symbolise a child's current and past experiences and give an indication of their unconscious phantasies. Play is crucial to observe in psychotherapy with younger children, as it is an essential tool in helping the child to communicate. Melanie Klein pioneered the use of play in therapy with children. She discovered that through the techniques of play, children could do the same as adults/adolescents do in their analysis, that is, to free associate. Play and gestures offered Klein insight into the child's unconscious world. Klein could see the important meaning of the child's use of phantasy to play out symbolically situations that they were anxious about or struggling to understand. Therefore, psychoanalytical interpretation of children's play can offer insight and understanding to the child's difficulties (Klein 1932).

In psychotherapy with young children a box of toys and other equipment is put together for the child. This box is then kept just for that child to use. The contents of the box can include toy animals, both domesticated and wild. Fences are useful and are often used to fence off some of the animals. The play people used are flexible enough to be able to move their limbs and these can represent the child's own family/extended family and ethnic origin. For the younger child puppets can offer a different means of expressing themselves. Creative materials are added in the form of pens, pencils, paper, dough or clay, string and glue. We also have toys that represent movement such as cars and I usually add emergency vehicles too. A blanket and a cushion

are also provided. This is not an exhaustive list but one that illustrates the kind of equipment used to aid creativity and imagination in the child's play. Symbolic play is crucial in the young child being able to communicate, as Segal describes, "*Symbol formation governs the capacity to communicate, since all communication is made by the means of symbols*" (Segal 1957 p396).

The therapist has a unique role in supporting and understanding the child's play as Magagna describes as follows,

This security in baby comes from having introjected mother's containing presence, which creates an internal mental space. This internal space permits him to develop a gradually increasing capacity to elaborate on his emotional experiences through play...to work on his preoccupying anxieties about being dropped and lost, picked up and held. He is able to use play to dramatize his phantasies of damaging and mending (Magagna 2002 p90).

The main areas of Poppy's play can be divided into three sections: creative materials; use of the dolls' house and other games; play and discussion about animals, insects and reptiles.

4.4.1 Play with creative materials

Poppy's use of creative materials was varied and included painting, drawing, sticking and clay. This medium was Poppy's preferred choice of play in her sessions. She used this to symbolically express her feelings and convey her worries. Poppy even spoke about her wish to be an artist when she grows up.

There were frequent mentions of three and this seemed to link with the Oedipal configuration of mother, father and baby. The way that Poppy presented this felt as if something was stuck, as if she was struggling to manage her feelings regarding the three-person relationship. There was also material suggesting she was searching for a strong paternal function that could manage her behaviour. In her first individual session

Poppy focused on a triathlon she was doing in school. This involves three activities; cycling, running and swimming. The way that she described this to me it sounded like a big challenge and effort for her to manage three things. This was also said in the context of her trying to manage her first individual session; attempting to keep mummy, daddy and therapist in her mind all at once. There was frequent mummy and baby play with the animals but the daddy was often left out and this continued even as the sessions progressed.

I will now use extracts from some of the sampled sessions with examples of this play. In the first individual appointment Poppy had brought something from outside into her session.

1st individual session (2nd sampled session of 11)

After settling into her session and choosing some paper...

Poppy reached for the glue telling me she was going to stick her stems (flower stems she had brought in from outside) down on the picture. Poppy said, "It's a shame we do not have clay". In the countertransference the therapist felt inadequate as it was being suggested by Poppy that she had not provided the right materials.

Later in the session she stuck three stems in a row with tape.

Poppy used the three flower stems she had brought in from outside to stick on the paper. It was interesting that these were stems without the flower heads and that there were three of them. I wondered if this could indicate the Oedipal configuration of baby and parents. If so, the stems could be representative of something feeling stuck and not able to grow as the stems had lost their flower heads. In later sessions she became able to think about rival others and tolerating the thought of me seeing other children. However, she had to be seen as the child who was

possibly better than the others. For instance in the 8th sampled session she showed the therapist how she had used the blue glitter even though it was dried up and told the therapist how she felt other children would not be able to do this.

There was an element of Poppy almost feeling deprived of resources when she indicated the one item, clay, the therapist had not provided. She was suggesting the therapist had not got the “right” materials for her as well as Poppy providing her own from outside the session. In the transference the therapist was made to feel as if she was not a good enough therapist who had not prepared for Poppy with adequate materials, just like a parent who might feel this with a premature baby.

Poppy continued to use creative materials to express her thoughts and feelings. In the next session she attempts to make a snake and this has a phallic quality to it linking it to a father figure.

8 months into treatment (5th sampled session of 11)

Towards the end of her session...Poppy decided she would make a snake using tissue paper. She told me it would be good if we had some wire and she asked if the therapist could get this. The therapist said no but spoke about the fact she wanted a daddy snake with a strong backbone. Therapist suggested she use something from her box. Poppy decided to use straws found in the room and joined three together, wrapping them in tissue paper telling the therapist she wanted the snake to be able to curl around. Therapist said it seemed she wanted the snake to do what she wanted it to. Poppy laughed and said, “We are control freaks”.

Later...

Poppy told the therapist the snake was a cobra. Therapist spoke about cobras being dangerous. Poppy agreed and told her they were poisonous and toxic but probably only bite you when they are frightened.

Poppy could have been symbolising a daddy with her snake and how she needed a strong one. Her own father had a back problem. Perhaps she was indicating her need for a physically and possibly psychologically stronger daddy who could manage her behaviour? She later says, "We are control freaks" as if she wanted a snake that she could control and perhaps a daddy who could control her. Poppy knows snakes can be dangerous and suggests they would only bite if provoked. Perhaps Poppy was referring to her own aggression and the provocation she can feel if frightened by something too. This could also link to her experience in SCBU having intrusive treatment that unconsciously might have felt toxic/poisonous and hurt like a bite. Poppy could have also created a snake to attack her therapist, poison and bite her as she continued to feel her therapist (like a parent in the transference) did not have the right art materials for her.

Flowers were used frequently in Poppy's art and in the next extract, some 15 months on in her treatment; there is an example of her reflective capacity and development.

15 months into treatment (7th sampled session of 11)

Towards the middle of Poppy's session...Poppy sketched a flower. Therapist asked if the flower could be standing for anything today. Poppy, "Well a flower grows and I am growing and it stands for all the sessions and how they help me to grow".

Her flowers, in the 7th sampled session, are a beautiful illustration of how she could symbolically convey her thoughts. This suggested her

ability to internalise the therapy and reflect on her learning and psychic growth.

Towards the end of the treatment Poppy was struggling with the ending of therapy. She was aware of her continued need for support and further work.

27 months into treatment (10th sampled session of 11)

After settling into her session ...Poppy did a sketch of an eye open and one that was closed. Therapist asked about this. Poppy said the closed eye was standing for not being here and ending. The open one was still remembering her sessions. Therapist talked about her still needing an eye kept on her and how she would have both eyes open thinking of her even after ending.

The final example illustrates Poppy feeling that she really needed someone to keep an eye on her as she was approaching the ending. Poppy knew she was not ready for finishing her sessions. The ending of her therapy was premature and came about at the request of her parents who felt Poppy was getting “too much individual attention”. Throughout her therapy Poppy showed annoyance with the therapist but was never physically aggressive. In effect this left a split as her parents still experienced the “bad” aspects (although this did lessen over the course of therapy at times) and the therapist had most of the positive transference. If the therapist had worked more actively on the negative transference perhaps the parents may well have felt able to continue with Poppy’s psychotherapy.

4.4.2 Play with the dolls’ house and games

At times Poppy played with the dolls’ house and play people. She was imaginative in her thinking and play. Towards the middle of her treatment Poppy made a snakes and ladders game using the art

materials. This was used by Poppy to think about her behaviour at home. If she could go up the ladders this meant her behaviour was “good” or if she was going down the snake she was not doing so well.

19 months into treatment (8th sampled session of 11)

Towards the end of the session Poppy decided we would play her snakes and ladders game she had made. When doing this she changed the rules of the game. Poppy wanted a big clap when she got on the ladder. She then wanted to clap with her hands and on her legs and then for me to follow. This felt like a mirroring game. In the countertransference the therapist felt she had to do as she was told.

The game Poppy made of snakes and ladders was inventive and interesting in terms of how she linked this to her behaviour and development. It seemed Poppy found it hard to speak directly about how things were at home so instead used this game as a measure to let me know how she was doing. The play that focused on clapping and asking the therapist to follow Poppy’s claps whilst she faced the therapist had a mirroring quality to it. Winnicott (1971) described the infant’s need to “mirror” the mother. For the baby this is a way of developing and identifying with the mother. In time the following of the mother’s movements can aid attunement and help the baby to, in turn, find their own identification. Poppy wanted the therapist to mirror her movements rather than the other way around. In the countertransference it felt as if she was saying she wanted the therapist to attune to her. The therapist also felt as if Poppy was an infant who needed nurturing and encouraging. In the transference the therapist often felt like a mother. This feeling sometimes got in the way of picking up the more negative transference. In hindsight, the therapist can see this would have helped Poppy to move forward more with her behaviour at home.

In the next extract Poppy used two shared pieces of equipment in the room, the shells and the dolls house.

23 months into treatment (9th sampled session of 11)

Towards the end of the session... Poppy looked at the shells in the box that belongs in the room. She carefully placed them in the attic space of the dolls' house telling me this would be a "museum". Therapist spoke of a museum being somewhere that you go to look at items from the past. Therapist said the attic space was in the very top of the house like in the top of the therapist's mind as if wanting her to think carefully about what she had been telling her today.

The shell museum in her play was unusual. In the countertransference it felt as if the therapist was to examine the shells in the attic, as if examining the unconscious matters in Poppy's mind. The dolls' house was one of the few shared pieces of equipment in the room. In one session Poppy queried the door of the dolls' house being open, as if thinking of other children who may have used this before her.

Animals, insects and reptiles were spoken about and used in Poppy's play frequently. I have therefore put this type of play into a section of it's own. However, I will discuss the findings of psychotherapy and play together with animals, insects reptiles after the next section.

4.5 Animals, Insects and Reptiles in Play and General Conversation

This section was chosen due to the number of times Poppy used animals, insects and reptiles in her conversation and play.

Diagram D
Frequency of animals, insects and reptiles used in 11 sampled sessions.

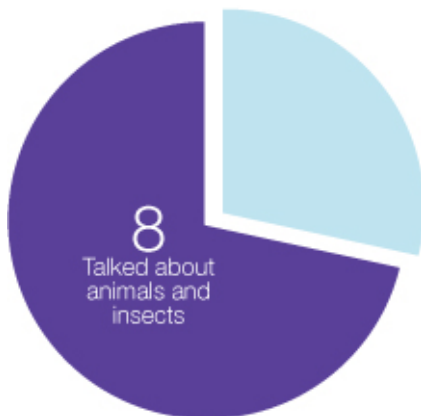
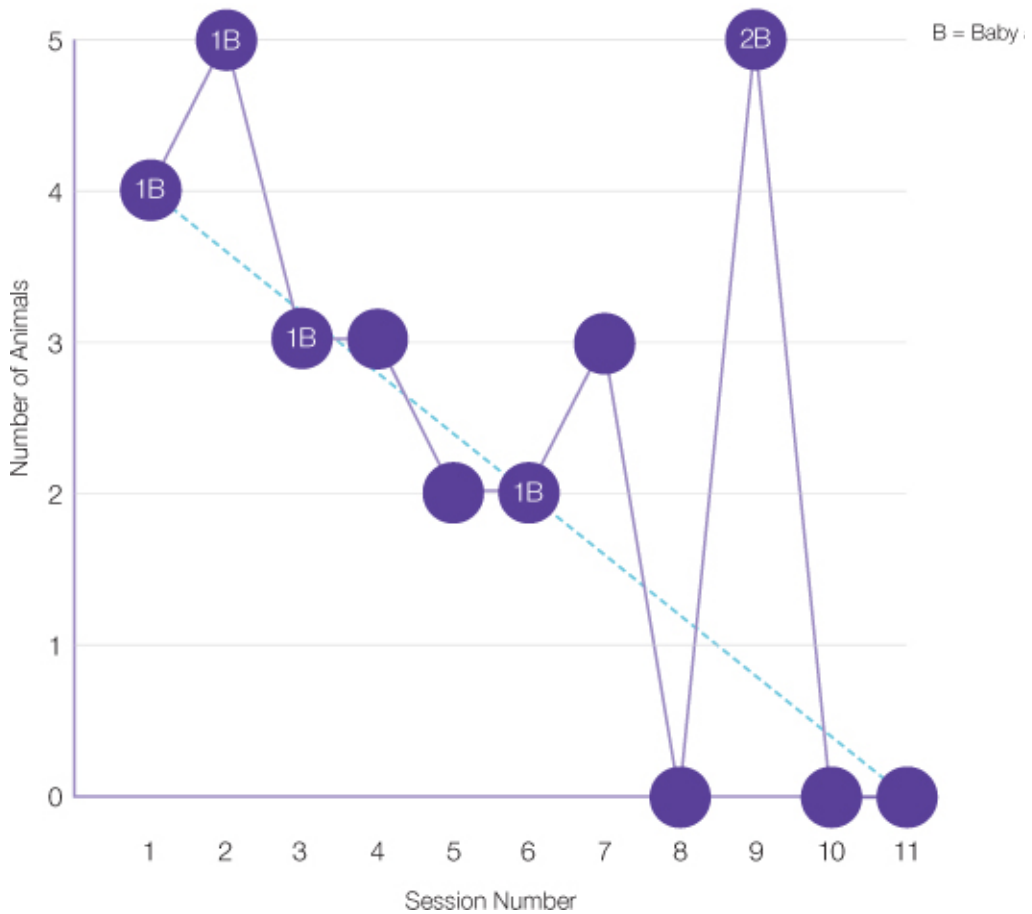


Diagram D shows that in eight out of the 11 sampled sessions Poppy made reference to animals, insects and reptiles or played with the toy animals. Animals had a particular significance for Poppy and were used to symbolise her experiences or for her to projectively identify with. Poppy was able to symbolise the difficult aspects of her personality and her early experiences via her play and discussions about animals, insects and reptiles. It was helpful for Poppy to be able to play out her fears and aggression in this way, as it was the therapist's hope that in time this would help to prevent her acting this out.

The next diagram E shows the number of animals, insects and reptiles Poppy used in her play and talking in each of the 11 sampled sessions. From this diagram we can see that her use of animals, insects and reptiles to projectively identify with gradually reduced over the course of the psychotherapy except for a peak in sampled session nine. This session came after a holiday break from therapy and might be the reason why she returned to thinking of animals to describe her feelings about the break. The diagram also shows how Poppy spoke more about baby animals in the early sessions (except for sampled session nine) and this shows a development in her thinking away from babies moving towards a more mature way of thinking.

Diagram E
Number of animals, insects and reptiles used in play and conversation



In this section I will not be going into detail about the baby animals Poppy referred to as this can be found in the material on babies. Animals, insects and reptiles were a popular topic of conversation for Poppy. As well as regularly speaking about them, Poppy played with her toy animals, insects and reptiles from her box. Poppy seemed to identify with animals, particularly cats and kittens. At one point in her therapy she began to refer to herself as a panther and we thought about the kitten and panther parts of her in order to integrate her behaviour and personality.

Poppy often referred to insects or reptiles, such as snakes, that could harm you. She spoke of snakes that were poisonous and that might bite

when frightened. She was fearful of wasps and in one session a wasp was in the room. Poppy hid under the table until I could get it out for her. Perhaps Poppy used the insects and reptiles to indicate fears about her own aggression too. There could also be a link with painful procedures she endured in SCBU. A bite from a snake or a sting from a wasp that suddenly hurts could, in phantasy, link to an association to her early months care with needles and procedures that came without warning and were very intrusive. The effect of pain in the infant from procedures in SCBU has been considered carefully and there are indications that this can have an impact on the child's development. Tests that were undertaken using psychological and behavioural indications of pain showed these infants were more prone to stress and "*...have heightened responses to successive stimuli*" (Bouza 2009 p722).

In Poppy's play the small prey-like animals, such as the rabbit, were often placed by the wild ones, such as the lion, and if this was questioned by the therapist Poppy would try and reassure her that the small animals were not in danger. For example, in the fifth session she placed a frog next to a snake. In her first family session she talked about animals that get "lost and found" and how she looked after them. So there was a contrast in her wanting to care for animals and at the same time communicating that they could be in danger. Another element that the therapist did not robustly pick up at the time was the more perverse part of Poppy that could be cruel. She cared for animals but I do think she wanted to hurt them too. Her parents told me of an incident where Poppy threw stones at swans in the pond after she had been told off at home for her behaviour.

In the next session Poppy spoke of her desire to have a choker with studs on and to place this around her neck like a dog collar.

1st individual session (2nd sampled session of 11)

After settling into her session and doing some art work...Poppy told me she was hoping to get a black choker with studs on it soon and this would go around her neck. She said the boys could then lead her around by her collar like a dog. The therapist found it hard to digest this comment, as the image in the therapist's mind was of her wanting to control the therapist or for someone to control Poppy in a rather perverse way. Therapist questioned why she would do this. Poppy told her she liked dogs and she would choose to be a chocolate Labrador or a Wolfhound.

In this session Poppy spoke of wanting to be led around with a dog collar by the boys. There were also two dogs she liked; a chocolate Labrador and a Wolfhound. This was a stark contrast of animals similar to the two aspects of Poppy's personality. A loveable Labrador and a rougher more wolf like part of her that felt wild and powerful. There was a shocking feeling to the idea of placing a choker around her neck. I was unsure why at eight years old she would want to be led along by boys too. This felt like Poppy was suggesting she needed to be controlled or to have her therapist on a leash at her beck and call. This was a perverse image that disturbed the therapist's mind and left her focusing instead on concrete details such as the type of dog rather than the idea of someone on a collar and leash. In the following session Poppy spoke about her favourite big cat, the panther, after talking about a kitten.

2 months into treatment (3rd sampled session of 11)

Poppy had brought a book about a kitten to her session. She told the therapist how the kitten in the story cried for his mum and was in a box with other kittens. The kitten scratched to get out but the other kittens were sleeping and did not cry. Therapist spoke of how Poppy might be telling her about a kitten in a box like a baby in an incubator who had

wanted a mummy. Poppy told the therapist she nearly died when she was in an incubator.

Later...Poppy announced she would now be a panther and she began jumping around the room. Therapist spoke about her going from a small kitten to a panther and that they could be dangerous animals. She told the therapist this one was kind. Poppy then drew a picture of a panther that she said was "cross and hungry".

As the sessions progressed Poppy continued to bring ideas to her therapy about animals such as the kitten that was crying for its mother and was stuck in a box. In the countertransference this felt so obviously linked to her prematurity. When the therapist raised this and made the connection to Poppy's own incubator experience Poppy seemed relieved to talk about this and gave the therapist details of her birth (see incubators and hospital section).

In that same session Poppy had wanted to be a kitten and to be fed with the toy baby bottle. Once fed Poppy then became a panther. Poppy said the panther was "cross". She had gone from being identified with a sweet little kitten that needed attention and feeding like all the other kittens to changing into a wild, potentially dangerous, panther. This was significant as it was one illustration of how Poppy could rapidly change from being a friendly amiable child to one that was aggressive. As the therapy progressed we began to understand the panther that Poppy identified with as the stronger and sometimes aggressive aspect to her personality. However, the panther is a grown up big cat and Poppy was trying hard to grow up and move away from her baby years and maybe she used the panther to try and do this. In the next session Poppy considers killing the panther off.

15 months into treatment (7th sampled session of 11)

In the middle of her session...Poppy spoke about how her sessions helped her to think about the panther part of her and making it like a “dead leaf”. Therapist suggested she felt she had to kill the panther part rather than to tame it. Poppy said she did not want to hurt anyone any more so the panther part of her was still there but was more like a dead part now.

A few minutes later...Poppy completed her picture of a flower and decided she would have a butterfly and bee coming out of it. Poppy told the therapist she did not like bees or wasps as they stung you but bees died when they stung. Therapist wondered with her if she was thinking about the parts of her that used to hurt people like a friendly bee that stung when it felt frightened and threatened in some way.

Poppy’s ability to reflect and think about the aspects of her personality was growing. She used animals and flowers to communicate her thoughts/ideas. For instance, the bee or wasp could be seen as aspects of her aggressive behaviour she did not like or that frightened her. As mentioned earlier this could also represent her unconscious memory of being “stung” by injections. On reflection the therapist was very kind to Poppy with her interpretations; always finding the positive aspect to Poppy’s aggression such as the bee that only stung when provoked.

4.5.1 Discussion of the material (psychotherapy and play / animals, insects and reptiles)

Poppy identified with animals that could be strong and powerful, such as the panther, and also smaller more vulnerable ones, such as the kitten. Using the animals Poppy was able to begin exploring aspects of her personality and convey her feelings of fear and vulnerability. It also felt as if, at times, she was trying to integrate the aggressive and infantile aspects of her personality but at other times this still felt very

split. Perhaps if the therapist had picked up on the aggressive part of Poppy more robustly we would have seen more progress with her behaviour at home and integration of the two aspects of her personality.

There was a sense of Poppy not feeling she ever had enough of any play materials, as if she was feeling deprived internally and no amount of extra resources could fill the gap she felt inside. For instance, Poppy initially looked at all the equipment in her box and spotted one item she felt was missing which was the clay. As the therapy progressed the therapist decided to supply the clay. The therapist did not provide all the “missing” materials Poppy wanted as she felt they needed to work on the feeling of something “missing”. This seemed to be connected to a missing feeling Poppy had about her early childhood and also in the transference to parents who were felt by Poppy to be not well resourced.

The Oedipal configuration of three arose on several occasions. In the countertransference this had a feeling of being stuck and needing some work. The paternal function was depicted as something that was needed to control the situation. The infantile aspect of Poppy was looking for a stronger internalised paternal function to manage her behaviour and for her to feel contained. There was also a desire for maternal and paternal attunement to her needs as we see in the example of the mirroring game.

The next section considers the important role of the psychotherapist in a child’s therapy.

4.6 The Role of the Therapist in terms of Transference and Countertransference

The therapist has a central role in the child’s therapy with regard to helping the child feel contained, understanding and interpreting the

child's symbolic play, maintaining a structure and keeping the boundaries of the session. In fact maintaining the boundaries and structure of the sessions enables the therapist to retain the state of mind they need in order to make use of the transference relationship (Joseph B 1998). In this section I wish to pay particular attention to the use of the transference and countertransference (for further discussion on other techniques used please see the literature review).

Enabling the child to use the therapist via the transference can promote change and understanding for the child. The child psychotherapist's training also helps them to make use of the countertransference in order to deepen their understanding of the child and their feelings.

Miller (1989) describes the importance of infant observation and how this entails becoming in touch with infantile states and emotions. This enables the psychotherapist to begin to understand the process of transference and countertransference for use in their clinical work. *“Correctly grasped, the emotional factor is an indispensable tool to be used in the service of greater understanding” (Miller 1989 p3).*

Although the transference and countertransference are linked, for the purpose of this section in order to highlight these more fully, I have separated them out under two headings.

4.6.1 Transference

The transference is essential in enabling the child to use the therapist to stand for people in their lives past and present. This gives the therapist insight into the child's internal objects and helps the therapist to understand what help the child might need.

A worker offers the child or client provision for open expression of feelings through play or talk within the context of a stable setting, and she offers her own thoughtful attention; it can then be possible

for emotions with an infantile content to manifest themselves readily in the transference relationship. The worker becomes the person towards whom such emotions are felt and the relationship with her has transference significance (Copley and Forryan 1998 p188).

Transference also occurs outside of the consulting room, however, the difference in therapy is that transference feelings can be worked through and interpreted by the therapist. The therapist, in the transference, may represent significant people in the child's life at different times. The therapist is likely to react differently to how the child has previously experienced these relationships; giving the child an opportunity to view situations differently and improve the relationships they have (Lanyado 2004).

There can be both positive and negative transference within the therapeutic relationship. Being able to acknowledge the positive transference whilst still being mindful of the fact that most of the child and adolescent psychotherapist's work is undertaken in the negative transference is an important part of the process.

"Possibly the most important distinctions are between the positive and negative transference. As these terms imply, the positive transference embodies those friendly, loving, trusting feelings which enable the patient to feel invested in the therapeutic process and come to his sessions, even when the sessions are painful and distressing. The negative transference contains feelings such as anger, hatred, rejection, envy and mistrust, which make the patient feel at times that he hates the therapist who is experienced as causing all the misery that he feels in his life" (Lanyado M, Horne A 1999 p59).

Poppy engaged well with the therapist and seemed to be looking for someone to process her experiences and make sense of them for her. Being able to emotionally contain Poppy's projections, digest them and put them into words enabled her to respond and think about situations in different ways. A disappointing and frustrating aspect of the

psychotherapy was the lack of negative transference. Poppy appeared desperate to keep her therapy space split off from anything “bad”. The Joseph paper (1985) gives examples of some technical difficulties in our use of the transference with patients. I considered, on reflection, such issues with my past work with Poppy. Poppy seemed to have seduced me into focusing on the infantile aspects of her presentation in the transference as she was really looking for an idealised object that could respond to her without becoming cross, irritated and worn out as her parents had become. I recall one session (not one of the analysed sessions for the thesis) where she shared with me a dream about a chocolate fountain that continually had chocolate pouring out of it. This may have been her phantasy of an idealized breast that continually fed her and kept her in an infantile state (something she seemed to have looked for in her therapist). The following are examples of Poppy’s use of the therapist in the transference.

1st individual session (2nd sampled session of 11)

In the middle of the session...Poppy began to draw hearts by the side of her picture. She told the therapist, “Sometimes mummy and daddy argue”. Therapist asked how she felt about this and she told her, “Scared as they shout and I don’t like loud noises”. Therapist spoke of how mummies and daddies do argue sometimes but this was not the children’s fault. Poppy looked at the therapist and asked her if she had a daughter. Therapist spoke about her being interested in her and if she was a mummy and she asked Poppy what she thought. Poppy said “Maybe”.

As the therapist remained neutral, and did not give details of her family, Poppy was able to use her own phantasy about whether or not the therapist could be a mummy and have a daughter like her. This was then an open invitation for Poppy to use the therapist in the transference as a parent figure and other relationships in her life too.

On reflection, this may have been an opportunity for the therapist to pick up on the negative transference. If at the time the therapist had invited Poppy to think of her as a possible parent who might also argue this would have invited the negative transference. Poppy made reference to her dislike of noise and, as mentioned previously, this could be related to the incredible amount of noise she would have endured in SCBU.

As the session progressed this led to Poppy thinking about her feelings of missing her mum and recalling how other family members stood in for mum when she was absent, as we see later in this same session.

1st individual session (2nd sampled session of 11)

Continuation of the middle of the session...Poppy took a large sheet of paper out and told the therapist she was going to make an aeroplane. She then changed this to a boat telling the therapist she had made this before with her granny. Therapist suggested maybe she was like a granny at the moment. Poppy smiled and began folding the paper over and over again. There were a few crumples in the paper that seemed to frustrate her but she announced she had a boat. Therapist said, you had an idea about how to get through the feelings about not being with mummy by making a boat, something you usually do with granny.

It felt in the transference that the therapist, at this point in the session, was standing for a granny, someone who cared for her in mummy's absence. This was an example of the positive transference. Perhaps, as this was her first session, the therapist had a feeling of needing to settle Poppy into her therapy. However, this is an example of where the therapist might have invited the negative transference too by suggesting she was a parent therapist who Poppy maybe felt cross with as she kept her away from her parents. Poppy seemed to use the same activity she had done with granny as a way to cope with being separate

from her mum. Poppy did have separation anxiety and later in the psychotherapy work this did improve and she was more able to manage separations with the help of the therapist. Sometimes it felt like Poppy was searching for someone to care for her and in one of her early family sessions she asked me if my colleague and I were going to look after her as if we were her new parents. In the next extract the therapist was placed in the transference role as a mother who was shocked and tricked.

Two months into treatment (3rd sampled session of 11)

Poppy was hiding in the waiting room and her mum told me she did not know where Poppy was and that she must have run outside. In the transference it felt as if the therapist was to be a parent was to be tricked and misled. Therapist stated she would find her and then Poppy jumped out and surprised the therapist. She held the therapist's hand and immediately began to show her a book she had brought about a kitten. Therapist reminded her to say goodbye to mummy. Poppy told the therapist she had found the book in her mummy's room and that it had really been for Christmas.

Once in the room she took some paper out and said she would be drawing a cat. Therapist spoke about her telling her she had been looking for Christmas presents. Poppy said she had found it and not told her mummy then she did tell her. Therapist spoke about Poppy being in places she was not supposed to go and how this had spoilt her surprise. She went on to say today she had been a shocked mummy therapist who did not know where she was hiding in the waiting area, perhaps how her mummy had felt when Poppy had found her present.

As soon as Poppy had entered the clinic she had ideas about how to use the therapist in the transference to give her the same feeling she had given to her mum about her finding Christmas presents. Poppy

needed to process what she had done, as there was a feeling in the countertransference that she had done something wrong. The therapist was able to gently work on this with her via the transference relationship. Possibly, if the therapist had focused more on the negative and cruel aspect of tricking and shocking the mummy, Poppy may have thought about this more. There was also a possible link with her feeling her babyhood, like a book about a kitten, had been stolen from her due to her prematurity. There was a desire for her to be a baby again. Later in the same session the therapist was to be a mummy to the kitten.

Two months into treatment (3^d Sampled session of 11)

In the middle of the session...Poppy decided she would be a kitten called Maisy who the therapist had to help by feeding her to make her better. Poppy pressed her head on the therapist's lap and told her the kitten needed food. Poppy pretended to drink from the toy baby bottle.

In this session her feelings of being an independent young girl who had every right to look for, find and use her Christmas presents changed into her being a little kitten who really needed to be cared for and fed. The therapist went from being a shocked mummy therapist who the baby had taken or stolen the book from to one who needed to look after her. In a way Poppy might have felt her care as a small baby with her mother had been "stolen" from her due to her prematurity and being in an incubator. It was as if she had an unconscious feeling she needed to be nurtured, as you would do a small infant, as she had missed out on this. In the next session the therapist represents a sibling in the transference and again a venomous snake appears in her material.

8 months into treatment (5th sampled session of 11)

In the middle of the session...Poppy made a tongue for the snake and faced it towards the therapist. Therapist said the snake was pulling its tongue out at her. Poppy laughed and turned to the side of her bottom

slapping this and saying “Nah, nah, nah, nah”. Therapist asked what she was showing her and Poppy told her that was what you did when you made fun of someone. Therapist said like teasing but maybe she had felt teased today seeing the therapist with another child. Poppy said “Maybe”.

In this part of the session, in the negative transference, the therapist was to feel like another child who was being teased and made fun of. Poppy may well have experienced this herself or indeed teased her peers in this way. Play connected to snakes was common and it is possible snakes had an unconscious representation with the sudden intrusive procedures she had endured in the hospital. Snakes can bite and a common theme, that links to her premature birth, was a feeling of persecutory anxiety about being bitten, hurt or stung. This could be linked to intrusive procedures and lots of injections to maintain Poppy when she was an infant. Snakes might also be symbolic of the curly, bendy tubes and wires connected to the infant in SCBU.

The negative transference was usually encountered prior to and after a holiday break from the sessions. This usually came in the form of Poppy making a huge mess with the paints in the room and leaving this for her therapist to clear up. It was also seen via her identification with a panther and this is illustrated in the next example.

3rd Sampled session two months into treatment

In the middle of the session...Poppy announced she would now be a panther and she began jumping around the room. (In the transference the therapist felt Poppy was using her to stand for a parent who was going to be attacked and pounced on at any minute. The therapist felt anxious yet confident this could be managed). The therapist spoke of how she had gone from a small kitten to a panther and that they could be dangerous animals. (The therapist’s voice and understanding of

Poppy's actions and the fact the therapist did not show any fear seemed to stop Poppy jumping around). She told the therapist that the panther was kind. Poppy then drew a picture of a panther that she said was cross and hungry. The therapist suggested maybe the panther was cross due to her speaking about the Christmas break. Poppy told her she had art on Fridays when she came to her session (a subject Poppy loved). Therapist suggested this was something to be cross with her about too.

At times the therapist used her countertransference feelings at the same time as acknowledging the transference. This now leads us on to think about the countertransference.

4.6.2 Countertransference

The countertransference helps the therapist understand the child's feelings and their internal world. In response to the transference the therapist can experience countertransference feelings and this deepens the understanding of their patient and the way they relate to others. In fact, in order to truly grasp some of the difficulties for the child and their family, this can only be assessed by means of the countertransference as the child is often conveying an experience that has no words. The child's experiences can come from current situations, the past and will include their internalised objects that are then transferred to the present with the therapist (Joseph 1985, Jackson 1998).

...comparing the feelings roused in himself with the content of the patient's associations and the qualities of his mood and behaviour, the analyst has the means for checking whether he has understood or failed to understand his patient (Heimann 1960 p10).

The therapist picked up feelings in the countertransference in relation to Poppy's premature birth and this aided her in making sensitive interpretations in this regard. During the monthly family sessions, which

led up to Poppy coming into treatment, there was often symbolic material that appeared linked to her early start in life and the trauma her parents experienced around her birth. A good example of this is from the first family session where Poppy brought a baby caterpillar with the feeling of this being a potential life or death situation for the caterpillar as it nearly got squashed. In the countertransference I felt strongly that this baby caterpillar was not going to make it to the clinic room. I was also thinking about whether I was going to be a therapist who could manage this child like a parent who is fearful of handling their fragile premature infant for fear they might not survive.

Winnicott DW (1947) wrote a paper entitled "Hate in the Countertransference". This illustrates the normal process within therapy of how the therapist can experience a dislike of their patient and this can inform their understanding of the areas to work on with them. I can recall ending one of Poppy's sessions prematurely. I had got the timing wrong and only realized when Poppy's mum was surprised to see us out early. I felt awful about having done this and analysed why this might have been the case. I think it was due to feeling exhausted by Poppy and tired of her material. This links with how the parents may have experienced her too. Winnicott (1947 p195) says, "*However much he loves his patient he cannot avoid hating them and fearing them...*".

In the countertransference I recall feeling afraid of meeting Poppy for the first time due to how her parents had described her. However, I did not feel this fear again after meeting her even when she had an aggressive episode in the waiting area that I helped her parents with. My countertransference feelings with Poppy were more related to a feeling of being with a very deprived and needy young child, who made me feel as if she wanted to be nurtured, understood and contained.

In the following example the therapist's countertransference informs her that she is being made to feel like someone who tells lies.

12 months into treatment (6th sampled session of 11)

Towards the beginning of the session Poppy made a ball shape with the clay and asked the therapist to roll this for her. She told her she was making a fairy. Poppy asked where the clay tools were and the therapist explained she had forgotten them today. In the negative transference this seemed like a part of Poppy that could be tricky and deceitful. My countertransference feeling was of being caught out and having done something wrong, perhaps how she also, at times, made her parents feel. She began to make a large nose for the fairy – she said it was like Pinocchio. Therapist recalled how his nose got bigger due to lies and that maybe she thought there were some lies around today. Poppy agreed and said she thought I was hiding the clay tools from her. Therapist suggested this would be a mean thing to do and at the moment she could not yet believe she had forgotten them. Poppy squashed the fairy's nose and announced she would make something different.

By using the countertransference the therapist was able to bring out the feeling that Poppy imagined she was not telling her the truth and to think about this with her. In doing so, Poppy was then able to say directly how she was feeling and could then move on and change her play. In the next example the therapist picks up Poppy's feelings of fear and anxiety and is able to link this to her infantile fear of noises.

12 months into treatment (6th sampled session of 11)

In the middle of the session... Poppy heard a noise and looked frightened. Immediately the therapist felt like a parent faced with an infant who looked so startled and alarmed that her body went rigid and she looked terrified. Images of infants in SCBU came to mind in the

countertransference and the therapist felt she needed to make sense of this for Poppy. She told the therapist she did not like noises and that when she was little she used to be afraid of the noise of the ice-cream van as she thought someone nasty was in there. The therapist spoke about how something so sweet like ice-cream, that children liked, had worried her when small but now she was bigger she could maybe understand a bit more. Poppy said she did not like the noise even now. Therapist suggested that this could be due to when she was a baby in hospital with all the noises in there. Poppy nodded and the therapist explained that now she was older they could think and talk about noises and what they mean.

The therapist had felt Poppy's fear and using her countertransference feelings responded and made connections with her early experiences in SCBU. As mentioned in the literature review, infants in SCBU endure bright lights, intrusive equipment and procedures, and the noise of all this machinery that is essentially keeping them alive.

In the final example Poppy is working towards ending her therapy, something that she does not feel ready for, as this was a "premature" finish to her work brought about at the request of her parents.

23 months into treatment (9th sampled session of 11)

Towards the end of her session Poppy spoke about wanting to decorate her bedroom with fluff and bright colours. Therapist suggested she maybe wanted a room like the inside of a mummy's tummy – all soft and protective. Poppy agreed and told her how much she liked the therapist's soft cushion in the room. Therapist spoke about how cross Poppy might feel that something she feels is soft is taken away. Poppy disagreed. She chalked out a picture of her design for her room with very bright colours. She had some outlandish ideas of having a "fog maker" or lights on the carpet. The therapist challenged her on this in

terms of asking for things she knew she could not get. It was then time to end her session and Poppy requested to take her picture home to show her mother. When the therapist reminded her she kept the pictures safe in her box Poppy became cross and stated that she wanted to take it. The therapist stuck to the boundary and suggested she could tell her mother about this instead if she wanted to. Poppy did not argue further about this and she knew the therapist would not change her mind.

If the therapist had not used her countertransference she might not have picked up a feeling of Poppy wanting an idealistic womb like experience in order to protect her from a feeling of a harsh ending as psychotherapy was something she had valued and wanted to continue. It seemed difficult for Poppy to express her anger about the therapist ending her work. However, at the end of this session she had managed to be cross with the therapist, as she had not allowed her to take her picture out to show her mum.

4.6.3 Discussion of the material

This section has specifically thought about the role of the therapist and how the use of the transference and countertransference can offer insight into the child's inner world and enable sensitive links to be made.

The psychoanalytical method enables the transference and countertransference relationship to develop within the clinical setting, and this relationship is subsequently used by the clinician as the basis for interpreting the meaning of the clinical material (Reid 2003 p211).

In the transference Poppy was able to use the therapist to represent parents, mainly a mother figure, to work through issues such as separation anxiety. In the first individual session Poppy was struggling with her feelings of being separated from her mother and this led to her

using the therapist in the transference like a mother figure, such as a granny who sometimes cared for her. Additionally, Poppy often related to the therapist within the transference as if she was a sibling or one of her peers. In hindsight the therapist could have addressed the negative transference more vigorously. This in turn could have helped Poppy more with her aggression.

In terms of Poppy's premature birth, the countertransference consistently aroused feelings connected to this that enabled interpretations to be made that appeared to offer Poppy some relief. In the family sessions, leading up to Poppy coming into treatment, there were often countertransference feelings that evoked thoughts about Poppy's early years. This was noted by the therapist and enabled her to have a greater understanding of Poppy's material in the individual sessions when a connection to her birth history was needed.

I will now move on to my analysis and thinking about the beginnings, endings and holiday breaks in the psychotherapy.

4.7 Beginnings, Endings and Breaks in Psychotherapy

Themes of anxiety around separations and transitions emerged when analysing the beginnings and endings of sessions. This was also the case when looking at the session material prior to, and after, a holiday break. In order to analyse this further I looked at the 11 sampled sessions and used extracts to illustrate this. Diagram F was used to analyse the material at the beginning and end of the sessions. I specifically looked at how frequently Poppy held the therapist's hand on the way to the sessions and at the end. I also examined how often Poppy brought items, including her cot blanket, to therapy. This was analysed in terms of how often this occurred within the 11 sampled sessions.

Out of 11 sessions Poppy brought items from home on seven occasions. For five of the 11 sessions she held the therapist's hand on the way to the appointment and on ending held the therapist's hand on two occasions. This would suggest that Poppy required a transitional object and/or a hand to hold to manage separations on the majority of sessions. Poppy was less in need of this physical holding at the end of the appointments due to how much more contained she felt. In a similar way Poppy used talking as a way to attach to the therapist on the way to the room. Out of the 11 sampled sessions she talked with therapist on the way to the room in all 11 sessions. She did not feel the need to do this at the end of the appointment.

Diagram F

Behaviour Indicators of anxiety at the beginning, ending of sessions and prior to and after a holiday break

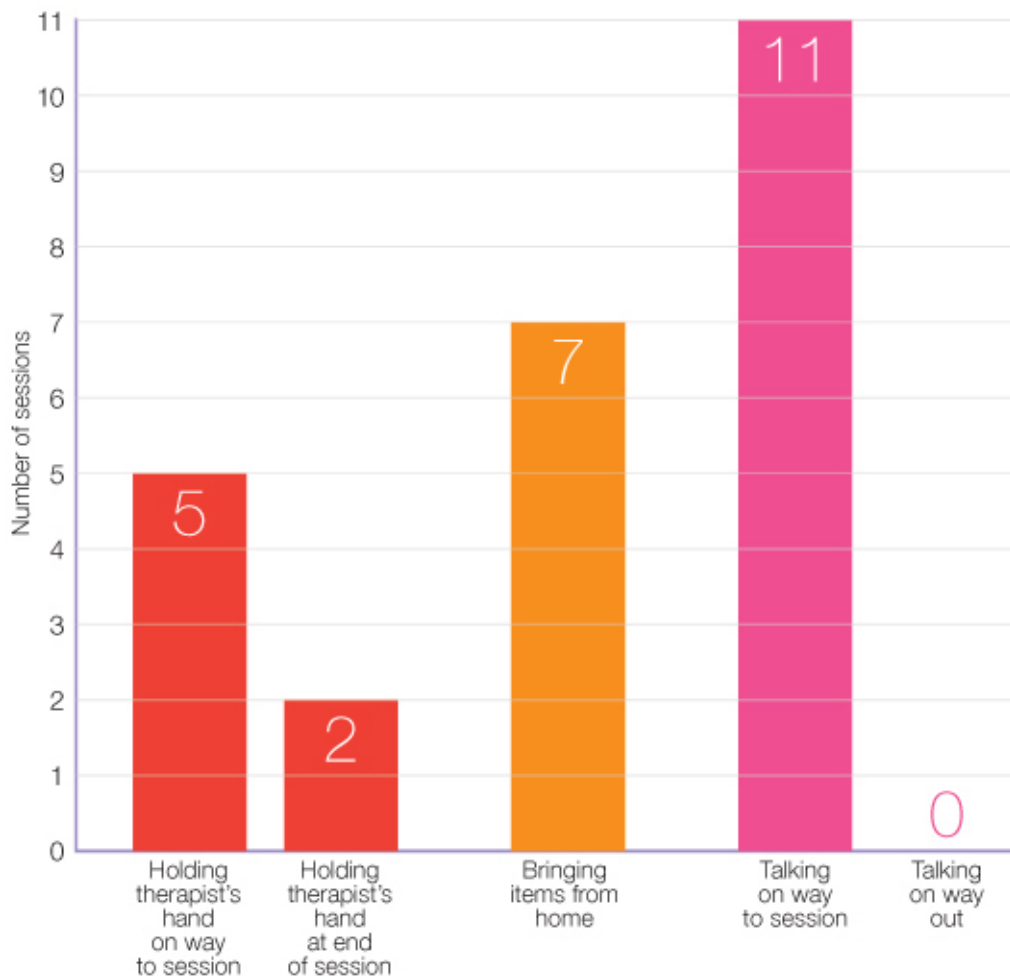
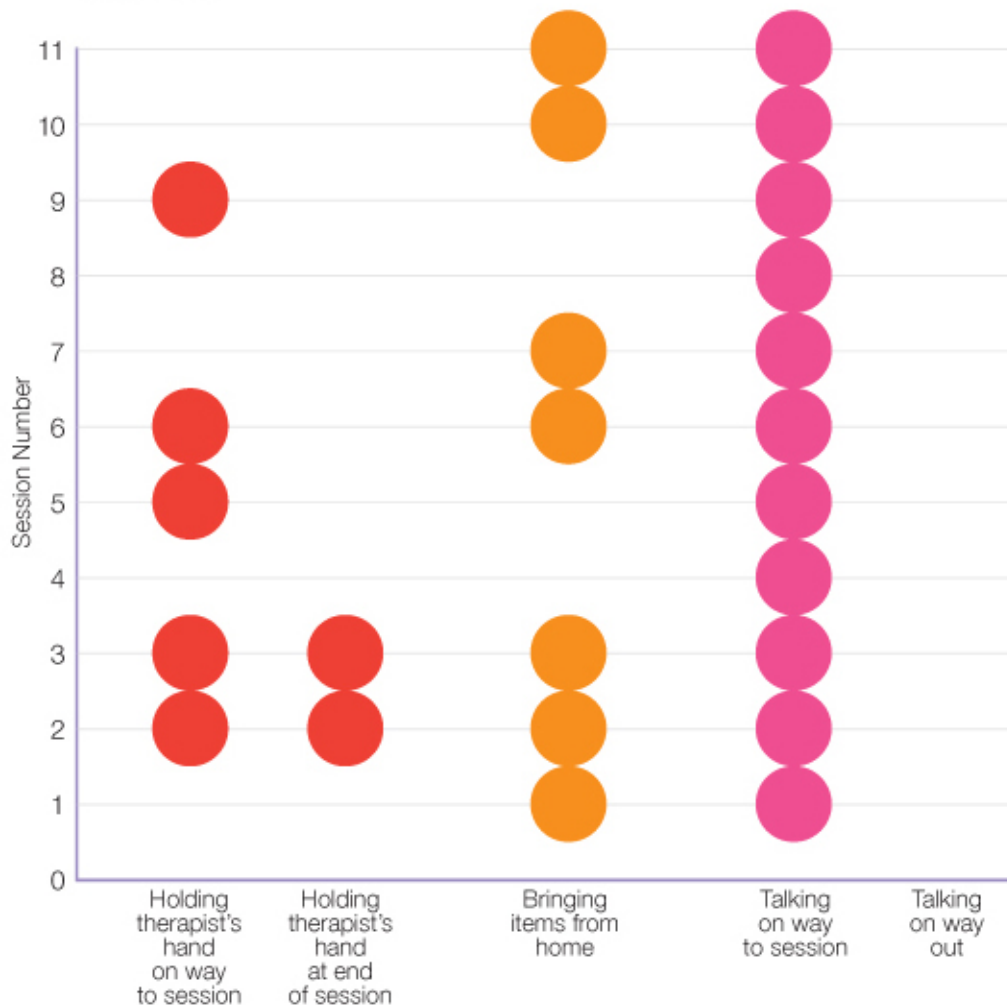


Diagram G charts the progress Poppy made over the course of the therapy in terms of her behaviour at separation. This indicated that Poppy was less in need of her hand being held as the therapy progressed. In session nine she returned to hand holding on the way to the session and I felt this was due to the fact this came after a holiday break. She continued to either talk or bring an item in from home as a way to manage separations throughout the psychotherapy.

Diagram G

Progress made over the course of the therapy with behaviour at separation from mum and therapist



I will now look at the beginnings of sessions in more detail, following this I will focus on the ending of sessions and the holiday breaks from psychotherapy.

4.7.1 Beginnings of sessions

On arrival to the clinic Poppy tended to dash over to the therapist and wanted to hold her hand or even put her arms around the therapist's waist. Poppy frequently brought items from home into her appointments and would then use these as the focus of her initial conversations with the therapist. A regular item Poppy brought to the sessions was her cot blanket. Poppy used items from home or outside the clinic as a way to manage the transition from her mum to the therapist. It was as if she was trying to find something to use to avoid the painful feelings and thoughts associated with the separation. Parting from her mother was often done in a rather abrupt way, with Poppy immediately turning to the therapist without saying goodbye to her parent unless she was reminded to do so. This could indicate a level of anxiety about the separation and a desire to form a substitute relationship with the therapist. It also seemed as if Poppy could not hold two objects in mind at one time, hence mother was ignored in order for Poppy to engage with the therapist. At times the therapist felt the need to remind Poppy to say goodbye. This seemed linked to the non-verbal responses of her parents to the way Poppy greeted her therapist and how mother was often not acknowledged.

A common theme was Poppy using physical contact to join with the therapist, usually by holding hands. This felt like a desire to attach to the therapist, albeit superficially, as a way to cope with leaving her mother. It seemed appropriate for the therapist to be holding Poppy's hand as she presented emotionally like a much younger child who was in need of help to make the transition from her parent to the therapist. The therapist would not always hold a child's hand to go to the clinic room but had done this in the past with much younger children. Over time Poppy was less in need of this type of physical holding, however in the initial 12 months she looked for this support. Bick (1968) described how some children she worked with had little or no sense of a

containing object. They did not seem to have experienced an internal space in which they could project into hence they resorted to sticking to objects. I felt this may have been the case with Poppy and that this could be due to her premature birth and the long time she spent in SCBU.

The hand holding, the talking on the way to the session all had an adhesive type quality to it. As diagram G shows, Poppy ceased the hand holding on the way to the session over time. However, she did return to this after a holiday break. It was only at the beginning of her two-year therapy that she wanted to hold the therapist's hand. Over time she became able to say goodbye to her mother and this indicated her growing ability to acknowledge and bear this separation with the help of her psychotherapist. The following extracts illustrate two beginnings of Poppy's sessions.

First individual session (2nd sampled session of 11)

Poppy rushed over to the therapist and flung her arms around her. She then showed the therapist some stems from flowers that she had picked outside. The therapist explained she needed to say goodbye to mummy and then they would be going to the room. She rushed back to her mum, gave her a hug, picked up her cot blanket and then she held the therapist's hand. As they walked to the room she told the therapist she had completed a triathlon at school today on her bike, then running and swimming.

12 months into treatment (6th sampled material of 11)

Poppy ran over to the therapist and held her hand as her mum called goodbye. Poppy launched into telling the therapist about her Wellington boots she had on for fundraising at school. Therapist said they would have a proper look at them once at the room. In the room the therapist looked at her Wellingtons, which had a skull and cross bones on them.

Poppy then showed her new cot blanket and the therapist noticed how soft this was.

The cot blanket appeared to be used by Poppy as a comforter and we might think of this as what Winnicott (1971) termed, a “transitional object”. This is an object that is usually adopted by a child to symbolically stand for something that is between them and their parents, which they can turn to for reassurance and comfort in their absence.

The talking Poppy did as soon as she saw the therapist was another way to adhesively latch on to the therapist, not allowing the transitional space from the reception to the clinic room to have any silence or thinking time. Perhaps this was due to fears that this would be filled with anxious thoughts about the separation.

In both extracts Poppy spoke about activities she had to do at school. The triathlon felt symbolic of Poppy explaining the effort she had to put in; maybe to manage at school but also in getting to her therapy and overcoming anxieties about leaving her mum.

The therapist did not work with the skull and crossbones on her wellington boots analytically. On reflection, it seemed this could be an indication of the aggressive part of Poppy. At the time the therapist continued to focus on the more infantile aspect of Poppy such as the new cot blanket that she showed her therapist.

4.7.2 Endings

It was also important to think about how Poppy presented at the end of sessions in terms of her ability to manage separations from the therapist and the reunion with her mother. In terms of Poppy’s reunions with her mother, the therapist recorded very little detail of this in the

process material for analysis except for the second sampled session where Poppy ran to her mother and hugged her. In the 10th sampled session (27 months into treatment) she dropped a magazine in her mother's lap when she saw her. The impression the therapist had was of a great deal of anxiety around separations and reunions between mother and child. Mother seemed particularly anxious when Poppy returned from therapy as if she was unsure how Poppy was going to greet her. On parting from her mother Poppy acted as if she had forgotten to say goodbye and that her mother was of little importance to her. However, the therapist felt she was acting in this way due to her extreme anxiety about the separation. The therapist noticed Poppy's mother could often look hurt and rejected by Poppy's actions. This led the therapist to become more active in helping Poppy to say goodbye. This did change over time and Poppy was helped to manage and acknowledge the separations. The next three extracts illustrate the end of an appointment on her first session, then at two months and at six months.

First Individual session (2nd sampled material of 11)

It was nearly time to finish and the therapist let Poppy know. Therapist suggested she needed to slow down after thinking of exciting things (bungee jumping). (The therapist felt Poppy was spiraling out of control just before she was due to end and go out to her parents so she needed to help her to manage the ending). Poppy left a male figure hanging on the bungee jump by his legs telling the therapist he would dry off there. She dried her hands and picked up her cot blanket. She held the therapist's hand to walk back to mummy. Once she saw her mummy she ran to hug her then came back to the therapist and hugged her asking if she could wave to her through the windows.

In the first individual session we can see Poppy was very anxious. At the end she left a toy male figure dangling from a bungee jump as if she

had been left up in the air having to end. Another possible interpretation of this was Poppy wanting to leave the therapist dangling in a precarious position as a reaction to being told she had to end.

Poppy anxiously held the therapist's hand and wanted to continue the goodbye by waving through the windows. It was as if Poppy was concerned about leaving the therapist and wanted to ensure the therapist continued to think about her after she had left by continuing the goodbye.

Prior to the first holiday break in her sessions Poppy began to think about her feelings in connection to this. Part of her wanted to hide her feelings behind a mask for fear of the response from the therapist.

***2 months into treatment prior to a Christmas break
(3rd sampled material of 11)***

Middle of the session...Poppy drew a mask and then wrote she loved the therapist. The therapist spoke of how behind the loving feelings there were other feelings too. She wrote on the mask "angry" and "sorrow". Therapist suggested they could think of these feelings and she did not have to hide them. Poppy told the therapist she was scared to show them as she might upset her. Therapist spoke about being strong and how she could help her with these feelings. Poppy drew around her hand and wrote Happy Christmas. Therapist said she was letting her know her happy, angry and sad feelings at Christmas. Poppy looked tearful. Therapist reminded her they would be back after the break.

Poppy grabbed the ball and they played catch. As they played this game the therapist named the days of the week as a reminder of the day she would be back. When it was time to finish Poppy held the therapist's hand and walked quietly out to see her mum.

In the session above Poppy used mature language to describe how she felt. She was able to express her fear about showing feelings. She seemed worried about becoming aggressive or angry, as if protecting the therapist and her sessions. It was hopeful in terms of her development that she was beginning to talk about her feelings.

In the next extract Poppy had rival others on her mind. She was beginning to think about the possibility of the therapist seeing other children. This was a positive step in her beginning to process Oedipal feelings, as she was able to consider others existed and she had to share the therapist with other children.

6 months into treatment (4th sampled material of 11)

Towards the end...Poppy glanced over at the dolls' house and told the therapist the door was open as if by magic. She asked if she had left it like this. Therapist suggested she was thinking about whether she saw other children and if they used the house. She asked the therapist if she did see others and what their names were. Therapist reminded her about privacy and that she could not tell her the names of the other children. She completed the rabbit she was making from the clay and announced this was a girl. It was time to end and she washed her hands and went to find her parents. Poppy did not hold the therapist's hand.

Poppy did not talk on the way out from her appointments as if she was feeling calmer and more contained. In the later session she was also able to walk back to see her mum without holding the therapist's hand. This was possibly due to the processing and digestion of Poppy's anxiety by the therapist within the sessions. This helped Poppy to feel calmer and able to manage the transition better.

During the course of the therapy, Poppy questioned if the therapist saw other children. On one occasion Poppy saw the therapist with another child prior to her session. The feeling was one of relief from Poppy that she was not the only child being seen and who needed help. This was evidenced by her relaxed expression and saying to the therapist she was pleased she now knew she did see other children.

4.7.3 Psychotherapy breaks

The holiday breaks children have in their regular sessions are important to work on as they can ultimately help them with separations they encounter in their lives. When children become more able to cope with separations and retain the containing function of the therapist it is likely that they have begun to introject, that is, take in the therapist's reflective function and the child's capacity to think has developed. Bion tells us, "*If the capacity for toleration of frustration is sufficient the 'no breast' inside becomes a thought and an apparatus for 'thinking' develops*" (Bion 1967 p112).

As evidenced in the previous section, two months into treatment Poppy was beginning to express her feelings, with the therapist's help, about separations. She spoke of "angry" and "sorrow" feelings in connection with the Christmas break. Breaks from therapy brought up feelings around separation for Poppy and this was helpful material to work on with her. The following extract illustrates more of Poppy's responses to holiday breaks. The first example was of Poppy preparing to go on her family holiday.

6 months into treatment (4th sampled session of 11 and prior to her family holiday)

Poppy was in the middle of her session and was making a vase. She told the therapist she would be going on her holiday soon. Therapist asked how she was feeling and she told her "excited". Therapist

recalled on Friday she had been feeling...Poppy finished the sentence and said "Frightened". She told the therapist she was still frightened of flying.

Later...

Poppy asked if I had heard of 'Nero pets'. She told the therapist they were imaginary pets but you still had to feed them or they would die. She told the therapist she had to feed hers when she got home to stop it from dying. Therapist said after talking about holidays and being away from her sessions she had thoughts about keeping things alive. She reminded Poppy she would continue to have her in mind when she was away. Poppy said she would think of her therapist too.

Poppy seemed apprehensive about going away on holiday, particularly as she was going to be experiencing something new. She also imagined a separation or break from the session could be a death rather than something she could manage. In the next session, 12 months into treatment, in preparation for the holiday break, Poppy began to think about how she could transfer her thinking with the therapist to home with her parents. Poppy used sophisticated language to describe aspects of her behaviour. The therapist had not previously used this terminology.

12 months into treatment (6th sampled material of 11)

After settling into her session and getting out the clay, Poppy began to tell the therapist she had been talking to her daddy about the "uncooperative and cooperative" part of her. She had told daddy when she feels cooperative she puts her thumb up, and her thumb down when she doesn't. The therapist spoke of her taking away some ideas from her sessions to try and help at home. The therapist suggested Poppy was getting ready for the holiday break and thinking about how

to manage this. The clay she was using ran out and Poppy then needed the toilet. On return from the toilet Poppy told the therapist how she had turned the light off but held the handle door so she could open it. The therapist suggested that talking about the holiday break had left her feeling she was in the dark and she needed to hold on tight. Poppy nodded. The therapist reminded her that she would be coming back after the holidays and she would continue to think of her, leaving the light on in the therapist's mind.

Poppy began to internalise her psychotherapy and was introducing ideas at home to communicate how she was feeling. Hence the “uncooperative” and “co-operative” signs she devised with her father. Poppy was making progress in communicating her feelings. However, she was still anxious about breaks. One indication of this was after she had talked about the break she needed the toilet and symbolically described a need to hold on tight, as she feared being left in the dark. The next extract is from the session where she arrived back from another family holiday.

23 months into treatment (9th sampled session of 11)

This was the first session back after Poppy's family holiday. Poppy hugged her mum hiding her face from the therapist. Mum explained Poppy was tired and she had to wake her up in the car. Poppy took the therapist's hand and began to tell her she had gone swimming last night in the sea and the wave had gone right over her head. She had been very scared...

Once in the room she spoke more about the wave. The therapist suggested she was coming back from holidays with some fears. Poppy chose some paper and told the therapist about the street kittens she had seen on holiday that had no mummy. Therapist spoke of her feeling scared and lost with no therapist mummy whilst she was away. Poppy

nodded and told me she was. The therapist reminded her she was back now and they could do some thinking about this.

The waves felt symbolic of overwhelming feelings that had almost engulfed her and left her feeling scared. Kittens were, as discussed previously, often used in Poppy's descriptions and play. In naming the parts of her own character she spoke of a kitten and a panther. She talked about kittens crying for their mothers in a storybook she had in one session. In the session above she speaks of street kittens on her holiday. She seemed to projectively identify with the kittens in distress that had no mummy as if telling me about her absent therapist during the break. This could also relate to Poppy's experience in SCBU, feeling abandoned and without a mummy to hold her.

The theme of anxiety around separations and transitions was a common one for Poppy throughout her therapy. As the psychotherapy progressed it was clear Poppy was bringing more of her anxieties and feelings about separations. Poppy began to see, via her therapist, that separations could be tolerated and managed. She could now think about this in relation to parting from her mother. Poppy began to say goodbye to mum without needing to be reminded.

The material shows how Poppy made some progress in managing separations and began to feel more contained as we see in the endings of her sessions. Her expression of feelings, particularly around the therapy breaks, also increased.

4.7.4 Discussion of the material

What does this material tell us about Poppy and her being born premature? Poppy did seem to find separations hard to manage. The question is could this be related to her premature birth? The long-term impact study (Tideman, Nilsson, Smith and Stjernqvist 2002) looking at

the mother/child relationship indicated that the attachment relationship with premature infants in later childhood was less secure. More emotion was expressed between the mother and her child than those children born at full-term. They concluded that children born premature are more vulnerable emotionally in relation to attachment and separation in adolescence and adulthood. We could say there is a possible link between Poppy's premature birth and the way in which she managed separations. There is evidence in her material that indicated anxieties around transitions and separations. It is also possible that if she was born full-term she might still have anxieties of this nature. The question is could this have been increased by the experience of being born premature and having to be physically separated from her parents in an incubator for three and a half months.

The early processes of attuning to an infant and responding to their needs when they are born premature can temporarily impact the development of the early relationship between parent and child (Macey, Harmon, Easterbrooks 1987). Poppy did struggle with goodbyes to her mother and it was only towards the end of treatment that she could acknowledge and think about this separation.

It is significant that Poppy presented as a much younger child emotionally. For instance, she needed her hand held and a transitional object, her cot blanket, to manage the separations from her mother. It seemed that Poppy's emotional development was delayed and that it is possible to consider this could be due to her early childhood experiences. Being born too early, before she was ready, may have had significance in her managing separations and increased her separation anxiety. Poppy made progress in this regard during her treatment. She was less in need of her hand being held and, towards the end of her psychotherapy, she no longer required a cot blanket.

4.8 Summary of the Findings Chapter

The findings are a result of detailed analysis of 11 sampled sessions. In analysing the material themes emerged and I considered their possible relevance to Poppy's premature birth.

Poppy had difficulties with separation anxiety and transitions. I discovered this by analysing the beginnings and endings of the psychotherapy sessions. In addition to this I analyzed the sessions that occurred prior to or after a holiday break. Poppy used handholding, talking and bringing objects from home as a way to manage the separations from her mother. The anxiety about transitions and separations did improve as the sessions progressed. The study by Tideman, Nilsson, Smith and Stjernquist (2002) concluded that attachment relationships with premature infants and in later childhood were less secure. These children were more vulnerable emotionally in relation to attachment and separation in adolescence and adulthood.

Analysing Poppy's symbolic play highlighted her interest in creative materials and how she used them to express her emotions. Poppy's discussion and play about animals often centred on baby animals, such as the kitten, and adult ones that were powerful and strong, such as the panther. The baby animals were often crying for their mother and feeling abandoned. Links were made to Poppy's experience in the incubator. The animals also represented her desire to develop and grow, such as the kitten growing into the panther, but also to the aggressive part of her. The insects that could sting or bite, that she was fearful of, were possibly linked to the intrusive procedures she endured as an infant, although the psychotherapist did not make this connection during the treatment.

Poppy did talk about SCBU and hospitals in her psychotherapy. She appeared to need her therapist to process her experiences of this.

Poppy also focused a great deal on babies and growing up. There seemed to be an internal conflict for Poppy as she was trying to leave her infantile experiences behind but struggled with this. One of the research papers I read suggested children born prematurely often have difficulty with transitions particularly from adolescence to adulthood (Allen, Cristofalo, Kim 2010).

The transference enabled the therapist to help Poppy work through feelings she had in certain relationships, particularly in connection with her separation anxiety. On reflection the negative transference was not so actively taken up by the therapist and if she had done so this might have helped Poppy more with her aggression. The countertransference often highlighted to the therapist the feelings connected to Poppy's premature birth both from her parents and Poppy. Both were important to the development that I have evidenced here as Poppy progressed through her therapeutic journey.

5. Conclusion

5.1 Introduction

This thesis has set out to research whether a premature birth can impact a child's internal world. I considered whether the memory of the birth and experience in SCBU could be recalled by the child and re-enacted in their play or was it more of an experience felt in the body? External information from family about the birth could also form part of the narrative and therefore be a memory given to the child.

In terms of methodology, qualitative research, with the aid of grounded theory and thematic analysis, was the most suitable approach as it helped to investigate, in detail, the child's experiences. Within the qualitative approach, the single case study is the most widely used in psychotherapy as this helps to place theory and practice together with the possibility of new theories and understanding being formed as a result (Midgley 2006).

The single case study I discussed was of a young girl I re-named Poppy who was eight years old at the start of her two-year treatment. I randomly selected a session every three to four months over the course of Poppy's psychotherapy in order to analyze the session material. I also used the first appointment where I met Poppy with her family. There were five months of monthly family sessions I undertook with my colleague, a Clinical Psychologist, before taking Poppy into individual treatment. This was to help Poppy to get to know me in the presence of her parents. It was also to assess the viability for change in the parents. It was not agreed with her parents that these notes would be used in the thesis. Therefore the family sessions have not been discussed in detail but just mentioned briefly within my introduction and as part of my discussion in the findings chapter.

During the family appointments my countertransference feelings enabled me to become in touch with the trauma that Poppy's premature

birth had on her family. I felt fearful and anxious about meeting Poppy after her parents had described to me a “monster child”. Perhaps this was how she felt to her parents due to her aggression and response to them. There were many symbolic references made to Poppy’s birth. There was also a feeling of walking on eggshells, as if her parents feared Poppy would erupt in an aggressive way at any time. This reminded me of the life and death experience of Poppy’s early years in an incubator. Would she survive, die or be left disabled? These were questions that may have gone through the parents’ minds at the time.

The conclusion begins with the literature on this subject and the link with Poppy’s early experiences. I have considered in detail the impact of Poppy’s birth on her parents. I end with a discussion about the ending of Poppy’s treatment and how this too was premature.

5.2 The Literature on Prematurity and the Link with Poppy’s Experience

When researching prematurity I found several articles on the impact of a premature birth on the infant. This included the possibility of the infant being left with a disability. The articles also focused on the infants’ experiences in an incubator. It was stated that a great deal of medical equipment would be attached to them and there would be lots of noise coupled with bright lights that they had to contend with. All of these factors set up an environment that can be over stimulating and unnatural for the infant. With this set of conditions there also comes pain in the form of intrusive medical procedures.

The link with this early experience and Poppy at eight years old was striking in her psychotherapy sessions. She often spoke of insects that stung, could bite or that were toxic. This could be connected to her early experiences of injections that would have hurt and stung too. Poppy often described her fear of noise to me. In some sessions she was

visibly frightened by a noise she had heard. In one such appointment she asked if there was a hospital upstairs in the clinic due to a noise she had heard (6th sampled session). Thoughts of hospitals never seemed far from her mind and this could be connected to her early experience in a hospital as an infant.

As I analysed the clinical material, in relation to her premature birth, the question in my mind was whether this came from Poppy's unconscious memory or if it was from the trauma being projected into her from her parents? One revealing factor was the discovery, some months into treatment, that, when she was seven years old, Poppy had been shown the video of herself in SCBU in the incubator.

Poppy was emotionally immature and presented as younger than her eight years. I felt she struggled to process the video she had seen and some of her phantasies about her birth experience were made too real for her. In one session she spoke of feeling "left" in the incubator by her parents. She told me the doctors and nurses had to look after her. There was a sense of this little girl feeling abandoned, even though in reality this was not the case. I also considered what kind of internal objects Poppy had introjected having had an incubator experience. She would have undergone intrusive and sometimes painful treatment and been unable to be held by her parents. Does this mean she could have internalised a persecutory internal object?

Thinking in more detail about Poppy's experience in an incubator, we know from research that these circumstances of early separation between an infant and mother may impact on the security of the attachment relationship (Bowlby 1969, 1973, 1980). I can only imagine how alien this must have felt to her and how difficult this must have been for her parents too.

Poppy had a very anxious attachment with her mother and difficulties with separation anxiety. A longitudinal study of children, when aged nine and then nineteen, who were born premature and those that were born full-term revealed that emotions expressed between the mother and child was significantly heightened in the group who were born premature. *“The results indicate that preterm children may harbour emotional vulnerability regarding attachment and separation as young adults”* (Tideman, Nilsson, Smith, Stjemqvist 2002 20 (1): 43-56).

Moving on to think about the capacity for the child to retain the memory of their birth, I read the Winnicott (1949) paper that indicated that the patient could obtain birth material from their family but he also said it was something that the child held in their body too. Gaensbauer (2002) indicated that birth trauma could be retained in the child’s memory and resurface in their symbolic play. Rank (1924) stated that patients often repeated the early trauma of their birth at the end of analysis.

Further studies I looked at suggested that children who are born premature can be more at risk of developing mental health problems such as anxiety, phobias, depression and ADHD (Johnson et al 2010. Elgen et al 2012. Treyvaud et al 2013).

I found four journal articles that linked the emotional difficulties the child was having to their premature birth. This surprised me as my training had always indicated the importance of the birth history to the child’s current presentations. The articles made reference to the difficulties in the early containment of the child due to their prematurity and how this impacted their current emotional difficulties (Miller 1980. Urwin 1998. Carling 2003. Blessing 2006). I felt this was the case for Poppy too. Certainly her aggression was feared and avoided by her parents and therefore never really processed or contained by them. This could have been due to her parents having their own mental health problems as

well as the fact of them having to cope with a premature infant. Kenrick J (2006) tells us about the process of anger and how important it is to contain this without responding in an angry way back to the child.

In order to avoid a reactive response it is important for the other – usually the adult – to become more aware that some of her feelings may emanate from the child. This may help prevent her from actually becoming the angry person responding to the child in ways that the child may over time have come to expect...if the mother cannot tolerate the projections of her child, either because of her own state of mind – for example, depression – or impingements on it, such as domestic violence, then the child will not develop a secure base for making sense of his own experiences of life. Indeed, a base can be formed for an anxious and persecutory view of his experiences of relationships and of the world (Kendrick 2006 p25 p26).

From a neuroscience perspective trauma has been shown to have an impact on brain development and on the ability of the child to regulate their emotions. Reactive behaviours that were seen in Poppy, such as her aggression could be understood in terms of the trauma she experienced due to her premature birth and how her parents were not able to manage this.

We know that infants who have consistent and attuned care giving develop the ability to ‘self-regulate’, whereas experiences of either neglect or trauma might not be consciously remembered but will affect not only behaviours and attitudes, but also the very structure of the brain as well as the HPA axis, a central part of the neuroendocrine system that controls reactions to stress, particularly through the releases of hormones (Music 2006 p44).

Music (2006) goes on to tell us that such early patterns of relating and behaving become entrenched and can be difficult to alter. However, he did feel over time in therapy, it may be possible to effect change.

At times Poppy could be rather omnipotent and controlling over her parents and in turn she did not like to be controlled. Hopkins (2006) discusses how children who have been abused can feel insecure when

in a position of power over adults and yet fearful when adults take charge too. She says, “*Their disruptive behaviour invites adult control, which they both need and dread*” (Hopkins J 2006 p99). She goes on to say,

Although abused children can make significant changes in therapy, their liability to respond violently to unexpected reminders of trauma may remain. If therapy lasts long enough, they may come to recognize ‘trauma triggers’ and try to counteract their effects (Hopkins J 2006 pp104-105).

Although Poppy was not reported to have been abused, she was suffering the effects of early trauma.

The literature also gave me insight into the trauma experienced by parents whose child is born premature. Most parents have nine months to prepare for the birth of their infant. Going into labour prematurely must be a huge shock. They also have to cope with the consequences of an infant who is seriously ill, or that might be left disabled and may or may not survive. How the parents then respond to the infant due to these circumstances leads me on to the next section.

5.3 The Significance of Parental Response to the Birth of a Premature Infant

On writing my thesis and re-looking at the material, I became particularly struck by how parental response to the birth of a premature infant can affect the internal world of the child. One hypothesis, which began to develop in my mind, was the idea that if the trauma of having a premature birth and the early difficulties related to this stress are kept alive in the minds of the parents, throughout the child’s formative years, this may impact the experience and recovery of this trauma for the child.

In Poppy's case I felt the trauma was not only kept alive but continually re-evoked leaving an open wound that had not had chance to heal. It was almost as if her family had never been able to move on from the crisis of her birth. This was being painfully re-enacted periodically mainly with episodes of Poppy's aggressive behaviour and her family's response to this. Viewing the video of herself in SCBU left her with a narrative of feeling abandoned or as she put it, "Left on my own". This gave Poppy an acute awareness of her susceptibility to a near death experience. I believe this built up internal resentment in Poppy.

Garland (2005) talks about the difficulties some people experience in recovering from traumatic events, "*...for some people the support of family and friends is not enough and a traumatic event remains an open wound, deeply pre-occupying to the wounded and often very perplexing and taxing for the unwounded*" (Garland 2005 p246). I believe Poppy's family remained trapped inside the trauma of her birth. This possibly opened up old scars from both parent's past. Therefore emotional recovery of the traumatic event of Poppy's birth had never been achieved.

Cantle (2013) describes how a premature birth can feel like a loss for the mother.

For the mother of a premature or sick baby her story may include the loss of the pregnancy too early, the loss of the phantasy of the birth and of the ideal baby she had hoped for. It includes premature motherhood and anxiety about the baby's health and development. It is a story that frequently includes trauma (Cantle 2013 p257).

Cantle goes on to describe how parent and infant work with a Child and Adolescent Psychotherapist can help with the difficult circumstances in SCBU. The Child and Adolescent Psychotherapist can use their skills in observation and understanding of the unconscious processes to benefit

both the infant and their parents. In terms of the hospital staff she talks about their ability to encourage parents to take part in the main care of their infant when possible as this has a bearing on how well parents feel they can manage (Cantle 2013).

Mr. and Mrs. Abbott were very traumatized by the strain of having Poppy so early, with the added fragility of her birth and fears of whether or not she would survive. In addition to caring for their premature infant, Mr. and Mrs. Abbott had Poppy's older sister to look after too.

Learning to cope with the many stressors associated with caring for a preterm baby is added to whatever burdens and stressors may already exist in the lives of these families. The critical challenge this presents to even the most intact family is readily apparent. What happens to an already dysfunctional family is difficult to understand (Allen 1995 p172).

5.4 The Link Between the Ending of Psychotherapy and Poppy's Premature Birth

After two years the decision to end psychotherapy was brought forward by Mr. and Mrs. Abbott. There was a demand for Poppy to make more progress and frustration that her behaviour at home continued to be difficult. I advised the family that Poppy was not ready to end, however, Mr. and Mrs. Abbott felt Poppy was "getting too much individual attention" and they wanted psychotherapy to finish. On reflection, I wondered if they had felt they had not got enough attention. The Clinical Psychologist, that had been supporting them, had been on maternity leave and so they had not been receiving the same support as before. On her return from leave they expressed their wish for the psychotherapy to end. Perhaps unconsciously they had felt envious of the Clinical Psychologist who had a healthy baby at full-term? The timing of this decision also came after the four-week summer break when Mr. and Mrs. Abbott expressed their anger at me for "leaving Poppy for so long" and their dismay at how her behaviour had deteriorated in the break. I can recall after the first summer break in the

work, Mr. Abbott asked me how I was going to “repair the damage” I had done to Poppy caused by the break from the sessions. In my mind I considered whether Mr. Abbott was projecting his own anxieties and fears of damage that he felt he had done to Poppy particularly in relation to her premature birth. Even though the parent counsellor, Clinical Psychologist (who was undertaking the parent work) and I tried to encourage the parents to leave Poppy in treatment this was to no avail. Therefore we planned an ending giving Poppy four months to work towards this.

Poppy was very upset about the decision to end and repeatedly told me of her wish to continue. She felt emotionally held and supported in her psychotherapy and was not ready for this to end. In the final few months her attendance was poor. She found it hard to attend knowing she would be ending and I think her phantasy was that if she did not attend the sessions would not end. In effect her ending felt premature as if she was being expelled from a womb like place.

Psychotherapy enabled Poppy to express her feelings symbolically and to develop an emotional vocabulary. Her chaotic and confused behaviour, which I observed initially, gradually became calmer and more focused. She began to become more thoughtful and reflective in her sessions.

There were many disappointments for Poppy, particularly when she was aware her behaviour was deteriorating at home. Mr. and Mrs. Abbott found responding to Poppy in a different way, and without becoming too anxious, a real challenge. On reflection thinking about the techniques used by the psychotherapist and re-looking at the clinical material we might suggest that if more of the negative transference had been taken up this could have helped to improve Poppy’s behaviour. Her parents may then have felt more able to stay with the therapeutic

process. After psychotherapy ended the family were referred to Social Care for support in managing Poppy. She was made subject to a safeguarding plan.

5.5 Personal Reflections Regarding Undertaking this Research

Becoming a researcher did not come easy to me. I had to work hard to understand the concepts needed to do this work. At first I thought it was similar to writing a clinical paper where a narrative account could tell you much about the child and the clinical material. With the help of my supervisors I realized this was not the case and the research needed to be systematic. To do this I had to have sampled material chosen in a more ordered and consistent way in comparison to the clinical papers I have written in the past.

I had to suspend and contain my own anxiety about the fact that this might mean some material, which would have been useful to the research question, had to be dropped. My fears that the sampled sessions would not provide material of relevance to the research question were unfounded and in fact new ideas emerged from undertaking this research approach. In analyzing the 10 individual sampled sessions and the first appointment, new material that could be connected to the history of a premature birth, was found. For instance the difficulties Poppy had with separation linked with her birth history. Equally the material on biting and stinging seemed suggestive of procedures experienced by a premature infant. I also would not have considered the possibility that the parents struggle with the trauma of her birth could have been projected into Poppy if I had not used a research approach and looked at the material using line-by-line analysis.

Therefore I have learnt that undertaking psychotherapy research can be stimulating and I have gained a deeper understanding about Poppy and her material.

5.6 Final Comments

This thesis has sought to understand the experience of one child's premature birth and the impact this may have had on her growing internal world. In my opinion it has evidenced, through her psychotherapy material, that this had a tremendous affect on Poppy and indeed on her parents too.

The impact this has had can be seen in her anxious attachment to her parents and her difficulties with separation anxiety. The psychotherapy helped to alleviate this anxiety and as the sessions progressed some improvement was seen with Poppy better able to manage separations.

Poppy had internalised fears about noise and of being stung or bitten by insects. This could all link to the intrusive procedures she endured in SCBU and the false environment of the incubator with the bright lights, noise and medical equipment surrounding her that kept her alive.

The question still remains as to whether this experience was internalised by Poppy at birth or stems from her parents sharing this information with her? Certainly her family seemed to have held onto, and possibly not recovered from, the trauma of their daughter's birth and could have been unconsciously projecting this into her. I can only conclude that this may have been a combination of these two factors; Poppy's own unconscious birth memory experiences and the projection of her parents' experience of this too. What I am clear about is that Poppy had internalised the trauma of her birth. This has been evidenced in her psychotherapy material in terms of her symbolic play and her discussions too.

I wondered how Poppy experienced her family? I got the impression from her that she was aware she was exhausting her parents. There was a feeling of her struggling to be contained by her parents and this seemed to have been a theme that was written about in the other articles about children who had been born premature (Blessing 2006, Urwin 1998, Miller 1980). Poppy's experiences were compounded by her parent's own mental health needs. Putting all these factors into context it would seem that Poppy's presentation was likely to have been due to her early experiences in SCBU. However, the parent's own difficulties meant it was harder for them to contain this challenging young girl. Poppy's behaviour in fact increased the parent's own anxieties.

What are the lessons that we can learn from this single case study? I think this thesis has shown the importance of helping parents to digest and process the trauma they may have experienced. I know that groups and individual support, over the short-term, can be available to parents in these circumstances but this is sometimes not taken up. I was not aware that this had been offered to Mr. and Mrs. Abbott at the time of their daughter's birth. They were vulnerable parents who both had mental health difficulties and so needed a great deal of support. Mrs. Abbott's parents were not alive and so not able to offer her the emotional support she may have needed. This thesis has highlighted the need for specific and focused psychoanalytical support for parents, who themselves have a mental health difficulty, in order for them to cope with the trauma of having a premature birth. The parent counselling they were having alongside Poppy's psychotherapy was well attended by them and this was with a counselor with adult psychotherapy training. I am not clear whether the trauma of Poppy's birth was addressed in these sessions or not as they were confidential. The parent sessions with the Clinical Psychologist helped them to look

at strategies for managing Poppy's behaviour. However, there was a long break in this work due to my colleague taking maternity leave.

Poppy did require psychotherapy to help her process her experiences and improve her emotional vocabulary. She needed longer in therapy alongside her parents receiving support too but sadly this was prematurely ended.

5.7 Recommendations

As there are so few psychotherapy papers focusing on the link with a child's premature birth, I would recommend that further single case studies explore this subject. I think this would be useful to the Child and Adolescent Psychotherapy field. I would also recommend an audit of all Child and Adolescent Psychotherapy journal articles to see if the birth history is significant in terms of prematurity even if this is not the main focus of the papers.

In my own area a perinatal service is in existence and an under fives service is being developed. I believe it would be imperative to share my findings with those developing these services in order to potentially offer psychotherapy services to support parents whose infant's are born premature. This could take the form of group support prior to and after the premature infant has been discharged from hospital. Some families may also need individual therapy.

This thesis would also benefit all CAMHS teams as it highlights the importance of obtaining a full birth history and its possible significance to the child and family you are working with.

My recommendations are for all parents to be offered both practical and emotional support in order for them to cope with a premature infant. I believe this is required whilst the infant is in hospital and for an

extended period when they go home too. Some parents may also need their own psychoanalytical psychotherapy to process the experience, particularly if they have a mental health problem. This may then reduce the potential risk of projecting this trauma into the child. It may also be necessary for the child to be offered psychotherapy if the memory of the trauma continues to be acted out in the present via their behaviour.

I will end with Poppy's symbolic material and remind you of the "baby mouse" who she told me needed a "tiny boat" and the family who needed a "lifeboat" (2nd sampled session). I believe this tells us a lot about what her family required in terms of support.

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Appendices