The role of shame and humiliation in relation to the technical difficulties in providing psychotherapy to a six–year old boy in care.

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Abstract

This thesis is a single-case *post facto* research study designed to better understand the intensive psychotherapy treatment of a six-year old boy in foster care, who I refer to as Freddy.

There were considerable technical difficulties I wanted to examine, including how interpreting and other attempts to bring attention to the internal world and psychic reality stirred up shame and humiliation for a boy with a history of maltreatment.

The literature review refers to work with looked-after children with childhood maltreatment by child psychotherapists. Theories from adult psychoanalysis on narcissistic personality structures and object relatedness are also reviewed, and the link between shame, narcissism and the *Ego Ideal* is also explored. The growing body of knowledge that neuroscience offers our understanding of maltreatment is also reviewed.

The research methodology used Grounded Theory to analyze psychotherapy sessions, from which initial codes and categories were developed into over-arching themes. The findings indicated that, despite difficulty in understanding the therapy as it progressed, important processes took place, and shifts in psychic development were evident, particularly in the ability to gain a different view of relating. Changes in Freddy's ability to communicate relational anxiety were also observed.

The findings are discussed in terms the importance of the development of a mechanism for thinking about experience, and how early trauma and maltreatment can contribute to shame, humiliation and difficulties with psychic reality. Further discussion include the implications of maltreatment for child psychotherapy, clinical practice and future research.

Word Count: 242

I declare that while registered as a UEL student, I have not been a registered or enrolled student for another award of this university or any other Academic institution.

I declare that my research required ethical approval from the University Research Ethics Committee (UREC) and confirmation of approval is embedded within the thesis.

All identifying information has been removed, and pseudonyms are used throughout

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CHAPTER 1 INTRODUCTION

The aim of this single-case study research was to gain a better understanding a long-term intensive training case with a looked-after child, who I shall call Freddy, who was six years-old at the start of treatment. Freddy had an early-years history of maltreatment, specifically severe deprivation and exposure to domestic violence. Compared to other training cases, I rarely felt much confidence that I understood what was happening with Freddy in the therapeutic encounter. The work was hard, painstaking at times, and without service and Tavistock supervision, would have proved too much for me to manage. At the same time, I appreciate the task for Freddy was just as difficult, and in some ways, even more so.

I go on to illustrate this case study with session excerpts. During many of the sessions, particularly early ones, Freddy's way of communicating often involved physical attacks, spitting, and trying to smear me with urine and faeces. While the illustrative sessions capture elements of this challenging behaviour, my research aim was to see past this, as it were, and hopefully observe progress, change, and development.

I had been aware from an early stage that Freddy experienced a great deal of both shame and humiliation in the process of therapy, and I feel that these two areas were a good starting point from which to conduct *post facto* research. At the same time I wanted to explore how the therapy helped Freddy, and what I could take from this experience and apply to future clinical practice. I chose to use Grounded Theory as a method of investigation, and the rationale for Grounded Theory as a 'well suited partner' for researching psychotherapy will be reviewed. The detailed session write-ups, over 270 in total, were the main material data for my research, and through the application of Grounded Theory, themes emerged from a coding of individual sessions, which helped to organize the session data into something overarching and provided an opportunity to understand the material differently.

The relevant literature is reviewed in Chapter 2, including accounts of work with looked after-children by child psychotherapists, ideas about narcissism and shame, and rele-

vant findings from neuroscience. The methodology for Grounded Theory, and developments in child psychotherapy research, are outlined in Chapter 3. In Chapter 4 the findings from my analysis, and my initial thoughts in addition to some contextualization are described, and in Chapter 5 I discuss the findings in greater detail. In Chapter 6, I draw conclusions from the research, including recommendations for clinical practice and future research.

To avoid confusion I use he/him to refer to a child, and therapy/psychotherapy refers to psychoanalytical therapy with children. Psychoanalysis/analysis is used broadly to refer to all psychoanalytical therapy, both with children and adults, unless otherwise stated. I use the acronym LAC (looked-after children) only in the context of formal proceedings such as reviews and meetings. Maltreatment refers to neglect and deprivation, abuse and traumatic experiences involving caregivers. Where required, I differentiate between the types of maltreatment being considered. Freddy's main foster carer was male, and unless otherwise stated when I refer to his carer I mean the foster father. Mr F refers to Freddy's birth father.

Before describing in detail the research process, I will outline the relevant details from Freddy's early history, family and care situation, CAMHS involvement and psychotherapy progress.

1.1 Overview of the clinical case

I will provide an overview of Freddy's early years and what was known prior to and around the time he became known to social services, his removal from his birth parents, and both his education and foster care history. I will also outline important developments external to his therapy that would most likely have had an impact on how his foster placement, and consequently his therapy, ultimately developed.

As a reference guide to the outline provided, a timeline of Freddy's significant life events is given in *Table 1.*

Table 1: A timeline of Freddy's significant life events

Age	Year	Event
0	Early 2002	Born
1;4	Mid 2003	Name placed on child protection register under category of *Neglect*
1;8	Late 2003	Category *Emotional Abuse* added to Child Protection Register
2;11	Early 2005	Father imprisoned for assaulting mother. Continued concerns for mother's mental health, and substance abuse
3;9	Early 2006	Care proceedings initiated. Interim care order granted. Freddy and mother living in refuge at time. Behavioural concerns raised. Freddy placed in foster care.
3;10	Early 2006	Father applies for custody. Behavioural concerns increase in foster placement.
3;11	Early 2006	First change of foster placement due to aggressive behaviour.
4;2	Mid 2006	Permanent care recommended by LAC review panel. Extended family offer long term care but ultimately withdraw.
4;9	Late 2006	Following assessment of father's capacity to look after Freddy, LA recommended adoption.
5;0	Early 2007	Child and Family Court guardian recommended return to father. Referral to CAMHS, consultation to social worker commenced.
5;3	Mid 2007	Father's application for sole care denied. Mother has re-partnered, Freddy's half-sister born. Contact with parents continues.
5;6	Mid 2007	Move to third foster placement
5;10	Early 2008	Move to fourth foster placement, where Freddy remained throughout most of his psychotherapy.
6;7	Late 2008	Psychotherapy assessment
6;9	Early 2009	Intensive psychotherapy commenced
7;9	Early 2010	Freddy's half-brother born.
7;10	Early 2010	Temporary social worker took over case.
8;7	Late 2010	Original social worker resumed case responsibility
8;11	Early 2011	Fourth foster placement ended. Remained in school. Placed temporarily with respite carer. Weekly psychotherapy at school commenced a few months later.
9;7	Late 2011	Moved to residential therapeutic school
9;11	Early 2012	Follow-up visit at residential school.

1.1.1 Early years history

Freddy was born in early 2002, the only child of his mother and father's relationship. He and his parents are white British. Unfortunately, little was documented about his post-natal and early development. He had two older paternal half-brothers, and an older maternal half-sister and half-brother. At the time of his birth, his older maternal half-brother, Jim, 14, lived with Freddy and his parents. Mother was known to have a long history of both mental health and substance misuse problems. His father (Mr F) also had history of both heavy drinking and substance misuse when younger. At 16 months old, Freddy's name was placed on the Local Authority's (LA) Child Protection Register under the category of *Neglect*, due to serious concerns that he had been left for prolonged periods unattended in his cot. There were further concerns that Mr F, who was not supposed to be living at the family home due to violent behavior towards mother, continued to visit, and shortly afterwards he was charged with physically assaulting Freddy's mother, although not in Freddy's presence.

Within months there was another assault by Mr F on mother while Freddy's mother was holding him. The category of *Emotional Abuse* was added to his Child Protection registration. Other reports of physical assault by his father were made by his mother, but were not substantiated. Over the course of the next year, when Freddy was turning three, his father was twice imprisoned for assaulting his mother. Freddy was present during these assaults. Mr F refused to accept responsibility for the assaults, blaming mother because she was looking after Freddy while drinking in a pub. The situation continued to decline, and despite support from social services, concerns increased about Mr F's aggression and mother's ability to provide basic care and ensure Freddy's safety. This was in addition to mother's deteriorating mental health and ongoing substance misuse problems.

1.1.2 Care proceedings

In the months leading up to his fourth birthday**,** Freddy was accommodated by the LA following under an interim care order. Due to father's ongoing assaults on mother, she and Freddy were living in a refuge, but had been asked to leave due to Freddy's

unmanageable behaviour. Freddy was placed in foster care. Mr F nonetheless applied for custody of Freddy. A few months after Freddy's fourth birthday, the Children's LAC Review Panel requested permanent care proceedings be initiated for Freddy, at which time maternal grandmother, and paternal uncle and aunt were considered as carers but ultimately declined due to Freddy's challenging behaviour. It was documented that in his initial foster placement, where he was placed with older children and a young baby, his behaviour was very challenging, including physical aggression aimed at his carers and the staff at his nursery. At one point, he kicked the baby in the head, and was removed after three months to a new placement, but little information was provided about this second placement. He remained in the second placement for 17 months. There were reports in this placement of periods of both sustained settled behaviour, and periods of challenging, particularly aggressive, behaviour.

Permanent care proceedings took place throughout much of 2006, delayed by assessments of father's suitability to take long-term sole care of Freddy. By late 2006 the Local Authority, based on assessments of Mr F's inability to meet Freddy's long term needs, were considering adoption as the care plan Freddy. However, in April 2007 his Guardian recommended Freddy be gradually returned to Mr F's care, and under this direction, support to work towards this plan was put in place. In mid-2007 the plan to return to father was deemed untenable, and a full care order was granted to the LA recommending permanent foster care. Regular twice-weekly contact with Mr F was to be maintained. Contact with his mother, who had a daughter with her new partner, was arranged on a termly basis. (In the time I worked with Freddy, this contact was inconsistent, often cancelled at the last minute, or attended by several people as well as mother, including her partner, his new half-sister and members of mother's partner's family.)

1.1.3 Contact with CAMHS

Freddy was referred to his local CAMHS when he had just turned five. This referral was made by his social worker, a specialist in the LA's looked-after children team. A few months later, his second foster placement ended due to his challenging behaviour - specifically aggression aimed at his carers and their property. He was moved to a placement where he was the only child of two foster carers. Permanent foster care arrangements were being pursued.

CAMHS referral

The CAMHS referral occurred during the assessment of father's ability to look after Freddy long term, as recommended by the Child & Family Court Guardian. His social worker had been working on Freddy's case from the early days of accommodation by the LA, and remained his social worker until the end of his psychotherapy, and beyond. There was a period of approximately eight months when she worked on a different team, and Freddy's temporary social worker (male) became involved, and met with CAMHS on a regular basis.

For approximately 18 months prior to Freddy's assessment for psychotherapy, consultation was provided to his social worker and her colleagues involved in his case. Mr F was not invited into this process due to his refusal to accept responsibility for Freddy's situation. Twelve months before starting intensive psychotherapy in January 2009, Freddy had moved to a fourth placement - a permanent foster care arrangement. These foster carers were a married couple with adult children, and were considered 'difficult behaviour specialists', mainly due to their many years of experiences and extra training. At the time he was their only foster child, and was supposed to remain so. However, six months after intensive psychotherapy started the carers began to foster an older boy of 13. This became a long-term placement.

Following a psychotherapy assessment, long-term intensive psychotherapy was recommended for a minimum of one year, with the likelihood of two years being needed emphasized. Intensive psychotherapy consisted of three 50-minute individual sessions a week. I had just begun my trainee child psychotherapist post and was allo-

cated to work with Freddy. As a trainee child psychotherapist, I was employed to acquire clinical and professional competence in providing psycho-analytical psychotherapy to children and adolescents referred to the CAMHS team, in addition to contributing to generic CAMHS assessments. Overall 'on-site' supervision was provided by a service supervisor in the clinic, with specific case supervision provided one-to-one by Senior Child Psychotherapists at The Tavistock Centre, London.

Freddy's treatment was offered on the basis of on-going termly reviews with foster carers, their support social worker, and Freddy's social worker, the CAMHS case consultant and myself. Weekly support meetings with the case consultant (my service supervisor), who completed the initial psychotherapy assessment with Freddy, was arranged for his foster carers. This consisted mostly of discussions around behaviour management, as requested by the foster carers. While the CAMHS case consultant met Mr F and, occasionally, mother at LAC review meetings, I never met Freddy's parents.

A report provided by his social worker at the time of starting intensive psychotherapy outlined Freddy's needs and history. He was described at the time as quick to pick up on changes in mood, and having trouble differentiating fiction from reality. He became easily scared by some television programs, and had been observed acting out violent scenes in an aggressive way. His concept of fact and fantasy was considered comparable to that of a much younger child. He could be polite and attentive but "likes to have control of his environment and manipulates situations to gain his own way, exhibiting anger and frustration when others do not comply with his wishes". He had the capacity to show warmth to others when in a secure environment. An independent psychiatric report, commissioned early in the care proceeding process, raised the issue of possible attention deficit and hyperactivity disorder (ADHD), but this was not pursued further by Social Services as they seemed to accept CAMHS's view that his early history of maltreatment offered a better explanation for his difficulties.

1.1.4 Education

Freddy was subject to a Statement of Special Education Needs (SEN), which related to his challenging behaviour and delayed development. Throughout his psychotherapy, he attended a specialist school, located 30 minutes' drive from the CAMHS clinic. This facility provided for children with complex learning, behavioural, and emotional needs considered unsuitable for mainstream school. As part of the LAC review, annual reports of development in key areas were sent to CAMHS, and Freddy was considered bright and highly observant, but intellectual assessment revealed global delay. He also had to wear glasses for complex visual deficiencies, and had documented fine motor problems. It was reported that neglect in his early years had been a likely major factor in these issues.

1.1.5 Outline of psychotherapy and pertinent external events

Feedback at termly psychotherapy review meetings reported slow but steady progress in the foster placement. Freddy's relationship with his carers improved, and he seemed slowly learning more about ordinary family life, contributing at home to family activities, such as cooking, and he was responding to boundaries. Feedback I provided to the reviews seemed well received, and helped his carers to understand some of his internal struggles.

About one year after his therapy began, Freddy's mother had another child, a son. In contrast to the interest Freddy expressed for his younger half-sister, he rarely mentioned his half-brother. For example, when a contact with his mother had to be cancelled due to her ill health, Freddy voiced concerns to his foster carers about mother's ability to care for his younger sister, but did not mention his baby brother. Of all his siblings, Freddy was the only one had remained in long-term care; his siblings were either too old for the care system or lived with at least one birth parent.

The temporary change of social worker about 15 months after intensive psychotherapy began seemed to have a significant impact on the system. Freddy's temporary social worker began to express his view that Mr F should be allowed overnight contacts with

his son, which had always been resisted by social services. Their resistance was mostly due to Mr F's refusal to accept responsibility for the role he played in Freddy's situation, and because he could not adequately manage Freddy's challenging behaviour. An independent psychological assessment found that Mr F not only denied any responsibility, but constantly asked Freddy to tell him why he acted the way he did - to "explain his actions".

Mr F began to actively push for overnight contacts, despite reservations expressed by CAMHS and the foster carers. These overnight contacts did not ultimately happen, but a worsening relationship between Mr F and foster carers ensued. Mr F became critical of what he described as their negative view of his ability to parent Freddy, and also described feeling inadequate when Freddy was seen to 'play up' and disobey him when returning to the carers' home after contacts. Freddy began to regularly voice the idea that he would soon have his own room in father's house, and the relationship between Freddy and his foster carers steadily deteriorated.

1.1.6 End of foster placement and follow-up

The foster carers ended the placement, citing Freddy's increasingly challenging and aggressive behaviour as the primary reason. I also sensed an increasing degree of antipathy between Freddy and his foster carer, and the 'final straw' it seems occurred after a psychotherapy session, when Freddy refused to get into the car with his foster carer, and became increasingly physically aggressive to him, and then to me. I had offered to help Freddy at the time but he ran away, essentially around the outskirts of the clinic, but did not leave the premises. I was alarmed when his carer made no efforts to ensure Freddy's safety as he ran around the clinic.

Freddy soon moved to the care of his regular respite carer who he had known for several years. His foster brother, who moved to temporarily live with the foster family, remained permanently in their care after Freddy left. At the time his intensive psychotherapy ended it was possible, after a short break which included the Easter holidays, for Freddy and me to meet once a week at school until such a time permanent care arrangements were made. We met over a five-month period, apart from the school

summer holidays, at this new venue. Despite what must have been the disappointment of another failed placement, Freddy conveyed, what seemed to my mind, the ability to hold on to positive elements of his experience in that placement. On one occasion, Freddy had learned that the CAMHS clinic had just moved to near where his former foster family lived. In a very straightforward manner, he said it would now be easier for his foster carers to get to the clinic - in his mind their appointments at CAMHS continued. I was surprised and heartened to hear he did not seem bitter towards them.

A multi-agency planning meeting attended by Social Services, education, Freddy's respite carer, representatives of a therapeutic residential school being actively considered by the LA and myself in the case consultant's stead revealed something that I believe ensured he went to the residential school. The deputy head at his current school described how fond the staff were of him, but that he had made no education or social progress in the three-plus years he had been there. His CAMHS treating team and his school considered the residential school the best place for him at this stage in his life. The school was led by child psychotherapists, with psychodynamic approaches underlying the therapeutic ethos.

A month before Freddy moved to the therapeutic residential school, I met with his social worker, who had returned as his case manager over a year earlier. It was agreed I could visit Freddy for a one-off follow-up a few months after he had settled in. A write-up of this visit is in *Appendix A*. Freddy moved to the residential school shortly before his 10th birthday. He was eligible to stay until he turned 13, and a few months before his thirteenth birthday I contacted the school to enquire how he was doing. I was informed he had left a year earlier and was doing well in a different foster placement, attending a Steiner day school for children with specific learning needs. His social worker had retired, and I was unable to learn anything further from the LA's social services' care team, apart from an offer that his new social worker would send him my best wishes if deemed appropriate. It was heartening to hear Freddy had an opportunity to live with a foster family again, as I always felt he wanted that.

CHAPTER 2 LITERATURE REVIEW

From reading during my clinical training at the Tavistock Centre and from academic supervision, I found four main areas of most relevance to the research I wanted to undertake.

- The large body of work on therapy with looked-after children, with histories of maltreated, written by child psychotherapists. For research purposes I have included children who have been adopted and also have histories of maltreatment

- Psychoanalytical ideas about shame and humiliation - particularly post-Kleinian thinking in this area

- Psychoanalytical ideas about narcissism, particularly the observation of a 'turning away' from the object to avoid dependence

- The significant research and growing knowledge base on the neurological impact of maltreatment on the developing brain in the context of its growing relevance to clinical practice in work with looked-after children

Review process

1) I initially completed an electronic search of the *Journal of Child Psychotherapy*, (hereafter referred to as *The Journal*) using the terms 'looked-after children", "foster care", "adopted", "deprivation/deprived", "abuse/abused", "neglect", "maltreated/maltreatment" and "domestic violence" in different combinations *via* article title and abstract. A small number of papers related to traumatic early experiences, although not written about looked-after children, were helpful and will be included.

2) I completed the same search process through two further journals, *Journal of Child Psychology and Psychiatry*, and *Clinical Child Psychology and Psychiatry*. I wanted to keep my focus on clinical accounts of work with looked-after children coming

from a psycho-dynamic/analytical viewpoint. I was aware that child psychotherapists have written articles in these journals, but was also interested in finding contributions from other professions of relevance to the area of study. The search was narrowed by specifying 'case studies' as the primary methodology.

3) In order to clarify whether relevant papers had been published in other journals/books, I conducted an additional search with the combination of the criteria as used in 1) above of the following online databases, again using 'case study' to specify the scope of the search.

- PsycINFO
- The PEP Archive
- Psychology and Behavioural Sciences Collection
- Psycarticles
- Psycbooks

4) Reading lists from my clinical training workshops while training at the Tavistock Centre provided relevant sources:

i. The Fostering and Adoption Workshop
ii. The Neuroscience Workshop

5) Initial reading pertaining to post-Kleinian theories of narcissism were recommended in academic supervision, in addition to the reading I was already familiar with from theory seminars during clinical training.

6) Readings on psychoanalytical views of shame were suggested in academic supervision, and a search of "psychoanalysis" and "shame" in combination using the online databases in 3) above was completed.

7) Published doctoral theses, related to psychotherapeutic work with children, available online through the Tavistock Centre library, provided additional sources. These are completed by child psychotherapists during training, or as professional development for more experienced qualified child psychotherapists.

Before reviewing the literature that resulted from the above search process, I will provide a brief overview of looked-after children in the UK, focusing on mental health, education and diagnostic issues. I then outline research findings of the long-term impact of maltreatment, and consider aspects of maltreatment on attachment behaviour.

2.1 Looked-after children

Under the Children Act 1989 a child is considered looked-after if he or she:

- Is provided with accommodation for a continuous period for more than 24 hours;
- Is subject to a care order; or
- Is subject to a placement order.

The Department of Education (DOE) provides an annual overview of looked-after children in England. At 31 March 2015 there were 69,450 children who met the above looked-after child criteria at some point in the preceding 12 months (DOE, 2015a), 75% of whom were in a foster placement. Of the 69,450 children and young people, 42,030 (60%) were looked-after under a care order. In the same period, 31,070 started to be looked-after, and 31,100 ceased to be looked-after. One hundred children were placed in residential schools. Culturally and ethnically, 73% of looked-after children from white British backgrounds, similar to the general population of all children. Children of mixed ethnicity tend to be overrepresented in the looked-after children population, and those of Asian ethnicity tend to be underrepresented.

2.1.1 Education, mental health and diagnosis

The DOE has been collating information on looked-after children since 1992 across a variety of outcomes including health, wellbeing and education. For statistical purposes, the DOE considers a looked-after child as one who has been continuously looked-after for *at least 12 months*.

2.1.1.1 Education

Educational attainment on measures of literacy, numeracy and mathematics are covered in a report for looked-after children in England to the year ending 31 March 2015 (DOE, 2015b). According to this report, two-thirds of looked-after children have an identified special educational need (SEN), and over half of these children have a statement of SEN. This is compared to 15% of the general population. The attainment gap between looked-after and non looked-after children has fallen slightly over recent years, but a very sizeable gap remains. For example, 63% of looked-after children achieved level 2 or above of Key Stage 1 in writing compared to 88% of non-looked after children. Although falling over recent years, school exclusion rates for looked-after children remain very high. Looked-after children are twice as likely as non-looked after children to be permanently excluded, and almost five times more likely to have a fixed-term exclusion.

2.1.1.2 Mental Health

Unlike the educational progress outlined above, DOE data (DOE, 2014) indicate that mental health problems for looked-after children have shown little change over recent years (as captured by the Strengths and Difficulty Questionnaire, SDQ; Goodman, 1997). The SDQ data indicate that just half of looked-after children have what is considered 'normal' emotional and behavioural health, and over one-third of looked-after children have mental health problems that are considered 'cause for concern'. The SDQ is used mostly for screening purposes. The more complex relationship between mental health and maltreatment, in particular, is outlined below.

2.1.1.3 Diagnostic issues

Lindsey (2006a) describes a number of studies that aimed to better understand the mental health needs of children and young people in the general population and the looked-after population in particular. A steady increase in adolescent conduct problems for both boys and girls of all social classes and family types in the preceding 25 years has been observed. Government reports (ONS, 2000; 2005) indicated a 10% increase in general mental health disorders in the 5-16 year old general populations. Another ONS study (2003) showed that 45% of looked-after children up to 17 years of age had at least one diagnosable mental health disorder, with conduct problems, depression, and anxiety the most common. For those looked-after children in residential care, the rate of diagnosable disorders was highest (72% - mostly conduct disorder). The importance of placement permanence is also suggested by the findings, where rates of clinically diagnosable disturbance was 49% for those in the first year of placement, and 31% for those in the fifth year.

In her overview, Lindsey (2006b) writes that a diagnosable disorder can be made for almost 50% of looked-after children. Furthermore, looked-after children with an early history of maltreatment are more likely to have developmental delay, physical health problems such as epilepsy, and speech and language problems. Other studies show that one-third of looked-after children with a significant mental health disorder has contact with a specialist mental health professional (Lindsey, 2006a).

Lindsey (2006b) makes an argument for the usefulness of appropriate diagnoses for looked-after children despite some concern that diagnoses represent unhelpful labelling. Ensuring that provision of appropriate mental and psychological needs are in place to complement educational support is one example of such benefits. DeJong (2010) agrees that psychiatric diagnostic categories are helpful in order to classify for a variety of purposes, particularly to aid in treatment planning. However, De Jong also argues that diagnostic categories capture only one element of the issues at hand for looked-after children. A psychiatric diagnosis results from an assessment that may involve carers, teachers, social workers etc. which may then result in the provision of

tailored interventions within CAMHS for example. However, the diagnosis itself cannot speak to the specific role played by pre-natal experiences such as maternal drug use or the impact of the uterine environment of domestic abuse, versus the impact of direct abuse towards the child in the early months and years of life. In other words, a diagnosis captures part of the picture, but does not explain how the child gets to the point where a diagnosis is applicable. Furthermore, DeJong reminds us that many maltreated children have significant difficulties, sometimes across several developmental domains, but these problems may be at a sub-clinical/sub-diagnostic threshold, and may not meet the criteria to be seen in CAMHS.

2.1.1.4 Long term consequences of childhood maltreatment

The World Health Organisation (WHO, 2002) recognizes five subtypes of child maltreatment: physical, sexual and emotional abuse, neglect and exploitation. More recently, witnessing domestic violence is now a category of maltreatment (Gilbert, Spatz Widom, Browne, Fergusson, Webb and Janson, 2009). Child maltreatment is not a psychiatric diagnosis, but is considered a phenomenon that significantly affects children and young people, and, in particular, increases the risk of psychopathology in later life (Jones, 2008). Early experiences appear to be significantly linked to outcome. For example, compared to children raised by their birth families, children who are adopted in infancy and not subjected to maltreatment have only moderately increased rates of mental health difficulties (Lindsey (2006a). The rates of complex mental problems increase significantly children who are adopted or placed in long-term foster care when older have experienced maltreatment when in their birth family's care. The average age of adoption in the UK is three years and 10 months (Fagan, 2011), and many of these late-adopted children are likely to have experienced at least two to three years of maltreatment prior to adoption.

In one of the recent papers in the *Lancet* journal series on child maltreatment Gilbert, Spatz Widom *et al*. (2009) describe how, in addition to an increased likelihood of poor educational and employment outcomes, mental health outcomes are significantly

poorer for maltreated children compared to non-maltreated children. Specifically, maltreatment increases the risk of behavioural problems, anxiety and depression, and PTSD later in life. Behavioural problems associated with witnessing intimate partner/domestic violence are not as yet confirmed as being independent of other types of maltreatment, but children who suffer one type of maltreatment are often exposed to other forms of maltreatment, and the risk of other forms of maltreatment co-occurring with witnessing intimate partner violence is 30-60%. Gilbert and colleagues go on to highlight the importance of recognising the cumulative effect of different forms of maltreatment, and that there is no point beyond which services for children can be considered hopeless; that every risk factor that can be reduced matters.

Research examining the toll that maltreatment plays on cognitive development has shown that due to cumulative experiences of deprivation and abuse from which there is little hope of escape, children's attachment behaviour and related difficulties are affected in tandem. For example, Zilberstein (2014) outlines difficulties in cognition that impact psycho-biological regulation, particularly at times of stress, leading for example, to confusion about other people's intentions in group or one-to-one situations. Furthermore, cognitive difficulties may impede maltreated children's ability to adequately convey their needs to caregivers, running the risk of an inappropriate response from the caregiver, further compounding the problem. This will, in turn, affect their ability to feel securely attached, and increases the risk of disordered attachments developing (Zilberstein, 2014).

Several factors that appear to increase the risk of childhood maltreatment include factors 'in the child' such as children under three years, children with difficult temperaments, and physical/mental health issues (Jones, 2008). However, the research is not clear on whether vulnerability factors are possible causes or outcomes of maltreatment (Gilbert, Spatz Widom *et al*., 2009). Jones also describes risk factors in parents including substance misuse, poor impulse control, and personality disorder, and highlights how, overall, child maltreatment is more likely to happen in families from socio-economically disadvantaged situations, with poor extended family and community network support.

2.1.1.5 Implications of maltreatment on attachment behaviour

In considering the diagnostic and clinical categories of relational problems maltreated children can exhibit, there are particular disorders of attachment that are relevant to this research study. Bowlby's (1969, 1970, 1980) development of attachment theory emphasized the function of infant attachment behaviour, a biological instinct, as one that ensures the survival of the vulnerable infant. Attachment behaviours promote proximity to a caregiver, which in turn ensures the infant's basic needs are met. When applied to babies and young children, attachment theory also encompasses psychological and emotional needs. As Prior and Glaser (2006) write, secure attachments that result from positive early care experiences and environments are protective factors against later stresses, and the way in which attachment behaviours become organized are determined by the caregiving environment. Thus, disorganized attachment behaviours, marked by the absence of coherent organized strategy for dealing with the stress of separation from the caregiver (Main and Solomon, 1986; 1990), are associated with early childhood histories of maltreatment.

One diagnosis included in the Diagnostic and Statistical Manual fifth edition (DSM-V) that requires early neglect in the early years of life before criteria are satisfied is *reactive attachment disorder* [RAD] (American Psychiatric Association, 2013). Reactive attachment disorder is also listed in the International Classification of Diseases, tenth edition (ICD-10) by the World Health Organisation (WHO, 1992). This diagnosis describes the absence of comfort-seeking behaviour from appropriate adults in distressed children who have been socially neglected and/or have experienced change of carers in the early years of childhood. Less than 10% of children who experience social neglect go on to develop a RAD, which suggests a considerable degree of resilience in some children who are socially neglected and/or experience multiple change of caregiver, at the same time suggesting a degree of vulnerability in those who do develop RAD.

While in the DSM-V 'social neglect' as a term is not well delineated, attachment research has focused on maltreatment including but not limited to neglect, deprivation and exposure to domestic violence (Prior & Glaser, 2006). These authors, in a review of attachment behaviours particularly those that do not follow what has been termed

'organized' patterns, suggest that disorganized attachment styles and RAD may have a greater degree of overlap than is typically thought. For example, some of the behaviours required as part of RAD diagnostic such as lack of attachment/indiscriminate attachment to appropriate figures may actually be a complex form of disorganized attachment which, despite initial appearances, are attachment behaviours nonetheless (Prior & Glaser, 2006).

In relation to my research, I do not wish to argue that a label of RAD is relevant to Freddy's relationship with his caregivers. Although what is known about his early years would meet some of the DSM-V criteria for RAD, he was also observed to be capable of showing warmth when in a secure environment. His relationship with his foster carers, The Ws, was also noted to be improving at the time of his psychotherapy assessment. I would argue, however, that a pattern of disorganized attachment could apply to Freddy. As Prior & Glaser (2006) highlight, research into disorganized attachment behaviour has shown that one correlate of early maltreatment in infancy is coercive controlling behaviour towards adults and peers in middle childhood years. I have wondered about what type of disorganized attachment would best describe Freddy's behaviour but such an endeavour is typically unreliable without opportunity to observe both the infant and caregiver in the home setting, and such opportunities were obviously not available to me. Furthermore, no detailed information about these types of interactions were documented by social services. Moreover, a child psychiatry report completed early in Freddy's care proceedings did not indicate formal attachment disorganization or disorder.

2.1.1.6 Recognition and prevention of childhood maltreatment

Gilbert, Kemp, Thoburn, Sidebotham, Radford, Glaser and MacMillan (2009) draw attention to the significant underestimation of prevalence rates of maltreatment by professionals. They cite a lack of training in detecting possible signs of maltreatment, and perceptions that reporting maltreatment may 'do more harm than good' among reasons for this problem.

In their review of interventions to prevent and respond to childhood maltreatment, MacMillan, Wathen, Barlow, Fergusson, Leventhal and Taussig (2009) outline the potential usefulness of interventions for neglected children, and children who have been exposed to domestic violence. An example of research that shows promise but in need of both replication and further assessment includes mother-child therapy in cases of domestic and intimate partner violence, and child-focused therapy for neglected children. More recently, research into therapy aimed directly at the mother-child relationship has indicated a degree of reparative work can be done in this area (Levendonsky, Bogat, and Huth-Bocks, 2011). In this study, Levendonsy and colleagues argue that therapy aimed at promoting the mother's capacity to understand how her own abusive experiences from her partner before birth make it more difficult to be psychologically available to her young baby can lead to a generally better attachment and relationship between mother and baby once this insight is achieved.

Importantly, MacMillan *et al.* (2009) found that foster care placements may lead to benefits compared to children who remain at home or those who reunify with families from foster care. Additionally, in her overview of mental health needs of looked-after children, Lindsey (2006a) documents that the majority of late-placed children can form satisfactory attachments to new parents/carers despite adverse early life experience.

The issue of childhood resilience highlights the complexity involved in how some children respond and even manage to adapt to adverse environments. The quality of early relationships, and genetic factors have been linked to particular outcomes later in life for children who have been maltreated. For example, Jenkins (2008) highlights that early attachment styles are not only linked to the infant's temperament, but also the parents' mental health, with 'difficult' babies more likely to have less secure attachment styles with their parents. Attachment styles formed in infancy go on to have an impact on the development of subsequent peer friendships in primary school-aged children. Strong friendship groups have been identified as a source of resilience for some maltreated children, thus it may be that being born with an 'easy' temperament can lead to generally positive outcomes, making this a likely source of resilience. Similarly, Caspi, McClay, Moffitt *et al*. (2002) concluded from their research that genetic risk factors play a significant role in adult social adjustment to child physical abuse. Some children are thought to gain a degree a resilience from their genetic make-up.

However, the relative lack of longitudinal studies into childhood resilience makes it difficult to be go beyond mere association to establishing the 'cause and effect', particularly the protective qualities, of what are considered resiliency factors (Jenkins, 2008).

2.2 Psychotherapy with maltreated children

In reviewing this part of the relevant literature, I opted to divide it broadly into themes that have developed overtime from clinical accounts in the Journal and other publications. As will be discussed, early work was drawn together into one volume and subsequent work has developed along broad themes that I have devised for presentation purposes. This review is not intended to convey any agreed-upon categorical distinctions in the literature. A similar review by another author may have resulted in different divisions.

Although not the very beginning of this type of treatment, one is immediately mindful of the collection of accounts of psychotherapy with severely deprived children, edited by Mary Boston and Rolene Szur (Boston and Szur, 1983). This body of work collated the experience of clinicians who attended workshops at the Tavistock Clinic on psychotherapy with this clinical population. These clinical accounts help the reader make sense of the bewildering experiences of treating such patients. Some had already been described in the Journal. In a subsequent format (Boston, Lush and Grainger, 2009), Boston reminds us that maltreated children had previously been considered untreatable with psychotherapy. In bringing together psychotherapists' experiences of providing treatment to some 80 maltreated children, Boston & Szur gave a distinct voice, not only to the psychoanalytical way of understanding the needs of such children, but to the dynamics and technical difficulties inherent in the work. The authors put it best themselves:

> *"The most illuminating aspect of this study has been the vivid and dramatic way in which all these children have managed to convey to their therapists the*

intensely painful emotional experiences they have suffered, in spite of their individually different ways of communicating" (p.8).

Frequently reported themes include *falling*, and *endless evacuation* (into the therapist of chaotic, confused and unwanted feelings) - evacuation in the earliest stages of development being something that has previously been linked to the infant being deprived of a mind to manage his distress and other difficult feelings (O'Shaughnessy, 1981). The poignancy of these children's deprivation can accompany the opportunity that individual therapy affords in facing up to their painful experiences.

2.2.1 Beginnings of child psychotherapy with maltreated children

Earlier writers in the Journal, such as Winnicott (1966), drew explicit attention to the impact of external experiences on the internal world. These ideas relate to how deprivation contributes to the development of what Winnicott called *anti-social tendencies*, both minor and more severe. Winnicott (1966) clarified his stance as following: childhood deprivation is linked to anti-social behaviour later in life, early privation results in personality distortion. Winnicott had also previously described his belief that the child's early environment would determine personality development: the *good enough mother* and the 'true self' versus poor maternal environment increasing the likelihood of a 'false self' development (Winnicott, 1960). The development of the 'false self', a defensive structure primarily aimed at hiding the 'true self', is linked to failures in the early infant-care giver relationship. The infant's needs are not met in a way that promotes normal development because of the lack of a good enough mother whose own needs prevent her capacity to be adequately in tune with those of the baby. Winnicott (1966) went on to emphasize the importance of working in therapy with the history of events/personal history that the child gives, not the external factual history *per se*. In other words one helps the child by helping him get in touch with his feelings of deprivation.

Boston (1967, 1972) stresses her belief that what the child brings to his/her world plays an important part in the manner in which therapy can help. Taking Winnicott's above ideas as a platform to advocate for psychoanalytical treatment with deprived children,

Boston (1967) proposes that through observation and analysis of the therapeutic relationship deductions can be made about the contributions, both by constitutional factors and the patient's previous experience. Knowledge of the patient's actual experience and history assists the therapist to understand both the transference dynamics and defences the patient relies on when encouraged to get in touch with his own deprivation. Boston also warns against the possibility of colluding with the patient in using external difficulties as a means of avoiding his own contributions to them. Put simply, "it is not helpful to allow historical explanations to be used as excuses for present difficulties" (p. 22). Central to this argument is the belief that in ordinary development the child moulds his environment as well as being moulded by it. In order to be helpful, therapy with children who have had very difficult early environments will nonetheless need to show in detail the way in which their internal experience of history still interplays with their present feelings and behaviour, and enable them to modify their attitudes and make a more appropriate adjustment to reality.

Rosenbluth (1970) also argues that in cases of severe deprivation, the deprivation needs to be understood and interpreted in terms of how the child experienced it. For the severely deprived child there is an element of truth in the belief that something fundamental was withheld, and events of the past cannot be undone. However, the psychic reality that develops as a result of maltreatment can be thought about in therapy. Rosenbluth stresses that only internal reality can be influenced in treatment. Some children may hang on to grievances and nourish resentments, whereas others may deny reality and pretend that their early experiences were idyllic. Ultimately, in Rosenbluth's view, the internal situation will determine whether deprivation is experienced as either predominantly persecutory or depressive in manner, making internal reality that which needs to be understood and interpreted.

The subsequent volume of work in the Journal describing psychotherapy with children whose early history is marked by deprivation focuses, for the most part, on the ways in which psychoanalytical psychotherapy can help such children. Included in the work I will go on to review are technical issues, the therapy's reliance on professional networks and the impact therapy has on the therapist. Strong feelings can be provoked, particularly dislike towards the patient when they are projecting the parts of themselves

they want to disavow. However, Symington's (1993) work on narcissism and the turning away from the object that is often precipitated by early trauma at the hands of caregivers, offers a different point of view - one whereby there is more room to allow for deprivation/trauma and personality to be thought of as closely linked. It is helpful but nonetheless challenging to be minded that the traumatic impact of severe deprived which leads to psychopathological development can respond to psychotherapy. However, among all the other work to be done this is hard to keep in mind and usually even harder for the patient to bear. Maltreated children are also placed at a disadvantage because their capacity to develop more genuine feelings (for example empathy, compassion, and altruism) is severely curtailed, making treatment more difficult when their resultant 'unlikeability' frequently interferes (Music, 2009). As Music also writes, the challenge is to keep in mind that abused and neglected children have themselves suffered terribly, while developmental and neuroscientific evidence consistently shows that deficits in pro-social capacities add to an already demanding psychotherapy by virtue of working with children who often have reduced capacity to self-reflect and see another's point of view. Thus, while psychotherapy can provide an opportunity to be in touch with feelings, the enormity of the task for the child cannot be underestimated.

2.2.2 The psychotherapy setting

Work with looked-after children has to begin with the adults in whose care they have been placed. Thus the relevant literature related to the care network will be briefly overviewed first. Subsequently, individual psychotherapy in different settings will be reviewed with its various emphases as expertise has developed over recent decades.

2.2.2.1 The network around the child and professional dynamics

> *"Children come to therapy through adults. It is because adults are worried about a child and have hopes that therapy can help that child and therapist ever meet.....The situation then, when a child's care is shared between local authority social services and parents, brings yet more adults and agendas into the picture"* (Hunter, 2001; p. 22).

As Hunter and others have written, offering treatment to children with histories of early maltreatment who are removed from their families will involve social workers with parental responsibility, or their adoptive parents who for some periods are supported by local authorities. Britton (1983) argued that

> *"Psychotherapeutic process...needs a viable, comprehensible and predictable framework in which it can take place"* (p. 106).

For treatment to have a decent chance of succeeding, the network of people around the child or adolescent will require joint working, support and consultation, and at times educating as to what can be expected when psychotherapy with such children is undertaken (Barrows,1996a; L. Emanuel, 2002). Furthermore, Russell (2011) reflects on the complications when the looked-after child's network is 'at odds' with the therapist's task of attempting to facilitate a thoughtful state of mind and emotional connectedness. In her account of working with a boy with severe learning disabilities, Russell describes repeated efforts to argue the case for continued regular, intensive psychotherapy for her patient, who had several unplanned changes of placement over four years. With varying success in making this case, Russell goes on to describe the negative impact that reduced frequency of sessions had on the therapy, particularly on the level of connectedness and maintenance of therapeutic gains. Russell (2011) concludes that while significant work can be done in therapy for children such as her patient, the work may have been better served by more robust network systems, particularly support aimed at her patient's carers, who, due to his several placement changes, wielded considerable influence over his ability to avail of therapy at any one time.

The stirring up of children, especially adolescents, in residential facilities is linked closely to an understanding of their internal parental couple and families, which are often characterized by high levels of aggression, neglect and perversity (Cregeen, 2008). As Cregeen also argues, staff in such settings are often required to draw on their own capacity to think parentally and make good couple relationships - something arguably akin to the function and challenge of the individual therapist in the consulting room. Moylan (2012) reminds us that facing Oedipal reality is as much a challenge

for an organisation as it is for the individual. When the individual can achieve Oedipal development the rewards include the development of his own personal identity and greater freedom from a world of living in projective identification. But an organisation is more than one individual, and separateness in particular is likely to stir up difficult feelings in an organisation prone to its members feeling rivalrous when differences among the members are not tolerated. An organisation that looks after troubled children is by no means immune to such dynamics; reflected for example in the rivalries between social workers and clinicians in the network which are fed by a reluctance/denial to acknowledge the other has something separate to offer.

The challenges to the network are varied and often intense, and pressure on social workers from colleagues, carers and families can add extra layers of complication to an already demanding psychotherapy. Getting a psychotherapy referral for children in care, clarifying with whom the responsibility for initiating the referral lies and ensuring regular attendance are all factors that impact on the provision of psychotherapy to children with very special attachment needs, and who show little capacity for trust (Lynch, 2000).

More detailed exploration, as follows, of some of the processes inherent to professional and foster/adoptive parental network dynamics helps to understand some of the frequent challenges.

2.2.2.2 Foster Carers

That foster carers are now referred to as such instead of foster *parents* might say something about a reluctance to acknowledge what is really being asked of them. Asked to ‘care for’ as opposed to ‘parent’ children removed from their birth families does not capture the enormity of the task. Those entrusted with looking after a child on a daily basis, one who has historically been subject to neglect, deprivation and abuse are in the face of re-enactment of these early experiences (Boston & Szur, 1983), which can leave them bewildered and in turn frustrated and angry. Moreover, providing looked-after children with good experiences of love and safety is frustratingly not enough to prevent such re-enactment.

Henry (1974) put forward the idea that a severely deprived child's *primary deprivation* results from abusive early neglectful experiences at the hands of primary caregivers. The *secondary deprivation* occurs when the child, as patient, cannot make sufficient use of therapy or other similar intervention due to their reliance on 'crippling defences' to manage the original traumatic deprivation. This *double deprivation* was expanded (Sutton, 1991) to include the notion that the child's rejection of therapy/care leads the therapist and their carers to "switch off", compounding the problem over and again. The result is a *triple deprivation*, and L. Emanuel (2002) exemplifies this dynamic with accounts of difficulties in the provision of psychotherapy to children in care. Emanuel argues that when insufficient attention is paid to the needs of foster carers who look after disturbed and challenging children, attempts to treat a child are likely to fail or be undermined. The therapist him/herself can also be stirred up, resulting in the potential for rivalrous feelings between protection of therapy and security of placement being acted out, ultimately at the potential expense of the placement.

Other accounts of the frustrations that foster carers encounter in their efforts to provide a home to maltreated children also point to the difficulty for these children in accepting what is being offered; partly because of the idealization of the birth family, and partly because of an anxiety that exists about allowing oneself to be "seduced by the good life" with foster carers (Kaplan, 1982). As M.E. Rustin (2006) also writes, children let down by others tend to be mistrustful of their own goodness and terrified of their hatred and destructiveness. Yet at the same time maltreated children's adoptive parents can find themselves at times idealized and other times kept at bay and tested to their limits. What is particularly tested is their capacity to hold on to the child in the face of extreme provocation, and attempts by some children who have experienced sexual abuse, to seduce them. Children with extreme difficult histories may make considerable effort to split parental couples and re-enact abuse in some way. One can see that, as such, some looked-after children with very difficult early starts in life have the most difficulty in taking advantage of what adoptive families seek to provide, and by virtue of their own mistrustful natures, perpetuate rejection and loss.

Children who move from residential to foster care bring a challenge to the child that foster carers are expected to bear. The child's disturbance and challenging behaviour

that was previously meted out to a larger number of staff, is presented in a less diluted form to the foster carers, thus making the experience all the more intense. For example, Cant (2005) describes supporting foster carers who offered a home to girl who had been in residential care for four years prior to moving to foster care aged 13. Their initial fostering experience left them exhausted. While continuing to see the girl for psychotherapy, Cant also helped the fosters carers understand, in separate meetings, aspects of the anxiety the move would likely provoke, and contextualized some of her patient's behaviours and anxieties, giving the placement a decent chance of survival.

2.2.2.3 Social workers and residential carers

Managing the network's anxiety related to the child's behaviour and other concerns forms part of the consultation process prior to any individual psychotherapy being thought about. With this in mind, Rocco-Briggs (2008) warns of the risk for child psychotherapists working with looked-after children becoming isolated from the network, partly due to the task of being expected to:

> *"take the child's difficult feelings away and restore more adequate, acceptable behaviour"* (p. 197).

Existing pressures at the start of the consultation process include guilt on the part of the social worker for not having intervened earlier, or the risk under which the placement is considered and further anxiety created by anticipation of any such breakdown (Rocco-Briggs, 2008). Indeed, the concern for the child's inner experience can often feel the concern solely of the psychotherapist; the network's concerns often differ to a greater or lesser extent.

Painful processes that are often part of a child's experience in therapy can be observed when the network supporting the child gains insight into what a child's early experience may mean to them at a deeper level. In supporting residential staff in a home for children with disabilities, Emanuel (2012) describes how regular group su-

pervision facilitates thinking around the reliance for some children on 'mindless, habitual' behaviour that may at times be a way for the children to cope with their inner world and actual experiences. As a result some staff began to appreciate what they may really mean to such children at a more personal level. This, in turn, stirred up anxieties when the staff no longer 'turned a blind eye' to the children's experiences. Thinking about the actual plight of looked-after children, which includes what they have endured and also try so hard to keep psychologically at bay, is something that residential staff, with the right support, can bring to their work. The ongoing work of the child psychotherapist is to support staff who, once in touch with this insight, can continue to work with children in this new way.

Canham (1998) wrote that children who have been neglected, abused and traumatised use defences against psychic pain on a large scale, and that one of most basic and primitive ways to defend against pain is to subject someone else to it. Children and young people in residential homes will often do so *on a large scale* thus the care team and manager, as Canham also writes, will be confronted by raw emotions from many children sometimes on a daily basis. The staff need support to not defend themselves too greatly against pain. Canham puts it thus: the crux of the matter is that children and young people often identify with and introject the institution they live in and the people who work in it. If they introject an organisation capable of continuing to think about painful issues they are more likely to go on to develop this capacity themselves. Being central to promoting this model of work is an important role the child psychotherapist can play in the consultation process.

2.3 Individual psychotherapy with maltreated children – an overview of psychoanalytical treatment

The relevant literature, broadly speaking, initially speaks to the challenge of working with children who had very disturbed internal worlds, and how re-enactment of real cruelty ran the risk of entering the consulting room. I have chosen to begin with descriptions of this early work, and go on to describe the main specific themes and areas

of work that have emerged from the accounts child psychotherapist as the specialty has developed over recent decades.

There have been many accounts of individual and (usually) long-term work with maltreated children mostly, though not exclusively, in the Journal. When the child is looked-after the treatment will, as discussed above, need to be carefully considered beforehand and supported by the network. A relevant idea, outlined by Youell (2012) partly as an exploration of Hamish Canham's thinking, relates to the challenge looked-after children face if they are given the opportunity to access psychotherapy, and reminds us of an important issue to be borne in mind. When parents' ability to look after the child is called into question, or abuse is suspected, more attention is paid to the efforts the parents are perceived to be making without proper account being taken of the experience of the child. As Youell argues, babies/young children cannot articulate their wishes but as child psychotherapists we can aim to offer an insight into what behaviour actually means. When seen in psychotherapy, the active work of helping the child himself gain a similar type of insight can begin in earnest.

2.3.1 Early thinking about child psychotherapy for maltreated children

Many early papers on this topic give considerable space to thinking about management of disturbance and understanding at a very concrete/physical level, while offering a psychoanalytical approach to deeper conflicts.

The thinking about the suitability of psychotherapy for maltreated children began to take form with accounts of more intensive treatment; once weekly therapy being often considered insufficient to offer the necessary containment required to bring about sustainable shifts towards more trusting and concerned attitudes to others (Boston, 1972). More containment (in Bion's sense) is required and with deprived children the forceful nature of projections is often concretely expressed by throwing objects at the therapist in order to communicate the need to project painful feelings stirred up when treatment becomes more intensive (breaks mean more and absences felt more acutely, etc.). Fury at breaks can be stirred up at the same time as containment fosters a sense that

the therapist can withstand the child's way of communicating his hurt feelings. All the while, worry and even persecutory feelings about dependence on a good therapist continue to fuel difficult behaviour, and it takes considerable time for this to be worked through (Boston, 1972).

Newbolt (1971) offers a detailed account of a severely deprived and neglected girl who began treatment at seven-and-a-half years of age. Although the therapy was ended rather abruptly at the mother's insistence, a happy ending as such can be gleaned from this account as reunion with the birth family was ultimately possible. The provision of space and regularity for this girl, which she used not least to convey her feelings about her deprivation and internal conflicts, allowed her birth mother to gain a more positive view of services that had hitherto 'simply removed her children from her'.

One of the 'add-on' challenges in working with severely deprived children was initially outlined in Gianna Henry's paper, which brought into focus the dynamics that can significantly interfere with the child's capacity to use what is on offer psychoanalytically (Henry, 1974). In addition to the original deprivation over which the patient has no control, a secondary deprivation is derived from internal sources related to the crippling defences and the extremely poor quality of internal objects. In describing her patient, Henry argued such dynamics made 13-year-old Martin an orphan both inwardly and outwardly. While Martin provoked very violent emotions in others he himself appeared to be devoid of feelings. Martin's defence at times to identify with a hard unfeeling brick wall against which he could test out whether or not he was a brick wall spoke to his confusion about what an internal object ought to provide. Rather than an internal source of strength in the face of adversity, the internal object with which he identified, was pre-occupied with itself, unfeeling and ultimately unavailable. Projecting such identifications into the therapist make taking back anything the therapist has to offer all the more difficult - the second level of deprivation Henry proposes. Citing Bion (1959), Henry goes on to say that the patient is allowed an opportunity not previously available - to deploy projective identification in a more ordinary sense, but with this comes a more acute awareness of the poignancy of deprivation, accompanied by associated feelings of resentment. All this too needs containment, and considerable patience from patient and therapist.

2.3.2 Establishing the function of psychotherapy

The provision of the therapy can provoke despair and feelings of worthlessness and uselessness, and if not gathered in and fed back in manageable amounts in the transference interpretations, can add to the child's difficulties. Berse (1980) for example recounts how her patient, a nine-year-old boy, at times used his therapist as a 'drain' for effluent-like projections, understandably unwilling to take these back, however modified they could be by the therapist. The saving grace, as it were, is that Berse's patient at least found a way to make his therapist understand him. Miller (1980) also describes work with a teenage girl, Eileen, not only motherless from birth but also born two months pre-mature and used to an early life behind incubator glass. Not recognising separateness and difference from the therapist gave way to a slow recognition for Eileen that to get help she needed to acknowledge another separate mind, one genuinely interested in her, and thus one to which she could bring things to talk and ultimately think about. Miller also proposes that the provision of a regular therapy time just for this teenage girl whose history had been overly marked by unpredictability and being 'handed around' was in itself a central part of what the treatment could offer.

Other earlier accounts of psychotherapy draw on an understanding of the consequences of very early experiences being inadequately responded to and contained. High (1982) gives an account of a six-year-old girl seen over four years whose therapy in part aimed to bring about change by helping her get in touch with aspects of herself to do with her unintegrated internal state and a painful, disturbed experience of her skin. High's patient, Mary, although fostered from three months of age, had been badly neglected up to that point. Both the impact of a lack of early containment and a resulting reliance on secondary skin defences to defend against the fear of disintegration (Bick, 1968), needed to be examined in the safe predictable space that her psychotherapy provided. Similarly, Fry (1983) advocates the importance of offering a more paced form of psychoanalytical containment as outlined by Alvarez (1983) - containment, communication and conceptualization. Fry describes her use of this process for those patients heavily reliant on projective identification. One expects and knows from experience with very deprived children that they continue to use maladaptive defences as they get older. Alvarez herself also writes that more disturbed children will have difficulty accepting an interpretation that another less disturbed child can take

in more easily or earlier in treatment. For Fry (1983) the linking not only of Alvarez's ideas but that which Winnicott (1956) calls 'primary maternal preoccupation' and lack thereof for many deprived children offers a framework to help children even in once-weekly work. As Winnicott describes it, primary maternal pre-occupation involves a psychological state in an expectant/new mother, whereby the interest in and sensitivity to the child is almost akin to an extreme psychological disturbance, short lived and not necessarily achieved with every child the mother has.

2.4 Specific themes in psychotherapy

The early work, as described above, set the scene for psychotherapy with abused and deprived children to focus on areas including how to manage and at the same time treat an aggressive and ultimately very frightened child in the consulting room. The development of understanding psychic reality, adapting technique, and trying to facilitate the complexities helping children adjust to new families, are all important areas that child psychotherapy has developed over the last 30 years or so.

2.4.1 Managing violence and aggression – a real challenge

Treatment for looked-after children is complex. Hoxter, (1983) argues that long-term work with deprived children shows their pre-occupation with complex experiences related to deprivation, which leaves little space for other things in their lives. At the same time however, for some maltreated children who struggle in their attempts to trust their therapist, there is often little *initial* capacity to think about their inner experiences. Researchers and therapists endeavour to understand why this can be, especially when interpretations are uniformly rejected, ridiculed or worse, felt to be concrete attacks on the child. Barrows (1996a), for example, draws on Freud (1914a) who introduced the 'compulsion to repeat' concept. Barrows suggests that rather than painful aspects of their difficult past being cut off from awareness and continually played out through re-enactment, maltreated children can benefit from support via the addition of insight and understanding offered through interpretation. However, as Barrows advises, a degree

of re-enactment and the therapist being enlisted into some of the child's early relationship experiences is required to allow expression of disturbed object relationships to be properly worked through.

M.E. Rustin (2001) also suggests that some hurts are essentially unbearable, and "threaten your sense of humanity, your sense of being a person" (p. 273). In trying to work therapeutically with maltreated children who are burdened with doubts about their own goodness, capacity to trust, and who may be of a mind that some pain is best left unexamined, one will sometimes get it wrong and be left feeling inadequate, particularly in the face of severe maltreatment. The impact of such work can mean

> *"We are liable to find roused in ourselves defences which are not dissimilar to those of the deprived children"* (Hoxter, 1983; p.126).

A further compounding matter is that as a therapist one often stands for the adult who failed the child, thus the therapeutic task is to be ready to receive the child's angry outbursts to help him better tolerate his own feelings. The child is at times literally behaving towards the therapist as he feels he has been treated by the absent parents and forcing the therapist to experience his insufferable feelings (M.E. Rustin, 2001). When projective identification is extreme it can be particularly difficult to continue to function as a thinking person with the ability to reflect on fast projected feelings rather than act on them. Anna Freud (Freud, 1966) describes this phenomenon as an *Identification with the Aggressor.* Furthermore, Hoxter writes that:

> *"the themes of rejection and counter-rejection have been sharpened to the cruel cutting edge of revenge and counter-revenge"* (Hoxter, 1983: p. 129).

All the more disturbing, as Hoxter argues, is when one's own sadism is aroused in response to these dynamics. When this happens one runs the risk of losing sight of the patient's communication and struggles, instead acting-in in a manner where one can react punitively in response to feeling provoked.

In her descriptions of two deprived and neglected boys in long-term weekly psychotherapy, M.E. Rustin (2001) argues:

"*it takes a lot of guts for such children to begin therapy*" (p. 274).

It is easy, when one feels under attack in the consulting room, to worry about one's own state of mind and even survival at the expense of how anxious the child is when taking the risk in trusting another adult. Rustin further writes that for her deprived patient (Tim) the only way to protect himself from psychological pain was to become the person who inflicted the pain. A further complication is that if he did get hurt in his mind nobody would care about how he is feeling. The combination of these beliefs led to a ferocity and intelligence in defending against feeling vulnerable, linked to worry for his own survival. The challenge is not just managing the aggression that comes with such a state of mind, but also the absence of an ally in the room when trying to explore ways in which other forms of relating could happen. If Tim's aim was to make his therapist feel stupid then one has to bear this kind of re-enactment of humiliation in order to understand the feeling communicated, yet at the same time remain 'firm' enough not be rendered impotent and ineffectual. Little wonder Rustin found herself having to take risks with her usual therapeutic practice, as ordinary interpretations or technique were not enough, timely or appropriate. A need to essentially be creative is required at such times.

Rustin also outlined (M.E. Rustin, 2006) some particular difficulties in personality characteristics that can invade the therapeutic space for looked-after children. The question of how to maintain enough of an analytical stance to allow highly disturbed object relationships to enter the consulting room and thus the transference relationship is further examined by Canham (2004). Particular thought is given to how to work with physically aggressive children who "hit [Canham] in exactly the same parts of the body where they were hurt themselves" (p. 143). For example, in children who have very early experiences of lacking a containing and thoughtful mind, Canham argues that being 'pulled into' the children's internal world, often peopled with perversity and distortion, is not only inevitable but also helpful. While keeping in mind one's psychoanalytical training and the purpose of boundaries, 'acting in' can be one of the best ways to understand that which the child brings to the treatment *vis a vis* the transference.

Both an examination of the transference as it unfolds and noting one's countertransference, which may involve a degree of acting in by the therapist, allow for greater understanding. Canham also reminds us, however, that

> *"it is not possible to sit and examine your countertransference if a child is throwing things or attacking you"* (Canham, 2004; p. 145).

There is a need for a response at these times, and this is when the risk of acting-in heightens. However, Canham also poses the question of how else a child can let an adult know about a truly terrifying feeling that would have accompanied being hit when too young to respond. This serves to remind us that if the therapist can keep his/her head and provide different experience a model for painful emotional states being borne rather than acted upon can be made available to the child.

Further accounts of the nature of the pressure placed on therapists working with maltreated looked-after children offer an understanding of the types of psychic reality that predominate, and render real contact very difficult. Cregeen (2009), for example, describes a defensive structure that relates to the sexual abuse of a 12-year-old male patient, Steven, at the hands of his father. Keeping in mind that the countertransference may convey something the patient is very frightened of having awareness of, Cregeen details an attempt in therapy to tolerate and understand his patient's struggle with a mind that was felt to be totally invaded by his father's perversity and thus remained pre-occupied by phallic, masturbatory relating. Such relating was understood as an identification by Steven with the sexual abuse; an identification with violence and phallic functioning. Phallic functioning is considered to be linked to a restricted mental space and limited development. In contrast, Birksted-Breen (1996) posits that the introjection of the 'penis-as-link' conversely serves to promote mental space and thinking in that it recognizes the full Oedipal situation including the parental relationship. Another way to understand these different modes of relating draws on Hannah Segal's ideas on symbolic equation as opposed to *symbol formation* (Segal, 1957). The development of *symbol formation* also denotes increased capacity for mental space, particularly a move towards tolerating depressive anxieties of separateness and individuation, whereas *symbolic equation* represents the converse, limiting the capacities to think more creatively. In the consulting room, Cregeen describes an

attack on the separateness and creativity of the therapist's mind, coupled with a countertransference in which the therapist comes to feel small, impotent, and despairing. Moreover, the therapist:

"is to know what it feels like to be exposed to intense doubts; doubts regarding one's own emotional capacities and those of one's internal objects, including the possibility for a creative coupling between internal parental objects" (Cregeen, 2009: p. 35).

2.4.2 Internal worlds and psychic reality

With the idea of psychotherapy with maltreated children as both viable and effective firmly established, more recent writers (those writing in the 1990s onwards) have added to the body of knowledge by expanding the therapeutic scope of this type of treatment. For example, Piontelli (1995) stressed the importance of keeping in mind the type of memories that children who effectively lose their birth parents can cling onto as part of a deep-seated memory of very early experiences. Whereas earlier writers (for example Boston and Rosenbluth as documented above in Section 2.2.1) advocate caution about external realities being used as defence against accepting internal truths, subsequent accounts of the interplay between internal worlds and external realities further developed this area. Piontelli (1995) highlights that for some children removed from their birth parents at a very early age, the phenomenon of 'kin recognition' is an important idea to bear in mind. This idea draws on how pre-natal learning about mother's voice, smell and other unique characteristics set attachment in motion before birth. Vestiges of this very early learning can remain throughout life, and Piontelli advocates keeping in mind the interplay of kin recognition phenomena and later phantasies the child can come to develop.

Barrows (1996a) refers to helping maltreated children in their endeavours to develop a coherent sense of their life story. Such coherence, Barrows proposes, depends on the capacity to remain in touch with a shared view of external reality, depending in turn on the existence of a degree of fluidity between internal and external reality. This fluidity, Barrows further proposes, represents an important component of mental health itself. So much so that adults, in their own accounts of relationally difficult childhoods,

are found to have better adjusted relationships to their own children when they can offer a coherent narrative of these childhood experiences, be they positive or negative (Fonagy, Steele, Moran, Steele and Higgit, 1993).

Hodges (1990) also affirms the belief that the internal representations of adopted children and actual experience continue to interplay beyond adoption/placement, and are affected by experience. Treatment for these children needs to support the attachments to the 'new' parents. The task of psychotherapy with a child who no longer lives with their family cannot ignore the original family, as events in the present can throw into prominence troubling aspects of the past, which can allow a new way forward but also runs the risk of creating confusion and distress (M.E. Rustin, 1999). Fonagy and Moran (1991) proposed that to be effective analytical work must enable the child to achieve greater tolerance for previously warded-off mental content and to thus construct a better integrated and more stable self-representation. It is important to bear in mind that for looked-after children:

> *"bad times may erupt in ways which are deeply puzzling, since there is an absence of ordinary family memories which help to make sense of things"* (ME Rustin, 1999; p.61).

To maintain the belief that emotionally deprived children can, when afforded the opportunity in therapy, find an object with good qualities in the transference situation, one has keep alive the hope that somewhere in these children's inner world are traces of hope in such objects (Grunbaum, 1997). However, the defence against such prospects can be extremely difficult to surmount. In cases of severe emotional deprivation resulting from serious neglect, as in the case of an Eastern European orphan adopted to western parents several years later described by Micanzi Ravagli (1999), there is further complication in addressing the internal world due to an apparent total lack of an object to perform any form of containment that is required to begin the much needed work in the first instance. The work needed in the early stages of Micanzi Ragali's patient's treatment was geared towards recovering primary experiences to allow development of an inner world that can only then be examined more fully.

In an account of work on the internal world that had become more quickly established, M.E. Rustin (2009) describes the complexity for an adopted 12-year old girl, who was described as very depressed when initially offered time-limited psychotherapy. Part of her challenge in therapy was to reflect on how hard it was not just to 'tell the truth' in a more conscious manner in the presence of her therapist, but to face the truth that she was, despite contrary attempts, identified with abusive, neglectful parents and that this in turn was impacting on her adjustment and performance at school and with peers. Despite a very difficult start this girl had a wish to be different, and could recognize that some of her feelings towards her therapist were rooted in her mixed feelings towards her birth parents. At the same time she could begin to internally tease these apart, and figure out for herself what was real and what was distorted due to what she had to manage when younger. In describing some of the challenges in facilitating transitional psychotherapy for looked-after children whose care arrangements are likely to change, Wakelyn (2008) outlines how this type of therapy can provide an opportunity to model a boundary between internal and external worlds. The development of such a boundary has in all probability been very difficult for the child to manage due to early experiences in his family of origin. The aim here is for the boundary between the internal and external to become both resilient and permeable over time, eventually allowing both communication and a degree of containment to be internalized.

2.4.3 Oedipal anxieties

Canham (2003) writes about the psychic struggle for looked-after children linked to the Oedipal situation - namely having to internally accept the exclusion from the parental relationship. This acceptance can spur development as it has something to offer the child. As is so often the case for looked-after children, the parental relationship and its difficulties are partly why they are in care, and the child is then faced with the psychic terror of thinking as to why their parents could not/would not look after them, or gave them up for other parents to care for/adopt. It is unsurprising therefore that looked-after children are even more inclined to 'turn a blind eye' to the psychic reality of their creation and ensuing abandonment, especially when others who are not in a position of being placed for adoption/long term care can remain in a state of denial of

their oedipal psychic reality at the expense of more complete personality development (Steiner, 1985).

Bartram (2003) considers the impact of losing birth parents on the ability to negotiate the demands of the Oedipal situation. She has argued that for some children the wound inflicted by such a loss too drastically interferes with this ability, thus the capacity to tolerate a 'third position' is restricted or absent. However, for each child in care there is a different story about why they are in that position and the capacity of some children, with the support of more frequent psychotherapy, to begin to tackle the enormity of what a triadic internal world might look like, involves developments in the capacity to tolerate psychic pain (Jackson, 2004).

For those children who are older when adopted, many actual memories of their birth parents and the experience of being placed for adoption, and interim foster carers *et cetera* can be expected. Often the mix involves a lack of but strong wish for coherence in the child's life story. Green (1990) describes such complexities in her account of one year of psychotherapy with an 11-year old boy, Jack. Jack had been recently adopted, having been fostered by the same family following a period of several years of moving 'to and fro' from other foster carers and a residential home. The birth father was completely unknown to Jack, and his birth mother's ability to sustain any regular contact steadily lessened after he was removed from her, aged three and a half years. Despite this series of disappointments and rejections, Jack was quickly able to communicate his need to work through his losses, and begin an internal search for a father. In the mix too were games that conveyed a strong need to establish defences and ward off anxieties related to attack. The challenge, as Green recounts, is not to react to provocation initially registered in the countertransference, but to keep thinking. The expected feelings of belittlement and inferiority, once withstood, offer opportunities to see beyond the behaviour to the underlying, deeper communication.

Lykins Trevatt (1999) reminds us that 'the therapist should bear in mind the fear of vulnerability that forming trusting relationships might pose for a needy child" (p286). This important process can contribute to an internal movement from disorientation to orientation, and even allow the child and therapist the chance to enjoy the experience of a shared history. The ability to make this shift involves internal movement from

stuckness in a traumatic past towards acknowledgement of the child's own mind that can work differently - essentially engaging in a developmental process. Lykins Trevatt also proposes that the outrage of abuse is literally forced into both the minds and bodies of children. An important idea is that traumatised children do not need to be reminded of the abuse, but need to be 'not reminded' of it, while still using therapy to process some of its effects. A child who has been severely let down in the early years, during which time an ordinary ability to playfully communicate otherwise develops, will need not only to catch up in this regard, but will also have to gain some freedom from a harsh superego. The therapist too may need to be aware of his/her superego lest it prevents a developmental process from becoming an important part of the therapy.

2.4.4 Adapting technique

As mentioned earlier, ME Rustin (2001) described the need to take risks with technique, among other things, in working with a very deprived and difficult to manage boy. Writing about the novel idea of the role of the body as a medium in therapy for abused and deprived children, Lynch (2000) suggests that within the constraints of CAMHS and pressures to provide shorter term therapy for these children, the child psychotherapist is faced with a challenge whereby s/he needs to re-think theory, technique and practice. Drawing on neuro- and psycho-biological thinking, Lynch suggests a way of using bodily thinking to help the child gain greater insight which in turn can help the therapist to

> *"Go behind the trauma to engage at the earliest developmental level at which the child's connectedness was first compromised" (p165).*

This work is done in the face of therapists' tendency to turn away because of the horror of what is believed to have happened to the child, despite a wish to comfort the child. Lynch proposes that grasping an idea or thought psychically has some basis in physical grasping so inherent to early development. This ideas draws on accounts from Alvarez (1992) in *Live Company* where emphasis is placed on accounting for the early mother-baby tactile interaction, playfulness and responses 'at the right distance'. In her work with a six-year-old girl, Gina, Lynch describes how at first responding to non-

verbal communication, the tiniest of gestures (presenting her recently painted nails for brief inspection or allowing her therapist to re-tie her hair) eventually allowed Gina to develop language for experiences, and a greater capacity for objects to take on symbolic value. Lynch concludes her account by surmising that her patient clearly had an impaired capacity to attach, but her capacity for attunement was not lost.

It can be argued that the use of interpretations to bring about changes in the patient's relationship to his/her internal objects help gain more clarity and realistic views of the early family (Reisenberg-Malcolm, 1986). In applying such thinking to work with looked-after children, Kenrick (2005) revisits formulations from Klein and others about the content and timing of interpretations as part of thinking what an interpretation can effect. Kenrick notes over recent decades that there has been a move away from interpretation on part-object level and destructiveness to encompass countertransference and projective identification. However, in adult analysis the stability of the setting and the correctness of interpretation is all. With looked-after children, however, who are often projecting so fiercely while at the same time rendering interpretations useless, the analytical work needs to adapt in response. The liveliness in the room, the use of countertransference and the process of linking transference to the patient's past are all issues that need to be balanced against the risk of making premature links before the emotional experience has become real in the present. Also alluding to *Live Company* (Alvarez, 1992), Kenrick recommends that we keep in mind that very disturbed and damaged children can only manage comments on their play for quite some time until a link, albeit tenuous, can be received without being rejected when it feels too much to bear. Furthermore, the timing of returning projections from therapist to patient in modified form is considered vital, particularly for those children whose early experiences of containment processes have been far more damaging than helpful. Jackson (2004) also reflects on the impact of repeated traumas and suggests that constant re-playing of traumatic memories may not just mindlessness, but a preparatory act for real play at a later stage.

Along similar lines, Gatti (2011) described long-term psychotherapy with a late-adopted boy, and brings attention to the need, as she saw it, for the transference relationship to remain in the background for several years. Gatti argues that early reactivation of traumatic experiences through transference interpretations may not

only have overwhelmed her patient, but keeping neuroscientific findings in mind, Gatti was aware of her patient's poor capacity to cognitively structure his experiences. Similarly, in working with a young adolescent boy with a history of severe sexual abuse Briggs (2015) argues in favour of the process of 'psychoanalytical witnessing', needs to take precedence in earlier stages of therapy. This process is not about interpretation or seeking to symbolize traumatic experience through the therapeutic relationship. Instead, the traumatic memories, so often bodily-based when abuse happens in early childhood, needs another to bear witness to its various expressions, often done in the countertransference, before the transference itself is examined. Then the lengthy work of understanding the impact the real world has had, and the patient's interaction with elements of the real world, can be better understood.

In incorporating 'real world' considerations into psychotherapy, Hindle (2000) also reminds us of both the importance and challenge of the end of sessions and term holiday breaks providing repeated reminders of earlier real losses and deprivations at the same time as opportunities to try to work these through. For looked-after children what may be phantasy about abandonment for some, is based very much in reality. In describing an unusual, and particularly challenging, way of adapting usual technique in child psychotherapy, Klauber (1991) outlines how, for reasons of necessity related to both staffing issues and serious risk of the adoption of a 10-year old girl failing, she began work with family members together with the patient, and continued to see her patient in ongoing individual therapy. Apart from the challenges of maintaining boundaries of the patient's pre-existing therapy in the family work, Klauber suggests that her patient possibly benefited from experiencing a forum where the projections she felt she had to live with were witnessed by another. She could go also on to individuate some of her own early experiences of deprivation, and her feelings towards her adoptive family. Klauber also suggests that the family felt some of their struggles were understood, and hostility on both sides could be more openly acknowledged and thought about.

2.4.5 Facilitating new attachments

The difficulty for the older adopted child or those in permanent foster care with many prior changes of placements is often one of being unable to 'let go' of the early years of trauma or preventing it from contaminating or even seriously jeopardizing a permanent placement. For example, M.E. Rustin (1999) writes of a 'mental overcrowding' that can occur when children are in the difficult position of adapting to internally incorporating their new family, at the same time as trying to manage their internal relationship to their birth family. More specifically, internalized object relationships and attachment styles that result directly from early, maltreatment place internal demands for loyalty to that way of relating - relating marked by a swing between internal states of omnipotence to sudden feelings of helplessness (Fagan, 2011). Also in the mix are the fundamental issue related to the adopted/permanently fostered child's pre-occupations about who their birth parents were, what were they like, and 'why did they give me up'? (Hodges, 1984). The crux of this very complex situation for any child to manage, has been put as follows: "It is clearly crucial that the child accept the adoptive family" (Hodges, 1990). In her therapeutic work, Hodges encountered a girl who resorted to a type of magical defensive thinking which obviated the need to accept reality because in her conjured-up mind, she was still with her birth mother who had merely temporarily gone away. A child can be adopted, but equally important for some is the stage at which the child adopts the new family, without idealization and frees himself from self-blame (Kernberg, 1985).

Exploring observations of resistance to late adoption and facilitation of new attachments and relationships to adoptive parents, Hopkins (2000) proposes that disorganized attachment patterns wherein *all* experiences in infancy that strongly activate attachment behaviour without terminating it will result in disorganization of attachment systems. This means a broader range of caregiver behaviours have in common the violation of the attachment system's inherent expectation of protection and security. These behaviours evoke intense fear accompanied by anger and frustration at the parent - crystallized in that which Main (1995) terms 'fright without solution', and akin, as Hopkins argues, to Bion's idea of 'nameless dread' (Bion, 1962a). Helping the child to overcome the pervasive internal dynamic associated with 'fright without solution' is particularly pertinent to late-adopted children. Hopkins's clinical account of working

through anti-relating styles of attachment involves an externalizing of all the negative emotions linked, in the child's mind, to attachment types more through words than enactment. Her patient could then discover that alternative attachment possibilities are less threatening than he had expected.

Along similar lines, Edwards (2000) outlined the importance of helping her 6-year-old patient, Gary, in experiencing the 'gradual disillusionment' of the belief that the infant creates the needed breast (Winnicott, 1971). For Gary, the gradual nature of disillusionment was superseded instead by a primary disillusion and internal catastrophe that needed to be addressed. Without gradual disillusionment, some maltreated children can go through life being re-traumatized by ordinary events, something even dedicated adoptive parents and foster carers can unwittingly set in train. When children are re-traumatized by some kind of repetition of early negative events, a vicious circle is set up as their responses (usually extreme and behavioural in nature) often lead to another sudden change in placement, cementing feelings of rejection, worthlessness, and being unlovable. Underlying such difficulties, as highlighted by Hindle (2000), is the continuous internal struggle of managing expectations of an unpredictable and unreliable object, which further confounds any attempts to support internal rapprochement. Such rapprochement includes both longing for and resentment of identification with external parents who cause the child's external situation.

Kenrick (2000) argues that some children with several moves from family to family can, indeed often need to, be helped in therapy to manage these transitions. The therapist at these times is the child's main secure base, and the challenge is partly to manage anxieties, often related to the child's level of neediness and/or rage that consistently pushes others away. Case (2005) also advocates for the need for working with the child to prevent psychological trauma. The psychological situation for Case's patient was one where she felt she was an 'inside baby' not yet out of the womb and thus born into the external world. Case uses Rey (1975), whose image of a marsupial baby being physically but not yet psychologically born, as an illustrative example.

The aim in such psychotherapies described in this section can be thought of as ways in which one attachment can facilitate another (Hopkins, 2000), ultimately not allowing the past to always determine or shape the future.

2.5 Children in therapeutic communities

Cant (2002) makes an argument for the provision of psychotherapy as part of a more 'joined-up' type, particularly with reference to children in therapeutic communities, where psychotherapy forms part of the overall therapeutic experience. Cant sets out a clear argument for the child to be helped in mind and in body, securely, reliably and consistently. The psychotherapist is well placed to, among other things, support the residential staff in being mindful, managing and responding to the tendency for disturbed children who are:

> "*terrifyingly adept at using any small chink in the therapeutic provision an opportunity to project destructive aspects of themselves, and to create potential disintegration of the containment that staff seek to put around them*" (p. 269).

Cant, in her description of individual therapy illustrates its place as part of a joined-up endeavour, where transference to the whole community is collectively thought about by staff at the same time as distinct respect being afforded to the therapy, the therapeutic space and the constant work done to protect boundaries of all types.

Given the usual aim of therapeutic communities is for the children to move on, when ready, to supported foster placements, there are many children for whom that hope can seem slimmer once a more realistic assessment of their inner world and object relatedness is better understood. Cant (2005) describes one such patient, who having done a lot of working through needed to put her past behind her, not necessarily as a means of denial to make herself acceptable but also in service of a 'need to be able to forget' (Alvarez, 1992).

2.6 Contact

At this point some thoughts on contact with birth families are relevant, particularly in relation to the impact it has on the child and the therapy. M.E. Rustin (1999) writes that although there are expectations for looked-after children to have contact with the

birth parents as a necessary part of their care arrangements, the quality of the early experience is paramount for those who may have lived with a marked sense of helplessness in the face of severe abuse and cruelty from parents. Contact can re-ignite such helpless feelings, interrupting progress in both placement and therapy. Loxterkamp (2009) makes his views clearer when he argues that despite the prevailing view that contact is in looked-after children's interest in the longer term if not immediately, even contact that appears to be going well can cause emotional and psychological damage. Loxterkamp further defines his concerns in arguing that 'openness' as part of the contact process is a misnomer, as the reality of what was done to some children at the hands of their parents is evaded, resulting in 'systematic concealment' and 'misrepresentation' in the lives of these children and their new families.

Based on a review of best practice and research into contact for adopted and permanently fostered children, Frontline (2015) bring attention to some of the salient factors to be borne in mind when considering the potential benefits and possible disadvantages to looked-after children when contact with the birth parents is being considered. Factors associated with likely beneficial contact include children who are placed in care as infants, positive childhood memories and absence of major behavioural or mental health problems. Conversely, factors linked to difficult or detrimental contact include the child having negative memories, having witnessed domestic violence and/or having significant mental health and/or behavioural problems. Factors in birth parents that are likely to lead to difficulties in contact include unreliability and repeated lateness, denying causing harm to the child, and showing no remorse/regret. The Frontline (2015) publication also highlights the importance of keeping in mind that contact is a dynamic process, to be adapted as the child gets older and his needs in relation to contact with his family of origin change.

2.7 Narcissism, shame and humiliation - their interplay, and link to the maltreated child

In thinking about the needs of maltreated children and the understanding one attempts to gather from direct therapeutic contact, narcissism and shame, as areas of research within adult psychoanalysis, offer similarities that help to further one's understanding. The most obvious similarities appear to lie in the defensive manner of avoiding deeper connection that is germane to both.

2.7.1 Does a good experience create envy?

With the above review of psychotherapy with maltreated children in mind, the phenomenon of a narcissistic way of relating seems highly pertinent for the patient if only as a way to prevent further rejection, loss and ensuing pain. Added to the complication is that in an internal world predominated by narcissistic object relations where any dependence on an object and its possible helpfulness/goodness facilitated by psychotherapy will invoke a reaction whereby envy of the object and antipathy towards it get stirred up. Clinical caution and prudence will be necessary when a deprived child gets more in contact with what he has been denied and all the associated rage and pain will need to be worked through.

2.7.2 Initial ideas on narcissism

Early thinking on narcissism outlined by Freud concluded that the narcissistic state was a primary condition - the ego turned to itself for libidinal cathexis moving toward object cathexis later on (Freud, 1914b). Klein (1955) did not agree, and argued that object relatedness exists from birth but as a result of excessive projective identification to manage paranoid schizoid anxiety, the unwanted parts of the self are projected into and reside within the object, obviating the need to recognize the object as separate and thus something to be valued or needed. Freud (1914b) also developed the *ego-ideal* as an internal mechanism to account for the subject both letting go of itself as an

object to which it cathects but also having something of itself to which it can remain connected - to hold onto something of the time when the object was its own ideal. For Chasseguet-Smirgel (1984) this makes the *ego-ideal* a spontaneous creation. It is another route to genitally achieve a type of incestuous fusion that was once experienced pre-genitally in the primary narcissistic state of eternal fusion with the mother which implied no separation - no 'other' to be loved/needed as all needs are met from within. Again, Klein's view of an *ego-ideal* relates to her thinking about idealization of an object that is imbued with goodness as a way to manage persecutory anxiety derived from a fear of reprisal from spilt-off bad objects. Excessive identification with an *ego-ideal* obviates the need for another object thus narcissistic object relations are triggered. For Klein an *ego-ideal* pertains to narcissistic defence mechanisms that follow object relatedness, for Freud narcissism precedes object relations.

2.7.2.1 Clinical accounts of narcissism in the analytical setting

In describing his work with narcissistic patients, Rosenfeld (1964) disagreed with Freud's view about the lack of a transference from the narcissistic patient towards the analyst. Instead, Rosenfeld emphasized the nature of the transference as marked by defence mechanisms strewn with denials of separateness, confusion between object and self, phantasies of omnipotence, and guilt about primitive destructive aggression that needs to be kept out of consciousness. The separateness of the object successfully denied, the ego is not at risk of experiencing envy, as the object has no qualities worth envying that the ego does not now possess. In other words, introjective identification has successfully obviated the risk of envy and any psychic pain that would ensue. While analysis has been offered to such patients, the course of treatment is usually very challenging, and as Sohn (1988) writes, the need for the analyst to provide a containing function in the face of entrenched, almost immutable defences, cannot be acknowledged lest it invite the envy such defences are partly engineered to block. Rosenfeld (1971) describes it succinctly; narcissistic defences have a very powerful effect in preventing dependent object relations in keeping external objects permanently devalued. This devaluing/belittling quality resonates with accounts from those who worked with maltreated and deprived children – it becomes the children's way of managing their internal reality.

2.7.3 Understanding destructiveness and aggression in child psychotherapy

A related idea has been explored in clinical work with children who experience marked difficulties in the development of a capacity to make mental links, particularly emotional links between different parts of the personality, and thus engage in ordinary relationships. Maiello (2000) argues that some destructive and/or violent behaviour can result from envious attacks on the capacity for linking. Bion (1959) had previously formulated his view that for some disturbed (mostly psychotic) patients murderous attacks resulted from extreme, envious feelings stirred up when the internal parental object's creativity is witnessed, a creativity the self can feel painfully excluded from. The resulting envy leads to attacks on links between self and object, parts of the object itself, and objects generated by the pair. As Maiello suggests, aggression and destructive behaviour seen in some disturbed children can result from these types of processes. However, for some children there may be situations where traumatic early experiences could lead to a more passive breakdown in the capacity to make emotional links. Here, attempts to make connections to the object that can underlie some types of aggressive behaviour do not exist. Object relations are devoid of attempts to make contact, resulting instead in 'mindless' violence and destructiveness. Maiello (2000) goes on to argue that this type of mental functioning closely corresponds to Bion's -H, (Bion, 1962b), a form of hatred that has lost its object and instead become incomprehensible and destructive. Along similar lines, Alvarez (1998) also incorporates Bion's ideas about *maternal reverie* and *alpha function*. Bion (1962a) argued that maternal reverie, the capacity of the maternal mind to receive her baby's projections and transform them into something he can take back in a more digestible/comprehensible form, constitutes alpha function. Alvarez draws attention to how understanding difficulties in making emotional links can be understood as a projection by the infant (or patient) of his own lack of alpha function. It is a capacity the very young infant lacks but should ordinarily go on to develop. But, as Alvarez (1998) argues, attacks on emotional linking may not always be about destructive attacks but could be a communication about something the infant or patient lacks and thus needs help to develop.

2.7.4 Narcissism and trauma

The impact of trauma on personality and psychological development is varied, depending not only on the age of the child at the time of the trauma, but also on the degree of caregiver support available (R. Emanuel, 1996). That caregivers can, and in most circumstances do, play a protective role when children experience trauma, highlights that babies and infants in their inherent state of helplessness and dependence need to make use of their relational state of existence to prosper and develop. But the complication in those situations whereby caregivers are the inflictors of trauma can create a dynamic wherein relating becomes hated and separateness is denied (Symington, 1993). This also means, Symington argues, that a relationship between parts of the self can be avoided so that unwanted parts of the self are not known.

Symington (1993) goes on to outline his view that an unconscious choice is made early on - to move towards object relatedness by choosing the *lifegiver*, or turning back towards the self, resulting in narcissism. In describing the *lifegiver* as a psychic object located in relation to a breast, penis, the self, or a therapist, Symington advises that it has no existence apart from them. Movement away from the *lifegiver* option also involves developing other, essentially pathological ways of managing any attempts of what is kept at bay from coming to the fore. Relationally, this makes psychotherapy very challenging, especially when there is a preponderance of pushing away the infant self that has been badly treated, opting instead to behave badly to others. In the treatment situation, projecting unwanted parts of the self into the *lifegiver* therapist is not only necessary for the patient to avoid these parts becoming conscious and thus thinkable, but it is a way for the therapist to get some sense of what the patient is so fervently pushing away. One is reminded of Canham (2003) when he wrote about both the risks and benefits of the therapist, to a degree, acting into some of what the child projects when internally managing persecutory anxiety. If allowed, the therapist can then help the patient to gain insight, bearing in mind that all psychic growth, as Symington (1993) reminds us, involves pain.

2.7.5 Shame and Narcissism

It is useful at this point to clarify the difference between shame and guilt. Shame, within psychoanalytical theory, incorporates ideas that separate it from guilt in important ways - guilt is often understood in terms of some contravention of the limits of what's 'acceptable' that has been put in place by the super-ego; a conflict the ego needs to manage. Shame, on the other hand, has been developed along lines of not living up to the *Ego-ideal,* and more to do with internal inadequacy arising from what one *cannot* do.

In understanding shame along a development line which follows on from depressive guilt, Wollheim (1984) argues that there is a realization that the object which the individual hates is the same as the object he once loved comes to be paralleled by the realization that he/she who now loves the object is the same person who once hated it. For Wollheim, this triggers an emotional reaction linked to how the individual has failed to live up to internal prescriptions - shame. Wollheim also argues that shame is closely linked to the internal phenomenon of a disparaging or reproving regard, unlike guilt, which lies in the voice, the spoken command or rebuke. Similarly, in proposing that Superego factors can be both negative and positive in the development of self-esteem and self-regard, Kernberg (1975) differentiated processes whereby realistic criticisms from the Superego when there is a sense of contravention exist alongside something more positive when the *Ego ideal* has been lived up to. Here, Kernberg's view of the *Ego-ideal* is one that incorporates into a superego structure, and although Shame as a construct is not specifically delineated, the capacity to develop self-esteem and positive self-regard is clearly linked to intra-psychic processes point to protective functions of the *Ego ideal*. Kernberg also highlights that the absence of the development of possible self-regard/self-esteem and over-dependence on external sources of love admiration and love can develop, which can be bring about yet another layer of complication in the treatment setting for some patients. Additionally, the loss of a love object and other difficulties including, but not limited to, failure to live up to the ego ideal may trigger a move away from libidinal investment in objects towards over investment of libidinal instincts in the self, a central argument in Kernberg's thinking of difficulties in narcissism.

There has been an established interest in shame and narcissism within the ego psychology school of psychoanalysis that helps to see where mental states of shame can easily co-exist with narcissistic object relatedness. Of importance here too is Scheff (1994), whose thesis on shame in social settings outlines its importance as a survival function. Namely, the infant from an early age has an innate capacity to experience shame, which in turn links to his/her sense of connectedness to the group it relies on for survival. Shame is experienced when connectedness is not. Humans are interdependent not just because of a need to be fed and kept physically safe, but because social interaction and healthy neurological development are so intricately linked. The infant needs others socially and emotionally, but where narcissistic relatedness comes to dominate, the infant's internal world throws up a barrier to accessing the much needed connectedness.

In developing her theory of shame, Rizzuto (1991) stresses the role in shame of conflictual relationships among fantasies, both conscious and unconscious. Such fantasies that illustrate the theory can become powerful motivating factors in psychic life, such as narcissistic concerns that connect to Oedipal issues, namely 'Am I worth loving?'.

> *"In ordinary life, the unacknowledged friendly greeting elicits shame or its defence, narcissistic rage, or both"* (Rizzuto, 1991, p. 302).

In the normal course of events such powerful fantasies that can cause shame undergo repression to allow ordinary development to proceed. But of course, looked-after children do not, by virtue of both their internal and external reality outlined above, have the 'luxury' of straightforward repression. Instead, they grapple with these very complex, emotive and painful internal situations and even in therapy are very frightened at examining these arenas of psychic life (M.E. Rustin, 2001).

In his overview of shame, Mollon (2002) draws together theories influenced by Kohut (1971) and Winnicott (1967). Mollon sets an important tone of the role of what the infant sees of himself in the mother's face - the mirroring in mother's face that the baby internalizes as part of the development of the self, and the devastation that can ensue

if nothing is reflected, precipitating early feelings of shame. Furthermore, Mollon highlights how strong feelings of shame can be routed in the psychic challenge inherent to the struggle between separation and individuation. Namely, the infant develops a capacity as he grows to conform internally/unconsciously to what the preferences of the other are. An early pre-Oedipal dyadic configuration is manageable as the infant can conform to that which he believes the mother's wishes are, for example, for the infant to remain an extension of herself. But without a capacity to negotiate the triadic space that should follow, the young child will not follow his own developmental initiatives. This can sometimes be a fulfilment of the mother's grandiosity, and for some a 'false self' that develops as a result of the infant's own development initiative being eschewed which in itself can be an expression of the mother's narcissism via an air of superiority shown to others later on. This idea echoes Chasseguet-Smirgel (1985), whose theory on understanding narcissism also places the pull towards an illusory pre-genital union between infant and mother that avoids (what should go on to be) genital identification with the father as central to disturbance that contributes to narcissistic relatedness.

Narcissistic trauma can also follow from the unconscious realization that the dyadic union is based on illusion and falsehood as the child of either sex does not possess what the third (father) possesses (Mollon, 2002). To protect oneself from intense feelings of shame associated with any expression of one's natural exhibitionism or desire, an air of superiority is needed but must be relinquished, when bearable, in the analytical setting in order for the 'true self' to be thought about. However, the 'true self', when observable, is likely to engender even stronger feelings of shame as truth about the self is not welcome. We are reminded of post Kleinian theories of narcissism here, but the origin and purpose of superiority in these patients is understood differently.

There are also other lines of thinking relating to narcissism that place shame more central to the phenomenon. Broucek (1982, 1991) argues that the origin of a defensive system reliant on the 'grandiose self' to ward off feelings of inadequacy in the relationship between self and object, where the *ideal-self* makes the actual self feel inadequate, is driven not by envy but by shameful feelings. Thus shame is a major contributing factor to narcissistic problems. A further difference is that the grandiose *ideal-self* (as a form of defence expressed through narcissism), develops later than it is

argued in post-Kleinian thinking (often referred to as the *omnipotent self*). In Broucek's view, objective self-awareness is required before any discrepancies between the actual self and the *ideal-self* can be observed, thought about, and if needed defended against by calling to arms a grandiose idealized self to ward off the shame that the discrepancy could trigger. Tension that can exist between the grandiose idealized self and the more ordinary actual self, particularly when the two may come closer (a possible aim of psychoanalysis, for example) can lead to narcissistic processes strengthening to prevent objective self-awareness (Broucek, 1982). Therefore, objective self-awareness is a more sophisticated and developmentally later process than early infantile splitting fuelled by unmanageable anxiety as described by Klein (1946). There is also a degree of overlap between objective self-awareness which, according to Broucek (1982) involves an awareness of oneself as an object of observation for others, and what Britton (1989) proposes. Britton argues that the infant's ego has to manage anxiety stirred up by being excluded from a relationship between internal parental couple figures, but at the same time being observed by this couple. Again, these Oedipal processes linked to Kleinian theory are thought to begin much earlier in life than the objective self-awareness Broucek describes.

Whether one subscribes to shame or envy as the motivating factor engendering defences, placing object relations central to understanding narcissism is especially useful as it can at least be brought into the transference for attempts at treatment and understanding (Alvarez, 2012), the difficulties in this type of work as highlighted above notwithstanding.

2.8 The impact of maltreatment on neurodevelopment

Research incorporating the so-called 'decade of the brain' in the 1990s (Schore, 2001) leaves little doubt that infant brain development both before and after birth is enormously sensitive to the immediate environment, particularly the quality of care the infant receives. The very same sensitivity that allows such rapid growth in response to predictable and nurturing experience also makes the developing infant (and his brain) vulnerable to adverse experiences (Perry, 2002). So much so that children who have

been maltreated are often at a distinct disadvantage as they are much more prone to interpret ambiguous or even benign events as threatening (Perry, Pollard, Blakely, Baker, and Vigilante, 1995). The tendency to react in a maladaptive manner can further perpetuate the child's problems with emotional development, leading to a vicious circle of abuse and dysfunction.

Twenty years ago, neuroscientists put forward ideas suggesting that children who consistently experience trauma can develop a range of relatively static behavioural responses as they grow up. The idea where 'states become traits' has gained considerable traction, especially as it is generally accepted that the infant brain seeks to create some internal representation of the external world (Perry, 1997). The research spearheaded by the 'decade of the brain' tells of a brain that at birth is ripe for stimulation, and its eventual shape and form relies heavily on the immediate environment – as Music (2010) puts it, the infant brain is 'wired to relate'. The neurological underpinnings for this complex process will be outlined next.

2.8.1 Early neurological development

The human brain consists of approximately 100 billion neurons (brain cells) (Perry, 2002; Glaser, 2003). A neuron communicates directly on average with 10,000 neurons via dendrites, which are branch-like extensions (Music, 2010). Chemicals, known as neurotransmitters, cross from the dendrite of one neuron to the dendrites (among other parts) of another. The area of chemical crossing of transmitters from one neuron to another is called a synapse. This crossing of neurotransmitters is the mechanism of information sharing, and is essentially the firing of the brain's cells which enables the brain to do its job - allowing us to breath, move, talk, and see (Glaser, 2003).

The brain develops in a genetically pre-determined sequence throughout gestation. By the time an infant is born, the vast majority of neurons will be in place continue to develop throughout childhood into early adulthood (Gerhardt, 2004). Those neurons that receive enough stimulation will survive into adulthood. Those that do not will wither and die (Perry, 2002). The stimulation required to promote neuronal strengthening and thus survival is complex, and often depends on the richness of the early

environment. The sequence of brain development proceeds from lower to higher brain centres, which is linked to human evolution as our species evolved (Music, 2010). Through evolution, our brains became more sophisticated, culminating in the development of the cortex, which houses the parts of the brain that control many sophisticated psychological and cognitive processes, including logical thought and reasoning, complex memory ability and most language and emotional abilities (Glaser, 2003). The 'older' parts (in evolutionary terms) of the human brain such as the brain stem develop first. These older parts of the brain (referred to as 'reptilian') are the most metabolically active at birth (Gerhardt, 2004), reflecting the need for the basic life support mechanisms such as the respiratory and nervous systems, which are neurologically underpinned by the brain stem and related areas, to be in place at birth.

As humans evolved, a survival mechanism for women carrying babies while they had to actively avoid becoming prey to larger animals resulted in children being born earlier to allow for the woman to be immobile through pregnancy for the least amount of time possible. This resulted in babies being born before their brains were fully developed (Glaser, 2003). Gerhard (2004) has also suggested that an advantage of this could be to help the infant's brain to develop in response to his/her early environment, which is only feasible with a brain that is not already hard-wired at birth.

The human brain continues to develop quite considerably after birth, with most postnatal growth occurring in the first four years, the highest rate being in the first year (Glaser, 2003). The reason for this postnatal growth is the very large, sequential proliferation and over-production of synapses (synaptogenesis) in the brain. As there is an overproduction of synapses in the young brain, some will have to be 'pruned' back due to lack of use. Therefore, the human brain seems to evolve to cater for a huge range of possible synapses, some of which survive, some of which will wither away.

There is a complex process by which some synapses continue to exist and become strengthened, and those that go unused die off. As Glaser (2003) tells us, it is environmental input, which includes sensory input and interaction between the primary carers and the infant, which determines which synapses will live. Furthermore, the overproduction of synapses is found especially in regions of the brain that have been genetically programmed to anticipate and respond to experiences which are part of

the expected environment of the infant. These experiences include sensory input, the handling of young infants, responsive gaze by the parent, and sensitive responsiveness to the infant's attachment behaviour.

There are certain aspects of the brain's development that are dependent on certain experiences. As Pally (2000) has written, there appear to be sensitive periods in brain development during which for certain functions to develop particular types of stimulation need to occur. For example, it is considered a general principle that for normal perceptual capacity to develop, the sensory cortex must receive very specific kinds of stimulation within a 'sensitive period' (Glaser, 2000). More precise wiring, particularly in relation to sophisticated functions, requires stimulation from postnatal sensory experiences. This is a process that has both benefits and disadvantages for the maturing infant's brain. It highlights the importance of what the neuroscientific evidence can tell us about the relationship between early experiences and emotional development.

Perry (2002) has posited a model of early brain development (neurodevelopment) that seeks to emphasize the activity-dependent nature of neurodevelopment. The newborn's neural systems are quite undifferentiated, and are dependent upon sets of environmental and micro-environmental cues such as neurotransmitters, cellular adhesion molecules and amino acids, in order for them to appropriately organize and develop from their undifferentiated immature forms. A lack or disruption of these critical cues can alter the neurodevelopmental process of differentiation, migration and synaptogenesis. Should any of these outcomes occur, there can be seriously diminished functional capabilities in the specific neural system where development has been disrupted. In terms of what this means for the developing brain, and thus the developing infant and child, there are two factors worth considering. First, neurodevelopmental sensitivity allows the infant's brain to acquire new skills at an astonishing rate, especially when one thinks of the rate of development in the time it takes the utterly helpless newborn to become a walking, explorative, socially engaged toddler – often only 12 months. But such sensitivity and capacity come at a cost, and this will be explored next.

2.8.2 Consequences of inadequate or deprived early environments

Citing Siegal, Music (2010) reminds us that psychological health has increasingly been understood in terms of a complex interdependence between brain areas, and that conversely for many diagnosed with psychological/psychiatric illnesses a less complex or interwoven pattern of links between brain areas is evident. Additionally, childhood abuse and exposure to violence can lead to numerous differences in the structure and physiology of the human brain that affect many areas of functioning and behaviours (Perry & Pollard, 1998). Research into the neurological impact of specific areas of childhood maltreatment is outlined in the following sections.

2.8.3 The impact of maltreatment on neurological development

The developing brain is exceptionally delicate, yet evolution has equipped it with various defences to deal with the significant trauma that is birth. For example, the skull bones of the new born are not fixed and are able to slide over one another to a sufficient degree to allow the relatively large infant's head to pass through the birth canal (Eliot, 1999). However, research has increasingly shown that the brain is far less resilient to some of the traumas that it experiences after birth.

2.8.4 Neglect

There have been startling findings from research into the neurological impact of neglect on the infant's brain. The effects of a neglectful early environment can be pernicious. Perry (2002) has reported that an extreme lack of stimulation can result in fewer neuronal pathways being formed in the developing brain. As a result, infants who have experienced extreme neglect have been noted to have significantly smaller brain circumferences than control children at three years of age. Furthermore, Chunagi *et al*. (2001) used of functional magnetic resonance imaging imagery (MRI), to demonstrate significantly decreased metabolic activity in various brain parts, including the orbito-frontal cortex, the amygdala, and parts of the hippocampus in children who were

raised in Romanian Orphanages compared to control groups. It is known that stimulation is needed for parts of the prefrontal cortex, particularly the orbito-frontal cortex to develop (Pally, 2000). The orbito-frontal cortex plays an important part in mediating social responsiveness (Gerhardt, 2004), and without the arousal states that ensue sensitive, interactive care-giving, this region of the brain will not develop properly. However, there have been studies that remind us that those children who were in Romanian orphanages but adopted by 18 months of age recover well, with positive follow-ups documented in later childhood (Music, 2010). Nonetheless, it seems that for those children who are deprived of stimulation and interaction, particularly beyond infancy, their brains risk a degree of underdevelopment, and for these children a failure to thrive is reflected neurologically.

2.8.5 Emotional, sexual, and physical abuse

Research into the impact of experiencing or witnessing abuse and violence has been concerned with some of the neurological changes that are known to co-occur in such cases. In a review of the literature in this area Anda *et al.* (2006) highlight the role of particular brain structures that are activated in infants and young children exposed to violence and aggression. Substantial research has focused on the stress response that children develop when faced with abusive caregivers in their environments. The hypo-thalamic pituitary axis (HPA) plays a critical role in the stress response of children and adults. Whilst this HPA-mediated stress response is integral in promoting appropriate survival behaviours in response to acute stressors, chronic and repeated activation of the stress response has been shown to have detrimental effects, particularly for the developing brain. One such result is that the hippocampus, one of the few parts of the brain that is able to grow new neurons into adulthood, is prevented from doing so (Read et al., 2001).

2.8.6 Exposure to domestic violence

Considered to be a form of emotional abuse (Tsavoussis, Stanislaw, Stoicea, and Papdimos, 2014), prolonged exposure to domestic violence results in the highest incidence of post-traumatic stress disorder (PTSD) for maltreated children (Delima and Timpani, 2011). Childhood PTSD symptoms include flashbacks, persistent avoidance of stimuli associated with traumatic events, irritability, anger, hyper-vigilance, and concentration problems (APA, 2013). Children who have prolonged exposure to domestic violence show particular brain structure abnormalities, especially decreased cerebellar volume (Delima & Timpani, 2011). Brain physiology and the development of normal neural connectivity have also been shown to be negatively affected (Delima & Timpani, 2011). Moreover, cortical changes linked to exposure to domestic violence can impair the ability to executive functioning capacities such as making judgments and understanding consequences. Other particular serious consequences include poor academic outcomes, problems with language and communication, lack of inhibition and inattention (Tsavoussis *et al.*, 2014).

2.8.7 Hormones

One particularly corrosive process thought to occur in abused children is the over-secretion of cortisol - a result of the over-activation of the HPA axis, as noted above. Such over-secretion is known to have an almost 'rotting' effect on the developing brain, particularly the hippocampus (Pally 2000). The hippocampus plays an important role in human memory, and the processing of memories from childhood experiences (Gerhardt, 2004; Music, 2010).

In contrast to the oversupply of cortisol, reduced levels of another hormone, oxytocin, are thought to also mediate some of the negative effects of neglect (Music, 2010). Oxytocin is linked to many positive feelings including love and trust. It can have specific benefits such as lowering social fear and by bolstering the immune system it can be a buffer against stress (Music, 2010). Oxytocin plays an important role in the 'pairing bond' nature we humans have and rely on in early development (Music, 2010). Importantly, compared to children from intact families, Romanian orphans who were

subsequently adopted did not release Oxytocin when cuddled by their adoptive mothers, pointing to one possible neurological impairment neglected children are left with in developing secure attachments.

2.8.8 Maternal depression

Increasingly, attention has been given the impact of maternal depression on the infant's developing brain. There is some evidence suggestive of differential development of brains of infants of depressed mothers, compared to non-depressed mothers. Davidson (1994; c.f. Glaser, 2003) has suggested that exposure of the young child to particular affective interactions could lead to enduring structural changes in pre-frontal areas of the brain.

An asymmetry has been noted in the electro-encephalograph (EEG) readings of infants and young children of depressed compared to non-depressed mothers. As Glaser goes on to suggest, infants of depressed mothers have been shown to exhibit (as measured by EEG) hyperactivity in the right frontal lobe, and relatively decreased activity in the left frontal lobe areas of the brain. It is thought that positive emotion regulation is sub-served by the left frontal lobe, and negative emotional regulation subserved by the right frontal lobe. Evidence suggests that children of depressed mothers become distressed through experiences such as a lack of attunement and intrusive behavior (Murray and Cooper, 1997). These experiences are thought to be linked to an increased activity in right hemispheric frontal areas of the young brain, with a relative lack of activity observed in the left frontal lobe (Schore, 2001). As Glaser (2003) writes, infants are thought to be particularly vulnerable to these effects between six and 18 months, and prolonged experiences of lack of attunement and intrusive maternal/parental behaviour can cause long-term structural change to frontal areas of the brain.

Neurologically, the imbalance resulting from an underuse of the left frontal lobe along with overuse of the right frontal lobe, promotes a bias towards processing of negative emotions. An added complication is that neglect and trauma cannot only lead to an over-use of right hemisphere functions in managing emotions, but can also lead to

poor communication between the two hemispheres via the corpus collosum. The reduced communication via the corpus callosum, leads to its underdevelopment and places the individual at further risk of more pronounced mental health problems in later life (Music, 2010).

2.9 The neurological impact of childhood maltreatment on emotional development

Increasingly, attention has focused on what adverse experiences can mean for the child as he grows, and the difficulties that can arise for those who try to help him. We understand that those children who experience fear, rejection and unpredictability more than love, acceptance and stability will have significant problems relating to others in a way that helps them to form supportive relationships. Child psychotherapists have for many years appreciated that these children often unwittingly perpetuate relationship difficulties as a result of their early adverse experiences. Neuroscience is now turning its attention to finding neural substrates for these complex problems.

2.9.1 When ‘states’ become ‘traits’

Over 20 years ago, Bruce Perry and his colleagues (Perry *et al*., 1995) suggested that the impact of traumatic experiences on the young brain could result in a relatively static range of behavioural responses as the child grew up. As Perry and colleagues argue, trauma is an experience that is internalized by the young brain. It is the brain that mediates all emotional (and cognitive and physical) experiences. As the brain is so receptive to experiences, and therefore vulnerable to traumatic experiences, understanding the relationship between trauma and neurodevelopment is key to understanding the maltreated child.

The infant’s brain seeks to create some internal representation of the external world (information). This process depends on the intensity of neuronal activity produced by sensing, processing, and storing signals, which, in turn, creates a pattern of neuronal

activity. The more this pattern is activated through input from the environment, the more likely the behavioural response that is associated with this pattern is used by the child. In this way a child will develop a particular response to repeated input from his environment. If the input in question is tantamount to a traumatic experience, for example a caregiver who is rejecting of an infant's cries of distress, or an adult who humiliates or degrades him, the infant's brain will develop a pattern of responding that is strengthened every time the traumatic experience occurs. As discussed above, the complex role of the HPA in managing stress is known to be compromised in those who repeatedly experience trauma when very young. This could effectively prevent the brain from protecting itself from stress. The brain, therefore, becomes used to reacting as though stress were 'normal' and to be expected. To the brain, and therefore the child to some extent, the idea of normality is one where stress is always high – danger is to be expected (Perry, 1997).

A further review of research in this area has documented physiological differences in the parts of the brain of abused children that are central to the function of the HPA axis (Teicher, 2002). When compared to control groups, abused children were shown to have significantly smaller hippocampi and amygdalae, particularly on the left side. The amygdala is known to play a crucial role in the emotional processing of memories, and is therefore particularly vulnerable in abused, traumatised children (Teicher, 2002; Gerhardt, 2004). The consequences for the child can be profound. Perry *et al*. (1995) argue that as the brain will naturally sensitize to traumatic experience, less and less stimulation is needed overtime to elicit a particular behavioural response. This can leave abused children at a distinct disadvantage. Essentially, these children will interpret ambiguous or even benign events as threatening, which is unsurprising if many formative interactions with carers and other adults have been threatening. Therefore such children, as they grow, need not be faced with an actual traumatic experience to react in a way that would suggest they were in actual danger. A slightly raised voice, a sudden loud noise, or a confusing social event might be enough to cause the child's brain to initiate a 'fight/flight/freeze' response, thus react in a maladaptive manner. The tendency to react in a maladaptive manner can further perpetuate the child's problems with emotional development, leading, for some children, to a vicious circle of abuse and dysfunction.

Perry and colleagues (Perry *et al*., 1995) have postulated that children develop particular ways of coping with traumatic experiences, and these ways of coping are mediated by the child's age. Essentially, the older the child is when he experiences severe and/or persistent abuse or trauma, the more likely he is to react with a "hyperarousal response" (fight/flight), which is marked by constant hyper-vigilance, anxiety and hyperactivity (Perry, 1997). Younger children and girls are more likely to develop a 'freeze' response to persistent trauma and abuse, which can become a more marked dissociative trait over time. Dissociative responses are marked by withdrawal, and over time by non-compliance with adult requests. Indeed, babies and infants can do little to get away from abuse, so dissociating at such times is entirely understandable. Furthermore, the relevant literature often reports adult female survivors of abuse as being more likely to suffer from dissociative personality disorder problems (Teicher 2002). One need not think too hard about the further emotional difficulties that such responses cause. Hyperactive children often exasperate adults, as indeed do non-compliant withdrawn children, often leading to sanctions, further frustration and ultimately further shame on the child's part. This can then reinforce the belief of poor self-worth and an internalized 'bad child' who must have done something to deserve this treatment.

2.9.2 The specific application of neuroscientific findings to psychotherapeutic practice

R. Emanuel (2004) describes a piece of clinical work that illustrates the point in hand with a clinical vignette. The vignette demonstrates a thwarting of emotional development in a child who did not have largely safe and predictable early relationships.

In his description of his work with an 11-year old boy called Michael, Emanuel tells us that Michael often displayed aggressive behaviour towards him. Emanuel believed this was part of Michael's need to 'test out' his therapist, as if to gauge how he (Emmanuel) would react to the boy's aggressive side. At one stage, the boy visibly injures his therapist, and the feelings that well up inside Michael are so overwhelming that he can't continue with the session. Emanuel goes on to describe how Michael seemed to have trouble remembering this incident. He posited that, of the two major types of

neurobiological substrates that underpin human memory, Michael was relying on the one that is more automatic, and does not allow for more rational processing of a event or feeling that is triggered in memory. Michael was, as Emanuel postulates, relying on implicit memory, which is largely unconscious. Michael's brain was possibly affected by the deleterious effects of an over-secretion of cortisol known to frequently occur in childhood abuse victims, with subsequent impairments to the hippocampus. He was thus unable to utilize the cortical memory processing system, which allows for rational processing of memories. Instead, Michael's brain was reliant on the memory processing system mediated by the amygdala, which allows for emotional processing of memories only. Therefore, it may have seemed to Michael that he was actually in the room with an abusive adult when his fears and particular emotional memories came back to him. Michael was in touch with the feelings from a time when adults would have mistreated him if he had hit them. The neurological damage caused by years of abuse as a young child made it much more difficult for Michael to discern between a frightening overwhelming feeling and an interaction with an adult who was trying to help him.

Divino & Moore (2010) outline ways in which they have integrated neurobiological findings into psychotherapy training and practice. Even in the classroom/lecturing setting, trainees are encouraged to keep their frontal lobes active in order to maintain reflective capacities when discussing trauma-related session material. The purpose is to avoid the likelihood of traumatic material triggering unconscious emotional responses that can block thought.

In their account of incorporating knowledge of *mirror neurons* into training approaches, we are reminded of the neurological underpinnings of the complex process through which nonverbal communication of affect can occur. Mirror neurons are activated in the brain when one is simply observing another performing an action - the same part of observer's brain is firing as the person doing the action, and it has since been established that this is the case for emotions and intentions, so much so that it may be the neurophysiological basis for empathy. Furthermore, research has also shown that one can experience emotions of another by observing facial expression, hearing vocal intentions or watching body language. We know from findings by Shore (2001), among others, that the non-verbal right hemisphere dominates in the first few years of

life. The subsequent engagement of left hemisphere allows more conscious verbal expression and emotional processing. If this left-hemisphere development is, however, prevented by abuse, the therapist in session will need to be especially mindful of abused patients' reliance on non-verbal communication and payment of close attention to body language, tone of voice etc. (Divino & Moore, 2010).

These ideas are reiterated by Alvarez (2012) in her writings about three levels of psychoanalytical work with disturbed children. Ostensibly, Alvarez draws parallels between the first level of insight with left hemispheric function, and second, more primary levels of understanding such as containment, empathy and attunement, with right hemispheric function. Alvarez ponders on the possible neurological substrates of the third level of psychoanalytical work she describes - the type that insists on meaning, or to 'vitalize'. What neuroscience has to offer in understanding this type of process remains to be seen.

CHAPTER 3 METHODOLOGY

This chapter is divided into sections as follows:

1. An outline of psychoanalytical research

2. Research in child psychotherapy

3. Grounded Theory
   Grounded theory in child psychotherapy

4. Ethical considerations and approval

5. Data
   Session selection

6. Outline of developments in thoughts of the clinical case and about material

3.1 Psychoanalytical research

In a review of research in psychoanalysis, Wallerstein and Sampson (1971) argued that the contribution by the study of individual cases has been far greater than the contribution of more formal research itself. Wallerstein & Sampson also argued that with this method, comes "a truly extraordinary range of insights into the structure of the mind, the organization of mental illness, forces at work in the treatment situation, the process of change, and the requirements of technique' (p. 12). However, as a method of research, psychoanalysis is not without its detractors, with some describing psychoanalysis as a 'pseudo-science' (Popper, 1963) or 'failed science' (Grunbaum, 1993). Against these criticisms, M.J. Rustin (2007) emphasizes that in attempting to understand its principal source of observational data - the 'clinical fact' - psychoanalysis will have distinctive and unusual features as a form systematic enquiry.

In one of a series of papers in a special issue of the *International Journal of Psychoanalysis,* Tuckett (1994) stressed that perceived methodological problems, particularly its over-subjectivity, are far less unique to psychoanalysis than is sometimes supposed. Furthermore, Tuckett argues, an observation in any situation in any field of enquiry is something of a matter of social convention. M.J. Rustin (2007) also emphasizes the importance of questioning the view that critics of psychoanalysis purport, namely that methods of investigation and proof in all scientific activity are uniform and invariant, regardless of the object of enquiry. This latter point in particular leaves considerable space for other forms of robust research into psychoanalytical therapy not just to be given a fair hearing but acknowledges the variety of forms potential scientific enquiry.

3.2 Research in child psychotherapy

Child psychotherapy could be expected to be in a similar position in relation to reliance on single case studies to develop a knowledge base (Midgely, 2006). For example, in a review of psychotherapy with maltreated children using both external measures and therapists' review of their single cases grouped together, Boston, Lush & Grainger (2009) show the ways in which this treatment can lead to both internal and external changes for the patients. They also recognize that at present this type of research would not be included in National Institute for Health and Clinical Excellence (NICE) in the UK. This is partly because of the preference for research designs using randomized control trials (RCTs), whereby comparisons are made between one form of treatment group to other treatment groups / a 'treatment as usual' group, with significantly larger sample sizes.

In establishing what child psychotherapy offers as a form of mental health treatment, there is increased impetus to 'prove' child psychotherapy's contribution from an empirical point of view, and any lack of development in this area runs the risk of jeopardizing the survival of this way of working (Fonagy, 2009). Fonagy (2003) had previously argued that attempts by psychoanalysis to offer an alternative epistemology to that of

scientific research puts it in an 'inferior position', and thus the need for empirical research is vital.

Comprehensive reviews into child and adolescent psychotherapy's application to mental health conditions have indicated its applicability as an appropriate and effective treatment for depression, eating disorders, disruptive disorders, psychological disturbance in maltreated children, and anxiety (Midgley and Kennedy, 2011). However, limited sample sizes and lack of comparative control groups, among other factors, limit the number of studies that met inclusion criteria as part of this review. These authors also remind us that the evidence base for psychodynamic therapies with adults has made significant gains in recent years (Shedler, 2010), but child psychotherapy has yet to respond in similar ways. Nonetheless, a study outlining the helpfulness of psychotherapy for adolescents with severe depression and employing the usually required application of RCTs, indicates exciting prospects for child psychotherapy for complex mental illness (Trowell *et al*. 2007). A large-scale study, aimed at establishing the outcome of both cognitive and time-limited psychoanalytical therapy in adolescents is now underway, and again will afford psychotherapy the opportunity to demonstrate its usefulness in treating complex mental health problems (M.E. Rustin, 2009). This IMPACT study (Improving Mood; Promoting Access to Collaborative Treatment) meets the standards presently required for inclusion in NIHCE guidelines.

There are, at the same time, arguments in favour of using the mainstay features of child psychotherapy practice as a research tool to further understanding of children's inner worlds and mental functioning. As detailed by Midgley (2006), Freud argued that each patient's treatment allows the clinician (as researcher) to learn and develop theory and to further clinical understanding. Fonagy and Moran (1993) have also suggested that psychoanalysis is in a position to provide unique information/data otherwise not available outside of the long-term intense setting in which such treatment takes place and thought about in the single case study approach.

The single case study subsequently fell out of favour in sociological and psychological scientific research endeavours but has, as Midgley (2006) also writes, enjoyed something of a comeback, longstanding criticisms notwithstanding. However, three main criticisms that Midgley draws our particular attention to are:

The data problem: whereby basic observations or data used in the case study are unreliable.

The data analysis problem: the ways in which data/observations used as part of the case study lack validity and do not allow assessment of the truth or accuracy of a particular hypothesis.

The generalizability problem: regardless of how the data lend themselves to analysis or validity, the findings derived from a case study are ultimately of limited value as they cannot be generalized outside of the case study in question.

Despite the above concerns, proponents of the way in which psychoanalytical practitioners work stress the importance of holding on to this way of working as a research and knowledge gathering enterprise. For example, MJ Rustin (2003) urges that we do not lose sight of how the primary source of clinical understanding has been and will remain the method of the consulting room. Rustin also reminds us that there is an 'orderly accumulation' and development of psychoanalytical knowledge through practitioners spelling out, comparing, linking and discussing their discoveries of single cases, from which broader kinds of mental phenomena can be generalized. Rustin (2007) later argued that similarities can be drawn between psychoanalysis and other forms of knowledge generation in human sciences, and sought to align psychoanalytical methods of investigation with biological and social sciences. He also proposed that:

> *"its presupposition of the reality of an 'unconscious' dimension of mental life gives it a further necessary particularity*" (p. 173).

Philps (2009) draws attention to keeping in mind that case studies are a unique resource in mapping and better understanding clinical phenomena integral to child psychotherapy when case study material is subjected to appropriate scientific investigation. Philps herself used material from two single case studies of looked-after children to exemplify how standardized measures of object relatedness, in addition to developing her own qualitative measure of data derived from case notes, can yield findings

not otherwise available for consideration, particularly in relation to a child's ability to process both their earlier experiences and experiences within new families.

Given the arguments that have been made in favour of the applicability and usefulness of single case studies in furthering understanding and research, it is also useful to note that some of the specific criticisms levelled at the use of the single case study approach were also addressed by Midgley (2006). For example, Midgley argues that generalizability is not always the aim of case study research but such research can in itself point others in the direction of what is possible. Furthermore, the assumption that quantitative research, which often averages-out findings, best represents the clinical group under study can be misleading by virtue of the fact that important individual differences are often lost in large scale statistical analyses. Statistical inference, therefore, is in itself not immune to research methodological problems.

In emphasising the usefulness single case studies and ways in which the design can advance understanding of what takes place in psychoanalytical psychotherapy, Fonagy & Moran (1993) also stress the importance of both objectivity between the researcher and the clinical material s/he is attempting to study, and the researcher collecting other sources of material as part of undertaking qualitative research.

3.3 Grounded Theory

Grounded theory, a systematic method of qualitative research in social science, was developed by Glaser and Strauss (1967) in their investigation of the ways in which staff in hospitals in the US broached the subject of death with terminally ill patients. This novel way of developing theories from bottom-up data analysis was fundamentally different from the usual deduction of testable hypothesis from existing theories. It has been used in psychoanalytical research where it has often been applied to extensive clinical records to gain more understanding (e.g. Anderson, 2006). In further development of the theory, Charmaz (2006) describes the process of grounded theory as involving the researcher being:

> *"open to what is happening in the studied scene….so that we might learn about our research participants' lives*" (p. 3).

Charmaz goes on to say that grounded theorists start with data, and by studying data one can begin to separate, sort and synthesize these data through qualitative coding. Coding occurs when labels are attached to segments of data that depict what each segment is about. Additionally, coding distills and sorts data, and gives us a handle for making comparisons with other data segments. The method of *constant comparison* between codes is central to grounded theory (Charmaz, 2006). An important process, *saturation*, occurs when the coding process effectively exhausts the data, where the data has nothing left to yield, and analysis is complete.

A potentially vexing issue in the application of grounded theory to psychoanalytical research is whether the researcher is able to apply this methodology in its purest form, i.e. the ability to evaluate data without *a priori* ideas or hypotheses influencing any conclusions drawn. It has been conceded that this is very difficult to do, and Glaser (1978) has argued that researchers are likely to use their background experiences that contribute to forming questions about the data to hand. Glaser recommends the researcher avoid reading too much background literature in attempting to code material, but acknowledges that one's training will sensitize the researcher before data analysis begins. Anderson (2006) expresses confidence in the psychoanalytical researcher's ability to stand back and survey material "with a mind open to new possibilities" (p. 334). Arguably, there are echoes of what Bion (1970) proposed, namely the suspension of memory and desire in approaching clinical work, and the challenge this incurs needs to be borne in mind in considering findings generated from such research.

In gathering different types of information it is possible to sort data into different levels, and then apply the process of *triangulation* (Denzin, 1970) to the data. Through triangulation, gathered evidence can be validated from different viewpoints and sources allowing for a more thorough consideration of data than the sole use of session notes.

Three levels of data that can be used in gathering together data from psychoanalytical work with children (Anderson, 2006) include:

Primary data

Reports from other agencies involved with looked-after children, such as social workers, educators, foster carers and other healthcare providers.

Secondary data

Accounts of clinical material written immediately after therapy sessions.
Exploration of these sessions with supervision at the time.
Review of these sessions with other supervisors (academic supervisors).
One's own reflections on the material some time afterwards.

Tertiary data

Grounded theory methods of developing codes and categories.

3.3.1 Grounded Theory in child psychotherapy

In discussing the application of grounded theory to developing the knowledge base within child psychotherapy, M.J. Rustin (2016) draws on arguments from Anderson (2006), whereby the degree of similarity between the usual clinically-based methods of line-by-line session analysis and reflection in supervision and the grounded theory method is emphasized. In grounded theory the process of returning to session data, enriched with supervisor's comments and 'after the fact' thoughts, can allow for a deeper understanding of data, adding to any existing understanding of causal happenings within the process of therapy. M.J. Rustin also advises that the broad body of, for example Freudian to Kleinian on to Bionian understanding and theory, has come from case studies, as have developments of other now central tenets of psychotherapy with looked-after children; namely the appreciation of what can be learned from both transference and counter-transference phenomena. M.J. Rustin (2009) also argues that while being used in the above way, grounded theory at the same time holds theoretical pre-conceptions at a distance. Just thinking of the literature review section above, one is reminded of the relevance of psychoanalytical understanding of the inner world of maltreated children, which has been developed from single case studies; not designed to be merely copied and applied to all other looked-after children that

child psychotherapists encounter, but to add to possible understandings of each child's difficulties and internal situation.

3.4 Data

The data used in this research project consisted of material mostly used for my professional development, and apart from providing anonymized case details, nothing else used appeared in Freddy's NHS file.

The primary challenge was to decide which sessions would best lend themselves to analysis, and provide the best opportunity to learn from the material more than a year after treatment ended. I shall first outline the ethical considerations and process of securing appropriate approval.

3.5 Ethical considerations and approval

In using material from a clinical case that bridged NHS and Local Authority (LA) Social Services, permission to use material was sought from the Research and Ethics Committee of my employing NHS trust as a first step. The use of almost entirely non-clinical training material (supervision notes) was highlighted. This email approval correspondence is contained in *Appendix B*, confirming I did not need to formally apply for local R&D approval. As a student at the Tavistock Centre and UEL, I was eligible to apply for UEL ethical approval as part of research protocol procedures agreed between the University of East London (UEL) and M80/North West London local research ethics committee (LREC - *Appendix C*). This form was duly signed and submitted but was not fully processed at the time, and I have since been unable to clarify why the application was not submitted as part of the grouping of similar research types at that stage. At the time of following this up, I was advised of the likely retrospective granting of ethical approval, as stated in the letter contained in *Appendix D,* with advice to be prepared to explain why I had not submitted through standard channels.

The UEL ethical guidelines for devising consent forms for those parental consent, in this instance Freddy's social workers, were followed. As Freddy had been subject to a full care order for several years, parental responsibility decisions were taken by the LA. In approaching LA social services, I initially communicated with Freddy's social worker who indicated, with her team manager approval, her support for the research project. A copy of information sheet and signed consent form for both Freddy's social worker, and her team manager, are provided in *Appendix E.*

3.6 Session selection

In terms of session material, there were just over 270 sessions written-up in varying amounts of detail. All sessions were re-read in the first instance. Some initial themes were identified but codes were not generated at this stage. Although Freddy's continued once a week at his school for five months in the time between his foster placement breakdown and moving to the therapeutic residential school, I have not used session notes from this period for analysis with Grounded Theory for two principal reasons.

First, I was very aware that Freddy needed to hold onto his defences to manage a difficult and uncertain time in his life, and trying to offer psychotherapy as it had been in the CAMHS clinic could potentially have been unhelpful for him given the degree of uncertainty he faced.

Second, the frequency and venue had changed and waiting a week between sessions was new to us both. I felt that he and I maintaining contact without thinking about what was going on for him internally was adequate at that point in his life. Both my supervisor and the CAMHS case consultant agreed with this idea.

For these reasons I did not consider the session notes from the last five months on a par with the write-ups of two years and three months of intensive psychotherapy in terms of providing data. However, I will go on to reflect on some of my observations from the last five months of therapy in the Discussion chapter.

Sessions brought for supervision on a weekly basis were generally more detailed, but not exclusively used as part of the initial generation of codes. In the process of initially re-reading all sessions for start of finish of the treatment, I considered a number that had not been brought to supervision as useful in exploring further.

Early in the process of *post facto* writing up of the research project, encouragement was given during academic supervision to develop session notes to include thoughts I had in mind that I was able to speak to at this stage, but had not written up at that point. These extra thoughts/ideas had nonetheless been discussed in clinical supervision but were not explicit part of the write-ups. The suggestion was to allow such initially unwritten thoughts to be included in order to enrich the data source from which codes, categories and ultimately themes could be drawn and developed. Thus, initial code generation was derived from sessions that had different viewpoints:

- session material written at the time
- thoughts at the time not written down but discussed in supervision
- thoughts that came to mind in re-reading the sessions for research
- ideas from clinical supervision
- *post facto* academic supervision

To develop initial codes, by which I mean codes generated from material consisting of small sections about of a sentence each, with columns relating to the sources of data highlighted above, I chose sessions near breaks. I started with six write-ups that were just either side of breaks in the therapy, and spread throughout the course of intensive treatment. I refer to these as 'near break' sessions. I felt early on that I would learn more about the therapy from sessions of this type, mostly because it seemed that the difficult feelings stirred-up would be more telling in terms of the main therapeutic processes and internal world dynamics that needed to be understood. Most of the sessions were quite vivid in my memory, and some stood out on re-reading as good sessions to start with. An example (excerpt) of a coded 'near-break' sessions is given in *Appendix F.*

On generating a list of codes from these 'near break' sessions, I then wanted to establish if the data would yield anything further. This was particularly in relation to dynamics occurring in 'mid-term' sessions, when the term's therapy had been proceeding for three to four weeks, and was not approaching a break. In coding 'mid-term' sessions I wanted to establish if the data had been saturated to that point, and if not, what other codes/categories and possible themes might emerge. Saturation occurs when gathering more data no longer generates new insights nor reveals new properties of core theoretical categories (Charmaz, 2006). An example of a 'mid-term' session (excerpt) analyzed through the grounded therapy process is given in *Appendix G*.

The 'mid-term' sessions did yield further codes, and ultimately contributed to themes, but at the same time these sessions also yielded a large number of the same codes as were obtained from 'near break' sessions. I decided on this basis to see if analyzing sessions over the course of one week, particularly a week following a substantial break, would yield further codes. This did not result in new codes, but a development in Freddy's capacity to manage his feelings around breaks was evident, highlighting the likelihood that some of the positivity and containment seen mid-term also existed for very brief periods even in the first week back, once he had begun to settle back into therapy.

Table 3 illustrates the sessions that contributed to generating both initial and further codes (saturation), showing whether sessions were 'near break' or 'mid-term'. Additionally, the sources of data available within each session are shown.

Table 3 - sessions used to generate initial codes and to achieve data saturation

			Addition sources of information		
Session No.	**Near break**	**Mid-term**	**Clinical supervision**	**Academic supervision**	**Thoughts at the time *and* subsequent thoughts during research process**
2	y		y	y	y
14		y	y	y	y
35	y		y	y	y
54		y			y
55		y			y
72	y		y	y	y
73	y				y
74	y				y
151	y		y	y	y
153	y				y
183		y		y	y
212		y		y	y
262		y		y	y

3.7 Outline of developments in thoughts about material

Looking back at Freddy's treatment as part of this research, I became increasingly aware of developments and shifts that were hidden behind the great challenges of the session-to-session work. A few initial comments early in the research process were instrumental in helping me to see things through a different lens. One idea from academic supervision was that I was holding in my mind but not speaking to a variety of processes during session. This suggested that perhaps a central tenet of the work, particularly in early days, was how I worked with Freddy - that I was sensitive to many processes and dynamics but was not putting them into words in session. Much of the time I was anxious he would feel criticised, and in turn humiliated by even what I felt were quite benign comments/observations. The development of this line of thinking helped me garner the motivation not to give up in my research quest. It was quite easy to not relinquish the strong feeling that I have no doubt Freddy had - that there was little thinking, development, or internalization, and that therapy was of little benefit. This line of thinking and the idea that his therapy may have helped him develop in a way that he outgrew the placement, was very useful. I was more able to see the value of looking through the material for signs of movement and even something optimistic, despite what was a very difficult end to his foster placement.

Comments during training supervision, particularly my supervisor's thoughts that Freddy may have been communicating something of having missed me over the weekend break for example, encouraged me to look at sessions after the bigger breaks but one year later. For example, I looked at Freddy's first week back after the summer holiday break and at the same period 12 months later, and then another 12 months later again. It was very revealing to see the shifts in his ability communicate, initially almost exclusively through challenging behaviour, to using words or non-verbal means such as making me feel left behind or 'a bit in the dark'. These important developments helped to confirm that he had a better capacity to manage his response to what relationships meant to him.

I also became aware over time of how many genuinely playful moments took place in the 2 ¼ years of intensive work, and in the weekly work after the placement ended. I

have regretted not embracing this more, or at least acknowledging that, for some children, playing with an adult is itself a therapeutic endeavour, and is not always, as I think I felt at the time, a distraction from the ‘proper’ work of therapy.

Ultimately, being able to follow-up Freddy to the residential school he moved to, and to let him know I wanted to see how he was getting on, helped to confirm that this in itself meant a lot to him, and that efforts to try are as important as the results themselves for children like Freddy who have had many experiences of people giving up on them.

CHAPTER 4 FINDINGS

The themes illustrated in this chapter are not chronological in terms of how they unfolded in treatment. This in itself speaks to the waxing and waning nature of development, and how breaks, in particular, seemed to stir up difficulties that up to that point seemed to some degree to have been worked through. I provide session excerpts to illustrate the themes that were derived from the grounded theory process. I have linked these themes to categories that were derived from data analysis, the 'near break' and 'mid-term' categories having initially been derived from codes. As explained, a core group of sessions provided the main initial codes, and other sessions provided more evidence of these themes but were not analyzed for further codes - the material having been qualitatively saturated by that stage.

4.1 Meaning – making the most of a scarce resource.

With much of Freddy's communication in his treatment, the opportunity to get even a glimpse at some of the meaning, let alone understand it, was difficult for a myriad of reasons. At the time, it mostly felt that his physical and verbal attacks were designed to mask any meaning or distract from any relationship developing. Yet distance and time has allowed a re-examination of the work that took place in the treatment, and its meaning.

From the time I had decided to use the material from Freddy's therapy for research, I wanted to keep the ideas about shame and humiliation in mind, but also needed to leave room for that which came up from the application of grounded theory to the material. There were many occasions when I felt that Freddy would misconstrue or misinterpret what I was saying as some sort of put down or criticism, and this presented the biggest technical challenge - how to offer my thoughts and interpretations that were needed for him to get better without adding to his experience of adults as unhelpful, sometimes abusive and certainly neglectful. However, the process of look-

ing back over the therapy with some distance, and thoughts from academic supervisors who see the work for the first time most certainly helped to gain a different perspective that allowed the combination of my sense of the therapy at the time and what can be seen more in the round after the treatment had finished. I had begun to develop a sense that the therapy represented something very frightening for Freddy, and as such he would need to protect himself when in touch with such potentially overwhelming feelings.

I was aware, even before first meeting Freddy, that being at the start of my psychotherapy training I would be tested and probably wouldn't be doing much thinking for quite a few months (this was advice from my placement supervisor). This was sage advice indeed, which helped when I felt that anything but thinking is going on, and that I was merely trying to prevent sessions getting completely out of control; trying not to get hit or spat on and so on. This was coupled with a worry that I would be considered as doing an inadequate job in the clinic and in supervision. But at quieter moments when I could gather some composure there was often a feeling that thinking was an anathema to Freddy, and it wasn't just about being below par or making novice mistakes. There was something to be understood about the aggressive anti-thinking stance that needed to be worked out, and this research project offered the opportunity to do something to that end.

In working with such a deprived child as Freddy one was faced with trying to help a psyche that has most likely turned away from others to the self in attempts to ensure survival. However, those survival and defence mechanisms that the infant psyche relies upon do not promote the development of more healthy relational capacities when older. In essence, the narcissistic object relationship, when it takes hold at an early age, will not relinquish its grip without incurring what can be felt as a threat to survival. Symington (1993) puts it:

> *"If someone has been treated cruelly by a parent, one of the ways of living with the trauma is to push away the infant self that has been thus treated and to behave cruelly to others"* (pp74-75).

However, Freddy came to appreciate, and I think internalize, that the needed object is not necessarily the cruel object. He could even go so far as to consciously recognize that one needs an object to develop and it can even enrich life - it might even be something he can allow himself be concerned about. 'Consciously' being the operative word, as Freddy related unconsciously to the object at times in a contorted manner, making it initially very difficult to help him learn something about himself – the ultimate goal of psychoanalytical therapy.

In my endeavour to make sense of the hundreds of codes from session material shortlisted from the 270 plus available, the initial codes seemed to fall into continua grouped broadly under *Relationship* and *Anxiety*, with a degree of overlap between the two. These codes are very broad and likely germane to any psychotherapy, thus not helpful in understanding complex processes in more detail. However, the nature of *Anxiety* when understood in terms of *Relationship* helped, where the codes, and ultimately themes, could go on to shed light on the complex processes at a finer grain level. In essence, the notion of *Anxiety* stirred up by concern for survival of the self versus survival of the therapeutic *Relationship* was a helpful starting point in understanding the treatment processes. Underlying these two themes was separation, and the psychic struggles required to bear it.

4.2 Themes

The following themes derived from the codes-turned-categories are designed to capture the main processes in the work with a boy who was always anxious about the therapeutic relationship - what it said about him, us, and ultimately how it helped him understand that relating is not necessarily harder than the effort required to get something from it.

The three main themes, two of which have sub-categories, are:

- Identification with the aggressor
- Allowing thoughts about the other
    i. Genuine concern
    ii. Meaning through symbols
- Two minds connecting
    i. Minding the gap
    ii. Thinking about thoughts

4.2.1 'Identification with the aggressor'

Anna Freud's ideas are helpful in understanding certain aspects of Freddy's reaction to therapy, and my experience of him at these moments, as a defence mechanism - a method of managing extreme feelings stirred up in treatment. A. Freud (1966) suggests:

> "*Vehement indignation at someone else's wrongdoing is the substitute for guilty feelings on its (ego's) account. Its indignation increases automatically when the perception of its own guilt is imminent"* (p 119).

Often in the course of therapy I felt 'accused' of having done something wrong, often *very* wrong, but the intensity of the aggression in the room seemed disproportionate to what had actually transpired. A. Freud's ideas suggest that perceived criticism is internalized and the offence is externalized. The 'externalization' is supplemented by another defence mechanism, the projection of guilt. I had often sensed that Freddy's

anxiety (the single most prevalent code developed from the grounded theory process) was associated with his guilt and the difficulty in managing it without constant recourse to projection - keeping in mind O'Shaughnessy's view of the impoverishment of the personality that can follow excessive projection (O'Shaughnessy, 1964). Often, Freddy's sensitivity to criticism (something that never felt far away) left me with the feeling that he feared humiliation (which in his mind came in the form of criticism when he felt he couldn't manage certain things). But frequently wrapped up in this was a sense of guilt, not just for what he couldn't do or regret at the attack on the object, but also the inadequacy that explained the rejection by his mother, and at times his foster carer.

The primary codes that formed the *Identification with the Aggressor* theme are listed in Table 4.1. In thinking about the codes, it became apparent that a continuum was a helpful way to reflect on them. For these codes there seems at one end of the continuum a degree of *Regression*, at the other end *Development* that related to some capacity to tolerate, albeit briefly, the painful, difficult feelings of shame and inadequacy.

Table 4.1 - Primary codes contributing to *Identification with the Aggressor*

Regression ⟺ **Development**		
Distrust	Disconnection from Therapist	Trust
Inadequacy	Dismissal of Therapist's ideas	Appreciation
Shame	Asking for help	Taking help
Attack		Looking for containment

Freddy had three birthdays during the course of therapy, all of which fell in the Easter break. His first session back after the first of these three birthdays was difficult. As I later became aware, the school holiday contacts with his mother did not always coincide with his birthday, thus he was confronted with the anniversary of his birth being a reminder of the absence of his mother, rather than the usual picture of celebration. The following session excerpts illustrate moments where, I believe, some of his aggression occurred when he was in identification with me as a reminder of the rejecting, disinterested maternal object, yet one he needed at the same time to help him achieve the psychic growth his ego wanted and knew it needed.

The first moments of the following session highlight the ease with which Freddy could feel humiliated and his speed with which he often projected his humiliated feelings.

Session 30 - (Monday - first of the week: first after initial Easter Break)

> *Freddy was behind his foster carer, who cheerily said hello to me. He had an upside down turned Lego bucket on his head, only his mouth left visible. He seemed in good mood, but quickly called his carer an idiot.*

A little later:

> *I found myself standing near the window waiting for something to happen, when Freddy announced that he had a birthday. He was seven, and he looked at me, expectantly. I wondered to myself if he thought I might be pleased. I said that he did indeed have a birthday, and that he was seven now. He nodded, and I said that he was six when we last met. He then suddenly turned back to the windows, and opened them, and then said that he got lots of presents. An MP3, a PSP, a DS, and a bike! I said he seemed to have got a lot, but at the same time I felt sad. He said (triumphantly it felt) that he had got 100 presents - the whole shop! It seemed he was trying to relate a sense of importance and it seemed untouchable in a way.*

He was sensitive to feeling ‘an idiot’ at the start, possibly because he was doing something the newly-turned seven year-old him would frown on, or he had been looking forward to seeing me but admonished himself as I was the same one who had stirred up difficult feelings over the break. Such feelings are likely to have left him feeling ‘an idiot’ as it potentially brings him closer to the level of his need for another in his therapy journey. Symington (1993) argues that

"The pull towards narcissism is intensified by the traumatic experience, so that the more intense the traumatic experience, the greater the pull towards the narcissistic option" (p. 79).

Symington also goes on to say that mental pain is inevitable if the person is to get better. I think at some level, aware that he had a chance to get better in his therapy, Freddy also had to deploy defence mechanisms to protect his fragile, underdeveloped ego. Starting the session feeling sensitive to criticism (among other feelings) was in some way linked to the unconscious dynamic that he had felt humiliated for missing his therapy/therapist, as it reminds him of what he didn't have available to him, namely an internal object that could sustain him over the break: the same object that reminded him of what he doesn't have inside. His way to manage at this early stage was to attack it, turn away from it and deny any need of it, yet this didn't really work and the 'gap' was still there.

A few minutes later in the session:

> *He then took a male figure from his box (I wondered if it might represent me) and distorted it by moving the legs into a splits position – contorting it even more. He threw it against the ceiling and even though it was hard, it didn't do any damage to the soft ceiling. …. He was laughing at this action, I had my hand out, and it was turning into a game of him trying to hit my hand. 'You're such an idiot!". I said after a moment that it seemed perhaps that it was difficult to know how to be because there had been two weeks since we met, and knowing what to do today was difficult? He stopped himself briefly, and I felt that something had gone in. I said that perhaps he was wondering if the rules would be the same after the holiday – would it be the same EM? He didn't respond to this directly, and after a moment he went over to the table, and started to throw what-ever he could find at me - his box, the small chair, even the small table*

As we got near the end:

> *Freddy started to kick me after I said that we would need to finish in a few minutes. ….. He got a little distracted by a mark on the wall, and he asked if it was poo. I said it wasn't, and didn't want to be distracted myself, but I thought afterwards if he might have thought it was another child who had made the mark.*

> *In the waiting area, Freddy was protesting with his feet and arms that he didn't want to leave and I was wondering whether to verbalize this outside the session. His carer suddenly yanked Freddy's arm and forcefully said 'Come on!'. Freddy looked very startled and frightened, and suddenly small and helpless.*

This was a session that showed his struggle with a pull towards narcissistic object relations away from ordinary object relatedness. But he so often felt that experiencing ordinary need, dependence and missing without allowing his ego to defend itself was unbearable, and his aggression led to tense interactions, particularly with his foster carer, as highlighted at the end of the session. This moment of aggression from the carer to Freddy was addressed in the parenting sessions, and the carer was aware of what had happened and tried to think about it.

The aggression that permeated many sessions, particularly early on, often left me feeling as though I had to be very careful in saying/not saying particular things lest Freddy feel I was out to humiliate him by exposing his 'weakness'. I often felt I had to be careful when Freddy was confronted with what could have been experienced as humiliation. Often I felt his anger with me for not completing a game properly or making him get it wrong, stemmed from his anxiety that he hadn't explained it properly. I think he was very sensitive to being thought of as 'stupid' or 'useless', but he did get better at being able to think about thoughts - something later sessions in particular show more clearly. Moreover, although themes are separated out for writing up purposes, one session can be used to illustrate several themes, speaking to the complexity of small amounts of material when viewed through the psychoanalytical lens.

At the same time as making me the aggressor there was some capacity to hear my thoughts. The following session excerpt, which took place two weeks after session 30, shows some slight shift despite aggression predominating much of the session. The telephone had been broken a few sessions before when Freddy threw it against the wall. He had missed two sessions earlier in the week due to bank holiday and then sickness.

Session 37 - (Thursday, usually third of the week)

> *Freddy looked at me when I opened the door. He was grinning, and he stuck his middle finger up at me. I sensed it was actually, in a small way, his way of saying hello. I remarked (feeling that I wouldn't comment on that specifically at that stage in the session) that it had been a while since he had been here. "A week actually", the actual length of the 'break' had only then just struck me. He seemed out of sorts, and he asked me where the phone was. … I said that the phone cannot be fixed - the bell was broken and I cannot fix it. "Sellotape it then!" he said anxiously. I said I could not be sure exactly when but it is possible to replace. But we would have no phone for a while, and the phone was important – Freddy speaking to EM through the phone. I added that it was something he had tried hard to not damage so it meant something to him. He suddenly looked furious and threw his box on the floor, quite hard. There was a cracking noise but I wasn't sure it was his box. I felt it better to let him quieten. He then raced over to the window and opened them, wanting to stand up. He took the teddy and threw it at the ceiling. I suggested if he wanted to throw it hard he could throw it at the wall. He did it once and then argued that he couldn't catch it if he threw it at the wall, adding that I was a "fucking idiot".*

We had some discussions about a session later in the week to make up for the missed bank holiday session.

> *He then 'retreated' under the chair, and said he was going to make room for all the pieces of paper, and wanted me to pass them to him. I said I could pass some and he could do the rest. He seemed a little pre-occupied, and then asked, more reasonably/politely it seemed, to pass the papers/toys and he could put them in. I felt this was ok, as it was a piece of joint working in a manner. He noted the Mummy lion that I passed to him, after explaining the difference between the lion and lioness. He crossly said he had a cub beside her. I was struck that he was cross I hadn't noticed, but then thought it was probably not that which made him cross. I said she was a mummy lion with a baby. "Shut up your talking!". I said he didn't want to hear me talking about a mummy lion and her baby. "Not so easy" I suggested. Freddy was then quiet*.

In the midst of the above processes was his mother, whom he rarely mentioned and never in relation to her presence around the time of his birthday. The only 'presents' he could describe made me feel sad as I think on a deep, yet accessible level, the one present he wanted was unlikely to ever come true. I often wondered how one could really expect such small boy to undertake the huge task of therapy *vis à vis* his internal world when his external world remained at times so challenging?

4.2.2 'Allowing thoughts about the other'

This theme came from material that showed Freddy's increased capacity over time to develop something that puts one in mind of Klein's ideas relating to the depressive position – namely the development of ability to use the mind not just in attempts to preserve himself but also to preserve the therapy, and finding ways to express that symbolically – another important development. It has been further broken down into two sub-themes to allow for its complexity. The primary codes from which this theme was derived are listed in Table 4.2.

Table 4.2 - Primary codes contributing to *Allowing thoughts about the other*

Self-preservation ⟺ Relationship		
Separation	Guilt	Warmth
Frustration	Projection	Reaching out
Fear of rejection	Communication	Collaboration
Humiliation	Taking a chance	Internalisation

4.2.2.1 'Genuine Concern'

Albeit difficult for Freddy, he was able at certain points to envisage a helpful object in his therapist, and recognize that my thoughts about him were more than 'reminders' of what he felt he missed or lacked. While the above section used sessions near breaks to highlight heightened states of mind, the sessions in the current section are from midterm. They capture more ordinary processes that, only on re-examination of material, demonstrate a capacity to develop ways of relating to therapy/therapist that could promote development, in some cases quite early on in treatment. These two

sessions were particularly helpful in deriving codes that capture some of the more ordinary, and thus hopeful, themes in treatment.

Session 54 (Monday - first of the week)

> *He went to sit on the sofa, then lay down. He seemed a bit bored and irritated and then quickly said that he wanted to play a game. Hot and cold. He then decided that it would be chocolate and melting. We then established that the chocolate was cold and the melting was hot. He couldn't help but add 'idiot!' to the end of it. My sense was that he was outwardly calling me an idiot but as often happened he worried he was an idiot for not explaining the game properly to me, therefore something lacking in him……. He grabbed my glasses and grinned as he tried to squash them. I took them back, and he didn't resist quite so much, and he then got quite riled as I noticed I was nowhere near as cross as when he had done this just before the previous Easter break. I found myself being largely calm, and he was about to peel the film of the window, when I stopped him, and he got onto the floor, and I had to stop him hitting me. He started to shout as he lay flat on the windowsill, and then started to have what was a mix between a tantrum, and a tirade of 'lick your mother's dick and father's dick'. After a moment, I said that I was wondering about the type of things he says – he has said them before. He was trying to speak over me, but I managed to say that I imagined they were difficult things to speak about, especially to others, which might mean Freddy is left on his own with them. He stopped and almost immediately calmed, and then went to put the film back on the window. In what was almost a tender moment, he used some saliva to stick the bit of film back on the window.*

On the following session (the next day) Freddy seemed able to hold onto something good that had been evident the day before. It felt that he actually enjoyed this session, his ability to use me to work out important elements of his past/where he came from. He demonstrated that he began to relate to me in the room as more than just someone out to humiliate, but to help - two functions located in the same person.

Session 55 (Tuesday - second of the week)

> *His foster carer looked sweaty as he brought Freddy to the door. Freddy sort of slid in, and sat in my chair. He looked worried, in a way I hadn't noted before. His foster carer was saying that they had had "A wonderful afternoon", clearly meaning the opposite. Freddy looked briefly at the door after his foster carer had closed it. He didn't even remark on the*

door sign. I wondered to myself if he was worried that his foster carer was displeased with him.

A little later in the session:

He then had an idea about rolling up a sheet of paper to make a telescope. He was unable to do it, and seemed cross, because some of the others at school had done it that day. I wondered if it might need practice - not an easy thing to do……He crossly asked me to do it, and I then tried, but he wasn't happy with the little piece of curled up paper inside that meant he couldn't see. He then, more gently, said (as though working it out for himself in a way that took away the frustration and started to reveal the softer side to him that remained for the rest of the session) he could just rip the piece of (occluding) paper away. He then wanted to sit on the windowsill, asking permission (highly unusual). He decided to play a game with the phone. I was the phone repairman, and he lived at no. 22. The roles soon reversed and I was to travel to Wales. He said I had to come to a different street! I suggested 22 Cardiff Street, and he seemed very pleased with that. He also wanted me to call him Fa Fa. I wondered if others had called him that? His dad? He smiled. He seemed generally quite pleased with me taking 'seriously' driving the motorbike, and settled more into us both almost 'taking on' these characters. He then drove us both back from Wales, really taking charge of this action of looking after me.

In session 54 Freddy experienced what felt like for the first time the therapy a process akin to the depressive position (Klein, 1935), in that he recognized the good object located in his therapist alongside the one that was usually going out of way to deprive or criticize (as had been happening earlier in the session). He was also able to almost immediately try to both repair the 'damage' he had done in the room, and succeed in keeping the momentum going the next day (Session 55) by allowing me to do my job as a therapist. I was allowed to fix modes of communication (the phone) after he managed to fix an aid to seeing things that can otherwise be difficult to see (the telescope). We also journeyed back to a place that had something in his mind to do with where he came from originally - the family link to Wales etc. He wanted to look after me to as he was more consciously aware the 'good' me was not separate from the 'depriving, rule-bound' me. A lot of important work took place in under two hours.

4.2.2.2 'Meaning through symbols'

Development in this area was rather unexpectedly evident following the second Easter break about 16 months into therapy. An unplanned week was added to the two-week break due to Icelandic ash cloud disruption to my return flight from holiday. Freddy became aware that I had been delayed coming back for this reason. He was a little manic in the first session back (week 2 of the term), but showed some unexpected symbolic expression of his anxiety that I had been both away and delayed coming back. Notable about the symbolic expression was both Freddy's ability to sustain the idea for a good deal of the session, and my slowness in picking it up for what it was.

Session 151, (Monday - first of the week)

> *Freddy arrived at the door, having knocked loudly, but waiting for me. Freddy was in 'playful' mood and suddenly after a few minutes of what seemed like 'small talk' asked me where I had gone on holiday!? He seemed embarrassed, and quickly said that Val, no his foster carer and DW said he could ask me where I had gone on holiday? What then came out in a rather spilling action, was that I had been held up by the ash, and had been away, and did I go on holiday on the Monday, the same day as he went? It was difficult to keep up. All the while he was lying across the couch, and seemed very happy to be there - relaxed almost.*

Later in the session:

> *He then wanted me to make planes - to make five planes by using two sheets together. He also crossly said I was taking up all his session – I had just said we were getting near the end. I pointed out that he had three planes and hadn't actually used them –* so *maybe best to keep EM busy? He got even crosser, and kicked me, but it wasn't hard, and it was as though he didn't know what else to do. I said, after he moved to the corner, that maybe we needed to think about how he might feel cross about last week, and not having his sessions. Maybe he feels let down – that EM should have been here, but wasn't because he was off on holiday? He agreed, and said I was off on holiday! He settled a little.*
>
> *It then suddenly 'dawned' on me the relevance of planes to the missed sessions, and I said to Freddy that I just had a thought that we were making planes, and he was aware that I was taking planes recently. He grinned, and although I don't think he was fully aware of it before that point, he grinned as though I should have been more aware. This seemed to allow a more playful last few minutes as he commanded me to pile the planes on one another, and then fly them. I commented that he is cross with EM, but also glad to be back? He didn't say anything, but seemed to enjoy the planes being flown in one go.*

Later that week, the juxtaposition of infantile anxieties, more sophisticated modes of communication, and an ability to bear my thoughts about what it all might mean was more evident. On reflection, it seems as though the breaks, as triggers for separation/survival anxieties, brought deeper issues to the fore alongside entrenched survival defences. There were communications that, on looking back, seem to speak to these anxieties but at the time were more often managed and not interpreted.

Session 153, Thursday

At the start of the following session Freddy had given me a comic-book drawing of *Batman*, and wanted to make a copy for himself with the clinic's copier. I said we needed to think about this.

Later in the session:

> *He then said that he needed to go to the toilet. I said that if he wanted to go, he would have to hold my hand on the way. This made him furious, and he remained mad, and spat at me, laughing a few times….He started to cry when he seemed 'convinced' that I wanted to humiliate him, and I said as much, that it felt not EM did not trust Freddy. He was eight now and wanted to be treated as such? He agreed but spat at me again, and tried to hit me, and bite my arm. He was furious now, pulling down his trousers, to show me the poo (it was quite messy), and he shouted that he needed to go! ….I had a thought that he was in touch with being left in his poo as a baby, and nobody bothering to clean him. I said that maybe it felt that EM was just leaving him to sit in dirty underwear, and just doesn't care? He didn't respond (and I didn't think he would be consciously aware of the memory/feeling) but he was quiet for a moment.*
>
> *It seemed that he really felt he was in the presence of a very cruel object, and I said that it must be very difficult now to feel there is anything good being with EM. He seems not out to help but make Freddy feel silly and little, and he also doesn't come back from his holiday to see Freddy. Might feel Freddy is just not important enough? He was quiet at this moment, and asked what I meant. I said that maybe he feels I don't want to see him, and I will be cross because he's been angry today. 'So you won't copy the batman figure?' he suggested. I said perhaps it feels I will retaliate like that – he expects that? He didn't respond, but got cross again about his laces, but wasn't quite so loud.*

The meaning that the near-soiling incident documented in session 153 can be understood in terms of Paul Barrow's ideas about soiling in younger children and its relation to Britton's ideas about the 'Oedipal Illusion' (Barrows, 1996b). Retaining faeces and soiling in younger children, as Barrows argues, can be thought of as a defence against

the anxiety caused stirred up by acknowledging ‘the facts of life’ - the sexual parents and their capacity to engage in something creative of which the child is a result, not party to or in control of. Gaining the illusion of control through retention of faeces in particular is the young child’s internal riposte. Freddy must certainly have felt he had no control at all over his parental objects, their commitment and availability to him, and indeed my leaving and re-appearing after the break. The soiling as described above may have been an expression of complete lack of control – of note too that the children in Barrows’s account were not as disturbed as Freddy, and had not had experiences of severe neglect to the extent of being left in soiled nappies as Freddy was believed to have had.*

Re-examining sessions from the therapy’s start to finish highlighted something that was not so obvious at regular termly reviews with social workers and foster carers. I increasingly felt alarmed and indeed saddened at that lack of warmth and disdain that the primary (male) foster carer sometimes exhibited towards Freddy. Given Freddy’s placement ultimately broke down, I think Freddy had possibly never really felt secure in it, and sensed (as was his previous experience) that he would eventually be moved on. But I was staying with him despite his behaviour and was even trying to think about it. I may have started the session as a superhero (Batman) in Freddy’s mind, or he had wanted to imbue me with super-heroic qualities to support me in working with him. Either way, this view of me did not last, nor was it required, as the task was to understand the infantile transference, and reality came to fore nearer the session’s end. This was manageable for Freddy at this stage as he was beginning to develop his capacity for symbolic formation as opposed to solely relying on symbolic equation (Segal, 1957). Making and flying the planes was could be seen as at least a step towards understanding the he needed to feel some agency/mastery, and not that having such a sense can be very frightening.

4.2.3 'Two minds connecting'

This theme captures both successful and unsuccessful instances both of Freddy's attempts and avoidance of connecting his mind to mine, and the times when I too did not appreciate his attempts, *in vivo* at least. It sometimes felt as though we were at odds much of the time, particularly early in treatment. There was much zig-zagging in sessions when connection was avoided and other things were brought up but these were often 'dead ends'. However, as others have argued, central to therapy with severely maltreated children is the therapist's ability to bear, and gradually reflect on, intolerable anxieties on behalf of patients (Boston, 1983). Even as the therapy progressed and reflection was offered and better tolerated, some important processes, particularly reflections on psychic reality, remained difficult to think about and had implications for technique. The theme *Two minds connecting*, is also broken into two parts to reflect its complexity.

Table 4.3 - Main codes contributing to 'Two minds connecting'

Challenges/exposes ⟺ **Provides**		
Destroy the weakness	Shutting off	Concern for therapy
Evacuation	Full up	Reparation
Self-distraction	Fragile skin	Participation
Loss of control	Maintaining distance	Coming together

4.2.3.1 Minding the gap

In an early phase in the therapy, Freddy seemed to almost resent any suggestion that he had a mind; one in which things went on and thoughts took place. I use 'phase' purposefully as I see it as similar to Melanie Klein's idea of positions; something to move in and out of depending on a variety of factors, both internal and external to therapy. Internal factors, such as an impelling urge to communicate, underlay Freddy's state of mind at those moments when he displayed intent, albeit unconscious to him and in spite of the part of him that warned against it, to connect with my mind. This is an idea that M.E. Rustin (2006) puts forward as of the importance of courage in psychic life - the durability of the impulses to search for a good object inherent to psychic survival. Risks must be taken however, and having a mind was something risky Freddy often seemed at pains to disavow.

The following material has been chosen to illustrate the difficulty with which Freddy managed not just breaks but the task of accepting his therapist who both left him and returned was also the one who still wanted to help.

Session 72 (Monday - first of the week)

This session is the first back after the first summer break and shows not just my inability to understand the symbolic nature of his communication but how difficult it was for Freddy to tolerate the idea that he had a mind with important things to understand which might prove helpful for him.

> *Freddy grinned as he saw me after I opened the door. He seemed to be hiding for a brief second…. Freddy then came in and sat on my chair initially. He immediately said, "Where's the stuff? Why don't I have the stuff back?". I asked if he meant the picture and clock, but he quickly said the house. I said that he seemed to be expecting new things, and that we could think about that. He cut across me to say "it's a new term!", almost accusingly…… He quickly pointed to his loose tooth, showing me what he had done over the summer. I said it might be sore, and he grinned and then moved over to the couch. He then picked up his box, and took a few toys out to throw at me, and the small tortoise and car hit my head, and he grinned, seeming quite cut off, not even frightened.*

Later in the session:

I took the chance to sit down, and said that it had been quite some time since we met, and it was difficult to get used to things here again. He then said the windows were opened and ran to check them. I said that the windows were closed, and he might be checking to see if the rules were the same as before. He quickly peeled the small square of film from the window, and after I stopped him from doing more of this, he then ran over to the wall to kick it. I said that he could hurt his toes if he did that, but he did it twice before I stopped him, leaving a mark from his sock. He laughed at it, and asked excitedly if he had done it (made a mark).

Freddy came back to his therapy with a sense that he was with an enemy rather than a friend, and in identification with this type of therapist I found it difficult to appreciate his frame of mind and relied on rules and boundaries in response rather than promoting the use of his and my mind to understand.

A little later in the session:

He was then distracted by the noise coming from the adjacent room, wondering why they were so loud… I said that the noise from next door was bothering him, and he was worried about what they were saying? But this didn't seem right, and I felt I wasn't getting anything right or connecting with him today….. He wanted me to move the chairs in line between the door and the wall.

Once the chairs were in line, he wanted the blanket to cover the top of two of the chairs, and I said that I wasn't sure the blanket was big enough. "*Just do it!*" *he said, and I said I would but was waiting for him to say please, feeling I shouldn't feed his omnipotence. He said please, then called me an asshole, and seemed cross with me.*

He remained very unsettled, swearing at me and displeased with everything, sour almost. Despite efforts to stop him, he urinated on the rug, and I let him know, gently, that we were stopping for today, and we would meet at the same time tomorrow for another session. He was actually more contained at that moment than I had expected (or feared).

He wanted then to know if I would tell his carer, and I said that I would say to his foster carer that we were ending the session now, and that we would meet again tomorrow as usual. I moved over to the chair for a second, keeping an eye on him, and at that moment Freddy hit me very hard on the side of the face, with tremendous force. He knocked my

> *glasses to the other side of the room, and he then laughed. I wasn't overly angry, but looked and said that he might be angry but he might also be worried that I might do the same to him now – I might hit him back? He continued laughing, and I said that he is worried now because we are finishing early, but we have a new session tomorrow…. There seemed to be an air of calmness as we left the room.*

The urinating, the communication of the much younger child at times of anxiety, also conveyed his feelings of being unwanted waste over the break. There was the additional risk that naming his feelings about the break felt as though I was also saying I *had* left him, as opposed to my intention which was to help him see I understood that he *felt* left. Added to this was the likelihood that concretely showing me his 'unwanted, waste' self was followed by rejection - something he unconsciously engineered yet confirmed his belief that he was only ever to be rejected. There were many moments in therapy which concrete thinking prevailed and made the task all the more difficult for us both. The aggressive manner in which Freddy hit me at the end of the session was also a way of letting me know that he equated me with an absent object that had come back merely to re-deprive and humiliate him - and this is in a way how the session panned out.

O'Shaughnessy (1964) proposes that strong defences disown strong feelings about [the coming] separation. Akin to Bion's ideas that the way in which the infant deals with the absent breast and its importance in the development of thinking, the way in which the patient deals with the gaps in his treatment will be critical for its successful outcome. A child who is not able to manage or acknowledge separation:

> *"Becomes more impoverished as he splits off more and more of his awareness until his personality seems to dwindle away"* (p 36).

At the same time the challenge for Freddy to be helped in this endeavour and my capacity to 'keep at it', despite all the deterrence, was a vital function of therapy. Speaking of the integral role of the absent object in the infant's development, O'Shaughnessy also says:

"It will be a major difficulty in the way of establishing the good internal object since hatred will be mobilized against it because of its absence, making it hard to keep the good gained in its presence" (p34).

However, my saying in a genuine straightforward manner that we would meet again the next day and that it would be a new session seemed to be one of the most helpful things for him to hear. This may have been because despite his attacks on me I wanted him to take away/introject the sense of an external object that could (eventually) help him contain the very primitive parts of personality that Bick (1968) argues are not as yet differentiated from parts of the body. Freddy's urinating could be understood as a communication not just of how he couldn't but spill out given how much he felt stirred up by the recent separation, but also of how, Bick also argues, separation in particular can highlight the lack in internal spaces of something that can make use of introjection from external spaces to develop psychic growth.

However, Freddy managed by the third session of the week to use his session to communicate something of his view of himself, and to a degree the week that had just been in therapy.

Session 74 (Thursday - third of the week)

As was often the case, things seemed quite tense between Freddy and his foster carer at the start of the session. I got something out of the way early in the session, letting Freddy know that starting the following week I would be removing his shoes at the start and leaving them outside the door for the session. Giving his some prior warning seemed to help him accept this better.

Later in the session:

> *Freddy was under the blanket for a few moments and was still cross. I said I just wanted to say one thing. That it struck me that being cross with people was maybe easier than showing them that you might quite like them. He had paused for a brief second but then wanted to move on with something, and I decided I had probably said enough at that moment. It seemed too difficult for him.*

> *Freddy gradually became quite playful, and I wondered if part of him wanted to make the most of something after two quite disruptive sessions. He said he wanted a den, but instead wanted to play school. I was to sit at the desk along with him, and ask him to do work. I was aware of there being no pens etc., and wondered how we would manage that. I was to tell him to do writing, which was quickly changed to do reading, and then to ring the bell for playtime. I had to make a loud rather unusual noise for the bell (the phone's bell is now broken), but he then withdrew to the quiet space under the blanket and chair (that he had earlier been so dissatisfied with). I sat back in my chair, and he then wanted me to tell some of the children off, to tell them to behave. He seemed to find this particularly satisfying. I said that some of the children might need help with behaving? Maybe they need some of the grownups to help them at times? He almost growled at this. I thought I would make the link to him at a later time.*

This sequence shows Freddy's ability, albeit fleeting, to tolerate a connection between our minds that facilitated something more meaningful after a difficult post-summer break reunion. I wouldn't go so far as to say that it led to a promotion of thinking as my interpretation led to a literal growl, but he had an opportunity to know his ideas were something I was interested in. This felt important as I was often anxious that his behaviour left him at odds with the other adults in his life, including his foster carers.

It seemed too that after the first summer break, as the absent object, I became on return from my break equated with object that came back simply to re-deprive Freddy again, and 'taunt' him with absence, presumably during which I was off having a better time. The physical attack on my mind (at the end of session 72) was triggered by an inability to separate me from an abandoning object that would probably retaliate in the same aggressive manner. However, by the end of the week Freddy was able to see that I could provide a space that help him work understand the side to him that he knew was working against therapeutic alliance and wanted something a bit different - especially when he experienced a therapist that could withstand, and would return, despite what at times felt like physical onslaught.

In the absence of a good internalized object, Freddy often resorted to infantile ways to communicate his fears and other powerful feelings stirred up by breaks. The therapist's job of course is to try to understand and interpret where possible. But all too often, particularly early in therapy, I was reacting, managing and telling off, invoking at

times a sense of shame by pointing out rules that were broken, reminding Freddy of where he failed to do things correctly etc. I will explore these technical difficulties further in the Discussion chapter.

4.2.3.2 Thinking about thoughts

The idea which paper planes continued to represent, especially as breaks approached, seemed to help him manage better when we thought about the breaks - almost as though he could get back a bit of much sought after control. As Freddy and I prepared for the second summer break (which we both knew in advance would be a five week break) he showed in a typical 'ebb and flow' manner that he could tolerate and even think about some of my thoughts, and acknowledge his thoughts and feelings.

A session from two weeks before this long second summer break captures elements of such processes quite clearly.

Session 183 (Monday - first session of the week)

> *Freddy arrived with a paper plane, and in very bossy manner he said to his foster carer before I even opened the door that he would see him at 4.50…. Freddy immediately brought my attention to his plane, and wanted to make another one over at the table. I was to make it. He immediately took his paper out, and counted his four sheets.*

Later in the session:

> *Rather unusually Freddy lay across the couch, and waited for me to complete the planes he wanted me to make. I asked if I could have a practice try, and I noted that I was being rather meek - I was trying to think about this. He seemed irritated as he shouted that I was not getting it right!*
>
> *He moved back onto the couch, having been on the larger plastic seat for a moment. I said that perhaps there were cross feelings about quite a long break? He might be worried about it, but also when he's not coming here he won't be able to talk to EM about some of the things that might be happening over the break.*
>
> *He then mentioned the calendar, and I was putting the finishing touches to the plane, and said that I would talk about that in just a moment. 'You need to concentrate?'. I agreed, and then finished. He took the plane and lay on the floor – looking away from me as I said that I wanted to*

> *check what he wanted on the calendar – that he had said on Thursday, but I got a bit confused. 'In your memory?'. I agreed, thinking he was interested in a more ordinary way for brief moments today.*
>
> *Before the end he got onto the sill [which is not allowed due to several 'near falls']. I asked him come down, and rather 'logically' he suggested we could think tomorrow about maybe him sitting on the sill instead of standing. I agreed this was good idea, impressed that he had made something that was previously so difficult and likely to induce humiliation, into something he could think about.*

In this session he shows an interest in thinking - me thinking, concentrating, and re-membering. His ability to hold onto thinking capacity as we got closer to along break was quite a development. There is also a lot of more unconscious communication in the session involving the importance of planes and their significance to breaks, which although not interpreted at that point (but was in a subsequent session), served an important function for Freddy nonetheless via symbolic function through which he could get some relief. The plane too was a way to help him 'fly' over the long holiday - a defence that touched on mania and omnipotence as defences, but was clearly a development compared to his ability to react to and manage breaks much earlier in the therapy.

A temptation to reduce the thought he might have needed for me/his therapy over the break and insisting I make the plane so that I could be criticized for not getting right, bring to mind Rosenfeld's ideas that need for the therapist to be denied/gainsaid, internally at least. The narcissistic flavour to object relationships does not promote the idea of dependence as something to be tolerated. Indeed, the needy self is scorned and the therapist criticized (Rosenfeld, 1987).

About a month after the summer break, Freddy seemed better able to manage feelings of rejection, humiliation and dependence while at the same time showed an increased capacity to listen to and offer thoughts. The following session shows a reverting to type on my part in enforcing boundaries perhaps more than was required, and at the expense of something more exploratory. However, the difference between what would have been manageable earlier on and the present session serves as a reminder of some of Freddy's achievements.

Session 212 (Thursday - third of the week).

> *Freddy arrived in a very angry state. He was shouting at his carer, and was very indignant as he pointed to his arm, saying his foster carer had hurt his arm. 'Look!' he said to me a few times.*
>
> *He then ran to the wall to kick it twice. After a moment, I said that he was very angry indeed, and if he kicks the wall then I would be telling him off about the wall, and that's all EM cares about – the wall, not Freddy? He agreed, muttering something about what I would say about the wall, but he seemed to calm down slowly. Grinning, then took shredded/mushed bits of paper from his pocket, and threw them at me. I felt quite stunned as though being showered with water, and it felt oddly shocking. It felt very clear that I was to feel ridiculous. I said that it seemed EM was to feel ridiculous today, and perhaps Freddy feels a bit ridiculous when he and his carer get into big rows like that? Freddy merely laughed at me…*
>
> *I suggested he was worried he wasn't getting on with his carer. He argued that he wasn't [worried], and that he was in foster care because his mum used "to go to the pub" and leave him with his brother! He said that his Dad could take care of him! He was almost tearful. I was quite surprised how frank he was being, and I felt I needed to be very careful. I said that other people didn't agree, and it's hard to understand maybe? He became a bit more settled, and wanted to play some football. He had also been throwing some toys at the ceiling to damage it. He knew that the items would be temporarily removed.*
>
> *Although I knew it would be painful, I said to Freddy that I was thinking how hard it was not to throw toys at the ceiling today when he had been told they would go outside if he did? Perhaps there was a part of him that doesn't feel he deserves to have good things? It's very strong today? He seemed very awkward, sitting at the table, and wanted immediately to say anything to distract me. I didn't pursue it any further.*

Although humiliation and what felt like belittling seemed to be taking place in this session, some definite strides are also evident. For example, tears with me in the room rather than aggression was a positive thing. Furthermore, although I felt Freddy was somewhat manic after he had showered me with paper, he was conceivably also trying out ways to express complex feelings in a more playful manner as he sensed I would not retaliate - something he probably didn't experience with his foster carer. Moreover, Freddy was, as the session progressed, able to think and ultimately put into words what were essentially the experiences that brought him into foster care – i.e. his mother was unable to look after him for those very reasons. Also evident is another

occasion when I reverted to reinforcing boundaries when I felt things were getting out of hand. But despite this somewhat atavistic trend in the session on my part, Freddy was able to listen and think about his tendency to deprive himself.

CHAPTER 5 DISCUSSION

Fundamentally, my aim was to explore how, after nearly two and a half years of intensive treatment, research into the therapy with Freddy would offer deeper insights into what took place. With the help of both a different type of lens to look through and time, I believe the research has led to some interesting and helpful findings. At the start of the research, my primary focus was on ideas of shame and humiliation, and how working with such strong emotional states proved very difficult. I prefer to initially turn my attention to the findings from the application of grounded theory, moving on to think about shame and humiliation more specifically, as I still feel they were highly relevant to the therapy experience. I also wish to consider the impact of the external situation on aspects of Freddy's therapy as I see it now, and link some of the findings from developmental neuroscience to my own. The themes are then further discussed in relation to the literature review.

I was aware, as Freddy's therapy was taking place, that the opportunity to offer interpretations was infrequent, thus rendering what made a difference harder to pinpoint at the time. While the difficulty in offering an interpretation to a child with history of severe maltreatment has been recognised, the usefulness of a verbal interpretation in helping the patient to understand himself and to communicate with himself cannot be underrated (M.E. Rustin, personal communication). I could, therefore, possibly infer Freddy's therapy was of little value from this point of view. However, what seems much clearer now is that he did manage to internalize at least something of what I was trying to provide, and there were shifts in his ability to both manage difficult feelings, particularly as stirred up by breaks, and an ability to feel more at ease with the idea of a relationship between us. He could also think about thoughts.

5.1 The importance of a thinking mechanism

While a significant amount of the clinical accounts reviewed in Chapter 2, particularly *Adapting Techniques* in section 2.4.4, resonated with my experience of working with Freddy, I wish to focus here on something I feel relates not just, for example, to holding back interpretations until more timely opportunity arises, but to taking several steps back to appreciate what early maltreatment, particularly deprivation, means for the fundamental task in child psychotherapy.

I suggest that some of what I could offer Freddy can be best understood in terms of Bion's theory of thinking (Bion, 1962a). A point made by O'Shaughnessy (1981) in her commemorative essay on Bion's paper is a useful context for this research. O'Shaughnessy writes:

> *"Patients are anxious about their ability to learn from the experience of analysis. This is the transference emergence of their anxiety about not learning from their experience with their early objects"* (p. 189).

Although a theory of thinking, the starting point for Bion's theory is early emotional experience, particularly in relation to unmet needs and expectations. Specifically,

> *"This first form of thinking strives to know psychic qualities, and is the outcome of early emotional events between a mother and her infant which are decisive for the establishment – or not – of the capacity to think in the infant"* O'Shaughnessy (1981; p. 181).

While much of what Freddy could manage in the early stages of therapy seemed very different from active thinking, I am also struck by how much I had going on in my mind mostly in relation to what he was showing me. In essence, I wonder whether I was doing all the thinking for him? As mentioned earlier, I often felt Freddy was exceptionally sensitive to feeling he had done things inadequately, for example explaining to me a new game that he wanted to play. I sensed he was teetering on feeling humiliated, and needed to defend against this. However, it felt almost cruel bringing this to his attention in case I added to his experience of shame by naming what was going on for

him. Putting words to difficult and complex internal process can feel fraught with difficulties because of a degree of concreteness of mind that maltreated and deprived children often exhibit (M.E. Rustin, personal communication). Rather than bringing a dynamic to attention for thinking, I believe that one runs the risk of reminding the patient of his difficult feelings. In trying to be sensitive to his struggle without naming it, I would argue that over time Freddy's therapy became a consistent vehicle in which the opportunity arose for his therapist to receive projections and hold onto them for long enough until he could receive them back in modified form. This could be best described as a non-verbal process, and something I underestimated at the time in terms of its likely importance for Freddy. An important factor, underlying Bion's own theory of thinking, is the development of a thinking apparatus itself.

Central to Bion's (1962a) theory of thinking were the processes involved in the baby's as yet under-developed ego ridding itself of sensations both from without and within that s/he cannot tolerate. Sensations, whether good or bad, via the process of projection are expelled, as Riesenberg-Malcolm (2001) writes, because the baby can:

> *"Breathe them out, she can urinate, she can scream them out or use any kind of physical means at her disposal"* (p. 168).

Intolerable sensations are closely linked to what Bion called *beta elements*, which can be turned into *alpha elements*, through the process of maternal 'reverie' (Bion, 1962a). As previously stated in section 2.7.3, alpha elements are sense data that have been converted in order to provide the psyche with material that ultimately lead to the development of capacity to differentiate between self and experience. Maternal reverie facilitates the transformation of beta elements into alpha elements, and in doing so constitutes what Bion referred to as 'alpha function'. The infant's projective capacity is not just in terms of what Klein (1946) argued as a defence mechanism against intolerable anxieties, but a method of communication to the mother of what the infant needs

> "*Her to receive and know*" (O'Shaughnessy, 1981; p. 182).

Drawing on Klein's theories of a good breast to project into, Bion argued that the projection of beta elements into a good breast, where they 'sojourn' until modified into more tolerable form, provides the baby with a mechanism that ultimately promotes emotional development. Modified projections, ideally at least, are taken back as alpha elements and in time can be thought about. Bion (1962b) termed the maternal mind in this sense as the 'container', and the infant's mind as the 'contained'. Once contained, the infant's mind can do some important work, which will have varying outcomes. Most notably, the capacity to tolerate frustration when an expectation is unmet, such as a breast not being available when needed, leads to a 'thought' being developed. The thought (or experience of unmet expectation) when tolerated, needs an apparatus to further develop it. Bion, according to Riesenberg-Malcolm (2001), does not offer an explicit account of how this thinking apparatus might develop, so offers her own theory:

> *"I would have thought that it probably originates in the introjection of the maternal function as such"* (p. 177).

She adds:

> *"In this sense it would be the summation of these introjections that probably would permit the formation of a specific apparatus to deal with thoughts"* (p. 177).

Keeping in mind what Bion himself wrote about the capacity of the "well-balanced" mother's ability to transform projected intolerable sensations into something more meaningful, Riesenberg-Malcolm's ideas about the gradual introjection of the maternal function raises specific points of interest for Freddy's therapy. It is conceivable that his early experiences of anxiety, frustration etc. when projected into his mother for understanding were not consistently received by her 'to know'. Whatever Freddy would have introjected would have depended on his mother's state of mind at the time. This of course is hard to know, but it is reasonable to assume that someone living with depression, domestic abuse, alcoholism and other substance misuse would have struggled to 'receive and know' her son's early anxiety-laden communications. More digestible transformed alpha elements were unlikely to have been returned.

Overtime, Freddy would have, as Bion (1962a) wrote, re-introjected not an understanding of intolerable feelings/sensation but a 'nameless dread', and also would have identified with a non-understanding object which, despite attempts to communicate via ever forceful and frequent projective identification, remained unavailable to his psyche at a formative time. Anna Freud (Freud, 1954) also highlights an important point in her paper 'The concept of the rejecting mother', where she talks of the difficulty for the baby when the mother neither fully emotionally embraces her baby nor rejects him outright. If rejected outright, an opportunity exists for another mother/carer to provide security and love. The mother who 'wavers' between rejection and possessiveness does the more irreparable harm by:

> *"forcing her child into an unproductive partnership in which he fails to develop his capacities for object love" (pp. 379-380).*

I would argue that from what was known about Freddy's history his mother really struggled along these lines, and it left an indelible mark on his world of object relations.

In cases of extreme disruption to the container/contained relationship, Bion argued that having resorted to ever forceful projection into mother's mind, the infant over time begins to feel that whatever comes back has been denuded of meaning, leaving him with an 'internalized greedy vaginalized breast' that strips all goodness and:

> "*this internalized object starves its host of all meaning*" (1962a; p. 115).

Whereas Bion had psychotic forms of thinking in mind for more extreme cases, I would argue that elements of this type of dynamic contaminated Freddy's therapy, contributing to some of the difficulty I had with finding meaning in the work. Specifically, I would argue that a degree of internal vacillation existed for Freddy between the development of a thinking mechanism and a mechanism for the voiding of frustrating emotional experiences. In such circumstances, an ongoing struggle exists at times when Freddy found himself faced with the dilemma whereby he could either think about his frustration and all his past and present painful experiences that contributed to this

state, or avoid thinking about it altogether because the pain stirred up was too unbearable. This leaves avoidance as the only coping mechanism. The latter option, however, merely perpetuates an internal situation that further deprives, something Henry (1974) had linked specifically to the plight of maltreated looked-after children. It relates also to M.J. Rustin's arguments (Rustin, in press) about 'epistemic anxiety', namely an anxiety that is aroused in situations of learning, particularly learning that draws on elements of developing knowledge or understanding of oneself and others, which Bion (1962b) termed 'K'. I think it relevant to argue that for Freddy a degree of epistemic anxiety came into play when he was encouraged to spend time thinking thus learning about himself – what went on for him internally and about himself in relation to other people.

This challenging dynamic leads to a question that has been considered before when maltreated children have encountered psychoanalytical experience (Szur, 1983). What does someone with early experiences such as Freddy's do with therapy? In thinking about his therapy, and more specifically an opportunity to use an object into which he could project unwanted feelings, it is striking that Freddy had not completely given up on this well before his therapy had begun. To my mind this suggests that part of him understood psychotherapy as his chance to do some of what had not been possible when an infant. Whereas Freddy may well have been seeking an object to hold onto his intolerable, unwanted parts of himself, my aim, wherever possible was to bring to his attention the aspects of his inner world he showed to me in the therapy room. For example, Session 212 in section 4.2.3.2 highlights this struggle where Freddy was able to at least not attack me when I brought up something difficult for him – that he could not allow himself to have things he wanted. I saw this at the time as part of his tendency to re-deprive himself following his history of early deprivation. But I think it is also worth considering his identification at the time with a non-thinking/receptive object that he expected not just to not care, but an object that could not care. Two hundred and twelve sessions into therapy he was just about able to hear my thoughts about his capacity to learn something about himself, and possibly entertain the idea that I did care.

Despite his ability to slowly do something helpful with his therapy, I would also argue that Freddy often resorted to the 'frequent and forceful' degree of projection that Bion

alludes to, whereby a type of projective identification with a fundamentally uninterested/unhelpful object is built up. Such processes will, in Kleinian terms (Klein, 1946), lead to an identification with an object that is to be controlled lest it attack back – not an object to turn towards to seek support of any significant kind when the *paranoid schizoid* position predominates. Furthermore, some of Freddy's early sessions, for example session 72 in section 4.2.3.1, illustrate his ultimately intolerable anxiety, following the first summer break. Not only did Freddy communicate feeling like unwanted waste over the break, but he concretely evacuated such feeling when he urinated. He also deprived himself of a full session and he showed how difficult it was for him to manage the feelings stirred up by an object that may partially have been built up internally over the previous two terms of therapy going away and coming back. He had no sustaining absent object to help him over breaks - his object was not one that could help so imbued was it with early experiences of unmet need, frustration and a barrier to thinking about his inner world.

5.1.1 The role of the *Ego Ideal*

O'Shaughnessy (1981) draws attention to another important point in thinking about the capacity to think in relation to projection and introjection. Not only is failure in this area due to the mother/early caregiver's inability to provide an object unlike himself, an object that does not immediately evacuate the unpleasurable. Failure may also be due to the infant's hatred of reality or his excessive envy of his mother's capacity to tolerate what he cannot. To my mind Freddy did not relate unconsciously with a strong innate degree of envy. Interactions under the theme *Two Minds Connecting* capture much less a sense of envy of what he didn't have than an increased sense of his deprivation and feeling like unwanted waste (e.g. session 72). Similarly, session 183 in section 4.2.3.2 illustrates a Freddy who was able to tolerate my thinking capacity and patience etc. without having to 'do away with it'. Rather, he was calmly interested at times in how I might have been using my mind.

Linked to this idea I would suggest are arguments by Chasseguet Smirgel (1985), who draws together different views on the relevance of the *Ego Ideal* to the ability to manage internal reality. In the development of the ego, and its role in facilitating adaptation

to internal demands, Chasseguet Smirgel argues that for those infants who find the strength of persecutory anxiety too strong, more than just splitting as a defence against such anxiety takes place. Whole parts of the self, ego included, can be projected into the object, thus no integration of good and bad needs to take place. All the aggression can be got rid of elsewhere, and the object, now slowly becoming the *Ego Ideal*, imbued with goodness that should belong to the self, is introjected. But the introjected *Ego Ideal* is still fundamentally only the 'good' that was projected in the first place. The bad is 'still out there' and this aspect of psychic reality is to be avoided.

However, if internal reality is to be tolerated there are two barriers. *First*, the self is highly impoverished due to massive, constant projection and as such left without a solid ego to assist in facing up to psychic reality. This is similar to Bion's ideas (1962a) where the resulting excessive projection can lead to a difficulty for the infant's developing psyche to differentiate between self and experience. *Second*, the fundamental task of managing to tolerate all that was projected, once re-introjected, would involve not just trust in one's own capacity, but for someone like Freddy, trust in the consistent availability of containment in Bion's sense. Only then can he begin to start the process of relating in a more whole-object way. Something of the process of relying less on an *Ego Ideal* and more on an integrated figure was something Freddy came close to in session 54 in section 4.2.2.1. Therapeutically, I would argue that Freddy had an opportunity to move away from the paranoid schizoid position where projection dominates, to seeing how good and bad can reside together. On this occasion and in a rather concrete way, he could take back something that helped him to go on to repair (the plastic film on the window), and manage something more depressive. I would also argue that he was at that time free from the intense feelings of shame typically stirred up from not living up to an *Ego Ideal* that, as Chasseguet Smirgel (1985) proposes, is derived from periods of intense splitting and projection in reaction to overwhelming anxiety. Again, something more integrative, albeit fleeting, allows a degree of freedom or movement to explore something personal, and related to beginnings and ideas of origins. Barrows (1996a) and others have argued that this is an important part of the process of looked-after children's journey to developing better mental health - where internal and external reality can begin to reside more comfortably together.

5.2 Shame and humiliation

In further exploring how psychoanalytical theories of shame can help understand some of the findings generated from Freddy's session material, and linking it to above discussion of containment and a theory of thinking, I wish to consider one area in particular.

Post-Kleinian theories of narcissism and the ego school of psychology offer a useful framework for this type of understanding. First, is the idea of how what Chasseguet Smirgel (1985) refers to as the 'wish to be big'. This idea relates to how a child in the course of ordinary development will manage the transition of the development of an *Ego Ideal*, whereby something of the early narcissistic state should be projected onto parents in the first instance and then onto more advanced models, namely figures outside the immediate family. This will inspire the child's wish to be big, essentially the wish to grow and develop. The ordinary development of the *Ego Ideal* presumes that the child's development will have:

> "*a plan, hope and promise*" (p. 28).

However, in the context of a distorted parental relationship, problems arise in the child's ability to want to be grown up in a more ordinary way. A lack of admiration from parental figures will not push the child towards post-genital identification with the father, for example, when the time is appropriate. The child does not have to manage the father figure as a rival because there is insufficient separation from the mother figure to require a rival for her affections. A fusion with the pre-genital mother-child dyad results. It is important to note that Chasseguet Smirgel (1985) explores these ideas as part of her theory of perversity, which is not an argument I wish to make in relation to Freddy. However, there are elements of her thinking that I think apply to shame as something I wanted to explore.

In thinking, for example, about session 30 in section 4.2.1 which was one example of Freddy wanting an important milestone acknowledged, he wanted to let me know about his pleasure about being older, a little more grown up. But this was far from a

straightforward experience for him. Not only did his birthdays theoretically involve contact with his birth mother, which often did not work out, but even if the contact did go ahead as expected it was always a reminder that he was the only one of his many siblings not living with one or the other of his birth parents. Therefore, I would argue, in trying to understand why of all his siblings he was the only one in long-term care, Freddy must have thought he was fundamentally to blame, as we know looked after children often do (Boston & Szur, 1983). The defences that arise in managing such difficult feelings that Henry (1974) and others have written about explain much of the behaviour we often encounter in these types of psychotherapies. However, understanding what Freddy was defending against and keeping in mind my sense of shame and humiliation being 'in the air' throughout his psychotherapy brings these issues into stronger focus. As a transference object I could provide Freddy with opportunities to work through his feelings of shame - would I be happy he had his birthday? Do I admire his improvements? How would he handle the humiliation if he felt I did not? Comments and occasional thoughts about what he might think I thought about him were introduced but very quickly shot down - far more often than not these thoughts were unmanageable for him. But this would be unsurprising when what underlay the problem was that growing up and taking pride in being big was a root cause for his mother not just rejecting him (in his mind) because the baby was preferable to the growing boy, but continuing to let him down, miss contacts, and essentially be uninterested in looking after him, preferring instead to give her affections to her two younger children.

5.3 How shame and narcissism impact on therapy - being observed and triangular space

Symington (1993) has argued that the risk of narcissism is greater when the caregiver is the one responsible for the abuse and neglect. This was certainly the case for Freddy, and as Rosenfeld (1964, 1971) also argued, there is an intense anxiety created when true dependence appears in the transference relationship. It might also stir up all that he fears he was 'lacking' what his therapist has, but he would also place himself at greater risk of being in touch with all he has been deprived of. As noted above, Hoxter (1983) [section 2.4.1] warns of the difficulties when the maltreated child is reminded of what he has not had, the cycle of revenge and counter-revenge risks

being run, and needing to manage this is a vital therapeutic task. In reflecting on Freddy's wish to be big and have his development acknowledged, a line of thinking Mollon (2002) writes of adds another layer. Although I have little doubt Freddy wanted to bring the fact he was a year older, more able etc., into the therapeutic space, he was understandably guarded against a strong feeling of shame that would accompany this; not just because he would enter into unchartered relationship waters, but as Mollon reminds us, shame is associated with not having lived up to the *Ego Ideal.* As such, it is important to keep in mind Freddy's *Ego Ideal* was unlikely to have been one that promoted ordinary development, rivalry and acceptance of Oedipal exclusion. Instead, Freddy would more likely have been very wary, based on early experience, of development and individuation being something unwanted - that is, this development could be a narcissistic insult to the object.

Britton (1989), in writing about early Oedipal problems, argues in favour of the idea that when an infant can accept that there is a 'third' relationship, the one between the parents from which he is excluded, the capacity to experience not just what it is like to observe this relationship, but that one can also be observed, can in itself promote development. However, for someone like Freddy, I often felt that my observations of him quickly stirred up shame for what he lacked, and humiliation for what he had done wrong. Consequently, taking in what is on offer in therapy is further confounded. Furthermore, Houzel (2000), in an overview of the psychoanalytical experience of becoming a parent, draws together views that generally agree on the satisfaction parents draw from ordinary son/daughter identifications and how rivalries also reinforces these developments in the child. Houzel establishes a two-way street idea between parents and the child where reinforcement of ordinary pleasurable dynamics occurs when things in the early family life go well. Such reinforcements, when disrupted, can cement the parents' difficulties in offering the child what he needs to individuate without shame and humiliation predominating.

In considering the complications when narcissistic defences are strong, Jacoby (1990) suggests that when the individual has an experience of being observed, even understood or thought about, an internal reaction occurs whereby the idea that the observation is critical or if initially felt positive is quickly judged to be faulty, and leads to the thought 'who could love someone like me?'. Any positive regard is quickly turned into

a furtherance of an extremely poor view of self. All of this being at an unconscious level means it is challenging to bring into the therapy room for thinking about. Session 72 in section 4.2.3.1, I think, captures something of this dynamic. Not only did he have to manage his reaction to the break, urinating on the carpet and his shame at having done this, but also when Freddy looked at me whatever he saw at that moment drove him to a very concrete attack. The aim was to obliterate my mind, and I think to destroy any possible 'evidence' that he might be right about what he had put into my mind – my 'view' of him. This also puts one in mind of Reid's assertion (Reid, 1990) that an important experience for the baby is the discovery *with* the mother of both her appreciation of beauty in the baby, and the baby's ability to experience 'being beautiful', and internalizing this. One can again only assume, given what was known about his early years, that there would have been a dearth of such ordinary moments for Freddy, and that exploring this in therapy would have been yet another challenge. In particular, session 153 in section 4.2.2.2, captures something of Freddy's frustration at being another year older, yet still weighed down by far more infantile modes of responding, coupled with something to do with my image of a 'dirty, messy baby' left in his own mess.

5.4 The relationship between containment and shame

In terms of therapeutic technique, a challenge lay in having to find a way of not inducing shame and humiliation while at the same time trying to work within a framework that theoretically is encompassed in Bion's *Theory of Thinking* (1962a) and *Learning from Experience* (1962b). If one attempts to provide containment and facilitate re-introjection of more digestible projections in order to promote alpha elements by virtue of being 'well-balanced' enough, a complicated layer lies in the shame and associated humiliation when psychic reality is brought more into view. Whatever *Ego Ideal* Freddy would have built up and identified with and continuously felt he had not lived up to, I would argue that there was more shame stirred up when he also became more in touch with the psychic developments he had not managed to achieve, namely capacity to use his mind to think, not obliterate or attack. One's function as a therapist is partly to keep an analytical stance where possible, but this capacity can be very difficult for someone like Freddy to bear. Britton (1989) described the anxiety that can be aroused

when the therapist together with his/her thoughts are experienced as a couple relationship from which the patient feels excluded. To maintain an analytical stance I had to have thoughts, but for Freddy even the slightest hint of this could provoke shame for 'lacking' this ability and humiliation and an angry riposte for it being brought into the room. It is important to recall here that Alvarez (1998) suggested that in projecting what he cannot yet manage, the infant is conveying to the mother/caregiver that he lacks his own alpha function. It is yet another capacity that Freddy felt he lacked but I did not. I do not argue that this stirred up envious feelings, but that it would have stirred up strong feelings of shame.

More concrete reminders of what was missing were abound. The therapy room itself, having become almost stripped of many things that had been there at the beginning, even the window blinds, not only served to re-deprive Freddy via re-enactment, but also invoked more shame at being not good enough, undeserving and worthless. For me, concerns about propriety took over, and to help me manage emotional states expressed behaviourally at these moments, shoes were removed, items temporarily removed from the room – further shame for Freddy resulted. The original aim of promoting psychic development felt terribly set back at these moments and both Freddy and I had to find a way to survive it.

The above dynamics, when considered in terms of brief but very significant moments in the course of Freddy's therapy, to my mind relate to the notion of the value of the clinical fact in psychoanalysis. Spence (1994) argues that whether facts are true or not is less important than their clinical significance to the patient and to the therapeutic process. In my opinion, a clear example of a clinical fact occurred when Freddy told me in session 212 [section 4.2.3.2] that in his view his mother was not able to look after him but his father could. This was partially true, but it also indicated Freddy's need for such an idea to help him hang on to something fundamentally human in that his parents were unavailable to him for reasons other than him being not 'good enough' as their child. The painful work of facing up to what it might mean to be the only child of their union, that he was 'defective' as result of their inability to care without a robust mechanism of thinking and learning from experience to help remained very difficult, even though some movement in the right direction was evident at times. A relevant argument was made by Caper (1994) who wrote that when psychoanalysis is

working properly, by which he meant when a certain level of intimacy in the psychoanalytical setting occurs, therapist and patient can gain a type of conviction about the patient's psychic reality and inner world only available in that setting. Psychic reality is therefore the domain of clinical facts, and I would argue that there were several moments in Freddy's therapy when clinical facts could have been understood, but for complicated reasons, I would argue mostly to do with self-preservation, were obfuscated until now.

5.5 Examining particular technical issues in therapy

A particular difficulty for Freddy was the external situation which he had to manage at the same time as his therapy was taking place. Nearer the end of his foster placement with the W family, and subsequently his therapy, there was a growing worry that his father was intentionally giving Freddy constant messages that his placement was not good for him and that his foster carers didn't really care for him. In reality, Freddy would most likely have been very sensitive to what, certainly to me, seemed like ambivalence from his main carer, and often an outright antipathy when he was brought to his sessions, particularly when he was being 'handed over'. As was often discussed in supervision at the time, feeling handed over from carer to me must have stirred up earlier memories of being passed around, and yet again somebody else left to take care of him. As the placement ultimately broke down, although the reasons were complex, it was probably something Freddy had feared deep down was likely to happen to him again.

There are several technical issues that I want to discuss, particularly in light of what the findings from Grounded Theory application process have yielded. In addition to finding it very hard to 'find the right time' to offer interpretations or share my thoughts, I was also aware that the urge to 'manage' difficult situations was strong on my part. Whether this was in response to my anxiety about getting it right, worries about how my technique as an inexperienced trainee child psychotherapist would look if things got out of hand, or whether it was in part a response to something Freddy was projecting into me is worth considering further. For this latter point, in writing up this thesis

suggestions from academic supervision brought my attention to whether the management of sessions, particularly when I felt anxious that things in the room would get out of hand, stirred up feelings of shame and humiliation for Freddy that inadvertently created something he was unconsciously familiar with. Canham (2003) has written about something similar, particularly with physically aggressive children who have been maltreated and convey something of their early, often frightening, experiences, such as where on their bodies they were physically abused. But with help of both time and distance, Freddy's unconscious expectation of further shame that was never really far away has begun to make more sense.

5.5.1 Enabling insight without re-traumatising

One question that has remained with me is whether it would have been possible to find a way to address shameful and humiliating feelings without creating some re-experiencing those same feelings again. If the work of psychotherapy is truly about helping the patient gain internal world insight is the task always to be about finding ways to do this? One answer can be provided by keeping Bion's ideas of 'K' in mind, (Bion, 1962b), and that for some very deprived children, there is no minimum amount of therapy required before the internal reality can be more actively examined. Perhaps just the opposite is more helpful – that a mechanism for thinking, particularly one that is borne of the capacity to tolerate frustration, needs to be built up and this can take a very long time. We know (Music, 2010) that those children who lack an ordinary caring nurturing environment are often left with neurological development that creates a heightened sense of anxiety and interrelationship problems. Thus, considerable time will be required to get to a place when the therapist's mind is seen to have something good to offer, and the therapeutic space is one that can be trusted. In essence, the containment that was either mostly lacking or unreliable when Freddy was an infant is made available again, but of course we do not as child psychotherapists intend to collude with any idea that we re-parent children. Indeed Freddy himself made it clear that he knew he missed out on the original experience of being properly looked after, as he so clearly put in session 212 [section 4.2.3.2] that he was only in foster care because his mother could not look after him.

One needs to learn not just to offer timely and helpful interpretations but patience, and the skill of waiting for the child to indicate when he's ready and able to take in what we can offer him. It is important to keep in mind that Bion (1962a) described the development, in the absence of adequate containment, of the risk of the type of internalized object starving its host of all understanding made available. For Freddy, even a flavour of an object that denudes meaning from something ordinary that may be available to him, would essentially require an indeterminate amount of time to begin to appreciate that a different experience is possible. The feelings of shame that would also be stirred up when moving away from what the *Ego Ideal* demands, or the more conscious realization of being so disadvantaged helps to understand what Bléandonu (1994) suggests was one of Bion's important realizations. This is called the 'intermediary state' between healthy development and a total denial of reality, where omniscience is substituted for learning from experience. Again, for Freddy, there needed to be something substantial enough to give up his omniscience to allow himself to learn from experience. Time, rather than words, was the truer test of this.

5.5.2 The need for boundaries versus over-reliance on boundaries

Chasseguet Smirgel, (1984) describes processes linked to managing persecutory anxieties that play a part in understanding 'over-management' in a therapy such s Freddy's. When there is an over-reliance on projection into an object that becomes idealized by virtue of excessive splitting, the idealized object, often the breast, offers psychical sanctuary from what may come back from the bad object. At the same time, for some infants there can be an intensity of instincts which:

> *"seek unlimited gratification from the inexhaustible ideal breast"* (p. 179).

I would argue this creates an unenviable position for both Freddy and myself. When Freddy took the risk of trying to come to terms with an aspect of himself that is very psychically needy and possibly greedy, he also knew from experience he could easily be rejected when his needs were communicated. Neither option was easy for him. For myself as therapist, I needed, through the various mechanisms that therapy can

allow, to get a flavour of his level of need and nature of his anxiety. However, when one becomes identified with an 'inexhaustible breast', an unconscious defence can be to use boundaries and rules etc. to prevent that from being taken too far. I therefore denied Freddy something important at his moments of heightened need.

Given Freddy's early years lacked proper boundaries such as predictable routine, modelling of good behaviour, ordinary parental authority, I would argue he held a belief that no adults could be boundaried in an ordinary way. This meant during therapy that I identified with an object that immediately put boundaries in place before understanding of what else was going on. In essence, the urgency that existed when boundaries were felt to be missing prevented other aspects of therapy from developing. Keeping in mind all that could have stirred up fearful feelings for Freddy, arguably there were moments when Freddy did not feel safe in the therapeutic encounter, and being in touch with this anxiety I often acted quickly to keep it from getting 'out of hand'. I think another additional layer relates to the quick 'acting in' on my part. Canham (2003) and similarly Barrows (1996a) put the case forward for the importance of the therapist experiencing and even acting in at times in response to the most disturbing parts of the child's internal reality/experience in the therapy room given the child has no other means to convey it. When put in touch with what he felt he needed, Freddy would have engineered boundaries as a defence against this level of need. Again, the unconscious speedy reaction that at the time was 'all action and no thinking' on both our parts but for different reasons, can be understood in a new way. Not only might the speed at which Freddy may have worried his internal world was being exposed too swiftly, but I was tasked with trying to make sense of what Bion (1962a) termed *beta elements*. These two dynamics, when conflated, to my mind firmly reinforce the imperative that the work will need to proceed slowly, not just to prevent it feeing to overwhelming for the patient, but to allow adequate development of the required psychic mechanism to deal with the insights therapy may offer.

As a child psychotherapist in training, I felt a strong need to feel in control of the situation and not to allow Freddy's sessions to spill out into the rest of the clinic. It was helpful and interesting to hear fellow team clinicians working near my consulting room describe the noise coming from the room as actually helpful for their patients at the time. One adolescent girl said to a colleague (she had also been looked-after when

younger) that my patient was expressing things in a way she would have liked to - making noises and bringing attention to her internal struggles. These types of comments helped to keep in mind that the clinic was where children could come to do difficult work, and we look after *them*, they do not need to look after the clinic. Yet a concern remained that in order to distance myself from being in touch with Freddy's distress and more painful feelings I 'managed', as opposed to tried to find a way to engage with these feelings, and ran the risk of re-depriving him of containment. It is difficult to have a reasonable degree of confidence at times about whether the management I fell back on was genuinely necessary to keep Freddy safe, or was more to do with acting in, or to do with protecting myself to avoid looking incompetent.

A particular concern arises when Freddy exhibited a degree of understanding or capacity to make important links but I was too pre-occupied with boundaries to catch on. An analysis of sessions 151 and 153 in section 4.2.2.2 illustrates the complexity of these issues. Whereas I was pre-occupied about being kept busy as a defence against learning something important just after a break, Freddy almost immediately at the start showed me in quite a straightforward way something of his feelings about the break. I managed to catch up with Freddy before the end, but a remaining concern is that throughout therapy, particularly earlier on, there were instances where Freddy may actually have been communicating something important about his internal world, which could have been explored, had calling on boundaries not got in the way.

5.6 Impact of external world on Freddy's psychotherapy

It was evident throughout Freddy's therapy that his relationship with his main carer was strained, and this didn't really shift as the therapy continued. As the placement, like all previous foster placements, ultimately broke down, I think it is useful to keep in mind the restraints this situation would have put on Freddy, particularly his ability to trust that those who were 'tasked' to care really did care. He may not have trusted that I would not tell his carer about all the things he did - on a few occasions sessions ended early and some things that happened did have to be conveyed to his carer. I

would argue this anxiety at times placed a considerable restraint on Freddy's experience of his therapy.

In looking back at what it must, at times, have felt that I was asking Freddy to do, a real difficulty lay in the shadow the real threat of being 'booted out' of his placement. The world of therapy and the actual world in which he lived, both school and particularly his foster placement, probably proved too difficult to reconcile. An interesting comment was made by the deputy head teacher at his specialist school, when Freddy and I met for the final weekly stage of his treatment after his foster placement broke down. She said I would experience 'school Freddy', in that she felt he would be better able to manage his behaviour than I had worried he would, given the room in which we were meeting was full of toys, costumes and a range of items I worried would not survive the sessions. The therapy room was also next to a kitchen the students used to learn practical cooking skills. Being near a kitchen, a place of sustenance and probably evocative of a home setting, must have been provocative for him. However, the deputy head was right in that Freddy managed this new venue quite well. On reflection, given Freddy saw me for his intensive therapy at the CAMHS clinic at the end of the school day during which time he had been trying hard to hold himself together, there is little wonder he 'let it all out' in his session. I have little doubt his exuberance and at times forceful behaviour was not just to do with his anxiety about being in therapy, but was also rebounding from the 'school Freddy' he managed to be for the whole day.

A comment during academic supervision about whether the psychotherapy actually helped Freddy to develop in such a way that he outgrew the placement was thought provoking in that despite my concern that I 'over managed', there was sufficient contrast between the overall experience in therapy and the rigidity of the placement. Despite what I felt resembled something more paternalistic and 'firm', the degree of more maternal warmth that could be provided and more importantly tolerated by Freddy over time in therapy may have allowed him to become aware that he needed more from his placement, which was ultimately not forthcoming. Furthermore, the relationship between foster carers and Freddy's father soured considerably compared to how it had been earlier on in the placement. It was felt by the clinical treating team as the placement was nearing its end that Social Care did not take these concerns seriously. The

issue from their point of view was solely the foster carers' rigidity and inability to respond to Freddy's development. I would argue that although partially true, this was not the whole picture. Freddy, in some ways, was in a position that proved too much to bear, and he had to deal with yet another loss, but I feel he was able to use his therapy to learn about himself and take advantage of a different experience and to what end he will use this as an adolescent and adult I may never know.

5.7 Primitive modes of expression and their link to neurological development

In light of the ever growing understanding of the impact of early maltreatment on subsequent brain development, I wanted to incorporate elements of this research into some of my findings from Freddy's therapy.

Almost immediately Perry's work (Perry, 2002; Perry *et al.*, 1995) comes to mind, which established that maltreated children with poor early environments are much more prone to interpreting ambiguous or even benign events as threatening. I think session 72 [section 4.2.3.1] can be understood not just in terms of the shame he may have experienced, and difficult emotions stirred up by the break, but also the degree to which something I felt was at the time a benign moment, was anything but benign for Freddy. As a young child Freddy is known to have witnessed domestic abuse between his parents, including physical violence from his father to his mother, and as Anda *et al.* (2006) have shown, the reduced capacity to manage stress happens when the hypo-thalamic pituitary axis (HPA) does not develop, its underdevelopment often linked to early emotional abuse such as prolonged exposure to violence. Perry *et al.* (1995) put forward that for those children who have experienced prolonged exposure to violence when young, the usual 'fight of flight' response can quickly ensue when they feel they are in danger or at risk from harm, regardless of the reality of that perception. Freddy often seemed 'ready for the fight', and I think that when he hit me particularly hard on that one occasion just after the first summer break his 'danger' was doubtless psychically complex, but he was also at a disadvantage due to likely neurological predisposition to 'fight' at those difficult moments.

An extra challenge, closely related to psychic defences called upon in psychotherapy, relates to how *procedural memory* often underlies early traumatic exercise (Divino & Moore, 2010). As opposed to the more consciously accessible *declarative memory,* procedural memory underlies traumatic pre-verbal memories and experiences, and its likely role in consequent unhealthy relationship patterns in later life are not easily accessed or verbalized by the child as he gets older. This too will have an impact on the process of therapy (Divino & Moore, 2010), and I am sure had an impact on some of the difficulty for both Freddy and myself getting close to understanding his experiences.

Similar to R. Emanuel (2004), in his account of work with an 11-year old patient Michael, who had trouble recalling aggressive behaviour aimed at his therapist, there were moments when Freddy seemed to forget aspects of aggression that I sometimes wanted to address. However, I never had a strong sense that he had issues recalling these incidents, and I would argue that avoidance of these things constitutes a more likely explanation. I think this in a way was an advantage for Freddy, and his ability to make a link between something more aggressive and a wish to attempt reparation, that I believe occurred in session 54 in section 4.2.2.1 above, was possibly achievable because he could actively hold on in his memory to what he had done. Under the right circumstance he could then develop a more helpful, and I would argue different, response.

5.7.1 The impact of parental mental health on therapeutic process

The type of experiences children of depressed mothers are more exposed to, namely lack of attunement and/or over-intrusiveness (Murray & Cooper, 1997) can lead to an increased risk of negative emotional regulation that has been linked to underuse of left hemisphere functioning. It is also important to remember that infants are thought to be particularly vulnerable to such neurological outcomes between six and 18 months (Glaser, 2003). It was known that before Freddy's second birthday there were serious concerns about his mother's mental health and her ability to look after him. I think in a case history as complex as Freddy's it is difficult to know how attuned his mother would

have been to his needs, but being left for prolonged periods in his cot makes it highly unlikely he received consistently attuned care or was on the receiving end of primary maternal pre-occupation (Winnicott, 1956). I think it a testament to Freddy's innate drive to want something better in the face of not just gaining insight into his internal reality, or managing the external demands of psychotherapy highlighted above, but also how his early experience probably placed him at a neurological disadvantage in thinking about what he was missing.

5.7.2 Domestic violence and its impact on therapeutic processes

Exposure to domestic violence during infancy, particularly intimate partner violence, as established in section 2.1.1.4 above, increases the risk of experiencing other forms of maltreatment (Gilbert, Spats Widom *et al*. 2009). It has already been established that some of the neurological consequences of exposure to prolonged domestic violence include issues with language, communication, and inhibition (Tsavoussis *et al.,* 2014) For the child who has witnessed physical violence between their parents from an early age, as Freddy was known to have done, coupled with his known neglect and deprivation, it would be unsurprising that attempts at emotional connectedness or discussing feelings related to early experiences would invoke a tendency to react violently at such times. Moments of connectedness or reminders at the resumption of therapy after a break of the connectedness that felt withheld over the break could help to explain some of the violent reactions Freddy displayed.

Further difficult questions are raised, related to whether one needs to address either anxiety about dependence or actions/reactions linked to procedural memories that R Emanuel (2004) discusses in relation children who have experienced trauma at the hands of their caregivers. The answer is likely to be both, again emphasising the need to approach psychotherapy for maltreated children as something that requires a long-term approach. But that something that can address what Gilbert, Spatz Widom *et al.* (2009) describe as the 'burden' of child maltreatment when long term outcomes of poor mental health, education and employment are taken into account. I would argue it only realistic that, for some maltreated children, a considerable amount of time needs

to be devoted to therapy to begin to help them to take advantage of education and subsequent employment opportunities when older.

5.8 Further discussion of themes

Before drawing conclusions from the above findings and subsequent discussion, I will develop the findings further with more general reference to the literature review from Chapter 2.

5.8.1 'Identification with the aggressor'

Maiello (2000) has proposed a way of understanding aggressive behaviour and 'mindless' attacks that has been helpful in understanding some of Freddy's related behaviour. I should make it clear that Maiello largely refers to 'mindless' violence, one that appears to have no object, thus the aggression does not seek to link or communicate. I wonder if Freddy, who largely seemed interested in communicating with me, even at times of heightened aggression, nonetheless also displayed something rather 'mindless' at times. Bion (1959), in proposing his theory of the importance of links between self and objects, and links between one's objects, emphasized how such links help to build up an internal world that promotes thinking, language and other developments that gradually give meaning to the self, the world and the self in the world. But, as Maiello (2000) argues, when early trauma disrupts these links, communicative developments are compromised. It is understandable, therefore, that there was considerable 'identification with the aggressor' in the absence of ordinary linking - how could Freddy be expected to trust his therapist's mind would not be replete with aggression? And not just the aggression he may have communicated through 'ordinary' projection, but if his mind was struggling to make meaningful links, surely at difficult moments in therapy he experienced my mind as similar? Moreover, attacking my mind (physically and psychically) may have had a 'mindless' quality to it as there was nothing meaningful for Freddy to link to. Moreover, attacking my mind did not have an air of attack driven by envy, as destroying my 'mindless' mind would have been of no great loss -

it didn't contain anything lively or generative. It was simply another thing to attack, with no object relational quality attached.

5.8.2 Allowing thoughts about the other

In developing this theme, ideas put forward in sections 2.3.1, 2.3.2, 2.4.3 and 2.9.2 are particularly relevant. Ideas related to establishing the function of therapy, and the early ideas from work with severely deprived children are mirrored in this section's themes. In addition, issues relating to the Oedipal situation will be incorporated further.

5.8.2.1 Genuine concern

For Freddy, beginning to internalize something reparative/developmental required an appreciation of its function or purpose for himself. This is not a verbal exercise, but an experiential one; one that could provide him with his own predictable space, where he could begin to explore a particular relationship. Miller (1980), amongst others, described the importance of this process for children who have difficulty acknowledging the separateness of another's mind, but who can go on to obtain something important from awareness that another mind can provide something helpful. Additionally, Berse (1980) highlights the importance of experiences early in therapy that facilitate communication which may initially seem little more than effluent-like projections, but are important nonetheless for the patient to feel understood. Confidence in understanding can make some challenging feelings more tolerable to take back after a while.

5.8.2.2 Meaning through symbols

This theme also relates to developments linked to increasing acceptance and working through of both depressive anxieties and Oedipal issues that can lead, as Segal (1957) proposed, to mental development that ushers in the potential for creativity via sublimation. One form of such creativity is symbolic equation. Bartram (2003) has argued

that the capacity to negotiate the demands of Oedipal reality can be restricted or absent for some children removed from their birth parents. Canham (2003) described similar dynamics for looked-after children, and citing Steiner (1985), ME Rustin (2001) draws attention to a tendency of looked-after children to 'turn a blind eye' to Oedipal reality. In using airplanes to symbolize his anxiety as opposed to aggression, I think Freddy showed a considerable move forward in his psychic development. At the same time, I wonder how much such psychic development may be linked to differences in declarative versus procedural memory, described in relation to a maltreated boy by R Emanuel (2004) - section 2.9.2. Specifically, I wonder whether a reduced need to 'turn a blind eye' could allow Freddy to express his anxiety about both the planned break and the unplanned extra week, and remember his feelings about the break both before the session and during the session itself. The way his memory worked seemed more integrated and manageable for him, and it points to a possible link between intrapsychic and memory processes.

5.8.3 Two minds connecting

This theme can be further developed in terms of thinking about attachment processes, particularly disorganized attachment, and ideas about shame and narcissism that makes relating so challenging.

Prior & Glaser (2006) have outlined how secure attachment behaviour is associated with stable, predictable and nurturing early caregiving environment. The converse is generally true, so children with deprived and unstable early environments will show attachment behaviour of a disorganized type, with significant implications for how they relate to others when older. Freddy was reported to have shown secure attachment behaviour under certain circumstances but this was not consistent. His behaviour could also be very challenging and almost 'anti-relational'. I have little doubt his tendency to feel humiliated contributed to his difficulty in this area. Controlling behaviour, often linked to latency-aged children with histories of disorganized attachment (Prior & Glaser, 2006) can be understood in the context of ideas about narcissistic organization and shame that I will discuss next.

5.8.3.1 Minding the gap

In his discussion of narcissistic organization, Kernberg (1975) [section 2.7.5] proposes that when the self is 'happy and at peace with itself' it is able to invest more in external objects and their internalized representations. An investment of libidinal energy in ordinary narcissistic states, that eventually gives way to object libidinal investment, paves the way for a pulling together of split-off expression of love and hatred towards objects. After a sustained experience of this pulling together, the self is then reassured of its own goodness (also proposed by M. E. Rustin, 2006). This is made all the easier, later in development, when the *Ego Ideal* has largely been lived up to. However, a general movement towards objects can be halted when, for example, difficulties living up to the *Ego Ideal* occur. This is not necessarily something that occurs very early on. It can happen even after some generally positive development has already occurred.

In addition to issues with *Ego Ideal* identification, an example of a problem that may interfere with external object identification, and trigger more narcissistic tendencies, is a complicated mourning - something it could reasonably be argued Freddy experienced several times, if his moves between foster placements are included. But the 'trigger' so to speak, and the complications of *Ego Ideal* identification discussed above lead, as Kernberg (1975) also suggests, to difficulties in libidinal investment in the therapeutic relationship. This layer of complication does not emphasize fear of dependence as a barrier to treatment, but instead refers to an internal dynamic where capacity to invest in an external relationship, one that psychotherapy can represent, is either underdeveloped or has regressed partly due to external disruption. *Minding the Gap* reflects on the difficulties stirred up by the disruptive nature of therapy breaks, and how dependence on an object that 'comes and goes' is best avoided. However, it could also be understood as something that captures the re-experiencing of loss and mourning stirred up by breaks in a process where libidinal investment is withdrawn back into the self, away from the therapy/therapist. It adds to the argument that for children like Freddy, with such complicated early histories, only long-term therapy can properly address their psychological needs.

5.8.3.2 Thinking about thoughts

Wollheim (1984) suggested that shameful feelings can arise when some realization/acceptance takes place following depressive anxieties and integration within the ego of split-off qualities of the object. Specifically, the once-hated, frustrating object comes into view as the same object that is loved and idealized. Depressive guilt is experienced as a result. At the same time, Wollheim argues, the self also has to tolerate shameful feelings in accepting that it hated the same object it also loved. I think Freddy made strides when he was, in a rather straightforward manner, able to experience my mind (and its thoughts) as something of interest, something that perhaps even worked in *his* interest, rather than one that he previously felt viewed him as something to be forgotten, only worth depriving again.

Accepting that the breaks in therapy, and my mind as a separate functioning entity, was nonetheless a development that took place with considerable effort on Freddy's part. I believe that aspects that of his controlling behaviour, reported long before he began therapy [section 1.1.3], can be understood as his way of maintaining a degree of the *status quo*. At times of change, loss, or other anxiety provoking situations, I would argue Freddy needed to feel in control by virtue of engineering reactions from others that he expected. I believe his controlling behaviour was intended to try to keep at bay experiences that he only had an opportunity to safely experience in therapy - that separation can be tolerable and thought about, and that another person thinking was something he could gain from. I appreciate, now, how easy it can be to overestimate this capacity, even when one thinks one knows a child's history of early experiences.

CHAPTER 6 CONCLUSIONS

Implications for clinical practice

With the above discussions in mind, I wish to conclude on some areas relating to clinical practice that the current study highlights, in particular issues related to technique, behaviour management and foster placements.

6.1 Implication for technique - the place of interpretation

While the mainstay of psychoanalysis has been interpretive work (Joseph, 1985), the type of mind that can use an interpretation is one that does not need to project so fiercely, so for some patients another way of working is required. Although this idea has been considered in work with looked-after children in particular (Hunter, 2001), I now believe that sensitivity to internal world dynamics, such as the interplay of shame and being in touch with original deprivation is key to the ground-laying work only psychotherapy can hope to achieve. Hunter advocates 'interpretations in the positive' for some children with histories of maltreatment, where a re-wording of difficult dynamics indicative of psychic reality can be very powerful. However, I think even before this can be done, the mind receiving interpretations can simply need time to develop the initial capacity to think about experience, and for that a lot of patience for patient and therapist is required.

This brings to mind Kenrick's view that there can be a real risk in making premature links before the emotional experience becomes real in the present (Kenrick, 2005). This line of thinking is, in part, due to a shift, as outlined by Bott Spillius (1988), in post-Kleinian psychoanalysis from emphasis on destructiveness and part-object interpretations to emphasis on projective identification and countertransference. Both of these ideas became central to Bion's ideas about the importance of containment in both thinking *and* learning from experience.

6.2 Understanding the need to 'manage'

When over-management occurs, is it due to anxiety related to strong countertransference or, following Hoxter (1983), trying to prevent a spiral of revenge and counter revenge from developing? Whatever underlying reasons might be applicable, I think Lykins Trevatt (1999) made a salient point in arguing that the outrage of abuse is literally forced into both the minds and bodies of children, and for some children 'not to be reminded' of abuse can go a long way. This can mean that playful behaviour is not necessarily an avoidance of facing up to psychic reality. I still worry that my superego got in the way of allowing more genuine moments of playfulness that are in themselves a new experience for a child such as Freddy. I regret not taking more opportunity to have Freddy see me enjoying more of these moments with him.

6.3 When attention to the external world needs to be considered in the therapy room

The therapist's capacity to be aware of even the smallest shift seems vital for children, who like Freddy, have a series of disappointments in life. That said, in Freddy's case, his father, despite all the concerns, did show commitment to his son and rarely missed contacts. I would have thought that some of Freddy's relationship with his father transferred onto me. Given his father's refusal to accept any responsibility for the trauma and deprivation Freddy experienced, there must have been a feeling for Freddy that he got 'more of the same' with his father, in that there was little shift over the years in his father's ability to view things. As a result, Freddy may have been expecting much the same from me, and any indication otherwise may have been unsettling and actively worked against. For example, I wonder now what it meant to Freddy when I spoke to processes in the therapy about him missing me/his sessions when I went away - how I took responsibility for things that is helpful for an adult to take responsibility for. This speaks to the need for the therapist to be aware of external circumstances in these situations, as not only is the internal world a central pre-occupation, but the external world will inevitably impact in a variety of ways we might otherwise seek to avoid.

Boston (1967) wrote about this issue and advised holding a dual position of considering the impact the external world may have on treatment, but also remaining watchful of a tendency to be pulled towards using the same external reality as an excuse to avoid examining internal reality.

6.3.1 Contact and its impact on the therapeutic process

Freddy's contact with his parents continued throughout the time I worked with him. His mother's consistency was not so good, and there were several times he was disappointed at the last minute. I am unsure about his mother's attitude but his father did not shift. In fact, his father often asked Freddy to explain his behaviour. I think it adds to the challenges of an already difficult psychotherapy when, as Loxtercamp (2009) argues, the sought-after openness in the contact process doesn't always occur and children can be more harmed by concealment of the truth that may take place instead. This is an issue that I still think can limit the potential of psychotherapy. It is almost fortunate that due to the immense amount of work Freddy could have done once he had developed ways to think about his emotional experiences, this particular issue was not necessarily at the forefront. It remains, nonetheless, something that needs to be carefully considered when embarking on complicated investigations where the interface of internal and external reality is especially important (Barrows, 1996a).

6.4 Implications for foster placements

I wish to reflect more on the implications for a foster placement when a child with difficult and challenging behaviour is placed with 'behavioural specialist' carers, as was the case for Freddy. While one can feel at times disappointed in what therapy ultimately achieved, and I did feel very worried about the placement breakdown, there are more hopeful messages to be taken from this research. A comment during academic supervision early in the research process about how Freddy may have been helped by therapy to express his needs in such a way that it made the placement incompatible as time passed makes me now think about the place that support sessions for carers have alongside individual therapy for the child. It may have proved,

although I was unable to ascertain, that Freddy's development, both emotional and intellectual, would only be promoted in a setting such as the therapeutic residential school he moved to.

At the same time, however, I also wonder whether it would help for foster carers who manage and respond to challenging behaviour from a behavioural stance to be encouraged to understand internal world dynamics. L. Emanuel (2002) argues that in certain instances it can and indeed advocates that it may even be essential. This idea is echoed by Russell (2011), who argues that support for carers, especially in promoting an understanding of what psychotherapy entails and requires to be most effective, should be placed at the forefront when planning child psychotherapy treatment with looked-after children. Given Freddy's foster carers' predominately behavioural approach, it is unclear whether this would have worked in this case, but it may be something that needs to be thoroughly assessed at the same time as the looked-after child's psychotherapy assessment. This may, where feasible, help the placement survive, particularly if the child does, by virtue of his therapy, 'outgrow' the behavioural response, and needs something more sensitive and responsive to internal struggles and shifts. I believe Freddy ultimately moved to the best possible place for him and he later returned to foster care, but his foster placement ending while in therapy was yet another failed experience, and to him he must in some way have felt 'moved on' again, facing yet another disappointment.

6.5 The role of intensive psychotherapy for children removed from birth families - the opportunity to provide a different experience

Returning to the review by Macmillan *et al*. (2009) of childhood maltreatment, it is important to note what long-term foster care may provide compared to those maltreated children who remain at home, or return to their families after a period of care. Under optimal circumstance, where foster carers can support intensive psychotherapy (as was the case for Freddy) an opportunity to address the looked-after child's challenge of managing where they came from, where they are now, and where they may

go onto becomes available. Furthermore, at the time of moving to the therapeutic residential school, discussions centred on Freddy's likely return to his father's care once his time at the school would come to an end on his 13th birthday (see *Appendix A*). Although I was unable, on follow-up, to confirm more than the fact that Freddy had moved to a new foster placement (his fifth in total) from the residential school, it appeared as though he had not in fact returned to his father's care but was managing a more 'ordinary experience' with special educational provision. It may have been decided that returning to his father's care was not in his interest at that point, and foster care would be better for him.

As was raised at the follow up meeting in early 2012 between CAMHS and residential school staff (child psychotherapists) just before I saw Freddy (see *Appendix A)* the staff at the residential school described Mr F as someone for whom feeling humiliated was 'never far from the surface'. I wonder whether, for Mr F, more humiliation resulted from evidence that despite his wish to look after Freddy, the LA (and others including CAMHS) felt his care should be left in the hands of others. Mr F was no doubt committed to his son, but facing up to the actual reality possibly stirred up a degree of humiliation that made it untenable for Freddy to return to his care when aged 13. Such humiliation on Mr F's part may have been viewed as a risk factor in undoing the gains Freddy made at his residential school.

It was also unlikely Freddy received intensive psychotherapy at the residential school. To my mind this confirms that he had benefited, in part at least, from his experience of intensive psychotherapy which hopefully provided a space for him to work out important issues of identity, how his internal world worked, and enhanced his ability to go on to (again) enjoy a more ordinary family experience.

6.5.1 Never too late to intervene

As reviewed in sections 2.8 - 2.8.8 above, neuroscientific findings point to the importance of positive nurturing early environments in brain development. This could be interpreted as treatment only being effective before any 'critical period' has passed. However, an argument can be made for treating children who may otherwise be

viewed as ‘too old’ to respond to intervention. While neuroscientific research highlights the first two to three years as particularly important in this regard, Gilbert, Spatz Widom *et al.* (2009) also stress in their review of child maltreatment that every risk factor that can be reduced matters. In this respect, I would argue that child psychotherapists are well placed to provide maltreated children with an opportunity to address some of the psychological disadvantages that result from their early histories. This the domain of long-term psychotherapy, and although making an argument for what looks like an intensive and/or expensive treatment may seem unwise given current NHS financial pressures, there has to be acknowledgement of the even greater risk and cost in adulthood of maltreatment going untreated.

6.6 Implications for research

In this section arguments, as referred to in Chapter 3, are considered in relation the evidence base of mental health treatments, particularly for maltreated and looked-after children. I will first reflect on how the role for psychotherapy and personality problems related to maltreatment experiences could be developed by further research.

6.6.1 Child maltreatment and personality disorder - what does the absence of association indicate?

Given the lack of clearly established association between childhood maltreatment and personality disorder later in life (Gilbert, Spatz Widom et al., 2009), I believe interesting questions, that future research may elucidate, arise as a result.

Psychoanalytic theory suggests a clear link between childhood maltreatment and adult personality disorder, particularly narcissistic personality structures that arise from traumatic childhood experiences at the hands of parents (Symington, 1993). But if research into this area does not empirically support these findings, what could child psychotherapy research offer to bridge the gap between research and theory?

Drawing on this case study, I would argue that maltreated children, seen in psychotherapy at a relatively young age, can have a different trajectory from those patients whose personality issues are only recognised as clinical problems as adults. Those who are maltreated by their parents/carers but subsequently placed in foster care or other care arrangements that support access to psychotherapy may then respond to treatment that addresses the interpersonal difficulties maltreated children inevitably have to manage. However, for those maltreated children who do not access psychotherapy/other treatments, much clearly remains to be learned about why the research does not, at this point, indicate a clear association between maltreatment and personality disorder. We still do not know enough about what happens in the intermediate years before personality can be diagnosed in adulthood.

Cases studies, such as this one, are well placed to examine the issues that arise in these circumstances, particularly those interpersonal difficulties that can get re-enacted with foster carers, teachers or peers. I think it is vital to better understand what aspects of the internal world will help maltreated children enjoy better external world experiences. In thinking about my follow-up visit to Freddy at his residential school (*Appendix A*) I am aware that some of his behaviours towards peers (as when he intentionally frightened another child, and seemed quite pleased about it) if left unchecked, would most likely not bode well for him.

6.6.2 Current child psychotherapy research - what can be learned from comparable adult research?

With Shedler's review of the efficacy of psychodynamic therapy in mind (Shedler, 2010), I believe valid arguments can be made in relation to two specific important areas of child psychotherapy research:

1) As Midgley (2006) writes [see section 3.2 above], the objections raised in relation to the use of the single case study design in mental health research include the accusation that one study does not describe clinical phenomena applicable to many - the 'generalisability problem'. However, as Midgley argues, most large scale studies included in NIHCE guidelines involve findings that rely on statistical averages, and

important individual differences are lost when numerical properties of research are the sole focus. Shedler's review of psychodynamic therapy draws attention to some very important issues in this regard. He states that there is room for findings from case study meta-analyses of research to contribute to the knowledge base. The argument is not that many case studies equate to a large-scale RCT, but that findings that consistently point to similar outcomes, and the processes that contribute to those findings, are worthy of inclusion in the knowledge base. Staying with processes that lead to change in mental health research, Shedler also suggests that many processes and therapeutic techniques germane to psychodynamic therapy may help explain some of the findings from mental health research often attributed to other therapeutic approaches. What psychoanalysis uncovered and developed, other approaches have incorporated but not always with an acknowledgement of the credit deserved. Moreover, Shedler reminds us that RCTs do not serve to examine the theoretical approach involved or what it aims to do. A large scale RCT comparing different treatments for looked after children may help establish the benefits of one therapy compared to another approach, but it would not go as far as a case study in increasing our understanding of the precise ways in which therapies help to effect change. Without an opportunity to apply Grounded Theory or similar research tools, I cannot envisage gaining an understanding of some of the complex processes that came to light in this case study.

2) Shedler (2010) also argues that a sizeable amount of psychological therapy research is written for other researchers, with heavy reliance on statistical analyses in the findings. This presents a problem in making findings accessible to clinicians, and possibly contributes to how the dismissal of psychodynamic research findings has gone, to some degree, unquestioned for quite some time. Meta-analyses and reviews are required for the dissemination of findings to make them more accessible to practitioners, and as such reviewers have to be sympathetic to psychodynamic therapy to willingly include research that indicates the efficacy of psychotherapy. In the absence of this, Shedler argues, psychoanalysis has to get itself included in RCTs, without losing sight of the importance of its main techniques, if it is to get the acknowledgement it clearly deserves. The IMPACT study [section 3.2] outlined by M.E. Rustin (2009), aims to address this issue in the treatment of childhood depression.

There is, I would argue, considerable scope for psychotherapy with maltreated children to be included in a large-scale RCT. Boston *et al.* (2009) have already conducted research in this area and have documented the benefits of psychotherapy with maltreated children. But as the current research climate stands, more will be needed to ensure psychotherapy research is acknowledged, and the RCT still holds considerable influence. Nevertheless, Boston and her colleagues and the considerable body of work with maltreated children outlined in Chapter 2 serves to remind us that over several decades a substantial amount has already been learned about how psychotherapy helps this clinical population. The findings in this case study add to this body of knowledge. I believe that for some children with particularly severe maltreatment histories it shows that they will require something slow-paced and intensive that would hopefully address some of the fundamental psychic experiences Bion had highlighted over 50 years ago.

In the absence of the provision of long-term intensive psychotherapy to maltreated children, a manualized treatment of time-limited therapy, such as one developed by childhood depression IMPACT researchers (Catty, Cregeen, Hughes, Midgley, Rhodes & Rustin, 2016) could provide some structure to the likely and helpful processes and dynamics of such a therapy. Based on findings to date, and from this case study, areas to include could be:

- Management of intensive projection
- Enactment (of earlier abuse and trauma)
- Acting in (paying close attention to)
- Interplay of internal and external reality
- Stages of development of a thinking mechanism
- Narcissistic defences that may explain aggression and/or shame

6.6.3 'Linking' and maltreatment - what can be learned?

In understanding psychotic illness, Bion (1959; 1962a; 1962b), emphasized the importance of linking, and argued that through a process of massive projection the external world could be filled with 'bizarre objects', a contributing factor to symptoms of psychosis such as hallucinations. I believe an argument can be made for significant research into the impact of maltreatment on the capacity to link. Arguments have been made of the centrality of the containment process in infancy to both clinical problems, and detailed research, which is more easily achieved by case studies, could help to shed light specifically on how a thinking mechanism can be facilitated through psychotherapy. I have already argued that the long-term nature of this work is important to acknowledge, and I also wish to argue that understanding how this can be done, once the provision of long-term work is agreed, would be a valuable undertaking. The impact of maltreatment on brain development is increasingly understood, and knowledge of which centres of the brain are compromised could be helpful in psychotherapy for maltreated children.

6.6.4 Neuro-imaging and psychotherapy

In outlining the ways in which neuroscience helps researchers understand the variety of benefits of various types of treatments, Zilberstein (2014) writes that neuro-imaging has shown some cognitive improvements in adults who have had cognitive behaviour therapy (CBT). However, similar research with children has not yet been conducted. I would argue that, as Zilberstein highlights, the verbal capacity generally thought necessary for CBT to prove effective is only part of the way in which psychotherapy can effect change. As such, psychotherapy as a treatment may well find an ally in neuroscience, as one can confidently argue it has in confirming the importance of early years experience and subsequent mental health.

6.7 Limitations of the research

This case study was designed to understand one child's therapy better, and as such its application to other children, even with similar histories and experiences, will be limited. Although the intention is to learn from one case and apply this to another, the variability amongst all children, and looked-after children in particular, requires caution.

One question that would need to be carefully considered is how suitable is intensive psychotherapy for all children? Are they at a point in their lives when they are ready to address fundamental issues such as the extent of their deprivation, and what this means for them in relation to peers, non looked-after children, and so on? For some, regardless of whether they might be 'psychically equipped' to attempt this type of treatment, it may stir up too much for reasons that as yet need to be better understood.

The need for a supportive network has already been discussed above [section 2.2.2], and it is difficult to conceive of an intensive therapy as described in this case study being replicated in significantly different foster care settings. Furthermore, whether intensive psychotherapy with a maltreated child a few years older than Freddy, or an adolescent, would be workable is doubtful if the degree of behavioural 'acting out' was replicated. Managing aggression and violent behaviour has its limits, and speaks in another way to the timeliness of treatment and issues of safety for patient and therapist alike.

There are possible cultural limitations to this case study's findings. As discussed in section 2.1 above, children from mixed-race backgrounds are over represented in the LAC population, and children from Asian backgrounds are underrepresented. With this in mind, how representative the conclusions from therapy with a white British boy would be to children with different cultural experiences and identities cannot be conclusively stated. Only specific research in this area, incorporating these variables, could address such issues.

6.8 Concluding thoughts

I wish to conclude on one of my observations of Freddy when I had a follow-up visit meeting with him several months after he had moved to the therapeutic residential school (*Appendix A)*. I was struck when I heard a staff member comment that he was reading *Harry Potter*. My experience from therapy was of a boy who barely wrote a word, and showed very little interest in reading. That he was reading full novels was almost incredible.

Having thought more about this, I now wonder whether the intensity of the individual therapy experience made it too challenging for Freddy to attempt something he had may have an anxiety about doing, particularly if he felt he would be closely observed. He would have had to face the same person three-times-a-week for an indeterminate amount of time, so perhaps he wanted to avoid this. Almost in reverse form to what Cant (2005) describes for foster carers experiencing the intensity of a looked-after child's needs that had previously been experienced in more diluted form by residential staff, I wonder if Freddy could allow himself to take more risks after his intensive therapy experience finished. Perhaps he quickly sensed that the (residential) therapeutic experience was more diluted, spread among all the staff, not just one.

My clinical supervisor, when I updated her about Freddy's visit and his reading skills, rightly reminded me that Harry Potter lost his parents and has magical powers. Perhaps Freddy could, at last, be at peace to indulge in identification with omnipotence that other children were allowed to, without having it questioned or analyzed. He could simply enjoy it for what it was.

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APPENDICES

APPENDIX A

Account of follow-up visit with Freddy at his residential school in early 2012

APPENDIX B

Email from Research and Ethics Committee of employing NHS Trust, confirming local R&D approval *not* required for current study.

APPENDIX C

Protocol procedures agreed between the University of East London (UEL) and M80/North West London LREC, and submitted form.

APPENDIX D

Letter from University of East London LREC, confirming likely retrospective ethical approval

APPENDIX E

Copy of information sheet and signed consent form for both Freddy's social worker, and her team manager.

APPENDIX F

An example of a coded 'near-break' session as used applying Grounded Theory. (excerpt)

APPENDIX G

An example of a coded 'mid-term' session as used applying Grounded Theory. (excerpt)

APPENDIX A

Account of follow-up visit with Freddy at his residential school in early 2012

Visit to Freddy March 2012 – Residential School

There was approximately 20 minutes of discussion between myself, CAMHS case consultant, and three members of school staff prior to my meeting Freddy - I had not seen him since the middle of the preceding October at his former school. The October meeting had been his final psychotherapy session with me, for which he had arrived 15 minutes late, making it feel very rushed. Freddy was at that time in the care of his respite foster carer, who had known him for many years. She was against Freddy moving to residential school as she felt in her care his behaviour was settled, not challenging, and she had a good relationship with father. (A breakdown in the relationship between birth father and previous long-term carers was cited as one of the main reasons the long term placement had broken down).

Much of the conversation centred on the extensive involvement between Freddy and CAMHS, particularly setting up the psychotherapy, and the consultation that CAMHS offered to the network for about 18 months before the psychotherapy started. The conversation regularly returned to birth father, and the plan for Freddy to return to his father's care once he turned 13 (the upper age limit for children at the school).

Interestingly, after I asked whether Freddy would get more psychotherapy, and the staff said it was unlikely as he had over two years of intensive psychotherapy with me. The CAMHS case consultant mentioned my plans to do a thesis on my work with Freddy. I explained that I was particularly interested in exploring the themes of shame and humiliation. The staff, who by the time of this meeting had begun to get to know Mr F (I had never met him) explained that they felt *he* was very sensitive to feeling humiliated. This was something never "far from the surface" they had noted quite early on in their work with him (Mr F)

Meeting Freddy

Freddy was brought to the room we had been meeting in by one of his key workers (a woman in her late twenties). Freddy immediately looked awkward and down at the floor when I first saw him. He took everyone in with a quick glance, and I wasn't sure if he could see the card I had in my hand (the card had been written by staff members at the clinic who had known Freddy when he attended CAMHS). He seemed shy and a little overwhelmed. Very quiet too.

I quietly said hello. I can't recall if the other school staff said anything much at that point. One of them suggested that Freddy might like to show me around the school, and Freddy had been expecting this and nodded eagerly. (I had in my mind around this time the thought that he might have been worried about his 'old staff' and 'new staff' meeting to discuss him etc.). Rather than dawdle I felt I quickly needed to get things going, and I said that perhaps he could show me around the school? His key worker echoed what I said and he very quickly became keen to show me around.

He began by showing me some staff offices that were on the same floor as the room in which we had just met. He named some of the staff that would be there - they were not on that occasion. His key worker had to remind him that those particular staff were not there/didn't work on that day (Friday). He began to move faster and

faster, seeming a little manic, and his key worker had to remind him a few times to wait to knock on doors, and not to rush into rooms.

We went from the offices to the learning area, and Freddy stopped to show me a photo-board (prompted initially by his key worker). I was a little embarrassed as I didn't recognize his photo and he had to point it out. He immediately lost interest in the photo board, not looking at his photo as he pointed it out. I said that he looked different in his photo, he had grown, but I felt in his mind I had forgotten how he looked in the preceding months (forgotten *him*), and he was not going to bear witness to it any longer than necessary.

As we went into the classroom, his key worker pointed to a side room/area where she said Freddy sometimes takes time out from the class to read if he needed to. "You were read Harry Potter don't you Freddy?". I was quite taken aback at what seemed like an almost impossible stride in his reading, recalling for a moment all the times in therapy he had avoided reading, not wanting, as I thought, to risk humiliation if he failed.

As we got into the classroom, his teacher nodded to Freddy (she was with a few members of staff at a table as it was lunch time), and she asked him if he was with his 'guest' that he had told everybody about. Without speaking to anyone in particular she said that Freddy had been talking about his guest all week. Freddy didn't seem particularly moved/embarrassed by this comment (as I expected he might), having gone through the classroom to leave through another door. The key worker reminded Freddy to show me the *papier mache* figure he had made (I can't recall what he had made - a lion I think). He didn't seem very interested in showing me. This surprised me, and I said it reminded me a little of the things he had tried to make in our sessions - the origami things. He looked as though he really had no idea what I was referring to, and continued out of the classroom into the area near the gym/sports hall. (He had shown an interest in Origami about a year into therapy, and he maintained this interest for quite some time, which on the whole was unusual).

We then went into a large sports hall (which was empty) and as the key worker was saying this is where they had been only yesterday and we turned to go back out, Freddy ran to kick the wall (not very hard) and he turned and grinned at me. I said, unable to stop myself smiling, that it made me think of all the times he had kicked the wall when we met, but here I couldn't really do anything about it because I wasn't in charge. He grinned, and seemed very aware of what I was saying. A moment later, as were leaving the gym hall, he put his hand in my trouser pocket, almost demanding to know what was in there (it was empty). I waited for a moment, unclear in my mind who was 'in charge', and said that although I wasn't in charge here I was in charge of my pockets, and he can't put his hand in there. The key worker seconded this, and I was glad for a moment that some of the reactions I had had to aspects of Freddy's more intrusive behaviour were similar here at the residential school.

(I think around this time Freddy commented that I needed a shave. His manner was one of a gentle chiding towards me, and I was surprised, as he knew I wore a beard, and also he usually was quite anxious if he spotted what to him might have seemed

like even a small change. He seemed to almost briefly take the role of the parent/carer, but in a benign manner).

Freddy seemed to quickly settle, and didn't get angry about being gently told off. We went on towards the house he was living in (still the initial *assessment* house that all the new children stay in for about 12 weeks after arriving). On the way, we crossed an open space (not unlike a small village green) where a boy about Freddy's age was just ahead on a skate board, and Freddy seemed unable to stop himself from running behind him and attempting to scare him by shouting "boo!". The boy almost cried out, clearly perturbed by this interference with his task, quickly looking cross. I sensed Freddy knew this boy would react in this way, and he then shouted at Freddy and the key worker calmed him down, and kept Freddy moving. She told the boy it was ok, only a joke, but to my mind Freddy seemed pleased in the response he had been able to evoke, smiling to himself as we kept walking.

We got to the house, and Freddy quickly wanted to go up the back stairs. This seemed to suit as there was a meeting in the front room. We looked quickly around some of the free common rooms, and then went to Freddy's bedroom. He was keen for me to see it, so despite my reticence, I followed him, and it quickly struck me how bare and dark it looked, and it made me sad that it was all he had been left with at his age. There were a couple of posters (power rangers) on the otherwise bare yellow walls. I gave him his card at that point, and said it was from some of the ladies who worked at CAMHS who used to let him into the building. He nodded when I asked if he remembered them. He seemed a little unsure about taking it (as though his didn't know what to think as opposed to actual reluctance).

We moved onto the main landing, and as we went down the stairs I said that I had something to let him know. I said that my time at CAMHS would be coming to an end in about six months. He looked at me for a second, but didn't say anything, leaving me unsure how he might be feeling. I added that I had been thinking before I arrived that after today if he did in the future want to write to let me know at some point how he was getting on I would like to hear from him. He quickly and animatedly said that he could e-mail me! I nodded, and said that he could also, with his key worker's help (she nodded) and his social worker too, write to me at CAMHS and they could pass the letter on to me, and I could write back in time. He nodded, and we continued down the stairs to the front living room. The other house children had been meeting there for about five minutes and Freddy was encouraged by his key worker and another staff member (male) who came out of the room to join in. It suddenly seemed very rushed, and I quickly said to Freddy that it was great to see him today. He seemed a little embarrassed, and quickly dashed off to join the others, and as it was similar in manner to when I said goodbye to him the preceding October at his old school, the finality left me feeling sad.

APPENDIX B

Email from Research and Ethics Committee of employing NHS Trust, confirming local R&D approval *not* required for current study.

Emmett Maher

From: Emmett Maher
Sent: 05 September 2012 15:13
To: Emmett Maher
Subject: research proposal

From: L
Sent: 06 June 2012 09:36
To: Emmett Maher
Subject: RE: research proposal

Dear Emmett,

Thank you for your email and apologies for the delay in getting back to you.

I have discussed your project with our Clinical Trials Manager and we do not need to register this as a research project and you do not need to gain Trust approval for using this data.

This is a case study so you can use the data but consent is still required (even though it will be anonymised) so please ensure that the appropriate consent approvals are in place.

Please contact us if you have any further queries.

Best Wishes,
L

Research Governance Administrator

Research & Innovation

NHS Trust

Floor 3 | Learning & Research building | Hospital | . . . | . | 5NB

T: 0117 323 5209 | http://www. . nhs.uk/research

From: Emmett Maher
Sent: 31 May 2012 17:38
To: Research
Subject: FW: research proposal

I have not as yet a reply to this e-mail so I am resending it.

Emmett Maher

From: Emmett Maher
Sent: 14 May 2012 13:22
To: Research
Subject: research proposal

I am currently employed as a trainee child psychotherapist in . . based at . . . Hub - . CAMHS. My fixed term contract has run from 1.10.08 and will end on 30.9.12. My post is to learn how to undertake intensive longer term psychotherapy with children and adolescents under supervision within the four-year period.

I am also a registered student on a child & adolescent psychotherapy clinical training at the Tavistock Centre in London. I attend seminars, supervision and workshops in the Tavistock on Wednesdays during the academic term time. As part of my course at the Tavistock I am also registered on a professional doctorate in child psychotherapy at the University of East London. UEL grant a further academic degree in child psychotherapy in addition to the clinical qualification granted by the Tavistock.

As part of my doctorate I am required to complete an extensive thesis. I wish to applying a qualitative grounded theory approach to one particular case I worked with over two years - i.e. a single case study design. I have been granted approval at UEL to undertake this type of study, and I know need to register this study with my local employer - .

The case details are as follows:

I began treatment with a then 6 six-year old boy who lived in foster care at the time. He attended intensive three times-a-week psychotherapy for two years, three months, and in that time I wrote detailed notes of one session per week for supervision purposes. I brought these ***anonymised*** supervision notes for discussion and training with a senior child psychotherapist at the Tavistock Centre on a weekly basis. This is part of my training requirements. (The detailed notes did not form part of the child's NHS CAMHS file - I wrote separate notes for his NHS file.) His psychotherapy treatment ended in October 2011, and his CAMHS file is soon to be closed as he has moved away from .

As part of my doctoral thesis I would like to use these supervision notes as part of the single case study design. I specifically wanted to apply grounded theory to the supervision notes to get a better understanding of the complex psychological processes that were part of his treatment. The work was very challenging, and I feel he opportunity to re-examine the work as captured in the detailed notes would be a valuable contribution to my training and study in child psychotherapy.

I should stress that I do not need to use or have access to any information from the child's NHS file. The supervision notes I need to use have always been anonymised to ensure confidentiality. These are the only source I need to use, and have always been kept as separate study/training notes.

I am aware consent from the child's social worker and /or his father may be required. I have discussed this idea and they are happy to give signed consent at the appropriate time.

I trust this information is helpful,

Please let me know if there is anything further you require.

Emmett Maher

APPENDIX C

Protocol procedures agreed between the University of East London (UEL) and M80/North West London LREC, and submitted form.

Guidance for students, tutors, service supervisors and doctoral supervisors on research ethics procedures.

Tavistock/ UEL

Professional Doctorate in Child Psychoanalytic Psychotherapy M80, M80T (including NSCAP and SIHR)

Every student needs to be sure that they have obtained the necessary ethical approval for their particular project/thesis.

This document is designed to help you through the stages and is accompanied by a pack of relevant documentation. Please look through it and check you understand the requirements.

The process.

The first step for everyone is to talk with your service supervisor and your doctoral thesis supervisor (or tutor if the supervisor has not yet been identified).

There are usually two bodies to be considered; the NHS and the University. If your project involves data which has been collected in a non NHS setting, there may be other ethics procedures to take into account (e.g. Local Authority).

NHS

1. The first person to consult is your local Research and Development Lead. They will tell you what their view is as to what you need to do in relation to your particular project and the local requirements. The documentation in the pack may be very helpful in reassuring them that we have a robust system. However, if they insist that you submit an application to your LREC, you will have to do so.

2. If your thesis is going to be based on a clinical case (or small number of cases) seen as part of your ordinary clinical work, your project will fall within the protocol worked out between M80 and the North West London Research Ethics Committee. If you follow the process carefully and have the necessary signed consent forms, you can complete the Internal Ethics Monitoring form and send it to the M80 course administrator.

3. If your project does not fall within this scheme (e.g. if you are running groups or want to conduct interviews with patients, their parents or members of the professional network) you will probably need to seek full NHS approval from an LREC. Because the course is a Tavistock

programme, you can opt to submit to the North West London LREC. Altenatively, you can go to a committee in your own locality.

University of East London

We have an agreement with the University Research Ethics Committee that candidates whose projects fall within the agreed M80/North West London LREC protocol do not need to fill in a UEL ethics form. We will collate the information given to us on your M80 Internal Ethics Monitoring form and will submit a list of approved projects to the University Committee for formal approval.

If your project falls outside the protocol, you will need to complete a form. However, if you can show that you have NHS approval, the University committee usually confirms approval without raising questions or objections.

The UEL ethics form is available on their website or can be obtained from the M80 admin office. Please seek help and advice on filling it in if needed.

The important principles to bear in mind in talking about ethical issues or filling in the forms are as follows:-

- Informed Consent: Patients must be given clear, accessible information about the research and must have the opportunity to ask questions and to think about it before making a decision.
- Patients must have the right to refuse permission and must be able to withdraw consent at any stage.
- If patients refuse permission or withdraw consent they must be reassured that this does not have any adverse impact on the care/treatment they receive.
- Parents can give permission for their child's clinical record to be used but if the child is deemed to be "Gillick Competent" (ref Fraser Guidelines 1985) they should be consulted themselves. In some cases it may be that preliminary consent is obtained from a parent at the beginning of treatment and informed consent from the patient themselves at the end of treatment.
- Parents do not have access to clinical theses written about their child's treatment.
- Theses are normally held in the Tavistock and UEL libraries but can be put on restricted access by arrangement.

If you still have questions, or cannot see how your project fits into the process, please contact Biddy Youell (byouell@tavi-port.nhs.uk)

Tavistock & Portman NHS Foundation Trust
Child Psychotherapy DPsych Psych

NHS Ethics

Name of student: EMMETT MAHER

Title of thesis THE ROLE OF SHAME AND HUMILIATION IN RELATION TO THE TECHNICAL DIFFICULTIES PROVIDING PSYCHOTHERAPY TO A SIX YEAR OLD BOY IN CARE

Has the local R&D lead been consulted? (Yes) / No

Does the proposal require full local LREC approval? Yes / (No)
Has the submission been made and approved? Yes/No

Does it require approval from other bodies? Yes/(No)
eg. Local Authority, Education

Or

Does the proposal fit the M80/North West London LREC protocol? (Yes)/No

Has informed consent been obtained? (Yes) / No
Parent / Child
Social Worker

Is the signed form attached? (Yes) / No

If no, has paperwork requesting consideration been submitted to IRB? Yes / No

Outcome

☐ Agreed

☐ Referred for further action

Detail of further action needed:

_____

_____

Has the UEL ethics form been submitted? Yes/No

Has a response been received? Yes/No

NB If your project is in line with the North West London/M80 protocol you do not need an individual UEL form. Your project will be listed in a group return.

Any other information or comment?

.....

.....

Signed: _____ Student

_____ Supervisor

Date received and logged _____

APPENDIX D

Letter from University of East London LREC, confirming likely retrospective ethical approval

EXTERNAL AND STRATEGIC DEVELOPMENT SERVICES
uel.ac.uk/qa

Quality Assurance and Enhancement

Mr Emmett Maher
1/57 Mitchell Street,
Bondi Beach,
NSW 2026,
Australia

24 February 2014

Dear Mr Maher

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

Study Title: The role of shame and humiliation in relation to the technical difficulties in providing child psychotherapy to a boy in care.

I am writing to inform you that the University Research Ethics Committee (UREC) has received your NHS application form and Consent Form, which you submitted to the Chair of UREC, Professor Neville Punchard; but no evidence of ethical approval has been provided. Please take this letter as written confirmation that had you applied for ethical clearance from our UREC at the appropriate time; it is likely it would have been granted, although no ethical approval has been obtained. Please note this does not place you in exactly the same position you would have been in had clearance been obtained in advance. Therefore, when responding to any questioning regarding the ethical aspects of your research, you must of course make reference to and explain these developments in an open and transparent way.

For the avoidance of any doubt, or misunderstanding, please note that the content of this letter extends only to those matters relating to the granting of ethical clearance. If there are any other outstanding procedural matters, which need to be attended to, they will be dealt with entirely separately as they fall entirely outside the remit of our University Research Ethics Committee.

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

Yours sincerely

pp: Catherine Fieulleteau
Ethics Integrity Manager
For and on behalf of

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Quality Assurance and Enhancement

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APPENDIX E

Copy of information sheet and signed consent form for both Freddy's social worker, and her team manager.

Information sheet for concerning proposed research study on supervision notes from psychotherapy completed with

Date: 3rd July 2012

Title of proposed study: The role of shame and humiliation in relation to the technical difficulties in providing child psychotherapy to a boy in care

This information pertains to my request for permission to use certain material from my work with as part of an academic qualification.

As explained, I have been working in , CAMHS as a Child Psychotherapist in training since 2008 and my post finishes at the end of September 2012. I have throughout this time also been a registered postgraduate student at the Tavistock Centre, London and the University of East London on the Professional Doctorate in Child Psychotherapy (course name is M80). The Tavistock is staffed with NHS clinicians who also work in a training role.

I will continue to be enrolled as a postgraduate student after my training post finishes.

In seeing three-times weekly for individual psychotherapy treatment over two and quarter years, I took detailed notes of one of the three sessions for supervision with a senior Child Psychotherapist at the Tavistock on a weekly basis. These notes were always anonymised, with all identifying information removed. These supervision write-ups were separate from entries I made in CAMHS file. They were for my training purposes only.

After finishing my training post here in , CAMHS I will have an opportunity to write a doctoral thesis using a single case study. As part of a case study I would like to revisit and analyse the supervision notes to get a better understanding of the work which was at times very challenging. I would need to include some background information, but this would be minimal and of course anonymised.

I feel there is more for me to learn from the psychotherapy with ., and going back to spend time analysing the supervision notes and linking it to other accounts of similar/related work and psychotherapy theory would be very a useful and rewarding learning experience.

Once study is complete: I might at some point after finishing the thesis want to publish in academic journals for other child psychotherapists and professionals, including social workers. If I were to publish I would use a pseudonym to protect confidentiality and privacy. *At no stage in completing the study would I use name or other identifying information.*

Once finished, which is likely to be in two to three years, I would be happy to provide an overview summary of the study, highlighting the main findings from my research.

Consent: As .'s social worker, I need your permission to go ahead. If you have any further questions we can arrange a time to speak. If you are happy to give your consent, I would be grateful if you could complete the attached consent form and return it to me at Hub.

E. Maher

Emmett Maher

Informed Consent Form

Consent Form for social worker with statutory responsibility

Title of Project: THE ROLE OF SHAME AND HUMILIATION IN RELATION TO THE TECHNICAL DIFFICULTIES PROVIDING CHILD PSYCHOTHERAPY TO A BOY IN CARE

Name of clinician: Emmett Maher

1. I confirm that I have read and understand that Emmett Maher intends to use supervision notes and some of the case record on his completed work with :n his thesis as explained in information sheet dated 3rd July 2012. I have had the opportunity to consider the information, ask questions if necessary and have had these answered satisfactorily.
2. I understand that my agreement is voluntary and that I am free to withdraw it at any time without giving a reason.
3. I understand from Emmett Maher that use of supervision notes and some case record history will be completely anonymised to ensure confidentiality.
4. I understand that material arising from the competed thesis may be submitted for publication in professional and academic journals at a later date, and that Emmett Maher proposes to publish any such material under a pseudonym to ensure :'s confidentiality.

Name:

Signature:

Designation Social Worker

Date: 18.7.12.

Informed Consent Form

Consent Form for social worker with statutory responsibility

Title of Project: THE ROLE OF SHAME AND HUMILIATION IN RELATION TO THE TECHNICAL DIFFICULTIES PROVIDING CHILD PSYCHOTHERAPY TO A BOY IN CARE

Name of clinician: Emmett Maher

1. I confirm that I have read and understand that Emmett Maher intends to use supervision notes and some of the case record on his completed work with in his thesis as explained in information sheet dated 3rd July 2012. I have had the opportunity to consider the information, ask questions if necessary and have had these answered satisfactorily.
2. I understand that my agreement is voluntary and that I am free to withdraw it at any time without giving a reason.
3. I understand from Emmett Maher that use of supervision notes and some case record history will be completely anonymised to ensure confidentiality.
4. I understand that material arising from the competed thesis may be submitted for publication in professional and academic journals at a later date, and that Emmett Maher proposes to publish any such material under a pseudonym to ensure confidentiality.

Name:

Signature:

Designation SERVICE MANAGER

Date: 18/7/12.

APPENDIX F

An example of a coded 'near-break' session as used applying Grounded Theory. (excerpt)

Session 2 15.01.2009	Expansion of my thoughts and feelings in the session	Thoughts that arise on looking back	Thoughts from supervision at the time	Thoughts from Academic supervision	Codes
1 As I collected Freddy from the waiting room, where he was playing with the Lego board, I wondered if he would readily come with me to the therapy room, which he did.	(Freddy had been somewhat reluctant to come with me the previous session hence my thought today.) Something in his attitude today also conveyed some reluctance	I wonder now if he wanted to convey an image of himself not simply 'waiting' for me but in fact busy with something else			Mixed feelings (P) Anxiety (T) Protection/Defence (P)
2 He didn't smile at me when he saw me, and looked perhaps a little worried.	I wasn't sure at the time what his worry might be about.	I imagine now that as it was only session two he was worried about the whole process, and what might unfold			Anxiety (P) T's sensitivity
3 I told Mr W that we would be back in 50 minutes, partly to remind Freddy of the time.	This was as much for my reassurance that there was a definite end as for either Freddy or the carer				Boundaries

Session 2 15.01.2009	Expansion of my thoughts and feelings in the session	Thoughts that arise on looking back	Thoughts from supervision at the time	Thoughts from Academic supervision	Codes
4 Once in the room, he asked how the lights had come on.		Something happening without warning or something obvious leading up to it probably unnerved him more than I saw at the time			Thinking Curiosity/worry (P)
5 I recall having explained this before to him so I was puzzled.	I was aware from just one session how observant he was, and that he had a good memory	It might have been as though he was starting over again, and had not held onto the previous session. He might also have been unconsciously worried I had forgotten him, so he did the 'forgetting' to preempt this feeling.	Does he feel he's starting over again? Talk to him at beginning and end about coming three times a week.		Relationship (P-T) Anxiety (P) Communication
6 I explained that the lights come one once you come into the room.					Direct communication

Session 2 15.01.2009	Expansion of my thoughts and feelings in the session	Thoughts that arise on looking back	Thoughts from supervision at the time	Thoughts from Academic supervision	Codes
7 He looked suspiciously at me and I pointed out the sensor in the ceiling, thinking he might be interested in it.		He might have felt watched in some way, as though his movements were under surveillance.		I suppose you are imagining he might feel watched. But slightly strange to put this to him without him really giving you reason to.	Anxiety (P - Suspicion)
8 But he had 'lost' interest in the lights it seemed and he then moved over to the dollhouse and said after a quick inspection that I had put it back "didn't you?". (tidied it)	I was in response employing the technique of avoiding a straight answer where possible	As I hadn't left it in the messy state from the previous session he might have many thoughts in that second, but voiced that I had tidied it (not another child for example)	Revisit the introductory meeting concepts (function of sessions think about different feelings he has). Help him make links by talking about when he was last with me.	he passes on to something else however –that's fine. I guess the 'other child' is something you might have mentioned, since he is wondering who has done what since he was last there.	Rivals Anxiety (P- re: above)

Session 2 15.01.2009	Expansion of my thoughts and feelings in the session	Thoughts that arise on looking back	Thoughts from supervision at the time	Thoughts from Academic supervision	Codes
9 He asked me again, and I wondered what he thought? He said "yes you did!", irritated it seemed with my indirect response		I didn't think at the time about what his fantasies might have been, nor do I think it was helpful to just leave it with him, hence his irritation			Lack of containment/ Concave container Frustration (P-T)

Session 2 15.01.2009	Expansion of my thoughts and feelings in the session	Thoughts that arise on looking back	Thoughts from supervision at the time	Thoughts from Academic supervision	Codes
10 He threw the ball a few times, as though needing something vigorous to do, and quickly said that his first throw was "rubbish".	I remember feeling a little sad that he was so self-critical	I wonder now if he worried he would be judged harshly by me for not doing it well. He seemed to have two judges in the room, making it difficult to feel there could be an opening to offer any thoughts. Did he also feel the need to do something vigorous in the face of what felt like a lack of containment from my indirect answer		Maybe you have left him feeling in the dark, not knowing what he is feeling. What happened to the doll's has not been resolved or led to any thinking. Yes, this is the point I am making above. I don't think it is his throwing that he is worried about. More a nameless anxiety that undermines him.	Second skin Super-Ego Anxiety

Session 2 15.01.2009	Expansion of my thoughts and feelings in the session	Thoughts that arise on looking back	Thoughts from supervision at the time	Thoughts from Academic supervision	Codes
11 He wanted me to see him throw it again, and it was quite a throw. I noted that it had rolled from the window over to the other wall, and he looked at me with a "see how I can throw it" look, and he threw it hard a few more times.	There was definite aggression in the action, as though he was warning me a little.			yes	Communication

Session 2 15.01.2009	Expansion of my thoughts and feelings in the session	Thoughts that arise on looking back	Thoughts from supervision at the time	Thoughts from Academic supervision	Codes
12 He turned his attention to the house, and started to fire the pieces of furniture out like missiles almost.	I was anxious the toys would be broken more than he might hit me - although this in itself was a concern. I was aware of my thought (from the very first meeting with Freddy a few days earlier in fact) that the DH would be very provocative for Freddy - that the idea of a home would stir up his lack of one (with his birth family)			There is still the possibility that what is upsetting him is the fantasy that other children have been with you and playing with his doll's house. This is a double dose of the doll's house as metaphor for a family, since it is one that others may have taken his place in. But such provocation may not be a bad thing – he does think about these matters.	Too much' Rivals Pain Anxiety (P) Anxiety (T) (boundaries/equipment)

Session 2 15.01.2009	Expansion of my thoughts and feelings in the session	Thoughts that arise on looking back	Thoughts from supervision at the time	Thoughts from Academic supervision	Codes
13 One of them hit my leg and he asked me if it hurt, but not overly concerned.	I did feel irritated, and also felt a little aggrieved at being targeted	I wonder if Freddy had difficulty in showing any real concern as he would have had to take responsibility in a proper sense, of which he was not at the time capable.		But you have lost sight of why he might be angry and upset. You feel it as a motiveless aggression. I don't think the issue is his general capacity for concern or not, but why he might be feeling angry and aggressive now.	Avoidance/distraction/ defence (Something missed)

Session 2 15.01.2009	Expansion of my thoughts and feelings in the session	Thoughts that arise on looking back	Thoughts from supervision at the time	Thoughts from Academic supervision	Codes
14 I said it did, not finding it too difficult to be calm, and he said "Sorry", and ensured he didn't hit me again, and was less forceful.	I hadn't been sure at that point if he really meant it, bit felt it was a little bit of an effort on his part to protect/safeguard the therapy			Well, both of you are now trying to protect the therapy. This is posiitive no doubt, as a way of keeping the atmosphere calm and safe, but it is a little at the expense of trying to understand the meaning of what has happened, what the aggression was about.	Anxiety Protection (of therapy) Avoidance
15 He looked and said all the furniture was on the floor, and I agreed.	I was thinking for a moment that he might be quite pleased that he had emptied the house, dismantled it as such, but I wasn't sure what was being conveyed in his tone				Observation

Session 2 15.01.2009	Expansion of my thoughts and feelings in the session	Thoughts that arise on looking back	Thoughts from supervision at the time	Thoughts from Academic supervision	Codes
16 I said I noticed the house was empty, and he was startled for the briefest second, and then agreed it was	I wondered if 'reality' hit home, and but also that it was emptied at his hands, and he might not have meant to be so forceful	This makes me think of the idea that I tried to address at later stages in the therapy - mainly around talking to his tendency to attack/destroy things that seemed beyond his control.			Thinking Double deprivation
17 I was expecting him to push the entire house off the table, and was readying myself to step in.	It didn't feel he was 'finished' there				Anxiety (T)

APPENDIX G

An example of a coded 'mid-term' session as used applying Grounded Theory. (excerpt)

Important to note that I had missed the first week of that summer term due to Icelandic ash cloud disruption. Freddy was aware of this at the time

Session 183 (19.07.10 - first session of the week)	Expansion of my thoughts and feelings in the session	Thoughts that arise on looking back	Thoughts from supervision at the time/subsequent supervision	Codes
33 I said that it was probably going to be difficult because I could appreciate that he didn't want me to put his shoes outside,	I wanted to show him that I could appreciate his point of view even if I was doing something he didn't like		There is a question of why the shoes have to be outside - doesn't this make the situation visible outside the session? Isn't this a kind of humiliation for him? MR	Re-enactment Understanding (T) Humiliation (P)
34 but if he was able to *try* to be calm, then we could agree to something.	I wanted him to also see that I would notice his efforts, not necessarily the end results			boundaries
35 To my surprise, FREDDY settled in a matter of moments, and turned his attention back to the plane.	This was a relief given how he has reacted in the past		He and I have been through a lot together and I'm still here. We're both working hard. He is trying hard	shift/development
36 He counted that he had five sheets of paper (including his plane)				self-reassurance
37 I agreed, and wondered who made the plane – did someone help him, or had he been practising really hard?	I was genuinely interested in the plane he had brought, and wondered if he had made some gains in recent weeks			Curiosity (T)

Important to note that I had missed the first week of that summer term due to Icelandic ash cloud disruption. Freddy was aware of this at the time

Session 183 (19.07.10 - first session of the week)	Expansion of my thoughts and feelings in the session	Thoughts that arise on looking back	Thoughts from supervision at the time/subsequent supervision	Codes
38 I added that it looked like a good plane.				ordinary (T)
39 'No need for you to know'.	I immediately felt left out, as well as amused at this unusual comment			Communication
40 I said E was to be in the dark about it then?	I wondered if this was his intention, so wanted to put it to him	He might also have enjoyed being the one in the know for once		Control (P)
41 He didn't look at me, and flew the plane, which moved very swiftly over to the windowsill.	I knew I would have to wait longer in this 'unknowing state'	Something from his early years he was very familiar with		PI Internal world (communication of)
42 He had in mind that I copy the plane exactly as it was.		As this was a 'good' plane, and the need for me to produce a good plane was paramount given in his mind I was taking jetting off over the holidays, he needed to get results.		Anxiety (communication of) Meaning (of break)

Important to note that I had missed the first week of that summer term due to Icelandic ash cloud disruption. Freddy was aware of this at the time

Session 183 (19.07.10 - first session of the week)	Expansion of my thoughts and feelings in the session	Thoughts that arise on looking back	Thoughts from supervision at the time/subsequent supervision	Codes
43 I was to 'make the folds perfect'!			He wants me to make something for him - come what may I will be there for him	Defence Communication
44 I said I could try, and I was also aware that I was being kept busy.	it left me unable to decide if this would be a collaborative enterprise or a distraction	I am struck by how easily I too can be suspicious of his motives		Defence (P) Insight (T)
45 However, rather unusually Freddy lay across the couch, and waited for me to complete it.	It seemed as time went on that he was interested in what I would produce			Curiosity/interest
46 I asked if I could have a practice try, and I noted to myself that I was being rather meek, and that I was 'afraid' that Freddy could be set off at any moment, and wreak havoc	I was aware that I wanted to please him and keep in his good books	Was this a projective identification with a part of him that wanted to do the same before we parted for five weeks?		re-enactment (T) identifying with P's internal world
47 I was trying to think about this.				Thinking (T)

Important to note that I had missed the first week of that summer term due to Icelandic ash cloud disruption. Freddy was aware of this at the time

Session 183 (19.07.10 - first session of the week)	Expansion of my thoughts and feelings in the session	Thoughts that arise on looking back	Thoughts from supervision at the time/subsequent supervision	Codes
51 It was unusual for a moment as I couldn't quite get to grips with whether I was being kept busy for the sake of it (as has been the case lately)	I felt as though I had got myself into a scenario that I was quickly regretting			difficulty keeping role (T) defence
52 or whether he did want this plane just so, and the original plane was special for some reason.	There was another feeling in the room which seemed to suggest something slightly different	I appreciate now the specialness of the plane		Shift
53 I wondered again who made the plane, and I think I must have said it in a mostly innocuous manner as he said his teacher, and perhaps might not have wanted to say anymore.	I recall thinking it was a male teacher, although I am not sure if FREDDY at the time had a male teacher			rivalry (T) Communication (ordinary)
54 I merely nodded, and he was still in rather imperious/aggressive mood,		I am struck by the simultaneous occurrence of a chatty FREDDY and the aggression that is never far away. How draining it must be to		Internal reality defence

Important to note that I had missed the first week of that summer term due to Icelandic ash cloud disruption. Freddy was aware of this at the time

Session 183 (19.07.10 - first session of the week)	Expansion of my thoughts and feelings in the session	Thoughts that arise on looking back	Thoughts from supervision at the time/subsequent supervision	Codes
71 He immediately sounded suspicious, asking how I knew he was going to [Respite carer's].	I expected this so had an answer ready		Possibly respite care is a painful thing for him. Most children do not have to have respite care! It defines him in a certain way, as too much for his carers. MR	external reality anxiety (P)
72 I said I didn't, that he *might* be (I was about to speak to his suspiciousness but he went back to the plane, getting agitated about it again, so I decided to come back to it later).	I sensed he wouldn't be receptive to more thinking in a suspicious frame of mind		Is the business with the plane - a teacher making a perfect one, can you do one? - About whether anyone can make a safe container in which he can be moved around? Perhaps the sense of ultra-quick transport reflects how his moves feel to him. MR	Timing (T) Anxiety (P) Reality (P) Symbolisation (plane) Containment (wish for)
73 I continued with the plane, and seemed to be generally getting it right.	He was generally less critical, which was a relief and I was glad to be able to help	Was his reduced criticism linked in some way to the relief that might have come from my earlier comments about the summer holiday and all he had to manage?		Shift/development