Switching the Light On:
Can Intensive Psychoanalytical Psychotherapy Enable a Child Diagnosed with Developmental Delay to Become Unstuck?

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Abstract

This research is a qualitative single-case study focusing on a child diagnosed with global developmental delay who was ‘stuck’ in their development. The aim of the research was to investigate whether they could be moved along the developmental trajectory by receiving an intervention of intensive thrice-weekly psychoanalytical psychotherapy treatment.

The research question was: can intensive psychoanalytical psychotherapy enable a child diagnosed with developmental delay to become unstuck?

The data was collected from the therapist’s observations of sessions as recorded in the detailed write-up of their process notes. Ten sessions were selected for analysis from the first year of treatment, and three sessions from the second year. The main methods employed for data analysis were thematic analysis and matrix methodology. Three themes were identified by this in-depth analysis. The first was ‘finding a voice: language development’, the second ‘play and space – peekaboo’, and the third and final theme was ‘the body: feelings, evacuation and physical holding’.

The research results demonstrated that development did shift, and that the patient became less stuck and was able to move along their developmental trajectory. More specifically, the findings showed that language developed substantially, from only six words in the first analysed session and one-word sentences to sentences of four, five or more words and interactional conversational language. It was evident that the development of language opened up the patient’s world relationally, and that they were much more able to communicate and get their emotional needs met. The research illustrated increased awareness of others, a growing sense of time and place in which the present, past and future were more understood, and a place in which sequencing and linking began to occur.

Thus the patient was able to shift from a flat, two-dimensional world to a livelier, curious, three-dimensional world in which the notion of a third began to exist

and the beginnings of Oedipal development emerged. The development enabled the patient to look around more; the world became a bigger and more interesting and accessible place. The patient began to manage other developmental issues such as anxiety about separation and object constancy, and to develop an understanding that the therapist would return after a gap or break. A more reliable object relationship developed. Holding another in mind during absences was achieved, and anxiety was alleviated. There was a clear shift from using non-verbal communication such as acting out and projective identification to being able to use their language acquisition, to stay with a thought and use thinking. The results showed an increased sense of self and a stronger identity. There was evidence of mental growth and of more of an internal psychic structure, as well as of a notion of play and a developed use of symbolism, and developmental milestones were negotiated and worked through.

The conclusion reached is that the research has provided evidence of the benefit of long-term intensive psychoanalytical psychotherapy for this patient group that supports other work in the field of global developmental delay.

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Definitions

Counter transference: The conscious and unconscious reactions and feelings of the therapist who responds to the transferred feelings of a patient. The therapist uses her responses and understanding of those feelings to try and understand the communication or feeling state of the patient.

Projection: Putting a state of mind in ourselves that we do not want to own into someone else. This is an unconscious process.

Projective Identification: Melanie Klein named projective identification as an early mechanism of defence in which the splitting off and getting rid of unwanted parts of the self that causes anxiety or pain are put in to another.

Transference: The re-creation in the relationship with the therapist that of another past relationship, for example the therapist may unconsciously represent a person from the past such as a parental figure in the patient's mind.

Abbreviations

GDD – Global developmental delay

BR – Blue Room

TA – Teaching assistant

UEL – University of East London

INSET – In-service training day for teachers

NHS – National Health Service

NAS - Neonatal abstinence syndrome

Acknowledgements

I would like to thank the following people for all their support, encouragement, patience and input, as without it I would not have been able to carry out this piece of research.

In particular I would like to thank the late Maggie Fagan, who has been in my mind so much throughout the whole process of writing this research. As I revisited material from the sessions and relived many moments of the work, Maggie too was very alive in my mind at these times. Maggie was my supervisor for this case and offered thought, sensitivity, encouragement, insight, and a great deal of knowledge and support throughout the case, all of which helped me to develop my thinking, my practice and my understanding of the work I was doing with Andrew. It saddens me deeply that she is no longer here and able to read about Andrew.

I would like to thank my two academic supervisors, Barbara Harrison and Sue Chantrell, who have guided, supported and encouraged me throughout this long and challenging journey. I would also like to thank my dear colleague and friend Monique Maxwell, who has been an inspiration for me to persevere in times of difficulty. Also my longstanding friend Edwina Pearwt, who too is involved in writing a PhD thesis, albeit in a completely different area. The support and thinking of both of them has been valued and appreciated.

There have been many others along the way I would like to thank. In particular, I would like to thank Lisa Miller, Antje Netzer-Stein and Carol Hanson, all clinical supervisors from whom I learned so much before, during and after training to be a child and adolescent psychotherapist. The learning from them has been invaluable, thank you.

Finally I would like to thank Andrew and his family for enabling this research to be possible. Without Andrew there would be no research. He will have a place in my mind always.

Introduction

I have been interested in both children and adolescents who have had difficulties with communication and learning for a long time. Prior to training to be a child and adolescent psychotherapist, I came from a background of special needs teaching and dance movement psychotherapy. In both these professions I worked extensively with many children and adolescents who were non-verbal, all of whom had difficulties with communication and being understood. I observed their frustrations in communicating, being heard and understood. This contributed to my interest in this piece of research and the case I chose to investigate.

This research is taken from an intensive psychoanalytical psychotherapy case which I undertook during my training to become a child and adolescent psychotherapist at the Tavistock Clinic, London. I decided to focus on this case study as my area of research because I was aware that significant changes and developments had taken place through the psychotherapeutic process. I wanted to examine the evidence and investigate what changes and developments had taken place over the course of treatment.

The research will be presented in the form of a single case study. An aim of the research is to provide the clinical evidence for the developmental changes that I selected.

First there will be an introduction to the case, the setting and referral process, and background information regarding the case. There will then be an outline of the remaining chapters.

Andrew

Andrew was five years old when I initially met him in July 2009 with the intention of assessing and treating him in intensive psychoanalytical psychotherapy. At this particular point Andrew was living with his mother, his older sister, who was nine years old, and his maternal grandmother and maternal grandfather. When I met Andrew my first impression was that he was small for his age and was a

shy-looking little boy, with blond hair and a fair complexion, who was attractive to look at. I was struck by his large, bright blue eyes with unusually long, dark eyelashes for such a fair complexion. There was something appealing and likeable about him.

Family History

Andrew was born to parents who were both addicted to heroin, and his mother had regularly used heroin prior to his conception and during the pregnancy and birth. Sadly, due to this, Andrew was born addicted to heroin and was in an incubator in an intensive care unit for the first four months of his life. Andrew was monitored and given a methadone-like substance to help him recover. It was reported that apart from his being born addicted to heroin, Andrew's actual birth was uncomplicated. However, he was born with hydrocephalus (fluid on the brain). His mother reported that this drained naturally through his body over time and a shunt was not required.

Other developmental information of relevance was that Andrew was bottle-fed and that he had struggled to be weaned and introduced to solid food, which he was unable to eat until he was four years old. Prior to this, mum and grandmother had blended all his food. There was little information in relation to his physical development, but it was known that Andrew did not crawl but shuffled on his bottom, and began walking at approximately 16 months.

Due to his mother's addiction problem, his maternal grandmother and grandfather took responsibility for Andrew's care and looked after him for the first year of his life. Andrew's mother was trying to come off heroin during this time, and returned to the family home after approximately one year, when she then became more involved in Andrew's care. Andrew's father was not living in the same household, and it was verbally reported by both the mother and the grandmother that he had had an accident. There were slightly different versions of what had happened to Andrew's father from each of them. The mother reported that Andrew's father had fallen from a height at some point during the pregnancy, was badly injured and might not survive. The grandmother described the event as being a drug-induced psychotic episode during which he

fell. The fall led to Andrew's father having a head injury, which left him not functioning fully.

Referral

Andrew first became known to Child and Adolescent Mental Health Services (CAMHS) in 2007, when he was three years old. He was referred from the school nursery, prior to his referral for intensive psychoanalytical treatment in 2009. There was a concern that he had been slow to develop in areas such as speech, play and gross movement. There was also concern regarding his behaviour at home. He was not potty-trained at the age of three, and was smearing the walls of his home with faeces. He was seen for an initial meeting at CAMHS in 2007, and it was reported that he got distressed every time the CAMHS therapists talked to either his mother or grandmother. At this meeting the grandmother reported that Andrew's mother was better with him than she had been in the past. I understood this to mean that she was increasingly involving herself in his care. It was hard to know if this was predominantly physical care or if she was also involving herself more emotionally. It was also observed in this meeting that both mother and grandmother struggled to set any boundaries with Andrew. They linked this to his difficult beginning in life. My understanding was that they felt sorry and guilty for what had happened, and this guilt interfered with them providing the boundaries necessary for his development and for him to feel emotionally secure and safe in relation to them. The outcome of the meeting with CAMHS was that Andrew was allocated a worker from the early intervention team who went into the home three mornings a week to offer parenting support. I was unable to find out how long this had been on offer.

Subsequently Andrew was referred for an assessment for potential intensive psychoanalytical psychotherapy treatment at the age of five. The referral came to the NHS through a child psychotherapist who was working in the special school on behalf of a local CAMHS team specialising in services for children with disabilities. The service is an inner-city multi-agency service provided by a local authority. One aspect of the child psychotherapist's work, in conjunction with her CAMHS team and the teachers and head teacher, was to identify

children who were struggling with their development at school and who might need further emotional help and support to aid their development. Andrew's referral was due to increasing concerns on the part of his class teacher, his mother and grandparents, and the above-mentioned on-site CAMHS child psychotherapist. The concerns related to his slow development and worry that his development appeared to be 'stuck'. There were additional concerns that he might also be depressed, and that he was not learning and developing in the way the school felt he had the potential to do. His mother and grandmother also shared these worries. Areas highlighted were his language development, his social interaction, his state of mind (depressed) and his gross motor development. It was considered that a period of long-term intensive psychoanalytical psychotherapy should be offered to see if it could help Andrew with his development, hence my involvement.

Initial Observations and Assessment

My assessment of Andrew did not take the form of a more traditional child psychotherapy assessment, in which the child psychotherapist may meet with the child for three or four sessions over a period of time to see whether the child has a capacity to make use of psychoanalytical psychotherapy, to describe their state of mind, and to have some understanding of the state of internal object relations (Rustin 2000). There was a sense of urgency that Andrew needed treatment, and some preliminary work had already taken place. The on-site child psychotherapist had met with the school family support worker, the class teacher and Andrew's mother and grandmother. The on-site CAMHS child psychotherapist was experienced in identifying children for intensive treatment in this school. On the basis of her observations and previous work there was already a strong notion that Andrew was in need of intensive treatment, and therefore it seemed more appropriate for me to make a series of observations of Andrew at this stage, rather than a formal assessment in the traditional sense.

Two observations of Andrew in his classroom setting were made at the end of the school year in July 2009. Several things were apparent from these observations. Andrew could make good eye contact with someone when he wanted to gain their attention. He seemed to require considerable verbal

support from his teaching assistant (TA) in order to stay within a classroom task, as he would easily lose focus. Andrew would engage in group turn-taking activities, but only with continual support and encouragement from an adult, and even then his focus would soon move off to something else in the outer area of the classroom. I observed a couple of warm and intimate interactions between Andrew and a peer in which they made eye contact and had some verbal interactions, and an interaction in which Andrew reached out and touched his peer's arm in a communicative gesture. There were also some interesting interactions with his TA in which Andrew would initiate speaking, as if attempting to ask her something. However, in my observation it was not possible to understand the content of his verbal communication to the TA, although it was apparent that not being attended to or understood by another frustrated him. The TA's attention towards Andrew was not reciprocated.

Other observations revealed Andrew demonstrating a certain level of curiosity when there was any interruption in class, such as someone coming in or going out. I observed some instances of echolalia in Andrew's speech – he would repeat one word numerous times. There were examples of intense body action in which Andrew would flap his hands in a manic way and beat his torso. It was unclear what triggered this, but at this point I wondered about either excitement or frustration. During my observation the class had to move to a different location in the school building for another activity. This move/transition required all the children going on a journey. I was aware of how toddler-like Andrew appeared as he moved physically with his peers from one place to another. He seemed to lose connection with those around him and showed no sense of any boundaries or parameters, spatial or physical. Once more he struggled with focus and attention. His gross movements appeared to be uncoordinated, giving the impression he might be under the influence of some substance, e.g. alcohol, even though I was sure he was not.

From observing Andrew in a group context I was struck by Andrew's initial interest in what was going on. However, this was not sustained or ongoing as he would change to a different state, one of appearing solitary and remote. It

was whilst he was in this solitary and remote state that the body action mentioned previously seemed to get triggered.

I wondered what Andrew's experience of my observations was, and whether he was aware that it was him I was there to observe. I was left feeling uncertain about this. I am sure he was fully aware that I was someone new and different in his class, but he did not look up or make much eye contact with me during the observations, only fleeting acknowledging glances.

I concluded from my observations – and from the additional information and discussions/liaisons that had taken place with the CAMHS child psychotherapist, Andrew's mother and the class teacher – that Andrew could certainly benefit from a period of intensive psychoanalytical treatment. Andrew seemed to exist in an anxious, flat inner world, with limited interest in the world around him, and his language development appeared significantly impaired. Andrew had had little experience of consistency, emotional understanding or containment, or of a mind that was a place where thoughts existed, and it was hard to make contact with or engage him. I supported the notion that intensive psychotherapy could provide Andrew with a time and space that would be his, where he would have the opportunity to build an ongoing, consistent therapeutic relationship in which he could be the priority and be thought about. The intensive nature of thrice weekly treatment would offer Andrew an opportunity to experience a sense of sustained consistency and to develop a therapeutic relationship in which trust and secure boundaries could be experienced. The therapist's attention, observations and thinking could help to understand and put meaning to Andrew's non-verbal communications and emotional expressions, and could also reveal what was going on in the relationship between Andrew and the therapist. It would also be an opportunity for Andrew to have his internal and unconscious communications considered, thought about and understood.

Intensive treatment meant that Andrew and I would meet three times a week for a period of one year. At the end of a year the treatment would be reviewed. Sessions would take place on Mondays, Tuesdays and Fridays. The rationale

for this was as follows. Monday is a day at the beginning of the week, a time of transition from the weekend at home back into school. This particular transition can be hard and challenging, and I thought Andrew could benefit from help with this emotionally. Tuesday was selected to provide continuity from Monday, and Friday because it is at the end of the week, and as with Monday might help with the school/home transition before the weekend. Friday also provided the experience of a short gap between sessions, which could be worked with and thought about in relation to separations. The sessions being organised in this way also meant that the gap between sessions would be no more than two days at any time, thus hopefully offering a period of consistency and continuity. On Mondays the session was at 1.30pm, immediately after the school lunch break. The Tuesday session was at 2.30pm, and the Friday session was at 10.30am. This enabled me to see Andrew at different times in his school day, as well as fitting into my busy schedule. On Tuesdays he left PE to come to his therapy, and on Fridays he left soft play. There is a schedule of all the session dates, days, times and holiday breaks in Appendix One.

The School and the Therapeutic Setting

The psychotherapy treatment I am using for this piece of research took place in a school setting. The school was located in an inner-city environment, and was a school for children and adolescents with a range of learning difficulties and complex needs. These ranged from children with severe and profound learning difficulties to children who were autistic or on the autistic spectrum. Many children had additional needs arising from complex social and family situations. The school was well established and appeared to be a creative, warm and nurturing place in which the child's development was paramount.

It is important for the reader to have some understanding of the therapeutic environment in which the treatment was conducted. Later, in the analysis section, different aspects of the therapy room will be referred to, so it is important to have a context in mind.

To support the referrals and the therapeutic work the school offered, the school had created an appropriate area in which therapy could be provided on site.

The space was slightly different from more traditional therapy consulting rooms, in which there might be a barer space with basic furniture such as a table, a sofa and two chairs.

Unlike the more traditional therapy room, this therapy room had more in it. There was a table to the immediate left as one entered, directly in front of a window. Two hard chairs were placed at the table, and there were a variety of things upon the table such as a pot of pens, a basket with shaped wooden cones, a small lidded box full of glass stones, and a red plastic toy telephone. Opposite the table was a small red sofa with two yellow cushions. To one side of the sofa were a large basketful of wooden shapes and a locked cupboard. On top of the cupboard were more toys, including a spiral/bead toy and a shape game. Next to the cupboard was a cot with a baby doll in it. On the other side of the room were a larger, more comfortable chair and another table with a covered sand pit. Next to the sand pit was a large old circular tin full of toy animals. Initially I was struck by how many items were in the room, wondering if there was too much and how confusing it might be. However, this room offered a colourful, creative, warm and inviting ambiance.

I have named the therapy area the Blue Room, and will use the abbreviated term BR for the purposes of this account and in later sections of the research. The BR was a purpose-built area on the school site that was self-contained within a part of the building. It was off a main school corridor, and had an outer door that led onto a small, contained courtyard area that was open to the sky and contained a small tree. The BR had two windows, one at the front and one at the side, and its own front door. Attached to the front door was a small railing and a slightly raised area offering disabled access. To the left-hand side of the BR was quite a high fence, and to the right a gate. In front of the BR were two large flowerpots full of geraniums. (Please see Appendices Two and Three for images of the inside of the BR and outer courtyard area.)

Despite the many stimuli for play already provided, as a child psychotherapist I also took in a ‘box’ for Andrew. Child psychotherapists work with a box when they work with young or latency-aged children. A rationale for this is to provide

play material so that the therapist can have access to the child's unconscious communications arising from their play. It also provides something for the child that is continuously theirs for the duration of the treatment and is not 'shared' equipment with other patients. In Andrew's box there was some paper, a small selection of pens, a yellow telephone, a miniature bus, a teddy, a small tea set, and a selection of small dolls representative of family members. I also took in a small plastic dolls' house that could be opened and shut. This was for Andrew's use only, and along with the box was provided at each session in addition to what was already in the room.

Thesis Structure

Following on from this introduction to the case will be the literature review, Chapter One, which will cover the following areas: learning disability and global developmental delay, defining the terms and giving a historical overview of them; trauma and neuroscience; and psychoanalytical theory, particularly in relation to development from an object relations perspective. In Chapter Two the research question and the methodology selected for this particular case study research will be outlined in detail. The research findings are divided into three further chapters, Chapters Three, Four and Five, in which extracts from the research data will be provided and discussed in depth. The chapter titles are: 'Finding a Voice', 'Play and Space', and 'The Body'. The thesis will then finish with a final discussion and conclusion from the findings.

Throughout the thesis pseudonyms have been used for reasons of confidentiality, and all names of settings and places have been changed.

Chapter One: Literature Review

This literature review will focus on psychoanalytical ideas about early development, and on psychoanalytical literature relating to work with children with developmental delay. Numerous themes have been identified as relevant to this research which will be the focus of this review, such as global developmental delay, developmental delay, trauma, psyche, soma and addiction.

The initial section of the literature review will concentrate on literature relevant to the area of psychoanalytical psychotherapy with children who have experienced some form of global developmental delay, with emotional deprivation apparent alongside organic damage. These children have suffered doubly (Williams 1997). The review will focus on trauma and the effect trauma can have on the developing child, and will consider the emerging areas of neuroscience, where consideration is given to the effect trauma has on the developing brain and on child development in general. As much of the clinical research will be drawing on non-verbal communication and behaviour, there will be a section considering bodily communication, psyche and soma. There will be a brief component looking at the effects of drug addiction on both the developing foetus and the child, comparing this with a more 'normal' developmental experience. There will be a final section considering child development within a psychoanalytical framework.

Defining Some of the Terms

Numerous terms have been used over the decades to describe children with developmental delay, such as 'retardation', 'mental handicap', 'learning disability', 'developmental delay' and 'global developmental delay', to name just some. This thesis will define some of these terms, because various terms can be used to describe the group of children I am considering. It has been apparent that the terminology tends to relate to the historical context of the time the writing took place, and terms have materialised chronologically, changing over time.

Learning Disability

Around 1.5 million people in the UK have a learning disability which affects the way they understand information and how they communicate. Mencap defines learning disability as follows:

> People with a learning disability tend to take longer to learn and may need support to develop new skills, understand complex information and interact with other people. The level of support someone needs depends on individual factors, including the severity of their learning disability. For example, someone with a mild learning disability may only need support with things like getting a job. However, someone with a severe or profound learning disability may need full-time care and support with every aspect of their life – they may also have physical disabilities. People with certain specific conditions can have a learning disability too. For example, people with Down's syndrome and some people with autism have a learning disability. Learning disability is often confused with dyslexia and mental health problems. Mencap describes dyslexia as a 'learning difficulty' because, unlike learning disability, it does not affect intellect. Mental health problems can affect anyone at any time and may be overcome with treatment, which is not true of learning disability. It is important to remember that with the right support, most people with a learning disability in the UK can lead independent lives. This means they can have difficulty understanding new or complex information, learning new skills and coping independently. (https://wwwmencap.org.uk/handout-learning-disability-definition 3.3.12)

Learning disability can be mild, moderate, severe or profound. Learning difficulty happens when a person's brain development is affected before or during birth, or in early childhood. Several factors can affect brain development such as a mother's illness in pregnancy, or excessive use of alcohol or drug use/dependency in pregnancy. Other contributing factors can be problems at birth, in which a child might not receive sufficient oxygen. There can be genetic and chromosome abnormalities, as seen in conditions such as Down's syndrome and fragile X syndrome. Illnesses such as meningitis during childhood can also leave a child with a learning disability. Alongside the learning difficulties there may be other associated difficulties, such as physical disability or emotional and behavioural difficulties.

Developmental Delay and Global Developmental Delay

As Bartram and Clifford point out, 'this term is used to describe children whose skills and abilities… are not developing as expected' (2013: 6). Areas of development that might be affected include fine and gross motor skills, language and communication development, relational and social skills, sight, hearing, and thinking, remembering and processing skills. A child with this diagnosis could have difficulties with all of these areas, or could be struggling with any one from the above list.

The term 'global developmental delay' as outlined by Bartram and Clifford 'indicates delay in all aspects of development, a specific developmental problem may leave other areas of development unaffected' (2013: 6). A further definition of global developmental delay suggests: 'a child may be described as having global developmental delay (GDD) if they have not reached two or more milestones in all areas of development (called developmental domains). These areas are: motor skills, speech and language, cognitive skills and social and emotional skills' (www.cafamily.org.uk/handout/medical-information/conditions/g/global-developmental-delay.aspx 16.6.16).

This term is used to describe a child who is struggling with aspects of their development, and it is often diagnosed during the developmental period of a child between 0 and 18 months. For other children it is diagnosed later, when a learning difficulty becomes more apparent, such as at nursery or when the child starts school. For the purposes of this thesis I will be referring to a child who was diagnosed as having global developmental delay.

Mental Handicap and Learning Disability

These terms were used by professionals in the 1980s and early 1990s, and are frequently cited by Sinason (1992), whose work I will be referring to and drawing from later in the text. The term 'learning disability' replaced 'mental handicap' and has been defined as affecting the way a person learns new things in any area of life, not just at school. 'It affects the way they understand information and how they communicate. They can have difficulty understanding new or complex information, learning new skills and coping with independence'

(www.nhs.uk//wewell/childwithalearning disability/pages/whatislearningdisability.aspx 30.08.12).

In the past, children diagnosed using the terms learning disability, learning difficulty, mental handicap or global developmental delay were a group that struggled to be recognised as having rights and being worthy of many aspects of life that society can offer, such as education and psychotherapy.

Whatever the term or category used, what is important currently is that this 'group' of patients have begun to attract attention concerning their psychological needs. Authors such as Hollins and Evered (1990) criticise the lack of direct psychological attention paid to this group in the past. In 1996 Enfirls and Tongue did a large-scale study of psychopathology in children and adolescents with learning difficulties living in the community, and found that 40.7% could be classified as having severe emotional and behaviour disorders, or as psychically disturbed.

It is important to note that whatever the terminology, this group have been neglected in the past, and a focus of this research will be to review how provision and thinking has changed and developed. Evidence will later be presented along with an in-depth discussion of clinical work that will highlight aspects of this.

Historical Context

In this section of the chapter I will look in greater depth at the historical context, mapping the development of psychotherapeutic input and services for the above-mentioned patient group. Several key people have brought this patient group and their psychological needs to the forefront, arguing that this group too has a right to and a need for the same psychological help as the rest of the population.

In 1979 some pioneering work was done by Neville Symington, a psychoanalyst and clinical psychologist who worked at the Tavistock Clinic, an outpatient NHS clinic. He began treating an adult patient with moderate learning difficulties, and

subsequently set up a workshop at the Tavistock in 1979 for other professionals interested in this field of work. The terminology used at this point was ‘subnormal’.

Symington (1981) brought attention to how ‘handicapped’ patients, like all other patients, had conscious and unconscious processes at work which could be enriching or debilitating. He believed such patients might need access to psychoanalytical treatment, just like the rest of the population. In 1983, Sheila Bicknell wrote a seminal paper highlighting the emotional problems faced by people with learning difficulties and their need for psychological therapies. Bicknell noted that problems such as grieving, mourning, bonding and attachment are significant but only minimally tackled by psychotherapeutic methods.

In 1985 Sinason, a child psychotherapist, joined Symington in the Tavistock workshop. Interest grew in their work, and the Tavistock began to run courses.

Later, in 1987, Jon Stokes, a senior clinical psychologist in the adult department at the Tavistock Clinic who continued to run the workshop after Symington, wrote the paper ‘Insights from Psychotherapy’. The paper suggested that psychoanalytical psychotherapy could aid the understanding of mentally handicapped individuals and their families. Stokes (1987) referred to some research in which patients were seen over a period of seven years by a group of psychotherapists at the Tavistock. Stokes selected three areas to consider: first, the traumatic effects of handicap on the personality; second, the exaggeration and exacerbation of handicap as a defence through the opportunist use of handicap; and finally, the use of handicap as a defence against trauma. The author referred to the usefulness of distinguishing between ‘emotional’ intelligence and ‘cognitive ‘ intelligence’. He pointed out that there seemed to be ‘no clear one to one relationship between these, that is, some one can be quite emotionally intelligent whilst scoring low on a cognitive intelligence test and visa a versa’ (Stokes 1987: 55). He also argued that handicapped patients can move in and out of a handicapped state.

Developing further from the work of Symington and Stokes, Valerie Sinason published the book *Mental Handicap and the Human Condition* (1992). Sinason reiterated that little psychoanalytic psychotherapy had been available for patients who had mental handicap (learning disabilities) and emotional difficulties. Sinason stated that (at that time – 1992) few psychotherapists were confident or indeed interested in working with this group of patients. An important focus of Sinason's work was the attention to how the primary handicap/disability was made worse by the defensive exaggerations she called 'secondary handicap'. Significantly, and of relevance to this piece of work, she highlighted how trauma is a handicapping agent, stressing 'The damage done to the emotions and intellect when we are crippled by intolerable knowledge' (Sinason 2010: 2). The author believed that psychoanalytic psychotherapy could aid the process of recovery for such patients, through retaining thoughts and speech and sharing history.

In this book, Sinason (1992) gave a historical overview, outlining that there was no formal psychoanalytical psychotherapy treatment offered to mentally handicapped patients. It was Sinason's commitment and belief that this group of patients was reachable and could benefit from psychoanalytical psychotherapy that led to their receiving more treatment. She believed that 'all human beings have an inner world as well an outer one, an unconscious as well as a conscious, and therefore those with a handicap need just as much attention to these aspects of life as others' (1992: 74). The author also drew attention to learning-disabled adolescents and how they need additional help as they struggle with the problem of difference.

An example regarding the issue of difference arose in own work prior to my training as a child and adolescent psychotherapist. I was practising as a dance and movement psychotherapist, and had been running a group for young children with Down's syndrome. The group began when they were four or five years old. When they reached adolescence, some 10 years later, one of the girls became very tearful in the group. When we explored together what was so upsetting, she said: 'I wish I had Up's syndrome, not Down's syndrome.' It was an extremely moving moment, as she was able to articulate her struggle with

her identity as an adolescent girl with Down's syndrome and the painful acknowledgement and acceptance of her difference.

In 1995 the Learning Disabilities Service at the Tavistock Centre was set up with the aim of providing psychoanalytic psychotherapy for children, adolescents and adults with learning disabilities. There was a multidisciplinary team who offered assessment and treatment within a psychoanalytical framework. In 1996 Bichard, Sinason and Usiskin produced a paper 'demonstrating patients who underwent long term weekly individual and group psychotherapy showed improvement in their symptoms and in measures of social interaction, as well as measures of cognitive functioning that included an emotional dimension' (Simpson & Miller 2004: xx).

Graeme Galton (2002) wrote a fascinating article evaluating Sinason's contributions to psychotherapy with the learning-disabled population. He referred to her early work, which highlighted that learning-disabled patients receiving psychotherapy were likely to make considerable improvement in their linguistic and emotional functioning.

In 2004, just over a decade after Sinason's 1992 book, Simpson and published the book *Unexpected Gains: Psychotherapy with People with Learning Difficulties*. Miller, a child and adolescent psychotherapist, and Simpson, a psychiatrist and psychoanalyst, both worked at the Tavistock and continued to facilitate the Tavistock workshop. Miller and Simpson brought together a collection of chapters from practitioners of varying professional backgrounds who wrote about their clinical work with this client population.

Prior to this publication, Miller (2002) had written about some of her work with older adolescents with learning disabilities and their difficulties. One of the themes Miller highlighted was the harsh superego that could be adopted, and how this could be traced to their early experiences of being a disabled baby – the experience of the disappointment or shock revealed in their parents' eyes as they were looked at. The author pointed out that infants who perceive themselves through their parent's eyes as not being the child they wanted will

internalise this perception. Miller suggested that this might generate the formation of a harshly judgmental superego. To elaborate further on this notion, it might be helpful to refer to a paper Winnicott wrote in 1972, in which he argued:

> A child with an abnormality does not know about disparity at the beginning. Gradually in time the child has to recognise the fact of the deformity. What a child must adapt to is the attitude of the mother and other people towards the deformity and eventually it will become necessary to see her/himself as abnormal. (Winnicott 1972: 9)

Winnicott (1972) also referred to the mother's ability to join up her emotional involvement, which is physical and psychological. To return to Miller's point about the development of a harsh superego, Winnicott also suggested that 'distortions in the ego may come from those distortions of the attitude of those who care for the child' (Winnicott 1972: 15). This is an important issue that I will consider further when discussing the clinical component of this thesis.

For the next part of this literature review I draw on selected chapters from Simpson and Miller's (2004) book, as well as more recent articles by child psychotherapists contributing clinical papers to the *Journal of Child Psychotherapy*. These clinically based articles were written by psychoanalytical child psychotherapists, demonstrating more current work and thinking on this treatment modality for patients with developmental delay/learning disabilities. Today (2015–2016) there is evidence that more child psychotherapists have become interested in working in the medium of psychoanalytic psychotherapy with children diagnosed as having learning difficulties or global developmental delay. More articles are being published, and more journals are presenting related articles under the theme.

In recent years several authors have written about their work with this patient group, and have described emerging themes from their work that appear to be common. Kakogianni (2004) suggests that it is not unusual to find a child who has severe learning difficulties and has also suffered emotional deprivation.

Kakogianni (2004), Baikie (2004) and Chantrell (2009) all refer to their patients having limited language, and having fluctuations in emotional states that might be extreme and exhibited though difficult behaviour. All three authors observe and find from their clinical work the inability of the patients to manage their emotions in their minds before undertaking psychoanalytical psychotherapy. Prior to psychotherapy, emotions might have been evacuated (got rid of) or acted out in a more physical or action-orientated way. The authors all find that the experience of psychotherapy helps patients to build a therapeutic relationship and develop more speech (Baikie 2004). Chantrell (2009) highlights that after psychotherapy treatment her patient had an increased emotional vocabulary and more awareness of her feelings. She also described her patient as having improved 'emotional intelligence' after a period of work with her.

These authors utilise a variety of techniques in working with children with limited or no language. Baikie (2004) refers to her skills from her previous training as a drama therapist and special needs teacher, in which she used intensive interaction (Nind & Hewitt 1994). Robinson (2008) refers to her use of observational skills as the only tool available to gain understanding of the patients' non-verbal communications and emotional states.

Separation and loss are other emerging central themes. Baikie (2004) discusses how clearly from the psychotherapeutic work her patient found more words to speak about and face her losses. Robinson (2008) concludes that the patient was able to experience object constancy and mental and physical boundaries in relation to me and not-me (Winnicott 1972) and inside and outside. This repeated work helped the patient to move towards separation and develop a capacity to be held in mind by others outside himself. Chantrell (2009) takes into account the losses a family might have to face when the fantasised 'perfect baby' is not born and they have to come to terms with having a child with disabilities. Chantrell (2009) further argues that emotional intelligence can be viewed as a capacity to be in touch with and express feelings. The author also stresses the importance of the patient' s family and how they feel about having a child with a disability.

Emerson and Hatton's (2007) research states that 36% of children and adolescents with intellectual disabilities between the ages of five and 16 have a diagnosable psychiatric disorder, as well as noting that this group has less access to helpful forms of formal support such as CAMHS compared with young people who do not have learning disabilities. This is an essential contribution to the field.

Hence throughout this period, this patient population has been increasingly seen clinically, and has been offered psychoanalytical psychotherapy as a treatment modality. The Tavistock Clinic continues to offer specialist treatment for this patient group, but patients are now receiving help in CAMHS clinics, voluntary organisations such as Respond,[1] and other specialist services set up to prioritise the needs of this patient group.

This literature review highlights how all these authors have worked in the field of developmental delay/learning disability and have illustrated both the value and the usefulness of psychoanalytic psychotherapy work with this patient group. From their closely observed and recorded clinical work, it is apparent that the work has made important contributions to patients, such as the development of language and increased speech, and a move from the evacuation of feelings and acting out to a place in which thought and thinking become available. Alongside this the authors illustrate how their patients became more emotionally aware, and how underlying issues such as loss and trauma could begin to be thought about and worked with. Beail (2005, 2003) and Newman and Beail (2002) have done research in this area and – combined with other research, such as that by the Royal College of Psychiatrists (2004), which looked into psychotherapeutic approaches for this patient group – it suggests an increased evidence base for the development of this work.

Trauma and Neuroscience

[1] Respond works with children and adults with learning disabilities who have experienced abuse or trauma, as well as with those who have abused others, through psychotherapy, advocacy,
campaigning and other support. Respond also aims to prevent abuse by providing training, consultancy and research.

Trauma was briefly referred to in the last section, as Sinason (1992) referred to how trauma can be a handicapping agent. In my clinical research, trauma was apparent: the trauma of being born heroin-addicted, and the traumatic effects of heroin on the developing foetus in the womb; the trauma of separation at birth and potential attachment issues relating to this; and hydrocephalus (fluid on the brain). This section of the literature review will consider trauma and some of the effects it can have on development. It will include ideas relating to the impact trauma has on the body as well as the mind, and will relate to new research in the field of neuroscience and how neuroscience is helping psychotherapists in their understanding of trauma in the developing child.

Consultant clinical psychologist and psychoanalyst Garland (1998) defines trauma as a kind of wound. Garland elaborates on this definition:

> A traumatic event is one in which an individual breaks through or overrides the discriminatory, filtering process and overrides a temporary denial or patch up of the damage. The mind is flooded with a kind and degree of stimulation that is far more than it can make sense of or manage. Something very violent feels as though it has happened internally, and this mirrors the violence that is felt to have happened, or indeed has actually happened in the external world. It is a breakdown of an established defensive organisation. (Garland 1998: 10)

Perry et al. (1995) wrote a paper on the neurobiology of adaptation and focused on various aspects of the impact of traumatic experiences on infants and young children, looking specifically at the relationship between neurodevelopment and traumatic experience. The authors state: ‘depending on the severity, frequency, nature and pattern of the traumatic events, at least half of all the children exposed may be expected to develop significant neuropsychiatric symptomatology’ (1995: 273). They further state that one of the most researched ‘neuropsychiatric syndromes is Posttraumatic Stress Disorder… and that children exposed to trauma may have a range of PTSD symptoms such as behaviour disorders, anxieties, phobias and depressive disorders’ (Perry et al. 1995: 273). The authors point out that ‘understanding the organisation, function and development of the human brain, and brain mediated responses to threat, provides the key to understanding the traumatised child’

(1995: 273). They usefully remind us that children are not as well equipped for flight or fight (the freeze or surrender responses) as older children and adults are, and that in initial stages of distress a young child will communicate by using vocalisation. If a threat is persistent, depending on the age of the child and nature of the threat, the child will move along the hyper-arousal continuum. A concern for children who have been traumatised is that they can develop a sensitised hyper-arousal or sensitised dissociative pattern, and will often use the freezing mechanism when they feel anxious. 'For some children this can escalate into complete dissociation' (1995: 280). The authors define dissociation as 'a disengagement from stimuli in the external world and the child attends to the internal world in activities such as daydreaming, fantasy and depersonalisation' (1995: 280). In an interview with Graeme Galton in 2003, Sinason referred to her work with trauma and abuse, reiterating the point that children under five are not able to conceive of a parent or carer being sadistic and, unlike older children, cannot draw on their flight/fight mechanisms and run away. Sinason stipulated that they have to look after themselves, and therefore flight inside is the only mode of survival (Sinason 1992).

Perry et al (1995) and Shore (2001) also point out that trauma occurring in the pre-verbal period can have a significant impact on the child's physiological development and psychic organisation. In her paper 'Peek-a-Boo: How "Can" You Be There?', based on analytical work with a severally traumatised two-and-a-half-year-old, Katrina Strah (2004) stresses that it is not clear whether and how the traumatic experience is registered, represented and remembered. She suggests that failure to integrate trauma can lead to the trauma being organised at a sensory and somatic level, while unconscious triggers can evoke a physical re-expression without conscious memories to accompany it. This brings us to consider how these experiences can be located in the body.

Hart (2011) highlights how the experience of negative attachment and abuse is within the body, and hence the therapeutic work involves the recognition, containment and processing through the countertransference of the child's body presentations in action. The author suggests that it is at this stage that the role of the therapist is to 'listen' to what is not yet symbolically formed or put into

words. Lynch (2000) refers to the child presenting what the body experienced at a psychobiological level, in a developmental form that predates neurotic re-enactment or conscious recall. McDougall (1989) has written about the effect of psychosomatic illnesses, suggesting that we can all somatise in moments when inner or outer circumstances overwhelm our psychological ways of coping. This author also refers to 'babies and how they are unable to use words to think and express themselves and therefore respond to emotional pain psychosomatically', and says that the 'infant experiences intense somatic experiences in the earliest months of life, long before it has any clear representation of its body image. It can, therefore, only experience its own body and the mother's body as an indivisible unit' (McDougal 1989: 9–10).

Child psychotherapist Monica Lanyado (1999) has written extensively about her clinical work with severely traumatised children and adolescents. An interesting question she raises when thinking about the impact of traumas on the developing child is 'what is the difference between an individual's ordinary pain in response to these everyday events in many parts of the world and becoming traumatised by events?' (Lanyado 1999: 300). She draws attention to the prevailing state of the individual's emotional well-being, together with the availability of loving emotional support following a trauma, and how that plays a significant part in shaping how severely the trauma affects the rest of a person's life. The significance of this research is that it highlights the psychical consequences of relational and external trauma, which can stop or inhibit vital brain development, particularly during the first two years of life; as a consequence, important neural pathways in a child who has been traumatised may not develop enough for them to be able to use a part of the brain, the cortex, to think about their impulsive behaviour. Another useful theme in this material is the author's comments on play. She emphasises that severely traumatised children are too reactive to be able to play, and a helpful job for the therapist is to aid the child to start playing.

As previously mentioned, the clinical component of this research will focus on a boy born to heroin-addicted parents. *It is relevant to include some information*

on children born heroin addicted and to consider how it impinges on their development.

NHS figures show that more than 1500 babies a year are born addicted to drugs. More than 7,800 new-borns have been recorded with "neonatal withdrawal symptoms" in the last five years. This includes 6,599 cases in England, 783 in Scotland and 464 cases in Wales. The figures show a 22% increase in cases in the ten years from, 1,192 in 2004-5 to 1,563 in 2014-15. https://www.theguardian.com/society/2014/aug/02/1500-uk-babies-born-addicted-to-drugs-nhs (9.11.16)

Research has shown that heroin slows foetal growth, causing intrauterine growth retardation and premature birth, as well as low birth weight, premature birth, and stillbirth. Babies born with NAS (neonatal abstinence syndrome) such as the child in this case study research can be difficult to care for due to feeding difficulties, poor sleep, irritability and this could prevent early bonding between mother and baby. The mother's inadequacy and guilt if the baby is born drug dependent may make maternal attachment more complex.

Drug use in a parent can often be accompanied by their own mental health issues and their children are then at risk of increased neglect and abuse, failure to thrive (grow and develop), have emotional, cognitive, behavioural and other psychological problems and educational difficulties. Often other family members e.g. grand parents will take on the care of these children to avoid them being taken into care. https://www.bestbeginnings.org.uk/parents-who-use-drugs (4.2.17)

Although there is still much to be learned about the long-term side effects of prenatal drug exposure, a number of studies indicate that prenatal drug exposure can cause learning difficulties as children grow. Singer's research (2002)*, found that cocaine exposed children were twice as likely to have cognitive delays compared to children not prenatally exposed. She also stipulated that children exposed to heroin prenatally also have similar long-term learning disabilities.*

It seems as if more on-going research in this area is still necessary as research is limited, but findings to date suggest that there are many consequences that affect children exposed to drugs such as heroin in pre natal and early development. The available research (2002, 2014) stipulates that these children will struggle with many aspects of their development such as focus and attention, developmental delays and other more general learning disabilities. As well, they appear prone to ADHD and other behaviour difficulties.

Therefore Emanuel's psychotherapy work with children traumatised in infancy is relevant. Emanuel (1996) explored a prototype of trauma when babies are born to drug-addicted parents, pointing out that the baby experiences two kinds of trauma: first, the painful withdrawal from the drug and the invasive medical procedures that accompany this; and second, the lack of available receptive parenting in which the parent has the capacity to help process the baby's emotional experience. The author suggests that this is where the role of the psychotherapist is of such importance, as they can help the child to make sense of their emotional experience. He also points out that in early infancy the psychic structures that are often shattered by trauma may not yet even exist, and therefore there is a cumulative trauma. Thus 'the mental apparatus which might provide some protection or resilience against the effect of trauma may fail to develop as a result of the trauma' (Emanuel 1996: 218). Pynoos (1992), in his post-traumatic stress disorder work, refers to trauma needing to be thought about in a developmental way, in that it affects both current and later development.

It is apparent that several of the authors are bringing attention to the particular role of the psychotherapist and what they can offer to these children, such as attunement (Stern 1985); help with making sense of their emotional experience; the provision of a mind and the necessary thinking; the naming of what they observe and experience through the countertransference, in order to provide both understanding and a narrative; and help for the child to develop their capacity for play, enabling the therapeutic processing of the traumatic experience to take place.

In recent years there has been a great deal more research and interest in the field of neuroscience and the impact this has on understanding trauma in the developing child and the implications for child psychotherapists. Music (2009, 2011) has written about the impact of trauma and emotional neglect in the early years of life. He considers a range of theoretical and research traditions, including neuroscience alongside psychoanalytical ideas. The author believes that there is a spectrum of neglect, and brings our attention to how the use of brain scans in severely deprived children has revealed profound alterations in the architecture of the brain. Emanuel (1996) stipulates that where traumatic experiences have not been processed they remain liable to be repeated: 'like an invalid ghost it cannot rest until the mystery has been solved and the spell broken' (Emanuel 1996: 220). It is a complex arena, with a great deal of work taking place in order to understand the emotional, psychological and physical effects that trauma has on development. These authors have made a valuable contribution as we proceed to know and understand more about the effects of trauma and the role psychotherapists have in the treatment.

Development

The section on trauma has begun to highlight how trauma affects what we would consider to be a 'normal' and 'healthy' developmental trajectory, touching on some of the implications trauma can have for ordinary development. To reiterate a point made by Emanuel (1996), a child who has been born to drug-addicted parents has also experienced trauma before birth as well as post-birth traumatic experiences, and then the child goes on to experience a third trauma – how the child is seen and experienced by parents who are struggling or unable to be emotionally and physically available for their newborn child. I would like to make a link here to the research work done by Piontelli (1992), who looked at how prenatal experiences affect postnatal development. In her book *From Foetus to Child*, Piontelli described her observations of the behaviour of several children, from the very early stages in the womb through birth to infancy and childhood. Her study was the first longitudinal study of its kind. The author suggested: 'the interplay between nature and nurture begins much earlier than is usually thought and that certain pre natal experiences may

have a profound emotional effect on the child, especially if these pre natal events are reinforced by post natal experiences' (1992: 1). The author refers to some cases 'in which acute fetal distress causes an exaltation of motility and movements become abrupt, forceful and frantic' (1992: 35). She goes on to point out that the fetal environment is rich with acoustic stimulation, coming from inside the mother's body through her eating, drinking, breathing and cardiovascular activity. Piontelli draws attention to the fact that the intrauterine world is not a static place but a place subject to many changes. I would like to consider more thoughtfully how the intrauterine experience of receiving heroin has an impact on the baby's experience in the womb – a rapid burst of a poisonous foreign agent. It must be experienced by the developing foetus in the womb as unpredictable, and have the force of an unexpected and potentially violent agent entering the system. The foetus in this fragile, developing state is not being considered or cared for by its mother, and is already being exposed to a state of emotional inconsistency, toxicity, addiction and abuse. This is quite a distressing notion to contemplate before birth has even taken place, and a notion to be kept in mind for the case ahead.

The following section will go on to consider more about child development from a psychoanalytical perspective.

Child Development Within a Psychoanalytical Framework

Child psychotherapists are interested in early development, and pay detailed attention to childhood and developmental history in order to consider the way in which the earliest relationships are important for how mental structure is shaped and how it affects the internal world of the child.

Due to the developmental delay of the child in this research and the research interest in growth and development a decision was made to focus on developmental literature within the field of psychoanalysis only, and not to look at the wider area of child development. Because the research was based on a piece of clinical work done by a psychoanalytically trained child psychotherapist who was primarily interested in the development and change that took place in in the child's internal and unconscious world, a further decision was then made

to limit the literature review in this component to the work of Bion (1962,1963, 1967), Klein (1946, 1952, 1959) and Waddell (1998). The focus on the literature and the work of these particular authors as well as their interest in internal and unconscious processes was considered. Alongside this the effect of early relationships between the infant and their carers and the internal structures that get set up (or not) psychically from these early relational experiences is incorporated. These authors were interested in these early experiences and the effect they could have on subsequent development. The work of Bick (1968), Winnicott (1964), (1971), (1972), Stern (1985), Alvarez (1992), Trevarthen (1974), Hoxter (1998) and Meltzer (1975) are not included in the literature review but their contributions to psychoanalysis and psychotherapy are considered and referred to in discussions throughout the research.

As stipulated previously, my research is about a child who was diagnosed as having global developmental delay and had been born to drug-addicted parents. The child was born heroin-addicted, and most likely suffered some level of early emotional deprivation due to having parents that were not able to care for him emotionally because of their own complex needs and difficulties. In the following section I would like to focus on some developmental factors that are essential for good-enough normal development to take place, in order to provide a context to think about what happens when certain aspects of development for whatever reason are missing, are not available or cannot be provided in the early relationship between a child and its primary carer(s).

Following on from Freud, Klein and Bion who were psychoanalytical clinical practitioners interested in the earliest relationships in infancy, the structures these set up internally, and how they affect the developing mind within the developing relationship.

Klein (1946) was interested in instinctual needs and how these were met. Klein's view was that if the needs of the baby were met with an external object, e.g. the mother, it resulted in a physically satisfying experience, an interest in the external world and a social relationship to the mother. Most significantly, it initiated the beginning of mental development. Klein brought a developmental

and forward-looking perspective to psychoanalysis, and was struck by the child's urge to know and investigate the world. Klein noticed that the child had phantasies of what was inside their mother's body. She also designated positions: the paranoid-schizoid position and the depressive position (Klein 1959). These were mental states, attitudes with which someone might view themselves (Waddell 1998).

Klein (1952) described the paranoid-schizoid position as the earliest position in infancy, and associated this state with anxiety – 'a fear of persecution and the fear of the nature of defence against such fears' (Waddell 1998: 6). In 1935 Klein began to make a distinction between two kinds of anxiety, persecutory and depressive, and noted that these were rooted developmentally in the two phases in the first year of life. In the first phase the infant is dominated by persecutory anxiety; the second phase occurs when the infant recognises the mother as a whole person. In the earlier phase the infant can only relate to parts of the mother. In the second phase the infant becomes more aware of the fact that the good figure (the one who provides for the baby) and the bad figure (the one that takes away or does not provide) are the same person. In this phase there is some recognition that the good and bad are located in the same person. During this phase feelings of guilt about aggression against the loved one arise, along with a fear of losing her through destructive attacks (Segal1981). The depressive position, which is more evident in the latter part of the first year, is when a more considerate attitude emerges in the infant. Feelings of concern and a capacity for remorse develop (Waddell 1998). This recognition can lead to wanting to makes things better, a sense of reparation. Klein highlights these positions, the paranoid-schizoid and the depressive, as differing states of mind, and stresses that each individual can move and fluctuate between the states throughout life. This can be more prevalent in times of stress and anxiety.

Bion was interested in Klein's notion of a infants basic need to know, 'to reach outwards into the world… and how modification by experience can take place' (Harris & Bick 1987: 166). Developing on from Klein's work was Bion's notion that the breast stood as a metaphor for the mind. 'In good enough development

the mother not only brings nurture and love, but also brings her thinking self, mental and emotional states, which encompass the chaos of her infant's psychic life, establish a pre-condition for a more integrated self' (Waddell 1998: 28).

Bion developed an important idea of the mother as a 'container' (Bion 1962: 90). In this model the mother/carer becomes the 'container' for processing an emotional experience. The mother/carer is there to see an infant's distress, receive it, try to understand the infant's projections, think about it, make sense of the communication, and feed it back in a way which allows the infant to feel that its emotional state has been understood.

Bion (1962) describes 'reverie' as the mother's state of mind which is necessary for her to be the container for the baby – for example, a mother who can engage with a baby's distress, contain it and dispel it. The mother can tolerate something in her own mind, and can stay with and experience the communication, which might be an internal anxiety, rather than trying to find an immediate solution. She can be said to have 'contained' the baby's anxiety. Waddell (1998) refers to how physical pain and psychic pain are indistinguishable. In Bion's model the mother manages to receive the projections from the baby, process them and hand them back. This diminishes the fright, fear or terror the baby may be experiencing. This process then enables the baby to reintegrate emotionally and shift from the previous state, in which s/he was more fragmented or in a paranoid-schizoid position (Klein 1952), to a more integrated state in which the fear and terror are alleviated, i.e. the depressive position (Klein 1952). The baby has introjected (taken in) something good from the mother/carer to enable this process to happen. This repeated process will enable the baby to develop an internal psychic structure of their own so they will not always have to depend on another to hold them psychically.

Waddell (1998) draws on the work of Bion (1962) and Bick (1968), and gives a useful account of defences infants employ against psychic pain when emotional 'containment' has not been available. An infant will find a range of its own

tactics to help it to tolerate a difficult emotional experience. The author describes how the infant's immediate response is to get rid of the difficult emotional experience by pushing it elsewhere, projecting it out. Bion (1962: 96) refers to something called 'nameless dread', a state an infant will be in when left with intolerable feelings if there has not been a mind available to receive their stress and feed back something that is less unbearable. When psychic pain is felt to be too much to manage, an infant will find various ways of managing, such as withdrawal or isolation:

> A child may retreat into a deeply withdrawn or borderline state, unable to allow anything in, so traumatic to the self's emotional survival has the 'loss' of a needed presence been felt to be… A deprived or frantic child has to make desperate attempts to deal with unbearable emotional experiences. (Waddell 1998: 44)

If a child has not internalised the necessary psychic structures from 'reverie' and 'containment', they may establish what Esther Bick (1968) refers to as a 'second skin'. Bick refers to infants developing a 'second skin' as an attempt to hold themselves together, as they could fall apart if threatened. This might be observed in different responses such as an infant's manic movement, fiddling, and/or attention on an inanimate object such as a light bulb.

This literature review has given an overview of relevant literature that I will consider in relation to my own research. It has included an overview of learning disability and global developmental delay, the historical context of terminologies used in the field up to the present, and a historical perspective on learning disability and developmental delay. It then looked at the field of trauma and neuroscience, before concluding with child development within a psychoanalytical framework.

Chapter Two: Methodology

This chapter aims to outline the research methodology I used for this research, considering the various stages and processes of the enquiry undertaken. I will give a theoretical overview of qualitative research, and within this my research choice of a single-case study. I will consider the single-case study as a method of research within the field of child psychotherapy and give some consideration to its history in this area, its strengths and limitations. The sampling of material and its analysis will be examined, and I will discuss the use of thematic analysis and matrix methodology as the main method to analyse the data within the case study.

This chapter will also consider ethics in relation to this research, and there will be some discussion about reliability, validity and reflexivity relevant to this piece of work.

Research Question

I set out with a research question: can intensive psychoanalytical psychotherapy enable a child diagnosed with developmental delay to become unstuck?

I was interested in looking in depth at aspects of intensive psychotherapy in order to evaluate the developmental change and progress that had been achieved for a child who had been stuck in their development and was not developing to the potential thought possible by the school and the family.

It was hoped the research would be able to identify and illustrate some significant changes that took place during the intensive psychotherapy process and that could be viewed as propelling the development of this child.
Drawing on one case only, this research is located within the tradition of single-case studies that has typified much psychoanalytic research.

The next section of this chapter will focus on qualitative research before going on to discuss the strengths and weaknesses of case study research.

Qualitative Research

Unlike quantitative research, in which measurable outcomes, statistics and the traditional testing of hypotheses predominate, qualitative research enables an examination of process and the generation of hypotheses. 'The word "research" simply implies a wish to investigate, to look again (re-search), to go beyond accepted viewpoints and to challenge the way we see things' (Midgley 2009: 90). As Rogers points out, 'it is only qualitative methodology that explicitly values the personal experience of the researcher and acknowledges and uses subjectivity as an inherent component of the research process' (1995: 5). Miles and Huberman refer to qualitative research as being 'a source of well-grounded rich descriptions and explanations of processes in identifiable local contexts. With qualitative data one can preserve chronological flow, see precisely which events lead to which consequences, and derive fruitful explanations' (Miles & Huberman 1994: 1). Midgley also suggests that 'it is an approach that aims less at prediction and statistical correlation and more at discovery and increased understanding of the human world,' and points out that it is 'a useful approach to elucidate or illuminate the meaning which people employ to make sense of their experience and guide their actions' (2004: 94). Qualitative research provides descriptions and accounts of the process of social interaction. 'It is an approach in which meanings and processes are emphasised and it is more flexible in research design' (Villainy & Webb 1992: 6).

Case Study

Case study is a research methodology situated and utilised under the umbrella term 'qualitative research', as opposed to quantitative research. Qualitative research is where the human sciences and psychoanalysis might be more readily located. As Stake points out:

> A case study is expected to catch the complexity of a single case… we study a case when it itself is of very special interest. We look for the detail of interaction within its contexts. Case study is the study of the particularity and complexity of a single case, coming to understand its activity with important circumstances. (Stake 1995: xi)

Case study research can involve the study of a particular instance or event, one case, or a small number of cases. The case investigated could be a situation, an individual, a group or an organisation, depending on the interests of the researcher. Donmayer (2000) describes the case study approach to research as a method that is more concerned with description and less focused on 'a need to know' something. I have already stated that a case study is about discovery and increased understanding of the human world (Midgley 2004). My research lends itself to both a qualitative approach and the use of a single-case study, as my intent is to gain a more in-depth understanding of Andrew from the intensive psychotherapy work that took place over a period of time. This approach also allows me to substantiate and provide evidence for the changes and developments that took place throughout the psychotherapy.

As a form of research, the case study has a long tradition in the field of child psychotherapy, and has been the most widely used form of research in this field. In the field of psychoanalysis and psychotherapy, the single-case study can be traced back to the turn of the 20th century, when Freud and Breuer (1895) published their studies on hysteria. Within these they gave informative and in-depth accounts of the inner lives of their patients. Freud (1915) argued that psychoanalysis was a research method in itself, and that it contributed to the scientific understanding of mental life. Freud also brought to our attention to how this constituted evidence of what was taking place in the consulting room.

Since the turn of the 21st century, Michael Rustin (2003, 2008, 2016) has been an important advocate in developing the awareness and significance of research in the profession of child psychotherapy. He states categorically that child psychotherapists do have and do practice research and always have done so. He stresses that if psychoanalysts and psychotherapists had not done research, then they would have no knowledge (Rustin 2003). Recently Rustin stated: 'psychoanalysis is above all a practice-based discipline, in which discoveries are made in the context of clinical work' (Rustin 2016: 180). Margaret Rustin, a prominent, experienced and published consultant child psychotherapist, stipulated: 'in one sense an individual piece of psychotherapeutic work is a research project – patient and therapist do not

know what the outcome of their exploration together will be' (Rustin 1984: 380). Usefully, Michael Rustin reminds us that in the history of child psychotherapy a great deal of knowledge has been published through publications of clinical case study material. This has included findings by Freud (1915) and Klein (1961), as well as more recent publications in books and journals by authors such as Reid (1997), Rhode (2015), Emanuel (1996), Music (2009, 2011), Miller and Simpson (2004) and Sinason (1992, 2010). Midgley (2006) too points out that every clinical paper in the field of child psychotherapy could be described as a piece of research on the therapeutic process and the nature of change, and this of course is true.

However, this piece of work is not a clinical paper, but a piece of clinical research. Research in this sense is about finding the data and the evidence, and showing it to others and to a wider audience. It is a more in-depth process than writing a clinical paper, because it has been through a process of analysis of the data to extract and provide the necessary evidence to support the development of hypotheses, and in this case in order to show outcomes.

Michael Rustin (2003) has argued extensively about the value and use of the case study as a research method, and states that the therapist's consulting room can be considered the primary laboratory in which psychoanalytical research takes place. This is a particularly important factor in this piece of research, along with the significance and consistency that the therapy room remains the same. Rustin (2008) further suggests that a single-case study can systematically analyse and look for recurrent patterns/episodes, and this in itself can then enable and facilitate comparative methods within this framework. However, in contrast to this, Rustin (2006) acknowledges that the case study can leave the child psychotherapy profession vulnerable to criticism and misunderstanding. This view has been supported by predecessors such as Cohen and Manion (1994), who are extremely blunt and harsh in their criticisms of the case study method, stating it is 'biased, impressionable, idiosyncratic and lacking in precise quantifiable measures that are the hallmarks of survey research and experimentation' (Cohen & Manion 1994: 107). However, more

favourably, Rustin (2006) continues to argue that the single-case study can add to an original body of knowledge in a particular field and subfields.

Midgley (2006) proposes that a case study has a number of functions. It can provide evidence or clarification of certain theoretical ideas that are already held; it can lead to the emergence of new ideas; and it can give opportunities to integrate clinical experience with theoretical concepts. In relation to my own research and Midgley's suggestion, I hoped that case study research would provide the necessary evidence in relation to my research aim.

This form of detailed single-case study research can enable others to get a sense of what goes on in the research laboratory (Rustin 2006) – the clinical setting. In later chapters I will be including direct vignettes of clinical material taken straight from the detailed observations of the clinical setting. This will undoubtedly give the reader insight into some aspects of the therapeutic work as well as the developing therapeutic relationship between Andrew and me (within the bounds of confidentiality) that would otherwise not be possible. Obviously, confidentiality has been considered, hence the use of pseudonyms.

The case study can provide a base from which to move towards a wider level of understanding, and can usefully bridge the gap between research and clinical practice. Stake points out that 'a case study enables a better understanding of a case as the case is looked at and examined mainly to provide insight into an issue or to draw a generalisation' (Stake 1994: 437).

Klein (1961), an eminent child psychoanalyst, emphasised the opportunity that the case study offers to demonstrate a certain way of working with children analytically, e.g. an evolving technique. It allows the reader to observe how to interpret and find confirmation in the material from the extensive notes. She was also aware of limitations of the case study, such as the lack of rigour and representativeness. In the 1960s Klein (1961) wrote about some of the limitations of her own case study approach, and was able to be honest in questioning her own certainty about accuracy when writing up the sequence of her sessions. Although this might still need to be thought about and considered

today, it is important to acknowledge change and development in the area of child analysis and psychotherapy in recent decades, in particular the rigour of child psychotherapy training in developing observational skills for child psychotherapists (Bick 1964).

However, observation can be a contentious issue, and Greenwood and Lowenthall (2005) draw attention to how different potential meanings can emerge from observations. Although I am not looking at phenomenology in this piece of research, I am interested in the idea taken from it in which the observer tries to understand what is there, and in how observation is a means of attempting to understand what is significant.

Midgley (2004) stipulated some areas of methodological weakness of the case study that are important to consider. There are two in particular that I would like to draw attention to here. First, he suggested that the 'evidence is so incomplete it is hard for the readers to draw their own conclusions' (2004: 91). I assume that what he means by the evidence being incomplete is that the reader does not get to see all the evidence, and the evidence relies on the accuracy of the observations and the note-taking. Midgley makes a useful and valid point that should be taken into consideration; however, ethically it is important for the researcher to be honest, and my intention has been to provide as honest an account as possible of the carefully selected and analysed material, giving the reader as true a representation as possible of what was taking place in the research laboratory (Rustin 2006). Second, he raises the issue that readers have little chance to make contact with the clinical data and reach their own conclusions. While readers do not have access to all the clinical data, as for research purposes it is sampled and there might also be ethical arguments against it, the aim is to use data extracts in line with the researcher's interpretation to enable readers to access key aspects of the case.

In a later paper Midgley (2006) furthered the debate about both the limitations and the strengths of the case study as a viable method of research in the area of psychoanalysis and psychotherapy. In this later paper he determined and categorised three major difficulties: a data problem, a data analysis problem

and a generalisability problem. In relation to the data problem, he pointed out that because the account is that of the therapist, it is only the therapist's memory of what took place. The implication is that parts of the account or write-up therefore have to be flawed. He questioned what happens to the components the therapist does not remember. Of course Midgley is right up to a point; however, in contrast to this, he does argue (2004) that child psychotherapists are good at recording in-depth, accurate observations thanks to their intense observational training. In a study of childhood depression (Trowell et al. 2003), a preliminary comparison was made between the transcripts from audio tape recordings and the therapist's process recordings. The authors found that 'no major discrepancies were found in respect of themes, of the sequence of material within the sessions, or of the reported frequency of transference interpretations' (Trowell et al. 2003: 158).

Midgley also drew attention to the editing that naturally occurs when writing up, and he linked this to the potential legitimacy or otherwise of the therapist's process notes. Again this could be a valid point to consider. Klein (1961), as previously stated, drew attention to some limitations of her own case study approach and was able to be honest, questioning her own certainty about accuracy when writing up the sequence of her sessions. There is also the issue of ethics and the responsibility of the researcher to be honest and respectful in how they collect their data, including as honest an account as possible of their observations. There will always be an element of natural human fallibility in writing. If a human is involved, there will always be occasion for potential unconscious error, which is what I assume Midgley is raising. This could be applied to many other forms of data collection that have any subjective component to them. Child psychotherapists participating in research do need to take these points into account and be as honest as they can in the writing up of their clinical sessions and in their reflective processes.

As I have already mentioned there are criticisms from the wider field of research about the methods of research in psychoanalysis and psychotherapy.

There have been some useful responses from the field of psychoanalysis to these criticisms. In relation to the case study, Rustin (2003) argues how researchers could 'group' their case study research together in order to compare and contrast the similarities and differences in findings. He suggests this could add strength to research findings, as well as allowing for more identification of patterns and themes, thus substantiating findings.

Midgley (2006) stressed how psychoanalysis could argue how 'case study' is a legitimate method within social services which needs to be assessed by criteria appropriate to its own methods' (Midgley 2006:123).

Fonagy (2003) suggests how gathering further evidence from outcome studies could be helpful in generating a change in attitude from a culture of knowing and certainty to one of questioning, uncertainty and progress. He also suggests that developing measures that 'reflect the kind of changes that psychoanalytical psychotherapy aims to generate' and talks about the 'different research questions requiring scientific methodologies' (Fonagy 2003:133).

Fonagy responds further to critics of psychoanalysis stating there are five ways psychoanalysis could change in order to strengthen their research agenda. He suggested, 'incorporation of data methods from social and biological science that go beyond anecdotal; making concepts more specific, to facilitate cumulative data gatherings; consideration of alternative possible accounts for observations, not just psychoanalytical; become more sophisticated about social and contextual influence on behavior and finally become more active in taking up scientific collaborations with other disciplines' (Fonagy 2003:134).

Midgley (2011) responds too by suggesting 'larger scale studies with carefully collected control groups' (Midgley, 2011:247). This to some extent supports Rustin's (2003) notion. Midgley (2011) also points out that 'research to date has also been hampered by the fact that it is lacking in systematic co-ordination and there has been little sense that the findings of any one individual case study have been used as the basis for conduction of further studies' (Midgley 2011:247).

These limitations are commonly acknowledged within the field of psychoanalysis. However as Midgley (2011) states, 'doing well designed research studies also require considerable resources as well as expertise'. Child psychotherapy and psychoanalysis has not been able to undertake such high-powered research yet due to these factors.

Ethics

This section will consider some ethical issues in relation to this piece of research.

According to Schnell and Heinritz:

> Research ethics addresses the question, which ethically relevant influences the researchers' interventions could bear on the people with or about whom the researchers do their research. In addition it is concerned with the procedures that should be applied for protecting those who participate in the research, if this seems necessary. (Schnell & Heinritz 2006: 17)

Flick (2014) highlighted eight principles, some of which are relevant and that I would like to consider for this research:

> Researchers should be able to justify why research about their issue is necessary at all; researchers must be able to explain what the aim of their research is and under which circumstances subjects participate in it; researchers must be able to explicate the methodological procedures in their projects; be able to estimate whether their research acts will have ethically relevant positive or negative consequences for the participants; assess the possible violations, damages arising from doing their project; must not make false statements about the usefulness of their research and respect current legislation of data protection. (Flick 2014: 49)

Taking up these points in relation to my own research, the first suggestion is that researchers have to be able to justify why research is necessary at all (Flick 2014). This is a matter I have taken into account. The aim here was to examine whether there was evidence that developmental change took place in a child who was stuck in their development. If so, the results could be of benefit to further knowledge in the field of child psychotherapy, with particular reference to the value of long-term and intensive psychotherapy treatment. If the research results found the treatment to have been successful, the results could contribute further to the argument that intensive psychotherapy treatment at an early stage in life can aid the propulsion of development for children who have, for whatever reason, got stuck developmentally. Although there has been previous research in the field of global developmental delay, it has been limited in the area of intensive treatment. The intention is for the research to have ethically positive

consequences, for the participant and for other, future children. However, an issue in relation to this research could be related to its time limitation and relational aspect. There would inevitably be loss for the child and the family when treatment concluded. Although the ending of the treatment was thoughtfully taken into account and prepared for, there could still have been an element of confusion and natural loss for the child and the family as the psychotherapy ended.

The research has taken into account the issue of current legislation concerning data protection, particularly in relation to ethics and confidentiality. This research was approved by the UEL Ethics Committee, and the letter of approval can be seen in Appendix Four. The methodological procedures have been clearly outlined in this chapter, and the researcher will not be making false statements: all the vignettes selected from the data are true accounts of raw empirical clinical material from the selected research sessions, which were also sessions that were supervised**.**

Additional factors highlighted by Dingwall (2003) were also taken into account, such as informed consent. Due to the child in the case study being extremely young and vulnerable and having developmental issues, permission for doing the research was acquired from the mother. This was done in the form of a meeting explaining the outline and rationale of the research. This was followed up with a more formal letter, outlining the research project and requesting either her formal consent or her non-approval. In this particular case the mother was extremely willing to give the necessary consent for this piece of research to take place, both verbally and on the consent form. She also expressed how important she thought the research would be if it could contribute in any way to helping other children in a similar position to her own child. Consent forms were also obtained from the class teacher and the family worker, in order to have their permission to refer to the minutes of feedback and review meetings we held regarding the case.

In relation to the data collection, there was complete and ongoing respect concerning anonymisation in relation to the patient, other professionals and the

setting where the patient was offered treatment. In individual case study research identification can sometimes be easier, so particular caution was exercised throughout the research project to ensure confidentiality at all times. As previously stated, pseudonyms have been used throughout the research.

After looking at the advantages and disadvantages of the case study and the consideration of ethics, this chapter will now consider the process of data collection and analysis, and the methodologies used to analyse the raw data

Data Collection and Selection Criteria

As previously stated, child psychotherapists are trained in observational skills (Bick 1964) and apply these skills to their clinical work by paying acute attention to what is happening in the clinic room, their research environment (Rustin 2006). Their detailed observations of each clinical session are written up as soon as possible in order to record as much information as possible, as accurately as possible. As previously stated, Midgley points out that 'most child psychotherapists have developed a high level of ability to observe and make detailed records of observation,' a skill also used when writing process notes on child psychotherapy sessions. 'These skills would be highly relevant and appropriate to any form of qualitative research' (Midgley 2004: 94). The process notes on each psychotherapy session aim to give as full and thoughtful an account of the session as possible, which might include what happened chronologically in action, time and place; the relational aspects of interactions between the therapist and the patient, including transference and countertransferential responses; unconscious and symbolic material; interpretation and reflection. It was from these detailed observational sessional notes that the data was obtained and selected for analysis in this research.

Due to the enormous amount of research material in the form of clinical data from the intensive psychotherapy, I had to make a decision about how to look for, organise and select the clinical data to analyse in a manageable and meaningful way for the research. A decision was made to select one session from every third week of psychotherapy treatment (there were three sessions each week) over the one-year period. The session chosen was to be a

supervised session. This process of selection was to reflect the different days of the week on which the treatment took place, at even intervals throughout the year. This was to make the research process a manageable one and to be as unbiased as possible in the selection process. A further rationale was to provide additional validity, which I will I refer to later in this chapter. This resulted in 10 sessions being selected for analysis from the first year of the psychotherapy. However, once the research process was under way, a further decision was made to include a small selection of sessions from year two of the psychotherapy. This was in order to consider whether and in what ways the observations and analysis of the first year continued to be significant in the subsequent years. It enabled consideration of further development as well as the impact of some extremely difficult external circumstances that particularly affected the second year of the psychotherapy. In year two, sessions had been reduced from three to two sessions per week, and in year three (two months only) to one session a week; the slow reduction of sessions was to prepare for the ending process in a sensitive and considered way. The analysis of sessions from year two consisted of one session selected from each term. The sessions were selected randomly, and again were sessions that had been supervised. Overall the child was seen for two years and two months.

Data Analysis

Flick defines qualitative data analysis as:

> The interpretation and classification of linguistic (or visual) material with the following aims: to make statements about the implicit and explicit dimensions and structures of meaning making in the material and what is represented in it. Meaning making can refer to subjective or social meanings. Often qualitative data analysis combines rough analysis of the material with detailed analysis. (Flick 2014: 370)

This section will describe in greater depth how I analysed the data in my investigation. I have already outlined why the single-case study approach was selected for this research, but I will reiterate how it enabled the incorporation of background, developments, current conditions and environmental interactions of the individual as well as the psychotherapeutic relational interactions. These were considered in relation to both internal and external influences.

Before I could clearly identify and clarify exactly what I wanted this research to focus on, I needed to organise the data to begin an in-depth analysis of what was actually there. Braun and Clarke (2006) outline some important steps that can be used when searching across data. I drew from some of these, which included familiarising oneself with the data, searching for themes, and defining and naming themes. This approach was taken from thematic analysis, which is defined as 'a method for identifying themes and patterns of meaning across a dataset in relation to the research question' (Braun & Clarke 2006: 175). My initial step was to reread all the raw sessional data I had chosen for analysis. This was done several times to refamiliarise myself with the session material. From this process numerous initial themes were identified as possibilities for potential analysis, which included: physical and bodily actions which took place as a means of expression performed by Andrew; relational interactions between Andrew and me; emotional states he communicated; Andrew's use of toys or objects; play; communications through action; and communication through sounds, words and latterly the language Andrew used. Alongside this I considered additional developmental and psychoanalytical issues I saw emerging from the data, such as his struggle to be held in mind, attachment and separation issues, emotional containment, testing of boundaries and the defence mechanisms he employed. I reread all the material, this time using different coloured highlighters to begin to identify and highlight all these different possibilities. For example, I used a yellow highlighter to signify all the actions, blue for play, pink for sounds and words, and so on. This could be considered initial 'thematic' coding (Braun & Clarke 2013), but was used in this instance to identify how much material there was in relation to initial themes for potential further investigation. Throughout this process I was aware that I needed to keep an open, exploratory mind in order to look for and be open to any new emerging ideas that might not yet have been considered.

It was from this initial process that I proceeded to select three major themes of interest that stood out in the material to analyse in more depth. The first was words and the development of Andrew's language; the second was his play, where it took place and how he used it to explore relational and developmental

issues; and finally, Andrew's shift from using actions and the body as a form of communication and expression to using more language and thinking.

The next part of this chapter shows the analysis process in detail for one of the selected themes above, that of language development. Matrix methodology (Miles & Huberman 1994) was then employed as the main tool to look at the evidence of what actually happened in Andrew's language development over the first year of intensive psychotherapy and three sessions from the second year.

The process involved going through all the selected data once again, this time drawing out the appropriate highlighted evidence, which signified all the sounds, words and uses of language I had read in each selected session. Every word and language-like sound was collected from the raw data and transferred into the first set of matrices. I chose the form of a column matrix at this stage, and drew up a list of columns with a dated heading for each analysed session, such as 28.9.12, 16.10.12 and 17.11.12 (illustrated in Figures One to Four). This approach was utilised for the 10 selected sessions in year one and the three selected sessions in year two. Under these dated headings I listed all the extracted highlighted words from each session. The words and sounds were listed in the appropriate dated column. The use of the matrix was both helpful and appropriate at this stage of my data analysis, as it helped me to organise the information coherently. As Miles and Huberman (1994) point out, in building matrix displays 'there are no fixed concerns of constructing a matrix. Rather matrix construction is a creative – yet systematic – task that furthers your understanding of substance and meaning of your database.' They go on to stipulate 'that the issue is not whether you are building a "correct" matrix, but whether it is a helpful one that will give you reasonable answers to the questions you are asking' (Miles & Huberman 1994: 240).

The matrices enabled clear observation of the data chronologically, showing exactly what was taking place and when it was taking place in relation to Andrew's use of sounds, words and language. I wanted to be able to see the patterns of change and development that had occurred over a period of time.

This part of the process was not only interesting, but also creative and rewarding. As the matrices evolved they allowed me to see extremely clearly the changes and developments in Andrew's use of words and language, and provided evidence of how it had changed and developed over time. The column matrices I chose provided clear visual evidence as well as highlighting other patterns of change and development, such as the shift from numerical words to language words.

From the first set of matrices I was then able to see that there were some word categories emerging, such as people words, feeling words, place words, object words, numerical words, colour words, command/instructional words and then conversational words. Further matrices were then produced to look in more detail at the use and development of those words over time before I moved on to examine other aspects of language development. These included Andrew's expanding vocabulary, from the use of one, to two, to three words, and then to more combinations of words and conversational words. Additionally I transferred the information gathered from the matrices onto graph-like charts. This was done primarily as another form of visual support to illustrate and show the patterns and change I had observed from the matrix data in relation to Andrew's language. To illustrate this process further, the graph charts can be seen in Appendices Five, Six, Seven, Nine and 10.

An example provided in Figures One, Two and Three is of the initial word matrices, illustrating how all the sounds and words were taken from the data and put into the first set of matrices. The example in Figure One illustrates the first four analysed sessions, 29.9.09, 16.10.09, 17.11.08 and 4.1.10. Figures Two and Three illustrate the subsequent sessions.

Figure One: First Word Matrix, Analysed Sessions One to Four (29.9.09 to 4.1.10)

28.9.09	**16.10.09**	**17.11.09**	**4.1.10**
Baby	Sara Sara	Sawa	Sara, Sara blue room
Red	Apple	Pictures sit sofa	Christmas holidays
Green	Sat	Sara hurt Andrew	One, two, three, four, five, six, seven
Yellow	Sara	Window	One, two, three, four, five, six, seven, eight (rings)
Mummy, daddy	Oophs	Sawa window	Andrew good idea
	Sofa	One, two, three, four, five, six, seven, eight, nine, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20	Counting steps, one, two, and so on… to 29
	Sawa	20 11, 20 12, 20 13	20 11, 20 12, and so on… to 20 19
	Sawa	Sawa window	Count with me
	One, two, three, four, five, six, seven, eight, nine, 10, 11, 12, 13, 14, 16	One, two, three, four, five, six, seven, eight	Nooo nooo
	One, two, three, four, five, six	One, two, three, four, five, six, seven, eight,	One, two, three, four,

		nine, 10, 11, 12, 13, 14, 15, 16	five, six, seven, eight
	One, two, three, four, five, six, seven	One, two, three, four, five, six, seven, eight, nine, 10	Ladybird
	One, two, three, four, five, six, seven, eight, nine, 10, 11, 12, 13	No, no (protest)	No no
	One, two, three, four, five, six, seven, eight, nine, 10, 11, 12, 13, 14, 15	Nooooo, room	
	One, two, three, four, five, six, seven, eight, nine	Hello	
	Sophie	No	
	Mummy at home	Apple	
	Nine minutes	Sophie	
	Sophie goodbye	Red group	
	Monday	Bye Sawa, Sawa	
Total six words	**Total 18 words and 66 numerical words**	**Total 31 words and 54 numerical words**	**Total 56 words and 26 numerical words**

Below, in Figure Two, are the matrices from the next four analysed sessions: 12.2.10, 8.3.10, 26.4.10 and 17.05.10.

Figure Two: First Word Matrix, Analysed Sessions Five to Eight (12.2.10 – 17.05.10)

12.2.10	**08.3.10**	**26.4.10**	**17.5.10**
Fairy	Teddy	Bye, bye, see you later	Hello
Bye, bye, bye	See you soon	Bye, bye, see you later	Wave
Bus	Sad	Teddy	One look only
Sara, sad	Toilet	Barrier	One look
Toilet	Scissors, ladder and ?	Ahhhh	Cow
Tin, animals	No animals	Boo	Toilet
Sara help, Sara help	Raining, snowing	Toilet	Toilet
Sara no	Tired, pillow	See you later	Door locked
Off, on	Strawberries	Goodbye	Pink class
Hello	Ahhhhh	See mummy later	Now blue room
Goodbye	Off	Sara belt	Buggy
Ahhhh	Sara outside	Mummy, home	No
Sara sad	Hello	Sophie	Lady
Sara, Sara	Apple	Bye-bye	Bus, baby
Sara	Banana, banana		No baby and bus are over the fence
Sara, Sara, Sara	Another word for three fingers		Bus and mummy
Sophie, Sophie, Sophie	Andrew, Andrew, Andrew, Andrew		Brummm brummm
Old MacDonald song, 18 words	Buggy		Bus mummy

	Sara back		Began to sing goodbye song
	Hello		Sophie
	Treasure, map		Bye bye see you Wednesday
	Goodbye		Pictures
	Sophie, bye bye		Banana
	Wednesday		Lady, one look
Total 50 words	**Total 42 words**	**Total 31 words**	**Total 56 words**

Below, in Figure Three, are the word matrices from the last two analysed sessions, 14.6.10 and 5.7.10.

Figure 3: First Word Matrix, Analysed Sessions Nine and 10: (14.6.10 – 5.7.10)

14.06.10	**5.7.10**
Wave goodbye	See you later, see you soon
Hello blue room	Hello blue room
Hello blue room	See Sophie later
Hello lady	Andrew in red class, not pink class
One look	Sara belt, Sara belt
Charmaine	See Sophie later, wave to Sophie
No animals over the fence	Wave Sara
No baby over the fence	Cake
Toilet	Sara belt

Bye	Sophie
Toilet	Toilet
Pooh, pooh	Ahhhh
Belt on	Pink class, red class
Pooh, pooh	Toilet
Pink class	Blue
Lady	Sara belt
Buggy	Sit
No	Five, four, three, two, one
No bye	Eight, seven, six, five, four, three, two, one
Banana	Count
Lady	Andrew, Sara took turns
One look	Seven, six, five, four, three, two, one
	Apron
	Red apron, green apron
	Bye
Total 43	**Total 60 and 20 numerical words**

Figure Four: First Word Matrix, Year Two, Three Analysed Sessions (2.12.10 – 5.4.11)

2.12.10	**18.1.11**	**5.4.11**
Hello Sara	Hello	Ahmed
No blue room	Ahmed, Ahmed, Ahmed	Lift
No blue room	No blue room, no blue room	Sara cross, angry
No blue room	Ahmed, Ahmed	Pooh, toilet
Andrew's bag	No blue room, no blue room	Ah bye Sophie
Patrick, JD, Shamus, James… Daisy, Ibrahim, Ahmed, Tania, Jonathan	No Sara	Dolls away
Snack	No blue room, no purple class	Mummy
No mummy	Purple class	Watching TV
JD	No PE, no purple class	Granddad reading
Tea play and naming friends e.g. Tania, JD, Shamus	Sara Monday	Watching TV
JD, Liam, Daisy… Patrick…	No Charmaine, no Charmaine	Nanny at home (question-and-answer dialogue)
Bye, dolls away		Watching TV
Dolls – mummy, nanny, granddad, Terry, Leah, Paul		Leah (Sara 'what is Leah doing?') Having a bath
		Terry football

		Goodbye song: 'bye bye Sara, bye bye Sara, see you on Tuesday, bye bye Sara' – this was repeated several times.
Total 45+ (not all names he said are listed)	**Total 39**	**Total 44+**

On the basis of the first set of matrices I became interested in the different dimensions of Andrew's words, and I saw categories emerging such as numerical words, people words, feeling words and no words. I then became more interested in how Andrew's conversational words developed, and I drew up a further matrix, again dated chronologically, with the addition of the following headings:

- Summary of what was taking place in our exchange
- My words to Andrew
- Andrew's response to me
- What happened next, words or actions?

Figure Five is an example, with random excerpts taken from four sessions from the first year of psychotherapy illustrating this. There was an enormous amount of matrix data generated from this process.

Figure Five: Year One, Matrix Outlining the Context, the Interaction That Took Place Between Andrew and Me, and What Happened After This

Summary of what was taking place in our exchange	**My words to Andrew**	**Andrew's response to me**	**What happened next, words or actions?**
17.11.09 We began our journey to the BR and Andrew sat down on the floor, getting stuck there. He began to kick me.	Andrew is showing me his angry, kicking feelings.	Andrew looked up at me.	I said: 'Andrew is remembering yesterday.' There was a pause and I then said:' Andrew cannot wait to get to the BR to show me how angry he was with me.' Andrew stood up and ran to the BR.
4.1.10 We were approaching the end of the session and as I initiated the goodbye song. Andrew said, 'No, nooo.'	'Andrew is letting me know it is hard to finish today, he does not want to finish.'	Andrew repeated 'No, no, no.'	It was hard to finish the session today.
17.5.10 As we were walking to the BR Andrew said: 'Toilet, the BR.' At the same time he ran to a random door to try to go though.	'Andrew knows that it is not a door he is allowed to go through'.	'Door locked.'	He was giggling as if it was a game.
5.7.10 I moved and sat down. Andrew sat next to me and took my hand, holding it.	'Sara and Andrew are close together.'	He smiled and snuggled up closer	It felt intimate for a moment but did not last long.

A third and final stage of matrices was drawn up, again linked to the dated sessions from which the data had already been laid out, for example 18.3.10. From this I was able list and name developmental, psychoanalytical and relational themes drawn from the previous matrices. Below in Figure Six is an example from the third set of matrices.

Figure Six: Year One, List of Themes from Three Selected Sessions

16.10.09	**18.3.10**	**5.7.10**
Being seen and understood through words. How to make sense of someone who comes and goes. Is this the beginning of questioning? Andrew appears more settled when I put what is going on into words, such as naming his actions. Does his increasing looking inside the BR represent me having more of an inside? When he counts, his speech is more confident. His speech shifts from numbers to people.	Begins to initiate talking, albeit as a command. Uses more symbolic language to count, e.g. 'banana, banana', and his tone is playful. He begins to name the day that I am there. Also begins to name what is next. Uses gestures and words together, and gets the context right. What he says has meaning. He is initiating more talking. He names a feeling: sad. I am also seeing that when he does this he needs the toilet. Begins to name things in his own box as he takes the items out of the box. Vocabulary still increasing e.g.	More discussion and clarification using our words. Where is he now? Andrew making sense of the past and the present, e.g. pink class, red class. Continual eight-way conversation exchanges between us. Free association words. Still struggling to hold onto feelings he does not like, and wants to evacuate them down the toilet. More physical regression as Andrew explores and communicates non-verbally that I am someone who understands him and helps him. At this stage he initiates physical support to get emotional support from me. More intimate non-verbal

	‘scissors’. A real two-way conversation between us.	behaviour/communication. When I name it, Andrew cannot sustain it. More new words: ‘red apron, green apron’.

From the matrix in Figure One I could see how the words clearly grew over time, and I chose this as the first dimension to focus on. The matrices identified how new words came into the sessions and Andrew’s growing and expanding vocabulary, and hence the second dimension was new words etc. The final dimension selected from the matrix was conversational words. Again the matrix showed the development and use of one to two, two to three and three or more words in our conversational interactions.

Primarily I adopted an inductive approach but did shift between inductive and deductive approaches within the matrix methodology. Midgley (2004) refers to how an inductive approach ‘is common to many qualitative approaches’ and how it ‘is especially relevant to psychotherapy researchers…in that it includes a detailed but systematic approach… with an aim of developing hypotheses or theories that are grounded in the data themselves derived from the constant interplay between observation and understanding’ (Midgley 2004: 92). Rustin (2006) reiterates the use of inductive approaches stating ‘it is a method which expects that meaning will emerge from the data which has little predetermined content or shape is appropriate to psychoanalysis as well as naturalistic kinds of research’ (Rustin 2006:188). My inductive research approach did enable me to probe beneath the surface and the matrices provided a beginning place in which to think and understand what the stages might be.

For example in chapter 4, ‘Play and Space – Peekaboo’ (which has not been outlined in such detail in this chapter as language and words) I knew there were symbolic elements from the play that needed further investigation than the initial matrix provided. Therefore I listed all the play that took place initially in matrix form, one matrix focusing on play with toys or objects, a second matrix focusing

on the play that took place in the different spaces in the therapy room. These initial matrices offered a starting place for observing patterns, however I then had to go back to the data to look for more detail and context. This led to an additional set of more detailed matrices being produced in which symbolic meaning could then be introduced and thought about - a more deductive approach. Strauss and Corbin point out how,

> *'Inductive and deductive thinking are both very much a part of the analytical process. For instance there may be times when the analyst is not able immediately to find evidence of the process in the data. When this happens the analyst can turn to deductive thinking…then go back to the data…to look for evidence to support…that hypothesis'. (Strauss & Corbin 1990:148).*

In relation to considering the limitations of matrices as a methodology it is important to note that matrices could become cumbersome leaving the researcher in a position in which they are overloaded with data. Another limitation could be the on going inter play between inductive and deductive approaches for checking confirmation and plausibility of findings. As Dey (1993) points out, although the matrix can be useful, the researcher 'may need to return to the original data as often as possible, for confirmation of patterns apparent within the data or to modify our earlier judgments' (Dey 1993:199). This could be time consuming. However, Miles and Huberman (1994) reiterate that 'conclusions most always need to be checked back against written up field notes. If a conclusion does not ring true at the 'ground level' when you try it out there, it needs revision. The very existence of matrices can sometimes lead you to unjustified feelings of certainty about conclusions' (Miles & Huberman 1994:243). They advise going back to the raw data to guard against this.

This constant interplay between the matrix and the original data was very much part of the process in this research, employing an element of both inductive and deductive approaches.

I also had other data, which included the minutes of meetings I had with Andrew's mother, either on my own or with the family worker, and notes from any meetings I had with the class teacher, the family worker or both. This data

was used as further evidence to compare with my findings and in particular to consider whether it lent support to what I had found. For example, in relation to the development of Andrew's language, for which I had clear clinical evidence, both the mother and the class teacher reported in review meetings that they had noticed his language development. Andrew's mother reported the following: 'Andrew is telling me more about school' (19.1.10). She said, 'there is much more talking at home,' and she spoke of his curiosity; for example, he would want to know where she had been. He was also telling her what he had done (15.5.10). In a later meeting, she relayed: 'I am pleased with Andrew's development. Andrew is talking more at home and is more intimate' (12.10.11). His class teacher reported: 'he seems happier, there is more communication and better understanding' (5.1.10). At a later date his teacher reported: 'he is talking more and I understand him better.' This additional data was able to show that change was taking place not only in the psychotherapy but in other aspects of Andrew's life as well, such as at home and at school.

Reliability, Validity and Reflexivity

Validity and reliability are important aspects of any research, regardless of the choice of research methodology. Hammersley (1990) draws attention to how 'validity refers to the accuracy of measurement and reliability to the constancy of measurement' (Hammersley1990:52) Harper and Thompson (2012) refer to reliability as particularly difficult in the context of qualitative research, and stipulate as well that it is helpful to think about reliability in terms of consistency. An example might be to consider whether a different researcher would see and find the same categories and concepts. Harper and Thompson (2012) also consider reflexivity and point out that researchers should not only describe the research process, but also assess the impact of their own role and presence, and declare the values and theoretical orientation that have guided their research. Reflexivity is about engaging in reflection about the research process (Travers 2001). Braun and Clarke (2013) point out that reflexivity 'is concerned with the role of the researcher in the research process and in constructing knowledge, and the fact that all of us have values, interests and standpoints that shape our own research. Reflexive research is, broadly speaking, research in which the researcher acknowledges and reflects on this role' (Braun & Clarke

2013: 303). *Thinking more critically about reflexivity, ideas require continual scrutiny. As May and Perry (2011) point out this is 'in order to develop ideas from new experiences and understand relations between production, transmission and reception of knowledge derived from research' (May and Perry 2011: 83). Reflexive practice requires careful diligence and caution against idealisation and 'keeping the self in the world in which we act' (May, Perry 2011:68).*

In relation to reflexively and psychoanalysis (2005) points out how reflexivity is 'conceptualised and fostered on the psychoanalytical observation courses at the Tavistock' (Brown 2005: 182). She goes on to stipulate that 'observers do emerge from the course (psychoanalytical observation) with a method of reflective practice' (2005:182). In addition to this prerequisite training to become a child psychotherapist, child psychotherapists have gone on to develop this skill of reflective practice further from their child psychotherapy training following the psychoanalytical observation course. The author further states how this observational method 'does not offer a model that could easily be quantified' as well as questioning how 'the literature on reflexivity is in danger of being too narrowly focused if it too rigidly calls for procedural guidelines on how to be' (2005:182). However whilst reviewing reflexivity in the context of this piece of research it is important to note that in the field of psychoanalysis a model has been developed in which clinicians have developed a capacity to think and reflect and they do bring this to both their clinical work and their research. It could be argued that they do more so than researchers from other backgrounds. A critic of this method from other fields is the subjectivity and how hard it is to quantify. There are those who continue to critique the subjectivity inherent in psychoanalytical research. However questions and notions of subjectivity are not just limited to the fields of reflexivity and psychoanalysis, but impinge upon many other areas of research too.

Reflexivity is about acknowledging subjectivity and arguing about the truth value of the results. As I have mentioned before, child psychotherapists are trained to observe and record what took place in the clinical session as accurately and truthfully as possible. They are also trained to reflect deeply and draw from both

their training and their own experience of psychoanalysis,[2] which cannot help but contribute enormously to this process. Obviously in relation to this there can be an element of human fallibility, and as Midgley highlighted earlier in this chapter, errors have to be accounted for in this process, such as possibly not remembering something from the session – e.g. a word or phrase, or the order in which some things took place.

The use of weekly supervision was a vital part of this research process. Supervision was a place in which the researcher took as detailed and accurate an account as possible of the session to be looked at in depth, reflected upon it and thought about it with the supervisor. The process of supervision enabled corroboration of what the researcher observed, as well as allowing aspects of the material to be looked at in further depth, and identified and considered in a way the researcher might not have been able to do on their own. The supervision process could be considered an additional reflexive process, as well as offering reliability and validity to the work.

Countertransference was also used throughout the psychotherapy as a tool for trying to understand and make sense of Andrew's non-verbal communication. Spillius gives a useful overview of countertransference, describing how 'nearly all Kleinian analysts now use the concept of countertransference, as a state of mind induced in the analyst as a result of verbal and non-verbal action of the patient, thus giving effect to the patient's phantasy of projective identification' (Spillius 1988: 11). The author also stresses that 'far more is involved in countertransference than explicit verbal communication,' and states that 'there is a constant non verbal interaction, sometimes gross, sometimes very subtle, in which the patient acts on the analyst's mind' (Spillius 1988: 13). Heimann (1960) claims that countertransference is an instrument of research into the patient's unconscious. Sternberg points out the necessity for the psychotherapist to be emotionally available for their patient so 'they can be in touch with the minute shifts both in their own and in the patient's emotions that

[2] A requirement for training to become a psychoanalytical child and adolescent psychotherapist is to be in psychoanalysis four to five times a week, prior to and throughout the training period, and often post-qualification.

need to be noted' (Sternberg 2005: 49). The author also states: 'The therapist's need to think carefully about how she is feeling and behaving is vital. These ideas then lead back to the importance of the therapist being able to be aware of, evaluate, and respond to the countertransference' (Sternberg 2005: 59).

In writing about some of her work with severely disabled people, Sinason gave a useful account of how she used her countertransference to understand the distressing head-banging non-verbal communication of a 10-year-old boy who had cerebral palsy (Sinason 1992: 118). I have used my countertransference throughout my research. It has been an important and primary tool for trying to understand and make sense of the non-verbal communication that took place between Andrew and me. To use this tool I had to make myself emotionally available and pay careful attention to the subtle and not-so-subtle communications from him at all times. I had to be aware of my own emotional states and distinguish between what belonged to me (an important task from my ongoing psychoanalysis) and what was a communication from Andrew. It was this careful and sensitive sifting process that gave me access to additional emotional communication from Andrew, and therefore a better understanding of his communications.

In pursuing quality in qualitative research, Spencer and Ritchie (2002) highlight three things: first, the contribution of the research, second the credibility it has, and third the rigour of its conduct. Contribution refers broadly to the value and relevance of the research evidence. Credibility concerns not only the believability of the findings, but also how claims or conclusions have been reached. In this research this will be discussed in detail in the final chapter, in which the findings and conclusions will be the focus. Spencer and Ritchie (2002) go further:

> If credibility rests on the evidence presented then a key question concerns the nature of evidence in qualitative research. They outline several possibilities such as descriptive accounts portraying the composition and categorisation of the raw data; interpretative accounts showing how the data have been put together to develop explanations, reach conclusions and generate hypotheses or theories; constructed

> representations such as diagrams, figures, case studies and extracts of raw data. (Spencer & Ritchie 2002: 231)

In relation to reliability, Flick (2014) states that in ethnographic research the quality of the recording and documenting of data is a central basis for assessing its reliability. He goes on to discuss observation and the requirement to train observers before they enter the field. Following on from this point, I would like to reiterate once again my previous point that in the field of child psychotherapy research all child psychotherapists are trained in observation techniques (Bick 1964).

Reliability in this sense is reformulated in the direction of checking the dependability of data and procedures, which can be grounded in the specificity of the various qualitative methods. For this piece of research the selected sessions were all supervised sessions, which as stated above enabled a second person, the clinical supervisor, to look at the material and contribute towards thinking and reflecting about the session presented. This process could be considered reflexive practice, as it enabled ongoing reflection, this time between clinician and supervisor, about the clinical material. This reflexive supervisory process led to a greater understanding of many aspects of the material, such as the chronological flow of the session, what was taking place relationally in the transference between patient and therapist, further exploration of the therapist's countertransferential feelings, unconscious and symbolic communication and meaning, themes, issues, developments, regression, and understanding the work in the overall context of time and place in the treatment process. The use of supervision could also be considered a form of validation, as another person was involved in the case and was observing and following the essence of the material presented throughout the treatment process from the detailed clinical data.

This chapter has given a detailed description of the data collection process as well as the selection criteria for obtaining the necessary data. Following this was a detailed account of the methodology: qualitative research in the form of a single-case study. Thematic analysis was used initially to determine the three

major themes for the research, and matrices were employed as a tool in this research. Examples of some of the matrices were provided, which took the reader through the process of how the data was selected for further analysis. The specific example given was taken from the theme of language development, illustrating how different dimensions within this theme were identified, such as number/numerical words, new words and people words, which were selected from then on. Consideration was given to reflexivity, reliability and validly, and to the use of countertransference in relation to this particular piece of research.

Chapter Three: Finding a Voice – Language Development

Using matrix and thematic methods of analysis (as discussed in detail in the previous chapter), I uncovered several themes in relation to my clinical data. In this chapter of the thesis it is my intention to present findings in relation to the language development that took place throughout the treatment process, and to discuss these findings in more depth. This is in order to understand more fully from the empirical clinical evidence how development took place during the treatment.

The first section of my analysis is related to language. I have selected language as a theme to analyse because the language developments that took place seemed to be significant and important, if the aim was to study what changes could be observed from the therapy. Three subthemes have been selected under this theme for which I will present the data and findings in this chapter. The three subthemes are as follows: first, the number of words used by the patient over time; second, the new words or vocabulary used by the patient in therapy – this will include new words linked to feelings, people, numbers and time; and third, conversation.

Prior to looking at the data and findings, I thought it would be helpful to introduce some expectations within normal language development in order to understand more clearly how delayed and stuck Andrew's language development was at the commencement of the intensive psychotherapy treatment.

In 'average' development it can be expected that by the age of one a child will have command of a few isolated words, at two years old will have the capacity to speak two- or three-word sentences, and at the age of four years will speak much like an adult (Atkinson et al. 1990). At the age of one and a half years a child might have a vocabulary of approximately 25 words, and by the age of six a vocabulary of about 15,000 words. It is useful to have this in mind as it gives some context for understanding how delayed Andrew's speech and communication were at the beginning of his psychotherapy treatment.

The first subtheme, the increased use of words, will focus on the number of words Andrew used in treatment from week one to the end of the first year of the psychotherapy treatment. Then there will be an overview of year two. This section is primarily concerned with how his vocabulary developed and increased as the treatment proceeded, in particular the number of words he began to use in the therapeutic relationship. The data will be presented in the form of extracts from the analysed sessions, along with some charts to highlight and support this visually. This will be followed by an analysis and discussion of the findings.

Increased Use of Words

When I began treatment work with Andrew it was most apparent that he had extremely limited verbal language, and that much of his communication was non-verbal.[3] I had a conversation early on in the treatment with the speech and language therapist who was a member of staff in the school where the treatment took place. I was interested in her professional opinion as to how much vocabulary Andrew might have at this point in his development. He was five years old at the time. The speech and language therapist suggested that Andrew had a spoken vocabulary of approximately 12 words. This was a useful additional piece of information to be kept in my mind whilst I began my own research journey of finding out more about Andrew.[4]

Initially in the treatment, the words Andrew used were expressed in a random way and did not appear to relate particularly to me; nor were they used within a specific context. My role at this point in our relationship involved trying to make a connection with Andrew and to begin to establish a therapeutic relationship. It is important to inform the reader that as I spoke to Andrew throughout the

[3] Before becoming a child and adolescent psychotherapist I was a dance movement psychotherapist and special needs teacher. In these roles I worked extensively with non-verbal communication.

[4] Before I draw from and use clinical vignettes to support my analysis and give examples of changes I saw in the treatment process, I would like to remind the reader – as discussed in the previous chapter – that a selection of sessions were analysed. In the first year, one clinical session was selected from approximately every three weeks of treatment, amounting to approximately one session in every nine. Andrew was seen three times a week throughout the first year of his treatment.

treatment process, my words were accompanied by my use of Makaton[5] sign language. This was another form of communication which I had at my disposal from my prior experience as a special needs teacher and dance-and-movement psychotherapist working primarily non-verbally. Makaton was also used in the school. It quickly became apparent that Andrew did have a basic understanding of Makaton, but he was limited in his own physical use of the medium. Makaton became an additional tool we had access to in our work, as I was able to use it alongside my words in naming and/or putting a narrative to Andrew's actions or explorations. Below is an extract:

> *Andrew and I were having what felt like an intense phone interaction in which we were both holding a plastic toy phone. I was saying hello to Andrew through the phone, and commenting that Sara was on the phone to Andrew and Andrew was on the phone to Sara. Andrew suddenly ran from the phone to the cot in the room and back to the phone. It seemed as if he did respond in some way to my words as he said 'baby'. However, in that moment I was unable to make a link or connection to his word. He then immediately stood still and looked out of the window in a remote state. Later in the same session, as he played with a ring game, he spoke clearly, saying, 'red, green, blue, yellow' as he played, placing the different-coloured rings on an upright structure. He was naming the colours correctly. I was pleasantly surprised by his words, and was aware he was letting me know he did have a repertoire of words and did know the names of colours.*
> (Analysed Session One: Monday 29.9.09)

The above extract is from the first session in the treatment, and it gave me an initial sense of Andrew's vocabulary, confirming that he did have some words that he could readily access. The data showed that Andrew used six words in total. At this stage in the treatment process he would often surprise me with his words, and this became a theme that continued throughout the treatment, such as his use of the word 'baby' in the above extract. It took me by surprise when

[5] Makaton is a form of sign language often used in special education in Britain with children who struggle with conventional language acquisition. It offers an additional means of communication.

he said ‘baby’ and I was not sure what the communication was about. It could have represented a baby aspect of himself, or it could have been an association he had to the baby doll he might have seen lying in the cot in the room. The word certainly could have had meaning and been a communication to me; however, at this point I was unable to understand or comment on the communication. I came to realise that Andrew had access to many words which were to become one way of letting me know more about him. As I analysed further sessions and collated specific information regarding his increased use of words, the data provided clear evidence that Andrew’s vocabulary was consistently increasing and changing as the treatment progressed.

In the second analysed session (Friday 16.10.09), the data demonstrates that Andrew spoke 18 words. The words ranged from my name to naming a couple of objects in the room – ‘phone’ and ‘sofa’ – as well as other familiar people in his world, such as his mother and class teacher ‘Sophie’. Andrew also counted out loud from one to 16. Counting was to become an interesting feature in numerous sessions as Andrew confidently began to count in numerical words.

> *Andrew and I were at the table; he was looking curiously at a small basket that had blocks in it. Andrew was standing up and I moved a chair to be beside him. He looked focused, and for the following 10 minutes he carefully took out each cube, one by one, counting out loud. As he did so he placed the cubes next to each other, creating a long line across the table. Initially he counted to 16, missing out number 15: ‘one, two, three, four, five, six, seven, eight, nine, 10, 11, 12, 13, 14, 16’. He seemed to grow up and become bigger to me as he did this, and I commented on how he was showing me what a big boy he was and how many numbers he knew and that he could count up to 16. He then began to count up to different numbers: ‘one, two, three, four, five and six’, then ‘one, two three, four, five, six, seven’, then ‘one, two, three, four, five, six, seven, eight, nine, 10, 11, 12, 13’.*
> (Analysed Session Two: Friday 16.10.09)

The above data illustrates that Andrew knew number words and had a range of number words in his vocabulary, even though his general vocabulary appeared limited at this stage in the psychotherapy. Already, only two months into the treatment, the data was beginning to illustrate that Andrew had a much larger vocabulary than either I or anyone else had realised. This is illustrated clearly in Figures One, Two and Three, which indicate the development of his number vocabulary and general vocabulary over the first year of treatment. Figure Four demonstrates year two of treatment.

The data relating to Andrew's use of words continued to show how Andrew's words increased as the treatment progressed. By the eighth and ninth analysed sessions (May and June 2010), the data showed that Andrew was regularly using 40 to 50 words each session. Some examples of the words used in analysed session eight were 'wave', 'one look', 'one look only', 'cow', 'door locked', 'pink', 'pink class', 'bus', 'pictures', 'wall', 'animals', 'fence', 'pooh' and 'lady'. By the end of the first year of psychotherapy, in analysed session 10, there was evidence of 80 words in total being used in the session. This included numerical and non-numerical words.

Soon after the 10th analysed session there was a long summer break coinciding with the school holiday of about five weeks. During this time Andrew did not receive treatment. However, despite the break from treatment, the data showed that Andrew's vocabulary had not decreased much when the treatment resumed in September 2010, as might have been expected after such a break. In the 11th analysed session (December 2010) there was data showing that he used 45+ words, and by the 12th analysed session (January 2011) the data demonstrated that he was still using used over 40 words, most of which were in sentences and in conversational language. Although I go into more detail about year two later in the chapter, it is important to note that his language acquisition was maintained in year two of treatment despite the very difficult external circumstances he had to manage.

Although this section has focused on the increased number of words Andrew used naturally, there were other aspects of Andrew's language development

taking place alongside this, such as an expanding vocabulary with the introduction of new words, and Andrew linking words together in sentences of two, to three, to four, to five or more words. This will be explored further in the last section of this chapter, under the subtheme of conversations.

The next section of this chapter, under the subheading ‘New Words’, will look at the data showing the new words Andrew brought into the treatment and the different sorts of new words he brought, such as feeling words, people words, protest words and place words, to name a few.

New Words

There was a break in the treatment due to Christmas and the school holidays in December 2009. On our return from the break in January 2010, the data illustrates that Andrew brought several new words to the therapy session, and that most of his language communication now appeared to involve two-word sentences. In the fourth analysed session, Monday 4.1.10, there was evidence of the following new words in the data:’ Christmas holiday’, ‘Andrew good idea’, ‘20 11’, ‘20 12’, ‘count with me’ and ‘ladybird’. The data demonstrates that Andrew had been able to hold onto his words and language from our psychotherapy work and our therapeutic relationship over the first significant break in the treatment, and that his language had continued to develop. The above examples also showed that Andrew used more two-word sentences after returning from the break. Prior to the break his two-word communications were just emerging in the treatment. His use of the words ‘20 10’ and ‘20 11’ were a particular example of how Andrew was developing his language in a creative and experimental way, albeit through a number vocabulary. This is an example of Andrew putting two correct words together in his attempt to communicate and make sense of what comes after 29. He was experimenting more confidently with his language. In ‘normal’ development at the age of one and a half to two and a half years, a child starts to combine single words into two-word sentences. These utterances can express the most basic of intentions. Such combinations might refer to naming something, asking for something, describing something, indicating the possession of an object, qualifying or questioning (Atkinson et al. 1990).

Number Words

Andrew's counting out loud was a dominant theme in the therapy, and number words seemed to be a verbal means that he was confident with and enjoyed bringing to the sessions and showing me. As mentioned previously, counting was evident early on in the data, and in the second analysed session (16.10.09) Andrew counted from one to 16 – missing out number 15 – and then from one to six, one to seven, one to 15 and one to nine. Alongside bringing new general vocabulary to the therapy, Andrew brought new number words and regularly experimented with counting to higher and higher figures. By the 10th analysed session the data showed Andrew beginning to count backwards as well as forwards. He said, 'five, four, three, two, one' and 'eight, seven, six, five, four, three, two, one'. The data revealed that by the 11th analysed session (12.12.10) in the second year of treatment, Andrew maintained counting to 45+ words. In data not included in this particular piece of research, there was evidence of Andrew using his numerical words to count from zero to 69, then onwards to 70… 74 and 75, and then to 95.

It is difficult to write up the development of Andrew's words and language without keeping in mind the context and significance of the developing therapeutic relationship, which was paramount to the treatment process. Andrew was using his new vocabulary, and he was developing a sense of trust, security and reliability about me and in our relationship. Andrew was beginning to be able to see me as a therapist who did leave but did return and consistently came back. There was a secure structure developing in the therapeutic alliance and in Andrew's routine that he began to know about, internalise and trust. He knew that I would arrive on a certain day at a set time and greet him, that he and I would begin the long journey to the Blue Room, that we would work together for a set amount of time and have an ending to the session, and that I would escort him back to class and say goodbye. Through this process Andrew became increasingly aware that I was very interested in him, and he began to be interested in me and how he thought I might be feeling. The next section is looking at feeling words.

Feeling Words

Andrew first introduced a feeling word in the third analysed session. He said ‘Sara hurt Andrew.’ Below is an extract illustrating this.

> *As I collected Andrew from his class, where he was doing PE in the hall, I was aware as I approached him that his attention was solely on me. When I arrived and said ‘hello’, he began to hit me. I spoke about his cross feelings, as we commenced our long journey to the Blue Room. He stopped, lay on the floor and began to kick a door close by. I spoke and said, ‘ Andrew is showing me his cross, kicking feelings again.’ Andrew looked up at me, he had no words. I commented further, stating he was remembering yesterday. There was a pause before I continued and said Andrew could not wait to get to the Blue Room and show me how angry he was. Andrew stood up and ran all the way to the Blue Room, where the exchange between us continued. I made another comment related to how he was still showing me his angry, pinching feelings as he attempted to pinch me. I said, ‘He wants to hurt Sara.’ Andrew replied, saying, ‘Sara hurt Andrew.’ I agreed that he wanted to hurt me and show me how hurt he felt by me by my going away yesterday. Andrew quietened.*
>
> (Analysed Session Three: Tuesday 17.11.09)

A noticeable feature in the above data was that Andrew, after acting out, did find some words for emotional expression. He was able to show through his actions that he had angry, cross and pinching feelings. He told me I had hurt him when he said ‘Sara hurt Andrew’ after I made a comment about his action of pinching me being related to his pinching feelings. I understood this as him wanting me to have the experience of being hurt, which was how he was feeling after being left and kept waiting by me from one session to another. He did manage to communicate this to me, first of all by acting out and then through language. Acting out is a means in which a child acts instead of speaks. It puts actions, which originally took the place of thoughts, in the place of words (Klein 1932). Bion (1962) refers to beta-elements and describes how the beta-elements are influential in producing acting, as they are objects that can be

evacuated and are stored not so much as memories but as undigested facts. In contrast to beta-elements, Bion (1962) describes alpha-elements as elements that have been digested and thus made available for thought. The data shows the shift in Andrew, from a state that was more fragmented, in which thoughts were not possible, only actions (beta-elements), to a state in which he was more integrated, and a thought could take place and words could be communicated to replace the actions. Psychically Andrew was feeling more contained. 'Containment is not a passive phenomenon, the patient has to feel understood in order to feel contained' (Steiner 1994: xii).

The data also demonstrates my use of words: I was the one putting words to the emotional communication I was receiving from Andrew's acting out. It was my role in the psychotherapy to understand his non-verbal communication and to name what I thought he was experiencing emotionally. This enabled Andrew to have the internal experience of being seen, understood and emotionally contained by me at a time when he felt overwhelmed by feelings that were too difficult to understand, manage or make sense of. As seen in the data, once I had commented on Andrew's angry feelings he was able to get up and move forward to the Blue Room. The developmental task before the infant is able to acquire the capacity to think his thoughts is the communication of these thoughts to another (Wolf 2003). Andrew's non-verbal expression of acting out his cross, kicking, pinching feelings allowed him to communicate, but highlighted that he did not yet consistently have the necessary internal resources or means to put his feelings and emotions into words.

Bion also refers to the important developmental task of the mother being able to receive a baby or a child's projections and hand back to them the quality of the experience, which makes the child feel divested of terror and capable of reintegration (Bion 1962). This enables the baby or child to absorb the projections psychically, to introject them (Klein 1959), so that they can get integrated into the personality. I saw this as an important part of my role in the psychotherapy treatment process with Andrew: to provide the necessary and essential emotional building blocks that Andrew had not received sufficiently in his early development prior his treatment. Bion states: 'If the projection is not

accepted by the mother the infant feels that its feeling that it is dying is stripped of such meaning as it has. It therefore re-introjects, not a fear of dying made tolerable, but a nameless dread' (Bion 1967: 116–117).

I would like to introduce a vignette from the fifth analysed session. The context of the extract was early on in the session, and we had just arrived at the Blue Room.

> *I made a comment: 'Andrew is very lively and keen to get to the Blue Room today.' He responded and said, 'Sara sad.' I responded to his comment by saying I was very happy to see Andrew, and Andrew was letting me know he was interested in my feelings today. Andrew then said in an excited way 'toilet'. I commented on how he was letting me know he could not hold on today as we began to think about feelings.* (Analysed Session Five: Friday 12.2.10)

In my analysis of the above data it was significant that Andrew used another new feeling word, 'sad', as well as the word 'toilet'. I understood this as him attempting to communicate something to me about himself by locating the feeling in me. However, after Andrew's exchange about his sad feelings he then needed to leave the session and go to the toilet. The introduction of this feeling word was possibly scary for Andrew, so he located the feeling in me rather than himself, as it was safer to do so. It was also apparent that Andrew was unable to sustain the emotional connection psychologically. Andrew could not stay with the sad feeling and keep the experience, which probably did not feel nice in his mind – hence his need to go to the toilet after he had said the word. Andrew's emotional expression got pushed into the body as something Andrew was unable to hold onto; he needed to get rid of it and evacuate it through a bodily action. This evacuation of emotional material was a theme that continued for some time during the treatment process, which will be explored in more depth in Chapter Five.

The data has shown Andrew's struggle to develop his emotional vocabulary, and how he would often need to evacuate his feelings or regress by acting out

when he began to get more in touch with his emotional states in the treatment. In the above data we can see how Andrew was unable to tolerate his own sadness and projected (Klein 1936) his sadness into me. Klein refers to the breast as something of the mother that can either give gratification or deny it. In the mind of the child this becomes imbued with the characteristics of good and evil (Klein 1936). Klein states:

> What one might call the 'good' breast becomes the prototype of what is felt throughout life to be good and beneficent, while the 'bad' breast stands for everything evil and persecuting. The reason for this can be explained by the fact that, when the child turns his hatred against the denying or bad breast, he attributes to the breast itself all his own active hatred against it – a process which is called projection. (Klein 1936: 291)

At the sixth analysed session (March 2010) Andrew used the word 'sad' again. This time I understood it in relation to not having seen me on the Friday, due to a school INSET day (a training day for teachers and staff in education, usually schools). Once again as we began to think about his sadness he asked to go to the toilet.

It was noticeable from the data during this time of Andrew's increasing vocabulary that Andrew had limited use of feelings words in relation to the rest of his developing vocabulary. For example, many other new words continued to emerge in the data, such as 'strawberries', 'pillow', 'buggy', 'barrier' and 'cow', to name a few. In the eighth analysed session, Andrew was consistently using new words and putting them into two-word sentences such as 'door locked', 'pink class' and 'bus mummy'. Alongside these two-word sentences was the emergence of the first three- and four-word sentences.

The next subsection will look at Andrew's 'no' words.

'No' Words

I have just stated that new words were emerging all the time, representing different aspects of Andrew's world. Andrew began to bring the word 'no' into the sessions as early as the third analysed session (November 2009). He said 'no' and 'noooo' with a prolonged intonation, letting me know he did not want

our session to finish. On this occasion his verbal response of ‘no’ was immediately after I had indicated verbally that we would have to say goodbye soon, and Andrew was introducing ‘no’ as a form of protest. This continued for some time and seemed related to his difficulty with ending and separating. The use of ‘no’ as a word began to widen to different contexts. In the seventh analysed session Andrew used ‘no’ to let me know he had remembered a boundary I had set in the previous session regarding not throwing the animals out of the window. As he looked at the window in the Blue Room he said ‘no animals’, and I responded by saying, ‘that’s right it’s a no-animal window.’ Below is an extract from the eighth analysed session, in which he begins to say ‘no’ to me in a different context and in a more assertive manner.

> *Andrew had had to leave the session to go to the toilet, and we were on the way back to the Blue Room. As we proceeded along the corridor another exchange took place. Andrew suddenly stopped walking. I said, ‘Andrew has stopped. Sara and Andrew need to carry on and get back to the Blue Room.’ Andrew replied ‘no’. I replied, saying ‘Andrew is telling Sara no.’*
> (Analysed Session Eight: Monday 17.5.10)

This data shows Andrew using ‘no’ again, but as a protest word in a more assertive, refusing way in relation to me – a different context from his previous ‘no’. His tone and intonation was wilful, letting me know he was saying ‘no’ to my suggestion that we continue our journey from the toilet to the Blue Room. He communicated clearly to me that he was not going to do what he thought I wanted or expected. Developmentally this was an exciting time in the psychotherapy, as it showed that Andrew was becoming more separate from me. Winnicott describes emotional development as a stage that is reached:

> When the individual can be said to have become a unit, he uses the term ‘I am’ (Winnicott 1958b) and the stage has significance because of the need for the individual to reach being before doing. ‘I am’ must precede ‘I do’, otherwise ‘I do’ has no meaning for the individual. (Winnicott 1971: 130)

This stage represents the child becoming more autonomous and able to take responsibility for themselves independently. However, it is a fragile state, and an individual can easily lose capacity for integration and independence. Winnicott links this 'I am' stage to Melanie Klein's (1952) concept of the depressive position, where a child can say what is inside me is me and what is outside me is not me (Winnicott 1971: 80).

In the sixth analysed session in March 2010, Andrew also began to use his new word, 'off', in a powerful and instructional way. I was wearing trainers; he looked directly at them, then looked at me, and then in a commanding, instructional tone said, 'off'. This instruction was short and sharp and spoken with intention. This seemed like a development of his assertion from the 'no' described above.

People Words

Another developing aspects of Andrew's language was his use of people's names. The next extract is from analysed session eight. We were approaching the end of the session, with about five minutes left.

> *I suggested it was time we began to put things away. Andrew said 'Sophie'. I said yes, we were going back to see Sophie. Andrew said 'Danny, Charlotte'. I said, 'That's right, Andrew's friends in red class. Tomorrow Sara will be back to see Andrew.' Andrew looked through the glass and said, 'bye bye Blue Room, see you on Wednesday.' I said, 'Sara is back on Tuesday, not Wednesday.' Andrew responded by saying 'pictures'. I replied, saying yes, we could look at the pictures on the way back. (The pictures show faces of other children in the school.)*
> (Analysed Session Eight: Monday 17.5.10)

The above extract is an example of Andrew using a wider range of people words; earlier in the psychotherapy it was 'mummy', 'Sara' and 'Sophie' (Andrew's class teacher). The data demonstrates him naming some class members as well as saying the teacher's name, which he had used in earlier data. In this data there is the added element of him saying his teacher's name in the correct time-related context. Although he did not name further friends in the

extract, he indicated he was thinking about others as he commented on wanting to look at the pictures on the way back. The pictures are of faces of other children in the school.

Below is an extract form analysed session 10.

> *As I collected Andrew from his class he wanted Sophie and me to take him to the classroom door. Andrew turned to Sophie and said, 'See you later, see you soon.' I spoke, saying, 'Clever Andrew, you will see Sophie later and now you are with Sara. It is Monday and Sara has come back to see you again.' After my comment Andrew was keen to get to the Blue Room.*
> (Analysed Session 10: Monday 5.7.10)

Both extracts above, from analysed sessions eight and 10, highlight the continual range of new words Andrew was accessing and utilising in the therapy work. The second extract above, from analysed session eight, illustrates Andrew's growing awareness of his separation from me, the beginning of his developing identity, and his understanding of what came next. Although he was already good at knowing what came next in his number words, he was now demonstrating that he knew what came next in the structure of his day (time) and was able to communicate it through his increasing vocabulary. In addition the data shows Andrew experimenting with new words, such as naming the day Wednesday. Although he does not quite get the day right, he does know I come back and is demonstrating that he understands the ongoing nature of our work. The data illustrates Andrew using language to communicate his growing sense of people, of who is who and who is where and when. As I stated previously, the therapeutic relationship had provided Andrew with a secure place and an adult who was interested in him and consistently there for him. It had also provided him with another mind, one to help him develop a capacity for his own thinking. Both extracts illustrate that Andrew was beginning to think for himself and apply his new words in relation to our developing relationship and me. It can be argued this data demonstrates that Andrew could have a thought and now had both the means and the confidence to use the words to express what he was

thinking. To think a thought is a developmental achievement that requires the aid of another. In the clinical context it is the therapist who becomes the patient's thinking partner (Wolf 2003).

Below, in Figures Seven, Eight, Nine and 10, are matrices illustrating Andrew's development and use of people words in years one and two of the psychotherapy. There was a huge increase in his use of people words in year two, which coincided with the development of his curiosity about the world and others in it, which will be discussed in more depth in a later chapter.

Figure Seven: People Words, Year One, Sessions One to Four (28.9.09 – 4.1.10)

28.9.09	**16.10.09**	**17.11.09**	**4.01.10**
Baby	Sara	Sara	Sara Sara
	Sara	Sara	Andrew
	Sophie	Sara	
	Mummy, Sophie	Sara, Sophie	
		Sara Sara	
Total: 1 name word	**Total: 5 name/people words**	**Total: 7 name/people words**	**Total: 3 name/people words**

Figure Eight: People Words, Year One, Sessions Six to Eight (8.3.10 – 17.5.10)

8.3.10	**26.4.10**	**17.5.10**
Sophie	See mummy later	Lady
	Mummy home	Bus and mummy
		Sophie
		Bus, mummy
Total: 1 name/people word	**Total: 2 name/people words**	**Total: 4 name/people words**

Figure Nine: People Words, Year One, Sessions Nine to 10 (14.6.10 – 5.7.10)

14.6.10	**5.7.10**
Hello lady	See Sophie later
Charmaine	Sara belt
	See Sophie later
	Wave Sophie
Total: 2 name/people words	**Total: 4 name/people words**

Figure 10: People Words, Year Two (2.12.10 – 5.4.11)

2.12.10	**18.1.11**	**5.4.11**
Sara	Ahmed, Ahmed, Ahmed	Ahmed
Andrew's bag	Ahmed, Ahmed	Sara cross
Patrick, Shamus, James, Daisy, Ibrahim, Tanis, Ahmed, Jonathan	Ahmed, Ahmed, Ahmed	Bye Sophie
Mummy	No Sara	Mummy
JD	No Sara	Granddad reading
Tania	Sara, Monday	Nanny at home
JD, Liam, Daisy	No Charmaine	Leah
Nanny. mummy, granddad, Terry, Paul, Leah	No Charmaine	Terry football Sara see you soon
Total: 22 name/people words	**Total: 14 name/people words**	**Total: 9 name/people words**

Word Exchanges and Developing Conversation

In this section of the chapter I will be looking at how Andrew's language developed from his initial one-word exchanges to conversational language. I would like to present data illustrating different kinds of conversational language, such as playful, bartering, questioning and relational language. In the two previous sections of this chapter (on increased words and new words) I made brief references to Andrew's use of some two-word exchanges as a development from his initial one-word exchanges. In this third section of the chapter I will present data illustrating in more depth the emergence and development of Andrew's conversational language, demonstrating the shift from one- and two-word sentences to sentences consisting of three, four, five and

more words. In addition there will be data relating to conversations between Andrew and me. In Appendix Six there is a chart showing the development of this over the first year of treatment.

It is important to note again that all the language development took place in the context of the developing therapeutic relationship. Below is an extract from early on in the treatment; the context involved me setting a boundary. I had set a boundary in a previous session in relation to Andrew opening the Blue Room window. He wanted the window open because he was exploring both the inside and the outside space around the Blue Room. However, I was concerned that he could hit his head on the window frame when he was outside if the window was open. It was a safety measure as well as a negotiation of boundaries between us.

> *In the session Andrew was outside, and I was opposite him but inside the Blue Room. We were looking at each other and making eye contact through the window. Andrew shouted to me in a commanding tone 'window'. I replied, saying ' I am not going to open the window.' He shouted once again in a demanding tone 'window'. I responded, saying, 'Sara is not going to open the window today, Andrew knows the rules.' He said 'window' again, still looking at me. I said 'no window'. Andrew then said 'Sara window'. The tone of the exchange shifted and was now more playful, and his manner was not so assertive and commanding as the previous few exchanges about the window. He was now giggling.*
> (Analysed Session Three: Tuesday 17.11.09)

The above extract shows Andrew and me in a continuous focused exchange with him using one- and two-word sentences. The data illustrates how the interaction goes back and forth between us as he tries to negotiate and test the boundaries. There was an underlying theme in the psychotherapy at this point about boundaries, and it can be seen from the data that Andrew challenges me about this. It also illustrates, through Andrew's demanding tone, how he experiments with his voice and intonation. In relation to his personality development as well as the testing of boundaries with me, Andrew is showing a

more assertive side of himself that can be viewed as the beginning of his developing a greater sense of who is in the world.

Below is another extract showing the use of three-word exchanges from three months later in the treatment.

> *Andrew and I were sitting on the sofa and Andrew initiated a playful exchange by saying 'Sara, Sara, Sara'. I responded and said 'Andrew, Andrew, Andrew'. He then said 'Sara, Sara, Sara' once more. Then he said 'Sophie, Sophie, Sophie'.*
> (Analysed Session Five: Friday 12.2.09)

This data demonstrates a playful interaction between us in the form of a name exchange moving back and forth. It shows Andrew beginning to link three words together, albeit through the use of our names. This was the beginning of Andrew developing three-word sentences and moving forwards from the more recent two-word sentences seen in other data. It also demonstrates, through the playful interaction just mentioned, the attunement (Stern 1985) taking place between us. Stern refers to different types of attunement, but this is affect attunement, where an imitation takes place in the interaction and some form of matching is going on. I match the rhythm and intonation of his verbal exchanges through my voice. As Stern describes, what is being matched is not the other person's behaviour per se, but rather some aspect of the behaviour that reflects the person's feeling state (Stern 1985). Andrew is using his language in different ways – to challenge, to experiment, to test and to play.

> The reason attunement behaviours are so important as separate phenomena is that true imitation does not permit the partners to refer to the internal state. It maintains the focus of attention on the external behaviours. Attunement behaviours recast the event and shift the focus of attention to what is behind the behaviour, to the quality of the feeling being shared… imitation renders form: attunement renders feeling.
> (Stern 1985: 142)

Andrew is able to communicate his assertiveness, then playfulness, as he experiments with his language, and as the feeling quality gets met in our exchange.

Trevarthen (1974) describes how 'a baby's behaviour is closely followed by the mother, and indeed her skill and understanding of what the infant is doing enable her often to obtain synchrony of emphatic acts so the two behave in complete concert as if dancing together' (Trevarthen 1974: 232). At this point there was much more of a sense that Andrew and I were attuned and in synchrony in relation to communications being understood.

The following extract is three months further on in the psychotherapy, and is a conversation relating to time, past and present, with Andrew using two- and three-word sentences:

> *Andrew had had to leave the session to go to the toilet. He was washing his hands. I was standing next to him. Andrew suddenly said 'pink class'. I said, 'You are remembering you were in pink class last year. Now you are bigger and are in red class, but Andrew is remembering pink class.' He responded and said 'now Blue Room'. I said, 'That's right, Andrew knows, he is remembering where we are going next.'*
> (Analysed Session Eight: Monday 17.5.09)

The data shows Andrew and me having a meaningful conversation within a set context, and again the evidence highlights Andrew's use of two- and three-word sentences. It also illustrates how Andrew initiated the conversation that was about himself and his experience. I understood his communication to be thinking about the past: he was remembering he used to be in pink class. Once he had felt understood by me, he was able to come back to the present and show me that he knew where we needed to go next, the Blue Room. Through his conversational language he demonstrated that he was making connections and was thinking and linking. He was showing he was using his mind more and putting his thoughts into speech.

The next extract, from a month later, shows a longer conversation between us.

> *I had been to collect Andrew from his class, and there had been a long exchange between us as we proceeded on our journey to the Blue Room. Andrew was letting me know he remembered he had thrown something over the fence. On arrival he said 'one look' in a questioning tone. I responded, saying, 'Andrew wants to look over the fence.' He got into place and peered over the fence. I asked, 'What can you see?' He replied 'Charlotte'.*[6] *I commented on the fact he was thinking about Charlotte now he was with me. He said 'look again', again in a questioning tone. I asked, 'What can you see now?' Andrew said 'wall'. I replied, 'Andrew really wants to look over the fence and see more. He has thought about Charlotte and has seen the wall.'*
> (Analysed Session Nine: Monday 14.6.10)

In this data Andrew demonstrates how he remembers and makes his own links and connections to a previous session. He shows his use of one- and two-word sentences in the interaction between us, and once again is trying to make sense of time – what was then and what is now – and shows he still needs my help.

There are several different aspects of conversational language use in the data. Andrew asks a question, 'one look?', as he remembers and makes a link to a previous session. When I ask what he can see, he says 'Charlotte' and answers my question. Although he cannot really see Charlotte, he is giving me insight (through his words) as to what is in his mind at that moment. He communicates that he is thinking about Charlotte, and the reality is that he has just left Charlotte to come to the therapy with me. His association to Charlotte might be linked to the process of separation and transitions, which was taking place in the psychotherapy treatment in parallel with the development of his growing ability to link and sequence his words. He is making links and connections in different aspects of his overall development, as illustrated by his greater sense

[6] Charlotte was a teaching assistant in Andrew's class, and he had a close relationship with her.

of place and time. Andrew goes on to initiate the next part of the conversation and informs me he is going to 'look again'. It is my cue to ask what he can see this time, and he says 'wall'. The wall is there and is a concrete object he can see, and he is letting me know he is now with me in the here and now. By being able to converse Andrew is able to let me understand more about his thought processes and have greater access to understanding his internal world. He is showing me how he has moved from something that is about transition and remembering to the present, and to something concrete in the here and now.

The next piece of data shows a conversation between Andrew and me from a session further on in the treatment.

> *Therapist – Andrew is interested in the pens now, he has tipped them out.*
> *Andrew – See Sophie later, wave to Sophie.*
> *Therapist – That's right, Andrew knows he will see Sophie later.*
> *Andrew – Wave Sara.*
> *Therapist – Yes, Andrew waves bye to Sara, when Andrew goes back to class he sees Sophie. Andrew is really thinking about this today.*
> *Andrew – Cake.*
> *Therapist – Oh Andrew said cake.*
> (Analysed Session 10: Monday 5.7.09)

This data shows Andrew having a longer and ongoing conversation with me as well as sustaining a continuous verbal interaction on the same topic. He utilises a variety of one-, two- and six-words sentence. The data shows Andrew describing actions, locating himself in time, and asking questions. All are illustrations of how far Andrew had come in his capacity to use his words and language in the therapeutic relationship and in his communications with me. This data is from after 10 months of intensive treatment. Although Andrew is developmentally delayed, the data reveals how Andrew's speech and language were progressing. As Stern points out, it is in the second year of life that language emerges and opens up a new domain for relatedness. He states:

> The possible ways of being with another increase enormously… It makes parts of our own known experience more shareable with others. In addition, it permits two people to create mutual experiences of meaning that had been unknown before and could never have existed until fashioned into words. It also finally permits the child to begin to construct a narrative of his own life. (Stern 1984: 162)

From a psychoanalytical perspective I wondered if Andrew's tipping out of the pens was a communication that something had felt messy about the transition from Sophie to me, and from class to therapy. However, Andrew was able to use his vocabulary to let me know what he was thinking about so that we could then think about it further together. My role was to acknowledge this and clarify he had got it right, even though unconsciously it might have felt messy. Once Andrew felt understood by me he could let his thoughts and words roam, and he made an association to cake. I understood the cake to be linked to something he would get when he went back to class – it was a ritual before he went home – another of Andrew's thoughts linked to going back to see Sophie after his session with me was finished, and to what came next in his world.

Summary

In this chapter I have presented data from Andrew's treatment during the first year of his intensive psychoanalytic therapy. The focus has been on Andrew's language development within our psychotherapeutic relationship. The data, in the form of both text and figures, has shown the enormous growth and development that took place in Andrew's capacity to speak and communicate. It has shown how his vocabulary, initially thought to be approximately 12 words, hugely exceeded this by the end of the first year of treatment, with him regularly using 50+ language words and 20 or more counting words. The data demonstrates many of the new words Andrew brought into therapy, as well as illustrating the different types of new words he introduced, such as feeling words, number words, people words, protest words and words related to the here and now, the past and the future. The analysis of the data has revealed the shift from using one-word exchanges at the beginning of psychotherapy treatment to the use of sentences of five, six or more words. It has also demonstrated his growing sense of being in a verbal as opposed to non-verbal relationship with his psychotherapist. It also illustrates the beginning of Andrew

having a capacity to think and put thought into words instead of acting out. In essence I would argue there is evidence of the emergence of Andrew's verbal self (Stern 1984).

This chapter has also shown that other developmental growth took place in parallel with Andrew's language development. It demonstrates his acquisition of an increased sense of who he was in the world, his capacity to test boundaries and his developing use of his mind, alongside his developing capacity to think, remember and make appropriate links and connections, and to be more separate. He showed he was feeling safer and more secure in relation to the psychotherapist, and that he did understand that the therapist went and returned, and that she was interested in him and his development.

Overview of Year Two of Psychotherapy

Although I am not including detailed data from year two of the psychotherapy treatment in this research, I think it is important to give an overview of aspects of it in relation to Andrew's continuing development. In year two Andrew experienced several unexpected changes in his external world. In the autumn of 2010 both his class teacher and I observed restlessness in him, as well as more general unsettled behaviour in the classroom and around the school, which caused us some concern. We considered that something might have changed at home that we were unaware of. With further exploration and help from the family worker based in the school, it emerged that Andrew's grandmother, who was a significant carer and important person in his world, had had a psychotic breakdown and been admitted to hospital. Obviously this meant huge changes for Andrew at home, emotionally and physically. At this time I felt my job was extremely important in offering consistency and emotional support for him through this unsettled experience. The psychotherapy seemed to 'hold' Andrew emotionally during this time. Andrew also had a very experienced special needs teacher who was thoughtful, interested in him and reliably there every day. This was important for Andrew, as school provided him with an important structure that was required for his development.

The development of Andrew's language continued to be sustained, with him continuing to use 45 words per session. Increasingly the words were used meaningfully and in an appropriate context. The words were most often related to people rather than inanimate objects.

In February 2011 Andrew (along with all the other children in the school) had to experience something particularly unsettling. Their school was to be closed down for a rebuilding programme. This meant everyone had to leave their classes and familiar surroundings to move to a different, temporary school site that was three miles away. This was to be for the duration of 18 months. What was more disturbing was the fact that builders appeared on site with large JCBs and began the demolition process of certain areas of the school before the children had been relocated. Although the move was recognised as significant, and careful preparation and thought had gone into the potential impact of such an upheaval, it was a huge event for Andrew. The move came extremely soon after his having to manage the change and turbulence at home. At this time, in the second year of psychotherapy, the word 'no' became dominant and was used consistently as a protest. It appeared that saying no in relation to me was also used as a form of control in our relationship. I understood Andrew's 'no' as a communication to me about control at a time when he felt he had little control over many external aspects of his life, and that internally he was unsettled and scared.

By the end of February 2011 Andrew had managed the school move. It had been an unsettling experience for him, but something that was managed emotionally through the constancy of our work, such as meeting at the same time on the same days, and through the similarity of the new therapy space, which had all the same furniture and toys in it, in relation to the Blue Room. The class teacher had also done some appropriate preparation for the move. It was noticeable during this period of the psychotherapy how the word 'help' became a regular new word in Andrew's vocabulary, and he clearly communicated to me that he recognised I was someone who did come and help him.

Chapter Four: Play and Space – Peekaboo

In this chapter it is my intention to look at the data related to the play that emerged within the psychotherapy. As a great deal of play took place during the sessions, I have had to be selective about which aspects to choose for analysis. I have focused on bringing together the different forms of play that emerged alongside a consideration of where the play took place in the therapy room. I have paid attention to the significance and meaning of the play,[7] and to how play was used to both communicate and explore developmental issues in the course of the psychotherapy, regarding 'a child's play and behaviour in treatment as a symbolic expression of his/her phantasies, enacted in a sense deliberately in the presence of a therapist' (Klein 1932: 8). Klein pointed out that 'play is the child's most important medium for expression' (Klein 1960: 8), as well stipulating that 'in its play, the child acts instead of speaking. It put actions which originally took the place of thoughts – in the place of words' (Klein 1960: 9).

It has been a complex process considering how to present the findings from the play analysis, due to the amount of raw data. In addition, many aspects of the psychotherapy play overlap – for example, play as communication and expression, play as a means to manage relational and developmental issues, and the psychoanalytical themes that emerged through the play.

The analysis of Andrew's play will aim to show how the play changed, shifted and developed over time, increased symbolically, and was used to express, communicate and work though many developmental issues and stages that had yet to be reached or fully negotiated in Andrew's development. Although the play and the location in which the play took place are the main focus of this chapter, interwoven alongside this will be a consideration of what kind of an object I was to Andrew, and how the relational aspect of this changed and developed over the course of the psychotherapy as seen through the play. It is

[7] I would like to remind the reader that in this piece of psychotherapy work, the therapy room consisted of an inside and an outside space. A more detailed description of this was given in the section on the therapeutic setting in the thesis introduction. Maps of the therapy room are given in Appendices Two and Three.

important to note that the most essential part of the whole setting lies in the receptivity of the analyst's mind as it offers an internal mental space for the child (Boston and Daws 1988).

There were numerous key locations Andrew was drawn to in the therapy room at the different stages of the psychotherapy, and it became apparent how significant and conducive each location was to the particular play that emerged there. The locations which will be referred to and discussed in this chapter are the light switch area, the sofa, the railing, the door and window, the courtyard, and the fence. These can be seen visually in Appendices Two and Three.

It is interesting to note that, from my overall analysis of the different locations of the play in year one of the psychotherapy, the data demonstrated that the sofa featured in 90% of the analysed sessions in year one.[8] The door, window and courtyard were also significant places, used in 50% of the sessions. The light switch and railing were utilised in 33.3% of sessions, with the light switch play being more dominant in analysed sessions one, two and five – an earlier part of the psychotherapy. The fence and courtyard became an important feature in the psychotherapy after the fifth analysed session.

This chapter will be presented under four subheadings: 'On and Off, In and Out, Up and Down'; 'Finding and Securing an Initial Base: the Sofa'; 'Peekaboo'; and finally, 'Being Dropped, Shut Out and Thrown Away'. The subheadings will also be linked to locations in the therapy room that were significant to the play researched.

On and Off, In and Out, Up and Down

This first section will focus on some of the early play that involved the use of the light switch and the phone. Themes were related to how Andrew and I came together, as well as his communications about his experience of inconsistency. Some of the first 'turn-taking' play emerged during this time. There is also material illustrating his attempt to get to a 'bigger' place and the struggle this

[8] Please see chart in Appendix Eight.

was for him – perhaps an early indication of his own unconscious wish to become unstuck and get to a bigger, more developed place. It shows the beginning of Andrew experimenting with me as someone who might be able to help him.

The first data presented is from the first analysed session in the psychotherapy. There will be two extracts. The first shows Andrew's interest in the light switch, the second in the phone. Both the light switch and the phone were used more at the beginning of the psychotherapy, but were returned to in year two, which I will address later in this chapter when I present a summary of my year two findings.

> *Andrew discovered the light switch and began switching the lights on and off. This was our first session, and as he did this I felt unsure as to what he was doing and struggled to understand or make sense of this communication. After he'd been doing it for some time I began to feel irritated by the constant on-and-off action he was repeating and thought how it reminded me of an autistic-like ritual. I was unsure how to intervene, and questioned myself as to whether I should intervene or just observe and bear witness to it. Andrew stopped on his own and moved to the door, where he repeated a similar ritual, opening and closing the door, then half going out and coming in. As he did this I began to get a sense of a more hello/goodbye quality to the communication. As he played with the door Andrew made eye contact with me and I felt as if there was a bit more of a connection between us. He returned to the lights, this time taking one of the plastic chairs so he could reach more easily. Again Andrew switched them on and off, on and off, on and off… He would speak and say 'off', leave them for a moment, come back and start all over again with great persistence.*
> (Analysed Session One: Monday 29.9.09)

The data illustrates how quickly Andrew was drawn to an inanimate object, away from me, and how he began a ritualised process of switching the lights on and off. At this point our psychotherapy relationship was new; we were getting

to know each other, setting up the structure of our meetings, and becoming familiar with the setting where we would be spending considerable time together (three times a week) in the forthcoming years. In the room with Andrew I was left feeling confused and unable to determine quite what his on/off communication was about. Reflecting on this with the use of my ongoing supervision, my supervisor and I wondered about the on-and-off play representing something that was not continuous. We reflected on his difficult prenatal experience and the fact that he was born drug-addicted, as well as the early separation from his mother due to his hospital stay. Andrew's mother was still addicted to heroin when he was born, and was most likely unable to offer him the ongoing emotional experience of a mother who is continually there and present (in mind and body) for him. He was bringing an experience of an inconsistent object to the psychotherapy. We considered whether the turning on and off of the light switch was a communication about his experience of a mother who was there for him a bit and then not there: an on-and-off mother. A child who has suffered emotional deprivation and a weak link to their maternal object can present as two-dimensional (Meltzer 1975), in an on-and-off world. Meltzer refers to time in this two-dimensional world and how 'it would be essentially circular' (Meltzer 1975: 225). The switching on and off of the lights might be symbolic of the on-and-off, circular world Andrew had experienced. Meltzer further states that in this two-dimensional world, 'the self would be impaired of memory and desire… its experiences could not result in the introjection of objects or introjective modification of its existing objects' (Meltzer 1975: 225). At this point in the psychotherapy Andrew was inevitably trying to work out what kind of an object I was, and who I was to him.

The data then indicates how Andrew managed to leave the lights and move to the door for a short time. Although Andrew was now in a different location, that of the door, there continued to be a two-dimensional quality to the action he was performing, that of opening and closing the door. However, it was here that he was able to make eye contact with me. I considered that his link to the door-opening action might have enabled him to look more, see me and make eye contact from a safe place in his mind. Although the eye contact was brief, it could have been an indication of the beginning of an opening to me in the

psychotherapy relationship. However, I also wondered if it could have been a communication about his experience of a leaky container. As the data demonstrates, he soon returned to the lights, but this time used some initiative and got a chair for help. This made it easier for him to reach the light switch, which might be considered as an action that helped Andrew feel he was in a bigger[9] position in relation to me. I was getting a picture early on in the psychotherapy of his developmental struggle to get to a bigger place. Getting the chair, and the determination with which it was done, might also be an example of his manic defence against an omnipotent urge. Klein (1935) refers to the sense of omnipotence as what first and foremost characterises mania. Klein states that her observations led her to conclude:

> This mechanism of denial originates in that very early phase in which the underdeveloped ego endeavours to defend itself from the most overpowering and profound anxiety of all, namely, its dread of internalised persecutors and of the id. That is to say, that which is first of all the denied is psychic reality and the ego may then go on to deny a great deal of external reality. (Klein 1935: 277)

The following extract is another from the same first analysed session, and illustrates some play with a phone. Andrew and I were inside the Blue Room at this point, away from the light switches and the door.

> *I sat on the red chair to the side of him and said, 'Hello Andrew.' I spoke about how he and I were meeting. I was aware that I did not have his attention as I spoke, and that he did not seem to be listening to what I was saying. He got up and moved to the table in the room, where there was a red toy phone. He was very excited by this and picked it up, placing it to his ear. I commented on what he was doing and said, 'Hello Andrew.' He looked at me, making some fleeting eye contact. His gaze shifted to the box I had brought for him, so I took this opportunity to introduce it to him. He had a quick look and rummage through the box and saw another phone, a yellow one. He picked it up, looked at it, and bashed the phone part aggressively against the base of the phone. I felt the tone of his action was charged and manic. He placed the phone*

[9] 'Bigger' in this context was both psychological as well as physically higher up.

down on the table, so now there were two phones, a red one and a yellow one. An intense interaction between us followed. Andrew placed the red phone to his ear and looked at me, and I said, 'Hello, Andrew is on the phone to Sara.' He put the phone down, so I said, 'Bye, Andrew.' This interaction between us was repeated many times. However, at times whilst this was happening Andrew's attention would drift off, and he would place the receiver in his mouth and suck the phone cord. In these moments I felt cut off, out of the interaction, and even wondered if I existed in the room with him.
(Analysed Session1: Monday 28.9.09)

This data illustrates how Andrew was attempting to join us together with the phone, but was unable to sustain it for long and would cut off. There was the beginning of an interaction, and he did make some eye contact with me and found a way to link to me through the phone. There was some taking of turns and a hello-and-goodbye exchange, which felt similar to the on/off exchange described in the previous extract. The phone play was action-orientated and gave some indication of how quickly he went from being an Andrew in an interaction with me to an Andrew that got frustrated, regressed and cut off. Boston and Daws describe how play is of particular value to the child as it provides possibilities for anxiety-provoking situations to be faced in a symbolic way. Anxiety can be reduced to tolerable and manageable levels (Boston & Daws 1988: 218). I am sure it was an anxiety-provoking situation for Andrew, being taken off to a room, away from the more familiar surroundings of his classroom and teacher, to be with someone he had yet to form a relationship with; his anxiety was apparent through his play communication. The data also indicates Andrew relating to me in an on-and-off way, not yet sure what kind of an object I was.

The extract below is from the third analysed session, some five weeks later in the psychotherapy. Andrew had just had a difficult journey to the Blue Room. At this point in the psychotherapy he was beginning to have some understanding that I came and went, and was beginning to show me how cross and angry my comings and goings made him feel. A theme of control was emerging in the

psychotherapy, and in his mind he was beginning to experience me as the one having all the control about the comings and goings.

In the following extract, Andrew was using action-orientated play and returned to the railing.

> *Andrew quietened after his angry outburst, and went to the railing just by the Blue Room door and began to climb up onto it. I stood close by and said, 'Now Andrew wants to be a climbing Andrew who goes up high.' He gestured towards me for my help. I was aware how floppy and wriggly his body was, and if I had not supported him at this point he would have fallen off the rail. He stood up high for a moment. I said, 'Andrew is high again, he is bigger than Sara when he does this.' As I spoke he let himself fall off into my grip, and as he did this he tried to hit me. I placed him on the ground, saying, 'Now Andrew is down.' He tried to climb up again on his own. I referred to Andrew not wanting my help; he wants to be a bigger boy who can climb up on his own. After my comment he gestured towards me for my help again.*
> (Analysed Session Three: Tuesday 17.11.09)

Andrew was in a little and collapsed place before he attempted to climb the railing. On this occasion I understood his attempt to climb as a way of trying to get away from the collapsed internal state he was in, full of difficult feelings; he was climbing up away from the feelings he did not like – even though there was an element of danger in what he was doing. The 'climb-up place' was also a place observed in the first analysed session, in which I considered the relationship between climbing and his manic defence and omnipotence. However, in this data Andrew was more in touch with how this bigger and higher place did not feel a safe place, or a place in which he necessarily got away from the feelings or felt bigger. He was unable to get there on his own, but was able to communicate to me that he needed my help to keep him safe there. This was a significant shift, in relation both to how he related to and used me in the relationship and to his ability to show and communicate his neediness and distress. He did not use his omnipotence in the same way as he had in

analysed session one. I was starting to see the beginnings of some trust in me as an object.

Finding and Securing an Initial Base: the Sofa

This section shows how Andrew finds a secure place in the therapy room. It illustrates how he begins to see me as someone who does return. From having a more secure base in the therapy room and a more consistent object Andrew has established a pattern of coming and going, and he begins to explore comings and goings more confidently. He also experiments with getting physically and emotionally closer to me. There is a sense of a child who is becoming securer in the psychotherapy relationship, as well as a child developing an increased sense of who he is in relation to me. Developmental milestones are being explored more fully.

The sofa was repeatedly used in the setting and appeared to offer Andrew a secure place inside the psychotherapy room. It was a place in which he could sit and be quieter and calmer. In the earlier part of the psychotherapy, Andrew was often drawn to the table at the beginning of the session, and the sofa became a place he would go to towards the end of the session. However, the sofa was also a place he would retreat to at various times in order to show me a difficult feeling state before he had the language to express it. The sofa was a place in which the first play about being seen and not seen emerged, and was a place in which there was exploration of trust in me.

Below is an extract from early on in the psychotherapy, in which Andrew used the sofa as a base.

> *Andrew had taken his shoes and socks off, and ran to the sofa saying 'sofa'. He reminded me of a baby as he lay down and hid his face in the cushion. I sat down beside him and was aware of how shy he seemed. An exchange followed. He said 'Sawa' in a baby-like tone. I referred to how he was right and that Sara was here again with Andrew, but how he was showing Sara how shy he was today. I continued, saying, 'Andrew really is surprised that Sara keeps coming back.' He got up and*

appeared to be looking for something in a restless way. He said 'phone' as he looked beside me. I wondered if he thought I had a phone beside me and put this into words, also commenting that the phone was on the table. He went to get the phone and brought it over. A short conversation took place between us in which he said 'hello Sara' and I replied saying 'hello Andrew'.
(Analysed Session Two: Friday 16.10.09)

This data highlights how Andrew felt shy, in an embarrassed and bashful way, about us reuniting. I wondered if his non-verbal communication was about him not believing his luck in relation to how he and I kept continuing to come back together. Once I found words to name his emotional state he appeared to feel seen and understood, and was then able to look for the phone and use the phone as a way of making a different kind connection to me – one which involved a verbal exchange.

The next extract is taken from five months later in the psychotherapy.

Andrew moved to the sofa and initiated a goodbye song.[10] Andrew lay on the sofa, and reminded me of a young child or even a baby as he did this. He proceeded to sing the goodbye song all on his own in perfect tune. He said the word 'Tuesday' instead of 'Monday', and then lost the words to the song for the second part of the song. It seemed as if he could not get the words out. I referred to how Andrew wanted to be the one in charge of the ending and of how he and I came and went. I said, as I pointed towards my watch, that we still had more time. There was a pause and Andrew became quiet for a moment before he began singing the song once more in a similar way. I spoke again about it not being time yet but he wanted me to know that he was ready to see Sophie (his class teacher), and he replied, saying 'mummy'. I continued by saying he was letting me know he was thinking about mummy and home as well. I

[10] The goodbye song was a song I introduced into the session early on in the work to help Andrew understand he and I were saying goodbye at the end of each session. It became a ritual that was extremely important for Andrew, and something he really did internalise.

said first it was goodbye Sara, and then Sophie, and then it was home and mummy. I also said, 'Mummy is thinking of Andrew when he is with Sara, and Sara thinks of Andrew when he is with mummy.'
(Analysed Session Seven: Monday 26.4.10)

This data shows how much more familiar Andrew had become with his place on the sofa and his ability to connect to our comings and goings, and highlights that Andrew was thinking about the impending ending of the session. I wondered if his introduction of the singing might have been an attempt to take charge of the separation, as a defence against having to face the difficult feelings separation evoked.

I was struck by his perfect pitch as he sang the song, and that it was the first time he had sung the song alone, without me. It enabled me to see that he had begun to internalise the song used for our goodbyes, and that it had become a ritual for him. However, I wondered if singing on his own might also be a communication about him not needing me, a communication that he could do 'it' on his own, and if he was taking charge of the ending in order to ease the anxious and difficult feelings he was experiencing about the pending separation. Alternatively it might have been a communication about him thinking what was next, or indeed a complex mixture of both things. The data illustrates how I chose to take up what was coming next and make a sequential link by naming Sophie; this was an attempt to help Andrew make a link to what was coming next in the sequence of his day. The data shows that after my intervention his thoughts leapt to 'mummy'. I thought there were three issues emerging in this data: first, his attempt to sequence and sort out what was now, what was next and what came after that in his external world; second, his continuing exploration of separation through his use of control to manage the difficult feelings separation evoked; third, his beginning to see me as someone (an object) who could help him to explore and make sense of separation as I became a more secure object in the psychotherapy relationship.

The data demonstrates that Andrew got the days wrong once he found his voice, and then he lost his voice. It seemed that once Andrew had got to a

thoughtful, thinking and naming place something became too much emotionally and Andrew lost access to his words. However, as the data highlighted, this was a temporary state, and something then got recovered and he was able to continue and communicate further.

The next extract is from the next analysed session, and is an extract from the beginning of the session.

> *Andrew was sitting on the sofa. I sat next to him and we were in close proximity physically. I said, 'Andrew is close to Sara and Sara is close to Andrew.' Andrew then moved closer towards me, cuddling in next to me; he looked at me warmly and smiled. I was moved by this connection between us and said, 'Andrew seems pleased to see Sara and Sara is pleased to see Andrew.' There was a pause and Andrew stood up, moving away from me, asking for the toilet.*
> (Analysed Session Eight: Monday 17.5.10)

This data demonstrates once more the use of the sofa. This time the sofa appears to offer Andrew a safe and secure base where he can experiment more with our relationship by getting physically and emotionally closer to me. The data shows how Andrew has an experience of me as an object that can connect to him, and I am able to put meaning to the emotional material he brings. The data also illustrates that after Andrew experiences closeness to me, he is able to hold onto the good feelings this has evoked, and that he has a place physically next to me as well as in my mind. However, the data goes on to show that Andrew cannot sustain this place for long; he quickly gets anxious about the closeness between us and spoils it. Initially in the relationship with Andrew I was seen as both a good and bad object, and the issue now is how the good and bad come together for him, so that he can understand that I am the same person and he can get more of a whole-object experience, not just the more familiar part-object experience. The data shows that Andrew only feels he has a place when he is good, and illustrates this when he is in touch with his own good feelings and sees me as a good object. In this place he can tolerate something warmer and closer. The data highlights that the good feelings do not

last long, and shows how he needs to move away, leave the therapy and go to the toilet. (Going to the toilet and the significance of this will be discussed further in the following chapter on the body.)

The next analysed session is from two months later in the treatment, towards the end of the first year.

> *Andrew went to the sofa, and then instructed me, in a commanding tone, to 'sit'. I sat down, and Andrew sat down next to me; then he moved close, so he was sitting right next to me, and he took my hand. His act felt close and intimate. I said, 'Andrew wants him and Sara to be close together.' He smiled at me and snuggled up closer, leaning his head on the side of my body. His act felt close, and I felt warmness between us and was moved by what he was initiating. However, once again the closeness did not last long, and Andrew stood up and moved away to the sandpit, taking off the lid. He had not used the sandpit much at all during our work. He sat on a chair, appearing to make himself comfortable, then picked up the scoop that was already in the sandpit. As the sand fell out of the scoop he began to count backwards: five, four, three, two, one.* (Analysed Session 10: 5.7.10)

This data shows another example, slightly (two months) later in the psychotherapy work, of Andrew using the sofa in an attempt to get close to me. This time he is more instructive and assertive. The data highlights my countertransferential response of feeling warmth and a more intimate connection between us. As in the previous data, the closeness is short-lived. However, instead of needing to evacuate the difficult feelings he experiences from the closeness by leaving the room, Andrew is able to stay in the room – an indication he was feeling more secure and able to manage the good feelings.

Peekaboo

In this section of the chapter, the focus is on how Andrew became more interested in our comings and goings, presence and absence, and how these themes were repeatedly brought back in his play in increasingly sophisticated

forms. It shows how the game of peekaboo developed through variations of the game. Alongside this were Andrew's continuing attempts to take control of the endings, perhaps as a defence against the emotional difficulties that separations evoked in him.

Peekaboo became an important element of play in the psychotherapy, and Andrew frequently used the door and window locations to experiment and initiate this game. The following extract shows an initial game of peekaboo.

> *I had a sense that Andrew was looking at what was inside the Blue Room more today. He had just looked in his box and rummaged around for the first time. After this he rolled on his back, taking a cushion from the sofa, then rolled onto his front, hiding his face in the cushion. I thought it seemed a bit like the beginnings of a peekaboo game. I said, 'Andrew seems to be hiding from Sara.' Then as his face appeared, 'Oh, Sara can see Andrew and he's looking at her.' As he hid again I said, 'Oh Andrew has gone again.'*
> (Analysed Session Two: Friday 16.10.9)

The above data illustrates how Andrew was showing me he was there and then not there in a game that took place inside the Blue Room. Peekaboo is a game that is often observed being played between mothers and babies, perhaps one of the first games they play together. The game as seen in the above data involved two players, Andrew and me; it was a game that was played once some contact had been made. The data illustrates the contact taking place between Andrew and me, and illustrates that it is a game about disappearance and reappearance and presence and absence as Andrew disappears and reappears from behind a cushion. At first the play was non-verbal, but I brought a verbal element into the game by using my voice to help establish further contact between Andrew and me. It felt like an early game of peekaboo as played between a mother and her baby.

The next extract is from an analysed session after the Christmas break, three months later. Prior to the break some of the peekaboo play had developed using the Blue Room door.

> *Andrew went to the door. Prior to this he had been inside the Blue Room. He went through the door, shut it on me and stood just outside, looking in at me. I was still inside and understood from his playful non-verbal communication that it was my cue for a boo game. He stood outside the door, waiting in anticipation for me to open it and say 'boo'. I did this and he smiled, jumped up and down with excitement, and came running back in again. I said, 'Andrew is remembering our boo game.' He was eager to repeat the game.*
> (Analysed Session Four: Monday 4.1.10)

This data demonstrates how the game was being brought back in a different and more sophisticated form compared to the previous extract with the cushion. It was taking place in a new location, at the door, and the door became the barrier between us instead of the cushion. Andrew was showing me it was a game he was remembering, and he was working out through his play more about presence and absence between us. Interestingly this game followed our first significant break over the Christmas period and a longer separation of two weeks.

There can be different variations of this game in relation to who hides and who initiates, and when the game begins it involves an arousal of responses that are instinctive. It is noticeable in the above data that Andrew initiated the game. These signals can be built upon to introduce new ways of hiding and new ways of revealing the hidden (Trevarthern & Grant 1979: 568). It is important to remember that the crucial feature of the game is the uncovering and the reappearance of the hidden object or person. The game can also provide a lot of excitement; the data illustrates Andrew's excited state.

The next extract is another development of the game, three months later.

Andrew had initiated a game in the courtyard in which he led me to a place by taking me by the hand. He would leave me there as he walked away from me. As he walked away from me he maintained eye contact all the time, often by looking at me from the corner of his eye. Suddenly Andrew would turn away and run into the Blue Room, shut the door and hide just inside the door. My established cue was to run after him once the door was shut. I would open the door as if looking for him, and he would be the one to say 'boo' as he giggled excitedly. I said, 'Andrew really wants Sara to find him.' This was his signal to begin the whole game again, and he played it twice more.
(Analysed Session Seven: Monday 26.4.10)

This data demonstrates that Andrew is in charge: he initiates the game, and it is clear he wants to be the one to hide and say boo. However, the primary communication is about him wanting to be found by me. Andrew now knows the rules of the game, some variations of the game, and that he can take turns. In the game of peekaboo the child may also be toying with their own body image, an image important for establishing identity (Cohen 1993: 20). Although it has been suggested there is a sense of object permanency (Bruner et al. 1976) associated with a child being able to play the game of peekaboo, and object permanency is the capacity to recognise the continued existence of an object when it is out of sight, the data clearly shows how hard it is for Andrew to just turn and run: he has to maintain eye contact with me, keeping me in sight until the last moment. It is not surprising how hard it is for him to accomplish the developmental task of object constancy when his experience of a maternal object has been so inconsistent.

Freud (1920) described a young child playing with a cotton reel with a piece of string tied around it, in the absence of his mother:

> The child would hold the reel by the string and skilfully throw it over the edge of his curtained cot, so that it disappeared into it, at the same time uttering expressive o-o-o. He then pulled the reel out of the cot again by the string and hailed its reappearance with a joyful da. (Freud 1920:17)

This then was the complete game – a game of disappearance and reappearance. Freud (1920) focused on the fact that the child was using the game as a means of expression of powerful feelings connected to the absence of the mother. The data illustrates that Andrew is playing out his control, being the one who goes away and being found by me. The joyful return of the object being played out is the defence against the unpleasurable experience of the separation (Alvarez 1992: 166). The peekaboo play is about controlling feelings of loss; Freud linked the game to feelings of loss and separation, and stipulated that through their play a child could 'act out' feelings and take control of the situation. In considering meaning in peekaboo play, Alvarez (1992) suggests that a child might play the game for a variety of reasons: 'to deny the mother's absence and her significance', 'to gain some control and make the absence more bearable', or ' to explore and try to learn more about the properties of absentable objects in their own right' (Alvarez 1992: 166). This elaborates further on the meaning of the game and how important it is to consider this in the context of the game being played and the child's individual experience of object relations.

Being Dropped, Shut Out and Thrown Away

In this section I will be presenting data that demonstrates Andrew's growing awareness of the experience of being dropped by me in the gap between sessions, and how he used the window, the fence and the animals in his play in an increasingly symbolic way to communicate his experience of being dropped during the gap between the sessions. Andrew showed his growing awareness of the gaps between the sessions and their emotional significance. He brought play in which he acted out being the one to do the throwing away, as both a communication and an attempt to understand what was taking place between us.

This play theme emerged in the psychotherapy work after six months. At this point, as previously stated, Andrew appeared more secure in his realisation or experience that I was someone who did come back in a consistent way, on the same day each week and at the same time. He was beginning to increasingly internalise that I was a reliable and consistent object in the psychotherapy.

However, he was still experiencing the separations as him being dropped by me in the gaps between the sessions.

Below is an extract in which Andrew begins to use the animals more symbolically.

> *Andrew picked up the animal tin, needing my help to open it. He took it across the yard and tipped out all the animals on the floor. I went out to join him and said, 'Oh dear, the poor animals tipped out on the floor, what a mess they are in on the floor.' He said 'Sara back'. I understood this communication as Andrew wanting me to put the animals back in the tin, and replied, 'Andrew wants Sara to put the animals back in the tin.' After my comment he ran back inside the Blue Room and opened the window so he could clearly see me. I could see him, and positioned myself so he was continually in my vision as I began to place the animals back in the tin. As I did so I said, 'The poor animals are all over the floor and they need help getting back in the tin.' Andrew was shouting 'hello' to me from the window as he observed carefully what I was doing. I replied, 'Hello Andrew, I can see you.' I took the animals back in, and he calmly placed the tin on the table.*
> (Analysed Session Six: Monday 8.3.10)

This data was the first in a series of play initiated by Andrew that involved toys being thrown away; in this data the focus is on the animals.[11] The data demonstrates Andrew throwing the animals away in a rather messy way, perhaps a communication about how messy he was left feeling when he allowed himself to think about our separations and the gaps between our sessions – that he felt thrown away by me. The data shows Andrew becoming instructive, taking control by telling me to put the animals back while he watched as I did so. I wondered if the instructive stance he took in our relationship was yet another example of his attempt to manage the messy feelings being evoked

[11] The animals were located in a tin which got named in the psychotherapy 'the animal tin'.

by the anxiety of his thrown-away feelings. Andrew needed me to pick up and contain his messy feelings that were evoked by the gap. As Hoxter states:

> Play is an activity which lies between two areas of reality, external and internal, and which in such a case forms a bridge between them. The symbolic area of play is a relatively safe area. When it can be used, anxiety can be experienced in a modified way. The child does not have to face the full blast of anxiety, guilt and other consequences. (Hoxter 1988: 218)

The data illustrates how Andrew managed to keep a connection to me through his eye contact and the verbal connection of 'hello' as I picked up the animals and put them back into the tin. I wondered if his instruction to me and his assertive tone were a defence – a need to be in control and take charge of the 'messy' separation material that emerged as he attempted to work through it in his development. He wanted to be in charge of the comings and goings, and to project his littleness into me. He was like a baby trying to find ordinary differentiation that could only happen when he was contained. Through my words, I tried to address that the animals needed help to be picked up and put back in their tin, and considered how symbolic they were of Andrew's place, both in the psychotherapy and in my mind. As the data highlights, Andrew was able to keep a connection: interestingly it was a 'hello', a significant word as it is the opposite of 'goodbye'. Andrew wanted a 'hello Sara' as a way of not having to face the 'goodbye Sara' and the separation and gap that came with goodbye.

In the next extract, taken from the eighth month of treatment, the theme of being dropped and thrown away continues, but has developed further.

> *Andrew stood on the chair, looking over the fence to see if he could see the teddy he had thrown over. In a previous session I spoke about Andrew wanting to see if teddy was there. I then had to say that teddy seemed not to be there. Andrew said 'barrier'. I was so moved by his use of this word it threw me, stopping my thinking for a moment. There was a pause and I said yes, that was right, and the fence was a barrier. He then*

got down, alert and lively, and went to the animal tin, attempting to take the lid off. He did so, and took out a giraffe and brought it back to the fence, indicating that he now wanted to throw the giraffe over the fence. I decided to set a boundary and said I could not let Andrew throw the giraffe over the fence as the giraffe lived in the animal tin – it was his home. Much to my surprise in the moment, Andrew appeared to be fine with this. However, he then attempted to throw the giraffe over the fence. I spoke then about how Andrew had felt I had thrown him away and dropped him over the weekend, but I could not let him throw the giraffe over the fence. Andrew accepted this and walked away from the fence to the courtyard.

(Analysed Session Seven: Friday 26.4.10)

This data illustrates how Andrew's throwing away of the toys has developed further, and that the location of the play has shifted from the door and courtyard to a different and new location, the fence. The fence[12] is too high for Andrew to see over without the use of a chair or help from me. On this occasion the thrown-away object is a teddy, and the data illustrates how Andrew is able to make a link to the previous session by remembering that he has thrown the teddy over the fence and is curious about where it is. When I verbalise that teddy seems not to be there, Andrew responds with a most profound and moving reply: 'barrier'. I had no idea his vocabulary extended to the use of such a word, and I felt moved by his perceptive and knowing response. In this instance I understood 'barrier' to mean a barrier to seeing teddy but also, considered symbolically, that the gap between the sessions was his barrier to seeing me. The barrier could also be symbolic of his worry about being dropped out of my mind. It is interesting to consider how Andrew immediately wanted to replace the lost teddy with another animal, the giraffe, perhaps to combat his anxiety about the teddy disappearing and the 'black hole' of me disappearing and not returning. Alvarez (1992) discusses the development of Freud's (1920) reel game by bringing attention to the child's inner state of object relations as

[12] The fence was located outside in the courtyard area, and served as one of the external boundaries to the courtyard. It was a high fence which was not possible to see over without an aid of some kind.

the child played the reel game, and questions whether the child was playing mainly in order to deny his mother's absence or was playing it to gain control and make her absence more bearable.

Segal refers to symbolic equations and symbols: 'The symbol proper… is felt to represent the object… It arises when depressive feelings predominate over the paranoid-schizoid ones, when separation from the object, ambivalent guilt and loss can be experienced and tolerated' (Segal 1981: 57). Andrew's apparent anxiety was contained by my explanation that the giraffe's home was in the animal tin and that the giraffe had a place. In the transference I was able to take up how Andrew too had a place in psychotherapy with me, and that he had his therapy home within the Blue Room, three times a week, and a place in my mind when I was not there. His anxiety appeared to be alleviated as he explored it symbolically through the animals. He was able to shift from a more anxious and fragmented paranoid-schizoid position to the depressive position (Klein 1952) in which more integration and thought can take place. Bion (1962) would describe this as alpha-elements: elements that have been digested and thus made available for thought.

The next extract is from one month later in the psychotherapy.

> *As we walked to the Blue Room, Andrew was remembering the fence and said 'one look'. Once we arrived at the Blue Room, Andrew rushed to the fence and stood there. He non-verbally indicated to me that he needed my help to see over the top. I lifted Andrew so he could see over the fence. As I did so I talked about him remembering the fence and how he was asking for one look today and my help to look. I asked him as he peered over the top what he could see today. He replied 'cow'. I commented on how the cow was still there. He wanted to get down, and walked into the Blue Room.*
> (Analysed Session Eight: Monday 17.5.10)

The data demonstrates that Andrew remembers the fence and is now asking to look over it. It is important for Andrew to be able to look for the cow and see it is

there, because the cow is a symbol of me, and I too have come back and am still there. The data shows how Andrew is reassured and contained by this, and is much less anxious than in previous analysed data. The data also illustrates that I have not only become a returning object in his mind, but also an object he can begin to ask for help.

The next session was another month further on in the treatment (June 2010), and the data highlights yet another development in Andrew's attempt to mange and make sense of the gaps and separations in the work and from me, an object who constantly returns.

> *We arrived at the Blue Room, and Andrew said 'one look' as he rushed to the fence. He positioned himself in front of the fence and gestured to me for a lift up. I lifted Andrew and he peered over the fence with great interest and curiosity. I asked what he could see today. He said 'Charmaine'. I replied that Andrew was letting me know he was thinking about Charmaine.[13] He asked to look again. I lifted him once more, asking what he could see this time. He said 'the wall'. I commented on how Andrew really wanted to see over the fence and to see more. Then I said he had thought about Charmaine and seen the wall today. After my comment he appeared to be satisfied, and went into the Blue Room and looked at his treasure box.*
>
> (Analysed Session Nine: Monday 14.6.10)

The data demonstrates again that Andrew clearly remembers from one session to another and is now making links for himself. He is less anxious, more curious and excited about the coming back together. He wants me to lift him up, and in the transference I become a therapist that shows him more of the world. Andrew is looking around more, seeing more, and my job is to give developmental support when there has been a deficit. In this data we see how the object, previously the cow, is now a person. He is able to hold in his mind the person he has just left in his class to come to his psychotherapy with me.

[13] Charmaine was a teaching assistant in Andrew's class whom he had a close relationship with.

He brings this to explore and think about. This is evidence of Andrew's shift to a more three-dimensional place (Meltzer 1975) in which thinking and reflecting are taking place. He is attempting to keep an object (Charmaine) alive in his mind when absent (Bion 1962). Bion (1962) stresses the importance of experiencing absence as a spur to formulating thought about another that is not there. Andrew was beginning to make links, so his world was becoming more symbolic. I was seeing a child who was beginning to get a notionn of play. As Winnicott describes, 'the beginning of play is in the safe space between the infant and the mother' (Winnicott 1971: 2). The psychotherapeutic relationship had developed sufficiently to create a 'safe place' in which Andrew's play was able to develop and move on.

Summary

In this chapter the focus has been on the development of selected aspects of Andrew's play, as well as on his use of various locations as bases for the play. It has looked at four different dimensions of Andrew's play, and some of the change and developments that took place during the psychotherapy treatment: on and off, in and out and up and down; finding and securing an initial base on the sofa; peekaboo; and being dropped, shut out and thrown away. It has shown how the play changed and developed, the increased use of symbolic play, and how Andrew used play to work through and master complex emotional material, particularly linked to separation issues and his sense of feeling dropped in the gaps between the sessions. It has also illustrated the shift in the object relationship and a move towards object constancy.

Initially there was evidence of turn-taking play through the phone, and Andrew's communication about his struggle to get to a bigger place and get on with his development. It was clear early on how he was drawn away from me to inanimate objects, such as the light switch and the phone, and was bringing his experience of an inconsistent object. He also brought his existence in a two-dimensional, flatter world. Meltzer describes 'the limitation of thought and imagination' in the two-dimensional world, and links it to 'the lack of internal space in the mind' **(**Meltzer 1975: 225). However, as the work developed the

phone was used in a different way, as something he and I could join together through.

Andrew brought both his relational and his developmental exploration of separation issues through his exploration of coming and going, with his developing trust in me as an object who did return and come back. There was initial hiding play, which developed into more sophisticated peekaboo play. The peekaboo play illustrated Andrew's exploration of presence and absence using play and games, and his attempt to understand the coming and goings. Although I went, I came back; he no longer needed just a 'hello Sara' that he hoped would be there all the time, but could begin to understand that both the therapist and others came and went, and that there were both hellos and goodbyes. The separations became more tolerable for Andrew.

There was an increase in Andrew's symbolic play as he attempted to put increased meaning to things and use his ability to think and make connections for himself during the psychotherapy. As Stern describes, 'towards the middle end of the second year, at around fifteen to eighteen months, children begin to imagine or represent things in their minds in such a way that signs and symbols are now in use' (Stern 1985: 163). This was a developmental shift for Andrew, and there was considerable evidence of how Andrew began to use symbols such as the animals, railings, and fence to explore and make sense of his world.

The data showed the development and change in object relations. Andrew began psychotherapy with an experience of an inconsistent object, and through the psychotherapy was able to experience and internalise an object who was more consistent, leading to the development of object constancy. There was a shift from a part-object relationship to one that was more whole-object relating, in which Andrew could begin to experience both the good and the bad in the same person, the therapist.

The changing play demonstrated the changing in Andrew, from a two-dimensional, on-off, concrete world to a world that became more three-dimensional (Meltzer 1975). In a three-dimensional place Andrew was more

able to look externally and explore his world. He developed more of an internal structure to draw from: three dimensionality is a place in which thinking can begin to take place. Biggs points out that 'thinking post Bion has given a lot of importance to "three dimensionality" as a criterion of psychic development… The acceptance of three or more in relationships has been defined as a key index for psychic growth' (Briggs 2002: 264). A 'third' began to exist in Andrew's world as he was able to hold in mind another when he was not with them; there was an internal place for more. Andrew showed the development he made from an anxious, paranoid-schizoid state, in which the play was primarily action-focused, to play which was increasingly symbolic, where thought and meaning were apparent – more of a depressive position (Klein 1952).

Andrew was able to communicate his struggle to hold onto things internally, as seen in his up-and-down climbing play, and the shifts when his omnipotent defence collapsed into his more vulnerable and needy state. When his defences were not in place there was evidence of his struggle to manage, but he increasingly recognised that the psychotherapist was someone who could help him, and he began to recognise this and ask for help.

Through the play there was evidence of Andrew's developing identity and his greater sense of self. The data clearly highlights the shift to more symbolic play, particularly with the throwing away of animals and his use of the fence, as he struggled to manage and make sense of the gaps between the sessions in which he felt lonely and thrown away by the psychotherapist. The data showed his progress and his increasing ability to begin to hold the thrown-away object in his mind – initially the cow, and then Charmaine, both symbols of his therapist in his communication about him being the thrown-away. As Andrew became more able to make meaningful links, his world was becoming more symbolic, and I saw a child who was beginning to get a notion of play.

Overview of Year Two of Psychotherapy

This was a challenging year externally for Andrew, as I have outlined in the previous chapter's summary of year two.

Prior to the school move, Andrew's play in the Blue Room continued to develop during the autumn term of 2010, and he moved on to begin playing with the tea set: teapot, cups and saucers. The play often represented a pretend tea party. Andrew would take each cup from the set and place all the cups and saucers in a long row before taking the teapot and pouring cups of tea. As he poured the tea he would name all his friends, such as Liam, JD, Daisy and so on. There was a link to reality, as all those named were either classmates or other members of the school – evidence again of his ability to keep three and more in his mind. This symbolic play took off and was a huge development in Andrew's play. What was particularly staggering was how his play continued to develop during the difficult and chaotic time he was experiencing externally. To remind the reader, at this point things at home were extremely difficult, with Andrew's grandmother having had a psychotic breakdown and being in hospital away from the family home. Andrew's continued growth made evident that something inside him was more solid, or solid enough to enable him to continue to learn, play and think.

However, during the spring term of 2011 Andrew had more disturbing changes to negotiate: the move of his school. In January 2011, after the three-week Christmas break, Andrew returned to his psychotherapy in a more collapsed state in which linking and connecting became hard for him again. He struggled to get to the Blue Room; it took some time, and he required a lot more help and support from me – I needed to do more again. He communicated how needy and collapsed he was with a return to body action as a communication. His language appeared to have collapsed, apart from the word 'no', which he used a lot in a resistant manner. It seemed that the three-week break over Christmas in year two of the treatment had been too much. Neither his teacher nor I knew what state of mind Andrew's mother was in after all the trauma with her own mother's illness. Andrew had come back to the school move, and it all appeared to be too much for him to hold onto his sense of ongoing being. My job became one of speaking to this collapsed place in him. Around him his school was literally falling apart and collapsing. I have a powerful memory of Andrew and me sitting in the corridor on the way to the Blue Room. He had collapsed to the

floor, unable to move. As we sat together while I attempted to speak to his state, in front of us through the glass window was a JCB digger demolishing another part of the school site. It was quite horrific and frightening to witness. Although the school had appeared to be thinking about the significance and impact of the move to another site in relation to the pupils, something had certainly not been thought about in relation to what Andrew and I witnessed on this occasion – what was going on around the school that the pupils had to witness and bear during an already turbulent time of transition. It was no wonder Andrew was struggling to put his experiences together at this particular time.

In the final term of year two Andrew had to experience another loss, the loss of a session with me. Although there had been careful thought and preparation for this, it was difficult because at a time in which he needed more support I was going to be there less.

Andrew and I had settled into our new routine in a different Blue Room in the new school. There was some regression, and more peekaboo play reappeared, particularly at the beginnings of the sessions. The re-emergence of peekaboo was perhaps to manage the longer gap and separation as we met less, as well as to manage the new and different transition from his class to the new Blue Room. However, alongside this there was a development of play with the small dolls. Andrew named the dolls as family members, for example mum, sister, grandma, grandpa and Paul (a cousin). He would name the dolls when I asked who was who. He was able then to develop the play. I might ask, 'What is mummy doing today? Do you think mummy is cooking, watching TV or sleeping?' Andrew would think and say 'cooking'. I was aware as well that he did not just repeat the last thing I said. He did think and then made a choice. However, I was aware that he still needed help at this level, and had not yet reached a place in which he would make the connection with what mummy was doing without some choices. This too was a big development, and it was also apparent that Andrew's choices were realistic – for example, Paul would often be playing football, and granddad would be watching TV.

Andrew continued to want and need my support at this time, with the move, the holidays and the reduction in his sessions with me. His play continued to develop despite all of these changes and losses, and he wanted my attention in a meaningful and thinking way.

Chapter Five: The Body – Feelings, Evacuation and Physical Holding

This chapter will draw from data related to the body and bodily action in order to investigate how the body was used in the therapeutic relationship as way of expressing and communicating emotional material, and how this changed over time. In addition it will look at the shift from the body being used primarily as a tool in communication to its being used in conjunction with words. I selected this as a theme because, from my initial searching and highlighting of the data, the area of body and action stood out as something that was prominent in many of the selected sessions. I made a decision to investigate it further and clarify more clearly what was in the evidence. From my search through the data I made a decision to select three themes that stood out as particularly interesting to me. The process that led me to this was rereading all the selected data and highlighting anything to do with the body and body action. From this a series of matrices were created linking the highlighted body action to the emotional response. This process revealed numerous body actions and emotional states, such as defiance, pride, excitement, anger, evacuation, collapse, mania, neediness, helplessness, testing and shutting out. From this process three themes were selected for analysis and will be presented in the sections of this chapter. The essence of this chapter is therefore about body action and its relation to expression, communication and emotion.

The first section will look at how the body was used to express mania/anxiety in the early part of the therapeutic relationship. The second will look at body action and anger, and the apparent link with the relational aspect of coming and going. The third will illustrate how the body was used as a means for expressing vulnerability and helplessness, alongside the difficulty of staying with difficult emotional material as feelings became increasingly conscious in the work. Interwoven with this I will be charting and linking the emotional expression and communication through the body with what I thought was taking place chronologically, developmentally and relationally from a psychoanalytical perspective.

These three areas will be presented under subheadings throughout the chapter: the first will be ‘Manic Body Action’, the second ‘Anger and Aggressive Impulses’, and the third ‘Evacuation and Being Physically and Emotionally Held’.

Manic Body Action

The first section of this chapter will look at the early stages of our therapeutic relationship, and how Andrew used his body action as a powerful means of emotional communication with me. As illustrated in Chapter One, this was primarily because at this stage in the work Andrew had limited means of communication in relation to his use of words, and in particular little evidence of an emotional vocabulary. He had to rely on non-verbal, body-based communication. Below are two extracts, both taken from different parts of the first session, presented chronologically.

> *I opened the door to the Blue Room, and Andrew was quick to run in. He seemed excited, perhaps manic or anxious, as he was jumping up and down and slapping his torso in a repetitive, even autistic sort of way… He moved to the table where there was a toy phone. He was still in an excitable/anxious state, and excited by the phone. He began to pick it up and put it to his ear. I commented on what he was doing and said ‘hello’ as he held the receiver to his ear. He did make some eye contact with me as I said this.*
>
> (Analysed Session One: Monday 29.9.09)

Although I had met Andrew before, it had been in a classroom observation context, and this was the first time he and I had gone to the therapy room together. Understandably, a first session would give rise to some anxiety. The above data illustrates how at this stage in our therapeutic relationship Andrew communicated both his anxiety and his excitement to me through his use of his body. I was a new person, he was worried, and he came close and then defended. The data shows how Andrew was using his body in several ways as a means of expression and communication by jumping up and down and slapping his torso. The jumping could express excitement, but it might also

express the unconscious feelings of uncertainty and lack of emotional safety in him as we begin our therapeutic work together. Jumping in its own right can literally give a sense of not being grounded. As well as being an action that leaves the floor, it temporarily elevates; it is not a rooting or grounding action. Although in developmental movement jumping is a stage children have to acquire, and which is seen often towards the end of the fourth year of development, it can be of high intensity. According to Kestenberg et al. (1999: 49), 'contractions in the outer genital zones create an overflow of energy and excitement which functions in the service of externalising immature sexual feelings.' In my countertransference I did pick up excitement in the communication from Andrew, but I was also aware of some anxiety verging on mania that was being expressed. The self-slapping which accompanied Andrew's jumping could be thought of in a variety of ways, such as a sensory experience in which one loses one's sense of self and therefore has to make contact with oneself in a physical manner. This could be to keep connected in some way, or to sense one's own aliveness. The therapist's use of countertransference is a vital tool for trying to understand and make sense of communication, especially non-verbal communication. As Sinason usefully describes it, countertransference is the 'conscious and unconscious reactions and feelings of the therapist who is responsive to the transferred feelings of a patient and uses her understanding of those feelings to further the work' (Sinason 1992: 323).

The next extract is from later in the same session.

> *Andrew picked up the phone, looked at it and bashed it aggressively against the phone base. I felt the tone of the action was overcharged and manic as he did this… There were two phones, we had a phone each, and there was a moment of intense interaction in which he put the phone to his ear and looked at me. I would respond on my phone, saying, 'Hello Andrew, Andrew is on the phone to Sara.' He would put the phone down and I would say, 'Bye, Andrew.' This game got repeated many times, and at times between the interactions Andrew would stop, drift off, take the phone receiver and place it in his mouth and then suck the phone cord. I*

felt out of the interaction in these moments, cut off, wondering if I even existed in the room with him… Later in the same session… there were moments in which Andrew did look at me and make eye contact, yet there were other moments in which I felt he could not relate to me. It was in these moments that I observed fast, manic-type interactions, such as fast stepping of his feet, some masturbatory-type light touching of his penis area, and body bashing in which he hit his torso with his hands in a fast and rapid motion.

(Analysed Session One: Monday 29.9.09)

This above extract highlights again Andrew's use of his body action to communicate an internal state that he has no other means of expressing or understanding. As mentioned above, Andrew did not have the words for emotional expression, and the data shows how he resorted to using action as a means of showing me his angry, overcharged and lively feelings. At this beginning stage in the work, it was hard to know clearly what the communication represented. However, I had thoughts about us being together and what this provoked emotionally for Andrew. The data shows that after his livelier interaction he then appeared more settled, and made an attempt to join himself and me together through the use of the phone. It also illustrates his struggle to stay with a together 'us' experience as he quickly became vacant, cut off and regressed to an oral sucking action (on the phone cord). My countertransferential experience from this interaction was one of non-existence. I wondered if these vacant and cut-off moments were a sign that Andrew might easily lose touch with who he was, or that he might be overwhelmed emotionally then defend against closeness and uncertainty. Interestingly, the data goes on to show how Andrew reconnected to a livelier and more manic state in himself by returning to his body and action – this time, rapid stepping, body bashing and a masturbatory action. The body was being employed as a defence. Andrew was full of beta-elements, which are influential in acting out (Bion 1962: 6). However, in both of these states he was not able to relate to me for very long. These physical states could be considered emotionally as unintegrated states, in which Andrew could only access beta-elements. Bion (1962) describes beta-elements as 'objects that can be evacuated' or used 'to

rid the psyche of accretions of stimuli'. 'They are stored as undigested facts' (Bion 1962: 6–7). Andrew needed to rid himself of something, most likely his feelings that were not nice or tolerable.

Esther Bick (1968) refers to the need for a containing object in the infantile unintegrated state, and how if this is not provided it then

> …produces a frantic search for an object – a light, a voice, a small or other sensual object – which can hold the attention and thereby be experienced, momentarily at least, as holding parts of the personality together. The optimal object is the nipple in the mouth, together with holding and talking and familiar smelling mother. (Bick 1968: 188)

I have outlined the difficult early experience Andrew had earlier in this thesis: his period of hospitalisation away from his mother, the attachment difficulties arising from this, his being born with heroin in his system, and a mother who sadly did not have the capacity at this point in Andrew's development to be emotionally available for him or see him as a priority. This data shows that Andrew did not possess the necessary emotional and psychic structures required to manage difficult feeling states that one might expect to see in a child who had had 'good enough mothering' (Winnicott 1972). Andrew's use of his body in this way could be viewed as him attempting to hold parts of his personality together in these difficult emotional moments, because he had not internalised a containing object. Therefore his use of his musculature and body became the 'container'.

Bick further states:

> This containing object is experienced concretely as a skin. Faulty development in this primal skin function can be seen to result whether from defects in the adequacy of the actual object or from phantasy attacks on it which impair introjection. Disturbance in the primal skin function can lead to the development of a 'second skin' formation through which dependence on the object is replaced by pseudo independence, by the inappropriate use of certain mental functions. (Bick 1968:188)

The data illustrates how Andrew cut off, went vacant, and then bashed his own body. In relation to Bick's (1968) notion of a second skin, Andrew could have been showing that he was trying to hold parts of himself together psychically through his body as he experienced this unintegrated emotional state.

The next extract is from three months later in the therapy. Andrew had been rummaging through his box prior to the following extract from the data.

> *Andrew went to shut the box lid and it would not shut. He turned towards me, looking at me, and said 'Sara help, Sara help'. I spoke of how he had found his words and was wanting and asking for my help. I could see that the ruler had got stuck at the back of the box, preventing the box from shutting. As my attention went from Andrew to the box and ruler, he very quickly began to take off his shoes and socks, then moved to the sofa and began to take off his trousers. I spoke, saying, 'Andrew does not take his trousers off with Sara in the Blue Room.' Before I had finished my sentence he had got them off and was sitting with his legs crossed, playing with his penis. I was feeling anxious and struggling to think and know quite how to intervene. I said, 'Oh dear, Andrew is taking his clothes off. Andrew knows he has to have his clothes on to be here with Sara in the Blue Room.' I referred back to lights-off Andrew and a light-on Andrew, then clothes-off Andrew and a clothes-on Andrew. I said Andrew needed to put his clothes on to stay in the Blue Room with Sara. There was a pause and gap that felt excruciatingly long to me, and I was anxious as to whether my verbal intervention was enough, but Andrew began to put his trousers back on. However, in the process he put two of his legs into one of the trouser legs. I then had to help him get his trousers, shoes and socks back on, like I might with a small child that was still struggling to dress itself.*
>
> (Analysed Session Five: Friday 12.2.10)

The extract shows that before turning to body action, Andrew was able to stay in a more integrated and thinking place as he asked me for help when he could not shut the box as he had expected to. It was a moving and significant moment

when Andrew asked for help. But very quickly I put myself in a position of physically helping him, perhaps momentarily taking my attention away from relating to him. I went to the problem of the box not shutting.

The extract shows that very quickly Andrew responded to my attention not being on him, and he began to take off his clothes and search for his penis as if he was extremely sensitive and used to an adult turning their attention away from him. This act stopped me thinking, and my countertransference was anxiety and fear about not knowing what to do. Something of Andrew's fears and anxieties was projected into me after he asked me for help, and he turned to his penis for soothing.

Anger and Aggressive Impulses

In the second and third months of the therapeutic relationship, as also seen in previous chapters of this thesis, Andrew began to bring his anger and frustration. The analysis of the data revealed how the anger came into the therapy sessions after the anxiety. I should stress that this was not an entirely linear process, and often different emotional states were complex and overlapping. The analysis of the data showed such changes and shifts, identifying with increased clarity the trajectory of emotional expression to which I will be referring. The data continued to illustrate how Andrew's main means of communicating his angry feelings at this stage in the psychotherapy was limited to his non-verbal, body-based actions. The two extracts of data that follow are taken from the second and third analysed sessions, and show how Andrew began to bring his frustrations and anger to the therapy but was still using his body and action to communicate how he was feeling to me.

> *Andrew had been placing cubes next to each other and counting to 20; he repeated it, going to nine. The use of number nine prompted me to make a comment about him being six and sister being nine. He suddenly changed the tone of the game, and took each cube individually and threw it across the room in what appeared to be an angry, throwing-away manner.*
> (Analysed Session Two: Friday 16.10.09)

The context of the next extract was that Andrew was putting his shoes and socks on so he could come with me when I went to collect him from his PE session.

> *I observed this was frustrating for Andrew. His class teacher also informed me he was waiting for me to come. I was next to him at this point and he began to hit me. I said it was not helpful to hit Sara, but he was showing me that he was cross. I continued and said Sara had kept him waiting again. As we left the school hall, he ran ahead to the Blue Room. Once we had arrived he took my hand, told me to sit, then ran to the Blue Room door and banged it. I followed him by going to the door, opening it, and said, 'Sara has come to say hello to Andrew.' He jumped up and down, smiling, as if he was very excited by this. I said, 'Yes, Sara has come back to see Andrew again.' Once again he came in and told me in a commanding way to 'sit'. Once again he ran out of the door, banging it very hard. I followed and said, 'Andrew is showing Sara his angry feelings again.' He came running back, repeating this game twice more before getting hold of my arm and pinching me – he drew blood, as I was unable to pull my arm way quickly enough. I spoke again, saying he was now showing me his pinching feelings and he wanted to hurt Sara. He ran out and banged the door once again, then came back saying 'sofa'. I moved towards the sofa and Andrew said 'Sara hurt Andrew.' In the moment I wondered if I had heard him correctly – I had. I said, 'That's right, Sara hurt Andrew by her going away.'*
> (Analysed Session Three: Tuesday 17.11.09)

In the first of the above sessions, which was still early on in the treatment, Andrew showed me his cross feelings for the first time. The data draws attention to how his anger was provoked by a comment I made, rightly or wrongly, when I made a connection between the numbers he brought into the session and his age and that of his sister. He immediately got angry at my mention of his sister; he showed me his angry feelings and threw them away. The throwing away provides another useful example of Andrew's lack of psychic

mechanisms to manage how he was experiencing his powerful emotions. As I have said before, Andrew's early experience had not been one of having someone to gather up his emotional communication at a non-verbal level. Andrew was a child for whom I was trying to find emotional meaning and make links and connections, order and sequence. My task at this point in the work was to try to pick up and understand his non-verbal, action-orientated communications and put a name to the emotional communication I observed and received through his body. I was trying to give him an experience of an object that could show him I could receive and tolerate his communication and provide reverie (Bion 1962). It is known that Andrew had a very difficult first year of life, and in relationship trauma in the first year nothing primitive is held, nothing regulated or got rid of. He had experienced having his feelings misunderstood.

La Barre (2001) highlighted how Klein brought words to a child's symbolic play, which was the child's only means of expressing anxieties of unknown origins. In Andrew's case I was providing words to name emotionally what I observed and experienced through my countertransference and Andrew's use of projective identification, a stage before symbolic play. At this point in the therapy I had to think about the idea of 'play' in the broadest context. The previous chapter showed the analysis of aspects of the development of Andrew's play. In this chapter I want to consider what precedes play developmentally. Before a child can communicate through play, they have to rely on their body and action as significant tools for communication, which may be accompanied by sounds, gestures or imitation to communicate a mood, feeling and so on. As Lynch (2000) states, at this stage 'the therapeutic work involves the recognition, containment and processing through the counter-transference of the child's "body" presentations in action. The receptive therapist is listening to what is neither yet symbolically formed nor yet able to be put into words' (Lynch 2000: 161).

Developmental patterns and progression might be widely acknowledged in child development studies looking at normal development from birth onwards, but for

children with disabilities, including global developmental delay, it is a much less linear and more complex process.

In the second extract from the data, a month later, Andrew's angry feelings are coming back again and again. In this session he expresses his cross and frustrated feelings, but this time they are clearly directed at me in a more relational way. I am directly on the receiving end of his actions. There is intent in the hitting and pinching, and Andrew wants to hurt me. He wants to give me his emotional experience of frustration, anger and hurt. He has no other means of letting me know what is going on in his emotional world, and he does not know how to manage the array of powerful and difficult emotions he is experiencing. He gets rid of them by putting them directly into me. Bion (1962) stresses the communicative aspect of projective identification, as well as the defensive aspect (Klein 1952) brought attention to. Bion states: 'Through projective identification thought itself takes on the function previously entrusted to motor discharge – namely ridding the psyche of accretions of stimuli; like "action"' (Bion 1962: 83). As I said above, Andrew has not had the experience of having someone to gather him up emotionally and provide the necessary experience of reverie in his early development. He has developed his own mechanisms along the way, such as using projective identification and directly acting out, and once again his body and action become the main means for expression and direct communication.

As I have just highlighted, the communication of his anger is now more relational and directed at me. This is different from his anxiety, which the data illustrates he turns in on himself with his body-bashing and masturbatory-type actions. The shift to being more relational is hopeful and a development in the therapy work. The action could also be thought about as evidence that Andrew is livening up a bit, experimenting as to whether I am an object who can bear, manage and contain his more alive and powerful feelings. I have to be an object who responds to Andrew, and although it is not in the extract above, I do have to set boundaries about being hit and pinched to keep both Andrew and me safe, and he needs my help to be safe emotionally. I do not want to excite the 'hurting Sara' perversion in him.

The data shows that after this exchange, something changes: Andrew runs away, but comes back saying ‘sofa’. As I move towards him he puts something into words, which is surprising, unexpected and moving for me. I have to ask myself whether I have heard Andrew correctly. He says ‘Sara hurt Andrew.’ This is a significant moment in the therapy, and I observe the shift and development in Andrew as he moves from action to words; he is now able to let me know, by communicating in a different and more sophisticated way, that he felt hurt by me and my going away. The action becomes a symbol. Also he is beginning to let me know more about how hard he finds the going away, and that he experiences the separations as hurting.

Through the course of the therapy there were other examples of how Andrew used his body and action to show me clearly how he was feeling. In analysed session six (March 2010), Andrew banged the floor a few times with his hands, then stamped his foot, made an arc-like shape with his spine and performed a jump-like movement. The movement was extremely communicative, expressing his cross and frustrated feelings. In session eight, two months later (May 2010), Andrew banged the door shut on me. I was able to take up how he was showing me what a cross and banging, shut-out Andrew he was, as well as an Andrew who was shutting Sara out. I thought this was connected to his cross feelings of being shut out by me between the sessions. Andrew was giving me a direct experience of his shut-out feelings. Later in the same session, Andrew pushed one of the pots in the courtyard over in an impatient, cross and angry manner. As I approached him to pick up what he was expressing emotionally – as well as to set a boundary about not pushing over the flowerpots – he made a stern arm and hand gesture towards me, which in Makaton clearly communicated ‘stop’ to me. He did not want my intervention at this point, verbal or physical.

The next section focuses on the use of the body in a different way. It illustrates how Andrew became more aware of his emotions, but struggled to hold onto them at times and moved to using evacuation of them. Also my body featured more as a physical container.

Evacuation and Being Physically and Emotionally Held

I have divided this third and final part of the chapter into two subsections, one under the subheading ‘Feeling and Evacuation’, the other ‘Neediness, Vulnerability and Physical Holding’. The first part will look at evidence of Andrew’s evacuative processes when feelings came to the fore; the second part will focus on how Andrew began to show more of his vulnerability through his body action, and how I became an object in his mind that could be helpful after the evacuation, holding and containing his more vulnerable feelings both emotionally and physically.

In this third and final part of the chapter I look at how the toilet came into the therapy and was used as a means of evacuating difficult feelings as emotions became more conscious in Andrew. First, I will look at how a more conscious awareness of emotional states developed in Andrew and triggered the need to evacuate and go to the toilet to get rid of the emotion. Further analysis of the data drew my attention to a cyclical pattern I observed emerging: feeling, evacuation, and then Andrew’s need to communicate his neediness and vulnerability to me. This was powerfully communicated through his body action, and was met with both my physical support and accompanying words. I turn now to the two subsections: feeling and evacuation, then vulnerability, neediness and physical holding.

<u>Feeling and Evacuation</u>

The following two extracts are from sessions in the sixth and seventh months of treatment, illustrating how there was a feeling and then a need for evacuation.

> *Andrew had run all the way to the Blue Room holding his bus. Once there, I spoke about how keen he was to get to the Blue Room with Sara today. He said ‘Sara sad’. I replied that I was very happy to see him, then I said Andrew was interested in Sara’s feelings again today. He replied ‘toilet’. I spoke about how he seemed excited, so excited that he could not hold on to his feelings. I asked if he needed the toilet and he replied though action, running rapidly towards the door.*
> (Analysed Session Five: Friday 12.2.10)

Andrew ran all the way to the railing outside the Blue Room and the outer Blue Room window before stopping. He looked at me and said 'sad'. I understood his comment as me being sad not to see him on Friday. He looked directly at me, then said 'toilet'. I said that he might be sad and cross I was not there on Friday and now he was keeping me waiting to go into the Blue Room, then spoke about him letting me know that he could not hold on to his sad feelings. I asked him if he still wanted the toilet. He said 'yes'. We went to the toilet; he went in one cubicle, then changed to another so he could see me more easily. After he had used the toilet he returned to the Blue Room quickly, with no stopping on the way.
(Analysed Session Six: Monday 8.3.10)

As Chapter Three illustrates, at this point in the therapy work Andrew was beginning to use his vocabulary to experiment with different kinds of words, amongst which were emotional words, showing his growing interest and awareness of emotionality both in himself and in me. The data above illustrates how clearly Andrew managed to draw on his words and language to name sad feelings. This was quite a development from the previous months of body-orientated emotional communications. However, it is evident from what follows – his running and need to evacuate by rushing to the toilet – that he was still unable to stay with the feeling and think about it with me.

In the second extract, we had not met as we should have done on the previous Friday, and Andrew was now in the rhythm of us being together and trying to communicate how it affected him when it got broken. Perhaps in my verbal intervention I moved from sad to cross too quickly for Andrew, and it triggered his need to go to the toilet to evacuate his feelings rather than being able to stay with me and with the feelings so we could think more about them. Our rhythm of coming together was broken, and he experienced it as feeling dropped by me. However, the data does show a shift in Andrew: he was not 'acting out' his feelings, as he had been in the second and third months of treatment. He was now expressing his feelings through his use of language. He named his feeling, demonstrating an emotional repertoire; but then something

felt too much emotionally, and he reverted to his body to run away, escape from and get rid of the feeling through evacuation. Being in touch with the emotion still felt difficult, uncomfortable and not nice for Andrew.

Neediness, Vulnerability and Requiring Physical Holding

The following extract (analysed session eight, in the ninth month of treatment) illustrates a new emotional development in the relationship. From this I observed and identified a new pattern beginning to emerge emotionally. This was linked to what actually took place between Andrew and me after Andrew's need for evacuation and use of the toilet.

> *After a visit to the toilet Andrew towelled his hands, and we began our journey back to the Blue Room. He said 'now Blue Room'. I replied that was right, Andrew knew and he was remembering. He then stopped walking and sat on the floor in the corridor by the windows we had reached. He was looking through the windows at the Blue Room. I commented, 'Andrew has suddenly stopped, but Sara and Andrew need to carry on and get back to the Blue Room.' Andrew said 'no' in an assertive tone. I commented on how he was telling Sara 'no'. I waited a moment and suggested that Andrew might need Sara's help to get back to the Blue Room after the toilet. He stood up and gestured for my physical help. I supported him from behind, as I might with a toddler learning to walk, gently supporting him under his arms. He gave in to his weight, leaning back into my arms, letting me support him. I said as we moved together how Andrew was letting me know today that he needed lots of help from me today to get back to the Blue Room.*
> (Analysed Session Eight: Monday 17.5.10)

Although I have not said in this extract what had taken Andrew to the toilet, I want to focus on and illustrate how something else had shifted relationally in connection to the current need for evacuation and his ongoing difficulty about being able to stay with thinking about his feelings. This extract shows a different shift, communicated primarily through body action: after the evacuation and use of the toilet, Andrew initiates coming back together with me in a regressed,

needy and vulnerable state. Although Andrew is still struggling to think about what he experiences as a difficult feeling – in this case that something has been broken between us – the extract shows that Andrew is able to come back to me and initiate a reconnection, albeit in a regressed state. Andrew shows me through his body action and non-verbal communication a different emotional state. He is not cutting off and running away, or turning in on himself or me; he is coming back and attaching physically through initiation, control, and the use of his and my body. It could also be thought about as a more 'merged' state, another means of managing something emotionally that felt difficult. The data illustrates how I observe and respond to his communication and use my thinking to understand and find emotional meaning for Andrew's communication. Andrew knows what it is like to have a mother who puts drugs before him, so my connecting up is a different experience for Andrew.

The following extract is from a month later in the treatment, analysed session nine. The context was that Andrew and I were having an exchange together about his teaching assistant; he was saying her name, as if remembering her. He had just left her in the classroom and come to me. Andrew was looking over the fence, saying her name; she was still in his mind, as if he might be wondering about the experience of leaving her and coming to me.

> *Andrew looked over the fence, then went back to the sofa, and said 'toilet'. We began our journey to the toilet and he sat down in the corridor on the way, looking through the glass at the Blue Room, saying 'bye'. I wondered if he had lost sight of where he was going. He stayed in this position for some moments before standing up and saying 'pooh, pooh' for the first time. When we arrived at the toilet, it was busy with other children. He opened a cubicle door, but another child was in the cubicle. Other cubicles were full, then one became free. Andrew went in, looked into the toilet basin and flushed it. He came out towards me again, saying 'pooh, pooh'. I wondered then if he did not want the toilet and the communication was more about him telling me about pooh. I suggested he did not want the toilet but wanted me to know about his pooh, and that we should try to go back to the Blue Room – he came willingly. As we left*

the toilet area we walked past the children's photos under the title 'pink class'. He said 'pink class'. He leant on me, and I understood this action to be a cue for some physical and emotional support to get back to the Blue Room. I placed my hands under his armpits, as I might if supporting a toddler to walk. He leant back into me as if enjoying my support of his weight and the help he was receiving. On the way back I spoke again about him not needing the toilet today, but that he did want me to know he can think about pooh and he wanted my help to get back to the Blue Room.

(Analysed Session Nine: Monday 14.6.10)

This extract shows that when Andrew gets in touch emotionally with us both coming back together, he is able to access feelings of presence and absence as he leaves his classroom assistant in order to come to me. He and I then come together for a moment on the sofa. It is hard to know if it is the intimacy of us coming back together by the fence and then the sofa, or the feelings of being dropped and left, that trigger Andrew's need to get away and evacuate by wanting the toilet. After our closeness he cannot hold onto the good feelings, a place in my mind. He gets anxious: a good Andrew and then an anxious Andrew, an Andrew that spoils closeness, the bit that messes about and goes all over the place. Either way, the communication appears to be about Andrew getting in touch with a feeling that is difficult to hold onto and keep as a thought. Interestingly, the extract illustrates how Andrew wants the toilet but on this occasion he does not actually use it. He is unsettled, perhaps by his emotional state, or by the toilet area being unusually busy, or by both things. But on this occasion he does not need to urinate and put his feelings somewhere else to get rid of them, as we have seen in previous extracts. On the contrary, he talks about faeces. This is a significant shift, because it is the first time Andrew has ever used the word 'pooh' in relating to me. Faeces is a much more solid substance than urine – it is more formed. It is also something that can be held onto and controlled, as well as be thought about as 'shitty' and not so nice. I wondered if this was indicative of Andrew showing that something not nice was going on inside him (the poohy, shitty feelings) and/or that he was able to hold onto the feeling, not put it down the toilet – he could name it and tell me about it.

Additionally it could be considered a baby part of Andrew, showing he was interested in what came out of the body. Was it something he could do – have a pooh? Developmentally a baby has to differentiate between wee and pooh.

The data shows that after this process, Andrew is willing to come back to the Blue Room with me but indicates he needs my help. Once again this gets communicated through his body action as he leans into me in a passive way and lets me support his walk back to the Blue Room again. He communicates that he could not manage the walk back on his own. I wondered about this need for us to be so close physically, as if he needed both my psychical and emotional support. I wondered as well about our closeness. Again it was a bit like a merging together, as if when the idea of something more separate formed in his mind it became too scary, and the coming together in such a way, although a regression, enabled the experience to become more manageable in Andrew's mind.

The next extract is from the 11th month of treatment

> *Andrew and I had been looking out of the window, naming what we could see. I said I could see a green chair and the sky. I asked, 'What can Andrew see?' He replied 'Sophie'. I suggested he might be thinking about Sophie, and that Sophie might be thinking about him being with me in the Blue Room. He leant forwards and pushed the window open. The wind caught it and it suddenly closed with a bang. I reacted and made an ahhh-like sound because I was worried he might have caught his fingers. Andrew was very quick to react to my response, and he looked as if he had done something wrong, as if he experienced my automatic response as a scare or that I was telling him off – which I was not. I spoke at once about how I thought I had scared and frightened him with my sound. He said 'toilet'. I asked if he needed the toilet, then said I thought I had scared and frightened him with my sound and he did not like those feelings so wanted to go and get rid of them all down the toilet. He went to the door and stopped, and I thought he might not need to go. He then ran to the outer door, saying 'toilet' again. I said we would go to the toilet*

and then come back to the Blue Room. He opened the door, and immediately to the right was the swimming pool door, which had always been locked but today was wide open. Andrew ran straight in. I caught hold of his hand with a sense of urgency, due to the potential hazards in such an area. He went floppy as I made contact, and fell to the floor like a slippery slug. I sat down beside him, embracing him. I spoke continuously, saying that I could not let him go any further, it was my job to look after him and keep him safe. I also spoke about how he and I could not do our work in this area. I continued, saying the door was open and Andrew wanted to have a look. There was a still moment. I reminded Andrew that he and I were on our way to the toilet, and that we needed to carry on to the toilet, and that Sara would help Andrew to get there. We had gone the wrong way but now needed to go the right way to the toilet. I said Sara would wait until Andrew was ready to go. He did not get up but looked to his right and said 'toilet'. I suddenly understood his communication to mean there was a toilet in the pool area that he knew about and I did not know about. I said Andrew was letting Sara know there was a toilet in here. Then I said he used red-class toilet when he was with Sara. There was a quiet moment before I then said to Andrew, 'We really do need to go now, and if Andrew needs Sara's help she will help him.' At that point, much to my surprise, he stood up. I said, 'Well done Andrew, and now Sara will help you go to red-class toilet.' Again I supported him from behind; he was a bit floppy but we found a rhythm to walk and move forward together. It felt like supporting a toddler from behind to aid walking. I said as we walked that he needed a lot of help from me right now.

(Analysed Session 10: Monday 5.7.10)

This extract highlights something different, which is Andrew's reaction both to an event and to my response to what happened. As the extract shows, the window suddenly shut quickly and violently, and my immediate worry/response was for Andrew's safety. I made a sudden reactive sound. From my observations of Andrew's response to my reaction, I thought he experienced my sound reaction as one of being cross with him. I took this up at once, speaking

of how I thought I had scared and frightened him with my sound. That interpretation was made from both my observation of Andrew and the countertransferential feeling I received. Interestingly, as soon as I put my observation into words, he asked for the toilet. For a moment I thought Andrew might be able to stay with the feelings and think about them with me, but this proved difficult. He asked for the toilet again and physically moved himself to the outer door. Once he was through the door, a boundary was immediately challenged when Andrew managed to get into an area (the swimming pool) that is normally locked and out of access. Andrew had very quickly gone into a potentially dangerous place (externally and internally), and I felt this powerfully. Andrew acted out, projecting his unsafe feelings right into me. I was propelled into a position in which I had to think quickly about how to contain and emotionally help him and negotiate our way out of this 'no-go' area we found ourselves in together. His body action was communicating clearly the collapsed and fragile emotional state he had regressed to internally, as shown by his actions of falling to the floor and becoming physically difficult to get hold of. I felt as if he could easily slip through my grasp, making it difficult for me to gather him up in any way, psychically or physically. Bion states:

> The attempt to evade the experience of contact with live objects by destroying alpha-function leaves the personality unable to have a relationship with any aspect of itself that does not resemble an automaton. Only beta-elements are available for whatever activity takes the place of thinking and beta-elements are suitable for evacuation only – perhaps throughout the agency of projective identification. These beta-elements are dealt with by an evacuatory procedure similar to the movements of musculature. (Bion 1962: 13)

The extract illustrates how hard I had to work to gather Andrew up with my words, as well as physically containing Andrew in my hold. I was using my alpha-elements. In this moment he needed a lot of extra support from me, as a baby might in a distressed and fearful state. Something shifted in Andrew emotionally, and relating between us began to take place again. He was able to take in and digest my words; I was being listened to and heard. Andrew then became able to communicate to me with his own word and gesture, informing me there was a toilet in this area I did not know about. Bion states:

> The infant depends on the mother to act as its alpha function – a fear is modified and the beta element thereby gets made into an alpha element… the beta element has been removed from it, the excess of emotion that has impelled the growth of the restrictive and explosive component; therefore a transformation has been effected that enables the infant to take back something. (Bion 1963: 27)

In this case it was the therapist doing this work with Andrew. He 'was getting an experience of being held in a primary emotional "psychic skin" equivalent to the physical skin which holds parts of the body together' (Waddell 1998: 33). Once an experience has been understood, it becomes possible to express it symbolically, which is shown by Andrew being able to do so by finding his words again. The extract also illustrates how something did get recovered emotionally in Andrew, and with physical support he was able to move from the horizontal, collapsed place on the floor to a more vertical, standing-up place, and to move, albeit with my help. His body action reflected the emotional psychic transformation that had taken place. Andrew was in a collapsed place in which he was full of beta-elements, and was using projective identification to act something out. Then with help from the therapist the emotional experience was transformed into alpha-elements (Bion 1962). When I do more alpha function, Andrew likes it and responds to it. The bodily shift from the horizontal plane to the vertical plane is also indicative of the psychical shift from a more collapsed, infantile place to a place in which Andrew could stand up, be vertical, face the world, and get up, move and find the movement to go forward.

Summary

This chapter charts another component of the developmental journey for Andrew. It focuses on the emotional journey and the shift from body-action-based communication to using words and actions together in order to get his emotional needs understood and communicated. The extracts from the data provide evidence that illustrate the changes and developments that took place and the different states of mind Andrew brought: first his anxieties, then his anger, then his vulnerability and neediness. The research attempts to show the defences Andrew had in place at the beginning of the psychotherapy work, and his struggle to move beyond these and change/move on from patterns that had been established in his past.

In the beginning the data illustrated Andrew's limited means of communication and how he relied on the strong use of body and body action as a main means of expression. The feelings were powerful, and we see he had limited tools for communication and little experience of having his emotional communications understood. First there was his understandable and appropriate anxiety, then evidence of his anger and frustrations. However, once he was able to see and experience the therapist as an object who was consistent, reliable, available and could tolerate, bear and contain his emotional communications, he began to use words and ask for help, and his established body defences lessened.

The latter part of the chapter examined how Andrew became more aware of his emotional states as they became more conscious in him. At times this was frightening for him and he was unable to hold onto his feelings for long, perhaps scared by these new and unmanageable feeling states that had been evoked in him. The extracts of data repeatedly show his struggle and need for evacuation, his urge to leave the therapy room use to the toilet as an attempt to get rid of the feelings. The material then illustrated how something shifted emotionally: Andrew began to be able to hold onto something more emotionally solid in himself. There was the shift from urine to faeces along with his increased use of words. Andrew began to see me as someone who could help him and contain and bear his emotional states. He became more able to ask for help and use his body action in a different way, this time for support rather than acting out and projection. This development was linked to his struggle to become bigger and more independent, and the evidence highlighted the ongoing struggle between this and his need to regress to a more merged state in order to manage the challenging transition to a more separate and independent state and the developmental growth it represented. He used me, my body and merging to aid this difficult developmental phase of separation, as a toddler might use his mother as he begins to master separation.

Overview of Year Two of Psychotherapy

As I have stated previously in my overviews of the year two psychotherapy work, there were many external events Andrew had to manage. In relation to

this chapter I was struck and moved numerous times emotionally by Andrew as he continued to see me as someone who was there to help him. In particular, he used the emotional support he knew he could get from me to negotiate the long journey from his new classroom to the new Blue Room when the school moved site. It was a longer journey than he had had previously, and involved going outside, through four doors and gates, and past a more senior part of the school as well as an outside area in which other students were often participating in their PE lessons. It was a complex journey physically, psychically and emotionally for Andrew, yet he was able to let me know that he needed a lot of help from me at this time. I would have to talk continually to Andrew, naming what we were doing, letting him know where we were and where we were going, putting a clear narrative to the experience. He often regressed to testing the boundaries again, and earlier on took every opportunity to run in the opposite direction or sit on a bench we would pass. However, he would also ask for my help, especially on the way back from the Blue Room to his class. He would say ‘Sara help’, and would position himself close, leaning into me, as described on several occasions in data in this chapter. I would take his cue and support him under his arms. Together we would find our rhythm and walk and talk. I would let him know that I knew he wanted my help, and reiterate what a long and difficult journey it was back to class after his time with me in the Blue Room. It became clearer how much was about the separation transition, moving from one place to another, and saying goodbye to me and going back to Sophie. At this time Andrew was managing so many difficult changes and transitions in his external world. However, he was now initiating asking for help, and seemed more aware of his own needs and how to get his needs met by me. He would use his words and his body together to communicate this, and was no longer regressing in such a collapsed way, as seen in some of the evidence above

In the second term (2011), the term the school and Andrew were due to move site, something did collapse emotionally in Andrew. He reverted to using his body action to express and communicate his collapsed internal emotional state and struggle. At the same time his language periodically diminished. It was a time when he needed more from me emotionally. Relationally we were in a

place in which I knew Andrew well, and he knew I was there to help and support him.

Chapter Six: Conclusion

In this thesis I have presented my research findings, along with a literature review and a detailed account of the methodology I employed in order to carry out the research, which was in the form of a single-case study. The aim of the research was to try to investigate the question of whether intensive psychoanalytical psychotherapy could enable a child diagnosed with global developmental delay become unstuck. As stated earlier in the thesis, during the course of the intensive psychoanalytic treatment I observed how developmental changes took place in the psychotherapy work with Andrew. The purpose of the research was to look in more depth at the data to see if there was evidence to substantiate whether changes and developments had taken place, and if so if they were in line with my research question.

I was drawn to this research topic first by the changes I observed in the psychotherapy over the course of the treatment. Second, this interest was consistent with my past professional experience of, interest in and commitment to the area of learning disabilities and global developmental delay. Third, I believed more research in this area would contribute further knowledge and information that could only be to the benefit of this patient group, the field of global developmental delay and more generally the area of learning disabilities. Finally, more research in this field could be beneficial to the variety of professionals working with this population in their differing professional capacities, such as teachers, medical professionals and social workers. It could also contribute to economic and political discussion about treatment options.

This concluding chapter will present an overview of my findings and discoveries made from the research process. It will be presented in the following form. First it will discuss the development and change in object relations, and the relational changes that took place between Andrew and me, with particular reference to the transference relationship. Then there will be a final overview of each of the three researched themes. The chapter will review the extent to which I have been able address my aim and answer the research question. There will be a reflective, evaluative component considering the research process, the methods

used and the adequacy of them, including the gains and limitations of the research. I will consider the contribution I think this research has made to the field of child psychotherapy. Finally, some thought will be given to the implications for child psychotherapy practice and the implications for future research.

Overview and Summary of My Findings

Three main themes were selected for research: language and development, play and space, and the body and emotion. What emerged from the analysis of all the data selected for the research was how much Andrew did develop through his intensive psychotherapy treatment, and how development was not a linear process. It became apparent that Andrew, at the age of five to six years, from having had the intervention of intensive psychoanalytical psychotherapy, was able to navigate his way developmentally through an earlier stage of development that he had not yet mastered and had got stuck in. These stages would normally be observed in child development in children between the approximate ages of 15 months and two and half years. Although I have broken down the findings gathered from the evidence presented in Chapters Three, Four and Five, this conclusion will provide more of an integrated overview of how Andrew's development took place. Prior to that, there will first be an overview of how the development of an intensive psychotherapeutic relationship provided the context in which all development and change took place.

I would like to begin with the changes and developments seen in the psychoanalytical relational aspect of the intensive psychotherapy treatment. It took time for the relationship between Andrew and the psychotherapist to develop and for trust to be established. Andrew brought to the psychotherapy his experience of his primary object relation, that with his mother, which we know was a complex one of inconsistency and absence. Initially my task was to develop a safe and contained physical and emotional space for the work to begin. Much of the early relational psychotherapeutic work was about observation, attunement, naming and labelling what was taking place in the room between the patient and the psychotherapist, as well as providing a narrative and a mind that was available and thoughtful. The psychotherapist

had to be an enlivening object (Alvarez 1992) who would react to the patient and whose mental reality was mature (Meltzer 1975). It became clear in the transference relationship that prior to the therapy Andrew had internalised an adult who told him what to do, and that he had also had an experience of having his feelings misunderstood. In the early transference the psychotherapist was experienced as an uninterested, here-and-not-here object, much like the experience the patient had already internalised. However, there was also a reality to this, as the psychotherapist did come and go three times a week, and was not there all the time.

The research illustrated how Andrew responded to the boundaries and structures set by the psychotherapy setting and that he found them containing. He responded to being gathered up psychically by someone who was interested in his development and wanted him to grow. However, early on in the treatment it was not possible for Andrew to realise that both good and bad existed in the same person. Over time there was progression: Andrew became able to manage developmentally that good and bad existed in the same person, and then there was more whole-object relating. When Andrew had internalised more about the good and bad coming together, he showed more concern for his object, and it was after this point he was more able to know that someone such as his TA or the psychotherapist would still be there or would come back after leaving. He became able to hold the notion of 'see you later' in his mind. Developmentally, once he had internalised more of a good, reliable object, he could then begin to add on. A focus of the psychoanalytical approach is to 'investigate, try to shift and modify, the internal object relationship and the corresponding state of the internal world' (Garland 1988: 4).[14] The transference relationship developed, and the psychotherapist became someone who did come back and was more reliable in Andrew's mind. However, there was still some anxiety and worry about the comings and goings and separations. To manage these anxieties, Andrew used his defence of control by wanting to take control of them.

[14] 'At its simplest, the 'object and the object relationship can be described as the internal representation of figures and relationships which are emotionally significant, whether positively or negatively' (Waddell 1998: 13).

His anxiety about his internal object allowed him to know what the experience of feeling more curious was like, as if there was more. This coincided with the looking over the fence as his inner and external world expanded. Intimacy and closeness in the transference continued to be a precarious place for Andrew, but gradually he became aware that the psychotherapist was the same person who made him happy and sad, and he became interested in basic differentiation: his psychic life depended on this – separate and together, inside and outside. There was more of an internal place developing in Andrew in which thinking and connecting began to take place.

Many of the themes and issues arising in the intensive psychotherapy treatment with Andrew were related to earlier phases of child development, those that one might expect to see between the ages of 15 months and two years. Due to Andrew's complex beginning and start in life, aspects of his development suffered; however, despite this, the research has provided evidence that Andrew was able to develop and progress in several aspects of his development in which he had become stuck. Development is a subtle process that emerges over time. The intensive psychotherapy treatment gave Andrew an experience of an intensive relationship in which he could feel safe emotionally, experiment, and try out and address issues that had not yet been mastered.

Andrew's language developed considerably over the course of the treatment, shifting from being primarily non-verbal to being verbal. His vocabulary shifted, from using one-word sentences to using two, three, four and five or more words. Andrew also acquired two-way interactional conversational language. The research highlighted the development from his having a vocabulary of 12 words, according to the speech and language therapist in autumn 2009, to having a vocabulary in the psychotherapy sessions of between 60 and 80 words (including numerical and non-numerical words), as shown at the end of the first year of psychotherapy in July 2010. Although Andrew had a much larger vocabulary, it was still limited due to his global developmental delay. It is

important to keep in mind that in child development, by the age of six years old, a child would be expected to have a vocabulary of 15,000 words.

The research also highlighted how Andrew's language was maintained after the first year of intensive psychotherapy treatment, despite difficult external circumstances in the second year of psychotherapy, when his home environment was in disarray because of his grandmother's psychotic breakdown. Alongside this was the disruption to his school life due to the school move, combined with the disruption by both the preparation for and the aftermath of this event.

Andrew's verbal self (Stern 1985) emerged, which is linked developmentally to becoming more separate. He developed a voice for himself that became bigger and louder. He became more assertive with his 'no' words, testing the boundaries between himself and the psychotherapist. This is a developmental stage often seen at about the end of the second year, coinciding with a child's acquisition of language and being able to speak. Alongside this was Andrew's developing identity, autonomy and increased sense of self. Andrew became more assertive in the therapeutic relationship, and was able to use his psychotherapist to safely test boundaries. Andrew liked the boundaries and, as stated previously, responded well to those provided by the psychotherapy. He was able to experiment with attachment and separation issues, and became less anxious about endings and separation once he began to internalise that the therapist would come back and return, and that he would not be forgotten, left or abandoned.

Other developmental changes evident in the research findings were the shift in Andrew from a flatter, more two-dimensional world to a livelier, three-dimensional world (Meltzer 1975). Accessing a three-dimensional world enabled Andrew to develop more of an idea of a third, and the concept that a third existed. This was illustrated in frequent comments he made, such as 'bye see you later' to his TA as he left class to come to his psychotherapy. Developmentally, having a sense of a third also showed Andrew's development of object constancy. Andrew became able to think and keep in his mind that

there was a third place, the beginning of something Oedipal. Oedipal development, according to Klein (Klein 1928), emerges at about 18 months in ordinary development. Andrew became increasingly interested in and curious about his therapist, other people and relationships, while his increased language acquisition allowed him to connect more to others. As the research highlights, Andrew's developing language and sense of verbal self opened up his world relationally. As Stern (1985:162) states, 'it makes part of our own experience sharable with others.' Wolpe describes how 'language thus becomes the basis for mental growth: for thinking, symbolism, understanding others, conveying thoughts and feelings to others and forming relationships' (Wolpe 2016: 34–35).

Andrew became able to integrate his language alongside his more familiar means of non-verbal communication in order to get his communications and needs met and ensure he was understood. He became able to ask for help, using both gesture and language, as he became increasingly aware of his needs and his differing emotional states, and he was no longer as defended as he had been at the beginning of treatment.

Andrew's play developed, and by the end of treatment Andrew was a child who had a notion of play and was able to use symbolic play to begin to explore and make sense of his world. This was a huge development from the early psychotherapy, in which the psychotherapist's main task was to name and attune to Andrew. At that earlier stage, the therapist had to listen for what was yet to be symbolically formed (Hart 2011) or put into words. Through play Andrew became able to initiate, make choices, and increasingly use play to explore and make sense of themes such as comings and goings, presence and absence, intimacy, and fears about being thrown away and dropped out of mind as he negotiated the gaps and breaks in the treatment. All these aspects are significant developmental milestones that he had not managed to negotiate prior to the intensive psychoanalytical treatment.

Relational intimacy remained an aspect that was hard for Andrew, but he did progress a great deal developmentally in this area. The therapeutic relationship

developed to a point in which there were many more moments of closeness and intimacy than there had been at the beginning of treatment. Although Andrew and the therapist were able to come together more, there were also many examples (as seen in Chapters Four and Five) when becoming closer was difficult for Andrew to sustain and the feelings evoked felt uncomfortable. At this point he initially needed to evacuate by leaving the therapy and going to the toilet, but there was a shift and he began to be able to stay with experiencing the emotion and thinking for longer periods of time.

At the beginning of the therapy it was apparent that Andrew had few mechanisms and little internal psychic structure in place for understanding or processing his emotions. He would resort quickly to non-verbal communication through action-based body actions, projection, projective identification and acting out. These had been his main tools for the expression and communication of difficult feelings he did not know how to manage or process. Andrew had not had an early experience of having had his feelings gathered up, contained and given back to him in a more digested form. This was another main area in which development took place during the intensive psychotherapy treatment. The defences Andrew had in place became clearer. The therapist became more able to see the difficult emotional aspects he was struggling with, such as his anxiety, his anger and his frustration, and it was apparent that he wanted help with his feelings. The psychotherapy provided a place in which he was able to experience having his emotions seen and understood, and to experience emotional containment. There was a shift from being full of beta-elements to more alpha functioning (Bion 1962). Bion (1962) refers to beta-elements and describes them as suited for use in projective identification. Bion also describes how the beta-elements are influential in producing acting out, as they are objects that can be evacuated, and are stored not so much as memories but as undigested facts. In contrast to beta-elements, Bion (1962) describes alpha-elements as elements that have been digested and thus made available for thought. When Andrew felt he was contained by the therapist, he could differentiate more and was able to access his capacity to think; however, when not feeling emotionally contained, Andrew was left feeling volatile and less safe to explore.

Over time there was less splitting and more holding together, which is the basis of symbolic functioning. In the transference the therapist changed and became the woman that showed him the world. The three dimensionality of this – his curiosity, his interest in looking around and seeing more – illustrated his developing inner world and exploration of the world around him. The world became a bigger and more interesting place in his mind. Andrew had developed more of a psychic internal structure which he could draw from: a place in which increased thinking was beginning to take place, links were being made, and things were being connected up more than they had in the past. Andrew developed more of a sense of time and place, and there was increased differentiation between presence and absence, then and now, here and over there. Links were being made so his world became more symbolic, and Andrew began to get a notion of play. At the end of year two there was symbolic play involving figures and teacups in which he played out scenarios with friends and family members. It was also further evidence of how he was in a place in which 'the third' was in his mind and was held in his mind when he was not with them.

In this concluding component I would like to summarise and reiterate the major thematic links between the findings in chapters three, four and five. The development of the therapeutic relationship was a major theme spanning across the three researched areas. As already outlined the therapeutic relationship both enabled and underpinned all of the growth and development that took place over the course of the treatment. The intensive nature of the therapeutic relationship in this research and the length of treatment aided this process. Andrew's on going growth and development was a major theme, which bridged all the researched areas in chapters three, four and five. Within this overall umbrella, as previously stated, many individual themes were highlighted that spanned the three chapters, such as the development of a verbal self, the increased sense of who Andrew was in the world and his sense of identity, the shift from two-dimensional functioning to three-dimensional functioning, enabling more curiosity, exploration, linking and thinking.

Another major theme encompassing the researched areas was Andrew's shift from action and use of his body as his initial main means of expression and communication, to being able to use words, language and thought within the therapeutic relationship. He was able to communicate more successfully and be understood.

Attachment and separation issues were evident across chapters three, four and five, and the research highlighted the development of a more secure relationship between Andrew and the psychotherapist. This was one in which emotional containment became evident, thus enabling more thought. Alongside this was the developing and changing object relationship, which was demonstrated later through the transference. The gains from the psychotherapy were evident, Andrew had internalised enough to allow him to experience a different kind of object, a more reliable and consistent object that was very interested in him.

The Extent To Which I Have Been Able to Answer the Research Question

Overall I believe that the research process has enabled me to answer the research question, as the analysis of the data provided evidence that developmental change did take place in the themes I selected to investigate.

As stated earlier in this chapter, it was clear from the research process that Andrew's development was not a linear process. Looking at three different themes made it most apparent how interrelated all three areas of development were. It was hard at times to focus on one aspect without being influenced more widely by other developmental changes – for example, separation and Oedipal issues – and therapeutic change, such as the object relational changes that were occurring in parallel.

In particular, for a child such as Andrew, who had early relational trauma and emotional deficits which inevitably contributed to his developmental difficulties, the intensive psychoanalytical psychotherapy treatment proved developmentally useful. Although clear evidence of developmental change has been provided in this research, I would like to briefly mention how other factors, external to the

therapy, could have also aided Andrew's development. In particular there was the school environment. Andrew was fortunate to have a good, nurturing and supportive school. He experienced a consistent class teacher, and teaching assistants who were interested in him and also offered security and continuity while he was at school. Throughout the course of the psychotherapy treatment and the complexity of the school move, Andrew remained with the same three important adult figures. The consistency of these reliable adult figures in his school environment could only support the psychotherapy work and experience Andrew was receiving from his intensive psychotherapy treatment. However, I would stress that it was the intensive psychoanalytical psychotherapy treatment that gave Andrew an experience of a one-to-one intensive relationship over a long period in which he could experiment with, try out, address and work through developmental, relational, unconscious and emotional issues that had not been worked through or mastered in the past. The opportunity of having a psychotherapist whose mind was solely available for the patient, someone who was trained in non-verbal communication and observation, knew about child development, understood unconscious processes and could receive, understand and make sense of communication for such a child as Andrew, provided a very different experience from that offered anywhere else in the school or home environment. The intensive psychotherapy relationship provided a safe, consistent place three times a week that was solely his, in which he was able to explore and work through important and necessary developmental and relational issues. Over time Andrew internalised that there was a place for him physically and psychically, both in the psychotherapy room and in the psychotherapist's mind. The development of the therapeutic relationship highlighted how much a psychotherapist can give developmental support when there has been an early relational deficit alongside global developmental delay.

Reflection on the Research method

A number of others have written and published clinical papers and done research on their work with children and adolescents with learning and developmental difficulties, all of whom have made highly valuable contributions to the field (Baikie 2004, Chantrell 2009, Sinason 1992, Miller and Simpson 2004, Robinson 2008, Wolpe 2016). This particular piece of work has been an

in-depth piece of single-case study research with a child with global developmental delay, involving an in-depth process of analysing the data in relation to the research question, aiming to show (an) outcome(s). An advantage of research over clinical papers is that it enables the more detailed study of a subject, aimed at discovery of information which could reach a new understanding or add further knowledge to a field. The additional value of this research is that it is not about the benefits of once-weekly psychoanalytical psychotherapy, but is about the more intensive treatment model of thrice-weekly psychoanalytical psychotherapy, which could add to cumulative knowledge in the field.

The overall research process evokes many words in my mind. It has been interesting, time-consuming, challenging, creative, informative, rewarding and conclusive. The task has been huge. It took some time as well as numerous processes of elimination to get to a place in which my research aim was clarified and confirmed. Although I had chosen to do a single-case study piece of research, it took careful consideration to identify the methodology most suited for approaching the analysis of the case. As outlined in the methodology chapter, the process encompassed selecting 10 sessions from the first year of treatment and three from the second year to analyse. The data was taken from original process notes, and it was from the application of thematic and matrix methodology that I was able to finalise and confirm three themes to analyse in detail for changes and developments over this period. Thematic analysis enabled identification of three themes, and matrix methodology was a particularly useful tool as it also offered a visual element, which allowed the organisation of data chronologically to see the evidence of change clearly over time. This worked particularly well for the analysis of language and words, as it aided clarification of the dimensions within this area, giving more precise information about the nature and extent of those changes.

I was surprised by the different dimensions that emerged in the language development: the themes of different words such as number words, object words and people words, and the development of sentence construction and conversation words. In the play chapter I was surprised by the interaction

between and importance of spaces and places in the therapy room in play, and how these seemed so influential in the exploration of different developmental issues, such as coming and goings, being dropped and intimacy. In the body and emotion chapter I was able to map Andrew's emotional journey with greater clarity. I was able to confirm the huge shift, from acting out and using projection and projective identification, to being able to name emotions and use language as an expression alongside gesture and the body to get emotional needs met. The overall shift from action to language and thought was paramount in Andrew's development – the beginning of linking together and sequencing, such as therapy and Sara, classroom and Sophie, then school bus home to mummy.

Inevitably there must be aspects in the research data that I have missed, overlooked, or not picked up or identified. As stated earlier, human fallibility in the research process is inevitable, and it needs to be mentioned in this reflection (Midgley 2006). Potential limitations of this particular research could be the accuracy of my writing up, what might have been forgotten or missed, and the fact that only one case was looked at. Research considering more than one case in the future could be a further useful contribution to the field. However, looking at multiple cases could negate the depth and richness that was achieved by only looking at a single-case study. The detailed level of scrutiny and analysis certainly led the researcher to having greater insight, knowledge and understanding about the inner life of Andrew.

What this research did not allow was the investigation of other areas which could have illustrated other significant changes and developments in Andrew. In my initial analysis of the overall data, other areas were highlighted as possibilities for analysis, but they did not get included because of the limitation of this task. Areas of interest for further investigation and possible future research not included here are: the mapping of how Andrew arrived at the therapy space and how he left; first encounters and interactions between Andrew and the therapist on collection for therapy; Andrew's relational state as the therapist returned him to class after his psychotherapy; mapping the emotional journey to the Blue Room in each session and how it changed over

time; what happened before a verbal intervention, what the response was after an intervention, and how this affected the subsequent mood or behaviour. There might also be scope for looking in more depth at what happened in year two: in this piece of research only three sessions were selected for the final analysis, leaving considerable material not looked at.

The provision of questionnaires for the carers and professional staff working with Andrew might have provided an additional area to consider, as well as incorporating more links to how the therapy was internalised and utilised outside the therapeutic domain, for example at home or at school. Although feedback was included, it was limited.

Contribution Made to the Field of Child Psychotherapy

The research in itself is a useful contribution to the field of child psychotherapy, as it supports and provides further evidence of the benefit of intensive psychotherapy for young children with global developmental delay. It also considers how intensive psychotherapy can alleviate trauma, relational neglect and development delay and aid with developmental growth, supporting movement along the developmental trajectory in areas such as language and speech, play, communication and emotional development. It supports the notion that children with global developmental delay are reachable and can benefit a great deal from psychological growth and change. As Symington (1981) states, handicapped patients, like all other patients, have conscious and unconscious processes at work; Sinason (1992) reminds us that all human beings have an inner world and an outer world, an unconscious as well as a conscious. My research findings support this notion, and provide further evidence following on from the work of Symington (1981), Sinason (1992), Galton (2002), Miller and Simpson (2004), Baikie (2004), Robinson (2008), Chantrell (2009) and Wolpe (2016). All these practitioners have proposed that psychotherapy can improve linguistic, symbolic and emotional functioning. I want to reiterate that thrice-weekly intensive psychoanalytical psychotherapy can provide the necessary early intervention to move a child along their developmental trajectory when they have become stuck.

It is the amount of collected and analysed data in the area of language, play and space, body and feelings that makes this piece of research distinctive to the work of others. The research provides evidence showing that a child who had an extremely complex beginning to life was able to move along the developmental trajectory and negotiate developmental milestones they had not previously. Although some areas from the findings might overlap with those of other authors, as stated overleaf, these research findings provide distinctive evidence that illustrates and supports the amount of developmental growth that can take place within intensive psychoanalytical psychotherapy treatment over the relatively short period of two years. To summarise the distinctive aspects: the increased and measured language development that took place. The evidence from this aspect of the research therefore advances the work of Bakie (2004) and Chantrell (2009); the development of communication and two way relating; the shift from two to three dimensionality enabling increased curiosity and liveliness as well as more awareness and interest in others; the research illustrated the patient's ability to link and sequence events within a time context; it illustrated the development of a different kind of object relationship, a more secure one, in which thought, feeling and thinking became more evident and present. Andrew's mind became a place in which thoughts and feelings could be contained, held onto and thought about rather than being evacuated and acted out, thus furthering the work of Kakogianni (2004), Bakie (2004) and Chantrell (2009). The research also conveyed that when developmental issues were being negotiated at a time when Andrew's external world became extremely chaotic, that enough from the psychotherapy treatment had been internalised to maintain and sustain development without regression and psychic collapse.

Another distinctive aspect of this research was the amount of emotional growth that took place. The research illustrated that when emotional understanding and containment were provided in the therapeutic relationship that there can be a huge shift from acting out and use of the body as the main means of communication and expression, to being able to use words, language and play to make sense of the world, communicate and get expressions communicated and understood. The research details the in depth shift from the use of the

body and non-verbal communication to the use of words. As well it illustrated how Andrew was able to use of his mind to make sense of experiences and communicate more successfully.

Finally it showed how unconscious issues became more conscious thus advancing the work of Symington (1981) and Sinason (1992, 2010).

I hope that this research will be a contribution to both the child psychotherapy profession and the wider professional field of global developmental delay, because it shows how much change can take place through the intervention of intensive psychoanalytical psychotherapy when a child has got stuck in their development. This research would be of benefit to many differing professionals in the field, such as teachers working in special-needs schools, parents of children with global developmental delay, medical practitioners (psychiatrists and GPs), social workers, and those working in the fields of disability, trauma and neglect. It can thus add to an original body of knowledge in a particular field and subfields (Rustin 2006). It might be useful as a consultative document to share insights and experiences.

As I stated previously, I was only able to do selected research because of the amount of data I had, and there continues to be a strong need for ongoing research in the field of global developmental delay in order to add further knowledge to the field.

Final Summary

Andrew was stuck in his development prior to the intensive psychoanalytical psychotherapy treatment. There were also concerns from school that he was depressed. He had experienced trauma before and after birth, then experienced a mother who had limited emotional availability for him due to her own difficulties at the time. Andrew had a difficult start to life, and he had a lot of development and catching up to do due to this. The research has provided the necessary evidence and conclusions to illustrate how he did move along the developmental trajectory and catch up with aspects of his development that had either been stuck or not yet achieved.

The research and findings could be used more widely to substantiate and reinforce the argument for intensive psychoanalytical psychotherapy, showing that early intervention can propel development for children who have global developmental delay who are stuck in their development. Although it could be considered a more expensive form of treatment in this climate of measured outcomes, evidence-based practice and brief interventions, an intervention such as this could contribute huge savings in financial resources in the long term in areas such as health, social services and education.

I think it useful at this point to refer back to the literature review, to the research of Emerson and Hatton (2007) and their reference to how the 'prevalence of psychiatric disorders was 36% among children with intellectual disability and 8% among children without. Children with intellectual disabilities accounted for 14% of all British children with a diagnosable psychiatric disorder.' The authors also stressed that a 'cumulative risk of exposure to social disadvantage was associated with increased prevalence' (Emerson & Hatton 2007: 493). The authors suggest that there is a much higher risk for children such as Andrew to develop mental health problems in the future, and I would like to propose that receiving a long-term, early intervention of psychoanalytical psychotherapy might help Andrew not to become one of these statistical figures in the future. It is conclusive that Andrew did move along the developmental trajectory at a faster pace than would have been possible without this intensive intervention. The research illustrated how Andrew became less stuck in his development, and became a livelier and more curious child whose world opened up after the psychotherapy intervention. He was not as flat and two-dimensional as he had been: his light was switched on. The experience of intensive psychoanalytical psychotherapy may have given Andrew enough internal psychic development to continue to develop without the additional support of further therapy for the time being. No one can predict the future, and it is possible Andrew might need more of the developmental and emotional support that psychotherapy offers in the future in order to manage other developmental milestones, such as the shift and transition into adolescence.

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Appendices

Appendix One

Calendar of Andrew's Sessions: Year One

Week 1	1	28.9.09 (m)	Selected Session: 1 (Monday)
	2	29.9.09 (t)	
	3	2.10.09 (f)	
Week 2	4	12.10.09 (m)	
	5	13.10.09 (t)	
	6	16.10.09 (f)	Selected Session: 6 (Friday)
Week 3	7	19.10.09 (m)	
	8	20.10.09 (t)	
	9	23.10.09 (f)	

HALF-TERM HOLIDAY

Week 4		2.11.09 INSET Day	
	10	3.11.09 (t)	
	11	6.11.09 (f)	
Week 5	12	9.11.09 (m)	
	13	10.11.09 (t)	
	14	13.11.09 (f)	
Week 6	15	16.11.09 (m)	
	16	17.11.09 (t)	Selected Session: 16 (Tuesday)
	17	20.11.09 (f)	
Week 7	18	23.11.09 (m)	
	19	24.11.09 (t)	
	20	27.11.09 (f)	
Week 8	21	30.11.09 (m)174	
	22	1.12.09 (t)	
	23	4.12.09 (f)	

Week 9	24	7.12.09 (m)	
	25	8.12.09 (t)	
	26	11.12.09 (f)	

GROUP RELATIONS (ONE-WEEK AND TWO-WEEK SCHOOL CHRISTMAS BREAK)

Week 10	27	4.1.10 (m)	Selected Session: 27 (Monday)
	28	5.1.10 (t)	
	29	8.1.10 (f)	
Week 11	30	11.1.10 (m)	
	31	12.1.10 (t)	
	32	15.1.10 (f)	
Week 12	33	18.1.10 (m)	
	34	19.1.10 (t)	
	35	22.1.10 (f)	
Week 13	36	25.1.10 (m)	
	37	26.1.10 (t)	
	38	29.1.10 (f)	
Week 14	39	1.2.10 (m)	
	40	2.2.10 (t)	
	41	5.2.10 (f)	
Week 15	42	8.2.10 (m)	
	43	9.2.10 (t)	
	44	12.2.10 (f)	Selected Session: 44 (Friday)

FEBRUARY HALF-TERM

Week 16	45	22.2.10 (m)
	46	23.2.10 (t)
	47	26.2.10 (f)
Week 17	48	1.3.10 (m)
	49	2.3.10 (t)

	50	5.3.10 (f)	
Week 18	51	8.3.10 (m)	Selected Session: 51 (Monday)
	52	9.3.10 (t)	
	53	12.3.10 (f)	
Week 19	54	15.3.10 (m)	
	55	16.3.10 (t)	
	56	19.3.10 (f)	
Week 20	57	22.3.10 (m)	
	58	23.3.10 (t)	
	59	26.3.10 (f)	

TWO-WEEK SCHOOL EASTER BREAK

Week 21	60	12.4.10 (m)	
	61	13.4.10 (t)	
	62	16.4.10 (f)	
Week 22	63	19.4.10 (m)	
	64	20.4.10 (t)	
	65	23.4.10 (f)	
Week 23	66	26.4.10 (m)	Selected Session: 66 (Monday)
	67	27.4.10 (t)	
	68	30.4.10 (f)	
Week 24	BANK HOLIDAY (m)		
	69	4.5.10 (t)	
	70	7.5.10 (f)	
Week 25	71	10.5.10 (m)	
	72	11.5.10 (t)	
	73	14.5.10 (f)	
Week 26	74	17.5.10 (m)	Selected Session: 74 (Monday)
	75	18.5.10 (t)	
	76	21.5.10 (f)	

Week 27	77	24.5.10 (m)	
	78	25.5.10 (t)	
	79	28.5.10 (m)	

MAY HALF-TERM BREAK

Week 28	80	7.6.10 (m)	
	81	8.6.10 (t)	
	82	11.6.10 (f)	
Week 29	83	14.6.10 (m)	Selected Session: 83 (Monday)
	84	15.6.10 (t)	
	85	18.6.10 (f)	
Week 30	86	21.6.10 (M)	
	87	22.6.10 (t)	
	88	25.6.10 (f)	
Week 31	89	28.6.10 (m)	
	90	29.6.10 (t)	
	91	2.7.10 (f)	
Week 32	92	5.7.10 (m)	Selected Session: 92 (Monday)
	93	6.7.10 (t)	
	94	9.7.10 (f)	
Week 33	95	12.7.10 (m)	
	96	13.7.10 (t)	
	97	16.7.10 (f)	

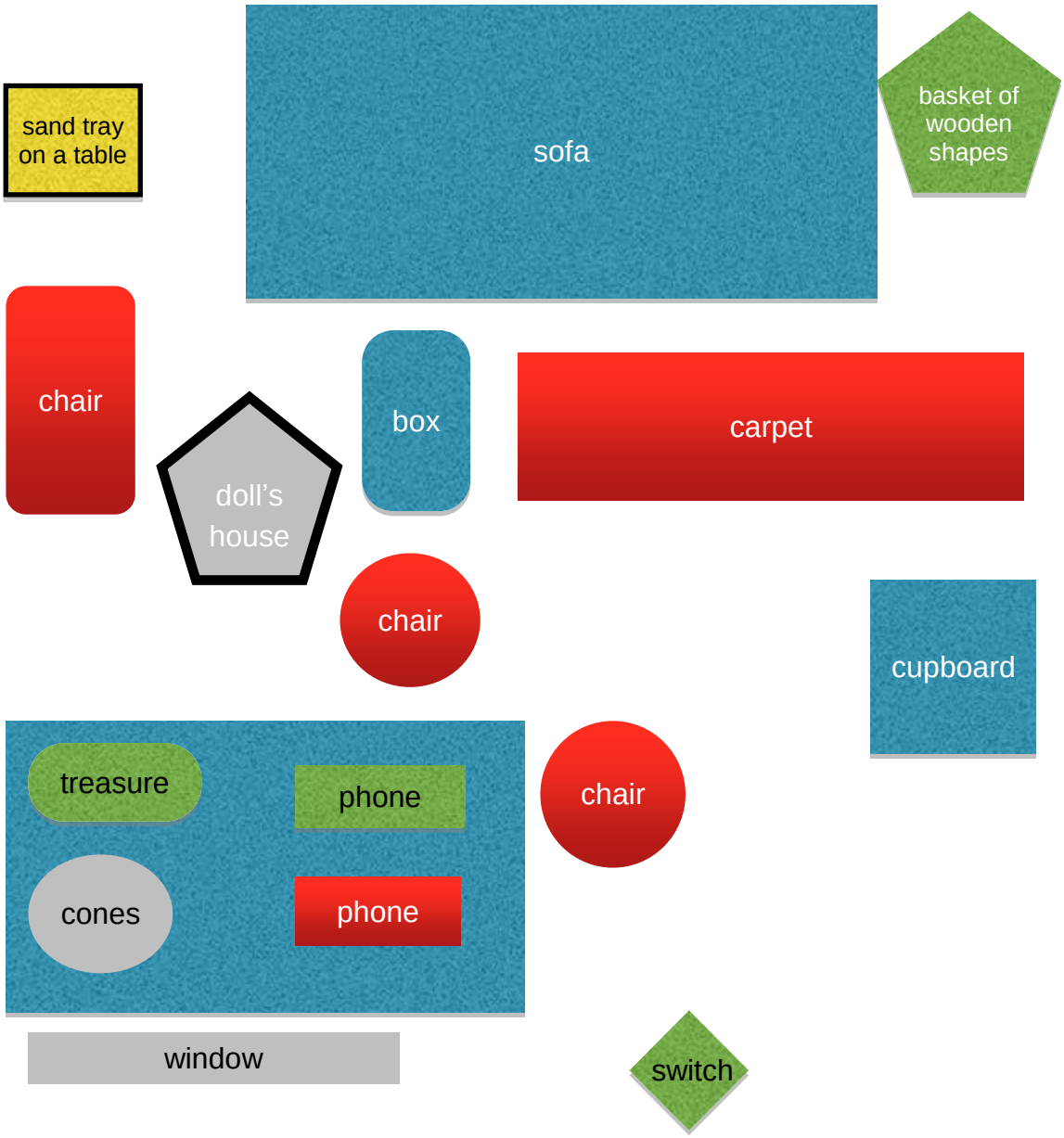
END OF SCHOOL YEAR 2009–2010: SIX-WEEK BREAK FROM THERAPY

Calendar of Selected Sessions: Year Two

12.12.10 (t)
18.1.11 (t)
5.4.11 (th)

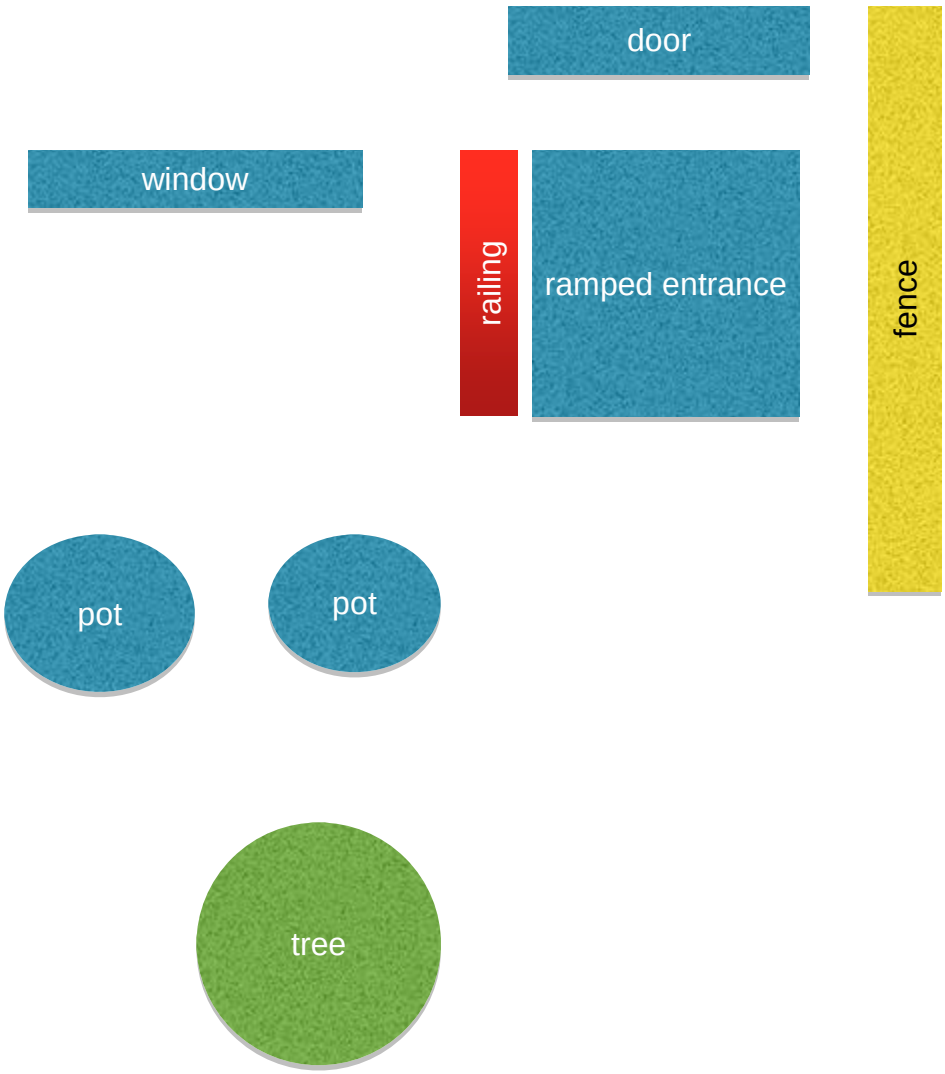
Appendix Two

Inside the Blue Room



Appendix Three

The outer courtyard area



Appendix Four

Letter of Ethical Approval

The Tavistock and Portman NHS
NHS Foundation Trust

Directorate of Education and Training
Tavistock Centre
120 Belsize Lane
London
NW3 5BA

Tel: +44 (0)20 7435 7111
Fax: +44 (0)20 7447 3837
Web: www.tavistockandportman.nhs.uk

Sara Bannerman
70a Coniston Road
Muswell Hill
London
N10 2BN

05 June 2013

Dear Sara

Re: NHS Ethical approval for your M80 doctoral project.

Title: '"Switching a light on" an investigation into the benefit of intensive psychotherapy for a child diagnosed with global developmental delay, born to drug addicted parents. A single case study research project'.

Director of Studies: Barbara Harrison

Thank you for the documents you have submitted. We confirm that your study falls within the agreement we have with the Camden and Islington Local Research Ethics Committee for single case studies. (NHS)

If any significant changes occur in your project which might significantly alter the ethical considerations, we expect you to inform us without delay.

Yours sincerely,

Beth Bradley

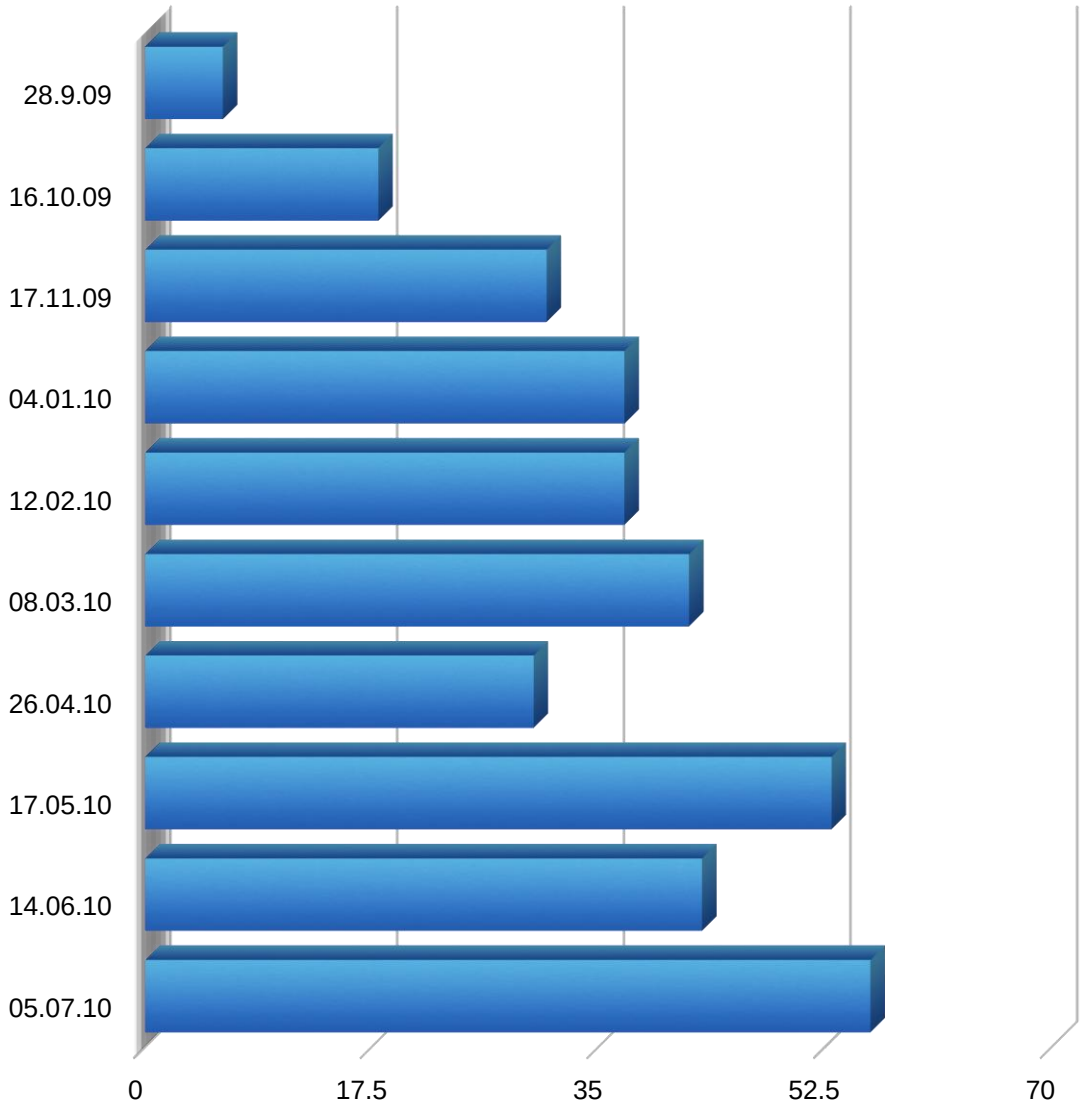
On behalf of M80 Ethics Review Group

cc Director of Studies

12/09 TC126

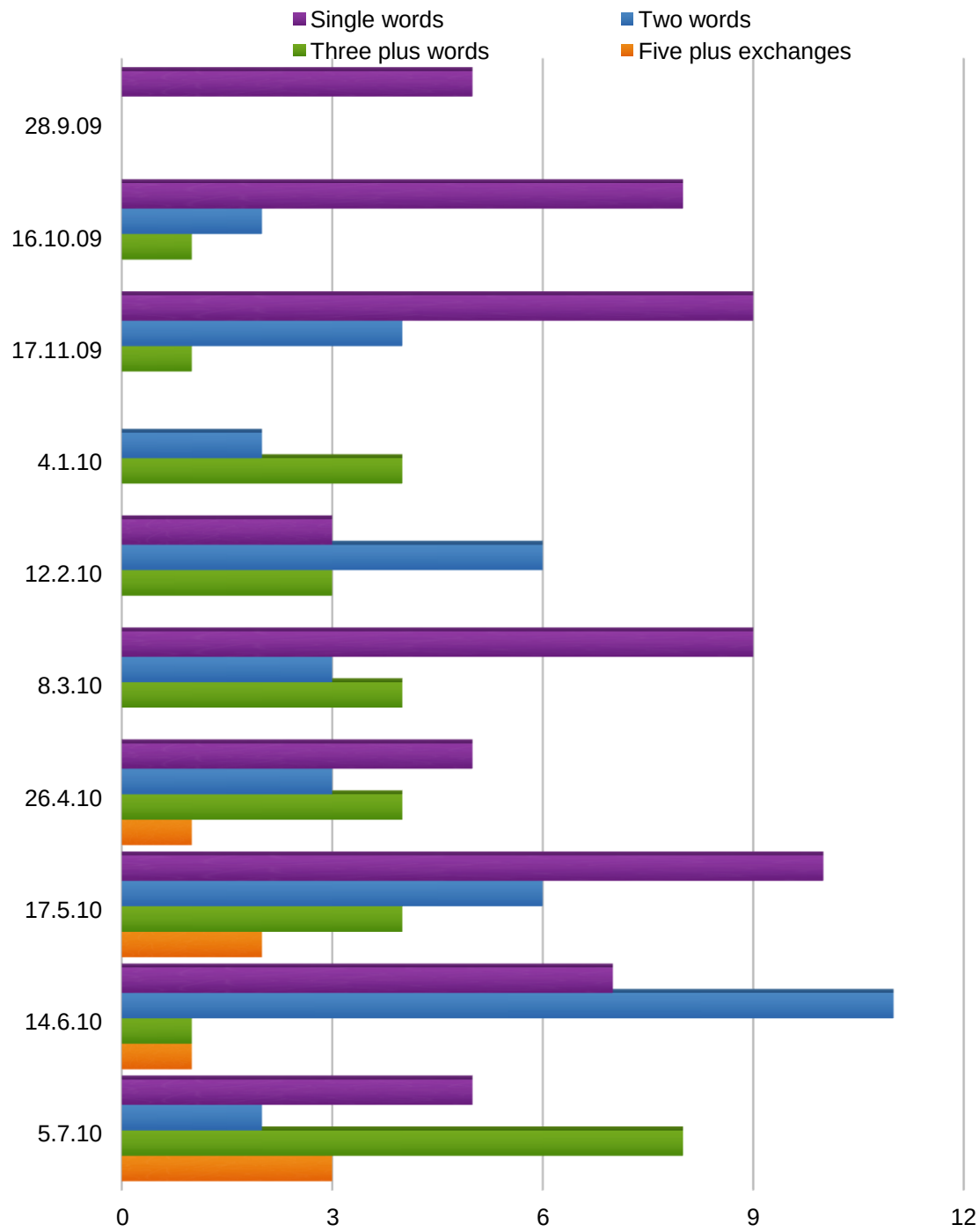
Appendix Five

Language Words: Year One



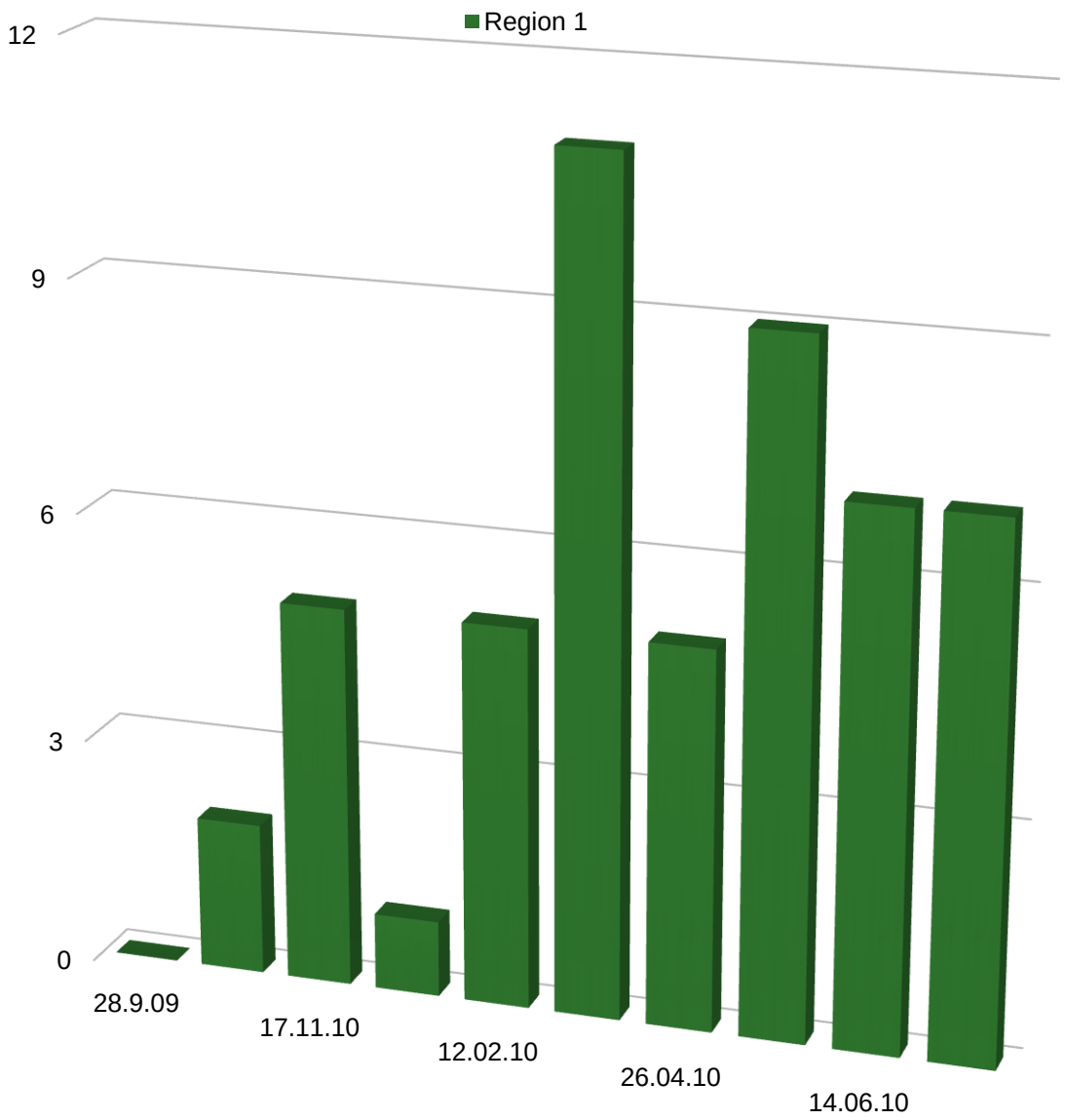
Appendix Six

Development of One-, Two-, Three- and Five-Plus-Word Exchanges: Year One



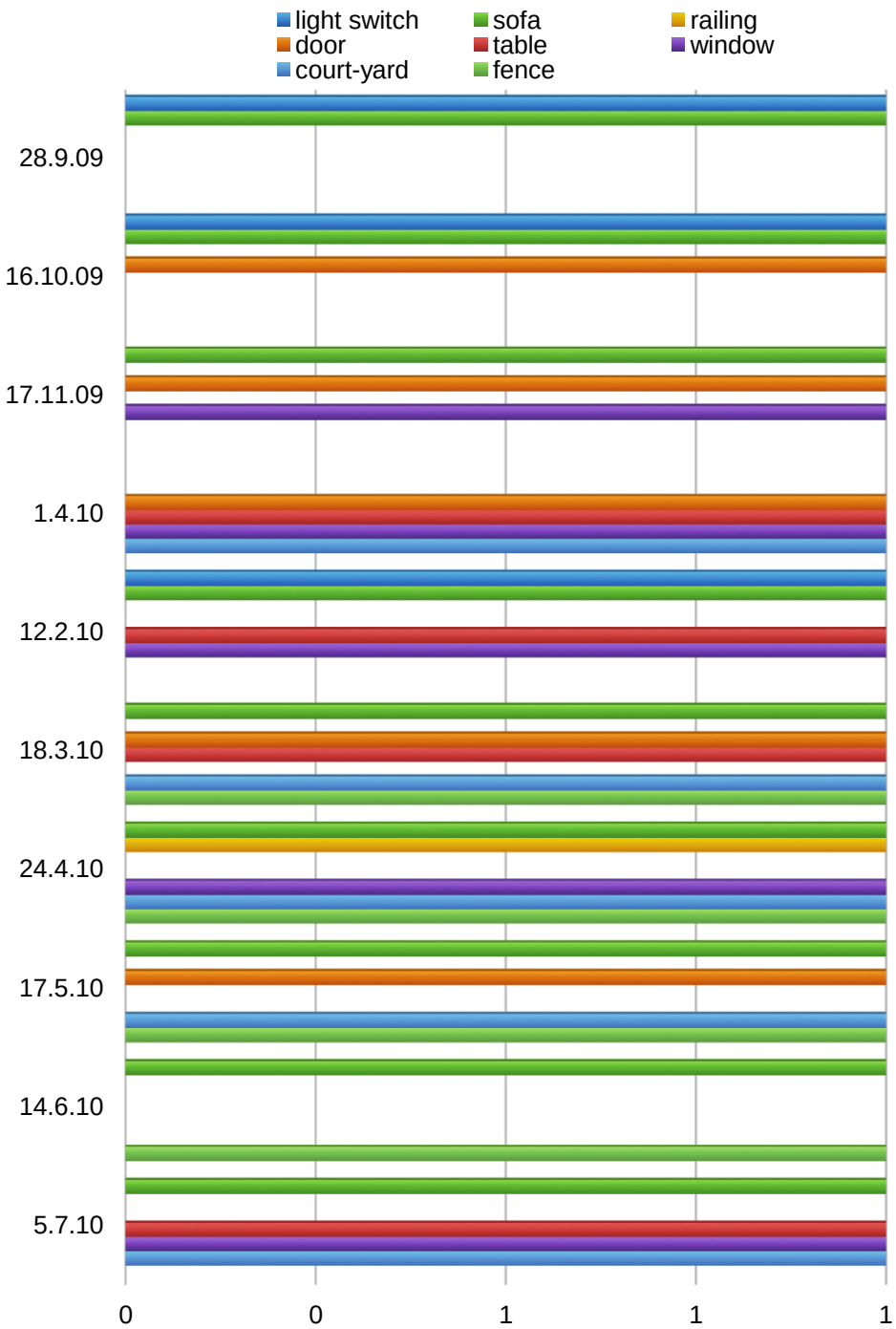
Appendix Seven

Object Words: Year One



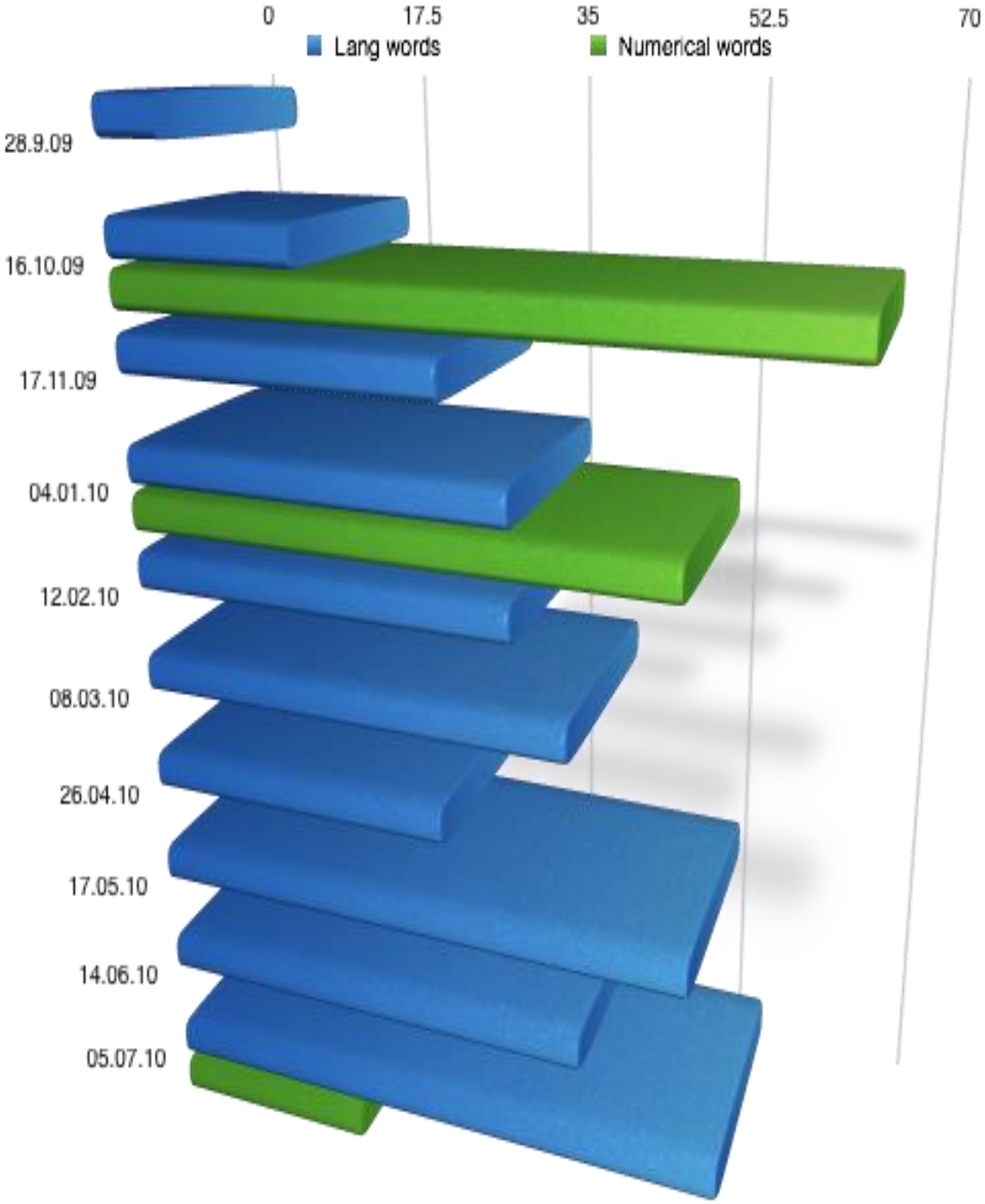
Appendix Eight

Places in which Play Took Place: Year One



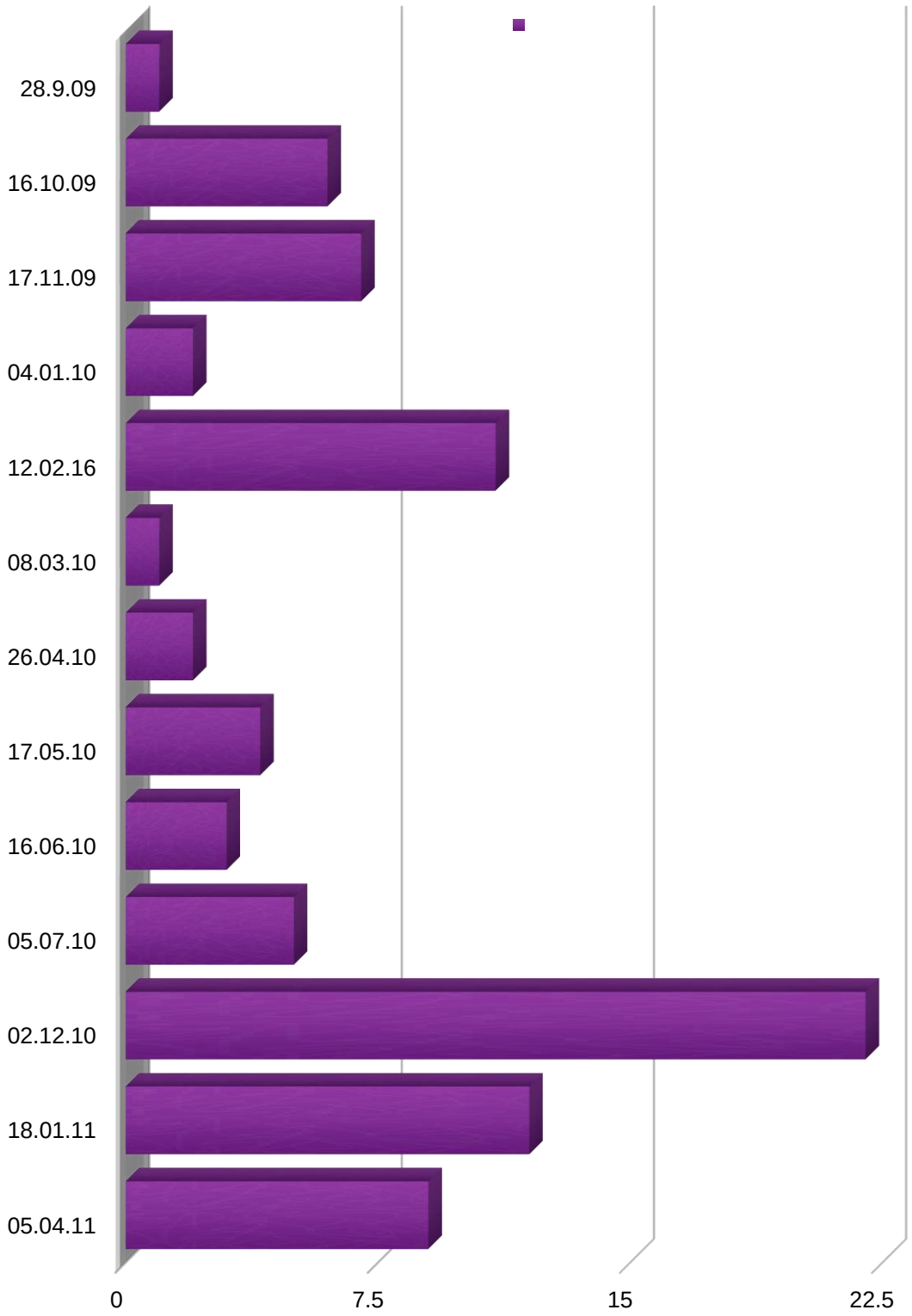
Appendix Nine

Numerical and Language Words



Appendix 10

People Words



Appendix Eleven

Please see attached session overleaf for an example of the initial coding that took place. The following coloured highlighters were used for the categories below:

Yellow – action.
Blue – play.
Pink – sounds and words.
Green – relating
Yellow and pink – emotional tone.

Andrew: Session 1: Monday September 28th 2009

Andrew is six years old and average height. He is fair with a pale complexion and blonde hair, big blue eyes with long dark eyelashes. He is attractive to look at. He was wearing tracksuit bottoms, a t-shirt, a sweatshirt on top and white trainers.

When I went to collect Andrew he was still on his lunch break and was in the toilet area. I had a short wait until he arrived back at his classroom. I went over to Andrew, bent down introducing myself and wondering if he had remembered me from before the summer break. I said my name and explained that he and I would be leaving his class for a short time to begin working together in a different room. Andrew made eye contact with me as I spoke to him, but I was unsure how much of what I had said had been taken in. I also felt something awkward in myself about me arriving in his school world and whisking him away from his classroom. However I was struck by how readily he took my hand and willingly came with me. I wondered if something in him was too eager and willing.

We had a longish walk to the blue room, involving doors, different corridors and many other classrooms on the way. As we walked together Andrew was looking at some of the pictures and murals on the walls as we went by, seeming easily distracted by them. I spoke to Andrew as we were walking, naming where were going and naming what he was doing along the way. I thought it was a long journey and that I needed to bridge the gap by keeping contact. I also felt that I was back in a familiar place, in a special school environment, with a child who had extremely limited speech.

As we went through the outside door into the yard area Andrew appeared delighted and was looking at the crab apples on the floor. I opened the door to the blue room and Andrew was quick to run inside. He seemed very excited, perhaps a bit manic, jumping, slapping his torso in an 'autistic' like way. He saw the sofa and went across the room and sat on it. I sat too but on a red chair to the

side of him and said 'hello Andrew' then spoke a few more words about he and I meeting together, which days we would meet and how this was our first day together. I did not think he was listening. He then moved to the table and chair where there was a toy telephone. He was excited as he picked up the telephone and placed it to his ear. I commented on what he was doing and said 'hello Andrew'. Andrew made some eye contact with me as I spoke. I noticed his gaze move to the box I had brought in for him. I introduced Andrew to it. Andrew had a quick look and rummage around, saw another toy phone, which was yellow. He picked it up, looked at it, and then bashed the phone part aggressively against the base of the phone. The tone of his action seemed overcharged and manic as he did this. He then put it down. There were two phones, one red and one yellow phone. Andrew went back to the table and we had some moments,which felt like intense interaction, in which Andrew would put his phone to his ear and look at me. I would say 'hello Andrew, Andrew is on the phone to Sara'. He would put his phone down. I then said 'bye Andrew'. This interaction/game got repeated many times. At times in these interactions he would stop and drift off, taking the receiver from his ear, placing it over his mouth, then would suck the cord. I felt out of it, cut off, wondering if I existed in the room with him in these moments. Andrew suddenly left the phone and ran and sat in the centre of the sofa, stopped still and just stared into space vacantly. This lasted for some seconds before he ran back to the phone and began another interaction with me.

Andrew left the table and ran towards the cot at the side of the room, which had a baby in it. He stopped, looked at the baby and ran back to the phone area. He did not pick up the phone but stood still and looked out of the window. I observed Andrew and tried to accompany what he was doing with a verbal commentary. I commented on how he was noticing what was in the room and was interested in going to have a look. As I said this he stopped being so excited and was looking out of the window. He looked at the sand tray then sprinkled sand through his fingers, and lifted the sand tray lid off, which was a large item for him. It dropped on the floor. Andrew ran back to the cot but this time picked the baby up saying in a high-pitched tone 'baby', and then placed it back in the cot bed. He stopped, noticing a game on the cupboard next to the cot. In a

quieter, stiller, less manic way he took each ring off the stick one by one placing the rings on top of the cupboard. He placed them one by one, in the wrong order in what appeared a random way. He then placed each on back on the stick. As he did this he named the colour of each one e.g. red, green, blue, yellow and so on. This surprised me, this slower, more focussed, speaking Andrew. I found myself staying in one place in the room and wondered why. I think it was a reaction to his moving and comings and goings. I felt I needed to be in one place and rooted.

Andrew then discovered the light switch and began switching the lights in the room on and off. I found myself naming what he was doing and commenting on the new things he was finding as well as him being in the room with this new lady. After some time I began to feel irritated by the lights going on and off and wondered about his autistic like rituals, such as the looking out of the window, the body slapping and the obsession with the light switch. It felt a familiar place for me. I was uncertain about whether to continue observing or to set a boundary. Andrew then stopped and became equally interested in the door, realising the door opened and closed. Andrew spent some time opening and closing the door, going half out and coming back in. I named what he was doing. Something in the action felt safe as if he was not going too far away and I wondered if the action had a bit of a hello and goodbye quality to it, or a peek a boo quality. As if a bit like the phone game? He did make eye contact with me in this game as if there was a slight connection. I wondered as well about boundaries, was he testing how far he could go from the door. I got up a few times as he went out of sight and he came running back. There was a playful feel to this interaction.

Andrew went back to the lights this time getting a chair to stand on so he could reach more easily. He switched the light switch on and off, on and off... Eventually I suggested he could choose, lights on or lights off? He said 'off' and left the lights off for a moment, before coming back and starting the whole routing again, with great persistency. I was not sure in this first session about how far to go with boundary setting.

He then returned to the door game and began to run further away towards the outer door. Each time he did this I felt tense that he would suddenly disappear through the outer door. But he came back. I also wondered if he was communicating that he had had enough for our first session as we had been working for thirty-five minutes, longer than I thought he might manage for our first meeting. He would run out of the door, run back and sit on the sofa. The sofa took on a base like role. He said on one occasion 'mummy, daddy, mummy, daddy, mummy, daddy nice'. I was unsure of what to make of his words. He was talking about mummy and daddy, so I referred to how he might be thinking of mummy and daddy in the room with Sara.

There were moments in which he did look at me and engage opposed to the fast manic like interactions such as stepping his feet, some masturbatory type light touching and rubbing of his penis area and body bashing.

He ran to the outside door and went to open it. I suggested that he might be telling me he had enough for today, but I suggested he and I go back to the blue room for a few more minutes. Andrew willingly came back in and we sat on the sofa. I referred to how I thought we had done enough work for today so would say goodbye and go back to class in a moment and that I would come back tomorrow afternoon for some more work with him in the blue room.