Anxieties and dilemmas relating to breaks in the therapeutic relationship with children whose relationships in early infancy were reported to have been emotionally unstable and traumatised

A SYSTEMATIC STUDY OF CHILD PSYCHOTHERAPY WITH A YOUNG CHILD WHO HAD SUFFERED EARLY ABUSE AND NEGLECT

BY

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“A desert can be so desolate
That no one believes it exists
The dead can be so dead
That no one can see they exist”

“1. They go out into a desert and meet energy
2. Time measurable on the whole only in terms of life
3. For instance the word desolation is in itself a denial of itself”

“En ørken kan være så øde
At ingen vil tro den er til
De døde kan være så døde
At ingen kan se de er til”

”1. De går ud i en ørken og møder energien
2. Tid der i det store og hele kun kan måles i liv
3. F.eks. er ordet øde i sig selv en dementi af sig selv”

Inger Christensen (1969): *Det. Handlingen: Symmetrier 1 and Konnexiteter 1. It. The Action: Symmetries 1 and Connectivities 1*. Translated by Susanna Nied (2005).

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My gratitude is especially due to Samantha who taught me so much about the need to go gently, not rushing into painful places of abandonment and despair. I am also thankful to her foster parents and birthmother who generously allowed this study, even contributing with essential information about the course of events before and after therapy.

At the forefront are many other troubled children, birth and foster parents whom I met over the course of many years of working as a child psychotherapist and clinical psychologist. Through these often deeply moving encounters, doing my best to tip the balance between pain and hopefulness, an imperative wish grew inside me to know more about central themes in therapy and the experience of breaks together with the courage to share what I learned with other child psychotherapists.

I am immensely grateful to Margaret Rustin who throughout the often strenuous routes of this project patiently kept up hope by invaluable advice, encouragement and supervision of the research process; reading draft upon draft, in moments of despairing incomprehension suggesting new perspectives; encouraging me to step back and approach the material from new perspectives. My heartfelt thanks also to my second research supervisor Dr. Nicholas Midgley, who encouraged my integration of qualitative methodology and critically and constructively reviewed my use of this, giving invaluable advice about how to avoid wrong turns and pitfalls. A special thanks to Professor Michael Rustin who initially encouraged and supported this project, decisive for my courage actually to get on with it.

A precondition for this work is and was the ongoing group of supervisors and teachers at the child and adolescent psychotherapy training under the aegis of the Danish association of Psychoanalytic Child and Adolescent Psychotherapy. Founded in 1995, the group has met eight times a year with supervisors linked to the Tavistock, Ms. Naomi Shavit and Dr. Catalina Bronstein the continuing figures. Immensely important to me as a psychoanalytic child psychotherapist; but also contributing greatly to the development in Denmark of a systematic training of psychoanalytic child psychotherapists.

Throughout my years of working with child psychotherapy, I have had a close and always stimulating cooperation with Honorary Professor, Dr. Karen Vibeke Mortensen, Aalborg University Denmark. Thanks also to Associate Professor, Dr. Judy Gammelgaard, University of Copenhagen, whose feedback on an earlier project of mine helped me appreciate the complex and trying nature of the empirical foundation of a psychoanalytic case study.

Finally, I am deeply grateful to Ole, trusting me to carry through to completion this project; keeping up patience during those several years in which I was more or less constantly preoccupied. I am happy to say that even if submission of this piece of research at times seemed to fade into the far distance; nevertheless en route to closure, I learned ever so much.

ABSTRACT

The present study is a psychoanalytic single case study; the intended aims of which were: a) to perform a systematic exploration of core features of the therapeutic relationship with children who have suffered early abuse and neglect; b) to investigate possible links between such core features and breaks; and c) to contribute to the development of a transparent and systematic methodology for the psychoanalytic case study by application of rigorous qualitative research methodology.

The clinical research data was case-file material from a concluded child psychotherapy case as well as transcripts from interviews with the six years old child's birth and foster parents, conducted 2 ¾ years after the end of therapy. The case material was analyzed in three different steps; at each step principles for transparent data selection and analytic strategies developed:

1) Inductive analysis highlighting four relational themes as central in the first 24 therapy sessions.
2) Deduction of empirical consequences from the central themes as distilled by the inductive analysis; the resulting predefined themes subsequently studied in notes from 4 consecutive Christmas break-sets, each consisting of 2 before-break sessions, 2 after-break sessions, and 2 no-break sessions. Christmas breaks chosen as the potentially most agonizing break of the year, especially for children in care.
3) Finally, the same predefined themes were studied with regard to how they appeared in reports from the child's various caregivers from infancy through her day-to-day life during and after therapy.

The inductive part of the study identified four relational themes characterizing the interaction and dialogue between therapist and child. A subsequent deductive analysis convincingly showed breaks a convenient way to highlight core features of the therapeutic process; suggesting the child's reactions to breaks to be a good indicator of change. Conspicuous links between breaks and the eruption of hostile parental and sibling figures in the mind seemed especially pertinent as well as characteristic difficulties of symbol formation in before-break sessions.

The completed data analysis strongly corroborated Hinshelwood's assumption that the relational themes found to be central in the therapeutic relationship would also permeate the child's past and current relationships (1991a).

With regard to the research method, the detailed results concerning breaks and the similarity of relational themes inside and outside therapy seem to confirm the value of systematic integration into the psychoanalytic single case study of inductive-deductive analytic principles from the qualitative research methodology of Interpretative Phenomenological Analysis. This combination of methods led to unexpectedly rich insights; it may be of special importance in the development of psychoanalytic and psychotherapeutic theory through single case studies.

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1 INTRODUCTION

My journey towards this psychoanalytic casestudy of core object relationsships and breaks by the systematic application of qualitative methodology was long, sometimes amusing and interesting, sometimes tedious and depressing; en route changing direction as initially my preoccupation rather was focused on dilemmas related to closeness-distance. Thus in more than 30 years of practice as a child and adolescent psychotherapist and clinical psychologist, I have pondered, at times despaired over a problem frequently encountered in the psychotherapy with a number of children who suffered early abuse and neglect, namely recurrent dilemmas concerning closeness-distance. Over the years, I have come to think that problems of how to find the right mental, emotional, temporal and geographical position in the play-room are part and parcel of the therapy of these children; any position at times either too close and thus invasive or too far away and thus neglectful, leaving the child to its own devices.

No matter what I thought I was going to look for, while perusing the recorded session notes from four completed child psychotherapies, I kept coming back to questions related to core themes and the impact of breaks. At the time I was not fully aware that to these children, who early in their lives had suffered abuse and neglect, breaks stirring up fundamental anxiety brought up intense distance-closeness issues; acute confusion, despair, rage and cold rejection surfacing in evocative ways, difficult to contain and render meaningful. In accordance with this impression, as described below breaks are often mentioned in child psychotherapy case studies concerning children who suffered early neglect and abuse; however very few systematic studies have been carried out. While pondering this, two important things happened to give me a push

eventually to make a decision. One important impetus was Nick Midgley without undue compassion pointing out to me that sometimes, if an investigation repeatedly goes in another direction than planned for, then it is because this direction is the right direction to go forward in. Another encouragement came from the joint Erica and EFPP research seminar in October 2008[1]. Encouraged by the dialogue with other researchers interested in the study of psychoanalytic psychotherapy with children and adolescents, I found myself telling Michael Rustin of this burdensome, self inflicted project of mine that apparently could not find a suitable direction to go; receiving not only immensely valuable suggestions about methodology and the possible links between breaks and distance-closeness dilemmas, Michael Rustin also suggested that this research might be relevant to the Tavistock's and the University of East London's postgraduate PhD-programme.

1.1. Aims of the study[2]

The present study is a qualitative, psychoanalytic single case study, the intended aims of which were threefold[3]:

1) To contribute to a detailed and empirically supported understanding of the core features of the therapeutic relationship with children who have suffered early abuse and neglect[4]

[1] A report from this seminar may be found at www.efpp.org.
[2] The specific research questions appear in section 3 Methodology (pp. 72).
[3] The terms applied below: The term *psychoanalytic child psychotherapy* refers to *psychoanalytic* and *psychodynamic child psychotherapy* as well as *child analysis.* The term *case study* refers to an empirical enquiry investigating a single example of a contemporary phenomenon within its real-life context.

2) To contribute to a detailed and empirically supported understanding of possible links between core features and breaks[5] in child psychotherapy with these children.
3) To contribute to the development of a systematic and transparent methodology for the psychoanalytic single case study by the application of rigorous qualitative research methodology.

I hope through this study to learn more about the minds and behaviour of children who have suffered gross early trauma and neglect; hopefully thereby also contributing to the development of clinical practice in relation to this group of children. Psychoanalytic child psychotherapy is a relational endeavor, among my intentions with this study is the wish to contribute to a better understanding of the dynamic interplay between the child's and the therapist´s ways of struggling with central object related anxieties as stirred up and amplified by breaks. Thereby enabling me and other child psychotherapists working in similar ways with similar children to improve our way of working. In relation to children, the psychodynamic meanings of core object relationship themes have been sparsely explored before, and even more sparse seems empirically grounded studies of the relationship between core themes and breaks. Thus hopefully this study may contribute with new knowledge in these areas.

[4] *Early abuse and neglect:* abuse and neglect (as defined in section 2.2.) occurring between 0-3 years of age.
[5] *Breaks*: Refer to any time-limited interruption of the scheduled structuring of the therapy sessions, whether planned or unexpected; no matter who decided the break; for whatever reason; and no matter the length of interruption provided that therapy started again at some later point.

1.2. Research setting

The study is a psychoanalytic single case study and concerns a concluded child psychotherapy, of which the researcher was herself the therapist.

The clinical case concerned a five year old girl, who had been taken into forced custody at the age of 1½ years because of abuse and neglect. She was referred for therapy by local Danish state authorities, who paid for the therapy, which was carried out in the therapist's private child psychotherapy consulting room to which the child was brought by her foster parents. The child was seen twice weekly for 51 months. The therapy was carried out in accordance with normal practice for psychoanalytic child psychotherapy in the public sector of Denmark, e.g. the overall treatment plan comprised half yearly network meetings to reassess the child's development and the ending of psychotherapy was decided by case authorities, following the recommendation of the therapist and the network.

Normal governance procedures with respect to confidentiality were followed throughout. Informed consent of the child's birth and foster parents was obtained 2¾ years after the end of therapy at visits to their homes, where the project was presented orally and in a printed version given to the parents for keeping[6].

The research was carried out as part of a PhD-programme in Child Psychoanalytic Psychotherapy at The University of East London. The project was supervised by Ms. Margaret Rustin, Consultant Child Psychotherapist, Tutor of

[6] The signed consent forms (in Danish) and my translation of these from Danish into English appear in Appendix, item IV.1. According to Danish law, in general, the birth parents of children taken into care keep legal custody of their child; this is so also for children in permanent foster care (see footnote below). This is why; consent forms were signed by both birth mother and foster parents.

the Clinical Doctorate in Child Psychotherapy, Tavistock & Portman NHS Foundation Trust; and Dr. Nick Midgley, Programme Director of Msc in Developmental Psychology and Clinical Practice, Child and Adolescent Psychotherapist in Family Support Services, The Anna Freud Centre.

The clinical research data are presented in detail below. They include already obtained patient data as well as data from follow-up interviews carried out 2 ¾ years after the ending. All data were anonymized.

1.3. Outline of this dissertation

The dissertation is structured into *six chapters*. *Chapter two* situates the research questions, reviewing these in a contemporary theoretical context. The literature reviewed concerns principles and outcome studies of psychoanalytic child psychotherapy; the challenge met with in psychotherapy with children who suffered early abuse and neglect; and literature related to breaks and central relationship themes in child psychotherapy[7].

Chapter three outlines applied research methodology; starting out with a case description and reflections on the consequences of the researcher's double role as researcher and therapist of the same case. Methods of data collection, selection, development of analytic instruments, and data-analysis are described.

Chapter four presents the findings, i.e. the relational themes found to be especially poignant in this therapy. Complex links between on the one hand central relationship themes in the therapeutic process and on the other hand

[7] *Relationship:* refers to the complex, repeated emotional, cognitive and sensory-motor web of interactions between children and their caregivers, constituting the unconscious object relations in the mind of the child.

breaks, beginnings, and endings were found, especially poignant as regards hostile parental and sibling figures erupting in the mind of the child. Furthermore, a striking similarity was found between relational themes inside therapy and as described by the child's caregivers from infancy to well into the therapy. Progress reported at the end of therapy seemed still to continue 2½ years later. The importance of sibling figures to this child was a quite unexpected find; therefore not included in the theory reviews. The nature of sibling relationships has aroused lively discussions in the psychoanalytic community in recent years and took me back to work I did before (Grünbaum 2011); the relevant theory is briefly reviewed in relation to the discussion of findings.

Chapters five and six recap and discuss the main findings in dual perspective of the original research questions and related theory. Chapter five relates to the clinical case, while chapter six evaluates the research design and applied scientific methodology and suggests recommendations for further studies of the link between central relationship themes and breaks.

A few words about *the appendix*. The main function of an appendix is to present information clarifying a point appearing in the study report but in itself non-essential to the understading of the report. Most appendices, thus also the appendix of the present study, contain documentation relating to ethics and consent as well as explanations of certain specific procedures for sampling, selection, and processing of data. However, in a qualitative study the appendix must also include a convincing amount of raw data on which the interpretations (i.e. findings) presented in the report are grounded e.g. extracts of recorded notes from therapy sessions with examples of coding; full interview transscripts; and lists documenting the transformation of initial coding into keywords and concepts.

This added burden of documentation in qualitative research means that appendices become quite lengthy, also this one.

2 THEORY REVIEWS

In this chapter research questions are positioned in a broader professional and theoretical context; starting with a personal perspective on psychoanalytic child psychotherapy; also specifying the setting and principles followed. Reviews include a summary of outcome studies of psychoanalytic child psychotherapy; definitions and developmental consequences of early relational neglect and abuse; and challenges inherent in psychoanalytic child psychotherapy with this group of children. At the end of the chapter case studies concerning breaks in child psychotherapy are reviewed; concluding the chapter with some thoughts about possible links between breaks and unconscious core object relationship themes[8].

2.1. Psychoanalytic child psychotherapy – Principles and outcome

This section outlines the principles, practice and outcomes of psychoanalytic child and adolescent psychotherapy.

2.1.1. A personal definition

Years ago, Wallerstein (1990) in differentiating psychoanalytic treatment methods from other therapeutic methods, ascribed as fundamental their specific focus on

[8] *Core object relationship themes*: A uniquely subjective core of unconscious object-relationships, assumed to permeate and be unconsciously repeated in a person's personal relationships (whether present or past; inside or outside therapy).

the interaction between therapist and patient; this interaction giving rise to a transference-countertransference relationship, in which central parts of the patient's unconscious world are actualised in the here-and-now of the session as feelings, phantasies and behavioural tendencies towards the therapist.

In agreement with this, I think of the therapeutic action of psychoanalytic child psychotherapy as primarily at work through the communication taking place inside the transference relationship, including verbal and not-verbal, symbolic and concrete, conscious and not-conscious modes of communication. Hence, the evolving relationship between therapist and child is considered the central vehicle of change, largely analogous to the therapeutic process. The following personal *definition of child psychotherapy* was inspired by Donald Meltzer (1967a, 1975c, 1976)[9]:

Psychoanalytic psychotherapy with children and young people is a specific dialogue between therapist and child, set in motion as a consequence of

a) *The therapist's creation of a specific therapeutic setting i.e. a certain predefined, bounded and containing geographical, temporal and mental milieu or space inside which a transference relationship may emerge and become embedded;*
b) *Therapeutic interventions by which the therapist on the basis of her observations of the child and her own feelings and mental states in certain moments communicates to the child an understanding of the subjective, emotional meaning of his/her play, verbal statements, or actions. The therapist focuses her attention on the therapeutic relationship, thereby*

[9] The above definition is an elaboration of an earlier attempt (Grünbaum 1999/00).

facilitating a transformation of this into a transference-counter transference-relationship[10].

In the framework of this definition, the therapist pays minute attention, closely observing the child's movements in the setting, whether verbal or nonverbal, minute or gross, noisy or silent conceiving of these as meaningful statements about the present state of the child's inner world, wishes/fears, feelings, phantasies and thoughts as related to the experience of the transference-countertransference relationship.

A personal perspective on therapeutic interventions

The therapeutic interventions are *whatever the therapist says or does in order to transmit to the child her understanding of, what takes place in the inner world of the child and in the therapeutic relationship*. As mentioned, psychoanalytic psychotherapy is a relational endeavour, the listening ear and mind of the therapist keeps a dual focus with respect to attention, outwards as she observes the emotional state and communication of the child, and inwards as she observes her own counter- transference sensations, images, feelings, and fantasies; keeping an open mind to whatever pops up. In her own private mind, the therapist reflects on her countertransference and its relationship to the communication of the child, consulting the inner reflective stream of her own consciousness before and after intervening.

[10] *A transference-countertransference relationship* is understood as a subjective link between the inner worlds of the child and the therapist, emerging as the child in the process of therapy unconsciously transfers to the therapist his/her relational expectations, subjectively coloured and internalised during the early relationships.

Probably most therapeutic interventions in child and adolescent psychotherapy concern *interpretation and clarification of transference related feelings, intentions, hopes, anxieties, fantasies and defensive manoeuvres*. Quite a number of interventions intend to *protect and maintain the setting*, most often *verbal*, sometimes as a *contribution to the play* of the child; a few times in hurried *action to put a stop to dangerous behaviour*, threatening to jeopardise the safety of child or therapist. Especially when working with severely troubled, sometimes desperately violent children, therapists must at all times remember that they and the children are not partners in play, but each are assigned a specific role in an asymmetric relationship, as formulated by Meltzer long ago, the therapist must remain in authoritative charge as the director of the setting, although not of the content and process (Meltzer 1967a).

Once in a while, from her ongoing countertransference process the therapist may stumble on a flash of sudden emotional-cognitive insight, akin to a "*Eureka – I found it*" experience; the mind of the therapist in a flash linking together hitherto discrete countertransference-transference observations and feelings, which separately seem quite interesting but first are understood as convincing and decisive, when suddenly experienced as fitting together in *a meaningful narrative pattern of object related phantasy*[11] (Bion 1962b, 1963; Damasio 1994; P. C. Sandler 2005). These moments may become true turning points, highlights creating immediate change; however they often seem to follow some sort of crisis in the transference relationship and in general presuppose the more humble

[11] *Phantasy*: An unconscious, basic mental activity; the primary content of the unconscious parts of the mind about relationships between the self or parts of the self and objects or parts of objects. The development of unconscious phantasy of object relationships assumed essential for mental growth; communicated in the child's play, thinking and behaviour (Spillius 2001).

background of lengthy stretches of ordinary therapeutic work[12] (Carlberg 2009, 1997).

The therapeutic setting

The firm entrenchment of the relationship inside clearly demarcated mental and corporeal boundaries is a precondition for the development of a transference relationship and a therapeutic process able to engender change. This setting or space in general is understood as comprised by several dimensions, all necessary continuously to protect and maintain (Meltzer 1967a; Lanyado et al 2009b):

1) The *therapist's listening attitude*, as rooted in her personal integration of *psychoanalytic thinking*.
2) The *geographical space and its physical objects* e.g. the therapy room, its equipment, and the personal toy box of the child.
3) An appointed *structuring of time*, creating a regular, predictable rhythm and duration of sessions.
4) Certain basic *methodological principles* for the therapist's conduct such as facilitating play understood as communication; maintaining her own ability to function as a therapist; guarding the setting; and seeing to it that nobody comes to bodily harm[13]; doing her best at all times to keep up an attitude of reverie and containment; interpretation of the continual stream of transference in the communication of the child.

[12] Examples appear e.g. in sessions 11(RE2) and 178 (RE3-4).
[13] For reasons which will appear self-explanatory, no such principle may be stated to avoid mental pain.

The four dimensions constitute what I shall call *the immediate setting.* However, children are not self-sustaining beings, but always in legal and psychosocial custody of adult parental figures[14]. Psychoanalytic psychotherapy of children is as stated primarily concerned with the inner world of the child, however according to experience as a ground rule the outcome also depends on due attention being paid to the basic conditions of everyday life and especially to the child's current relationships. The immediate setting forms a necessary but certainly not sufficient condition to sustain an ongoing therapeutic process through rough spots e.g. due to cut-backs in the community or a child's severe enactment at home or in school. An updated, contemporary model of *the setting needs to include a fifth dimension*:

5) *Parallel work with the parents* and usually also *the multidisciplinary network* of the child and the family to create a collaborative effort of carrying the responsibility for a viable overall treatment plan.

Although always an important part of the longstanding tradition of child psychotherapy, *parallel work with parents* has remained sparsely researched, but the few more systematic studies available point in the same direction as clinical wisdom, namely that work with the parents may be crucial to the outcome of treatment, especially important to younger children and severely disturbed children and adolescents (Szcapocznic et al 1989, Fonagy et al 1994; Tsiantis et al 2000; Margaret Rustin 2009).

Furthermore, today most families referred for child and adolescent psychotherapy are in regular contact with social, educational, and/or public health

[14] *Parents*: Throughout this work, the term "parents" may refer to birth parents, adoptive parents, foster parents, or other adult figures responsible for the daily care of the child.

service institutions, sometimes simultaneously dependent on quite a few of them, especially so if burdened by hardship, emotional or socio-economical deprivation, trauma, mental illness, and/or severely troubled children and adolescents. Therefore equally important to sustain the therapy and improve daily relationships may be *a multidisciplinary teamwork effort* including the parents, other caregiving figures, and key figures from the professional network in a collaborative, ongoing reflection on the overall plan of treatment of the child (Grünbaum 1998, Emanuel 2002, Kenrick 2005, Trowell et al 2007, Crockatt 2009).

Ways of working with parents and network have many variations related to the specific needs in the single case e.g. age and disturbance of the child; assent of the parents, psychosocial risk inherent in the case; if the child lives in a family or at a residential institution etc. Especially important to children in care are the conjoint effort of keeping together the often fragmented pieces of their personal life history; containing disagreements and conflicts related to projective identification and splitting; and in general providing a forum in which the aims of collaborative treatment efforts may be continually reworked, sustained and evaluated. Even to children living with their birth parents, especially if very young or severely disturbed, it may be important to arrange regular meetings between parents and teachers from daycare and schools in order to evaluate progress/backslide; create clarity concerning professional roles and tasks, reconciling different points of view. In the case of young people it may be recommended that he or she are offered as according to their own wish the opportunity for participation in such meetings, however as always it is important to take into consideration the unique individuality of the case.

2.1.2. One known method or unpredictable variations?

It may be questioned, if psychoanalytic child psychotherapy in general can be described as a uniform method, prescribing certain predictable conditions of context, setting and behaviours on the part of the therapist. Thus from its very start in the early 20th century, therapeutic setting and methods has been intensely, sometimes fiercely, debated (Klein 1926, 1927a, 1955a; A. Freud 1927, 1936, 1966). As well-known, the divergences eventually gave rise to the controversial discussions, a series of formal meetings of the British Psychoanalytic Society in the years October 1942-February 1944, eventually concluding on an agreement of coexistence, the debate for the time being indissoluble. The debate gave rise to painful conflicts but also brought fruitful theoretical developments, e.g. evidenced by a widely recognised appreciation of object-related thinking across the different traditions (Geissmann et al 1992, Likierman et al 1991).

The controversial discussions centered on fundamental concepts of psychoanalytic theory too far off my topic; however implicitly coming down to very practical questions, the essence of which still may befuddle any contemporary psychoanalytic child psychotherapist (Sandler et al 1980; King & Steiner 1991; Edgcumbe 2000):

- The role of symbolic play in the session – and what to do with children unable to play
- The nature of the therapeutic alliance in child psychotherapy
- The nature and fate of the transference relationship in child psychotherapy

- The balance between verbal interpretation of unconscious feelings and conflicts versus supportive or clarifying comments, addressing the child's external reality
- The balance between interpretation and/or enforcement of the setting
- The balance between interpretation of the child's negative and positive transference feelings
- How to include the child's primary caregivers and external network in the treatment, engendering a process of support for the therapy and benign change in the external relationships of the child.

In the remainder of the last century, diverse variations of psychodynamic and psychoanalytic child psychotherapies developed, some of them quite idiosyncratic; to mention but a few: early relational trauma and deprivation treated by regression and corrective experience, most often interpreted as gratifying oral-emotional care (Alpert 1959); an existential, Rogers-inspired play psychotherapy method (Axline 1969); in the Scandinavian countries a somato-psychic therapy, the so-called vegeto-therapy inspired by Wilhelm Reich, gained influence (Reich 1949, Grønseth 1971); ad hoc sessions on the child's demand (Winnicott 1977); systematic oral gratification inside an otherwise psychoanalytic setting (Moses & Moses 1986).

An impetus for this diversity probably was an increasing societal demand for child psychotherapies to reach out to children and young people, whose access to psychotherapy was difficult either for socio-economic and cultural reasons or because of severe pathology of the child. Even today, the development of a rich diversity of psychodynamic and psychoanalytic child psychotherapy approaches is

quite apparent, e.g. a contemporary textbook widely applied in trainings all over the world includes authors adhering to a variety of theoretical analytical backgrounds, including contemporary Freudian, Kleinian, Independent, and Jungian orientations, working within a range of different contexts and settings with children and young people with a diversity of problems ranging from autistic children to children exposed to severe neglect and abuse (Lanyado & Horne 2009a).

Diversity of methods clearly is a professional strength, furthering the flexible integration and development of psychodynamic and psychoanalytic psychotherapy with children and adolescents, adapting to the pluralistic treatment needs found in contemporary societies. However, the selfsame variation carries a certain risk that psychoanalytic child psychotherapy may lose its scientific footing in a cohesive theoretical system, whose elements have a certain, predictable relationship to each other and to the phenomena, it aims to explain or give meaning (Miles et al 1994). During the 1960's similar concern was voiced across different psychoanalytical traditions, e.g. by Esther Bick (1961) and Samuel Weiss (1964), who from their different perspectives of British-kleinian and American-ego-psychological traditions worried that while the field of child analysis seemed to foster a host of technical variations and the birth of numerous psychodynamic therapies, the psychoanalytic model's stringent focus on the transference relationship seemed to fade out, leaving the criteria for psychoanalytic treatment to rest solely on a question of the frequency of sessions.

A similar present-day discussion was raised by Cohen (1995, 1997), who reviewed the literature of the field, concluding that psychoanalytic child psychotherapy and analysis alike suffered from ambiguity, divergence and lack of

stringency in the formulation of treatment aims and methods. The review documented at least *three different ways of defining the specificity of the applied treatment as inside the psychoanalytic method*:

1) Some authors claimed *the scope of treatment goals* crucial, e.g. if focus was on a particular symptom or more broadly on personality change.
2) Others maintained certain, specific aspects of *the methodology* to be significant, e.g. whether main technique was interpretation of the transference relationship or acknowledging/meeting unfulfilled developmental needs e.g. for empathy.
3) Still others found certain aspects of *the setting* decisive, e.g. frequency of sessions or absence/presence of concretely gratifying or educative elements like board games, candy, cakes, lemonade, birthday presents, postcards during vacations etc.

As emphasized by Tischler (2009) and Golse (2001), quite a few European psychoanalytic child psychotherapy associations in recent time have developed well-defined trainings and standards for qualification mitigating this somewhat chaotic tendency. In accordance the European Federation of Psychoanalytic Psychotherapies (EFPP) during the last decades, aiming at providing the psychoanalytic psychotherapies with more stringent frames of work, has worked on the development of approved training standards. For the Child Section of EFPP, this resulted in a commonly approved certificate, a model set of standards for child psychotherapy training programmes that may be awarded to national training organisations, certifying that these training organisations are members of the national networks of the EFPP and have achieved the minimal standards of training according to the EFPP (EFPP 2011).

2.1.3. Outcome

For the last decades the progress of evidence-based principles in the practice of health care have engendered comprehensive discussions, among these of how best to conceptualise guidelines for psychotherapy to children and adolescents. One important dimension in this discussion is the necessity for evaluations of psychological interventions to relate to two separate dimensions: *efficacy* and *clinical utility*[15]. Thus one must take into consideration the possible tension between on the one hand *internal validity* (i.e. the unambiguous strength of causal relationships[16]) and on the other hand *external or ecological validity* (i.e. to what degree the results are related to and applicable in ordinary clinical practice[17]). Accordingly, Weisz et al (2005) concluded a critical review of 236 randomised trial studies of child psychotherapy (irrespective of therapeutic philosophy) that most of these randomised studies were seriously lacking in external validity, due to poor clinical representativeness of their samples, the therapists, and the settings. More than half of the studies had serious flaws related to sample selection and description as well as too small sample sizes and too voluminous attrition rates seriously undermining statistical reliability and validity. Similar problems are encountered in the broader field of child mental health treatments, Fonagy et al

[15] *Efficacy:* Criteria for evaluation of the strength of evidence in establishing causal relationships between interventions and disorders under treatment, i.e. the results achieved by a specific psychotherapy method in the setting of a research trial. *Effectiveness* is the outcome of the therapy as performed in practice as usual. Related to this is the broader concept of *clinical utility*: a balanced appreciation of available research evidence and clinical consensus including generalizability, feasibility, costs and benefits of interventions (APA Presidential Task Force on Evidence based Practice 2006, p. 272; Roth & Fonagy 1996, p.13).

[16]Such guidelines are derived from the Cochrane recommendations placing the RCT design (Randomised Controlled Trial with a carefully matched control group) at the top of a hierarchy, which at the bottom have retrospective, observational studies without control group (Higgins & Green 2011).

[17] E.g. to trained therapists treating children and parents presenting with a range of difficulties, among which is abuse and neglect.

(2002b) in a meta-review concluding that only 7 % of the included studies met the full criteria for a well-designed, randomised study.

Leaving this aside, Weisz et al (2005) concluded a growing evidence base to show individual child psychotherapy a suitable method of choice for a number of childhood problems and diagnoses. Carr (2009) reached a similar conclusion reviewing more than 350 treatment outcome studies, effect size across studies - no matter the specific form of child psychotherapy – estimated between 0,71 - 0,88 , which is comparable to what may be achieved in adult psychotherapy[18]. Earlier meta-reviews reached similar conclusions, showing around 75 % of children better off after psychological treatment than untreated controls (Kazdin 2000; Target et al 1996).

Studies evaluating *individual psychoanalytic or psychodynamic psychotherapy with children and adolescents* are sparser but several contemporary reviews provide substantial evidence that the treatment is effective as measured by well-validated, standardised research instruments with a range of psychological problems in children, at a level at least comparable to other empirically supported treatment methods (including children with complex difficulties) (Carr 2009; Fonagy et al 2002b; Midgley and Kennedy 2011). Midgley and Kennedy repeated a search strategy used by Kennedy (2004) to systematically review 34 studies, evaluating efficacy and effectiveness of psychodynamic psychotherapy for children and young people[19]. Only 8 of the reviewed studies were *randomised*

[18] *Effect size* of a treatment refers to the statistically estimated relationship between the applied treatment and a specific outcome, an effect size of 0,2 usually is considered small, 0,5 medium and over 0,8 as large (Midgley & Kennedy 2011). Effect sizes of 0,71 - 0,88 indicate that after treatment the average treatment case fared better than 76-81 % of untreated control group cases (Carr 2009). A note of caution in the interpretation of effect size as different methods of computing effect size may generate different results (Kazdin 2000).

[19] "*Psychodynamic*" was used as an umbrella term to cover all therapies describing themselves as psychoanalytic or psychodynamic.

controlled trials, most of which had insufficient statistical power because of too small sample sizes. 22 *observational studies* took place in clinical settings, offering psychodynamic psychotherapy to children with *mixed diagnoses and difficulties*; however only 8 of these included the use of control groups[20]. The fact that these 22 studies assessed ordinary clinical cases in naturalistic settings e.g. including mixed or unclear diagnostic entities preclude their influence on evidence-based guidelines for practice[21]. However, the selfsame characteristic enhance external validity, bringing the findings closer to usual practice, their recommendations easier to integrate in everyday clinical work as taking place e.g. in child welfare and school services. The majority of studies employed trained therapists in ordinary practice, which contributes to this aspect of the ecological generalizability. A limitation of these studies is the scattered tendency of findings, as apart from a few studies the findings of former studies are seldom used as the basis for future studies. Studies where psychodynamic psychotherapy was *compared to other treatments* showed a mixed picture, some suggesting psychodynamic treatment to be more, some less, and some equally effective.

An outstanding exception to the general tendency for non-controlled studies not building on each other's findings are a series of carefully designed, randomised controlled trial studies of the effect of *time-limited psychoanalytic psychotherapy and systemic family therapy on severely depressed children 9-15 years old* (Trowell et al 2003; Trowell et al 2007; Trowell et al 2009; Trowell et al

[20] An ethical difficulty of genuinely, untreated control groups is the obvious problem denying a randomized group of troubled children appropriate treatment. Among different attempts to compensate for this problem are the inclusion of a waiting list group and cross-comparison between different forms of treatment e.g. the beneath mentioned Tavistock depression study, which compared individual and family therapy.

[21] Unclear or mixed diagnostic entities refer to such troubles that do not correspond to a single psychiatric diagnosis in the ICD-10 or DSM-IV.

2010). This multicenter study, building on previous European studies, included 72 depressed children and was simultaneously conducted in London, Helsinki, and Athens to make cross-cultural comparison possible. Main results of the study, as measured at the end of treatment, showed both methods (individual psychotherapy with concurrent parent work and family therapy) effective in the treatment of childhood depression, with response rates at the end of treatment 74% (the individual therapy group) and 76% (the family therapy group); the individual psychotherapy group further improved at follow-up 6 months later (see below).

A German study, the Heidelberg Study, likewise built on earlier retrospective studies, examined efficacy of short-term psychodynamic psychotherapy in a quasi-randomized controlled trial, including 71 children, 6-18 years old, with a range of ICD-10 diagnoses, seen for 25 therapy session. A smaller part of the group received long-term treatment (an average of 82 therapy sessions), the effectiveness studied in a naturalistic design with no control group. The short-term group showed a significantly higher degree of change in social-communicative skills as compared to a waiting control group; both short-term and long-term psychotherapy were found highly effective in the treatment of a range of mental disorders (Kronmüller et al 2010). Deakin & Nunes (2009) reported a naturalistic study with a matched control group to show that after 1 year of supervised, once or twice weekly therapy, 23 Brazilian children aged 6-11 had improved considerably, showing a significant reduction in total behavioural and internalising problems (overall effect size 0,696) as measured by the Child Behaviour Check List (Aschenbach 1991) and an improvement of interpersonal relationships, affect modulation and perception of reality as measured by the Rorschach test (Exner & Weiner 1995). A Swedish study, The Erica Process

Outcome Study, investigated time-limited (1½ to 2½ years), focused child psychotherapy with 33 children aged 5-10 years old with a range of diagnoses. Change in global functioning was measured by standardised, well-validated instruments and large effect sizes 1.80-1.98 were found, however the study had no control group against which to measure improvement (Odhammar et al 2011). The retrospective registry study of the Anna Freud Centre is well-known and in general showed reliable improvement in 60-70 percent of children with moderately severe disturbance (Fonagy et al 1996; Target et al 1994 & 1996).

Midgley and Kennedy (2011) suggested *certain children are more responsive to psychodynamic psychotherapy* than others. Below are listed some of their findings:

- Some studies directly comparing *age-groups* showed younger children to benefit more than older children. However as shown in a host of other studies this does not preclude beneficial effects to older children and adolescents.
- A number of studies showed children with *emotional or internalising disorders* to respond better than children with *disruptive/externalising disorders*; however some indications were present to show this linked to the latter group's increased likelihood for premature drop-out of treatment[22].
- As mentioned above, a particular strong evidence-base is emerging for the treatment of children and young people with *depression;* in the UK psychodynamic treatment for this group is recognised as an evidence-based treatment.

[22] The influence of factors like age and internalizing/externalizing disorders probably is not specific to psychodynamic psychotherapy.

- A range of studies suggest psychodynamic treatment of children who have experienced *abuse, maltreatment and trauma* to be effective[23]. However these children often suffer complex problems and disturbances and probably will remain too diagnostically diverse for this ever to be reflected in evidence-based guidelines.
- Quite a few studies suggested *proportionality between children's degree of difficulty and the needed intensity and length of treatment*; children with less severe levels of disturbance responding well to less intensive, time-limited treatment (e.g. 25-30 once-weekly sessions); children with more severe and complex disturbance, if they are to improve needing more lengthy and intensive treatment.
- The role of parallel work with parents to the effectiveness of the child's psychotherapy is sparsely researched; a few studies suggest lack of parent work to be counterproductive[24].

2.1.4. Evidence as to long-term effect

Among the first to explore change of outcome over time in relation to psychodynamic therapy, Bell et al (1989) reported the effects of even relatively short psychodynamic playgroup psychotherapy with deprived and/or maladjusted primary school children to continue and even enhance for at least 30 months after the end of treatment. Another example of early exploration of long-term effect is a

[23] See also 2.2.3. below.
[24] Mentioned in this review is Szapocznik et al (1989). The above suggestion is in line with conclusions from the below mentioned Tavistock Workshop (Boston et al 1983); the register study at the Anna Freud Center (Fonagy et al 1996); and a Swedish review of several studies (Boëthius et al 2000).

single case study by Lush et al (1998), presenting a systematic follow-up of a 4-year long, individual psychoanalytic psychotherapy with a 10 year old, late adopted boy, who had been early abused; development assessed 6 and 12 months after termination of therapy.

Since then quite a few studies have indicated psychoanalytic psychotherapy to have *a delayed but sustained effect* compared to other treatments – usually named – *a "sleeper" effect.* Midgley et al (2011) found twenty studies, in which participants were followed for at least 1½ -4 years or more after the end of therapy, results at follow-up indicating a sustained or even enhanced improvement for some young people[25]. The above mentioned depression study at end of therapy showed similar good results for individual and family psychotherapy; later follow-up showed no children in the individual psychotherapy group diagnosed as depressed against 19% of the children in the family therapy group (Trowell et al 2002, 2007 & 2009). Muratori et al (2002) reported a study of 30 children with emotional disorder, randomly assigned to either brief, psychodynamic psychotherapy or community care; the children were asessed at beginning, after 6 months, and after the end at an 18 months follow-up; the psychotherapy group appeared most improved, results indicating long-term changes. Similar results were found in a larger study of 58 children with depressive or anxiety disorders randomly assigned to either brief, psychodynamic psychotherapy or community services (Muratori et al 2003). The Heidelberg study likewise found gradual improvement at 3 and 12 months after treatment, however as no control group was included, these figures are more difficult to evaluate (Kronmüller et al 2010).

[25] Some up to 40 years after the end of treatment.

A few studies undertaking *follow-up of psychoanalytic treatment in childhood* also indicate a long-term impact. Some of these indicates effect to last into adulthood, both in terms of objective measures and as seen in qualitative reports of the former child patient's own, now adult experience of treatment, even if these memories of treatment included both positive and negative experiences (Midgley et al 2005; Midgley et al 2006; Target et al 2002).

2.2. Psychotherapy in the case of early abuse and neglect

In relation to this group of children, this section reviews definitions of early abuse and neglect; outcome studies of psychoanalytic psychotherapy, traditions of psychoanalytic psychotherapy; and specific challenges related to their psychotherapy.

2.2.1. Definitions and consequences

Information of adverse early experience does not later on in itself tell us much about a certain child, its unique personal preoccupations, talents, relational capabilities, troubles or possible psychopathology. Nevertheless, the information indicative of certain emotional qualities of the child's relational past; it may predict certain subjective qualities to be encountered in the transference relationship during psychotherapy.

From a historical point of view, the concept *early maternal deprivation* was linked to infants in huge, inhuman residential institutions suffering emotional, cognitive, social, and sometimes also nutritional privation (Spitz 1945 & 1946; Bowlby 1951; Provence et al 1962). In a now classic review instigated by WHO of available research evidence, Ainsworth defined maternal deprivation as "*insufficiency of interaction between the child and a mother-figure"* (1962 p. 98). The concept of maternal deprivation subsequently was intensely debated, giving rise to controversies concerning the role of mothers; the differences between a mother and a mother-figure; separation and deprivation; acute reactions versus long-term consequences; and the relationship between deprivation, rejection and violence. Fifteen years later, carefully conducted studies beyond reasonable doubt had showed that even in well-equipped institutional environments with a high caregiver-child ratio, a policy of depriving the child of relationships to specific caregivers placed the emotional and social development of the child at serious risk; some but not all children harmed, the damage proportional to length and severity of the deprivation (Tizard et al 1975, 1978).

On the basis of two comprehensive research reviews, Rutter accordingly concluded (1972; 1978):

1) *Childhood deprivation* understood as *a complete or partial absence in early childhood of a continuous relationship to a few specific caregivers responsible for the daily care of the child* poses a seriously *increased risk of later disturbances* in personality development; probably especially to affect regulation, social adaptation, and the ability for mutual, emotionally intimate relationships including the ability for adequate parenting.

2) *Most children seem resilient* to deprivation as only a minority of children in later childhood may be expected to actually develop disturbances of personality.
3) *Long term damage* is most likely to occur when *multiple acute stresses arise against a background of chronic disadvantage*.

Since these early days a host of studies have repeatedly shown early deprivation to pose a risk of lasting harm to the emotional development of the child, especially of a massive, global character; however also repeatedly shown was that the majority of deprived children did not demonstrate problems; harmful consequences to some extent dependent on individual resilience e.g. cognitive status; alleviated by improvement of later care-relationships e.g. due to foster care or adoption, the earlier the better[26] (Tizard 1979 & 1991; Hodges 1984; Downey et al 1985; Hodges et al 1989; Zeanah 2000; Zeanah et al 2000; Tsiantis 1995; Rutter et al 2001, 2010; 2012; Colvert et al 2008; Stevens et al 2008; Smykel et al 2010; Zeanah et al 2010).

In 1978, Rutter defined early childhood deprivation as *early experiences in a caregiver-child relationship which disregards the child's basic needs for emotional and physical comfort and actively or passively[27] exposes him/her to recurrent acute traumatic stress*. Thus defined, infants and young children may be exposed to early relational neglect and/or abuse in different environmental contexts:

[26] The broad consensus that grossly inadequate and maltreating caregiving environments imply an increased risk of later disturbance is reflected in ICD-10 and DSM-IV, which both include attachment disorder. Not relevant to the topic of this thesis, I will not go further into ordinary patterns of attachment and the diagnostic issues of attachment disturbances.
[27] Passively e.g. by lack of protection.

1) *Institutional deprivation* occurs in residential, institutional environments without personalized care; opportunities for emotional exchange with a few specific caregivers insufficient. This happens even today, especially among internationally adopted children, born in poverty-ridden and/or totalitarian countries.
2) *Family related neglect and abuse* within a family-environment characterised by insufficient and unpredictable interactions with emotionally unavailable and uncaring parental figures and/or recurring violence, abuse, maltreatment or other overwhelming stresses.
3) *Discontinuity of early caregiver-child relationships resulting from lack of permanency*, recurrent periods of successively shifting caregiver-environments, the child thus exposed to repeated separation and loss as well as unpredictable shifts in emotional availability of caregivers. This may e.g. happen to a child repeatedly going into institutional care, interspersed with stressful periods of living with mentally ill birth parents or repeated shifts between a residential institution and failed foster care or adoption.

Today's conceptions of early high-risk care-giving environments imply both insufficient and/or disturbed early relationships, exposing the child to recurring states of acute traumatic stress. It is well known that *early relational abuse*, defined as *early social interaction of an adverse character with parental figures,* may give rise to early trauma and related developmental adaptation to a condition of more or less chronic PTSD (Gaensbauer et al 1979; Terr 1988 & 1991; Drell et al 1993; Gaensbauer1994 & 1995; Pynoos et al 1995; Scheeringa et al 1995; Perry 1997 & 2000; Twardosz et al 2010).

A contemporary definition of early neglect and abuse must include children who early in their life were abused by *siblings*. Already Melanie Klein described abusive sibling relationships; believing destructive hatred enacted by a stronger sibling terrorizing a weaker sibling to be in the first place aroused by parental neglect and abuse; but itself to have destructive consequences for both siblings (Klein 1927b, 1932b, 1932e, 1932f). Quite a number of newer academic studies and other works likewise concern siblings abusing siblings (H. Smith et al 1987; Cantwell 1988; De Jong 1988; Daie et al 1989; Johnson 1989; Cantle 2000; Green 2002; Wiehe 2002; Browne et al 2010).

2.2.2. An infant's experience of abuse and neglect

Any attempt at describing an infant's as yet non-verbal experience by necessity must be an approximation. Bion assumed the experiential world of the tiny infant to depend on an emotional link to a containing parental figure, without whom the infant's inner cohesiveness might fall apart, the resulting experience chaotic, consisting of raw, i.e. mentally undigested, bodily experienced sense impressions (1961, 1962a, 1962b)[28]. Thus uncontained, the tiny infant on his own is as yet unable to give emotional meaning to his experiences; sense impressions accordingly flooding his psyche, creating painfully overwhelmed states giving rise to fundamental, traumatic annihilation anxiety, fit only for bodily evacuation

[28] *Containment*: *"The capacity of one individual (or object) to receive in himself projections from another individual, which he then can sense and use as communications (from him), transform them, and finally give them back (or convey back) to the subject in a modified form. Eventually, this can enable the person (an infant at first) to sense and tolerate his own feelings and develop a capacity to think."* (Riesenberg-Malcolm 2001, p. 166). Bion named the unprocessed sense-impressions "*βeta-elements"* (1962b, p. 26).

through crying, screaming, spitting, vomiting, urinating etc. Repeated and prolonged failures of containment may create a permanently flooded, terrorized state of mind, by Bion termed *"nameless dread"* (1962b, p. 96). Such a state may be akin to a never-ending evil circle, the infant perpetually projecting and reintrojecting his own original fear of falling apart and in addition a permanent feeling that good parental objects turn forever bad and invasive e.g. as overwhelming noise, touch, taste; a preoccupied void into which one may endlessly fall; or a scary, estranged, misconceiving fiend.

In ordinary good early care-relationships, such terrorized states most often are prevented or at least mitigated by the parental ability through reverie and containment to understand and to some degree themselves sense the infant's distressed predicament. Most parents immediately will introject their infant's distress, in their own mind unconsciously able to unscramble this into comprehensible communications about needs, conveying this understanding back by such tender mental and bodily ministrations that make the child feel better (Bion 1962a, 1962b; Riesenberg-Malcolm 2001). Through recurrent introjection of benign circles of this sort, the experience of self as contained by the parental container gradually is constituted in the infant's mind as an ability to contain itself, i.e. to know and regulate its own needs, feelings and related emotional states.

Even at best, sometimes parental containment fails if for no other reasons than the common stresses of daily family-life. The *experience of non-containment* is an unavoidable part of normal early experience, and also to some degree considered necessary for healthy emotional development provided that it is not too often and lengthy; not exceeding the infant's capacity for keeping himself

together. If not painfully flooded, the infant may be able emotionally to accept the situation and in his mind start processing the feelings related to the absence of an external, containing parental figure. Experiences of this sort, if not mentally avoided, may stimulate the ability for thinking by transforming the incomprehensible pain of absence into a meaningful feeling, actually longing for the good parent of yesterday's interaction. In a psychological sense, this is a tremendously important experience in the direction of a capacity to own one's feelings and endure separateness, in time becoming able to feel and think about all sorts of relational experiences (Bion 1962a).

From this perspective, the experience of relational neglect and abuse may be understood as *recurrent helplessly flooded states*, experienced as a tidal wave of painfully raw sense impressions and fragmented phantasy, emanating from without and within. The terror of this inner break-down, for some children may become increased by a similarity between chaotic fragments of inner phantasy and the external violence taking place. The experience of disappearing parental attention and care in itself may be violent, leaving the infant in the abyss of his own inner chaos. Left to his own devices, the neglected and abused infant may have no other choice than falling back on his own precocious attempts at gaining control. This may e.g. be in the form of a permanently heightened muscular tenseness (Reich 1933); in time developing into a brick-like armour of defense (Henry 1974; Williams 1997a), or like the infant Samantha described in this work by night staying wide awake in the cot, picking her own skin until bleeding (see 3.2.; Bick 1967).

Recurrent and/or lengthy experience of deficient or disturbed parental containment may be the result of different forms of insufficiency or disturbance in early care-relationships:

a) The relation to emotionally *unstable parental figures not able to contain either the infant's feelings or their own often much too intense feelings*. This may be the prototype of the above described break-down of containment. The parent may well be able to decode and recognize the feelings of the infant but is unable to contain, becoming overwhelmed both by the infant's overwhelmed state and her own related feelings. The consequence of an unbounded intensity of parental response with no appropriate marker of reservation, is to place the infant at the receiving end of projective identification, thereby creating *an inverse containing relationship* in which the infant not only must bear his own flooded state but also the flooded state of the parental figure. This situation often are related to parental borderline states or other forms of severe helplessness and anxiety (Fonagy et al 2002; Williams 1997c).

b) A recurrent tendency to *gross parental misunderstandings of the child's emotions, needs and intentions* may be the result of deficient empathic and emotional understanding on the part of the parent. Disturbed containment of this type may *undermine the infant's sense of self and ability to differentiate between inner and outer reality*, creating what Winnicott termed *a false self* (Winnicott 1952, 1960; Fonagy et al 2002a). Such distortion of the fundamental ability to sense and understand the infant may be the result of parental mental illness; retardation; or substance abuse, which in some instances may produce such fatal misinterpretations of the infant's needs

that his survival is brought in serious danger (Grünbaum et al 1993). Sexually abusive, self-centered or emotionally tone-deaf parental care may also belong here.

c) *Unstable, insuffcient, or edgy parental containment due to anxiously preoccupied parental states* may in some instances be coupled with a tendency for sudden *loss of control*. This may be the sad result of *environmental situations in which the parents are or have been under severe stress*, for instance because of life-threatening somatic illness; devastating personal loss; exposure to societal violence and political persecution; extreme poverty; or other life-threatening, traumatizing, external conditions (Grünbaum 1998).

2.2.3. Outcome in the case of early abuse and neglect

Any child welfare worker by heart knows this group of children and their families. However, abuse and neglect being external events, the sequel in terms of the individual child is bound to be subjectively formed, providing *unclear boundaries of definition*. Thus from an evidence based point of view, this group is too mixed, made up by a diversity of diagnostic categories, social, emotional, and cognitive problems as well as any conceivable form of damage to personality development.

Nevertheless, in a comprehensive review including a broad varitety of psychological interventions, Skowron et al (2005) analysed 21 controlled trials of psychotherapy for child maltreatment (including neglect, abuse, and sexual abuse) and found a good effect of psychotherapy, irrerespective of the specific modality (e.g. whether focused on individual, group, family, parent-child, milieu, or

multilevel forms of treatment)[29]. Some variation in outcome seemed connected with theoretical orientation, the non-behavioural therapies (e.g. psychoanalytic, humanistic, interpersonal etc.) showing somewhat better results than the behavioural therapies. However, since the length of treatment varied, nonbehavioural therapies averaging a year, behavioral therapies only 3 months, it remained unclear if treatment gains rather were a function of the amount of treatment received. Results further suggested that comprehensive assessment of severity of exposure and complexity of psychological disturbance may be important to identify the level of intervention needed (Carr 2009; Saywitz et al 2000).

Exactly because of this complexity *length and intensity of therapy* may be of a special importance to the outcome also of psychoanalytic psychotherapy; a possibility needing further empirical testing (Midgley et al 2011, Muratori et al, 2002 & 2003; Boston and Lush, 1994; Fonagy et al 1994, 1996a).

An early systematical attempt to explore psychoanalytic child psychotherapy with this group was conducted by the Tavistock workshop on severely deprived children (Boston & Szur1983). This was followed by a study of 31 fostered, adopted and "in-care" children who received individual psychotherapy, once or twice weekly for up to two years (Boston 1989; Boston 1991; Boston & Lush 1994; Boston, Lush et al 2009; Lush, Boston et al 1991; Lush, Boston et al 1998). According to reported information from parents, carers, teachers etc. as well as independent ratings by blind raters the majority of the children at the end of treatment had improved considerably e.g. as regards

[29] An average effect size of 0,54, indicating that a treated case fared better than 71% of cases receiving no treatment or average community case intervention. Skowron et al cautions that selfreported outcomes were associated with larger treatment gains than behavoural observation of parent-child or family interaction (2005).

alleviation of referral problems; relationships; mood and trust; and capacity for learning and thinking. The research design was somewhat opaque; findings at best suggestive, e.g. unclear characteristics of control group; huge attrition level; non-validated evaluation instruments. Nevertheless, the original workshop report and the subsequent study at the time were absolutely ground-breaking, both in and outside UK, aiming at evaluating psychotherapy with a severely deprived and traumatised group of children most practitioners believed untreatable[30]. Thus probably the most important finding of this study was that trained therapists and/or therapists under qualified supervision are well able to work with this group of children in once or twice weekly psychoanalytic psychotherapy.

Trowell et al (2002) conducted a randomised intervention study of 69 sexually abused girls 6-14 years old. The relative efficacy of manualised, once weekly, focused psychoanalytic individual psychotherapy (up to 30 sessions) was compared to manualised psycho-educational group therapy (up to 18 sessions). Both treatments were supplemented by supportive work with parents and carers as well as coordinated efforts related to the network. Before treatment, the study showed high rates of psychiatric disturbance among the girls, especially post traumatic stress disorder, major depressive disorder and separation anxiety. After treatment, both groups showed a substantial reduction in psychopathological symptoms and improvement in general functioning, however individual psychotherapy led to a greater improvement in clinical manifestations of post-traumatic stress disorder. This study was rigorously designed; however the lack of

[30] To me personally the first report from the workshop (1983) was a most welcome eye-opener, enabling me to get a whole new perspective on the painful struggles taking place in certain of mine and my colleagues child psychotherapies, no less important opening up the possibility for a better platform for discussions with colleagues and administrators of possible treatments for emotionally deprived and abused children referred to a child guidance center covering the communities sur-rounding Copenhagen City.

an untreated, matched control group, the small sample size and a relatively high attrition rate limited the statistical power and the conclusions concerning causal relationships.

In an observational study, Heede et al (2009a) investigated the effect of two years of residential psychodynamic "milieu-therapy" on a group of 25 children, 6-15 years old, with histories of severe early deprivation and abuse[31]. Significant improvement were found on the WISC (Wechsler 1991), the Rorschach (Exner et al 1995) and other projective tests in regard to intellectual and emotional functioning, greater self-confidence; capacity for self-reflection; more positive and realistic expectations. A subsequent study compared the original results concerning the 25 children to equivalent measurements relating to the development of another 11 children, who in addition to the milieu-therapy were also offered individual psychoanalytic psychotherapy. The results suggested individual psychoanalytic psychotherapy significantly improved the effects of milieu-therapy, especially as regards cognitive abilities, which seemed to rise quite dramatically (Heede et al 2009b). The results are at best tentative because of lack of a matched control group and small sample size.

I have not been able to find other systematic investigations of the effectiveness of psychoanalytic psychotherapy focusing directly on this group of children. However, studies occurring in ordinary clinical settings with mixed diagnostic groups will include some children exposed to early abuse and neglect (Szapocznik et al 1989; Deakin et al 2009; Odhammar et al 2011). Of special

[31] The children were taken into care because of their parents difficulties to care appropriately for these very difficult children. They were placed at three residential institutions working according to principles of psychodynamic milieu-therapy, a group-oriented, pedagogical treatment method in which exploration of the self in relation to groups and the organizational setting are the main focus of the treatment (Heede et al 2009).

interest may be studies of children diagnosed with disruptive disorders, both because these children quite often are a heterogeneous group, and because children exposed to early abuse and neglect often in later childhood may be given a diagnosis implying behavioral disturbance. A considerable overlap between the two groups therefore is to be expected[32] (Eresund 2002, 2007; Jaffe et al 1986; Karr-Morse et al 1997; Killén 1988; Lyons-Ruth 1996; Lyons-Ruth et al 1999; Perry 1997; Perry 2000; Leuzinger-Bohleber et al 2010; Conway et al 2011).

A retrospective study of 135 children with disruptive disorders treated at the Anna Freud Centre showed these children more difficult to treat than children with emotional disorders, especially if the diagnosis was of conduct disorder (Fonagy et al 1994). Certain preconditions significantly increased probability for benign change:

1) Therapy continued more than a year[33];
2) Psychopathology was found in the parents[34];
3) Manifest anxiety alongside behavioral disturbance
4) the child was younger than 9 years at the start of treatment.
5) For younger children, intensive treatment (3 times a week or more) decreased drop-out risk and increased effectiveness.

Of the entire sample, 46 % showed clinically reliable improvement (and 69% of those who remained in treatment); however no firm conclusions concerning children who early were exposed to adverse care relationships are

[32] Inclusive oppositional defiant and conduct disorder, ADHD, ADD, and HDD.
[33] As mentioned, drop-out during the first year of treatment was common, a factor reducing effectiveness.
[34] Fonagy et al suggest this astonishing result due to the fact that disturbed parents were offered more intensive support than other parents.

possible because a retrospective study including a diversity of early care circumstances.

2.2.4. Across traditions - Perspectives on psychotherapy

The *Tavistock Workshop* summed up three conclusions (Boston et al 1983):

1) Transference might from start to end of therapy be completely *dominated by the child's negative feelings and severe chaotic, often aggressive enactment*, but this did not prevent a sometimes quite impressive effect of treatment in the form of improved behavior and relationships outside therapy. Thus *if the therapist was able inside therapy to contain the child's confused aggressive feelings, this seemed to increase his receptivity to parental care outside therapy, which again might start off benign relational circles* of care as the child's surroundings might experience less rejection.
2) The *psychotherapeutic prognosis* was better for those children who after the difficult start, at least for a period of their lives had had an *opportunity to bond and interact with a few specific adults*, responsible on a daily basis for the parental care of child.
3) The feasibility and effectiveness of the psychotherapy seemed more *dependent on the stable, motivated commitment of the parental figures* currently in charge than on the severity of the child's symptoms and early experiences of neglect and abuse.

Since then child and adolescent psychotherapists working from different perspectives in different settings between them have compiled an impressive sum

of experience with this group of children. It is impossible to mention all contributors, but a whole issue of the *Journal of Child Psychotherapy* (2000, 26(3)) was dedicated adopted and fostered children.

Several developments concern *the difficulties of containment of negative transference feelings and enactment, interpretation and related developments of technique as based on the therapist's awareness of her countertransference feelings* in work with these children. Among these, O'Shaughnessy (1981) and Alvarez (1983, 1996, 2010) addressed the need to adapt the setting and frame interpretations in modes carefully *matching the level of the child's pathology*. Pine (1985) correspondingly developed *techniques of interpretation framed in an ego-supportive mode;* Green (1998) and later Strati (2007) conceptualising *the therapist as a developmental (new) object*. Hunter (2001) drew attention to the therapist's awareness of *experiences on the edge of the unbearable*, framing *interpretations in a positive mode*; Kenrick (2005) and Miller (2008) stressed working with *the past in the present* and related *process interpretation*. Music (2009) described the use of countertransference in order to reach out to the *"undrawn", "unenjoyed"* child. Grünbaum (2010b) drew attention to the importance of patient *containment of silent states while attentive to minute present traces of past traumatic reactions*. Lanyado (2010) stressed the *power of play* to contain omnipotent, unreachable states of power struggle. A commonly described difficulty in psychotherapy with these children concerns *violent projection of terror and difficulties of containment of violent behaviour* (Hunter 2001; Canham 2004). Parsons (2009) building on Glasser (1998) described a need for the therapist to function as *a protective shield* against a *core complex of double terror of intimacy and abandonment* giving rise to a vicious circle of violence.

Concerning the need to work through, several authors described a need to work with *the specific Oedipal constellation of fostered and adopted children*, coming to terms with their identity as fostered/adopted and the reality that their birth parents gave them up (Hodges et al 1984; Canham 1999, 2003); the work of *mourning lost relationships* at the heart of the matter (Samuels 1995), no less so since the birth parents may repeatedly reconnect and then re-abandon the child (Hunter-Smallbone 2009). The importance of *sibling relationships* to cared for children were stressed by Hindle (2007, 2008) and Rustin (2007, 2008).

Henry (1974) noting the impact of deprivation on the inner world of the therapist formulated the seminal concept of a countertransference state of *double deprivation*, giving rise to vicious circles of rejection. This further was extended to a concept of *triple deprivation* (Sutton 1991; Emanuel 2002), based on the understanding that early deprivation and trauma not only resonates in the mind of the therapist but also in *the unconscious processes of network cooperation* and unacknowledged may endanger not only the therapy but also the relationship between child and adoptive or foster parents (Heinemann 2001). Ways of working at several levels to *monitor and link together therapy and networking* were suggested by Grünbaum (1997, 1998); Hunter (2001); Cant (2002, 2005); and Sprince (2008).

Summing up current perspectives on psychotherapy with children who suffered early neglect and loss, there still seem to be certain differences according to psychoanalytic traditions, especially in relation to interpretation of negative

transference and management of the setting. However, *certain commonalities* in these often difficult therapies seem more noticeable[35]:

1) *Active neutrality* is needed; the therapist inclined to reach out; attentive to even minor possibilities of interconnection and reconciliation. In many ways therapy with these children resembles communication with a tiny, vulnerable infant; you need to look out for *moments of opportunity*, tuning into such channels of communication that here and now is open.
2) *Holding on to countertransference feelings* for a longer period than usual often is described; the therapist patiently waiting for the child to be able to listen. A special sensitivity to countertransference is needed, at times the only means to be in touch with the child's inner state.
3) *Careful timing and wording of interventions* are critical, since real-life experience often have left in the child a tremendous vulnerability to flooded excitement, paranoid panic and collapse. Accordingly the therapist must take care, especially if addressing rage, desperation, and mental pain to frame this in such a way as to remind the child that therapist and therapy will not be transformed but survive his bad feelings.
4) *Interpretation in a context of firm containment:* Split and ambivalent feelings towards past and current personal relationships gives rise to an often painfully negative transference to the therapist. At the start, most children are not as yet able to own either tender or aggressive feelings as part of the self; the balance between on the one hand interpretation of deep-rooted survival strategies and on the other hand firm containment of aggressive attack and devaluation is critical. One must work with the aim

[35] The below overview is a personal interpretation of the above mentioned literature.

that in time children may experience the therapist as an ally in the struggle to accept and own their most hated and dreaded feelings, thus gradually retrieving/constructing a subjective meaningful narrative of the life story. Problems related to containment of violence are discussed in detail below.

5) *Awareness of unbearable experiences and flooded states inside and outside the playroom:* Vulnerability, desperation, envy, and especially an experience of depletion may spread around the child as ripples in a pond; reverberating not only in the therapist's countertransference but also in the network posing a threat to treatment alliance with those responsible for the childs' treatment.

6) *Attention to difficulties of symbolic thinking* may prevent the child's understanding the as-if nature of transference interpretations; it may be necessary literally to spell out the role of therapy in the child's life e.g. that of course the therapist is not as important to the child as her foster parents, but nevertheless the approaching summer holiday and ensuing separation will remind most children who lost their birth parents of this past.

7) *Attention to defensive pockets of dissociated, psychotic thinking wrapped around kernels of devastating real-life experience:* Disturbed and trumatizing early relations and memories of abuse and loss may have left unstable and britle the child's sense of reality; accordingly at times the therapist may need to affirm and support differentiation between the distressing external reality of real past events versus the inner reality of burning hunger pangs, rage and envy.

8) *Working through mourning and rage related to loss, neglect and abuse:* These feelings are often present below the surface from the first encounter

but not where to start the work; pain becoming unbearable if addressed ahead of a gradual development in the child of the ability to long for the therapist and some degree of conviction that therapist and therapy will survive desperation, confusion, and rage.

9) *Parallel work with caregivers and network* are critical to the viability and outcome of the child psychotherapy; a containing circle between them keeping together the fragmented life story and feelings of the child.

10) *Consideration of frequency and length of therapy:* Most workers seem to feel that the younger and more deprived the child, the more important is frequent sessions (2-3 times a week or more) and especially careful consideration of the length of therapy; there is no quick cure to be expected and 3-5 years apparently not uncommon.

Containment of violent assaults

Coming to life from the frozen wasteland of abuse and neglect may give rise to a widely recognized challenge; overwhelming pain and anger bringing about assaults on the therapist's mental and bodily integrity. Boston and Szur describing experience gained by several such psychotherapies related an early blissful honeymoon period of good therapeutic work soon to lapse into violence and destruction (1983). Instructive single case examples of therapy with assaultive children confirm this (Maenchen 1984; Hughes (1988, 1999); Alvarez (1998 & 1999); Cleve (2000); Hunter (2001); Canham (2004); and Edwards (2008). Daldin (1992)

systematized the indexed case records of 25 assaultive children treated at the Anna Freud Centre; describing *two main groups*:

1) One group primarily *struggling with issues related to closeness-separateness;* in their early years often had suffered unpredictable or unempathetic parental care. The assaults implied *desperate attempt to master the pain of separation and abandonment*, eventually *fear of engulfment*. The risk of assaults thus increased when they felt abandoned by their parents or therapists e.g. were left because of breaks.
2) Another group *re-enacting a sadomasochistic mode of parent-child relating;* apparently in their early years had developed a fixed relational pattern, highly resistant to interpretation. These children seemed excitedly to strive provoking or enlisting the therapist's collusions in constant strivings for physical and psychological pain and suffering; relating primarily via projective identification, threats and attacks contributed to a powerful experience of preoccupying the therapist's attention, while at the same time identifying the therapist as the aggressor.

Daldin pointed to the importance that therapists are in touch with their countertransference, thus able to encode the nature of the child's projections; however since countertransference notes practically never were included in the case records studied, this assumption could not be evidenced.

2.3. Breaks in psychoanalytic child psychotherapy

Although breaks often were mentioned especially in single case papers; very few studies were found focusing directly on breaks. In general therapists were aware of breaks as a potential influence on the transference relationship; however taking this for granted, more often than not the child's reactions before and after the break were not described in any detail, apart from general assumptions concerning separation anxiety seldom systematically linked to psychoanalytic theory[36].

Textbook guidelines concerning breaks

Searching a number of contemporary textbooks representing different traditions revealed that if mentioned, breaks most often were superficially dealt with; the author at best stressing the importance of sticking to a reliable time structure. Exceptions were Blake (2008), Hartnup et al (1999), Hurry (1998), and Lanyado et al (2009), who gave more detailed recommendations; e.g. a) giving notice to child and parents well before a planned break; b) providing a calendar marking number of sessions before the break, number of weeks missed, and no less important the week that therapist and child will resume work; c) staying attentive to emerging feelings related to the break, attending to the need for these to be understood in sessions; d) explaining to parents the possible emotional impact of breaks, enabling them to help their child during the break (Hartnup et al (1999); Lanyado et al (2009a).

[36] See appendix, item III.2.

A textbook dedicated to mentalization-based child therapy underlines that for children with difficulties in the ability to mentalize, any interruption even to end the session is difficult to accept, because with the therapist gone, the child may be overwhelmed by the perception of diffuse nothingness, feeling that no one is available to help verbalize its experience[37] (Verheugt-Pleiter 2008 p. 63; Slijper 2008 p. 189). A textbook advocating a relational perspective suggests cultural diversity as a prime source of lateness and missed appointments (Altman et al 2002). An early paper of Jackson (1970) is included here, describing difficulties raised by frequent and long holiday breaks in a day-school setting; a problem still highly relevant, also to children seen inside residential treatment institutions. She recommends the psychotherapy schedule to include extra sessions to shorten some of these breaks.

2.3.1. Breaks and dependency-separateness

A few classic single case studies focus in details on the experience of breaks as linked to containment of object dependency- separateness.

Klein's seminal writings of her work with 10-years old *Richard*, described sessions before and after a 10-days holiday break. *Before the break*, already existing, conflicting feelings increased; Richard in his mind attacking the frustrating soon-to-go-away therapist, in effect also damaging the good therapist, who accordingly turned bad. Ever more fiercely conflicting feelings mounting, on

[37] *Mentalization-based child therapy* builds on Fonagy et al (2002). The authors compare their approach to what previously was known as *developmental therapy* (Hurry 2008). Mentalization may be compared to Bion's concept of (relational) thinking. The concept "*nothingness*" may be compared to the concept "*absence*" as specified below.

the one hand persecutory anxiety of retaliation from the damaged therapist, on the other depressive guilt and anxiety of himself by hateful attacks causing the beloved therapist to get damaged and lost. The inner turmoil probably further intensified by scary real-life events, the therapy taking place during World War II, Richard aware that Klein intended to visit London. *During the break* reportedly more than ever inseparable from his mother; *after the break* he appeared worried, depressed and unable to engage in eye-contact. In following sessions he created the famous series of starfish-patterned drawings, which Klein successively linked to a painful phantasy of a tiny self hopelessly fighting against a frightful combined monster; the essence of which seemed to be a beloved maternal object turned bad, preoccupied and damaged by a dangerous paternal part-object intruder. Klein in conclusion linked the impact of the break to an internal reality in which the real absence of the therapist (the external reality of the break) intensified deprivation suffered in a disharmonious early relationship (*1945* pp. 375 & 377-378, *1961*[38]*)*).

O'Shaughnessy in two articles published 25 years apart directly linked the impact of the therapist's external absence to the child's ability during the break to keep in mind the good therapist (O'Shaughnessy 1964, 1989). The first article gives an absolutely delightful, almost graphically detailed description of the therapeutic dialogue unfolding as two children each in their way struggled to contain the pain of a break. *12 years old John* when told of an upcoming Easter break reacted with a stare of disbelief, eyes opened wide, a long while staring vacantly at the therapist as if not believing his own ears. In the following session he drew a volcanic eruption causing an ancient piece of land linking England and

[38] References to breaks in: Session 7/ loc. 822 & 888; sessions 35-40/ loc 3745, 3885, 3967, 4280 - 4293, 4304.

France to become flooded and sink, separating the two forever. O'Shaughnessy suggested that the coming break might be felt as a sudden catastrophic separateness, turning the therapist into a bad going-away-breast; the staring eyes aiming at expelling this bad presence in mind from the self into the therapist. John added a soon-to-erupt fire in the middle of the volcano while passing wind. O'Shaughnessy suggested John preferred getting rid of any awareness that the break felt like being burned up from the inside of an all-eating volcano fire of pain and longing. John apparently felt contained, able in a displaced form reflectively to ponder the ability to think as he drew a developmental line linking antecedent fore-bearers to concurrent human beings, specifying a progressive increase in their brain capacity. However, not for long able to hold onto this new awareness, he vividly depicted a threat of mental flooding by going back to the first drawing of a volcano, emphasizing that while at the inside the fire burned, at the outside everything was flooded by the sea coming in.

In the same article a *12 years old girl* initially seemed quite realistically to prepare herself for an approaching summer break, creating an illustrated calendar of the last month to go. However, drawing up a tea-garden of plenty, she apparently needed the consolation of a selfsufficient phantasy being the sole owner and consumer of good things from this garden; no longer dependent on the therapist. After the break she brought a dream, in which she stood at the edge of an uninviting, dark sea, into which her mother had advised her to go bathing. O'Shaughnessy suggested omnipotence to crumble during the summerbreak, the dream representing a beginning awareness of self-sufficiency as an illusion designed to evade the pain of coming out of phantasies of tea-gardens into the uninviting, grey reality of the absence of the therapist.

The 1989 article described *11 years old Leon*, whose infancy reportedly had been stamped with failing containment and adverse events, on top of which his mother got pregnant again when he was just four months old. At the very first break he failed to arrive for the last session before the break; arriving in a terrified state for the first after-break session, expecting the therapist to chuck him out for good; furthermore during the break he accidentally had smashed his glasses, at return literally unable to see clearly the coming-back-therapist. Eight months later, after being told of another upcoming break, he found it harder and harder to look at the therapist, sometimes keeping her entirely out of his field of vision, with cold conviction claiming that since therapy was empty and boring, he looked forward to the holiday break.

2.3.2. Breaks as a window to core object relationships

The so-called psychodynamic formulation builds on the assumption that object-relations are organised around certain fundamental, uniquely subjective core conflicts or core object relationships, which permeates and unconsciously are repeated in an individual's personal relationships (Malan 1979; Perry et al 1987; Luborsky et al 1996; Luborsky 1997; McWilliams 1999). The related unconscious tendency for repetition is assumed to take place in a tripartite structure, also called "*the relationship triad*", referring to *three separate areas of object-relationships*, i.e. inside therapy in the transference relationship, outside therapy in concurrent daily relationships, and in early childhood i.e. the interaction between the infantile self and parental figures (Luborsky et al 2006, p. 96). As for adult psychotherapy, this and related assumptions extensively researched (Popp et al 1990; Luborsky et

al 1990, 1994; 1997; Albani et al 2003); concerning children only a single empirical study was found (Luborsky et al 1996).

Hinshelwood (1991a) understood core object relationships as relational patterns repeated throughout the three areas of the relationship triad; these repetitions assumed to point directly to a core of painful objectrelationships: he further assumed this particular "point of maximum pain" to give rise to certain defensive phantasy formations of object relationships unconsciously used to evade that pain (Hinshelwood 1991a).

Accordingly, *this study* defined *core object relationships* as *a uniquely subjective core of unconscious object-relationships, assumed to permeate and be unconsciously repeated as reoccurring relational themes that could be shown to run like a common concern through three areas of the child's life* (as described below), and *to which certain corresponding phantasies and behavioural tendencies could be linked:*

1) *Relationships inside the therapy*, as communicated verbally, in play or behavoiur; and whether concerning the therapeutic relationship or other relationships.
2) *Current daily relationships* to e.g. foster parents, birth parents, teachers, birth siblings, foster siblings, school mates, play mates etc., as reported by the network.
3) *Early relationships* to birth parents and other caregivers; as reported in case files and by parental figures.

Clinical illustrations

In line with the assumption of this study, several of the case descriptions summarised below implied that during breaks, core object relationship themes may be intensified and reenacted in the transference relationship.

Spillius (2007b) recounted a wonderfully, detailed example from the therapy with 3½ years old Linda, who at 2 years of age completely stopped speaking after the birth of a little brother[39]. After the first longer break, Linda apparently believed her therapist in the break to have given birth; spending the first after-break session in a fierce mood passionately searching the therapist and the room for a hidden baby. She further approached the therapist in wildly manic-aggressive ways suggestive of a persecuted phantasy that the therapist viciously on purpose had left her with the intention of letting her down by aggressively getting together with her husband to make this baby[40]. The description seems indicative that the break intensified already existing, deeply resentful feelings of betrayal in relation to her parents, especially the mother; an emotional situation repeatedly enacted in the transference relationship with the therapist at the receiving end of violence. Spillius speculates to what degree Linda early witnessed a violent relationship between the parents, or if the violence enacted in the session rather was caused by projective identification, the break stimulating intense rage, in turn projected into the parental couple, Linda subsequently identifying with a violent aggressor. However, in relation to this study, the important thing is that according to the description, Linda's violent reaction after

[39] pp. 192-219.
[40] Linda had since 1½ years of age slept in the same room as her parents, who at that time experienced a difficult social situation.

the break brought about in the therapist's mind a sudden clarity of an especially painful, central object-related phantasy.

A number of therapists working with children who early had suffered *abuse and neglect* likewise described *desperate enactment around breaks as highly enlightening in terms of central object relationship themes*. These descriptions come across as *literal ways to communicate fragments of earlier traumatic experience*; the children through projective identification and role reversal turning passive into active. For reasons of space it is impossible to describe all examples, a few appear below but others are Canham (1999); Collier et al (2004); Green (1998); Grünbaum (2010b); Miller (2008); Pick (1967); Salo (1993); Silverman (2004); Sussman (2001); Williams (1997b)..

Azarian et al (1997) described a profoundly deprived and traumatised five years old adopted boy, who 2 years earlier had witnessed a violent knife-attack on his birth mother. The first summer break in the therapy elicited a major backslide, apparently reigniting catastrophic anxiety and literal sensorial memory bits from the traumatic event[41].

Mikardo (1995) described 4 years old Sam's reactions to breaks, which seemed reminiscent of early experiences when as a critically premature baby, his relationships were characterized by repeated medical interventions and the impassively shocked state of his parents. Seven months into treatment a holiday break occurred, during which Sam was left by both birth parents. At first he reacted to these events over which he had absolutely no control by becoming blatantly omnipotent, identifying with an almighty "King of the Empire", boosting his illusion of power by devaluating the therapist. This was followed by

[41] The authors believe this an anniversary reaction. If so, this does not exclude the possibility that it was intensified by the break.

behavioural enactment resembling the sufferings of a helpless, premature baby, not even able to breathe, feeling unseen and abandoned. At later breaks he nonverbally seemed to communicate a wish to be inside the therapist e.g. by hiding under the table, or trying to infiltrate the locked cupboard to get the goodies he believed the therapist to withhold and during breaks offer to rival patients. He would deny the pain of the separateness by claiming that he was well able to cope without the therapist; sometimes closing himself completely off, lying very quietly under the table, while in the counter transference the therapist felt like a mother at an incubator, unable to reach across and give the tiny baby comfort.

Before and after the break

In some descriptions reactions before and after the break seemed to differ (O'Shaughnessy 1964, 1989; Rosenbluth 1970; Labastida 1976; Tustin 1986; Hughes 1988; Margaret Rustin 2008).

Before the break some children reportedly became severely confused, ordinary cognitive functioning more or less radically breaking down e.g. thinking, identity and linear time. Especially autistic children might become confused, experiencing upcoming breaks as invasive attacks on bodily integrity, as if violently kicked out of a habitation inside the therapist; a violent rupture of cohesiveness; a literal rift through which all good radically leaked out to be replaced by a devastating presence of an unbearable "black hole"-object of separateness (Tustin 1986; Houzel 2004, 2008). Children who early had suffered abuse and neglect before the break seemed more prone to annull the emotional

meaning of the therapuetic relationship; omnipotently deny longings; missing out the last sesision before the break; fortifying defensive boundaries by devaluating the therapist, idealizing people and events outside therapy. The child's evasion of the emotional reality of painful dependency might spread to the parents and the network as a collective denial of the child's need for therapy, thus ultimately endangering the therapy's survival after the break.

After the break more individualized reactions seemed present, however confusion and ambivalence seemed common. Labastida (1976) describing the reactions of four children around a Christmas Break; their reactions before the break uniformly came across as coloured by separation-anxiety, after the break noted a diversity of reactions. Children who had suffered *early neglect or abuse* may after the break seem especially torn between longing and inability to forgive the going-away-therapist; e.g. fortifying their armaments of defenses; altogether avoiding closeness either physically or mentally; unable to look at the therapist; unable to remember the name of the therapist; in a flooded, wildly manic state; through violent projective identification casting the therapist as a no-good, abandoned, odd one out baby (Rosenbluth 1970; O'Shaughnessy 1964; Hughes 1988; Margaret Rustin 1989). *Autistic and psychotic* children often returned from a break in an unbounded and fragmented state, as if not only was the link to the therapist lost but also a vital part keeping together the self (Tustin 1986; O'Shaughnessy 1989).

Flooded states and self harming tendencies

Some case studies described flooded and/or self-harming states to endanger the therapy and sometimes the safety of the child. *Flooded and potentially self harming states* were described by several authors (Bornholdt 2009; Dale 1984; Mondadori 2009; Watson 1990; Williams 1997c). Alvarez e.g. described a 9 years old, who had suffered neglect and maltreatment and at two years of age suddenly lost her birth mother, just four months after the birth of a baby sister. This girl reacted to an unplanned half-term break some months into treatment with such despair that she placed herself in considerable physical danger climbing high up the door to the therapy room, her feet balanced on the handle, hands on top of the open door, while mockingly suggesting the therapist was scared (1992 pp. 171-173). Containment of reaction to breaks may be especially complex in therapy with children who experienced early neglect, maltreatment and sexual abuse; exemplified by Ironside, describing a child who after the first Easter break accused his therapist of sexual abuse (1995). Setting in train full child protection procedures, including the boy's temporary withdrawal from the therapy and a police investigation of the therapist, jeopardizing both the therapist's professional and personal integrity and also his own, much needed psychotherapy.

2.3.3 Breaks in perspective of Bion's theory of thinking

A universal psychoanalytic axiom is temporary absence of the external object (mother/therapist) as an integral aspect of normal development; thus strenghtening the child's ability to contain depressive pain and longing, coming to terms with

ordinary developmental dilemmas of dependency-separateness. Thus, on the one hand the maternal ability for containing care, mirroring and attuning to her infant's feelings is crucial to healthy development; on the other hand just as crucial may be her ability to subject her infant to well-dosed transient absences as a necessary spur to mental development. O'Shaughnessy referring to Bion wrote: "*The absent object has the character of offering a 'critical' choice, .. 'between procedures designed to evade frustration and those designed to modify it*". (O'Shaugnessy 1964, p. 21; Bion 1962b, p. 29). In this model, the development of an "*apparatus for thinking"* is dependent on the child's frustration tolerance, i.e. ability to contain and own the bad feelings stirred up by the temporary absence of the object (Bion1962a). In its turn the increased ability to think enables the child to mitigate the present pain of longing by linking to good memories of relational exchange with an object that can be trusted to return. O'Shaughnessy suggested that in ordinary development there is a need in any child to be able to tolerate the absence of parental objects; because if no absence (distance) is possible the relationship becomes symbiotic, detrimental to the experience of separateness and development of separate identity. The related development takes time and may run in three consecutive steps: "*first, it is a bad breast present; second, it is thought of as a bad aspect of the breast; and third, it is thought of as a good breast missing*" (p. 23). Considering this, it seems no wonder if children who early in their lives suffered neglect and abuse may find it especially difficult to weather breaks in therapy.

Based on this model, one might predict a child's *experience of breaks during therapy to pass through similar steps, although not necessarily in a continuously even way*[42]:

1) *An absent therapist is a bad therapist present*, breaks giving rise to acute feelings of persecution; the therapist experienced as e.g. all bad, mean, useless, a nuisance, invading, unfaithful, inattentive, fat, stinking, weak or whatever uniquely personal deficiency of parental objects, the child's already existing core object relations and the actual therapist's shortcomings may point towards.
2) *An absent therapist is some aspects turned sour of the (otherwise) good therapist;* breaks giving rise to a feeling that a formerly mostly good therapist are on the decline; e.g. no longer needed, more interested in her own fun, or in other partial ways turned bad. This may be a reason why some otherwise productive therapies soon after vacations are broken off rather abruptly[43].
3) *An absent therapist is a good therapist missing*; at the level of thinking the child is able to remember and long for the good qualities of the absent therapist; the containing therapist kept in mind during the absence, feelings related to dependency, separateness and longing may be thought of and owned. This is not equal to only good feelings emerging, at the opposite since by now anger can be contained by the apparatus of thinking,

[42] This model should not be taken literally, as a continuously progressive line. Children probably never simply start at base level and proceed orderly to the next levels. Since throughout life shifts occurs between persecutory and depressive modes of functioning, no person immune to backslide in moments of loss and need (Klein 1957; see also chapter 4.4.4.). Therefore, this model of three stages may best be understood as a ladder of possible reactions to break, shifts maybe even occurring in the same session.
[43] See for instance Kronengold's finely detailed description of a therapy with an adopted child, whose therapy abruptly ended after a summer vacation (2010).

ownership of the feeling is possible. It is rather that throughout the break, the child predominantly is able to keep up faith.

In accordance, Houzel (2004) presented clinical data of an autistic child's reaction to breaks, suggesting that a planned ending of therapy might be within reach, when the child continued to make progress even during breaks. This assumption finds further empirical corroboration in Rustin's description of a supervision of the therapy of a 4 year old very disturbed, hyperactive child; reporting two holiday breaks from the therapist's session notes, an early and a later break (1998b). The first, a Christmas break seemed to elicit an overwhelming separation anxiety and related defenses; the child in mindless, wildly manic states of mind denying any dependency. In the countertransference, the therapist felt overwhelmed by hopelessness, spreading like ripples, undermining treatment alliance with the parents, endangering the survival of therapy. In contrast, the later holiday break seemed to stimulate a developmental spurt, the child becoming able to contemplate in play and verbal dialogue his concerns about dependency-separateness.

2.4. Questions left by theory reviews

The above review leaves unanswered quite a few questions relating to the three areas of interest to this study; namely psychoanalytic child psychotherapy with children who early in their life experienced abuse and neglect; and the meaning of core object relationships and breaks in child psychotherapy.

There is a great need for systematic outcome studies of *the effectiveness of psychoanalytic psychotherapy with this group of children* in its own right and as compared to other *treatment orientations and modalities*. Unsettled issues are e.g. a possible proportionality between on the one hand *degree of disturbance and age* of child and on the other hand the needed *intensity and length* of treatment. Also needed is systematic examination of *the role of parallel work with parents, care-givers, and network.*

Most of what is known based on single case reports not methodically reported; quite a few of the important ideas remain tentative. There is a general need for a *more varied methodology of study* and especially for *more systematically reported case studies*. Especially sparse seems systematically reported studies concerning *core object relationships and the meaning of breaks,* thus there is a need for detailed exploration of *a whole range of questions*:

- If psychoanalytic child psychotherapy in line with adult psychotherapy produces *characteristic object relationship themes*, permeating the therapeutic relationship and process, parallel to reported early and concurrent daily relationships. If so, *which specific unconscious themes or conflicts* (core object relationships) may characterize these children? Will these *differ from other groups of children* e.g. autistic or psychotic children?
- An often-described problem in these therapies is *violent assault*; further exploration needed of links to core object relationships and the *therapist's counter-transference*.

- What is the relationship (if any) between *core object relationships*, the impact of *interpretation of positive or negative aspects of the transference relationship*, and the *outcome* of therapy?
- Is there a tendency for *an initial honeymoon period* soon to lapse into hostility and violence? If so, what is the *link to early experience and core object relationships*; and what is the role of the therapist's countertransference feelings?
- What are the *links between core object relationships and breaks*, e.g. will there be a tendency to intensify and re-enact core object relationships before and after breaks?
- Is there a difference in the emotional meaning attached to a break *before and after the event*; if so, how may this link to core object relationships?
- Is it possible to disprove or substantiate an assumption that *the child's reactions to breaks may be an indicator of benign change*, a planned ending within reach if the child continues progress during breaks?
- Finally, are the reactions of this group of children to breaks *specific or common also to other children* in psychoanalytic psychotherapy?

3 METHODOLOGY

This chapter delineates the research questions and setting; the clinical case; the rationales and procedures for sampling; the analytic methods as well as the process of data analysis.

3.1. Research questions

Based on the above recapitulation of status of research into core object relationships and breaks in child psychotherapy, the aims of this study were:

I. To contribute to a detailed and empirically supported understanding of the core features experienced in the therapeutic relationship with children who have suffered early abuse and neglect

II. To contribute to a detailed and empirically supported understanding of possible links between such core features and the experience of breaks in the psychotherapeutic process with these children

III. To investigate Hinshelwood's assumption of continuity of core themes found inside therapy with reported themes in the child's early, concurrent, and later daily relationships

IV. To contribute to the development of a systematic and transparent methodology for the psychoanalytic case study by bringing this in accordance with scientific rigour of qualitative human research.

These questions explored below, for convenience in the order of four areas:

1) *Identification of central relational themes in therapy sessions*

2) *To explore the manifestations of these core themes as experienced around breaks in the therapy*
   a) *The possible influence of breaks on core themes*
   b) *Did this change during therapy and how*
   c) *Was it possible to disconfirm or corroborate a similarity between the experience of breaks and session beginnings/endings*?
3) *If possible, disconfirming or corroborating continuity between these relationship themes as found inside therapy with reported themes in the child's early, concurrent, and later daily relationships*
4) *Systematic application of Interpretative Phenomenological Analysis*[44] *to explore whether this may improve the psychoanalytic case study's scientific rigour without depleting its unique clinical richness*

3.2. The clinical case – Samantha[45]

Samantha was referred to psychotherapy when 5 years 2 months old by a community childcare worker; she had been 18 months when taken into forced custody at

[44] In the following referred to as IPA.
[45] A thorough anonymization of case information performed, all personal details that might be recognized changed. Care taken as far as possible, substituting with information that did not change the substantial psychological meaning of events. It should be noted that from a scientific perspective, such substitution or omission may jeopardize reliability of the clinical case; since we cannot know for sure, which facts are crucial and which irrelevant to the conclusions of the study (Gabbard 1997, Michels 2000). This study was carried out in Denmark by a certified Danish psychologist and therefore adhering to Danish legislation and professional ethical guidelines to protect a client's privacy (https://www.retsinformation.dk/Forms/R0710.aspx?id=828); (http://www.datatilsynet.dk/offentlig/kort-om-persondataloven/) ; (http://psykologeridanmark.dk) stating ethical guidelines for members of the Danish Association of Psychologists).

a residential institution and 42 months when placed for permanent foster care[46]. The foster father worked as an electrician, the foster mother was at home taking care of Samantha and another foster child, a boy 10 years of age, who had been in the family since 2 years of age. The couple had two older birth children, a boy 21 years, and a girl 16 years old. At the time of referral, the boy had moved to a bigger city for his education.

At referral, the foster parents wanted therapy for Samantha, because they felt her development had come to a standstill, e.g. she had stopped playing, did not seem to catch what they said to her; her language deteriorating into meaningless parroting and copying the behaviours of the foster brother. They felt that although Samantha had attached to the foster mother in a kind of sticky way, areas in her mind were never really engaged in the relationship. They described her as anxious, delicate, and controlling; unable to tolerate any change, at one moment clinging desperately, the next angrily withdrawing. She allegedly was liable to compulsive, often self-harming behaviour e.g. picking her skin until bleeding; if stopped, going completely to pieces, for hours crying inconsolably. She was a finicky eater, often endlessly ruminating on her food, apparently unaware of bodily needs. She frequently worried about her bodily integrity e.g. complained of pains, especially in anus. She had difficulties falling asleep, would often wake up

[46] The English reader probably will find it objectionable to keep a young child in lengthy foster care rather than to settle her securely in an adoptive family. As noted above legal procedures for forced custody differs widely between UK and Denmark. In Denmark the rights of birth parents constitute the starting point for the legislation, which is founded on the belief that whether forced or voluntarily, it is in the best interests of most cared for children to maintain a bond to their birth parents. When a child is taken into custody, the community by law is obliged to offer such support to the birth parents that if possible in due time enables them to resume custody. Legal adoption in Denmark almost solely concerns international adoption and a few Danish children whose birth parents voluntarily decide to give the child free for adoption. Legal possibilities of foster parents to adopt a foster child are very restricted and include e.g. several years of the child's staying in the family, during which the birth parents have shown absolutely no interest or ability to keep in contact with the child. These features of the Danish legislation mean that some children, like Samantha, spend most of their childhood in foster care.

in the middle of the night, not calling anybody; staying awake for hours, wandering about alone or lying quite still in bed, eyes wide open, staring into the dark while picking her skin. She often fell and was described as quite clumsy, however never cried out for help even if badly hurt.

Early development: Samantha was the youngest of three birth sisters, her sisters 2 and 4 years older. She and the middle sister, Lea went together into custody at the residential infant institution. The oldest sister, Buzz some months later went into a residential institution for school age children. The residential infant home described Samantha and her sister as severely neglected and traumatised; recurrently exposed to abuse, witnessing the violent relationship between the birth parents. The two older sisters reportedly imitated the violent behaviour of parental figures by fierce assaults on their youngest sister, Samantha. At the residential institution, both birth parents had access but visited quite irregularly; after her placement in the foster family, birth mother kept up an unstable visitation, often indisposed or forgetting her appointments, while birth father dropped out of visitation.

Box 1. Assessment of Samantha (1 year 2 months)[47]:

"In general were seen a child with pervasive difficulties in her social contact both with her mother and the examiner. Her development of language is severely behind the expected age norms. Concentration and goal direction in her play are deficiently developed. The weakly developed abilities for social interaction lead to difficulties to cope with demands and it was not possible to establish mutual play. By close physical holding and the presentation of a picture book the examiner managed to establish a short lived infantile contact. The development of performance skills is inside the normal range and no specific cognitive difficulties should be expected... In the attachment procedure, we found a very lonely child with a pronounced tendency for retreat and isolation with her feelings. The conclusion is… at risk for an attachment disturbance proper. Samantha presents as a child in need of treatment. She ought to be placed at a treatment institution…"

Box 2 Assessment of Samantha (4 years 10 months old)[48]

"Samantha appears little for her age, pretty with big, watchful eyes… At first, she gives the impression of good development with a high degree of mastering. In most cognitive tasks, her developmental level is inside or above normal range, both in verbal and performance tasks, although her pronunciation often is quite infantile. Emotionally, she appears to be a very anxious and angry child who is quite expert in covering up her emotions with a precocious control over her affective displays. She has a pronounced tendency for imitation. She also has a pronounced tendency for idealisation, in this way keeping negative feelings at bay. She seems not to have developed ordinary trust in the figures of her environment, tends to keep at a distance; apparently not expecting any help. The conclusion is that due to emotional deprivation in infancy, the early attachment capacities are undeveloped and disturbed".

[47] The assessment was performed by a child psychiatrist and clinical psychologist at a child psychiatric outpatient clinic for infants.
[48] The investigation was performed by a community psychologist and included WIPPSI, draw a man, CAT, play observation, and observation in a kindergarten.

3.2.1. Child psychotherapy setting

Samantha was seen twice weekly from the age of 5 years 3 months to 9½ years old. The therapy took place at the therapist's private clinic, in a spacious room that at one end were equipped with adult sized chairs and a couch, at the other end a play area with a sandbox, a jug of water, a box of bricks, and a doll's house with furniture but without dolls. Samantha had a personal play box.

A social worker from a foster family agency superintended the placement on behalf of the community; paying regular visits to the foster family. Parent work with the foster parents took place at first fortnightly, later by monthly meetings undertaken by a community-based psychologist, whose sole function was to offer parent guidance to the foster parents[49]. The work was supportive, relational parent work, bearing the actual child in mind, while keeping the focus on the foster parent's role as parents. The psychologist aimed at finding ways to help them contain the anxieties and desperation stirred up by Samantha's comprehensive relational and behavioural difficulties; a working alliance founded on mutual partnership. This work was vitally important to Samantha's psychotherapy, a central part of the broader external framework needed to weather and sustain the therapy through often difficult and stormy conditions; similar parental work was described by for

[49] According to Danish legislation, the community responsible for placing a care order is obliged regularly to superintend the placement. Most children in care are placed in foster families rather than in residential institutions. Superintending the foster families in most cases is performed by a social worker with experience in the dual task of counseling the foster parents while safeguarding the child. If the child suffers special disturbances or problems of development, the community may decide in addition to offer specialist parent support to the foster family. This most often will be offered by a clinical psychologist specialized in children. In Samantha's case, for the first half of the psychotherapy, the work with the foster parents was undertaken by a qualified clinical psychologist in training as a psychoanalytic child psychotherapist under the auspices of the Danish Association of Psychoanalytic Child and Adolescent Psychotherapy and therefore able to bear in mind the infantile features of Samantha's personality. In the second half of the therapy, the work with the foster parents bravely was carried on by a newly graduated, systemic oriented psychologist.

instance Margaret Rustin (1998a, 2009); Horne (2000); Houzel (2000); and Emanuel (2006).

During the entire therapy, Samantha had the support of the same special teacher, initially in the kindergarten and later during school hours. Two yearly network meetings included the participation of Samantha's foster parents, the social worker from the foster family agency, the psychologist working with the foster parents, and the child psychotherapist. The therapist met two times for mutual information with the birth mother and the community childcare worker responsible for the placement; after 1 year and again after 2½ years of treatment.

3.3. Applied methods of data collection

As common to psychoanalytic case studies, the therapist was also the researcher; who accordingly somewhere between these two activities, therapy cum research, had to transform her attitude from therapist-in-therapy to researcher-after-therapy. Three sets of data were included, collected in different ways:

1) Data generated inside the playroom by the therapy, recorded after the session by therapist.
2) Case-file documents as assembled and written down by several caseworkers (a compiled list specifying sources and nature of these documents appears below, box 3a-b).
3) Data generated by semi-structured interviews, carried out by the therapist 2 ¾ years after the end of therapy.

3.3.1. Psychoanalytic child psychotherapy as data collection

In this psychoanalytic case study, the subjectivity of the therapist-in-therapy was committed not only to the task of becoming closely involved with the subjectivity of the mind of the child, she was also actively involved in the creation of a main part of scientific data included. Moreover, as part of the therapeutic task, the therapist herself also carried out observation and recording, and thus at the very base of this project, the researcher's previous role as a therapist-in-the-therapy by necessity will have influenced the nature of her observations in the playroom (Michael Rustin 1996 & 2009; Hinshelwood 2010). This double subjectivity carries doubt if the therapeutic obligation as far as possible to restore the child on the path to a healthy personality development is properly separated from the scientist's obligation to create new knowledge; doing her very best to observe and analyse the phenomena studied from a neutral (but not necessarily uninvolved) position (Midgley 2004; Fonagy 2009).

One of the problems of this sort of psychoanalytic case study is the epistemic nature of the subject of study, namely to gain knowledge of unconscious phantasy formations that solely develop inside the psychotherapeutic transference-countertransference relationship; thus not possible to study outside this. Such research, dependent on a view from within the relationship was by Moser termed *"on-line"* research as contrasted by the "*off-line*" view from without offered by academic psychotherapy research (1992). Therefore the credibility of a psychoanalytic case study, first and foremost depends on the therapist's commitment to a truthful depiction of her observations in the consulting room and her ability systematically and with transparent rigour to bring these observations explicitly to

bear on psychoanalytic theory (Leuzinger-Bohleber et al 2006; Stiles 2003 & 2009).

Hence, the researcher-after-therapy must do her best to balance between two opposite states of mind. On the one hand, she must approach the research process from a disciplined, but still subjective immersion in the fine details and emotional imagery of the therapeutic process. On the other hand, she must recurrently take a huge step or more back in order to question and if necessary kill off her own favourite ideas; from a neutral distance contemplating the possible bias born out of her emotional involvement in the case (Rosenthal 1966; Britton et al 1994; Sandell et al 2007).

What kind of data are a therapist's process notes?

The psychoanalytic case study often is conceived as equal to a psychotherapist studying her session notes, in a more or less systematic fashion picking out examples to explore and illustrate something specific; a new or especially interesting phenomenon as encountered in the course of therapy. Such research has long tradition, the development of child psychotherapy as a professional practice rooted in pioneering case descriptions by Melanie Klein (1926, 1932, 1961) and Anna Freud (1927, 1936, 1966); both contributing to development of a systematic therapeutic methodology and related ways to understand the decisive role of primary relationships in development. As shown in the above theory reviews, this heritage not only have preserved but also hugely contributed to the understanding of the inner world of troubled children.

However, intersubjective agreement an important part of scientific credibility, it is at length not sufficient to safeguard the scientific trustworthiness of a theoretical position. Hence, the psychoanalytic case study has to be supplemented and developed, to allow for the inclusion of systematic empirically linked methodology as e.g. evidenced by developments in adult psychotherapy research. Contemporary psychoanalytic single case research encompasses a broad range of qualitative and quantitative approaches; including numerous ways to create/collect, select, and analyse case data; the therapist's role in the research process also varying. To mention but a few examples, Moran et al (1987) applied a sequential, thematic analysis of the therapist's summary of process notes, comparing this to quantitative measurements of a diabetic patient's blood sugar levels. Alvarez et al (2004) compared summarised session observations with quantitative behavioural ratings from the same video-recorded sessions. Schneider et al (2009) described a quantitative method, the child psychotherapy Q-set, well suited to analyse videotaped sessions and recorded process notes, whether applied as a supplementing instrument in single case research or to compare features across a number of therapies, even of a different therapeutic orientation.

Even so, as stated by Midgley (2006) in an eloquent state-of-the-art paper, it is in no way possible to bypass certain possible weaknesses of a clinical case study, among which looms large *the problems related to the scientific credibility of session data*. Two different methods of recording therapeutic data mentioned, each with its own limitations: a) *the therapist's own recordings as written after the sessions*; and b) *video- or audio-taping the events of the session*.

Relying solely on *the therapist's recorded notes*, as stated above obviously has certain drawbacks (Fonagy 2009; Midgley 2006; Wallerstein et al 1971). Thus

no matter how conscientiously recorded, a therapist's process notes are a personally structured rather than a neutral set of data; her selective attention, perception, and memory favouring some information, while inattentive or forgetful towards other information. This is part of the package of the psychoanalytical case study in its pure form; a precondition for the study, the resulting narrative born out of a subjective transference-countertransference relationship. This also is its Achilles heel, since huge variation between therapists by necessity will decrease the trustworthiness and comparability of data and findings[50]. For such a data material to be of scientific value, a truthful effort on part of the therapist is to record every detail observed in the exact memorized temporal order of events, with no conscious attempts to superimpose logic or narrative-emotional order; no matter how cryptic, chaotic, or even shamefully stupid the resulting text appears. This demands that the therapist adopts *a multi-layered observational perspective on her own role, taking account of the evolving relationship* (Emde 1994). The resulting text in essence is a process narrative, inseparable from the unique subjectivity of the therapist.

Alternatively, *video- and audio-taping* are widely recommended and have the advantage of offering a complete moment-to-moment account of observable events, including such non-verbal behavioural data of which the therapist may not be aware. Furthermore, transcripts of such recordings enable the researcher more freely to select whatever sections fit the specific questions researched. There are however also drawbacks to be considered. One common objection e.g. stated by Klein (1961) is that taping the session may compromise the privacy of the relationship, thereby altering the therapy process by introducing the idea of a public

[50] This is one more reason why, the quality of child psychotherapy case study reports also depends on the quality of the training of the child therapist.

audience. Another, probably more fatal problem is a risk that the specific nature of the psychoanalytic process of cognition is impoverished, as videotaping in great detail captures manifest verbalisation, behaviour, and facial expression; but in reverse omits feelings, thoughts, and phantasies related to the transference-countertransference relationship.

As mentioned, a *central concern of this study was to investigate consequences for the "classic" psychoanalytic case study of the importation of methods from qualitative research*. Accordingly, the events of the therapy were recorded solely by memory of the therapist, in accordance with the usual way to record psychoanalytic child psychotherapy. Thus, although information from other case file documents and interviews is included, the main part of data consisted of the written notes of the therapist-cum-researcher. These notes, henceforth named "*process notes*", recorded the therapist's detailed observations of whatever had taken place, a sequential description depicting the natural succession of events as according to the therapist's memory.

In line with suggestions by Klumpner et al (1991) and Tuckett (1994b) recordings of clinical events in this study differentiate contributions of child and therapist, as well as the therapist's actual verbalisation and behaviours from her subjective states of mind[51]. Thus, as far as possible, *certain guidelines were adhered to in recording the process-notes*[52]:

1) Process-notes depict the detailed temporal sequence of events in such a way that the verbal dialogue, play, and any behavioural manifestation appear as a chain of events rooted in the interaction of child and therapist.

[51] A theoretically underpinned definition of countertransference appears in 4.2. below.
[52] "As far as possible", because as will be clear, one result of this study was highlighting the decisive, although unconscious, impact of the countertransference of the therapist-in-therapy on her ability to write up process notes (see section 4.2,)

2) Process-notes include a detailed, verbatim dialogue, recorded in such a way that the child's and the therapist's contributions are clearly differentiated from each other.
3) Process-notes include a detailed description of the evolving play and any behavioural manifestation; recorded in such a way that the child's and the therapist's contributions are clearly differentiated from each other.
4) Process-notes include the therapist's impressions of the child's states of mind; clearly denoted as part of the therapist's mind-space, i.e. her impressions and deductions as derived from the interaction.
5) Process-notes include the therapist's private reflection on her own emotional and cognitive states and thoughts; clearly denoted as such.

3.3.2. The semi-structured interview

The qualitative, semi-structured interview, at the heart of qualitative methodology aims at a dialogue with a purpose. Embedded in the researcher's theoretical preconception of the topic to be explored, this kind of interviewing makes it feasible to follow the evolving thread of a dialogue, allowing the researcher to get as close as possible to what respondents think about the topic (Kvale et al 2009). With this theoretically embedded purpose in mind, the interviewer's questions must be unsaturated, leaving ample space for the respondents to answer in their own way, taking seriously their perspective and concerns, through this approach gaining a richer understanding of their lived experience (Smith et al 2008; 2009; McLeod 2011). Accordingly, in line with this, the specific questions stated in the interview

guide were formulated broadly, during the interview functioning as signposts, showing the researcher in which relational areas to move around rather than taken as literal questions to ask in the way they were thought of beforehand (Tanggaard et al 2010).

3.4. Data selection and research questions

As described by a number of researchers, empirical sampling in qualitative studies is a purposeful, conceptually based process of selection coming along together with an interrelated process of demarcation and cultivation of the original points of interest. The research process usually starts with broad, tentatively phrased ideas/questions acting as a point of departure for the first, correspondingly broad sampling (Charmaz 2008; Flyvbjerg 2006; McLeod 2001; Miles et al 1994; Smith et al 2009).

This interaction between research questions and selection is essential to qualitative research; in the process sampling becoming more and more focused, increasingly based on theoretically informed concepts rather than on random choice, hence named *"theory based" (Miles et al 1994, p. 28),* "*theoretical"* (Charmaz 2008, p. 103), or *"information oriented"* (Flyvbjerg 2006, p. 230) *sampling*[53].

[53] This is of course not to say that random sampling is useless; its importance to quantitative outcome studies showed in chapter 2.1.3. Miles et al provide an instructive, still very useful overview of sampling strategies in qualitative research (1994, pp. 26-34).

3.4.1. Presentation of available case information

The scientific quality of a clinical case study is dependent on transparency relating to the nature, quality, selection, and sources of the included data (Miles et al 1994, Elliott et al 1999, Hiles et al 2007). In a study of risk-taking behaviour, Anderson (2006) suggested transparency of data to increase if keeping a clear mind not only of the sources of data but also of the distance from which the researcher considers the data. To this end, she suggested a distinction between primary, secondary, and tertiary data levels. The below presentation of the data included in this study was inspired by this distinction. However, Anderson conceived of case-supervision and the chosen tools of qualitative methodology as a kind of higher-level data (pp. 335-336). This view presupposes that the results produced by the qualitative analysis are part of the data material, although viewed upon from a larger distance, at a higher level of abstraction. In line with *modern constructionist thinking*, *Anderson's model* stress the point that any collection of data are constructed and therefore cannot be conceived of as unrelated to the researcher; no neutral collection of raw information waiting out there in the real world for the researcher to discover and analyze but rather as suggested by McLeod (2011), a text created as part of a purposeful activity.

This project conceptualized as data only such information that in principle were not yet analyzed. This notion builds on *a modernistic conception of reality*, stressing an *"empirical habit of mind"* as important; the ability to observe external reality while doing one's best to keep clear the boundaries between facts and theoretical inferences decisive both to valid research and good child psychotherapy (Michael Rustin 1996; 2001; 2009, p. 45). The scheme presented below therefore is *a personal re-interpretation of Anderson's model*, conceiving of supervi-

sion and analytic methodology not as data but rather as methods applied for the analysis of data. In line with Anderson's suggestions concerning distance, the below model makes an effort to conceptualise *the level of the researcher's personal involvement in the production of the data*, three levels included:

1) *The primary data level is clinical data collected by the therapist-in-the-therapy acting in this role.* At this level the least distance between the researcher and her data, since it consists of records she made herself of dialogues in which she herself partook. Here are process-notes from therapy sessions and sessions with foster and birth parents as well as records of network meetings. This is the level of maximum subjectivity, from a scientific point of view a possible source of bias; from a psychoanalytic point of view a necessary part of the research process. In this view, these data are genuine first-hand information concerning the clinical case, obtained from one of the participants in this case; as such constituting a unique, empirical raw data collection, the nature of which is intimately known to the researcher-after-therapy. The characteristics of the available primary level information appear below in *box 3.a.*
2) *The secondary data level is data collected by the researcher-after-therapy, exploring the participants' experience of their present relation to the child as well as their present memories of shared clinical experience.* This implies somewhat more distance, the data not seen through the subjective lens of the therapist-in-the-therapy, but rather through the lens of the researcher-after-the-end-of-therapy, the collection of data disciplined by systematic application of principles for the semi-structured interviewing. These data appears in *box 3.b.*

3) *The tertiary data level contains independent information obtained by external data sources; i.e. recorded quite independently of the therapist-cum-researcher.* Data at this third level are case-documents recorded by other case workers in direct contact with the child; not influenced by the therapy, either because they were not part of the collaborative network or because of distance in time, the information given well before the child's referral to therapy. These data appears in *box 3.c.*

Box 3.a. Primary data level: Therapist-in-therapy recording her experience

Process notes from 188 psychotherapy sessions[54]*:*
4 years, 2 weekly sessions of 45 minutes (Samantha 5 – 9½ years of age). Total amount of sessions 220 therapy sessions
Attrition: Notes are missing for a total of 32 sessions, i.e. an attrition rate of 15 %. The loss of data was mainly due to technical problems (a combination of a defect USB-device and a not quite reliable PC); but for other reasons 8 se*ssions* simply were not recorded. The 30 missing sessions are numbers 104-119, 142-147, 166-167, 172, 184, 188, 190, 193, 200, 212, 218.

Information received from external sources during psychotherapy[55]:
a) Recordings of 10 network meetings held approximately twice yearly; participants: foster parents, their supervisor, the caseworker from the foster family agency in the community, and child psychotherapist.
b) Recordings of 17 consultations of child psychotherapist with foster parents, some face to face, some by phone, randomly distributed throughout the therapy.
c) Recordings after 1 and 2½ years of psychotherapy of two consultations of child psychotherapist with birth mother and child-care worker in legal charge of the placement

Box 3.b. Secondary data level: Researcher-after-therapy exploring participants' experience

Semi-structured interviews 2 ¾ years after the ending of psychotherapy[56]*:*
a) Written notes from a phone conversation with the case worker from the foster family agency
b) Transcribed tape recording of semi-structured interview with the foster parents
c) Transcribed tape recording of semi-structured interview with the birth mother

Box 3.c. Tertiary data level: Information recorded by independent external workers

Case documents of early development, family background, and symptoms as prepared by independent agents
a) Samantha's problems as described at referral in letters and consultations. The referring agency was a caseworker from a foster family agency in cooperation with childcare worker from the community in legal charge of the placement.
b) The referring agency's information of early family background, relationships, events, and development as described at the time of referral.
c) Earlier interventions before placement at 1½ years of age: Support teacher in day care and at home, support family in weekends, psycho-educative parent guidance.
d) Clinical assessments at 1 year 2 months (clinical psychologist and child psychiatrist at an outpatient infant psychiatric clinic) and at 4¾ years (clinical psychologist on behalf of the community)
e) Court orders concerning forced custody and placement at a residential institution (from 1½ -3½ years); placement in permanent foster care (3½ years of age); and restrictions of birth mother's access (5 years old).

[54] *Process notes*: the therapist's detailed recordings of what took place in the single session, see above 3.3.1, pp. 83 for a detailed definition).
[55] These were recorded by the therapist-cum-researcher after each consultation/meeting.
[56] Tape-recorded and transcribed by the researcher-after-therapy.

3.4.2. The first 24 sessions – a baseline for central themes

The idea of distance-closeness dilemmas as related to unconscious core object relationships, and the related wish to explore the clinical manifestations of this phenomenon formed the point of departure for sampling all process notes from the beginning of therapy, i.e. the first 24 sessions. The beginning of therapy was chosen to establish a kind of baseline, a period in which the manifestations of central relationship themes presumably were relatively unaffected by the therapy process. The central themes subsequently operationally defined by sub-themes as distilled from the IPA; the manifestations of these predefined core themes studied in other case file documents and selected parts of the process notes from later therapy.

In emotional reality, the length of the beginning of a therapy varies according to the total length of the therapy and the uniquely defensive structures and anxieties of the child. In this study, the *beginning defined as the first 24 sessions*, which in an ordinary twice-weekly therapy approximately will cover 3-4 months depending on the number of holidays in this period. However, contrary to expectations, the first 24 sessions of Samantha's therapy covered a period of 7½ months, because barely started, after the first two sessions, unforeseen disagreement between community departments in each their way responsible for the child and the placement caused an interruption of therapy. This obstacle overcome, the summer vacation had started; therapy finally resumed after a break of 2½ months[57].

There are two reasons why 24 sessions somewhat arbitrarily were chosen as the demarcation of the beginning of therapy:

[57] The difficult start of this therapy cannot but have contributed to my unconscious counter transference reasons for choosing this instead of other possible therapies for a study of links between core object relationships and breaks.

1) In order to include the first Christmas break in the four Christmas break-sets studied, session number 24 was the latest possible to include in the beginning[58].
2) The four Christmas break-sets each contained 6 sessions; 24 sessions in total. The numerical tidiness of having 2x24 sessions to compare, occurring in a time-sequenced fashion, probably unconsciously appealed to the researcher's somewhat ruminative tendency for balance and order. However, it seemed convenient to be able to compare the same number of sessions in beginning of therapy as later, e.g. assessing which themes were central and which outlaying; and if and how change took place.

3.4.3. Four Christmas break-sets - central themes around breaks

One way to check out links between predefined themes and breaks would be comparing occurrence and quality in the *total universe* of all breaks in the therapy[59]. This exceeding my resources, I opted for a *smaller, theoretically informed selection of breaks*, in accordance with recommendations by Flyvbjerg (2006), selected to maximise the utility of information obtained. Aiming at a systematic, transparent reduction that offered readers a chance of evaluation, certain *principles of selection* was stated:

[58] See the rationale for sampling Christmas breaks below.
[59] Appendix, tables II.3. & II.4 show spacing of all breaks in therapy.

a) *Planned breaks spaced in time;* in order to show deterioration or improvement in containment of feelings stirred up by the break.

b) *Christmas breaks chosen, aimed at amplifying the effect of breaks*. Thus, yearly recurring holidays like Easter, summer or Christmas seemed appropriate, but their emotional implications differ. Summer breaks difficult as the lengthiest break of the year but for most children implying the promise of free time and leisure activities. Easter and autumn breaks are shorter and more neutral. Christmas breaks quite another story; most childcare workers, including child psychotherapists, probably would point to them as the potentially most agonizing break of the year, especially so for children taken into care.

c) *Sessions before and after four Christmas breaks sampled:* this therapy held four Christmas breaks; sampling the last 2 sessions before, the first 2 sessions after the break resulted in a total sample of *8 sessions before, and 8 sessions after a Christmas break.*

d) *Four Christmas break-sets formed, each including 6 sessions, of this two no-break sessions.* The no-break sessions were included firstly in order to increase possibilities to falsify assumptions of links between breaks and certain changes in core object relationships; secondly, to bring out possible difference between the ordinary rhythm of meeting and separating in a twice-weekly therapy as against the break-sessions proper. Therefore, *4 x 2 no-break sessions selected*; the principles of selection specified below. This yielded *a total sample of 24 sessions.*

Definition of no-break sessions to be included in break-set material:

- A no-break occurs *before not after the break in question* (to be able to assess possible interruption or discontinuation of themes).
- A no-break includes *two consecutive sessions*.
- No-break sessions must occur *at least 2 sessions before a planned or mixed break*, no matter how long the break[60].
- No-break sessions must occur *at least 2 sessions after a break*, no matter which kind of break and no matter how long a break.
- By possible choice of more than two no-break sessions, the two consecutive sessions with the *most detailed process* notes are included.
- A specific no-break session may *only be included once* in the break-set material[61].

[60] *Mixed break:* a planned break preceded and/or followed by unexpectedly cancelled sessions.
[61] In order to include the first Christmas break in the sample, by necessity the two no-break sessions of this break-set were also included in the first 24 sessions.

3.5 The nature of analytic instruments

Box 4. Inductive-deductive aspects of IPA as applied in this study[62]

The applied analytic strategies and instruments
a) Systematic inductive analysis to identify core themes
b) Deductive analysis by predefined relational themes as distilled from the above exploration
c) Coding predefined relational themes on a three-point Likert scale
d) Coding predefined relational themes on mapping charts showing temporal change

The presence of additional analytic minds in the research process
a) Supervision of the therapist-in-the-therapy, two sessions; after 6 and 12 months of therapy[63]
b) Supervision of the research process by Ms. Margaret Rustin, some face-to-face sessions, numerous Skype-sessions about meaning and structuring of the raw data material; development of analytic instruments and interpretation of findings
c) Supervision by Dr. Nick Midgley relating to qualitative methodology for instance the development of the IPA and related analytic instruments

According to Brinkmann et al (2010) qualitative research may be viewed as *an epistemological tradition* with its own field of enquiry or *as the initial part of a mixed methods study combining qualitative and quantitative* methods, e.g. starting with a qualitative analysis to identify certain attributes of the phenomena; secondly assigning to these attributes numerical values aimed at quantitative comparison. Such mixed methods were described by e.g. Edelson (1985); Elliott (2002); Moran et al (1987, 1991); and Schneider et al (2009).

[62] *Induction*: A form of reasoning, the researcher approaching the empirical field without preconceived assumptions, letting the data speak for themselves; the point of departure for development of a particular (local) theory concerning the field of study. *Deduction:* a form of reasoning, the point of departure is theory, from which certain hypothesis are derived; the consequences of these subsequently tested on empirical data and thus falsified or corroborated (Boolsen 2010, pp. 207-208).
[63] This took place in the above mentioned supervision group for supervisors and teachers at the child and adolescent psychotherapy training under the aegis of the Danish association of Psychoanalytic Child and Adolescent Psychotherapy (www.fpap/DSPBU).

A qualitative approach applied throughout this study, hence belonging to the first perspective. However; most qualitative methods include a deductive phase in which concepts distilled by induction are deductively defined and subsequently tested against the same and preferably also other samples (Miles et al 1994). In this study, as part of the testing certain quasi-quantitative instruments (a three point Likert-scale and sequential mapping charts) was introduced, leaning towards a mixed perspective. Thus, the inductive-deductive approach of the IPA gave rise first to certain core themes, then to the formulation of certain predefined relational themes, the empirical definition of which were distilled from keywords and sub-categories established during the IPA (see section 3.6.1.). The predefined themes subsequently were tried out on new samples, purposefully selected as described above. The epistemological status of this testing by predefined themes may be discussed depending on the preferred perspective of the discussant. Thus, possibly one may conceive of this as a second, deductive part of a mixed methods study; however, to this researcher it appears as a necessary subsequent, mainly deductive step of the IPA, namely the *analytic induction* of later stages in a project, aimed at moving from the particular assumptions of the single case to more general, theo-retical claims[64] (Boolsen 2010; Karpatschof 20007; Smith et al 2009).

3.5.1. Interpretative Phenomenological Analysis

The aims of this study being explorative, the inductive-deductive principles of IPA seemed well suited to guide the analysis (Smith 1996; Smith et al 1999, 2008,

[64] *Analytic induction:* A combination of inductive and deductive reasoning applied on qualitative data in order systematically to try out the consequences of general ideas (as derived from inductive analysis) on a selected field of empirical data (Boolsen 2010, p. 208; Smith et al 2009, p. 31).

2009). IPA is a systematic qualitative methodology aimed at bringing forth theory based on a description of topics as seen from the researched subjects' perspective; offering guidelines for analysis, synthesizing, and conceptualisation of qualitative data. It seeks to combine the dual perspectives of phenomenology and hermeneutic interpretation. The methodology considered *phenomenological* because intending to explore the world as it appears to the subject; illuminating the subjective experience of individuals trying to make sense of their life experience (Giorgi 2010; Smith 2010). Since the personal life world of the participants cannot be observed directly; the observation must depend on (and become complicated by) the researcher's preconceptions, which presuppose an interpretative activity. Thus, as pointed out by Gadamer (1975) any researcher needs to stand at a certain spot of the world, which he then cannot observe, in order to gain a perspective and observe other parts of this world. A research process cannot but be based on preconceptions, and in order to create and inscribe meaning to the observed data, an interpretative process has to be added; wherefore, the endeavour of IPA also considered *hermeneutic-interpretative*. IPA like all qualitative approaches are circular; the researcher going back and forth between an inductive reading through the whole and parts of the raw data, from this distilling certain ideas and concepts, the empirical consequences of which subsequently deduced and tested further out both in the initial and preferably also in new, purposefully selected samples.

IPA is a method for qualitative analysis of data relating to personal experience and its methodology developed to that purpose; specific techniques for collection and processing of data not recommended, since these must be re-invented to suit the researcher's specific project and way of working. Nevertheless, Smith et al (2009) recommended the semi-structured interview as convenient, elucidat-

ing the participant's own views of a phenomenon. In this study, IPA applied for an analysis of the written text of process notes from psychoanalytic child psychotherapy; the parents only in follow-up interviews directly asked about their point of view. One may therefore wonder if this is a legitimate use of IPA. I suggest it is; my claim that inside the psychotherapeutic setting of the playroom, the participants from each their role communicates uniquely personal, although not necessarily conscious points of view. The inclusion of unconsciously communicated experience moves this study further in the direction of the hermeneutic-interpretative aspects of the IPA. It should, however be remembered that the hallmark of qualified child psychotherapy is a keen ability for detailed observation and properly recorded process notes (as described above) containing a clear demarcation between empirical observation and interpretation, the therapist noting down any observed experience.

IPA demands the researcher systematically to go back and forth between the raw data and the deduced conclusions in a circular process, at an increasing level of abstraction. This procedure makes it possible to make explicit the selection and processing of data, in turn systematically to become conceptualised into themes. This may give rise to a further apprehensive protest, namely that the product of IPA normally is not a case narrative but rather a set of related themes. I hope this study will demonstrate the affinity between qualitative methods like the IPA and Grounded Theory, leading to a set of themes, and the analytic exploration and reasoning needed to construct a credible psychoanalytic case study (Tuckett 1994a). Thus in both instances, the researcher makes choices, in different ways representing a selection of such themes that always are present, providing conceptual structure to the case narrative. After all, no case study is the whole story of

the case, there will always be some aspects included and some aspects left out. IPA may facilitate the necessary role transformation from therapist-in-therapy to researcher-after-therapy, providing a systematic way to explore and think about what to include and what to leave out, firmly grounding the clinical hypothesis in the empirical data of the process notes.

3.5.2. Deductive aspects of IPA and the Likert scale

Subsequently, a primarily deductive analysis by predefined core themes as distilled from the 24 first sessions carried out; analysing four new data samples in order to assess absence/presence of themes as well as qualitative meaning of possible change. As described above, the themes anchored in and build up by empirical observations; this part of the study is best conceptualized as the conclusive part of the inductive-deductive approach of the IPA, rather than a second hypothetical-deductive part of a mixed-methods study. The new samples were:

a) The above described four Christmas break-sets;

b) All case file documents relating the child's life from infancy to start of therapy;

c) All case file documents relating daily life concurrent with therapy.

d) Transcripts of follow-up interviews with foster parents and birth mother

The relational themes distilled from data were operationalised i.e. meaningful, observable behavioural units (codes) were formulated to be looked for in a second set of data. Such second deductive steps considered an intrinsic part of qualitative analytic strategies like IPA and Grounded Theory; the predefined, conceptually focused coding making it realistic to sift through large amounts of data (Charmaz 2008; Smith et al 2009). The formulation of codes enlightened by the

detailed observations during IPA of first 24 sessions; next step was to look for these predefined themes in the new data samples. This procedure has some similarities to a deductive qualitative content analysis; the difference is that in this study, predefined themes (conceptual codes) grew out of empirical data, rather than out of theoretical claims. Nevertheless, in both, predefined themes constitute a deductive matrix of conceptual assumptions, tested in a second set of data (Moran et al 1987 & 1991; Fonagy et al 1993; Kohlbacher 2006; Elo et al 2008; Zhang et al 2012).

This procedure carrying a risk of begging the question, the researcher solely looking for statements that tally with preconceived ideas, some thought should be given to include discrepant events in the search, able to falsify these ideas (Edelson 1985 & 1988; A. Grünbaum 1997). Hence, five of the six predefined themes formulated to include discrepant, not expected events in the search[65]. *For instance*, a clear expectation derived from IPA of the first 24 session concerned a major dominance of empirical entities subsumed in the presence of *"hostile parental figures"*. To avoid entrapment in a self-fulfilling prophecy of solely coding for hostile parental figures, an overarching category to include the not expected quality of "protective parental *figures"* was constructed. This category, *"parental figures in mind"*, included the complete emotional spectre of experience, corresponding sub-categories *"protective", "hostile", or "mixed" parental figures*. The codes formulated during the initial IPA analysis of the first 24 therapy sessions further refined by repeated testing in the four new samples.

[65] *The five themes*: parental figures in mind, sibling figures in mind, increasing-decreasing differentiation internal-external reality, flooded versus contained mental states, steps forwards and backwards in cognitive-emotional development. A sixth theme derived from the IPA, namely therapist's response to the child in some ways disturbed, conceptually of another kind and coded categorically. See examples of this coding in appendix III.6-III.9. The applied codes (behavioural definitions) for each theme in their final form appear together with the findings in 4.1.-4.4.

The logical procedures involved are comparable to bringing a *three-point version of a Likert scale* to bear on the data (Likert 1932). A Likert scale is a psychometric scale widely used for survey research of attitudes and feelings, requiring the respondents to specify the level of agreement or disagreement on a symmetric scale for a series of statements. It usually contains at least five response possibilities, the middle score neutral; the distribution of scores at this scale assumed to measure the intensity of positive and negative feelings for a given item. This procedure makes possible statistical comparison of the scores given by any number of respondents.. In *this qualitative study*, the scale as described above restricted to three possible choices of behaviour in relation to development of each subtheme, namely in principle "positive" (≈+1), "mixed" (≈ 0), and "negative" (≈ -1). Therefore, so crude a version of the Likert scale to be almost categorical rather than numerical, but even so, questions of inter-rater reliability arises; in most studies achieved by two or more researchers coding the data independently, the level of agreement between their codes calculated statistically. For instance, Moran and Fonagy (1987) in a mixed methods single case study applied independent raters coding on a five-point Likert Scale to assess statistically the prevalence of predefined themes, similarly identified in a preceding, inductive part of the study.

In this study, the researcher herself performed the coding based on a comprehensive discussion with research supervisors on the formulation of themes and codes (see 3.7.1. below). The choice not to include independent raters is discussed below (see 6.2.4.), but it may be mentioned that conceptually focused codes of this qualitative study were not really a matter of clearly defined numbers but rather of what McLeod terms "slippery" words (2011, p. 266). According to Yard-

ley (2008), statistically calculated inter-rater coding is not appropriate unless the purpose is quantitative analysis, the codes strictly defined and easily identified, and the included samples large enough.

3.5.3. Comparable relational units and mapping charts

The detailed experience inherent in a psychoanalytic case study on the one hand constitutes the study's clinical applicability and trustworthiness; on the other hand, the selfsame intricacy posing a risk of the therapist-cum-researcher getting lost, not able to see the wood for the multitude of trees (Greenberg 1994). Accordingly, quite a few psychotherapy researchers have pondered how to distil and formulate lucid representational units of experience, able systematically to capture the essence of object relations of a psychoanalytic psychotherapy while still preserving at least some of the sessions' rich complexity (Fishman 2009; Glasser 1994; Luborsky et al 1990; Luborsky et al 2006; Reid 2003; Stiles 2009). One further complexity encountered, such a unit concerns a relational sequence, an exchange between therapist and patient about something. The outcome of this interaction is at a new level of interpersonal context; creating a new mutual meaning containing the contribution of both participants (Emde 1994). In this study such a unit, in the following termed *a relationship episode* was defined in accordance with suggestions by Philps (2003 & 2009) as *an episode in a single session, delimited by the interaction of therapist and child, each episode containing three dimensions*[66]:

[66] Included are verbal statements and communication through play or behaviour.

a) *a communication of the child representing an intention, motivation, wish, or fearful anxious expectation* (by Philps abbreviated TR, relating to the psychoanalytic concept of transference);
b) *The response of the therapist* (to the child's communication) *understood as linked to the emotional and cognitive qualities of her subjective mental states* (abbreviated CT, relating to the concept of countertransference);
c) *The response of the child to the response of the therapist, this response considered the outcome of this interaction* (outcome = OC); the outcome of one episode forming the start of the next episode

In order to establish a qualitative, time sequenced overview Philps developed a "*mapping process chart*", charting verbatim summaries (of the above scheme TR-wish, CT & OC) of successive relationship episodes (2009, p. 68). This understanding of *relationship episodes* is in principle quite similar to Luborsky et al's conceptualizing of *core conflictual relationship themes (CCRT)* and easily compares with Hinshelwood's *core object relationships*[67] (Luborsky et al 1996, Luborsky 1997; Hinshelwood 1991a). Luborsky et al applied the concept for quantitative research, comparing frequencies of specific themes; while this study in line with Hinshelwood and Philps were concerned with qualitative, individual characteristics. Another important difference to Luborsky et al, in line with Philps' and Hinshelwood's suggestions this study explicitly focuses on in-session movements in the transference relationship. Thus in Luborsky's version, a relationship episode may be the patient telling the therapist of an interaction with an external figure, like e.g. wife or parent, the answer of the therapist not necessarily

[67] See 2.3.4 above.

included. In this study, a relationship episode demands an actual three-pieced therapist-child interaction to have taken place.

3.6. Data analysis

The starting point for this study was a wish to understand the meaning of closeness-distance dilemmas experienced as a psychotherapist with a specific group of children; this leading to the selection of a concluded child psychotherapy case, in which these problems had appeared especially salient. An explorative reading of the case in total, shaped a new, in a conceptual sense more focused formulation of research questions (concerning core object relationships), explored in process notes of a selected sample of therapy sessions. This exploration brought new questions (related to breaks), leading to the sampling of four Christmas break-sets (as described above).

Box 5 below is an attempt to enable the reader to follow the conceptual and methodological steps in this qualitative analysis, in line with IPA combining phenomenological and hermeneutic perspectives on data. Moving back and forth between induction and deduction, the later steps in this process leaned more towards deductive than inductive reasoning, however continually checking back to the empirical data in session notes, case file documents, and interview transcripts. Research questions, sampling, and the application of analytic instruments interacted in a progressive spiral movement, the complexity of which is difficult to visualise:

Box 5 Overview steps in IPA as applied in this study

Steps in analysis	Development research questions clinical case	Selected samples	Analytic methods and instruments		Overarching research question:
I	Closeness-distance dilemmas	A concluded therapy	First reading case as a whole		
		⇓			
II	Relational core themes therapy	Sample A: 24 first therapy sessions	1) Inductive analysis ↓ 2) Deduction and testing empirical consequences six themes distilled by induction ↓ 3) Three point Likert scale ordering of possible variation observed empirical manifestations themes		
		⇓		⇒	
III	Vicissitudes of core themes around breaks: a) Possible impact of breaks on themes b) Did this change during therapy c) Falsifying/corroborating similarities reactions breaks and at session beginning/end ↓ Change in core themes in the course of therapy	Sample B: Process notes from four Christmas break-sets Sample A revisited: Process notes from first 24 sessions	1) Coding predefined themes in sample A and B according to 3-point Likert scale ↓ 2) Sequential analysis changes samples A and B by mapping charts ↓ 4) qualitative exploration common and outlaying case examples in A+B ↓ 5) Qualitative comparison other features A+B		Will systematic application qualitative methodology (IPA) improve scientific rigour without depleting richness of psychoanalytic case study?
		⇓			
IV	Falsifying/corroborating continuity and change core themes as found inside therapy and reported by early, concurrent, and later daily relationships	Sample C: Case files 0-5 years + Sample D: Parent sessions and network meetings Start-end of therapy + Sample E: Transcripts follow-up interviews birthmother and foster parents	1) Adaptation to case file reports and transcripts of empirical consequences six themes distilled by induction (step II) ↓ 2) Coding samples C, D, E in accordance with predefined themes Likert scale ↓ 3) Qualitative comparison examples/predefined themes samples A, B, C, D, E		(all samples, methods, and instruments involved)

3.6.1. In quest of core features – IPA and the first 24 sessions

In order to preserve the unique ideography of the case studied, Smith et al. recommended the researcher to proceed in a slow circular movement, going back and forth between the specificity of the raw data material as a whole and conceptual classification at increasing levels of abstraction (Smith 1996, Smith et al 2009). In this study, the process included several steps based on these guidelines:

1) *Reading the raw material as a whole,* including all available items as specified above (see 3.4.1.) A purely mental exercise, I did nothing apart from reading, as one might read a novel. The significance was to locate the gestalt of the experience of the therapist-in-therapy in the intuitive parts of the researcher-after-therapy's mind.
2) *Looking for anything of interest in the recorded notes of the first 24 therapy sessions*, while reading the sessions word for word, impressionistic notes added to the left margin of a copy of the original therapy records. The notes might concern anything interesting or significant, whether associations, interpretations, or attempts at summarizing meanings; however an effort was made to keep close to the descriptive level of the recorded sessions; theoretical considerations deterred.
3) *Looking for keywords and emergent themes and patterns,* left margin notes tentatively linked to each other, conceptual links eventually emerged, giving birth to meaningful broader themes and categories. At this point, the researcher again read the 24 sessions, now together with left margin notes, while noting

keywords in the right margin; also noting such emerging broader themes coming to mind, trying to grasp the higher order meaning of left margin notes[68]

4) *Linking keywords and themes,* connections explored by listing all preliminary key words and emergent themes in their order of appearance. At this point, thinking about the power of certain themes to for instance cluster together or acting as magnets on other themes, drawing them close, pulling them together, and maybe explaining their nature. As different clusters of themes emerged, the researcher repeatedly checked back to the original session notes making sure of empirical coverage, i.e. that emerging main themes actually were firmly rooted in the original text of the session notes.
5) *Linking meaningfully together themes and subthemes to create a masterlist,* the researcher-after-therapy repeatedly checked back to the raw material to ensure that any overvalued pet-ideas of the therapist-in-the-therapy did not distort the selection[69]. In this circular work process, some themes moved aside as redundant, empty in an empirical sense, impossible to confirm in the raw material, unrelated to the research questions or maybe impossible to fit into the emerging structure of themes
6) *At this point, the analysis of the first 24 sessions reached a more defini*tive structure, firmly linking each theme, subtheme, and related case data to each other. The analytic process, going back and forth between an emerging structure and session data, had reached a workable plateau, at which a structure of meaningful constructs seemed able to function as a coherent set of assumptions for the subsequent steps of IPA. This structure had the form of six relational

[68] An example of an annotated page of session notes appears in appendix, III.3. The original session notes were written in Danish. A substantial number of these were translated into English in order to share these with the research supervisor; one of these chosen as an example.
[69] An overview of credibility checks of this and later processing of data appears in section 3.7.

themes, distilled from the *process notes* of the first 24 sessions and firmly anchored in these. Linked to each theme and related sub-categories were notes specifying the exact location of related empirical entities (session examples) going into this theme, making it easy later to find narrative examples relevant to the report of findings[70].

At this point, theoretical concepts related to psychoanalytic theory entered the picture, enriching the researcher's thinking of how to apply this conceptual structure in subsequent steps of IPA. Thus, the balance between the dual perspectives now tipped in the direction of interpretative hermeneutics (Ricoeur 1977, 1981; Habermas 1980; D.P. Spence 1982, 1994a; H. Spence 1994; Michael Rustin 2001).

The first part of IPA inter alia yielded two main categories that from a psychoanalytic point of view might have special, fundamental meanings, namely two categories named *"wish for closeness versus fear of rejection"* and *"distance-closeness dilemmas"*. These two categories ostensibly formulated at different conceptual levels, taken together their sub-themes might point in the direction that anxieties related to *two unconscious core relational themes or dilemmas* in Samantha's inner world gave rise to a host of defensive phantasies and relationships[71]. *Dilemmas and contradictory tendencies related to wishing for dependency versus fear of rejection* might be analogues to the split relationships termed by Klein the paranoid-schizoid position (1959). The described *conflicts of distance-*

[70] Appendices III.4-III.6 show by examples this journey from the initial themes to the final master list of themes in details, from the very first list of emerging keywords, themes and clusters, over an intermediate step, containing a structure of seven relational themes, to the final masterlist of relational themes, complete with added references to the session data, giving information about which empirical entities went into this theme

[71] See chapter 2.3.2. above on core object relationship themes.

closeness seemed of a more mixed, defensive origin, often communicating desperate *attempts to avoid any awareness of separateness*. Thus, although at the time not at all in the forefront of the researcher's conscious considerations, nevertheless the IPA had produced two themes central to psychoanalytic psychotherapy, namely dilemmas and defensive reactions linked to *wishes for closeness and dependency versus fear of rejection and separateness*. This category seemed close to contemporary theory of personality development as proceeding in a dialectic motivational field between the development of capacities for on the one hand interpersonal relatedness (e.g. dependency) and on the other hand development of self-definition or identity (e.g. separateness) (Blatt et al 2009). At this point of the research process, the researcher-after-therapy took this as an indication that contrary to conscious intentions, preconceived psychoanalytic concepts unconsciously sneaked into main categories of the IPA masterlist. In this paradoxical situation, leaning on basic principles common to infant observation and qualitative research helped clarify the situation, namely as far as possible to place uncontaminated clinical observations as the foundation for the theoretical concepts going into the masterlist.

Consequently, reviewing the specific items subsumed in the two categories (wishing for closeness versus fear of rejection and closeness-distance dilemmas) it became blatantly clear that at the root both categories *concerned relationships between the self and parental and sibling figures*. Accordingly, the obvious solution were to stay closer to the phenomenological level of the session notes, subsuming related items under the headings of a predominantly empirically based, new supra-ordinate category *"the emotional quality of relationships to parental and sibling figures"*. The subcategories *parental and sibling figures* seemed per-

vasive in the material, each linked to a considerable amount of data, often to be found in the same relationship episodes. Thus according to the results of IPA, it seemed quite unclear to what extent parental and sibling figures tapped the same or different aspects of central relationship themes. In order not to beg the question, the two categories accordingly were kept apart in the subsequent analysis as two separate themes,*" the emotional quality of relationships to parental figures"* and *"the emotional quality of relationships to sibling figures"*. The emotional relationship between parental and sibling figures in mind were not at all part of the original research questions of this study, and thus a theoretical review was not included. However, since part of contemporary psychoanalytical discussions, in order properly to assess this important windfall, the relevant theoretical implications appear in the discussion of findings.

Eventually, the analysis of the first 24 therapy sessions yielded a structure of *six main themes*, analysis (box 6 below). In the later deductive part of the analysis, categories III, IV, and V showed certain overlaps; differentiation internal-external reality the more central question to this investigation, I decided to subsume in this the relevant sub-themes of IV and V.

Box 6 Six predefined behavioural themes and related sub-themes[72]	
I	The emotional quality of relationships to parental figures • Seeking closeness good, protective parental figures • Avoiding hostile, bad parental figures (rejecting, abuse, preoccupied, depriving) • Relating to mixed parental figures
II	The emotional quality of relationships to sibling figures • Relating to friendly sibling figures (affectionate, cooperative, responsive, interested, confident, social etc.) • Relating to hostile sibling figures (aggressive, envious, jealous, nonresponsive, avoidant, anxious etc.) • Relating to mixed sibling figures
III	Increasing/decreasing awareness differentiation internal and external reality • Behaviour indicative some awareness differentiation inner-outer reality (some awareness own pain/longing closeness-separateness and related defence; preoccupied by birth parents/siblings; foster parents/siblings; therapy/therapist/therapist's real life relationships; teachers/real life peers etc. • Behaviour indicative of decreased awareness differentiation inner-outer reality: Confused or withdrawn states; no-thinking, empty, sensory dominated states; compulsively self-soothing behaviour ; falling to sleep; frozen-indifferent state; paranoid panic attacks; wishful denial of separation; clinging; dissociation, violent attacks at therapist etc • Mixed or rapidly shifting states
IV	Flooded versus contained states • Behaviour indicative of flooded states e.g.needy states; manic/hyperactive behaviour, including falling/fear of falling; becoming overwhelmed; a wish to get rid of something; uncontained pain/anxiety/aggression spilled out of setting; manifest state of obvious anxiety/suicidal despair; sensory-dominated states of self-soothing or self-harming; repetitive behaviour; drawings/play-scenarios black, barren, dried up, closed off, locked up, disjointed, fragmented etc.; fused or schizoid states of projective identification • Behaviour indicative of contained states e.g. ordinary symbolic play, including messy ambivalence of ordinary family life; able to communicate meaningfully her feelings verbally or in symbolic play; genuinely at ease; confident, pleasurable-happy, well-regulated states • Mixed states: Rapid shifts from one to the other
V	Steps forward and backwards in normal cognitive-emotional development • Steps forward described e.g. new learning & capabilities, shifting in the direction of growth; locating her and me in time and space; depressive care for her objects; ordinarily curiosity and related exploration; ordinary wish for potency and related skills. • Steps backwards or stand-still described e.g. backsliding into more immature or deviant patterns of behaviour; repetition and denial; loss of learning and capabilities; • Rapid shifts from one to the other
VI	Therapist's experience of some emotional and cognitive disturbance in her response to the child • Emotional disturbance e.g. intensified disturbed or dulled feelings whether loving or hateful. • Cognitive disturbance i.e. unexpected changes in the stream of consciousness e.g. confused, muddled or blank states; sleepiness; bodily discomfort; or other disturbances of cognitive functions like attention, memory or the ability to think and put into words • Distance related disturbance defined as uncertainty, confusion or other difficulties of positioning at the right geographical or mental distance from which to address Samantha, feeling myself to be too close or too distant, whether in a literal or a mental sense • Otherwise mixed emotional-cognitive disturbance, emotional and cognitive components both noted[73]

[72]The behavioural definitions (codes) of these themes and subthemes distilled from empirical data of session notes appear in chapter 4 below (reporting the findings of the study); there organised in accordance with this structure of core themes, each section starting with the definitions of that theme. See also appendix III.6.

[73] If problems of distance were mentioned, the episode was not included here but above.

3.6.2. The hermeneutical perspective – Conceptual coding in IPA

As illustrated in the model overview of this study (box 5, pp. 104), the next analytic steps aimed at investigating the prediction that core themes found in the first 24 therapy sessions would also permeate the therapeutic relationship of later therapy sessions as well as past, present, and future relationships.

To this end, central relationship themes derived from the analysis of the first 24 sessions were applied firstly for an analysis of the 24 sessions included in the four Christmas break-sets (sample B), and secondly for an analysis of case file information of early infancy and concurrent daily life (samples C and D) as well as the transcripts of follow-up interviews with foster parents and birth mother (Sample E).

Further, aiming at a detailed study of the vicissitudes of core themes around breaks, mapping charts were constructed to depict an overview of the temporal development of themes through the four Christmas break-sets (sample B) and the first 24 sessions (sample A).

Model schemes of the predefined themes were prepared, a scheme for each specific theme; the specific Christmas break, the session number, and the number of the relationship episode noted[74]. All Christmas break-set sessions scrutinised in full, word for word, filling into each theme's model scheme short notes of what took place in relation to the theme.

[74] An example of a scheme for content analysis of predefined themes in Christmas break-sets appears in appendix III.7.

3.6.2.1. Mapping charts of relational themes

In the course of this analysis, the researcher felt a need for an analytic instrument providing an easy graphical, time sequenced overview of specific representations of relational themes in sessions and across sessions.

Philps verbatim descriptions came to mind; however differentiating inside each relationship episode the communication of child, the response of therapist, and the outcome (TR-CT-OC) this model was much too detailed to suit my purpose (see 3.5.3. p. 102). Hence, a simplified *mapping chart of relational themes* was developed, the occurrence of certain thematic phenomena registered simply by letters showing for instance the presence of parental figures and their emotional quality, H (= hostile parental figure), F (= friendly protective parental figure), M (= mixed emotional quality parental figure). First step was to divide the 48 therapy sessions (the first 24 sessions plus the 24 Christmas break-set sessions) into relationship episodes[75]. Each relationship episode were given a double number, stating the session number as well as the episode number, e.g. 7(RE3) refers to session number 7, relationship episode number 3[76]. To hinder ambiguity, each relationship episode contains one and only one sequence of TR, CT, and OC.

The *intention of the mapping chart of relational themes* primarily to systematize and discipline the subjectivity of the researcher-after-therapy, independent auditing of coding was not included[77]. However, even so, the mapping charts

[75] As defined in 3.5.3.
[76] Examples of sessions divided into episodes and coded appear in appendix I.1.
[77] The applied definitions of relationship episodes (RE) and codes (e.g. H, F, M) were discussed with Ms. Margaret Rustin, but the final design and systematic coding solely my responsibility. In principle, mapping charts like these are suitable also for quantitative analysis in mixed methods studies, in which case independent raters are indispensable. Even in a purely qualitative psychoanalytic case study like the present, it might have been a worthwhile supplement.

were a decisive help in the creation of an overview needed to differentiate between common, unique, and peripheral trends, and thus vital in creating a meaningful pattern of findings as presented in section 4. The mapping chart as such therefore in itself may be considered a methodological result of this study[78].

The example below shows *the occurrence and emotional quality of parent-sibling figures* throughout the 48 sessions (Box 9). The detailed findings reported in chapter 4; this is just an example in order to demonstrate how the mapping chart of relational themes works.

[78] It was no easy matter to decide where in this chapter to place the description of the mapping chart of relational themes, because this may be considered an analytic instrument; part of the description of how data were processed; or an important finding from the research process.

Box 7: Mapping the emotional quality of parent-sibling figures - First 24 sessions and 4 Christmas breaks - A graphic illustration

The first 24 sessions

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
RE 1	M	M	H	M f	H h	F	H h	m	M h	m	M	M	M	H	H	h H	H	H	M	M	M m	H	H	M
RE 2	M m	H	H h	H m	H h	H h	H h	H h	m M	F m	H h	H	H		H	H h	H h	H		H	H h	H	M	H
RE 3	M m	h H	m M	H	H f	F	H h	H h	H	H h	H h	H	H h		H	H h	H	H h	M	H	H h	H	H	
RE 4	H h		M	M	H	H h	M m		H	H h	H	M	H h		M	M		H h	M	H h	M f	M	H h	M
RE 5	M			M	M h	H h			M	H h	M	H	M		M			H		F f	M	M	H	
RE 6					M				M	H					H			h H		M		H		
RE 7										H														

Through 4 Christmas breaks (24 sessions)

	10	11	25	26	27	28	64	65	85	86	87	88	120	121	135	136	137	138	178	179	185	192	194	195
RE 1	m	M	H	H	H h	H	H h	H h	H	H	H	H	H	H	H	F	H	H	H	H	H	H H	H	H
RE 2	F m	H h		H	H h	H h	H	H		H	M	H	H	H	H h	F	M m	H	H	H	H h	M	H	H
RE 3	H h	H h	H	M m	H	H	M	H	M	H	F	H f	H	H	H	F	M m	M M	M	H	M	M	M h	H
RE 4	H h	H		H	H	H h	H	M	M	M		M f	H	M h	H	M m		M	H	H		M	H	H
RE 5	H h	M		H				M		F		H		H	H			M	M	M			M	H
RE 6	H																	M	M				M	H m
RE 7	H																	M	M h					
RE 8																		H						

Parental figures : Friendly=F; Hostile= H; Mixed=M
Sibling figures: Friendly=f; Hostile=h; Mixed= m
RE = Relationship Episode. RE 1 = Relationship episode 1; etc. Relationship episodes appear white .
Grey= No-session areas
If none of the above letters are specified it means that neither parental or sibling themes was found in this relationship episode.
Episodes in which parental figures occur together with friendly or mixed sibling figures are marked by green colour
Episodes in which parental figures occur together with hostile siblings are marked by yellow colour

3.6.2.2. Analysis case file reports parental caregivers

Box 8: Questions asked of external case file information (samples C, D, E)	
1.	If the central relationship themes distilled from the analysis of first 24 therapy sessions were present/absent in reports from external sources concerning Samantha's relationships outside therapy: 0-5 years, at referral, during therapy 5-9 years, and at follow-up 2 years 8 months after the end of therapy.
2.	If her daily caregivers during therapy, at the end, and at follow-up experienced improvement, backsliding, or no-change as assessed by an analysis of these predefined core features in Samantha's relationships

A separate scheme for each core theme constructed as a system of co-ordinates, in which the x-axis plots in behaviours indicative of progression, backsliding, or mixed behaviour in relation to the specific theme; the y-axis plotting in Samantha's age in 12-months intervals. Next step was to peruse case file documents, using this *simple Likert scale model scheme not only to assess the presence/absence of a certain theme;* but as part of a continual qualitative analysis also writing into the scheme the essence of the statements concerning the theme. A segment of a filled in scheme appears below[79].

[79] The fully filled in scheme of predefined themes in early relationships appears in Appendix III.8 together with similar schemes of predefined themes in reported daily relationships during therapy (III.9.).

Box 9: Example coding scheme predefined themes in early relationships

Theme 1: Emotional quality relationship parental figures

Age	Source	Seeks closeness/ dependency	Mixed behaviour	Avoids closeness/ dependency
< 1 ys.	Birth mother[80]	Barely remember baby-S before placement; claims close communication, especially at changing table		Baby-S waking up very early, allegedly not calling out for someone to come, for hours staying silent in cot, allegedly playing with her teddy
	Health nurse			Very worried, S withdrawn, timid and apathetic, in a "shutdown state".
1<2 ys.	Clinical Psycho-logist			Avoids closeness, appears withdrawn, can't engage in close mutual interaction. Go limp when tenderly held in arms, also mother's. At examiner's lap looks at picture book, quite passive, as a tiny baby. Comes across as lonely, isolating herself with her emotions
	Day Nur-Sery group	Seeks any nursery teacher when hurt May be allured into close exchange with one teacher or another (anyone), only shortly, won't return to same adult. Some smiling when nursery teacher fools about to please her		Keeps at a distance, no preference specific nursery teachers; gaze aversion. If unsupervised gives nursery group the slip, straying on her own. Leans out into space, when held in arms. The adult must maintain closeness, or else it dwindles
	Resi-dential infant insti-tution	Short periods of enjoyment, cuddled in St's arms[81]. Trudging at heels of St, not playing. Likes to sit close to St; asks for help. At times, likes to imitate St's movements to children's songs Likes playing house, takes maternal role towards baby doll, imitates caring relationships, cuddling, kissing, lovingly talking, singing to doll Shows preference for St, next to come is second special teacher. Asks for St when absent Needs adult at bedside before able to sleep Likes playing at making food to St, in play taking care food not too hot, lest St may burn herself. When together with St plays at phoning her birth family. When St available 4 days in a row[82], S closely cuddled in her lap, as tiny infant relaxed and intense eye contact. Comforted by St cuddling and carrying her Conflicts with other children, seeks support from adults.	Prefers verbal and rejects bodily closeness to St At times, shortly cuddling, then withdraws, running away, turning her back at St After breakdowns calmed by being held in St's arms; but only if positioned so as able to look out the window	Rejects longer tender closeness to St and other adults In St's arms, often described behaving like a passive sack-full potatoes When in arms, leaning herself out into space, no rest and no cuddling Rejects bottle, teddy and pacifier before sleep Don't like to be enclosed in the towel and dried after bath

[80] Birth mother interviewed of early relations by a community based clinical psychologist, Samantha at the time 4 ¾ years old.

[81] St refers to special teacher.

[82] Due to working hour regulations and collective agreements, this situation occurred only seldom.

3.6.2.3. Follow-up – interview guides and analysis

The purpose of the follow-up 2½ years after the end of therapy was to study how foster parents and birth mother remembered/experienced positive and negative change in relationships (as defined by core features) during and after therapy. To this end interview schedules aimed at bringing out the personal experience of foster parents and birth mother, from their respective positions remembering the past, experiencing the present[83]:

In principle, identical interview schedules applied for birth mother and foster parents; open questions addressing four areas of relational experience:

a) Present memory of the past therapy
b) Present memory and experience of Samantha's development and life since the end of therapy
c) Experienced positive and negative change after the end of therapy in the relationship between respondent(s) and Samantha
d) Experienced positive and negative change after the end of therapy in the relationship between birth mother and foster parents

Tape recordings of semi-structured interviews with foster parents and birth mother transcribed verbatim to a line-numbered, written text. The transcripts subsequently analysed by the predefined core themes; the coordinates described above again providing model schemes for each theme into which could be coded the experience of progression, backsliding, and mixed in-between periods. Again, reading through transcripts word-by-word, filling in for each core theme qualitative descriptions of the experiences related by foster parents and birth mother..

[83] See appendix III.1. Semi-structured interview guides, and I.3 & I.4. Transcribed and translated interviews.

3.7. Scientific credibility

A defining feature of qualitative research, findings are largely generated through the active personal engagement of the researcher in the area researched, which means that the findings inevitably bear the mark of the researcher's personal approach. Hence, a lack of uniform agreement between researchers concerning what constitute sufficient and necessary criteria for the evaluation of quality in a study should come as no surprise. The *criteria adopted as ideals for this study* were a personal integration of suggestions from several authors (Miles et al 1994; Tuckett 1994a, 1994b; Elliott et al 1999; Hiles et al 2007; Yardley 2008; Smith et al 2009; McLeod 2011)[84]:

1) A clear vantage point, specifying the researcher's sensitivity to context
2) An observing, reflective state of mind
3) Transparency and rigor of data collection, sampling and analysis
4) Procedures aimed at checking and triangulating the credibility of findings
5) Reflections on applicability, relevance, and implications for the field of study

The researcher's *vantage points and state of mind* are particularised in sections 3.1-3.3 above. Sections 3.3.-3.6 explicate *procedures applied for selection, sampling, and data analysis.* Below is described some *initial precautions to ascertain credibility* of findings. A detailed discussion of the relevance of design and trustworthiness of findings appears in chapter 6.

[84] Thus, the communal standards of quantitative research, namely *objectivity, reliability, validity and generalizability* were not applicable to this study.

3.7.1. Triangulation by inclusion of other trained minds

The concept triangulation relates to navigation, establishing the relative position of two or more points by calculations based on three different reference points. In relation to qualitative research, a method of enriching the researcher's understanding of a phenomena by viewing it from multiple perspectives rather than converging on a single consistent account (Yardley 2008). A common way to triangulate is to invite other qualified human beings into the design to check upon the chosen understandings (Miles et al 1994). In a clinical case study this may be done in different ways:

a) The addition of *a professional "auditor"*, e.g. another trained psychotherapist to review data and derived constructs for discrepancies, overstatements, and errors (Glasser 1994; McLeod 2001)
b) Checking derived understandings with *the original participants*, patient, therapist, both, or other like them (Elliott et al 1999)
c) The inclusion of *external raters*, i.e. trained professionals is common in studies mixing quantitative and qualitative methods. Several raters rating the same data for thematic categories and coding schemes will make it possible to compare the codings statistically, in this way getting a sense of how far the stated principles for coding reliably will allow other professionals to reach the same conclusions (Moran et al 1987; Fonagy et al 1993; Philps 2003).

This study incorporated other minds in two different ways. Firstly, in terms of data collection, the inclusion of *follow-up interviews with the parents of the child* providing an independent, non-therapeutic perspective on the meaning of

therapy to the child and the impact on concurrent and later development. In addition, *temporal sequencing* of the data made it possible to check themes as identified inside therapy against the concurrent experience of the adult participants in the original process of change. Secondly, in terms of data analysis, *two research supervisors* throughout the research process were included in regular discussions of the understanding of data, formulation of themes, categories, and coding guidelines. External raters were not included; the research questions stating as a priority a systematic application of qualitative methodology for working out a detailed, in-depth analysis of the therapeutic relationship.

Smith et al (2009) recommend the researcher to keep close to empirically documented descriptions postponing conceptual and theoretical explanations until such a stage where categories and themes are firmly grounded in close textual readings of empirical data. Doing my best to stick to this dictum, nevertheless, a few times I discovered myself in a dead-end; most often because inadvertently, mixing into the textual readings of session notes or case documents certain flotsam of developmental or psychoanalytic theory, prematurely washing up in my conscious mind.

This problem relates to the "double hermeneutics" of qualitative strategies like IPA and Grounded Theory, trying to combine the phenomenological intention of staying close to participants' own life-experience with a hermeneutic intention of questioning, taking a closer look and from a different angle puzzling over the nature of participants' experience (Ashworth 20008; Charmaz 2008; Smith et al 2009). Any clinical case researcher must face this paradox, but as pointed out by Anderson (2006) especially so the psychoanalytic case researcher. Thus, on the one hand, psychoanalytic theory of unconscious intentions and feelings is a source

of contamination, disturbing the qualitative case researcher's ability to listen closely to her participants (e.g. the recorded experiences of child and therapist in the playroom). On the other hand, at a certain stage the empathetic readings must link to a coherent body of theoretical concepts concerning the mind. The theory of clinical single case studies local, grounded in the specific case data, hence cannot be generalized by referring to a wider population, but rather by generalization to theory; this tantamount to an assessment of intersubjective credibility and thus the wider relevance of the study inside the professional field (Midgley 2004).

To resolve such impasse, the presence of two research supervisors were indispensable, each in their different way and at different stages of the process contributing with a valuable auditing of the researcher's understanding of the meanings inherent in therapeutic raw data (process notes) and the coding of derived categories and themes. Process notes from a considerable number of the sampled therapy sessions were discussed with Ms. Margaret Rustin, whose immensely valuable help contributed greatly to the cleaning out of preconceived, in the context unhelpful theoretical ideas e.g. as relating to the presence of unconscious antisocial organisations; not really grounded in the raw data. No less important was discussions with both supervisors of IPA-report and the annotated master list, bringing forth a number of very helpful questions concerning the categories.

At this stage, thanks to the ability of IPA to ground the analysis firmly in session data, the researcher-after-the-therapy was becoming aware of a marked difference between session beginnings and session endings. However, also trained as a clinical psychologist in the assessment of early attachment disturbances, I found it quite difficult to keep Ainsworth's styles of attachment at bay (Ainsworth et al 1978). A special thanks to Dr. Nick Midgley, who pointed out that in spite of

precautions, attachment theory had slipped into the behavioural categories; no such thing as theory-free observation possible, unknowingly mixing up theory and observation making it impossible to validate the otherwise clear presence of differential behavioural reactions as observed in the process notes.

3.7.2. Triangulation by several perspectives and methods

Multiple perspectives may also be achieved by data collected at different times; combining different theories or methods; checking and double-checking findings; comparing findings to relevant theory; comparing commonly recurring instances to outlying instances; and looking for disconfirming evidence, able to falsify assumed relationships (Miles et al 1994; Edelson 1985, 1988).

As mentioned, throughout this study, the therapist-in-therapy was the researcher-after-therapy, which may mean a narrowing of perspectives due to the allegiance factor. To counter or at least curtail this risk, the design included certain precautions[85]. Firstly, a second phase of the research separately validated the main findings of the IPA against mutually independent parts of the raw data; assembled at different points in time; from different informants some of which were not the therapist-in-therapy, and some of which were mutually independent and independent of the therapist-cum-researcher; by different methods of observation. Secondly, making an effort to look for evidence able to disconfirm the expectations of the researcher-after-therapy, I did my best not only to look for expected results (e.g. early in therapy hostile figures, flooded states, and intolerance to breaks; late in therapy good figures, contained states, tolerance to breaks). Thus

[85] See Box 10 below for an overview..

each single assumption used for deductive analysis (the six theme above), was formulated in such a way that not only the expected results was looked for but rather a continuum of possibilities in which were included unexpected findings (e.g. absolutely good figures early in therapy and flooded states late in therapy).

Box 10 Credibility by multiple perspectives and methods

- Information from different informants:
  Therapist-in-therapy; foster parents; birth mother; staff from residential institution; day-care staff; nursery staff.
- Different methods of data collection applied
  Generated by therapy and related teamwork; semi-structured interviewing; document analysis.
- Information gathered at different point in time
  The information was provided by different informants during a time span from infancy to 12 years of age.
- Comparison of recurring and outlaying instances
  Inter alia: Comparison hostile versus good parental and sibling figures (chapter 4.1., 4.2.2.); comparison real-life versus therapy and fantasy figures (chapter 4.3.1.); comparison sibling figures in before-break sessions versus in other kind of sessions (chapter 4.1.3., 4.2.4., 4.4.4.)
- Efforts to look for disconfirming instances
  Inclusion of no-break material; built into formulation of categories were the opposite quality of the one expected e.g. not only looking for hostile but also good figures; if looking for evidence of contained states of mind, also looking for evidence of flooded states, etc.

4 FINDINGS

This chapter concerns findings related to the two main propositions of this study. The first assumption presumes relational core themes to run as a continual pattern, connecting the therapeutic relationship to salient aspects of past and present everyday relationships from early infancy to follow-up at 12 years of age. The second assumption presumes that breaks may be conceived of as windows through which such core relationships themes can conveniently be studied.

The chapter is organised into five sections:

1) Core themes as observed in therapy, exploring a characteristic pattern of hostile inner family relationships
2) The therapist's experience of specific emotional and cognitive disturbances in her own response to the child
3) The behavior of core themes around four Christmas breaks
4) Core themes as reported in early and later relationships
5) Conclusions linking core themes and breaks; continuity between certain defensive core relationship themes shown, inside therapy and in everyday past, present, and later relationships.

As described above, predefined definitions of core themes as distilled from empirical case data were subsequently applied for coding and re-coding of the themes. The applied behavioural definitions appear at the start of each section[86]. The below presentation of findings contains in a narrative form the researcher's qualitative interpretation of empirical case data, illustrated by verbatim extracts from the therapy, case files, and interviews.

[86] The definitions as emerging from IPA of the first 24 sessions appear in appendix III.6: Masterlist with subthemes and links to session notes.

4.1. Core themes as observed in therapy

This section elucidates severely hostile and brittle emotional relationships between parental and sibling figures in mind; a feature combined with and reinforced by a precarious ability to regulate emotional states and differentiate internal from external reality.

Box 11: Summary of main findings:
Relational core themes inside therapy

- *A dominance of hostile parental figures in mind*
- *A dominance of hostile sibling figures in mind*
- *The appearance and emotional quality of sibling figures in mind highly dependent on the presence and emotional quality of parental figures in mind*
- *Brittle capacity for differentiating internal and external reality often overruled by flooded and paranoid states of mind, washing away any awareness of feelings related to loss and longing as well as motivation and ability to symbolize and explore*
- *The therapist's experience of her subjectivity in response to the child seemed indispensable to understand the emotional significance and meaning of core themes*

4.1.1. Parental figures in mind

Definitions[87]

Parental figures refer to any communication implying figures in mind assigned a vertical, adult position, attributed with parent-like authority whether conveyed verbally, in play or behaviour; and whether described as *friendly, hostile, mixed*.

Hostile parental figure: Characterized by aggressive, neglectful, selfish, rough, uncaring, sadistic, indifferent, apathetic, mindless, abusive etc. behaviour towards child figures and self.

Protective parental figure: Characterized by caring, nurturing, protective, tenderly loving; including ordinarily caring and regulating parental figures, setting proper limits to regulate unruly, splashy feelings aroused by ordinary family life and giving ordinary encouragement of separate development and exploration.

Mixed parental figure: Any combination not possible to include in the above.

The identities of such figures: Classified according to their relationship to internal-external reality:

Fantasy parents refer to creatures of phantasy and imagination, by Samantha identified as having no existence in external reality.

Therapy parents refer to Samantha's experience and phantasy concerning therapist and therapist's adult relationships. The identity of these figures most often were verbally declared by Samantha herself; a few times inferred by the researcher-after-therapy e.g. because of Samantha's way of relating to the therapist-in-the-therapy.

[87] For an overview of emotional quality and identity of parental figures in samples A+B, see appendix II.1 and II.9.

Birth parents, foster parents, and teachers refer to parental figures identified by Samantha as belonging to external reality in their formal role.

In the description above below, the identity of figures classified according to their relationship to internal-external reality:

Box 12 Inside therapy: Parental figures in mind

- Intense preoccupation hostile and abusive parental figures, most often therapy or fantasy figures, very few real life figures. This tendency stable from start to end
- In latter half of therapy, hostile figures still most common, but more benignly mixed parental figures; fantasy figures replaced by therapy figures; hostility gradually mitigated, less fantastic, more reality oriented
- A few unalloyed good parental figures, all in contexts of painful longings, protecting against feelings of deprivation and abandonment. Initially represented as fantasy figures, later as therapy figures; in general occurring in before-break sessions, giving rise to moments of blissful closeness in a context of separation to come
- Conflicts of geographical and mental closeness-distance to the therapist; linked to specific dilemmas:
  a) Longing for dependency and protective parental figures - fear of rejection from violently abusive, preoccupied parental figures
  b) Longing for a confident and competent self - fear of pain of separateness, parting, longing, loss, exclusion
- In the latter half of therapy, wildly manic, aggressively confused states indicate terror of and identification with violently aggressive parental figures; occurring together with manifest phantasy/play depicting confinement, abandonment, torment, and isolation from willfully misunderstanding, sadistic parental figures.

Wishing for closeness - fearing rejection

Samantha was intensely preoccupied with parental figures, whose emotional quality throughout therapy appeared *heavily skewed*. A recurring theme, expectations

of neglect, abandonment, and abuse by *hostile parental figures* was dominant in play, drawings, and verbally related fantasies. The same tendency seemed embedded in her approach to the therapist, in most verbal and behavioural inquiries casting us in complementary roles of a hostile parental figure vis-a-vis an abused and miserably neglected child. In contrast, undisguised wishes to be close to *good, protective figures* were rare. A number of *mixed parental figures* seemed to bridge the extreme split between these opposites; sometimes in a quite confusing mixture of *hopes for tenderness and care* versus *expectations of disappointment and hurt*. The therapist-in-therapy noticed confusion already in the first therapy session, as Samantha with lightening speed moved from anxious yet hopeful, expectations for good therapy to denigration and despair, in turn disclosing painful envious suspicions. Other early strands later to show importance were a disguised quest for power and a keen suspicious jealousy of other children on the mind of the therapist:

- *1[88]/Samantha looks pretty, frail, and fairy like; moving in an upright, stiff way, her face is almost devoid of expression. At the start of session very polite, she immediately sits herself in the only adult-size chair. (I am aware of her big worried eyes and get the impression of an over controlled, very, very anxious little girl. I feel acutely sorry for her; she looks not at all like a child but as a very small, burdened, and over-controlled adult. I notice that without hesitation she took the most comfortable chair in the playroom. I do not comment on this)... She looks around and wants to paint (RE1[89]). She paints in a most controlled way, a pattern in bright colours. She says politely in a small, controlled voice that it is good to be here; she has a friend in kindergarten, but somebody is teasing, including her big brother in the foster family... add-*

[88] Refers to the session number, here no. 1.
[89] In this and following session extracts, RE followed by a number refers to the cited relationship-episode, e.g. here relationship episode no.1. If appearing like this (1, RE1-5) in the text, it means that the point in question is exemplified in session 1, relationship episodes 1-5. These extracts appear in appendix I.1.

ing without my asking that her "real" mother" had something very heavy on her mind", which is why her three children cannot live together with her. Bente (foster mother) is "not my real mother, only foster mother". While talking, Samantha finishes her painting, leaving it aside to dry. The painting is boldly coloured black, red, green, blue, orange patches. (I ask about it). She dismisses my question, saying "pattern", immediately moving away to sandbox at the other end of playroom for the sandbox (RE2). She briefly mixes sand and water, and then leaves for the doll's house. She.. creates a doll family, mother, father, big girl, big boy, small girl, and a grandmother, all needing to go to the loo, one after another, then take a bath and finally go to sleep in their beds. (I suggest that they all need to get rid of something). Yes, she says, when getting in here, she herself needed to pee and have pooh, but by now, this is gone. She finds a cot for the baby (RE3). She .. can't find the baby, .. interrupts play, looks up at a high shelf where I keep other play boxes, wants me to have a look in those and pointedly says that certainly by mistake, I must have mislaid her baby doll in the box of another child. (I am amazed that already she has spotted the presence of other children; do not say this but suggest that even if she finds it hard to find the baby in her own box, it is to be found there. I help her find it). Once found, she does not like the baby doll and leaves it in the box (RE4). All dolls are asleep, except grandmother, again visiting the loo, then preparing breakfast for the family. At this point, Samantha leaves the doll´s house in a hurry.. She explores the content of her box .. Finds a giraffe family, father, mother, and foal. The foal seeks out the father giraffe. Again, she quite suddenly moves away, this time to dig in the sand box. (I mention that time is up). She ignores me but rises as I move to the door. (RE5).

Intensely hostile play scenarios often depicted violently abusive and preoccupied parental figures vis-à-vis a battered and starved baby-girl. The parental figures might act alone or as a couple in hostile alliances with aggressive sibling figures. A deprived and maltreated baby fell off high up roofs, sometimes because of lack of proper parental attention, sometimes deliberately pushed down. She was forever locked up in dark cupboards or even freezers; struggling to survive unpredictably dangerous, barren, flooded, or in other ways deadly overwhelming environments like e.g. deserts, tsunamis, and blizzards.

In her relation to me, similar split and fearful expectations seemed to motivate a host of defensive behaviours. She would e.g. for some minutes come close, then hurriedly retreat to the farthest corner of the playroom; turning her back on me, for a while preoccupied with hidden doings, until suddenly she again came close. She seemed utterly split between on the one hand merciless, sometimes frankly sadistic efforts to bully a weak me; on the other hand anxiously to avoid a me, presumably experienced as dangerously unpredictable; wilfully inflicting mental and physical pain on her. Quite a few times, she suddenly launched a vicious attack, as if my presence posed an acute danger of life to her.

Samantha quickly made herself known to me as a fiercely passionate child, whose faith in the reliability of her parental figures, including me, were at best tenuous. She most often would rather push me quite violently out of her way than risk any pining and fiercely dismissed any remarks from me referring to possible tender feelings e.g. about missing therapy or the absent me between sessions or during breaks. Clearly, if someone was going to miss anybody, she did not intend to be that person. Nevertheless, her attempts to avoid the pain of dependency were sometimes quite easy to look through since she could not help suspiciously to note even the slightest changes in the playroom. This immediately brought about painful, dissociated phantasies that hostile rivals pushed her out of my mind, forever replacing her in my attention.

- *10(RE3-RE6)/ (A no-break session, first of week).* At session start, Samantha eagerly hurried in, immediately going to work on her relationships, e.g. painting herself stand-

ing close to a boyfriend, wearing glasses like the therapist. At this point, she succumbed to the ever present bitter taste of betrayal, jealousy, and envy[90]:

".. She paints herself as a big happily smiling figure but soon covers the figure's mouth with black paint. (I suggest this is confusing; the Samantha on the painting smiles but also is quite black at the mouth). She points to the painting:"something bad came into her mouth". (I suggest the bad black in her mouth to be as if something bad from me got inside her, maybe the more so because it is 5 days since we last saw each other[91]). Samantha confirms: "Yes, she gets fire"(RE3). She notices the furniture in the dolls' house was moved since last session, leaves house saying: "Was someone in here"? (I suggest a bad, burning fire that somebody moved the furniture around). "Yes", she turns to brick building, ambitiously high, vulnerable towers crashing noisily (RE4). (I suggest the thought of somebody else in here makes something inside her crash). She listens: "yes, you did, and you are sent off, far away, because you are a loser". ..."You are a loser; you'll only get a husband, you'll be off with him and you just have to go around all alone being stupid"... (RE5). She turns her back on me, goes to the opposite end of the room... (RE6)..."

Absolutely good parental figures – scarce but yet important

A few glimpses of undiluted hopes of good care appeared, most often instantly reversed, tender longings evoking an overwhelming anxiety, at the edge of panic. Samantha might e.g. eagerly hurry in at session beginning, immediately go to work, happily playing and talking; some minutes later, her mood shifting, she aggressively hurled sand, paint, and playthings around, in the grip of a flooded, suspicious state. Hopes for a protective, nurturing relationship were e.g. depicted as a passive baby girl who was served her favourite dishes by a servant-nurse-cum-therapist; next thing, the idyll brutally broken, wilfully depriving, inattentive and abusive parental-cum-sibling figures erupting in her mind (6(RE1-2)).

[90] This session referred in some details in order to be able later on to return to this material from the angle of the therapist's subjective reaction, the end of the session appears in more details in section 4.2.2, page 153.

[91] I refer to the regular rhythm of this 2/weekly therapy, 5+1 day between the sessions.

To the surprise of the researcher-after-the-therapy, good parental figures did not appear in a context of containment and happiness but rather in one of unmet need and tremendous pain. Happy moments fragile and isolated, apparently functioned as a desperately brittle and unstable barrier, a last resort before drowning in a sea of depleted, panicky states akin to absolute despair. Ordinarily caring and regulating parental figures appeared only once in the entire data material; Samantha at this point able to imagine adults setting proper limits, containing the unruly, splashy feelings aroused by ordinary family life (20(RE5-6). Occurring in the context of especially frequent cancellations of therapy, even this scenario preceded by dreadful phantasies of a messed up and dangerous therapist-parental couple; Samantha struggling ever so hard to come to terms with ordinary ambivalent feelings and anxiety (20(RE1-4).

Six months into therapy, protective figures disappeared all together and first returned twelve months later at the end of a before-break session. To my amazement, at the end of two most difficult sessions, just before the gap of parting, a hopeful, genuinely meaningful and reality-oriented verbal exchange evolved; Samantha confiding to me her paranoid feelings and phantasies about a monster-me, chasing her in horrifying nightmares (85(RE3-4); 86(RE3-4).

Unambiguously good parental figures were last seen after 2½ years of therapy in another before-break session; Samantha for once back to the eager, lively mood of the beginning, eagerly settling down to work, sharing thoughts and fantasies with a therapist-me felt as good and nourishing. At this point, she fell into a movingly blissful, quite confused state; annulling the separation of the break to come by a dreamlike phantasy of incorporating into herself the tasty babies be-

lieved to inhabit the inner space of the good soon-to-be-absent therapist-mother (136(RE2-3)).

An impossibility of getting the distance right

Dilemmas between closeness and distance were frequent. Coming close to me, Samantha soon either shrank away or exploded in violence; sometimes pointedly passing me by in an exaggerated, large circle; not looking, not talking, not listening; sometimes coming uncomfortably close, standing just before me, screaming or droning a torrent of verbally devaluating abuse. Apparently, the therapist-in-the-therapy quite often tried to protect herself by increasing the geographical distance; this however often proved no-good, Samantha immediately coming quite close in an aggressive manner, e.g. screaming, hitting, kicking or spitting. Thus, it was quite difficult to establish a comfortable, workable distance; whether close or at a distance, quite often feeling myself in a wrong position, causing Samantha to become overwhelmed.

She often seemed split and confused, in the grip of powerful, irreconcilable feelings, which at any moment might collide, giving rise to either collapsed-confused states or cyclones of wildly paranoid-manic action. Preceding the frantic acting out, usually were certain behavioural pointers of inner emotional tumult akin to flooding, e.g. smearing with black and brown painting; aggressively transgressing my personal space; emptying her play-box on the floor; wilfully dismantling and overthrowing furniture; hurling sand about etc. After such stormy behaviour, she might collapse into confused states, sometimes quite blissful although very immature. At other times, she retreated into omnipotence, commanding me

around, in a hostile, menacing voice issuing orders to stay away, come closer or perform certain tasks as fit to her mood e.g. softening the plasticine, cutting her string, or finding her playthings in the box.

In these moments, Samantha apparently was in a quite entangled state, her awareness of separateness gone, e.g. she would shift about our roles as adult and child, in a mounting confusion culminating in violent accusations and assaults. However, if I was able to offer appropriate understanding of her anxiety, vicious and confused behaviour might change to verbal communication e.g. of murderous fantasies[92]:

> *9(RE5-6)/(First session after an unexpected cancellation).* Apart from a short sequence of play at session beginning; most of the session, Samantha in an excited, manic state rushes about the playroom, heavy-handed emptying out the doll's house, cutting to pieces her string, cutting fur off her Teddy, fiercely rejecting anything I say: *"(At this point, I feel stupid, apparently no matter what I say it seems wrong. I suggest humorously that no matter what, today she has to say no to me, it can't be helped). She looks surprised, laughs genuinely, and confirms (RE5). (I feel tenderness, when laughing she almost looks beautiful, quite different from her normal pale, transparent, and suspicious look. I suggest that in so many ways, she needs to fight me). She says intensely that she will kick my leg and my head until bloody but immediately appears worried, asks what I am going to do if she kicks me. (I suggest she is anxious that I will take revenge). She insists on an answer. (I say I am ready to hear all about her intentions, but no way will I allow her to kick me). She appears satisfied, calms down.. (RE6)".*
>
> *87(RE1-RE3)/First session of week and first after second Christmas break)*. At session start, Samantha appears confused and unable to look at me. She enters playroom in a strange sideways manner, averting her face, turning her back at me starts a drawing. "*(I suggest that she cannot bear to look at me, maybe in the break, I became all black and terrible in her thoughts). She starts shouting in a droning way (RE1). She barely stops to draw her breath, among many different threats and insults declaring me a*

[92] Sessions 9 and 87 appear in more details in appendix, see also 21(RE1-2).

dead woman. (I listen and occasionally suggest that much more is the matter with me. I feel a mixture of compassion, tenderness and a kind of strange certainty that it is absolutely necessary that I am able to stand this and don't allow myself to be thrown off balance by her stream of insults). This goes on for some considerable time (RE2). (I sometimes say a little to let her know I am listening). She starts to mix certain more loving phrases among the threats". At session end, she talks lovingly of her birth father and wants me to act his role in a play phone-conversation *(RE3)*

At times, her omnipotent state of mind crumbling, desperate painful anxiety about separateness emerged. Samantha knew no other relief than *radical avoidance*; in phantasy doing away with any awareness whatsoever of emotionality e.g. retreating to a frozen, indifferent mental state, e.g. pictured as a sleeping baby locked inside a freezer (6(RE2)). Samantha seemed literally to experience the dangers of coming alive from an emotionally frozen state as a *pain located in her body* e.g. she repeatedly fell ill travelling to and from her sessions, throwing up and developing a fever, or protesting at arrival that therapy made her ill (7(RE1)). The danger of radical retreat also was communicated by self-destructive attacks on her playthings and play scenarios of a girl doll oscillating between an everlasting sleep state and recurrent compulsive acting out of risky behaviour (9(RE2-3; 88(RE1-3)). In the painful hindsight of the researcher-after-therapy, evidently the therapist-in-therapy defending against knowing that the tremendous pain involved in coming to life from a frozen, indifferent state of mind almost made Samantha ill; thus unwittingly relentlessly reminding her of loss and longing, thereby probably contributing to her desperate renouncement of any consciousness.

4.1.2. Sibling figures in mind

The qualitative approach yielded an *unexpected find*, not at all looked for, namely *the importance of violently greedy and envious siblings erupting in the mind of a child, who had suffered early abuse and neglect.*[93]

Definitions[94]

Sibling figures: Any communication from Samantha implying figures in mind assigned a horizontal, sibling like position; whether conveyed verbally, in play or behaviour; and whether described as *friendly, hostile, mixed*.

Friendly siblings: Siblings taking care of each other, no traces of rivalry, bickering, greediness, aggression etc.

Hostile siblings: Siblings aggressive towards each other e.g. mean, sadistic, fiercely competing, cheating, envious, indifferent, careless, etc.

Mixed Siblings: Any combinations of above.

The identities of such figures: Classified according to their relationship to internal-external reality:

Fantasy siblings: Creatures of phantasy and imagination, by Samantha identified as having no existence in external reality.

Therapy siblings: Samantha's ideas and phantasies about the therapist's children, grandchildren, and other child patients. The identity of these figures most often were verbally declared by Samantha herself, a few times inferred by the researcher-after-therapy from Samantha's way of relating to the therapist-in-the-therapy.

[93] Since not sought for, the introductory theory review did not include siblings. Theoretical perspectives appear together with the discussion (5.1.1., pp. 216).
[94] In the same way as described above, definitions emerged from IPA – see appendix III.6.

Birth and foster siblings as well as schoolmates and other children: Sibling figures by Samantha directly identified as belonging to external reality in their formal role.

Box 10 Inside therapy - sibling figures in mind

- Occurrence and emotional quality of sibling figures dependent on emotional quality of parental figures
- First 1½ years of therapy, intensely preoccupied with violently hostile sibling figures, most often fantasy and therapy figures.
- In latter half of therapy; by far fewer sibling figures, more equal distribution hostile and mixed figures; hostility gradually mitigated, becoming more reality oriented; fantasy figures replaced by therapy figures.
- Unalloyed friendly sibling figures few; appearing in contexts of parental abuse, loss and abandonment, probably most often representing defensive phantasy, joining-up with siblings as a protection against feelings of deprivation and abandonment.
- In the second half of therapy, group and gang states of mind alternating; ganging-up probably caused by a terrorized, confused state of mind in anxious identification with violently scary parental-cum-older-sibling figure.

Parental figures a precondition for siblings – The converse not true

Samantha was intensely preoccupied with sibling figures, often from session start to end; especially in *the beginning* of therapy[95]. The intensity declined *later in the therapy*, fewer sibling figures appearing for one or at most two relationship episodes in a row. The sibling figures' emotional quality was severely askew, *hostile sibling figures* lurking everywhere, especially in the first half of therapy *completely outnumbering mixed and friendly figures*. Thus, in Samantha's mind persecuting sibling-bullies might erupt at any minute; sadistically teasing, monopolis-

[95] See appendix II.1. & II.6.

ing all goodies and parental care, for no good reason viciously attacking each other. Accordingly, she was hypersensitive to even the smallest signs in the playroom of the presence of other children (session 1(RE4)).

In general, *sibling figures never appeared alone and thus seemed to presuppose parental figures in Samantha's mind; the opposite tendency definitely not true*, as parental figures frequently occurred without the presence of siblings; this tendency strengthened in the later part of therapy. Furthermore, throughout therapy, when hostile parental figures were present in a relationship-episode, in general the sibling figures of this episode were also hostile.

Especially in the beginning of therapy, this composite hostile-parent-sibling object was massively represented, in a majority of sessions erupting in several consecutive relationship episodes; a tendency somewhat less conspicuous later in therapy. Hostile parental and sibling figures linked so powerfully together in her mind that boundaries between them were highly unclear; *the transition* from one to the other occurring almost instantaneously, *part and parcel of the same mental image and thought* (11(RE2-RE3)).

In general, Samantha's attitudes to the therapist rapidly shifting, she would one moment act as a persecuted child vis-a-vis a threatening parental figure; next moment *relate to a kind of therapist-sibling rival*; then turn the tables, herself identified with a violent, rejecting parent. In play, family scenarios regularly turned out violent, a parental couple attacking each other, similar violence erupting between the siblings; often spilling over into concrete assaults on the therapist-in-the-therapy. Accordingly, I regularly felt bewildered and helpless, like a naïve child confronted by a stronger, violent figure; flooded by everlasting violence, fearing that both of us and ultimately the possibility of good therapy were

at risk of drowning. At session beginnings, she might triumphantly run to be first to the door; shutting it in my face, blocking my entrance; very much in the same way as may happen in a ferocious fight between sibling rivals.

She apparently found it much easier to think and communicate about *therapy and fantasy siblings* than about real-life sibling figures; practically exclusively *preoccupied by the therapeutic relationship and internal phantasy rather than past or present external reality*. The very few direct verbal references to birth and foster siblings all occurred in the first half year of therapy; *foster siblings* in mind implied intense jealousy, in a split second displaced onto therapy or fantasy siblings. Occurring before a break, reference to *birth siblings* might be linked to retreat into a dissociated, blissful state of mind in which the absence of parental figures did not matter, since the joining-up with siblings fulfilled all needs (21(RE4)).

Purely *friendly sibling figures* appeared seldom, and only in glimpses, disappearing completely 1½ years into therapy. Quite remarkably, contrary to the expectations of the researcher-after-therapy, friendly sibling figures by far occurred in the context of *feelings of neglect and abandonment*, protective parental care not available (88(RE3-4)).

Gang and group states of mind

Although the same-session chains of terrifically hostile parent-sibling episodes after half a year disappeared, hostility was still the dominant quality. Later linked together episodes generally included at most two consecutive relationship epi-

sodes of a mixed quality. Concurrently, parental and sibling figures alike gradually *lost their fantastic quality, becoming closer to external reality*.

Hence, a development took place, in which more ordinary, mixed peer relationships replaced violent siblings and catastrophic anxiety. These newly minted peer figures in mind *related more directly to each other*, had their own interests and in general acted more as a *cohesive group*. Immediately before the third Christmas break, Samantha oscillated between keeping parental figures at bay by joining into aggressive sibling coalitions and a growing capacity for cooperative, genuine linking with benign sibling figures:

a) A wish to cope in more *aggressive coalitions*, to a certain degree begot by the absence of protecting parental figures (135(RE1-4))
b) Quite reparative, although immaturely blissful attempts to bridge the gap between good and bad experiences with siblings, accompanied by phantasies of *incorporating the therapist-mother's good babies*, thus making them part of the self (136(RE1-4)).

After the fourth summer break (8½ years of age), Samantha came across as increasingly explosive, merciless abusive, as in the first year of therapy prone to sudden concrete assaults. The above-described split between behaviour at home and in therapy culminating, I decided to put a more forceful stop to her violence[96]. This seemed to clarify what was going on inside her; a dramatic conflict between different parts of the self in a dramatic play scenario depicted as a terrified child taken hostage by a madman-sibling part, rejecting all parental goodness and authority, not willing to relinquish aggressive omnipotence. Confronted by the more forceful, authoritative stance of the therapist, a benign parental figure entered; a

[96] See 4.3.4. For a detailed account of the therapist's experience at this point.

policeman-therapist forcefully protecting against the madness of violent chaos by safeguarding ordinary law and order (178(RE1-6)).

Enduring the separateness implied by making an existential choice between belonging to a group or a gang did not come easy to Samantha; the following months ripe with relapses into ferociously vile states of mind, in which she seemed wholly identified with an antisocial gang of siblings. Three weeks before the fourth and last Christmas break, she once more seemed captured by a mad gang state of mind (185(RE1-3)).

After the third and last Christmas break, Samantha struggled ever so hard to contain the pain of parting. More than ever possessed by dreadful phantasy imagos of parental figures in mind acting as envious siblings, especially a raving mad maternal figure, quite unable to contain the pain of parting (194(RE1-RE6). In play-scenarios of the ending period, Samantha repeatedly reworked a phantasy of a group of self-reliant siblings, although deprived sticking closely together, as a strategy of survival, in violent surroundings aiming at protecting each other by keeping at bay the parental figures. Unfortunately, she thereby also tended to keep out the part of the therapist able to help. The approaching end of therapy evoked profound dejection and abandonment; but also in a parallel movement started a painful but essentially necessary and benign process of letting go of imagined omnipotence and enduring separateness. She was shortly able to work upon the dangers of separateness coupled with some genuine concern for her mates (195(RE1-RE4)).

4.1.3. Differentiation internal - external reality

The mental processes of differentiation between on the one hand the internal reality of one's own mind, and on the other the external reality of other people's minds and the corporeal world, are not directly observable but may be inferred from certain behaviours and verbalised preoccupations; indicative that such inner work takes place or is avoided. As described above, this theme brought forward by IPA of the beginning (sample A); the slow circular analytic sifting of empirical case data producing three categories, which eventually were subsumed into "*increasing/decreasing differentiation internal and external reality*"[97]. The below listed *observable behaviours and preoccupations* were produced by the initial stages of the IPA, appearing as subordinate keywords to the three categories. Thus the applied codes taken as *indicative of increasing or decreasing differentiation between internal-external reality* (box 14 below) grew out of the IPA in an inductive-deductive process staying close to the level of empirical data.

[97] The original three categories: III: increasing/decreasing awareness differentiation external/internal reality; IV: Flooded versus contained states of mind; V: Steps forward/backwards in normal cognitive-emotional development. See Box 6, pp. 110 and appendix III.6.: Masterlist with subthemes and links to session notes.

Box 14: Behavioural definitions increased/decreased differentiation	
Increased	• Some awareness (however shortly) of longings for closeness • Some awareness (however shortly) of separateness • Some awareness of defensive aspects in own behaviour and thinking • Verbalizing concerns of past and present real-life relational experience [98] • Some realistic awareness (however shortly) of the level of own skills • Some realistic awareness (however shortly) of own problems
Decreased	• Confused or dissociated mental states e.g. droningly shouting threats • Communicating paranoid anxiety, ideas, phantasy, verbally or in action • Flooded states e.g. hurling sand, striking out at therapist or corporeal objects • Projective confusion, e.g. believe others responsible for own destruction • Mixing up phantasy and sensory perception e.g. at thought of sticking a knife in therapist, same moment sees blood coming out. • Dare not enter playroom because of paranoid dreams/phantasies e.g. of "monster-therapist" • Self-sufficient attitude e.g. composed but rejecting contact, back turned, whispering etc. • Self-harming behaviour e.g. secretly molesting Teddy, own paintings/things, picking skin etc.
In between	Such states that cannot be subsumed above, e.g. • Rapid shifts among working well i.e. exploring feelings and fantasies and out of context exclamations of confusion, repetition, empty passivity, manically rushing-about etc • Self-sufficient attitude, interspersed with meaningful self-insight.

[98] Preoccupied however shortly with e.g. life as foster child; birth and foster parents; therapy and therapist; birth, foster, or therapy siblings; teachers, schoolmates; own future, etc.

Box 15 Inside therapy: Differentiation internal-external reality

- Brittle differentiation inner-outer reality. Frequent oscillation awareness-mindlessness
- Frequent flooded states ruled out differentiation, ability to explore, search for relational knowledge.
- Flooded states of mind often linked to mental and bodily assaults on therapist
- Short moments of awareness and existential real-life inquiries
- Most often exploring reality of therapy and therapist; a few times own identity as foster child; infantile past and birth parents.
- Fervent quest for knowledge therapist's private life represented genuine capacities for passionate emotions, fuelling work on identity issues.

Flooded states versus relational exploration

As described above, Samantha quite often was flooded by chaotic feelings, composed by mental pain related to loss; paranoid anxiety and explosive rage. In the grip of such states, differentiation of inner and outer reality in split seconds might crash; resulting in violent attacks on the therapist, furniture or her own playthings, smashing or cutting these to pieces. In the next session she often had done away with awareness of her own ferocious rage; suspiciously projecting blame for damaged playthings into other children or me.

Even so, from the start, moments appeared in which Samantha was at ease, able to explore *topics linked to ordinary developmental curiosity and the world at large*. These preoccupations had the frank curiosity of any small child exploring relationships and the world in general. Locating herself and the therapist in time and space; she would e.g. share her personal theories concerning nourishment and defecation; the inside anatomy and functions of the body; the difference between men and women, children and adults; thoughts about love, marriage, reproduction; birth and death; and a host of more neutral questions e.g. related to society

and nature. Concerned with her own abilities of mastery and skills; at times she communicated ordinary wishes for potency and related practice, no obvious magic or omnipotent-manic features present. She would e.g. practise new techniques for brick-buildings, painting and drawing; rehearsing the alphabet, the numbers, the art of writing and reading; asking all sorts of questions about a host of ordinary subject matters.

In short glimpses pondering her *identity and relationships as a foster child* (1(RE2; 4(RE2)), such inquiries most often immediately evoked painful feelings of confusion, anxiety, and loss. Direct inquiries concerning *birth parents* were seldom; but struggling to hold on to personal inner memory, she did question the whereabouts of birth father, and why birth mother was unable to care (e.g. 21(RE4); 87(RE3); 138(RE3-5)). She was preoccupied by questions of to whom she rightly belonged; sometimes verbalising phantasies that someone, presumably the foster parents or the therapist intended to steal her away from a "real" mother, alternately birth mother or foster mother (e.g. 88(RE4); 194(RE5)).

A few direct references to the *foster parents* seemed to represent a need to feel securely grounded in a predictable everyday life, as compared to the internal tumult of despair and contradiction. Comparing an idealised birthmother to a correspondingly devaluated foster mother; next moment she was preoccupied by comparisons of therapy related, scary parental figures to the ordinary mixed parental figures in the foster family, maybe even telling me of real improvement outside therapy e.g. that she recently achieved bodily containment, no longer incontinent at nights (e.g. 20(RE5)).

By far most of her inquiries concerned *the therapy and the therapist,* since presumably she found it easier to explore the displaced media of the therapeutic

relationship rather than the real daily life with parents and siblings. Samantha thus kept returning to the *why, what, and how of the therapy and the therapist;* e.g. why was she sent to therapy; what is therapy anyway? What does therapy do, maybe by magic turn naughty children into good – or rather the opposite, turn good children into naughty ones? What is the use of a therapist, if she is not supposed to be an obliging servant? Painfully preoccupied by the therapist's whereabouts between sessions, she insistently asked for details of my private life. Thus in the midst of severe mental pain and related episodes of flooding, she was able in a multitude of ways to communicate in the therapeutic relationship a sometimes breathtakingly genuine and moving capacity for commitment and passionate feelings of love and hate e.g. a vehement wish to be my most dear and special child (11(RE2-5)).

4.2. The therapist's subjectivity in response to the child

The process notes of the therapist-in-the-therapy included frequent recordings of her states of mind as experienced in the session. The researcher-after-therapy elucidates these notes below, probing their meaning. One may wonder why the therapist's experience of her subjective response to the child is at all included in this study of core relationship themes and breaks, since whatever is the relevance of the subjective states of mind of the therapist? There are several reasons; firstly, IPA strongly indicated the therapist's contribution as central in the unfolding of themes. Secondly, as stated above, psychoanalytic psychotherapy a relational

endeavour, there is no such thing as contemplating a pattern of relationship themes in child psychotherapy without taking into consideration the therapist's contribution (Grünbaum 1999/2000). In addition, preparing the below account, the researcher-after-therapy repeatedly experienced doubt whether to address the subjective quality of the therapist's response to the child in the correspondingly subjective language of a first-person narrative; or whether to stick to the objectified third-person perspective applied elsewhere in this work, distinguishing the therapist's from the researcher's position. However, since this section focuses directly on subjective experience the third-person perspective felt somewhat artificial to adopt, and accordingly the below account primarily (but not wholly) is written from a first-person perspective. Related to this, difficulties arose in deciding whether to apply such theory-based concepts to a psychoanalytic child psychotherapist almost felt as second nature, e.g. "transference", "countertransference", "projective identification", and "introjective identification". In line with recommendations by Smith et al (2009), in the end I decided to postpone to the discussion terms like this, instead sticking as closely as possible to the verbal formulations of the process notes i.e. the empirical level of data. However, where doubt may arise, the appropriate psychoanalytic concepts appear in footnotes.

The presentation is organised into three parts: 1) Different types of subjective experience; 2) a closer look at the therapist's distance-related reactions; 3) the therapist's experience of a violent crisis in the course of therapy.

Definitions

Included in the below descriptions of the therapist's subjective states of mind were such recorded notes in which explicit mention was made of the inner states, feelings and thoughts of the therapist-in-therapy; *excluded* were notes recounting solely the content of verbalised interpretations, the inner state of the therapist not specified.

It seemed meaningful to differentiate between *four different types of subjective experience*[99], emerging from the IPA[100]*:*

a) *Emotional response,* the therapist's experience of intensified, disturbed, or dulled feelings, whether loving, hateful, or indifferent.
b) *Cognitive response,* the therapist's experience of unexpected changes in the stream of consciousness such as confused, muddled or blank states; sleepiness; bodily discomfort; or other disturbances of cognitive functions like attention, memory or the ability to think and put into words.
c) *Distance related response,* the therapist's experience of uncertainty, confusion or other difficulties of positioning at *the right geographical or mental distance from which to address the child,* the therapist-in-the-therapy feeling too close or too distant, whether in a literal or a mental sense[101].

[99] The formulation *therapist's subjective experience, response, or disturbance* henceforth broadly corresponds to what psychoanalytic child psychotherapists usually may refer to as *countertransference*
[100] These categories emerged during the inductive part of the analysis of sample A, and then deductively brought to bear on sample B; in the process slightly revised. See Appendix III.6: Masterlist with subthemes and links to session notes.
[101] These episodes included both *emotional and cognitive* aspects but seemed distinct from mixed episodes (d). Similar counter transference states are also touched upon in 4.1.1.above, here mainly from the perspective of Samantha's dependency-separateness dilemmas.

d) *Other mixed emotional-cognitive responses*, instances where emotional and cognitive components. were both noted[102]

Box 16 Therapist's subjectivity in response to the child

- Recordings of subjective states had a containing function, restoring the mindfulness of the therapist-in-the-therapy.
- Most notes of subjective experience belonged to one of three types differentiated by the IPA, namely primarily emotional, cognitive, and distance-related responses; this differentiation seemed helpful in understanding the meaning of core themes.
- Distance-related phenomena may be analogue to early warnings that closeness-separateness issues are enacted in the therapeutic interaction.
- Therapist's regularly experienced emotionally split or depleted states of mind; paralleled split communication from the child, e.g. a deprived infant-self longing for closeness versus a disillusioned, defiant part of the self, scared to death; identified with pervasively abusive, self-preoccupied parental objects.
- Faltering or blocked attention and memory often were combined with a depleted emotional state, at times reducing the therapist's ability to record the sessions.
- As the child's frozen, indifferent state of mind gave way to emotional life, an increasing split between outside and inside the therapeutic space developed; parallel to which, the therapist experienced an intense subjective crisis.
- A crisis experienced by the therapist gave rise to a confrontation, followed by benign turning point; in the play of the child depicted as a firm police officer-therapist forestalling a madman-part unleashed in the inner world of the child

4.2.1. Four types of subjective disturbance

Throughout the therapy, I regularly experienced *painful states of emotional disturbance* affecting my ability to contain Samantha and the relation between us, e.g. feeling split between, on the one hand compassion, tenderness, concern, and on the other vigilant apprehension, impatience, disgust, and even hate. Sometimes I found myself defensively turning down the emotional heat of paranoid anxiety and hateful attacks, leaving Samantha partly uncontained to cope on her own with

[102] If problems of distance were mentioned the episode was not included here but in (c) above.

states of flooding and catastrophic anxiety. At certain points, her recurrent enactment of chilly rejection, devaluation and exclusion would resound in my mind, giving birth to a raw vulnerability, affecting not only my therapeutic stamina in relation to Samantha's often awful behaviour, but now and then spilling out of sessions to my personal and professional life as well. Especially agonizing were states of depleted weariness, despondency, and despair, feeling incompetent, not able to kindle any hope for this terrible therapy to develop into a meaningful experience.

Instances of *cognitive confusion, disturbance, or blockage* appeared more puzzling, giving rise to enquiring states of mind, questioning whatever it was that took place between Samantha and me; *short-lived* states usually occurring *without premonition*. They might e.g. concern *memory,* forgetting to mention upcoming breaks, cancellations, or even session ends just a few minutes ahead. At one point, I got so utterly *confused about linear time* that in good faith I ended the session too early, causing considerable embarrassment in the foster mother. Sometimes my *ability to think and verbalise* seemed to fragment, giving rise to *numb and empty states*, in which I was unable to find appropriate words or think of anything to say. My abilities for reverie and containment shortly were disturbed by *strange inner images or sensations*; sudden *preoccupation with private affairs*; or *sleepiness*. *Weary emotional states* accompanied by loss of memory, motivation, and energy occasionally *prevented my taking down detailed notes* after sessions. In the most difficult periods, I recurrently experienced agonizing states of *anxious vigilance* related to the risk of physical attacks, occasionally accompanied by *hypersensitivity to noise*.

Sometimes, I felt quite puzzled as my subjective self-experience went through *rapid transformations from one type and quality to another*. I might e.g. experience swift conversion from a primarily emotional reaction to something strange happening to my cognitive faculties, or more disturbing I might fell into an *indifferent, impatient mood* that I felt quite alien to my normal state of mind and self-image as a therapist (5(RE1-6)).

4.2.2. Distance-related doubt and confusion

Especially in the beginning, I quite often experienced doubt or confusion concerning *my position in geographical or mental space*:

Geographical distance: No matter where I located myself in playroom, I felt at an awkward distance to Samantha; e.g. towards the end of sessions, Samantha suddenly taking off to the sandbox, I was so often indecisive whether to follow. A painful doubt arose in me, when confronted by the need to set limits to Samantha's often chaotic or sadistic enactment, e.g. how directly to interpret flooded states, manage direct physical assaults and undiluted sadistic terror. On these occasions, Samantha's ears and mind closed off to verbal interpretations, I would hover between ending the session; taking physical hold of her to prevent further attacks; or at the opposite putting more distance between us, hoping for her to calm down. My immediate personal inclination was to increase geographical distance, which seldom worked; probably because Samantha felt let down and took my moving away for anxious retreat; a sign of weakness inviting the monster-her to more violence, until at last she succeeded in making me stop her by force.

Mental distance: I regularly experienced difficulties in finding the right mental position from which to address the raw pain of abandonment, loss, burning jealousy and envy. One problem, about to whom and how I addressed myself e.g. the degree of *direct versus circumscribed verbal interpretations*; often feeling strangely inept in finding the right *emotional intensity* and *wording*. My words would e.g. feel as if coming from so very far away, barely able to reach either me or her. At the opposite, coming too close; more as impulsive attacks rather than proper interventions; Samantha reacting as if suddenly hit by a shock out of the blue, violently bearing down on her vulnerability. Ordinarily, I experience myself as a quite gentle therapist, leaving much space for my patients to fill out interpretations; however with Samantha, at times I barely recognized my own therapeutic self, going head on into sore spots, evoking much too much pain e.g. quite bewildered when suddenly finding myself strangely insistent, not leaving it for Samantha to decide whether to approach or avoid my interpretations. Especially; Samantha's tendency to shut down, radically avoiding the pain of separateness at times evoked in me a tendency to relentlessly remind her of loss and longing not unlike an appallingly non-empathetic maternal object; probably at times contributing to her desperate renouncement of any consciousness.

In the agonizing hindsight of the *researcher-after-therapy,* difficulties of finding the right mental and physical distance seemed to have a dual origin. On the one hand closely linked to the pervasiveness of abusive, self-preoccupied parental and sibling figures in Samantha's mind; on the other, in certain critical moments difficulties also arose because of the *therapist-in-therapy* defending against the tremendous pain evoked, Samantha slowly coming to emotional life from a frozen, indifferent shutdown state of mind. In this retrospective perspec-

tive, the flaws in my empathy grew out of inadequate containment of certain personal residues of despair, envy, and jealousy; stirred up in my mind by the insistent pervasiveness of abusive, self-preoccupied parental and sibling figures in Samantha's mind. Two early, consecutive no-break sessions seem especially telling about the complicated nature of this link between Samantha's and my own subjectivity (10-11). At this point, I have to try the patience of my readers, going back to sessions 10-11[103]:

> *10/ (A no-break session, first of week).* As will be remembered, Samantha in the first episodes of this session preoccupied by painting; culminating in painting herself with her mouth all covered with black paint, representing the smoldering embers of the fire of burning jealousy experienced when she noticed traces from the play of other children; she takes to build brick towers crashing to the ground….. *(RE1-4). (I suggest the thought of somebody else in here makes something inside her crash). She listens: "yes, you did, and you are sent off, far away, because you are a loser". (I feel confused about who of us is she talking about; hesitate, then ask lamely: What more is going to happen to me)? She says: "You are a loser; you'll only get a husband, you'll be off with him and you just have to go around all alone being stupid". (I suggest that worst of all, she is going to miss the stupid me). "No", she states in a firm voice, "not at all, you only have your husband to be together with" (RE5). She turns her back on me, goes to the opposite end of the room, firmly stating that I am not to follow. (I am in doubt but anyhow, I feel it important to move a little closer, from this midway position suggesting that she wants to be the one to decide that I am to be sent far, far away). "So you already are", she says firmly, turning her back on me to dig in the sandbox (RE6). She soon throws sand all around… (RE7).*
>
> *Session 10 revisited from the perspective of the researcher after therapy*: Samantha's phantasy of sending far away the therapist with some loser husband or another did have an obvious parallel in the external reality of her life story; birth mother repeatedly dropping out of visitation to move in with a boyfriend. From the vantage point of Samantha, if anybody was to be lonely and miss somebody, this certainly was not going to be her, so at this point it was not possible to address directly her feelings of

[103] Sessions 10-11 appear in details in appendix I.1 pp. 8-10

abandonment. However, Samantha's phantasy-scenario also had important parallels in the personal life of the therapist, relating to feelings of loss implied by adult children leaving home. At this point, although familiar with Steiner's therapist-oriented approach (1993), unconsciously defending against the reverberations in my own mind of similar feelings, I was not able to find a way to address the black, empty feelings left behind by burning jealousy. In the safe distance offered by the passing of time, but probably even more important equipped with the knowledge acquired by this study, the-researcher-after-therapy believes that today I might be able to address such unbearable feelings more gently, e.g. by trying out how far the child could bear to have such feelings verbalized from the position of a send-away-loser-therapist.

In the next session, I again felt doubtful about where to locate myself, struggling to contain the resonance of painful deprivation and jealousy:

11/ (No-break session, second of week): *Hurrying into the playroom, Samantha settles down and paints a yellow female figure. She tells me this is herself, and then looking at me changes her mind. Now this is not herself, but me; saying "look, what happens to you", she pours black paint onto the figure until it no longer is visible. She paints a number of paintings picturing me and attacks these in similar ways, meanwhile in a flat voice threatening to soil and stab me. (Astounded by the lack of emotion, so violent a content, but no feelings at all in her tone of voice; I feel uncertain, how to handle this split between content and form. I suggest that since last session, I turned into something bad inside her). She continues the destruction, still devoid of feelings (RE1). (I cannot think of anything sensible to say and keep quiet). Gradually her messing .. gives way to an intense activity, scooping up all paint in one container. (I feel apprehension that she will leave no paint for the next child to come but realize that in fact there is lots of paint in store. I suggest that she wants to use up all my paint, preventing other children to get anything at all). She looks intently into my eyes, asking if she is the first child to come, because if so, I am not stupid, but if she is not, she will cut my throat. She makes a cutthroat movement at her own throat (RE2). (At first, I feel relief; at least she is not emotionally dead now. Then I am puzzled about the meaning of her wish to be the first, asking her what it means). Instantly, turning her back at me leaving for the sand box, she orders me not to follow. (I am doubtful of what to do and say, deciding to stay put). She darts back, grabbing a dirty painting brush, she attacks me, threatens to run out with the brush (RE3). She continues … mocking me, wilder and wilder. (Apart from stop, I still cannot think of anything sen-*

sible to say. In the end, I feel it urgent to take hold of her, which I do. I tell her that she may say anything on her mind, about what she wants to do to me; adding firmly that it must be said in here in the playroom, and the paint must stay at the table). She calms down and goes to the sandbox (RE4). Pouring sand in a plate, she chops it up with a fork, shaking the fork at me, and intensely says that she chops me up in bits, eating me all up until nothing is left[104]*. She goes on flooding the paint box with water. (I suggest that this flooding has to do with me being destroyed and not there. I forget to mention the session is about to end). She says that she just felt like pouring water and besides "you are stupid, very stupid" (RE5).*

Session 11 from the perspective of the researcher after therapy: At session start, a rapid transition seemed to take place, Samantha looking at the painting of me, it seemed to equal me, and the me she saw was a spoiled, unfaithful, preoccupied me, letting other children take her place, which in the preceding session she discovered at a reality level. Getting all mixed up, her state of mind allowing for no space between self and therapist, between her and me, because if so, somebody might intrude between us. She seemed to fight ever so desperately to keep away depressive feelings by a defensive split, verbalizing murderous intentions without any emotion, thus communicating that someone, not felt to be part of her (probably the hostile intruder-rivals) spoiled me. The therapist-in-therapy was aware of the lack of affect, but didn't grasp the full emotional implication, thus unable to address her own subjective contribution to Samantha's flooded, jealous state. Nevertheless, Samantha apparently felt contained, however partly, by the suggestion of the absent therapist felt as an inner persecutor. The feeling part of Samantha revived, so came to life her longing for more love, and destruction was transformed into ordinary, normal greed, scooping up paint to the best of her ability. In a parallel process, by mindless identification with the insufficiency of the parental figure implied by Samantha's behaviour[105], the therapist-in-therapy at first felt depleted, then realized the unreality of this. Consequently, at this point, at a much deeper level I seemed able unconsciously to identify with a plentiful maternal/supervisory object able to contain the painful burning jealousy of sibling rivals. Samantha immediately took this suggestion in, taking the lead, in her own language expanding on the deprived foster child's passionate longings for love, to be someone's dearest, special child in a tender relationship. Murderous and suicidal feelings of burn-

[104] I do not speak to my therapy children in a language of body-parts; however it is my experience that younger children in twice-weekly therapy quite often spontaneously do so.
[105] In psychoanalytic terminology: *Introjective identification* (Bell 1998)

ing jealousy followed; if not my special child, both she and I had to die, because feeling so close to me, killing me meant to have a dead parental figure inside, equating to the death of the self. She probably felt my unempathetic question (what it means to be the first) as chillily forcing her to lump her own longings and murderous intentions as well as the painful relation to a mindless (stupid) parental figure/therapist[106]. Not surprisingly, immediately flooded, she raised havoc in the playroom, first to be stopped as I literally set limits to enactment. Feeling contained, once more she was able to elaborate in her own language and movingly went on symbolizing a wishful phantasy about doing away with the space between us (and thus also of the approaching session end) by eating me up, thus making me part of herself[107]. Session end approaching, Samantha again flooded by the jealousy and pain of separation; I became even so dumb as to forget session-end to come. A dimly perceived, depressive awareness that gobbling me up might mean that she didn't have me anymore probably contributed to Samantha's avoidant tendencies, e.g. why she left me in the first place for the sandbox, thus keeping me at a distance to protect me. At a much more primitive level, one of the confusing aspects of Samantha related to a precarious ability to split between the bad and good parts of her parental figures, in the therapeutic relationship to me. I assume this pre-splitting state of mind to compromise both mental and bodily incorporation of good parental mental and bodily care, thus further strengthening avoidant tendencies; at a bodily level related to her eating difficulties e.g. as reported by the foster family compulsively going on forever chewing on the same bit of food (Roth 2001, Pinheiro 2004).

After 1½ years of therapy, distance-related countertransference reactions still seemed to embody a complicated relation between on the one hand Samantha's painful dilemmas of closeness-separateness and on the other hand parallel unresolved themes related to leave-taking in the therapist's personal life; through resonance brought into focus of my subjective emotionality:

65/ (No-break session, first session of the week. I have a small plaster in my face due to minor surgery; some time ago, I tightened the setting to curtail violent assaults,

[106] In psychoanalytic terminology: ..."forcing her to lump her original *projective identification* together with the painful relation to ..." (Bell 2001).
[107] In psychoanalytic terminology: *oral-aggressive introjection*

locking off the sandbox, and removing the paint; crayons and felt-tip pens still available).

In the waiting area, Samantha immediately reacts to the plaster, anxiously pointing to my face: "What is this, what happened to you?". She grabs a Donald Duck magazine, settling down to read but at foster mother's instigation follows into the playroom. Her first act is to empty her folder, spreading onto the floor the drawings. She spots the back of her drawing pad has come loose, claiming this to be my fault. Catching sight of an earlier drawing on the pad, she declares this to be very, very ugly. She accuses me of letting other children use her pad. (I suggest that she needs so much to be sure that she has got me all to herself. I suggest that today this is even worse because of the changed time). She nods (RE1). Then she asks who has beaten me up. (I suggest that maybe she feels I ought to be beaten up or even killed for allowing the time to be changed, making her feel so painfully unsafe)? She says that no, no, not at all; she intended only to stick into me until blood were coming out. She points to my face, "isn't that blood on your face?" (RE2). She draws two women, one big and one smaller; their arms looking strangely small. (I am about to comment about that when my attention is deflected by her next move, forgetting all about this for the rest of the session). She leaves the table and goes onto the sandbox, jerking violently it's by now closed and locked lid. (Recognizing her wish to be able to get in, I suggest that most of all, she wanted to get away from looking at the plaster in my face). She calms down, fetching the blanket from the couch (RE 3). She covers the sandbox with the blanket, in this way sparing herself the sight, while at the same time making a cosy den out of the space beneath it[108]*. She hides in the den for some moments then ducks out and soon turns it into a game of "peek-a-boo", regularly going into the den and coming out again. (I experience some confusion, split between tender feelings and an extremely anxious atmosphere. I do not say anything; just fulfill my part of the game). After a while she starts crying in a quite artificial voice and complains that her legs have become stuck in the sand box (RE4). (I miss the fact that the session is coming to a close and suggest that she is so scared that if we get too close to each other, she will never be able to become free again). She nods. (I tell her time is up). She denies this and stays crawling on the floor, refusing to stand up. (I talk to her about a wish to be carried). She shouts: "I don't want to be carried as a baby". She stays on the floor, totally limp, and in the end, I have to carry her out (RE5)*

[108] There may be a certain similarity between this hiding the temptations of the sandbox from sight by covering up and her birth mother hiding the disturbing sight of parental violence from the infant by covering up her face (see 4.4.1. & 4.5.2.).

4.2.3. The therapist's subjective experience of a crisis

My work with Samantha recurrently complicated by violent, physical assaults; I had to weather hitting, kicking, spitting, biting, and throwing things at me. In spite of the regularity of such attacks, I often felt like a naïve child, falling into quite unprepared states of mind, bewildered in the face of escalating violence. At pains to prevent and cope with this, verbally addressing her violence did not seem to work and neither did my taking distance; Samantha pursuing me, kicking, hitting and spitting, until finally, I felt compelled forcibly to restrain her, while doing my best not to hurt her, protecting myself. I often despaired about how to contain this child, struggling to contain my own rage, keeping in mind that Samantha's violent reactions indicated her to be scared stiff, suspecting me of dangerously aggressive intentions. But then again, her behaviour sometimes frankly sadistic; I felt as a poor defenceless infant, gruesomely abused, and rejected; at other times rather as an overburdened, beaten-up wife vis-a-vis a violently devaluating adult or spouse. In time, I learned better to firm up my bearing and voice; in such moments from a standing position, *forcefully ordering her to stop* attacks immediately or I would end the session. I also learned to listen carefully to my inner voice*; monitoring* whether to stay put; decrease or increase *the distance* between us, e.g. whether *verbally to address directly her flooded state* or leave this to a later more calm moment.

After 2½ years, an increasing split between inside and outside therapy developed; Samantha in the external world steadily improving, inside therapy ever more violent and difficult to contain. The last reference in session notes to distance-related disturbance was written after an absolutely terrible session, Samantha frankly hostile, mercilessly bullying, exploding in a violent corporeal assault,

at which point I despairingly felt my therapeutic ability to reach rock bottom (120(RE1-RE4).

After this appalling session, I experienced a surge of hateful anger coupled with a clear awareness that I could not possible go on being bullied like this. I suspected Samantha of all her might trying to make me give up on her; although having no clear idea about how to proceed, I did not intend to stop. I was, however, painfully aware that a decisive change in my management of violence was needed and decided to work out firmer and earlier limits. Putting this into practice already in the following session, no more states of indecisive distance-closeness confusion were recorded; instead intensely emotional countertransference states ascending (121(RE1-RE3)).

Change not easily accomplished in this therapy; often perplexed by Samantha's violent assaults, I did not quite grasp their meaning. In retrospect, the researcher-after-therapy felt the assaults to have their origin in *two different, internal contexts of anxiety.* Most simple to grasp were *confused paranoid states of mind,* Samantha striking out in desperation, as if under hostile attack, forced to defend herself in order to save her life. More difficult were vehemently goal-directed attacks, as if intent of tormenting me for the sheer sadistic pleasure of it, maybe *in total identification with an overpowering, violent daddy figure*. In this state of mind, she was much more unpredictable.

I found the goal-directed, sadistic attacks especially difficult to contain; Samantha pouring out menacing cascades of insults, shrieked at the top of her voice, sometimes aping anything I might say. At this point, a sort of *anticipatory counter reaction* grew inside me; its emotional quality maybe best compared to the stressed state of an infant and small child, recurrently traumatised by exposure

to overwhelmingly threatening sounds and movements of domestic violence. The therapeutic relationship thus at times took on *a twofaced nature concerning the distribution of victim and perpetrator*. On the one hand, as longing for tender closeness came to life, relating to me seemed to evoke a near unbearable pain in Samantha. A contributing factor probably was such moments in which a non-empathetic therapist insistently brought to her awareness the pain of loss, longing, and separateness.

During the next year to come, Samantha's fierce attacks waxed and waned. Although doing my best to keep up determination and courage, I felt increasingly burdened by her. It helped me to carry on that according to the foster parents; Samantha at home had become affectionate, genuine, and better tempered, also at school doing much better. However, after the fourth (and last) summer break her behaviour in sessions worse than ever, going through a kind of subjective crisis; I began seriously to doubt my ability to help her[109]. Once more, I decided to confront her that change was necessary (178(RE1-RE4).

Accordingly, I told Samantha that this foul behaviour had to stop, but more important that *no way could she get away from the fact that she had changed and was well able to control herself*. Samantha received this in a confused, mixed way, in the immediacy of the moment benignly taken by surprise, the healthy parts of her personality feeling supported by the thought of positive change; for some moments looking blank, then an expression of surprise spreading over her face, mumbling: *"I have developed"*. A few moments later, she fiercely protested: *"I couldn't care less"*, apparently scared stiff of the idea of change, her being well

[109] Before this study the therapist-in-the-therapy believed an increase in the number of breaks in this period to be the most likely explanation for Samantha's foul behaviour. Yet as shown, (appendix II.3), the number of breaks in this period moderate as compared to other periods; in fact the level of breaks were fairly constant throughout therapy.

able to control herself if she choose so. At this point in the session, I experienced a surge of concern; for the first time understanding with full emotional impact that I could not carry on feeling her feelings for her; she had to take upon herself that responsibility:

> 178 (RE4-7)/ (First no-break session of the week, autumn before the fourth Christmas break). *(I say that I know it to be true, she developed very much outside therapy, but she also has to develop in here together with me, because if not, I am unable to help her in any lasting way). She appears thoughtful, shaking the last remains of the stuffing out of her teddy bear*[110] *(RE4). She rolls small pellets of the stuffing, making a fenced off space, placing the pellets in there. (I point to the sad sight of the by now very empty skin of the Teddy, with the big slash in its stomach and its fur tightly cut down. I suggest that this is how she sometimes thinks of me, as an empty shell without value, all got through and of no use to her anymore). She moans: "yuck, please don't" (RE5). She tells me that during the last many months she has suffered nightmares. (I suggest she tells me about them). She won't. (I tell her that I know it to be scary, however in not telling me she prevents herself from getting my help). She takes some dolls and start playing (RE6). The dolls are inside the castle, playing with each other. At the entrance stands a knight in full armour. A police officer wants in but can't pass by the knight. They struggle; the police officer says, "Move or I will shoot you. I must get in; it is life or death, a madman is broken loose in there". (I suggest a likeness between the police officer and me; she has to let me in to get my help to stop this madman-part of her before it destroys all good feelings)... (I believe the session ended but apparently did not record either her reaction to this interpretation or the end) (RE7).*

Subsequently, this crisis seemed to bring about a *decisive turning point for the better*, Samantha from this point on apparently becoming more self-contained and able to work on issues related to the pain of separateness.

[110] Some time ago she cut up the teddy with the scissors and for the past weeks now and again have taken lumps of the stuffing out, at will spreading it around in the playroom for me to tidy up.

4.3. In therapy - Breaks and the experience of core themes

This section elucidates the shifts taking place around breaks, session beginnings, and endings in Samantha's experience of parental and sibling figures as well as in her awareness of differentiation between internal and external reality. Included here also are the temporal dimensions of therapist's subjective experience. At the end, findings summed up indicating breaks to intensify specific core theme preoccupations and phantasies (Box 17).

Box 17 Summary core themes in breaks, beginnings, and endings

Parental figures:

- No-break sessions, after-break sessions, middle parts and beginnings more likely to contain hostile figures than before-break sessions and endings.
- Before-break sessions and session endings include episodes of manifest anxiety and desperately confused attempts to negate separateness; by violence, by merger with therapist, or with an alliance with all-good parental or sibling figures.
- Session beginnings and after-break sessions: In the first 1½ ys., A prevailing tendency eagerly to come close; thereafter, an increasing tendency for desperately confused conflicts closeness-distance.
- An especially trying accumulation of planned and unexpected breaks brought forward indications of a central phantasy in mind: an unreliable, sexualised therapist/maternal figure conjoined with a dangerous daddy figure; the couple producing babies scared stiff because forced to look at the vile doings of a tremendously violent parental couple.

Sibling figures:

- Hostility of sibling figures most pronounced in middle parts/no-break sessions rather than at end/before-break sessions.
- First half of therapy, sibling figures unlikely to appear at end/in before-break sessions; after 2½ ys., more sibling figures at end/in before break sessions may indicate increased ability for symbolisation.
- Preoccupation with birth siblings and birth parents at session beginning or end had a protective function; the evasion of painful longing was followed by decreased differentiation, e.g. by phantasies of merger with birth siblings into a close group, excluding the therapist.

Differentiation and preoccupations internal-external reality:

- First 1½ yr., confused states, avoiding awareness separateness at end/in before-break sessions.
- After 1 yr., especially around breaks, shortly able to work directly on fundamental identity issues relating to therapy and status as a permanently fostered child. Existential preoccupations seldom at ends and beginnings. This pattern stable to end.
- After 2 ys., persecuted, flooded states and related bodily assaults most likely in after-break sessions and beginnings.

4.3.1. Parental figures

Throughout therapy, Samantha preoccupied with her relation to the therapist, parental *therapy* figures were more common than any other kind; next were parental *fantasy* figures, while *real-life external parental figures* e.g. birth parents and foster parents were seldom[111]. Quite contrary to the expectations of the researcher-after-therapy, from a quantitative point of view, Samantha throughout therapy would just as likely relate to purely hostile as to mixed parental figures; furthermore, it made no difference whether the sessions in question were no-break, before-break, or after-break sessions. A more detailed, qualitative study did however reveal that certain other features seemed to change:

1) *The hostility of parental fantasy figures* in time seemed somewhat relieved by friendlier or even warmer feelings; however, Samantha apparently *transferred the hostility to parental therapy figures*.
2) Fearful expectations of neglect and abuse never quite disappeared, but in time, an apparently *inverted link between mixed and hostile figures* came across. Thus mixed figures in the last half of therapy was relatively more frequent for several episodes in the single sessions; concomitantly the fierce, fantastic quality of the hostile figures *more confined and closer to ordinary everyday reality*.
3) *Although protective parental figures were seldom, they seemed important in terms of benign change*. They disappeared completely after the first few appearances; first to return after 1½ years of therapy, at which point they seemed closely linked to friendly feelings towards the therapist rather than

[111] Identity of parental figures as defined above (pp. 126-127).

pure phantasy creations. This may indicate that after all benign development took place.

Especially dominant in the memory of the therapist-in-therapy were episodes from the second half of therapy of turmoil at session beginnings; Samantha fearful, avoidant, and explosively paranoid. The more surprising were the result of IPA of the first seven months of therapy, which contrary to expectations alongside avoidance and assault showed *a genuinely hopeful and expectant part of self*. This Samantha visible in glimpses seemed spontaneously joyful at first sight of therapist, keenly inclined to move close.

Eagerness petering out, *after the first 6 months*, Samantha more often than not *started sessions in a foul mood*; at arrival apparently possessed by excruciating anxiety and conflict related to closeness, sometimes neither able to enter nor to stay out of the playroom, literally stuck in a painful in-between position at the doorstep, blocking the entrance to the playroom. From there, she would incessantly drone hostile insults and a high-pitched, non-stop humming sound, filling up the clinic and my inner space with an embittered hopelessness that this might never ever get better (85(RE1-2); 86(RE1-2); 88(RE1); 121(RE1-2); 178(RE1-2)). Thus her behaviour communicated to me a most painfully haunted state of mind; in my subjective inner imagery pictured as the live presence in mind of something akin to an inner perception of havoc, filled up and surrounded by viciously quarrelling, unpredictably violent parental-cum-sibling figures.

Session endings often were equally difficult, Samantha at the brink of parting *intensely desperate*, sometimes heartrendingly *confused*. She often seemed *in the grip of grossly contradictory feelings*, e.g. at the top of her voice, interspersed

with threats fiercely protesting that she never would return to me. Quite early in therapy, her longing for a state of no partings and separateness movingly assumed a quite cannibalistic form, as near session-end she indulged in verbalised *phantasies of gobbling me up* part by part (11(RE5))[112]. Sometimes, she would spend the last quarter of the session teasingly encircling the door as if to *leave early*, when time actually was up hurriedly resume play, point-blank refusing to leave. Sometimes literally *clinging to me*; sometimes in a state in-between doing it for real or play tying down possibilities for leaving, e.g. by *stringing together all furniture*, in the process having a go at fastening me to a chair as well; or taping together the handles of the double-door out of the play-room (13(RE4-5)). Sometimes, she ignored the information that time was up (88(RE5); *hiding underneath the sand box*, where it was just possible for her to squeeze in. Once in there, she might cling with her hands to its legs, causing me considerable difficulties in getting her out without hurting her (185(RE3)). Although session ends never became easy, for every new Christmas to come, Samantha appeared *increasingly able to contain the pain of parting*. After 1½ years of therapy, sometimes she might even leave in a friendly mood, bidding me an ordinary goodbye that appeared genuine (86(RE4); 87(RE3)). After 2½ years, she was most often able to leave calmly, in a mixed or sad mood, determinately closing the door.

After the first 15 sessions an especially poisonous conglomerate of five tightly spaced planned and unexpected breaks occurred[113]. Concurrently, Samantha's phantasies of parental figures attained a more fragmented quality than the

[112] I don't speak to my therapy children in part-object language relating directly to body parts, but it is my experience that in general, young children in psychoanalytic therapy very often spontaneously speak or act in ways directly linked to bodily experience, and more specifically that once the therapy gets going, young deprived children often voice outright cannibalistic fantasies.
[113] Sessions 16- 26, see appendix II.3.

fortified, hostile characters described above. Her paintings became black, gray or brown, depicting e.g. dried up, closed up topics; dark, disjointed faces or randomly placed body parts; a solitary tooth not conjoined to a mouth, or a partially defined face with a single, misplaced eye (20(RE2,RE4); 21(RE1-RE2); 25(RE1); 26(RE1,RE5)). In one of these sessions, she verbalised *an especially petrifying phantasy, which in a more or less fragmented form recurred at later breaks*. In this an unreliable, sexualised therapist-me shut her out to keep company with a dangerous, filthy daddy figure; the two of us producing shitty babies scared stiff; forced to look at the vile doings of a tremendously violent parental couple (20(RE4). In the next session (last before the break to come), she voiced the pain of parting with suicidal and murderous intensity; a cut throat movement at her own throat, verbally threatening that if I ever was to see any other children in the break, both I and they alike were dead forever after (21(RE2)).

Later in therapy, the impact of breaks seemed more diffuse, e.g. quite contrary to the expectations of the researcher-after-therapy, the purely *good parental figures* occurred in *break-related sessions* rather than in no-break sessions, and most of all in the last before-break session. Vice-versa, *hostile figures* seemed more often *linked to no-break sessions* than to break-sessions, while *mixed parental figures* most often occurred in break-related sessions[114]. Even at the end of therapy, in the very last session, Samantha still worked ever so hard reconciling love and hate; handing me a card on which she had written: "*For Liselotte. Thanks for the stupid and good years together with you. You been stupid and sweet. From Samantha*".

[114] Appendix II.1.

4.3.2 Sibling figures

In another quite unexpected result, the IPA brought forward complicated links between sibling figures and breaks, session beginnings and endings; furthermore, distinct changes seemed to take place in the course of therapy[115].

In *the first 1½ years of therapy*, hostile sibling figures usually *appeared from session beginning*; *hostility continuing throughout the session*, the identity of sibling figures *undergoing several transformations* e.g. *from birth to fantasy to therapy sibling*. At the opposite, sibling figures never made their first entrance *at session end*. Later in therapy, the link between siblings and session-beginnings dissolved.

Throughout *the four Christmas break-sets*, sibling relationships *seldom occurred in before-break sessions* but mainly *in no-break sessions and after-break sessions*. Thus, 2½ years of therapy went by before sibling figures appeared in before-break sessions. Assuming siblings in before-break session to represent a capacity to contain and symbolise feelings related to separateness (the separation to come); the reappearance of siblings in before-break sessions in the later part of therapy may indicate benign development. This assumption may be further substantiated by comparing *before-break sessions of the first and the last Christmas breaks* (26(RE3-RE4) and 192(RE1-RE3))[116].

In *session 26*, Samantha in a black and violent mood, flooded by pain was unable to play, repeatedly attacking the therapist. In the end, she retreated into a re-run of an earlier blissful play of three "waterdog sisters"[117], evading awareness

[115] See appendix II.6 & II.8. Emotional quality and identity sibling figures
[116] See the discussion of the implications in 5.2. pp. 235-141.
[117] The expression "water-dog sisters" was Samantha's own, referring to an earlier play, in which she and her two birth sisters together licked up water (21(RE4).

of the pain of separateness to come by recreating an experience of belonging to a closely-knit group of siblings sharing the same fate. Since the Christmas break to come was a heavy challenge, this time the retreat did not work; she never got around to a real symbolic creation of the sibling figures, just in a desolated state licking up a little water from the three basins.

In *session 192*, Samantha, now almost 9 years old related to the break to come in a self-possessed and symbolic way, staging an elaborated play scenario of two siblings on the run, who eventually were found and brought home by someone, who was or was not their real daddy. At this point, before the last Christmas break in the therapy, Samantha seemed more able in a symbolic form to confront a *fundamental question of the identity of a permanently fostered child, namely who is the real parents*. She still needed fortifying herself against the pain of parting, joining up in a sibling alliance, rallying together in an effort to separate from the soon to disappear therapist-cum-fake daddy. For this to succeed, she had to mobilise some aggression; however although mixed with doubts, in this play parental care was around, and so protective adults took action, bringing back the flamboyant runaway children.

4.3.3. Differentiation internal from external reality

In the first three years of therapy, Samantha was prone to oscillate between on the one hand moments of some awareness of her own feelings and states of mind; on the other hand, flooded states followed by blank shut down, manically rushing about, or vicious mental and bodily assaults. After two years, this tendency

seemed to localize around breaks, and as described above, beginnings and after-break sessions became increasingly difficult.

Nevertheless, throughout therapy moments occurred of existential preoccupations; Samantha calling into question the personal meaning of therapy, her birth family, and her identity as a foster child. This awareness most often occurred in before- and after-break sessions rather than no-break sessions, a pattern stable throughout therapy. If occurring at session beginning or end, her preoccupations rather took the form of an idealised, wishful longing for care; feelings of abandonment mitigated e.g. picturing her birth father as dead in Heaven, sad about not being able to take care of his children (7(RE4)). Thus, even if severely trying to both Samantha and the therapist, breaks unexpectedly also seemed to stimulate important and mindful work on her *identity as a permanently fostered child* (26(RE3-RE4) and 192(RE1-RE3).

4.3.4. The therapist's subjective experience

The impact of breaks on the subjective experience of the therapist seemed diffuse and compared to the impact on Samantha much more difficult to pinpoint and describe. This is of course not to say that breaks were of no consequence to the therapist. Rather, the appearance of specific types of disturbed experience seemed to have a quite complex background. Thus, in the context of the therapist's personal sensitivity, a time factor related to the overall length of therapy and the position in the single session seemed influential.

Box 18: Breaks and the therapist's subjective experience

- The impact of breaks complex, the therapist's experience linked to the episode's position in the therapy as a whole, in the single Christmas break, and in the single session.
- Emotional and distance related reactions were equally common and most often noted; distance related reactions steadily declined, practically disappearing after 2 years of therapy. At the opposite, notes of emotional reactions steadily increased during 4 Christmas breaks.
- Emotional experience throughout therapy more commonly noted at session beginnings than any other type.
- Cognitive experience throughout therapy more commonly noted at session ends than any other type
- Moments of confusion and merged experience of separation anxiety were described in details in before-break sessions.
- After 2½ years, at the peak of a countertransference crisis, in session beginnings and after-break sessions the child's droning, high-pitched shouting resonated in the therapist's mind as a painfully haunted state accompanied by subjective imagery picturing something akin to an inner perception of havoc, filled up by the noise of viciously quarrelling, unpredictably violent parental-cum-sibling figures.

As mentioned, it was surprising to discover that even if the therapist-in-therapy carefully had recorded Samantha's immediate spontaneous eagerness at first sight, at the time I apparently was not able mentally to digest this perception and transform it into a thought. The reason for this probably partly that Samantha's short-lived advances was lost in my efforts to contain the ensuing turmoil; partly because of a certain personal vulnerability stimulated by Samantha's tendency to avoid closeness.

In the beginning of therapy, notes of *emotional and distance-related reactions* were equally common, while cognitive disturbances appeared more sparsely. However, comparing the first half of therapy with *the last half of therapy*, dis-

tance-related experience lost momentum, in the second half practically disappearing, while notes of emotional experience more than doubled.

The experience of cognitive disturbance seemed highly dependent on the episode's position in the single session; thus after 1½ years of therapy, this most often would start just before parting *at the end of sessions*; throughout therapy more likely to appear there than any other kind of subjective experience. At the opposite pole, the therapist's notes of emotional and distance-related experience practically never started at the end of the session.

In relation to breaks, notes concerning subjective experience were *most frequent in no-break sessions*. *Distance-related doubt and confusion* almost exclusively mentioned in no-break sessions and never in after-break sessions; at the opposite *cognitive disturbance more likely than any other type in before-break sessions*. Emotional experience seemed to occupy an in-between position, seldom in before-break sessions, most often found in no-break sessions.

No matter how the researcher-after-therapy organised this material, *I kept concluding that before-break sessions posed special difficulties, at least to this therapist and this child*. In accordance with this assumption, a single *mixed episode* occurring before the first Christmas break strongly suggested anxiously estranged feelings and phantasies passing more or less freely between Samantha and the therapist-in-therapy, momentarily giving rise to *merged subjective experience and ideation* e.g. the therapist's bodily experience of freezing cold gaps of separation (25(RE1)).

4.4. Core themes as reported by past and present caregivers

Going back to the original aims of this study, a remaining question is if possible, to disconfirm or corroborate Hinshelwood's assumption of continuity between core relationship themes as found inside therapy with reported core themes in the early, concurrent, and maybe even later daily relationships of the child (2001).

Accordingly, this section elucidates reported relationships (age 0-12 years) to parental and sibling figures, followed by cognitive-emotional development of differentiation of internal from external reality[118].

4.4.1. Reported relationships to parental figures

The summary below depicts an overview from 0-12 years of age of reported characteristics in relationships to parental figures. Although change related to Samantha's increasing age and the therapy process are easily detected, at this point I will rather focus on the remarkable stability of certain characteristic anxieties and dilemmas and corresponding self-protective (defensive) relationships

[118] See appendix I.3.-I.4. transcribed interviews with birthmother and foster parents and III.8-III.9. for a more comprehensive description of reported development 0-12 years

Box 19 Reported relationships parental figures[119]			
	Early relationship themes (0-5 ys)	Daily relationships (5 – 9½ ys)	At follow-up (12 ys)
Wishing for Dependency versus Fearing Rejection -Abuse	Immediate joy and eagerness first sight Bm then hostile/apathetic withdrawal, (Dn 0-1½) Short joyful exchanges, soon broken off (Bm, Dn, Ri 0-2) Difficult to calm; Stressed by bodily care; Apathetic states; Gaze aversion; Rejects cuddling, Seeks no help; Goes astray strangers (0-5) Seeks closeness-comfort, at St's lap pining for Bp (1½-3)	Immediate joy and eagerness first sight Bm then hostile/apathetic withdrawal (Beg. – C-br IV) Short joyful exchanges Fm, soon broken off (C-br I-II) Seeks comfort-support parental couple; Less withdrawal, faster reconciliation (C-br II-III) Complex splitting: couple & Fp–Bm (C-br I-III) Seeks tender care Fm; lengthy talks Ff (C-br IV)	Immediate joy and eagerness first sight Bm, but still terrified her anger Close, tender, loving relationships Fp Some tendency splitting parental couple; Less confident Ff Going blank if insecure (stoneface)
Striving for Autonomy -Identity versus Avoiding Separateness	Persistent problems letting go, falling asleep; Wide-awake hours, not calling out, staring, roaming, self-harming behavior (0-5) Denial partings e.g. no reaction (Dn); "forgets" Bp after failed visitation; Denies loss St (Ri); No reaction at end visitation, later bodily pains & tantrums (Ms, Fp) Running away to be found, when found rejecting closeness (Bm, Dn, Ri 0-2) In St's presence, short joyful episodes role-playing; St not available: tearful rage & dejectedly trudging at heels any adult (1½-3)	Persistent problems falling asleep; Wide-awake hours, not calling out; staring, roaming, self-harming behavior (Beg-C-Br II) Denial partings e.g. Stoneface parting from Bm, bodily pains & tantrums (Beg -C-br III) In T+St's presence able to relate at Kg-school; No special attention available: daydreaming, furious-defiant tantrums & withdrawal (Beg-C-br III) Confused-paranoid assaults St after conflicts P (C-br III) Able to let go, sharing St with P (C-Br IV)	Some denial separateness & parting left e.g. turns back at Ff at bedtime At perceived risk of loss Fp, traumatic relapse, backsliding to adhesive ingratiation e.g. when older Fs moved to his birth-mother Relates to differentiated parental couple with separate roles Improved and still developing capacity for adequate protection self transgressions and disappointments Bm & Fs; Convincing network of her needs for protection Some difficulties speaking up her own mind (going blank)

[119] Beg=Beginning of therapy, Bf=birth dad, Bm = birth mom, Bp=Birth parents, Bs=birth sibs, C-Br=Christmas Break, Dn=day nursery, Ff=foster dad, Fm=foster mom, Fp=Foster parents, Fs=Foster sib, Hn=health nurse, Kg=Kindergarten, Ms=social worker monitoring visitation, P=peers, Pf=parental figure, Ps=Psychologist, Ri=residential institution, St=special teacher, Sw=social worker, T=teacher.

Infancy: reported relations to parental figures

Irrespective of the source of information, a running concern throughout Samantha's early years were conflicting tendencies in care relationships between seeking out closeness versus mental and bodily withdrawal:

(Samantha< 12 months): According to birth mother, although happy moments of closeness occurred at the changing table, mostly she remembered an irritable and restless baby, not to be comforted, unable to go to sleep. Already at this tiny age, the mother remembered Samantha for hours wide-awake in her cot, silently staring into the dark, not calling out. In the turmoil of a violent family life, birth mother would soothe the baby by covering her face with a cotton napkin. Concurrently, a worried health nurse reported Samantha to be much too passive, in a withdrawn and severely "shutdown" state.

(1½ years): Nursery staff noted short episodes of close interchange and in the afternoons observed her at first sight of birth mother to show manifest, expectant joy. However, although shortly able to engage in good close exchange with a specific nursery teacher, Samantha soon turned away. She would give her nursery group the slip, wandering off in the space of the larger institution. After placement at a residential institution, a special teacher assigned to her likewise noted conflict-ridden tendencies in close contact, e.g. when held in arms, Samantha would passively go limp, leaning outwards in space, then withdraw, taking physical and

mental distance[120]. She seemed severely stressed at the changing table and did not like tender enfolding in a towel[121].

(2-3 years): The residential institution described a slow unfolding of a more benign development e.g. Samantha now liked to cuddle at her special teacher's lap, seeking comfort when hurt. Sometimes, she pined for her birth parents, whose visits were highly unstable. Nevertheless, she continuously showed joy at first sight of her mother and would snuggle in the lap of her special teacher, talking about her longing for birth father. She often relapsed severely after visitation, e.g. walking on tiptoe; becoming very disturbed and vulnerable with lengthy break-downs, during which she was out of reach and could not be comforted. At this age, a persistent tendency developed for self harming behaviour when left alone e.g. at bedtime plucking at her lips and nipples until sore and bleeding.

(2 ¾ years): Her beloved special teacher left the institution; Samantha reacted to this new loss, for a period subdued and sad; but reportedly attached well to a new special teacher. However, subsequent descriptions leave the general impression of a more vulnerable Samantha, increasingly split in close relationships. She easily felt neglected, reacting strongly defiant if not given exclusive attention; developing lasting difficulties settling in on the lap of her second special teacher. The aforementioned tendency to seek out peripheral relations apparently returned.

(3½ years): Placed in permanent foster care, the foster parents initially reported Samantha eagerly to seek out closeness, e.g. sticking closely to the foster

[120] The residential institution assigned to each child a specific adult for individual attention and care. When this special teacher was at work, she was supposed to be always available to her special child. In the abscence of the first special teacher, an appointed secondary teacher would take over.

[121]Notice the discrepancy to birth mother's description above. Samantha's anxiously stressed reactions may indicate mental pain linked to the loss of birth mother; and/or a tendency for idealization in birth mother's blissful descriptions.

mother, but sadly, for the next two years, her development apparently faltered in all areas. Thus, the foster parents continually reported a striking lack of benign change; Samantha's ability for eager commitment to close, reciprocal interchange apparently relapsing into the well known cliché of a deprived child with limited motivation and ability for closeness to specific others. Earlier forms of disturbance reappeared e.g. withdrawal from physical closeness; tendencies to go astray, seeking out attention from strangers; splitting, in the form of voicing bad feelings towards her birth mother to the foster mother and vice-versa. Sleep disturbances and self-harming behaviour very similar to the descriptions from early infancy reappeared (wide-awake in darkness, not calling out; picking at her navel until bleeding) as well as tendencies for behavioural imitation of stronger more aggressive sibling figures (parroting sentences and copying defiant behaviour of an older Fs). She even developed new forms of disturbance not mentioned before; i.e. rumination of food.

(4½ years): Samantha reportedly did reasonably well in kindergarten, however was liable to withdraw from direct view, seeking no contact and comfort by adults. She allegedly showed little preference among staff members, withdrawing if tenderly caressed; but at outings dramatically broke down crying, if not able to get sole attention from preferred adult.

5- 9½ years of age: Reported relations to parental figures

(First year of therapy, 5-6 years): The foster parents reported pronounced tendencies for oscillations between ingratiating sweetness, defiant withdrawal, and aggressive attack. Samantha would e.g. eagerly come close, suddenly to withdraw,

or react with defiantly obstinate aggression. She appeared highly vulnerable to disappointments, often showed temper tantrums, taking refuge in her room, refusing to come out. Reports from the kindergarten somewhat less bleak, she stayed close to a few well-known adults, anxiously rejecting peripheral ones from other groups. At excursions, she needed exclusive attention, crying violently if not allowed to hold hands with a preferred adult.

Shortly before the first Christmas break (7 months into therapy); Samantha reportedly initiated a new heartfelt need for closeness to the foster mother:

- *(Between sessions 20-21): The foster parents told S that her birth mother had moved out of a boy friend's apartment; Samantha immediately broke down crying and cried at length with all her heart in the foster mother's lap. The foster mother felt her crying as genuinely sad, completely different from her usual, angry crying. Afterwards Samantha mentioned missing her birth dad.*

(Second year of therapy, 6-7 years): Foster parents reported more moments of genuine affectionate interchange; for the first time ever, Samantha after a nightmare called out for them, cuddling into a gentle embrace. Split feelings in relation to the parental couple, especially the paternal figures became increasingly evident, Samantha idealizing a phantasy of a lost birth father, while keeping at a distance the real-life, available foster father:

- *(Between sessions 78-79): Foster mother reported Samantha to have told that when a small child at the residential institution, she and her sisters rescued their father from drowning. After a visit to birth mother, she claimed to have had a phone call from birth father and said: "I am sorry for daddy that he can't come to see me".*

She started school that autumn, her teachers reporting huge disciplinary and social problems[122]. Assigned a full time special teacher, Samantha still proved difficult, defiantly stubborn and unrealistic; omnipotent rejecting all requests.

(Third year of therapy, 7-8 years): A fierce split between relations at home and outside home developed, the foster parents reporting huge improvement on all dimensions but concurrently Samantha's relations at school and in therapy deteriorated (see 4.2.3.). Before the third Christmas break, her ability of relating to the foster parents as a couple reportedly had greatly improved; assigning to the parental figures differentiated roles, daily making sure that foster father would help with lessons, while she told of her achievements and problems. However, after the third Christmas break, her teachers reported Samantha more difficult than ever, quite unrealistic in her rejection of discipline, defiantly stubborn with ferocious fits of rage. Furthermore, after conflicts with her classmates, she had taken immediately to assault her special teacher; often subsequently running home.

(Fourth year of therapy, 8-9 years): A temporary relapse during the summer break occurred, probably due to the dual effect of a break and an increased intensity of birth mother's visitation. Samantha became increasingly difficult and for a time seemed to re-enact former straying tendencies, behaving ingratiating towards male strangers. Half a year later, good development at home resumed, she was described as genuinely affectionate, especially towards the foster father. During the fourth and last Christmas break, Samantha was told that therapy would come to end the following summer. She allegedly acknowledged this, after a silence adding that she would miss the therapist and make her a beautiful present for the last session. At this point, she did well at school, able without special support to

[122] Children in Denmark normally start school at 5-6 years of age; Samantha's start was postponed a year because of her difficulties..

participate in all activities, even allowing her special teacher to help her classmates[123].

(A concluding network meeting shortly before the end of therapy, 9 ½ years): The foster parents said that they never believed they would get as close to Samantha as they now are. They felt her to have become genuine and frank, a very different child from before, when they often felt her to relate in a falsely sugary and ingratiating manner. They added that although she still had her vulnerable points, closeness had become so much easier, as by now she was able to own up to her feelings and talk about them.

Lingering split feelings towards birth mother: Although reported improvements of parental relations seemed impressive; apparently no real change occurred in relation to birth mother, Samantha's feelings throughout therapy remaining highly split and infused with anxiety. Thus e.g. at supervised visits, Samantha continued to show the by now familiar pattern of manifest joy at the first sight of birth mother, then going all-limp, listlessly leaning away from mother's hugs. Nevertheless, after 2½ years of therapy, birth mother herself described, Samantha as more receptive to tenderness. This may have been part of the above-mentioned tendency for splitting since concurrently foster mother reported Samantha to idealise birth mother, who again had forgotten her birthday. Just like in infancy, Samantha reportedly remained very disturbed before and after her visits, especially so before and during the fourth summer break, when for unknown reasons, court authorities for a short while had allowed unsupervised visitation at mother's place. After the first of these visits, Samantha behaved so aggressively confused at school, endangering her own safety that the teacher phoned foster mother to take

[123] The reasons why the school kept on the special teacher were not very clear (See below).

her home. Some weeks later Samantha and birth mother in unison prematurely broke off a visit by together seeking out the foster mother, who was waiting in a park nearby the mother's apartment. Soon after, birth mother for a prolonged period dropped completely out of visits.

12 years, at follow-up: Relating to a complex parental couple[124]

Samantha still lived in the same foster family, attending the same school. The older foster brother Dennis permanently had moved out, first to his biological mother, then to shifting residential institutions for adolescents with severe behavioural problems. According to the foster parents, who kept up regular contact, he had sadly hardened into a tough young bully with a criminal record. Shortly before the interview, the foster parents had taken in an infant for temporary foster care. A couple of weeks before the interviews took place, Samantha's birth father died; she and her birth sisters participating in the funeral, there meeting with the birth mother after several years of absence. According to the childcare worker, since the end of therapy, the birth mother's mental health and general condition had severely deteriorated; visitation with her children had for more than two years ceased. On Samantha's request, last year a meeting was arranged, however the birthmother again stayed away without notice, Samantha thereafter blankly refusing further contact. After meeting with birth mother at the funeral, Samantha had asked for a meeting, which was supposed to take place a few days subsequent to the follow-up interviews.

[124] Based on follow-up interviews with foster parents and birth mother. Translated transcripts in appendix I.3-I.4.

The foster parents described important *benign changes* during therapy in their relationship to Samantha, feeling her capacity for mutual emotional exchange much improved, at follow-up they reported her still to be in development. By now experiencing a warm and tender relation between Samantha and themselves, they felt her to have developed a close, dependent relationship; showing this in much the same way as their by now adult birth children when at her age, e.g. they laughingly cited Samantha to claim that she would not leave home before thirty years old.

During therapy and after, they had felt Samantha gradually to develop a new ability to ask for their help, engaging in a dialogue concerning her emotions and relational problems. By now, she allowed the foster parents to suggest possible new ways of thinking and behaving and most often was able to listen.

Asked about *remaining difficulties relating to separateness and partings,* the foster parents said that through most of the therapy Samantha found it difficult to part and let go of the adults taking care of her. This extended e.g. to her special teacher at school, Samantha unable to let go of her, calling out as soon as the teacher was not right beside her, immediately available. At the end of the therapy, Samantha allegedly had developed a better sturdiness in letting go, at school even allowing her special teacher to help her classmates. After the end of therapy, apparently she had been able to integrate meaningfully the parting from the therapist; sometimes initiating a talk with the foster mother about the therapist and the years of therapy; when doing so even at follow-up still strikingly peaceful and serene. The foster mother felt sure that even if Samantha had experienced therapy as exhausting and sometimes hard to bear, she was well aware of its meaning and aims; knowing it to have helped her change in important ways.

As mentioned, a year ago after the failed appointment with *birth mother*, Samantha got angry, feeling ever so much let down:

> *Foster mother:" ... and this anger she shared with her sisters, when they met ... Consequently, her sisters told their mother certain truths; and ... the other way round ... were told off by her. For this to happen always was Samantha's big, big fear; and I believe it still is... "*
> *Foster father: "She has known her mother to become most terribly angry and scolding".*
> *Foster mother: "She believes she has known this, because she heard so from her older sister Lea." (FP/135-172[125]).*

According to the birth mother herself, even after the missed visit and more than two years of unexplained absence, Samantha was immediately joyful at seeing her again at the funeral of the birthfather; allegedly spontaneously and without reservation hugging and kissing her birth mother:

> *Birth mother:"... I saw her at the rather sad event, some weeks ago, as the father of the children passed away. I had brought a letter from my mother and wanted to give this to Samantha. ... As I delivered this letter to her, at the end her throwing her arms around me, giving me a really big hug ... ; ... me of course hugging her too, giving her a kiss on her forehead, telling her I love her. And this she has kind of given a little thought, so now I am actually going to meet her in a couple of days. ..." (BM/53-62[126]).*

Asked about *other remaining problems*, the foster parents said Samantha at times showed difficulties verbalising her worries. Even so, waiting for her to initiate the dialogue, she usually would come of her own accord, listening to their experience of the problem; a huge difference compared to before:

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[125] Here and below, this refers to the position of the citation in the specific interview; FP=Foster parents. The interviews appear verbatim in full in the appendix:
[126] BM=Birth mother.

Foster mother: "By now, S had become quite good at speaking her mind"...
Foster father: "But still, she has this thing, we are not supposed to tell her, even when we feel for sure something to be wrong. We can tell her this, but then we have to wait until she herself comes back, because even now, we cannot make her speak up. ..We have to wait. This is quite difficult to explain to the psychologist (i.e. their supervisor from the foster family agency). We cannot just demand her to tell us... One gets nowhere, when S starts on this". (He and Fm look at each other, laughing together).
Foster mother: "No, we can't... and just as you think now I am getting through, but no; S must be ready for it, if not it is no good". (FP/174-197).

Especially, in new situations or among strangers Samantha still found it difficult openly to show her feelings; liable to keep up, what the foster parents termed her "*stone-face*". Sometimes even the foster parents themselves found it difficult to read her mood:

Foster mother: I believe we have a good close attachment to S. What I feel difficult is... it doesn't last for long at a time, but sometimes she is difficult to read, even if she is happy or sad. This I think; but attachment there is, and I also experience her in so many ways to show her attachment..." (FP/ 318-323)

According to the foster mother, even their adult birth children noted this difficulty e.g. their 28 years old son, who some time ago invited Samantha and his mother to a performance at the theatre, at which he works. This really thrilled Samantha, laughing so much during the show, thoroughly enjoying herself. However, as often happen in new places and situations; when during the interval they met with the son, Samantha had on her stone face, making it impossible for others to see how much she enjoyed herself. After the show, her son felt very insecure himself, asking his mother whether Samantha had had fun. A similar thing happened at the hairdresser's, who recently cut Samantha a new style of coiffure that

she really loved so much. However again, putting on a stone-face, afterwards the hairdresser felt so much in doubt that she phoned the foster mother, asking if Samantha was dissatisfied with the cut.

They described Samantha as especially close to the foster mother, and more insecure towards the foster father, keeping him at a certain distance; e.g. at bed-time, sometimes turning her back on him, when he approached to kiss good night. Both foster parents seemed able to contain this behaviour, believing it to be rooted in Samantha's past, assuming that she never had been close to her birth father, whom she had not seen since her placement in foster care:

Foster father: "I believe her to be more closely attached to you. ... she has a little thing with men; a little more, keeping them at a distance. I believe it dates from her father....I believe her mother often had it in for him, him often to have got a tongue-lashing; ... her older sister said something[127]*. not trying in any way, but just the same, ... as if something...still is... She may ...come to cuddle a bit, but just as often when I am about to wish her good night ... she turns her back at me.*

Foster mother: "She may do that to me also, but probably more seldom. You get it in the neck faster than me. (Both laugh).

Foster father: "I probably protest more when she talks bullshit, earlier than you do She always had this, keeping me slightly at a distance, but it did get better... Maybe she felt a little let down by her father ... As if, she doesn't quite know what to make of me ".

Foster mother: "She never had her birth father at as close quarters as her birth mother ... Verbally she easily may defend herself that she had a father and all that, but emotionally this is ever so hard on her, and she never had anyone with whom to compare you" (FP/ 326-365).

[127] This is quite new information, as according to the files mostly the violence was on the birth father's side.

When it comes to the performance of other parental functions, the foster parents felt that on the contrary, Samantha preferred the foster father to help her. She would e.g. rather have him to take her shopping for new clothes, presumably because of his greater patience in waiting for her to make up her mind, and because Samantha rightly assumed the foster father was more easily persuaded into buying her expensive, designer clothes.

4.4.2 Reported sibling relations

The summary below depicts an overview from 0-12 years of age of reported characteristics in relationships to sibling figures. Especially noteworthy, the close link between Samantha's experience of relationships to parental caregivers and her feelings towards sibling figures. Thus, the experience of deprivation and disappointment seemed immediately to fuel excessive jealousy, envy, and persecuted anxiousness, enacted in withdrawal or fierce competition. The continuity across development of this theme further substantiates an assumption of stable core relationship themes.

Box 20 Reported relationships sibling figures[128]			
Recurring Sibling themes	Early relationship themes (0-5 ys)	Daily relationships concurrent therapy (5–9½ ys)	Relationships at follow-up (12 ys)
Relation to sibling figures contingent quality parental care	P-relations contingent availability St (1½-3): After loss first St, faltering P-relations	P-relations Kg contingent availability T (Beg) → Fm's lap: Reparative phantasy Bs-Bf, sibling group rescues Bf from drowning (C-br I) → P-relations school contingent availability St (C-br II) → After conflicts P, violent assaults St (C-br III)	In relation Bm: Lingering sibling jealousy, teasing weaker Bs In relation Fp: Friendly relation short-time infant-Fs and Fps' young adult birth-children
Fierce wish to be first-best-only child to come	Intensive jealousy, envy, possessiveness, fierce rivalry attention, collapse if crowded out (1½-5):	Intensely preoccupied hostile rivalry Fs (Beg) → At school, fierce rivalry attention St, collapse if crowded out (C-Br I-II)	Copes with conflicts, no black-outs rivalry, able timely withdrawal. No support school; Attends ordinary club
Preoccupied Scared by hostile persecuting sibling figures	Abused by older Bs (0-3) Bullied by P, panicky scared, easily victimized (1½-3) Copes well with few P at a time, especially younger (3-5)	Easily feels victimized & excluded (C-br I-II) → Plays well bosom friend (C-br II) →More accepted, different playmates, often younger (C-br III)	Better at making and keeping friends; still improving Able to sleep-over friends Wearing out preferred P No best-friend
Submissive identification hostile sibling-cum-parental figures ↑↓ Tender, supportive identification benign, older sibling-cum-parental figures	Submissive imitation stronger, aggressive P ≈ Spoils play, grabs things, no empathy (1½-3) Anxious imitation older, more aggressive Fs, wants same food whether hungry; parroting defiant, foul speech (3-5) ↑↓ No examples found	Controlling, angry fits if crossed, e.g. stoning P (Beg) →Bossy, controlling (C-br I-III) → Still some difficulties P-relationships (C-br IV) ↑↓ Participating group-work ordinary conditions, less bossy	Tendency ganging-up Bs towards Bm. Anxious identification and survivor's guilt prevents accept loss older Fs ↑↓ Close affection Fps' birth children, female identification (daughter); tender admiration drawing skills (son). Better ability protection self at transgressions Fs

[128] See more details in appendices I.3-I.4 & III.7-III.8. Beg=Beginning of therapy, Bf=birth dad, Bm = birth mom, Bp=Birth parents, Bs=birth sibs, C-Br=Christmas Break, Dn=day nursery, Ff=foster dad, Fm=foster mom, Fp=Foster parents, Fs=Foster sibs, Hn=health nurse, Kg=Kinder-garten, Ms=social worker monitoring visitation, P=peers, Pf=parental figure, Ps=Psychologist, Ri=residential institution, St=special teacher, Sw=social worker, T=teacher

Reported sibling relations in infancy

According to the birth mother, *the older sisters* maltreated the infant Samantha, especially the four-year-older Buzz. After taken into care, this was also noted by the residential institution (1½-3½ years), reporting Samantha's reactions towards her two birth sisters split; apprehensive towards Buzz, initially affectionately dependent on the middle sister Lea, e.g. sitting close, lovingly talking and singing about her, playing at phoning her. During her stay at the institution, the relationship to both sisters deteriorated; since both mistreated their smaller sister if not closely supervised. Samantha accordingly appeared quite disturbed after visitation; e.g. walking on tiptoe, developing panic attacks. For the same reason, supervised visitation was decided; and the sisters placed in separate foster families[129].

Since infancy, Samantha reportedly had shown a split attitude to *peers*, on the one hand wishing to join into their play, on the other perennially frightened and hostile. A gradual benign social development was observed at the residential institution; Samantha on good days able to wait and take turns, join in play, and play at being baby or mother with another child. On bad days, she was desperately needy and jealous; at best insisting to play at being a passive baby cared for by her playmate and the adult.

The benign social development apparently continued, however according to descriptions, Samantha's abilities to engage in sibling relationships always depended on her feeling secure in relation to parental figures, deteriorating at experiences of separation and loss. Thus, after the first special teacher left (Samantha 2¾ years), the institution noted her peer relations to falter. This happened

[129] Sisters Samantha and Lea initially was at different wards at the same residential institution, while Buzz went into another institution. The residential institution arranged regular reunions between the three sisters; continued after their placement in foster care.

again after placement in foster care (3½ years), but now at 3½-5 years of age, the above-mentioned global relapse apparently included a terrified-confused identification with the older foster brother, Samantha in a literal sense parroting his defiant behaviour and foul speech.

Reports from kindergarten were somewhat less bleak. The staff reported Samantha to keep aloof, hiding out of plain sight, getting nervous if she had to relate to more than a few children at a time. Also noted was, however, an ability to join in social play and games, adapting to the rules of group activity and playing well, especially with younger children.

A psychological assessment (testing) at 4 years 9 months of cognitive-emotional development explicitly noted blurred differentiation between parental and sibling figures in mind.

Reported sibling relations during therapy

(5½ ys, 6 mths into therapy): The kindergarten reported that Samantha easily felt neglected by her preferred adults, and when so relating to other children as hostile enemies, competing fiercely for sole attention, crying inconsolably.

The foster parents struggled to find resources of time and strength to meet the emotional wants of two very needy foster children; including the demands created by having to adapt the calendar not only to visitations of two birth mothers, but also to Samantha's twice-weekly psychotherapy. On top of that, in the early beginning, they felt therapy to worsen Samantha's relation to her 11- years-old foster brother; her submissive parroting giving way to hostile rivalry, bickering, and fights. The foster brother had lived in this family since 2 years old; the

supervisor of the foster parents referred to him as "*the first foster child to come*" and felt him to be the preferred child in the family.

(At 6 ys., Christmas-Break I): According to the school, Samantha was hostile, bossy, and controlling towards her classmates; very touchy with fits of rage, e.g. furiously throwing stones at another child. At this point, things had eased up in the foster family; e.g. Samantha telling the above-mentioned reparative phantasy of the sisters in a good teamwork, rescuing from drowning a good daddy. Thus, presumably, the siblings in her mind mitigated, working together to keep alive good aspects of parental objects in mind, preventing these from becoming sucked into a persecuting whirlpool of violently aggressive inner images and feelings. At this point, she also got a bosom friend, with whom she was able to play well; this girl apparently quite as able as Samantha was to stand up for her rights.

(7 ys, Christmas-break II): Samantha still had her bosom friend, but reportedly peer relations at school were still anxious and hostile. However, she had started worrying about this; frequently complaining to the foster parents of exclusion and harassment at school. In relation to the foster brother, her ability to keep up boundaries around herself reportedly was improved; most often able to keep herself apart, parroting seldom.

(8 ys, Christmas break III): The school steadily reported improved peer relations; Samantha now well accepted in class, more often played with her class mates, and in general behaved less bossy and controlling. However, she was still vulnerable, getting into fiercely passionate conflicts with peers, after which she would attack her special teacher, provoking a fight during which she had to be physically restrained. At home, the foster brother caused the foster parents con-

cern; reacting increasingly defiant and violent, reportedly involved in shady gang activities.

(9 ys., Christmas-break IV): Samantha reportedly did well at school, in most subjects equal to the middle of her age level; now able to participate in group work on ordinary conditions. Teachers felt her peer relations much improved but claimed that she still was somewhat vulnerable to rejection. To the worry of the foster parents, Samantha preferred playing with much younger children. Just before the end of therapy, a decision was made for the older foster brother (now 15 years of age) to move back to his birth mother. Samantha reportedly felt sad about this parting but also looked forward to have his room, which because of its size always had been the prerogative of the eldest child of the foster family[130].

(9½ ys, End): Samantha reportedly did even better at school, having friends her own age, treating them better than before.

Reported sibling relations at follow-up

According to the foster parents, Samantha's relation to other children since the end of therapy had steadily improved. At the time of follow-up, the school and after-school club apparently felt her relations to classmates good enough for her to manage without support. The foster parents felt her to adjust well to the infants in temporary foster care; able to share the attention of the foster parents; enjoying to help care for the children.

[130] As will be reported below, this may have been true but was not the whole story, which included a severe relapse.

A close, mutually friendly relationship to the foster parent's adult birth children was reported; the difference in age considered, Samantha seemed to relate to them with appropriate affection and esteem:

> *Foster mother: "They are just like real siblings ... S still is good at drawing and painting. ... Our son, 28 years old is into martial arts including some Chinese symbols. Then he asked her, if she might do three painted pictures, and this she did. She actually did, and they were superb, really. Moreover, he was simply ever so pleased and got very impressed. He hung it over his settee in his sitting room; and as he had done that, we went to have a look. Then one could see in S's face that ...really. ... And our daughter, 24 years, S also uses her much, for the real girl's stuff – the two of them go shopping or they go to my daughter's place, S sleeping over, then they are into all possible kinds of girl's stuff. There, she has a really good relationship to the two big ones. (FP/398-413).*

Thus, 2½ years after the end of therapy Samantha seemed well connected in warm, healthy sibling relations. The reality that her adult foster siblings were of each gender, seemed a great help in her development; thus as reported, she made use of the daughter as a big sister, helping her to become a woman; and of the son as a big brother to flirt with in the sense innocently to admire and be admired by.

As mentioned, the older foster brother, Dennis shortly after the end of therapy had moved out. This reportedly had an acutely devastating effect on Samantha, her feelings of fundamental security apparently collapsing traumatically. Hence for some time, her behaviour towards the foster parents radically deteriorating; she became artificially sweet, anxiously "*ingratiating, nearly falling over backwards to please*". At first, the foster parents did not understand why and what to do. Helped by their supervisor, they eventually understood her reaction as reflecting a profound anxiety that if she was to behave aggressively, as Dennis for

sure often did, she might be the next to go. They tried in vain to assure her that no matter what, she would stay with them, but in the end, they had to get the community-childcare worker to visit, telling Samantha that she was going to stay with them until grown-up. After this, she calmed down and regained her formerly improved composure. However, still anxiously preoccupied by the whereabouts and feelings of Dennis, even at follow-up Samantha would often ask why he could not join the family for vacations and Christmas. She was said recently to keep at a certain distance, e.g. to avoid being left alone with him without adult supervision:

Foster mother:" The first half year after he went, S was bending over backwards to please us... It sounds disgusting, when I say so, but really it was nauseating ... Then we got the explanation [from the supervisor] that she was ever so anxious, trying to please us. Finally, we told S that Dennis going was ... decided by the community.. not us, we felt it .... a really bad decision ... we told her, you are going to stay put. We had to have her childcare worker to come here and talk to her ..: You will stay here for good ... to have proper words spoken to her about this, things that we ourselves must not say[131]*. It was so good; afterwards she calmed down, didn't she. But it was like, well we are going to have a cup of coffee; and immediately S would be there, shouldn't I...she was that scared. But we talked about him, now he is placed for the 7th or 8th time since he was here, and we do feel so terrible about this ... he has changed, to S he is still the good, old Dennis, and she feels it ever so sad, it ended like this. We explained to her that these things we could not fight...*
FF: By now, she no longer feels comfortable going together with him to the service station.

[131] According to the Danish legislation at the time of this therapy; even if highly unlikely; and even if a lengthy care relationship, in the event of improved abilities for care of the birth parents, foster parents should prepare the child to go home to its birth parents. Although legislation changed; in general foster families are still not supposed to tell children that they will remain in their care until adult enough to manage on their own. This uncertain legal position inevitably stresses both children and foster families considerably; bound to produce anxiety and pain as the birth parents of the child in periods stakes their claim for custody and visitation. Thus although the legislation eased somewhat up on this, in cases like Samantha's, lengthy foster care demands a nearly superhuman degree of composure from the foster parents, e.g. during the sometimes heavy upheaval in relationships due to puberty.

FM: No, because she senses very well how he changed, the ways he changed, the behaviour into which he... (FP/436-464).

Samantha's general ability to socialize with peers; making and keeping friends seemed greatly improved and still developing. Not even remotely possible at the end of therapy, by now she was able to join girlfriends for a mutual sleep over at home or at their place; Samantha mostly enjoying this, and if not, she was well able to withdraw, coming home. At this point, she had no best friend, rather connecting friendly with a wider, less closely-knit set of pals; in this respect apparently fallen back. The foster parents ascribed this to a remaining tendency for passively sucking dry her close relationships; in time wearing out her preferred friends. They talked a lot with Samantha about this problem, trying to teach her principles of friendships e.g. taking turns. Although improved; clearly she still found close relationships to peers quite difficult to cope with.

4.4.3. Reported differentiation internal-external reality

This section concerns Samantha's abilities for emotional-cognitive differentiation between her own mind and the outside world of corporeal things and other people with other minds. As mentioned above, integrated also are reports of emotional-cognitive capacities that presuppose differentiation, e.g. exploration and thinking. As shown below, a close link emerged between the quality of parental care and the development of abilities for exploration, thinking, and differentiation. Furthermore, even mitigated by age, parental care, and therapeutic treatment, the persistent influence of characteristic relational anxieties and defences seemed quite

impressive, in some aspects lastingly hampering Samantha's resilience in keeping up a stable differentiation between her own and other peoples' minds.

Box 21 Reported differentiation internal-external reality[132]			
Recurring themes	Early development (0-5 ys)	Concurrent therapy (5–9½ ys)	At follow-up (12 ys)
Loss Neglect Abuse ≈ Faltering differen-tiation	Needy, stressed, shut-down state, too much stumbling, no exploration, severely retarded all areas (0-1½)→ Improved care Ri, but persistent overeating, vulnerable frustration, decreased awareness own bodily needs (1½-2½) → First St left: General backsliding all areas (2½) → Accept second St: Catching up (2½-3) → Placement foster family: Relapse all areas until well into therapy (3-5)	Blank, shut-down states; Panicky falling apart, screaming, hitting; Pain anus and other bodily complaints; Too much stumbling; Compulsive insisting sameness; Rumination food; Omnipotent control Fm's body; Confused, omnipotent defiance (Beg+C-br I-II) → At school: Sudden hypotonic, stumbling / abstracted states of mind; Defiant omnipotence, paranoid states, risk-taking behavior, ferocious fits of rage, bodily assaults St. (C-br III) → Some concern overeating (C-br IV)	Psychosomatic reactions at anxiety and stress Going blank, shut down (stone face) when socially anxious, facing new experience, even if happy with the experience. Tendency overeating in face of stress, stuffing herself with sweets
Protective relation adult caregiver ≈ Ordinary develop ment differen tiation	After placement Ri: Catching up to age-level most areas e.g. self-care; playing hide-and-seek; verbal and bodily exploration own and St's face, body; knows to which group she belongs; differentiates known adults-strangers; knows own gender identity girl; differentiates male-female sex, generations, Bs Lea from other P; loves creative activities (1½-2½)	After 1½ year of therapy: Faster reconciliation; Continence urine-faeces; Improved learning & constructive play; Asks real-life questions; improved mood, vitality, self regulation, thoughtfulness (C-br I- II) → More resilience frustration, change, limit-setting; Ordinary anger; Stable mood, happy, vital; motivation schoolwork (C-br III) → Biking alone school; More realistic; Less defiance; More verbalizing feelings; Doing well at school; Good reader, eager to learn, middle of class (C-br-IV)	Improved, and still in development: More realistic self-insight, -esteem, assertion; Stable mood; More emotional nuances; Achieving up to her level school, attentive, eager to learn, well above middle level, motivated for homework; Moving into ordinary puberty, incl. age-appropriate curiosity and courage to seek out new experience; do the same things as classmates

[132] Ri= Residential institution; Pf=parental figure; Fp = Foster parents., Fm=foster mom, Ff=foster dad, Bm = birth mom, Bp=Birth parents., Bf=birth dad, Bs=birth sibs, Fs=Foster sibs, P=peers; St=special teacher; T=teachers; Kg=Kindergarten; Ps=Psychologist; T=therapist, Th=therapy; Beg=First 24 therapy sessions; C-br=Christmas break..

Infancy: Reported differentiation

At admission to the residential institution, a psychological assessment found Samantha severely behind expected age-norms, especially in personal-emotional and language development (1½ years old). Her motivation for exploration was weak; she did not react to pain; differentiate between staff; or in general differentiate between pleasant and unpleasant sensory-impressions e.g. cold-hot and hard-soft. In most areas improving surprisingly fast; after some months she allegedly responded selectively to her special teacher and a few other, well-known adults. She eagerly explored the special teacher's face and mind and soon confidently explored the physical and social milieu of the residential institution. In general, a cognitive-emotional spurt took place; e.g. she was soon able to differentiate between sex and generation, including her own identity as a girl. In time, eagerness to know and learn was commonly mentioned, e.g. motivation and ability for playing and talking about her birth family, sitting on the lap of her special teacher while expressing feelings and fantasies of longing. The benign development continued, and by discharge from the institution, her cognitive-emotional development seemed within the normal range for her age (3 years old).

However, already at this age, descriptions also evidenced certain enduring vulnerabilities in Samantha's ability to differentiate internal from external reality. Frequently noted was e.g. a recurring inability to function on her own; some days vehemently insisting on being carried; passively clinging to the adult caretaker, protesting any form of bodily separateness. Concrete, bodily exploration of the special teacher's face and body continued well after the expected age level; this however was apparently not enough to hold together the self, enduring the pain of separateness; instead turning against the self. Thus a persistent tendency for self-

harming behaviour developed, Samantha in lonely moments liable to pluck at her lips and nipples until sore and bleeding. At 2-3 years of age, a host of behaviours indicative of *defensive avoidance of separateness seemed to be established as part of her personality* e.g. she was described compulsively to playact a clichéd baby, while impossible to reach in a real contact.

After the placement in foster family (3 years old), a most striking shift for the worse was soon noted. Samantha radically relapsed from eager readiness for closeness, exploration, and differentiation to a faltering development in which a psychotic-like, avoidant mental state completely seemed to take over her mind; reminiscent of the early shutdown states observed by the health nurse (1-1½ years old). Thus from this point, case file notes describe the foster parents' observations of confused and blank states; parroting communication without comprehension; mindless imitation of stronger peers; and even a breakdown of the ability to differentiate yes from no.

In accordance with this, at 4 ¾ years a formal psychological assessment of cognitive-emotional development showed Samantha as a potentially bright child, whose development was threatened by severe emotional and social disturbance. Special notes were made of a quite brittle ability to differentiate parental from sibling figures as well as difficulties of visual memory.

Concurrent daily life: reported differentiation

(First months of therapy – Samantha 5 years): The foster parents felt Samantha to falter even more in her general ability to function; getting ever so anxious if routines were changed, rigidly insisting on sameness; if not possible falling apart in a

frenzy. Her differentiation between events inside and outside therapy was brittle e.g. getting upset at home because of smears on her clothes from painting in therapy, refusing ever to wear this dress again.

(6 months into therapy – 5½ years): Foster parents felt Samantha to have developed in her emotional-cognitive abilities; becoming more open and able to express verbally her thoughts and feelings as well as more motivated for realistic mastery of new skills e.g. she learned to write her first name in block letters.

(1½ years into therapy – 6½ years): Her differentiation of internal from external reality developing but still was quite brittle. On the one hand, according to the school her concentration and memory for numbers and letters improved; and at home she was reported thoughtful, asking realistic questions concerning her birth family. On the other hand, sometimes she seemed more confused than ever, e.g. insistently seeking control of the foster mother's bodily movements; at times so preoccupied by negative, paranoid fantasies that she was unable to hear good things coming e.g. to be allowed to watch a film or get ice-cream, which normally she would love.

(2½-3 years into therapy – 7½-8 years): Samantha reportedly liked to be together with foster mother, talking about photos from her infancy of her birth family. In this period, she suddenly might go limp, loosing bodily strength. She was still liable to unrealistic defiance, in anger shutting herself in her room; however, these episodes were shorter, and her tolerance of reproof better. Described as more open, she began talking to the foster parents about her feelings and liked to show her drawings. At the end of the period, for the first time ever, she biked alone from home to school (600 meters), which was impossible before as suddenly she would absent-minded forget to bike, going limp and fall off. At school,

she still had many problems but reportedly was somewhat more socially responsive. Her ability to differentiate seemed for a period to deteriorate in school, e.g. in class where she behaved defiantly stubborn with ferocious fits of rage. She did fairly well in most topics but was liable to lose concentration, exploding in rage as she discovered the class to have gone on to another subject.

(In the last year of therapy – 8½ - 9½ years): Still somewhat stubborn, Samantha reportedly was much more realistic both at home and in school. Her teachers described her as bright, motivated for learning, a good reader, doing well in the middle of class, probably equal to her cognitive resources. According to the foster parents, she adapted in a very new way to the ground rules of family life.

At follow-up - reported tendencies differentiation internal from external reality

At 12 years of age, Samantha reportedly did really well at school; her ability to hang on keeping attentive and concentrated as well as her motivation for new learning seemed greatly improved, as did her ability to take in and retain new experience and knowledge. At the end of therapy, her abilities in mathematics and motivation for homework had improved very much; at follow-up, she reportedly was well able to keep track with her classmates, achieving above the middle of her age level.

Other important areas of major improvement reportedly were an increasing openness to new experience, curiosity about the world, and ability to seek out and contain such new experiences as appropriate to her age. Thus at 12 years of age, Samantha seemed to enter a normal stage of pre-puberty. She liked e.g. to experi-

ment with tasting foreign foods when travelling together with the foster family and reportedly developed a new interest in her looks, greatly stimulated by the benign interest of the foster father and the foster parents' adult birth daughter. She seemed ordinarily sensitive to the mores of her peer-group, wanting to try out the same things as they did.

On this account, when dining out at a restaurant with the foster family she ordered sushi, which she claimed to be the only one in her class never to have tasted, because no one else in the foster family liked it. Getting the dish, she even contained her disappointment that after all she did not like it either; frankly admitting this, accepting an invitation to share the chosen meals of the other family members.

As mentioned, at the end of therapy and even more so at follow-up, the foster parents felt Samantha's ability to reflect on her feelings and behaviour very much improved; relating that although sometimes Samantha did not like the results gained by thinking things through, nevertheless, her ability to do so was greatly improved. The birth mother likewise thought that Samantha through therapy had become more emotionally reflective, achieving a better insight in her real feelings, good or bad:

> *Birth mother: "... she was 4-5 years old as she started [therapy]; and she always wanted everything to be ever so cosy and idyllic. Everybody must feel good, all negative locked away. ... Today she dares speak her mind and knows this to be OK. Therefore, well, I am ever so glad she went to see you and got what to say, those aggressions out ... found out that it is OK to be cross and mad. Then, we cannot all us go around happy every day of the week, all smiles ... "(BM/436-464).*

According to the foster parents, especially important in getting the development of Samantha going, was that therapy gave her a new sense of self-esteem and faith in herself as a human being worth counting in:

> *Foster father: "... what especially boosted her were the years she went to see you that is for sure. If not, I don't believe she would have developed so far; I am quite certain, this is so.*
> *Foster mother: "As true, because it gave her faith that she counts as a human being. Even when she was a small child, she might look so utterly hopeless...Like, you know, why and to what purpose was I put on this earth. There was such a hopeless, utterly forlorn look also in her eyes; she couldn't make head or tail of anything... Therefore, we believe this.*
> *Foster father: "Yes, today one may have a much more sensible talk with her" (FP/235-264).*

Another important development mentioned was motivation for exploring her personal identity, including the how and what of past personal experience; entering into pleasurable exchange with the foster parents of the type "do you remember when". These talks about past life also included her painful early life story; e.g. about the residential infant institution and how she was, when the foster parents first met her. Conversations about early relationships became much easier already during therapy; Samantha more able to listen and reflect on this, in time it became much easier for the foster parents to talk to her about her current behavioural problems; providing advice as to how she may improve her relationships to others:

> *Foster mother: "We saw that last week. S lost her birth father and we talked about many different things. Among others, how she was, when first she came to us...also about the food not supposed to be mixed on her plate; and now... she is able to listen without getting hurt, doesn't hear this as criticism.*

Foster father: "Well, maybe shortly the moment you say this, but it'll pass". Foster mother: "Not like the old days, years back, if she got cross, she would turn her back and immediately into her room, door closed. Today she is able to listen to what one tells her, even when we say, listen this is not to criticize but just information that... I am sure; she has come so very, very far" (FP/247-259).

Finally, at follow-up, both foster parents and the foster family worker found Samantha's ability to reflect upon her relationship to birth mother improved; more realistic with a better ability for verbal objections; e.g. able to close off visits at the birth mothers' continuing unreliability. Samantha not only had become able to protect herself adequately by saying no to further visitation; the network also seemed to have learned by experience, supporting her decision.

4.5. Conclusions linking core themes and breaks

This concluding section sums up main findings concerning continuity of core themes, linking between core themes and breaks. However, since the protagonist of this study was Samantha, for the record it seems appropriate to include here a short overview of developmental status at follow up, benign change and lingering vulnerabilities as experienced by foster parents and birth mother (Box 22 below).

Secondly, relating to the question concerning continuity of central relationship themes, this section provides an overview, illustrating a striking continuity of defensive relationships, assumed to protect the self against fundamental anxieties derived from core-theme anxieties (Box 23 below).

Finally, linking breaks and core themes, certain main findings concerning breaks recapped, showing breaks as especially powerful indicators of painful core relationship themes[133].

4.5.1. Samantha's development at follow-up

At follow-up, the foster parents felt their relation to Samantha much improved and most often felt able to help her contain recurring feelings of inner want and emptiness by talking to her about the problem. Some traces of earlier tendencies for mental flooding, confusion, and self-harming states of mind were still detectable, e.g. a slight tendency for *bodily reactions* when under pressure; short relapses into *comforting herself with food*, especially with sweets; difficulties showing her feelings in new situations and to strangers instead presenting a *stone-face* without expression..

[133] The remainder of conclusions concerning breaks appear in Box 17-18 above.

Box 22 Overview reported progress and vulnerabilities at follow-up

Parental figures:

- Warm tender dependent relationship to a complex parental couple
- Ordinary age-related curiosity and strivings for separateness
- Improved and still developing capacity:
  - Enduring separateness and longing
  - To ask for help, take advice, engage in verbal dialogue of relational feelings and problems
  - Adequate protection of self against transgressions and disappointments birth mother.
- Lingering vulnerabilities, often expressed psychosomatically:
  - Flooded by traumatic anxiety, collapsing into false-self behavior at perceived risk of loss
  - Vulnerability separateness, backslide to split parental couple
  - Fearing birth mother's anger

Sibling figures:

- Close, mutually friendly relations to foster parents' young adult children
- Improved and still developing ability:
  - Socializing with peers, making and keeping friends
  - Adequate protection self against transgressions and disappointments older foster brother.
- Lingering vulnerabilities:
  - Tendency for wearing out preferred friends
  - Trans-generational themes in relation to birth siblings

Differentiation internal-external reality

- Improved and still developing capacity:
  - Containment flooded states
  - Self esteem and confidence
  - Relational thinking, motivation and ability emotional exchange
  - Exploration self and central others, including infantile past,
  - Learning at school
  - Sturdiness change and new experience.
- Lingering vulnerabilities
  - Tendency to stone-face at new experience
  - Psychosomatic reactions at stress

Samantha's above described submissive reaction at the removal of the older foster brother indicated *a lingering tendency of traumatic relapse in reality orientation and -testing when feeling in risk of losing parental protection*. In the same line, the foster parents experienced Samantha especially vulnerable at meetings with birth mother, reacting with bodily queasiness. In their characteristic mode, these reactions seemed very much like her reactions in early days of therapy, when Samantha was liable to get dizzy and throw up in the train, sometimes even getting a fever:

> *Foster mother: Yes, we also saw that elsewhere, especially at her mother's visitation, but not...Oh yes, now you mention it, I remember well, us standing at the station, and "Oh no; not again", but yet, as we moved on, she got better... She had this bodily reaction; now actually, she feels unwell because come Friday she is to meet with her mother. A visit S herself asked for, she did not have visitation for two years. Moreover, this really affects her"* (FP/115-126).

In the same line, she still appeared especially prone anxiously to keep back her wishes and points of view in relation to birth mother; too scared, not having pluck enough really to speak her mind, believing her mother's anger to be dangerously uncontrollable. The foster mother believed her birth sister Lea to kindle this, as Lea had experienced the birth mother's anger full blast, when she confronted herwith letting her daughters down.. The birth mother herself confirmed this, in her interview spontaneously reporting that she was unable to contain herself when confronted by Lea's critical words; pouring out a torrent of rage and frustration. Samantha reportedly likewise harboured intense complaints, wishing to give vent to these, however not daring directly to confront her birth mother. At the instigation of the foster mother, Samantha instead wrote a letter, intending to hand it

over at the visitation to come. However, this event coming close, Samantha took fright; no longer sure, she wanted her mother to read this:

> *"This was the great fear of S, it still is, I believe. Because, now she wrote a fine letter and showed it to me; I said shouldn't we post it? However, no, we should not post it. Then S wished this visitation arranged, planning to let her mother have the letter at the end, before leaving. Therefore, we had a meeting with Ms. Tobin (the foster family worker) to plan this. But then, the other day this changed as S told me that she did not intend to give her mother the letter, but would just tell her that she was cross because of what happened last year, nothing else. I said to her, it is for you to decide, but you need to think carefully about really getting to say this, because afterwards when we have left, you can't do it. We are to have a short meeting today with Ms. Tobis to update her on the new version, because she will participate in the visitation. As a grown-up, you easily may be a little confused; therefore, it is important for you to tell, what kind of help you want from us that we do not like overstep... To me it is also important to have a cosy time with her mother; but even so, one may speak one's mind. However, S is so terribly afraid that her mother will become angry."*
>
> *Foster father: "She knows her mother capable of becoming so very furiously angry, scolding".*
>
> *Foster mother: "She believes herself to know, because her sister Lea told her so. Therefore, she is so fearful. She is very anxious about this, but I believe it is important to her" (*FP/148-173).

Noting these long-lasting vulnerabilities, important is also to note that in the experience of the loving foster parents, Samantha had developed into a genuine and affectionate young person capable of mutually affectionate relationships to them both and their grown-up birth children as well as a healthy ability to relate realistically to her birth mother and former foster brother.

The foster parents described Samantha's *ability* to contain her own and other people's feelings as greatly improved, her former tendency for loss of control, blacking out all over the place completely gone. She seemed now able in detail to reflect on events and relationships between herself and others, her ability to recognise her own contributions to social problems much improved:

> *Foster father: "She improved at school ... doing much better... keeping up on learning".*
> *Foster mother: "... not that all her troubles disappeared, she still has some problems, but she became so much better in recognizing her own contribution when things go wrong. This was something she found exceedingly difficult. She sometimes still finds this hard but improved in her ability to take this in; keeping this in mind for a while then telling herself, well maybe after all this was not all rubbish what the grown-ups told me...."*
> *Foster father: She also got so much better withdrawing in case of trouble.*
> *Foster mother: Oh, yes, she is much more contained, able to cope with things; before when things got out of hand, she immediately fell apart"* (FP/16-30).

To me it was especially amazing at the end of my investigation to find Samantha so well integrated in her foster family. I was most surprised to find that after all her overwhelmingly strong, paranoid anxiety towards sibling figures seemed to have given way to allow her the joy of membership in a healthy group of siblings attending tenderly to each other. Her relations to peers also seemed improved and in development.

Another conspicuous change related to a steadily improved ability for thinking about her own and other people's intentions and feelings. However, especially important seemed her reported openness to new experience, curiosity about the world, and ability to seek out and contain such new experiences as appropriate to her age. This improved general ability to contain and seek out change seems espe-

cially important, Samantha's age at follow up taken into consideration. Thus at 12 years of age, Samantha seemed ready to enter a normal stage of puberty.

4.5.2. Defensive relationships in therapy and real-life

So far, distinct constellations of core themes inside therapy were shown. Especially prominent were a multitude of horrifyingly hostile parental-cum-sibling figures flooding the mind of the child, not only overruling her own ability for thinking and differentiation, but also strongly resonating in the subjective experience of the therapist (sections 4.1.- 4.2.).

Linking core themes in therapy with reported core relational preoccupations (section 4.4.) striking similarities appeared. For this child, who had suffered early abuse and neglect, it seems with some confidence safe to conclude that a pronounced similarity and continuity of self-protective (defensive) relationships as found inside therapy and in daily life, from infancy to twelve years of age (Box 23 below). Hence, this summary distilled from the preceding overviews of core object themes as found inside therapy and in past and present relationships, seems to evidence that even if this therapy brought a considerable improvement; at follow-up, certain defensive object relations, salient in early infancy and during most of therapy, were still visible as lingering vulnerabilities.

Box 23 Continuity defensive relationships in therapy and real-life[134]				
	The therapeutic relationship	Early relationship themes (0-5 ys)	Daily relationships (5 – 9½ ys)	Relationships at follow-up (12 ys)
Perceptual ↓ emotional-cognitive shutdown	Mindless hyperactivity Th-subjectivity-blank states of mind Th-subjectivity-attention, concentration, thinking, memory	Bm cotton-nappy at infant's face through violent nights → Shut-down, apathetic states→Mindless hyperactivity → Deficient symbolization, attention, concentration → Hiding from direct view & specific difficulties visual memory	Blank stone-face Mindless hyperactivity Difficulties attention, concentration, learning (Beg-C-Br II + before/after breaks & visitations)	When anxious new situations, even if enjoyable goes blank, difficult to read, stone-face
Mental pain & rage transformed to psycho-somatic states	Throws up dizzy, headache, fever to and from clinic Flooded states Wildly manic-confused states Self-soothing repetitive rocking Th-subjectivity freezing cold	Non-selective, greedy overeating anything at table; Doesn't register hunger-thirst; Refusing food, picky, ruminating food Self harming behaviour Language deterioration, bumbling talk, parroting sentences without comprehension	Throws up, dizzy, fever, tummy-pain, pain anus before/after visitation Self harming behaviour (Beg-C-br II)	Before planned meeting with Bm after prolonged absence, dizziness, tummy-ache, overeating
False self	Appeasing, ingratiating, falsely sweet	Appeasing, ingratiating, falsely sweet	When insecure, appeasing, falsely sweet (C-br I-II)	At imagined risk of loss, backsliding to anxious submissive pattern Sucking dry close friends
Complex splitting & Confusion	Clinging to Fm - Denigrating Th, Forced into clinic, Stuck at doorstep, Droning shouts (C-Br III) Th-subjectivity depleted states Th-subjectivity-intense crisis	Idealizing Fm-denigrating Ff & Bm	Splitting Between Fm &Ff; Between Fp &Bm Between Fp &St (C-br I-III)	In face of separateness and loss tendencies splitting: Parental couple at bedtime Bm-Bs at visitation Fm-Bm after loss Bf (Letter)
Omnipotent defiance & ganging up	Self-sufficient denial pain at partings Confused ganging up peers against Th Vicious assaults Th	Rejection adult authority; Imitation aggressive P & Fs	Ferocious fits rage at school Vicious assaults St Running home to Fm (C-br-III)	Ganging up Bs against Bm vs. relevant protection of self?

[134] This overview distilled from a more detailed thematic scheme (Appendix III.10).
Abbreviations: Bf=birth dad, Bm = birth mom, Bs=birth sibs, Ff=foster dad, Fm=foster mom, Fp = Foster parents, Fs=Foster sibs, P=peers; St=special teacher, Th=therapist, C-Br=Christmas Break

4.5.3. Breaks as intensifiers of relational core themes in mind

Linking core themes to breaks (section 4.3.), strongly suggested a decrease around breaks in the child's ability to symbolise her feelings, especially before breaks at the brink of parting. Furthermore, findings strongly suggested that breaks by intensification of persecutory feelings and imagery might clarify certain aspects of highly personal, subjective core phantasy. Samantha primarily showed this as a tendency for repetition around breaks of blurred, incomprehensible, frightening sights and unbearably piercing sounds. She most often communicated these impressions by action that in short glimpses might become invested with symbolic meaning e.g. a painted and verbalised narrative depicting the eyes of a terrified infant vis-a-vis a hateful parental therapy-couple, united in mutual violence. Thus, to survive mentally this blurred fusion of terrifying sounds and sights, the infant in her mind found no other protection than a blank, shutdown state, obliterating any sign of emotional life.

In the subjective imagery of the therapist, after 2½ years, at the peak of an intense countertransference crisis a related phenomenon occurred. At this point, the child's droning, high-pitched shouting at beginnings and in after-break sessions resonated in the therapist's mind as a painfully haunted state accompanied by inner pictures, a stark visual and aural perception of something akin to an Armageddon of viciously quarrelling, unpredictably violent parental-cum-sibling figures.

Thus, at the end of this investigation, the over-all conclusion related to the healing force of psychoanalytic child therapy, in the case of Samantha, there seem to be a dual consideration to keep in mind. Thus on the one hand, a twice-weekly, four year long psychotherapy performed by a trained child psychotherapist may

be the minimum of what it takes effectively to help children like her, the process of benign change apparently still moving several years after the end. On the other hand, it may also be that even so, the damage done in infancy by lengthy exposure to domestic violence, abuse, and gross neglect may leave certain lasting defensive object relations that in face of future strain and trauma may increase vulnerability and risk of psychosocial adversity.

5 DISCUSSION OF CASE FINDINGS

Box 24 Research questions concerning the case
1) Identification in session notes of core features in the therapeutic relationship 2) Whether a continuity of relational core themes might be disconfirmed or corroborated between what took place inside therapy; in the child's early relationships; in her concurrent daily relationships outside therapy; and in her daily relationships 2½ years after the end of therapy. 3) The possible links between breaks and these relational core themes: a. Which influence, if any? b. Whether these reactions changed during therapy and how c. If a similarity between reactions to breaks and reactions in the beginning and end of sessions might be disconfirmed or corroborated

Four main themes seemed pertinent to the understanding of the therapy of this child, namely

- *Parental figures in mind* (summary box 12)
- *Sibling figures in mind* (summary box 13)
- *Differentiation internal from external reality* (summary box 15)
- *The therapist's subjectivity in response to the child, henceforth named countertransference*[135] (summary box 16)

A main result was *a striking continuity of core object themes and related defensive relationships* as found a) inside therapy in play and attitude to the therapist; b) reports concerning primary relationships of Samantha's early, concurrent,

[135]Hitherto, in line with guidelines for IPA, I took care to omit the conceptual language of psychoanalytic theory. However, in a discussion of findings, a main thing is to inscribe findings with theoretical meanings (Smith et al 2009), which in this psychoanalytic case study imply linking to an appropriate body of psychoanalytic concepts.

and later real-life relationships. These findings are discussed below under the heading *the internal family – core object relationship themes*.

Unexpected results not at all looked for concerned the crucial mental impact on this abused child of *an overwhelming predominance of hostile sibling figures in mind*. To this child, the emotional quality of sibling figures was heavily dependent on the quality of parental figures in mind. Hence, the possibility of *a causal connection between parental and sibling figures* is discussed; this link the more convincing since initially predicted by the IPA, only to be deliberately set aside by the researcher.

Furthermore, *relationships to parental figures seemed decisive to this child's abilities for telling apart internal from external reality*; this link popping up whether researched inside therapy or in relation to reports from daily caregivers concerning concurrent and early development. If a similar dependent relationship holds true also for other children, who have suffered severe early abuse and neglect, it may have so important implications for the understanding of learning difficulties and related interventions.

The impact of breaks was appreciable but much more complicated than anticipated by the researcher-after-therapy. Especially *before-break sessions* seemed pertinent, apparently intensifying certain crucial aspects of relational core object themes and bringing about a salient decline of the child's ability to symbolize as measured by the absence of sibling figures. Further discussed are pronounced similarities between on the one-hand session beginnings and endings, and on the other after-break and before break sessions. Finally, several indications point to that the child's reactions to breaks may function as an important signifier of change.

Linkages between breaks and the therapist's countertransference seemed complex and difficult to see through. The propensity of breaks to stimulate comprehensive splitting processes in the mind of the child might lead up to a weakening of the therapist's capacity to contain, bringing on such countertransference mistakes that initiated a vicious escalation of attacks on the therapist. An intensive *countertransference crisis seemed pivotal; producing what appears as a benign turning point*; in the play of the child represented as a firm paternal figure, able to put a stop to destruction. Developments in the therapist's countertransference seemed closely *intertwined with a triangular structure of change*, emanating from outside the therapeutic space; the *team collaboration of the network pivotal as a triangulating third.*

5.1. The internal family- core object relationship themes

As shown, a pronounced parallelism of relational themes and dilemmas emerged as found inside therapy, in infancy, in concurrent daily life; in spite of considerable improvement, certain aspects were even visible at follow-up. The formulation of such parallel themes is often referred to as the *"psychodynamic" or "psychoanalytic""case formulation"*, in adult psychotherapy considered an important tool for assessment, training, and research (Hinshelwood 1991a, McWilliams 1999, Perry et al 1987, Luborsky 1997, Luborsky et al 1996, 2006). At least in relation to this child, the psychodynamic case formulation seems just as useful in child psychotherapy as a tool for early and later psychodynamic assessment.

Especially noteworthy were characteristic split reactions of approach and withdrawal, running as a continuing theme from the earliest relationships until the end of therapy, faint remnants even present at follow-up. These reactions appeared already in the first four therapy sessions, pointing to *the first meetings and partings with the therapist as indicative of central later relationship themes.* Another continuing characteristic likewise appearing in the first therapy sessions was a tendency for somato-psychic modes of experience, confusion and mental pain subjectively localised in the body rather than the mind. Both patterns were appearing in and outside of therapy; in therapy their intensity increasing until reaching a peak in the third year of therapy, after which they abated. Split and somatised behavioural patterns were apparently especially longstanding in relation to the birth mother, reported even at follow-up e.g. as confined in psychosomatic reactions and frightful stress before the wished for but also dreaded reunion with birth-mother.

In line with this observation, Gaensbauer described foster children, who in early infancy had suffered abuse later on liable in relation to the abusive birth parent to relapse into the same disturbed behavioural patterns that characterized their early history. This apparently true, even when the child seemed recovered in all other relationships (Gaensbauer et al 1979; Gaensbauer 1982, 1994, 1995). Samantha's split behavioural reactions presumably were rooted in the opposed motivational forces of simultaneous longing and terrible fear of rejection; the dilemmas kept alive by traumatic memory traces of dreadful terror; her mind preoccupied by a running backcloth of violent sound, sight, touch, and movement. Thus, it seems probable that *early exposure to domestic violence, abuse, and loss facilitated a pathological fate of ordinary, early object relationship dilemmas*

related to the capacity for splitting. Faced with overwhelming, traumatic anxiety, the infant and small child Samantha unconsciously may have taken a pathological short cut, aimed at getting away from dilemmas of dependency-separateness, however getting stuck midway, caught in *a dead-end track between paranoid-schizoid and depressive states of mind* (Roth 2001; Britton 2001). In therapy sessions, this stuck position at times created such terrifying combinations of depressive pain and catastrophic annihilation anxiety that the analogy of a tiny, fragile newborn baby scared stiff may be most to the point. In line with Hinshelwood's version of the psychodynamic formulation, this specific inner stuckness creating *a point of maximum pain* from which a host of defensive relationships emanated, all designed to answer a fundamental question: *How does one manage such pain?*

5.1.1. Hostile parents usher in hostile siblings

One striking result was the predominance of hostile sibling figures lurking everywhere, out to snatch whatever crumbs of good attention and nourishment were available. Thus whenever Samantha felt deprived, abused or abandoned by parental figures, vicious sibling figures erupted in her mind; a link more or less persistent throughout therapy. Assumptions concerning a strong *causal link between hostile parental figures in mind and feelings towards sibling figures* were amply corroborated by uniform reports from her early years; anxious hostility towards other children increasing whenever she felt pushed aside in the attentions of preferred adults; decreasing when feeling safe and well-cared for. Samantha's bossy and controlling behaviour at school likewise indicated phantasies of fierce competition for the attention of parental objects. The hostile sibling representations

seemed contingent on anxiety, lest the abused baby in her mind be pushed aside and forgotten; benign parental attention felt as interchanged to the painful presence of uncaring, violent parental figures in alliance with viciously aggressive sibling figures.

Probably, the hostile sibling-scenarios in Samantha's mind did not directly reflect an external reality of abusive birth and foster siblings, as evidently, the more intense Samantha's emotional involvement with a special adult, the more hostility seemed to infuse her relation to other children. This may e.g. explain why in the first half year of therapy her relationship to the foster brother deteriorated. Contributing probably also was spillover into the foster family of feelings of deprivation in relation to the therapist, the many unexpected breaks of the beginning considered.

This, of course is not to say that real life experience did not matter; the infant Samantha for sure had suffered abuse by older birth siblings, and in later childhood may have had reasons to feel maltreated and pushed aside. Consider e.g. the observation of Samantha able to cope only with a few children at a time. This probably was linked to early trauma;the noise produced by many children together acting as a reminder, bringing to life a violently fused parental couple in the abused infant's mind; in its wake ushering in imagos of hostile older siblings doing evil things to the defenceless baby. This explanation would tally with the events in therapy, Samantha in collapsed moments, panic-stricken preventing any verbal communication by incessantly shouting "shut up". In such moments, she presumably experienced the therapist as a composite, extremely threatening collusion; in phantasy combining a bad maternal figure invading her inner space with a violent paternal object and a hostile mob of siblings. A further indication may be

found in the difficult transference-countertransference constellation; Samantha's frankly disturbing tendency to emit violently noisy, non-stop sounds, evoking in the countertransference of this therapist a state akin to a helplessly overwhelmed tiny infant, drowning in the experiential chaos of deafeningly loud domestic violence. It seems likely that to a child, who early in her life had suffered severe domestic violence and abuse, the dominance in mind of *an overwhelmingly bad, combined phantasy of parental-sibling figures may contribute to block introjection and identification with good relational experiences of everyday life*. Hence, keeping in mind the psychological assessment performed before therapy; the faulty differentiation between the generations probably originated from this phantasy. An inner conviction that siblings who got to the breast before her had fully occupied her parental objects, in the transference the therapist, already had, and forever would grab whatever crumbs of attention might fell from the shifting moods of unreliable and violent objects.

Thus, no matter from which angle looked at; this study seemed to *falsify an assumption of sibling figures as an independent force in Samantha's mind.* Therefore, an *overarching conclusion* at least to this child, *the appearance of siblings in mind was secondary to feelings of abandonment, frustration, and jealousy in relation to parental figures.*

This finding may be linked to contemporary psychoanalytic discussion, if *the development of children's perception of the parental couple and their perception of internal-external sibling relationships* may be considered separate developmental lines or rather stepping stones on the same path of object related, emotional development leading towards the depressive position and Oedipal concerns. In current debate there seem to be two major positions. Margaret Rustin (2007)

holds the quality of the parental couple in mind to provide the fundamental context inside which sibling relationships develop; like a matrix providing certain possibilities for the connection between horizontal and vertical family relationships. Coles (2003) and Mitchell (2004) are more inclined to a lateral view, in which sibling relationships independently add to the oedipal parent-child structuring of the internal world. Probably, no coincidence at one side of this debate is a child psychotherapist, on the other adult psychotherapists. Thus going back to the cradle of child psychotherapy, Melanie Klein and Anna Freud alike believed children primarily to view their siblings as parental accessories – the first love relationships with the parents forming the foundation for positive sibling relationships. Sibling rivalry and anxious hostility towards peers caused by the children's projection of their own hostile feelings, envy and jealousy leading to a belief that sibling rivals monopolise the attention and love of the parental objects (Klein 1945; Freud & Burlingham 1944; Freud & Dann 1951; A. Freud 1955).

Klein was convinced that in normal development, hateful and envious feelings of the child inevitably lead to imaginary attacks on the 'good' mother and her inner babies; the siblings thought to nest in her body and mind. Therefore, the emotional quality of inner siblings inevitably takes colour from the emotional quality of children's internal link to their mother, especially the degree to which sufficiently helpful qualities suffuse the inner mother or if she at the opposite is perceived as unavailable and persecuting. According to this vantage point, children look upon their external siblings and peer through the lens of a phantasy in which mother's inner space is filled up by her unborn babies, conceived by the parental couple also imagined to cohabit the inside of her body (Klein 1932c, 1932d, 1961).

Thus, the difficult transference-countertransference constellation found in this therapy tallies with an assumption that *among the residues of very early, gross neglect is a pervasive feeling that somebody else is getting the goods*. Coming second in line thus seemed a running concern to this child, a permanent pain never to become *"the first child to come",* not even to her therapist.

This finding was unanticipated; the researcher-after-therapy did not go looking for it, still quite surprised by its clarity. It is in line with Klein's assumption that the strength of the child's loving and hopeful feelings towards the internal mother offers some protection against the hateful aspects of a phantasy of sibling rivals nesting inside mother's body and mind. However, if the infant in question is an abused and neglected child; most likely frustration, jealousy, and envy may overwhelm the child's feelings of love and safety in relation to the inner mother. If so, projection and displacement may lead the child to attribute to the inner father and siblings extremely dangerous properties, henceforth regarding them as dehumanised things *"to be hated, envied, and destroyed"* (Klein 1932e, p 198). In the course of development, the imagined attacks upon the mother's inner objects will give rise to persecutory fear of retaliation as well as depressive guilt; the result disturbed sibling relationships and consequently general difficulties in the capacity for social adaptation (Ibid, p. 207-208). In the same direction points the early, still exemplary observational study by Freud and Dann of sibling relations in a cohesive group of six children, who together had survived concentration camp (A. Freud et al 1951; A. Freud 1955). Highlighting the lifesaving capacities of sibling relationships in a context of severe neglect and abuse, this study shows the children's ensuing difficulties of social adaptation. Hence, in dire want of opportunities to engage in loving parental relationships, the children kept desper-

ately close together responding to any adult invitation with cold indifference or active hostility. All attempts at individual care bouncing off, the staffs were unable to reach out to any individual child. During the year of observation, some specific links between individual children and teachers developed, however giving rise to increased possessiveness and jealousy. Anna Freud (1955) accordingly concluded: "*Jealousy between brothers and sisters is not a direct envy of what the other possesses but […] is an envy based on their relationship with the parents*".

Jumping to contemporary psychoanalytic studies of the sibling relationships of children, who in their early life suffered parental abuse and neglect, these seem few, excepting Canham et al (2000); Canham (2002); and Hindle (2007, 2008)[136]. Debbie Hindle found helpful aspects of sibling relationships among abused children, researching a psychotherapeutic assessment model related to the difficult decision of whether to place siblings taken into care together or separately. She showed that after going into care, even quite young siblings in their play enacted shared experience and memories clearly suggesting their sibling figured as an important, benign presence in their mind. In ordinary clinical work with looked after children, this ability may be quite overlooked as one rather tends to stress the destructive quality of sibling relationships of abused and neglected children. Thus, Hindle's research showed the professional adult network, including the foster families, was often unaware of the strong sustaining links between siblings, and even inclined to deny such a possibility (Hindle 2007, 2008).

In this study, hostile feelings lingering throughout therapy, very few unalloyed friendly or protective figures appeared. Nevertheless, in time, hostility ap-

[136] Quite a number of academic studies concerning siblings inflicting injury or in other ways abusing siblings were found but not included, as too far off my topic (to mention a few: Caffaro et al 2005; Cantwell 1988; Daie et al 1989; Green 2002; Kiselica et al 2007; Simonelli et al 2002; Skinner et al 2013; Smith et al 1987).

parently contained by conversion into less terrorizing, more realistic and mixed figures. An important early pointer of benign change, after 1½ years *hostile chains of linked together parental-sibling episodes disappeared* probably was indicating a less flooded state.

Presumably linked to Samantha believing more in her survival as a baby in the therapist's mind, the disappearance of such chains may represent growth and mind space for ordinary mixed relationships. In accordance with this assumption, improved peer relationships were for the first time reported.

Another indicator of benign change, *hostility relocated from fantasy figures into therapy figures*; the wider theoretical implications discussed below. An *increasing number of mixed figures* after 2½ years of therapy presumably were yet another indicator of beginning integration; allowing for more relative weight of a depressive-ambivalent perspective, while persecutory and split perspectives still frequent. Philps in her study of foster children found a similar complexity of change as assessed by the Personal Relatedness Profile, a quantitative measure designed to evaluate the relative presence of paranoid-schizoid and depressive states of mind (Philps 2003, 2009). Both Philps' and the findings of this study are in line with Klein's conception of the positions as ever interchanging perspectives on life rather than stages of personality development (Klein 1940, 1959; Britton 2001, Temperley 2001).

The significance of group and gang states of mind

The first half of therapy introduced a passionate Samantha with a fragile self, feeling ever so persecuted by relentless sibling-intruders; the second half of therapy

brought a change, Samantha now 8-9 years of age, developing a more outgoing, socially active, but also increasingly defiant self; in sessions behaving ferociously difficult, rejecting and devaluating. Thus inside therapy, gang states of mind dominating; the self in phantasy ganging up with hostile sibling figures against parental authority; Samantha's behaviour quite similar to Canham et al's descriptions of such states in group work with psychosocially deprived children (Canham et al 2000). The splitting involved in this was evident, since teachers and foster parents concurrently reported peer and sibling relations to improve. In Samantha's mind, the gang state seemed fundamentally linked to moments of identification with a violent and traumatically scary parental-cum-older-sibling figure. Thus right to the end of therapy, her initial scepticism of adults still showed, in the transference of my credibility. On the one hand, *moments of ganging up with siblings in a vicious denial of dependency* occurred; on the other, sometimes this preoccupation with the gang rather seemed to reflect *an ordinary developmentally derived struggle to achieve separateness*, finding her proper place in the sibling group vis-a-vis adult care and authority.

Linking to the early work of Melanie Klein, the gang state of mind may refer to a specific cluster of eroticised, unconscious phantasies of sibling figures ganging up against the supremacy of the parents (Klein 1926, 1927a, 1927b, 1932a, pp. 111-120 & pp. 240-248). She understood these phantasies as combined, mixing up the young child's normal, but immature erotic feelings with his/her just as normal, intense wishes for closeness, separateness, and potency. Klein stressed the double nature of such phantasies, born as they are out of the contradiction between longings for love and attention versus hatred and jealousy stirred up by inevitable disappointments. Accordingly, she considered *the balance*

between hateful and loving tendencies of inner sibling phantasy decisive for their impact on the further development of the child. From this perspective, the phantasy of joining up with like-minded sibling-conspirators may be an important part of ordinary psychosexual development, because being in league against parental authority and sexuality brings relief from intense oedipal anxieties, serving to help the child to let go of the close union with mother. However, if joining up becomes a lasting destructive alliance in which a stronger sibling terrorizes a weaker one, this may have dire consequences for the development of both. Thus, a predominance of destructive hatred, aroused by parental abuse and neglect may lead to excessive projection of hostility both into the parental couple and into the other sibling (Klein 1932b, pp 42-43)[137].

Like Klein, Meltzer initially suggested internal 'gang'-like formations to be "*a holding position*", easing the intense dependency of parental figures by *"By means of the dissemination of parts of the self into members of the group ... foster the gradual lessening of the splitting, diminution of the omnipotence and easing of persecutory anxiety through achievement in the real world." (p. 55)*. Meltzer and Harris later accentuated primarily the dark side of the picture; assuming ganging up to point in the direction of *a pathological narcissistic structure* (1976).

Towards the end of Samantha's therapy, the therapist-in-therapy felt doubtful whether her future development would point in the direction of healthy or twisted peer relationships; after all no child psychotherapist aims at pseudo-independence and devaluation of adult guidance and protection. However, the researcher-after-therapy finding consolations in the improved relationships de-

[137] The children Klein referred to are Erna (1926), Gerald (1927a, 1927b), Peter (1927b), an unnamed, delinquent boy of 11 years (1927b), and the brothers Günther and Franz (1932, pp. 111-120, pp. 240-278),

scribed at follow-up; further felt confident that single session chains of hostile sibling episodes had disappeared, since assuming such chains to communicate an unconscious tendency to follow the proverb "if you can't beat them, join them".

In the last year of therapy, Samantha working through feelings of abandonment, apparently a less poisonous inner situation came about; less preoccupied by oedipal concerns and more able to achieve comfort by the thought: "Hey, I can be together with my mates, so all this old family-stuff doesn't matter so much anymore". Commensurate to this assumption, Samantha reportedly appeared more genuinely fond of both foster parents, aware of the couple and less prone to exclude and devaluate the foster father. Her age probably in itself contributed; after all 5 years old when therapy started, she was 9 years old by the end. As suggested by Klein, evil sibling phantasies due to the split between love and hate in the course of normal development tempered by loving interactions, concurrently phantasies of objects lose some of their fantastic character, coming closer to external reality (Klein 1957).

In conclusion, siblings in mind alleviated in the course of therapy, more open to adult support, however still sticking together for mutual comfort and protection; a solution which to this child even at follow-up apparently worked to contain deep feelings of deprivation, hurt and anxiety. Probably, to foster children like Samantha, the *group-gang question may not be either-or, but rather a fine tuned balance between an unsettled, readily persecuted gang state of mind versus a depressive ability for concern*; not losing sight of the ordinary ups and downs of sibling relationships. Even so, as suggested by Anna Freud (1955) the tendency for sticking together with like-minded sibling figures may in later adolescence and adulthood form a barrier against benign identification. In general, Samantha's

relation to peers at follow-up seemed much improved but still somewhat vulnerable; this finding in line with academic research of children, who early in their life had suffered prolonged institutionalisation before later adoption (Tizard & Hodges 1978; Hodges & Tizard 1989; Zeanah & Boris 2000).

If more general to abused and neglected children, the predominance of hostility in relation to sibling figures may have implications for the difficult question of when to separate siblings taken into care. In clinical practice, as child psychotherapist and clinical psychologist I met with many siblings in care to whom being placed together had lifesaving potentials, especially important if previous care arrangements broke down e.g. during puberty. The abandonment trauma at the very start of these children's personal life may mean that placement together with birth siblings offer to the doubly abandoned child a benign rooting of identity; a shared life history at least means sharing the same fate. Then again, the complexity of real life relationships muddling up simple solutions; I also met quite a few children like Samantha to whom it would have been absolutely poisonous to go into care together with her older siblings. Never the less, it should be noted that at follow-up, Samantha had formed benign relationships to her sisters, bolstering her identity and functioning as a protective barrier against recurrent strain in relation to the birth mother. Thus in conclusion, there seem to be no quick and easy solutions; careful assessment of unique external and internal sibling relationships is needed before intervention.

5.1.2. Mindfulness and the ability to separate

A basic assumption of psychoanalytic developmental theory, the capacity to differentiate between internal and external reality presupposes an awareness of sepa-

rateness-dependency in relation to the absent object. In Kleinian terminology, the depressive position's ability to contain mental pain and mourn lost positions and relationships. Fluctuations of this ability, are considered part and parcel of ordinary mental life, related to ordinary changeability of depressive and paranoid-schizoid modes of functioning, (Klein 1940, 1946, 1959; Britton 2001; Spillius 1994a). This development is ever so difficult to weather, if the child in question is a child, who early in her life suffered abuse and neglect; to such a child any new development implying change may be equated with catastrophe, meaning a change of life from foreseeable bad to unpredictably (traumatically) worse. As normal curiosity and exploration become fraught with perceived dangers, the wish to know about one's objects is impeded; exploration interchanged to terror-stricken manic-defiant states of mind, preventing the child from paying attention to the important existential questions of her real life.

Inside therapy, Samantha's mindfulness came and went, sometimes much like a young, bereaved child drifting in and out of states of awareness; at other times she radically avoided the pain of this twice-weekly partings therapy by seeking refuge in frantic mindless hyperactivity or at the opposite in mentally shut-down states, preferring to obliterate any signs of mental activity. A prevailing *tendency to shrink away from closeness* seemed caused by at least *two different states of mind*:

a) *Persecuted by a bad, unpredictable therapist-object* felt to threaten the survival of vulnerable, tender parts of self.
b) *A depressive part of the self terrified of the confusion*, keeping the therapist at a distance in order to *protect us both from her impulses* (e.g. burning jeal-

ousy and possessiveness leading to alternating urges of cut throat threats and wishes to gobble up the therapist).

Case files of early development amply evidenced a substantial continuity between early defenses against traumatic experience of abuse and domestic violence and specific later disturbances of cognitive functioning. Her stunted courage for any exploration as shown was present from early infancy, and presumably linked to early experiences of a violent and neglecting family life, leaving in her mind a tendency to equate between any quests of knowledge whether relating to external or internal world and terrified states of mind flooded by hateful noise and violence. There is no getting away from the fact that according to case-file descriptions, Samantha's cognitive-emotional development and motivation for learning new skills and ways of thinking waxed and waned, depending on the circumstances of emotional care. Correspondingly, disastrously split and stuck states reported all the way through development, from the infant Samantha's early relationships to concurrent daily relationships during the first 3 years of therapy. Thus to this child; *very early disturbance of ordinary splitting and related difficulties of introjection-projection also seemed to have hampered some aspects of her ordinary cognitive-emotional development*.

An example would be *prolonged concrete exploration* of the first special teacher's face, which taken together with *persistent self-harming behaviour* may be understood as indicative of anxious denial of separateness of the object. It may be that already at this tiny age, *excessive pathological splitting blurred out differentiation*; Samantha on the one hand bodily striving to hang on by touch, merging with her good, protective special-teacher-object; on the other hand just as con-

cretely in attacking her own body attacking the split-off bad objects, which she felt residing inside herself. In this split phantasy, the painful result of a desperate avoidance of separateness, she might feel the good going-away-teacher in split seconds defensively transformed to a bad object, then introjected and attacked. The parental figure felt to be deserting, transformed to a lasting inner bad presence deeply perverting Samantha's need to hang concretely on to the object by turning her anger towards the self, onto her own body. The persistent damaging impact of this pathological splitting seems evident as self-harming behavioural tendencies continued even after placement in the foster family, first to disappear during therapy.

Mentioned might also be the four-years-old Samantha's *difficulties of visual memory*, as detected by psychological testing. This presumably linked to *avoidance of traumatic memory traces*, Samantha shutting her inner eyes to recurrently intruding images of horrendous violence, thus unconsciously reproducing the blindfolded state of infant-Samantha covered by a soothing nappy; birth mommy shutting out violence from her baby's field of vision. Samantha in later childhood, at nights seemed still mentally covered by the nappy, keeping wide-awake, immobile staring with unseeing eyes into an endless darkness, while picking vehemently in her own skin. In the countertransference of the therapist bringing to mind painful images of a terrified baby, struggling to forget the sight of unpredictable violent eruptions between her parents and attacks launched by her older siblings; ceaselessly invaded by horrible violent shouts and noise, probably leaving her for hours on end in the shut-down paralysed state described by the health-nurse. The protective nappy blurring out external reality, by introjection in time probably became *a mental black-out curtain, at points of anxiety offering an au-*

tomatic way out, drawing the mental blinds on any explorative challenge in both internal and external reality[138]. This understanding would be in line with case files, describing Samantha's abilities for exploration although rekindled at the residential institution, by later change and loss sadly shut down again, e.g. after the loss of the first special teacher, and even more radically so after the placement in foster care. *In conclusion*, this *early adaptation to traumatic reality in time developed into a comprehensive avoidant organization, at a high cost Samantha achieving peace of mind by shutting down curiosity and learning*.

I assume the alarming backlash further speeding up because the emotionally charged, complex sharing of ordinary family life probably rekindled early traumatic angst; Samantha feeling so much safer in the structured milieu of the institution than in her new foster family. The earlier loss of the special teacher probably set the stage for this, stimulating *an early prevailing phantasy, ascribing parental loss to the presence of preferred sibling rivals*. The reason why her first special teacher left not known, but whatever it was, the then 2 ¾ years old Samantha was bound to have developed phantasies about the reason why. This assumption is in accordance with *Houzel's suggestions concerning autistic children's abiding anxious hostility towards other children as caused by an unconscious fantasy ascribing the loss of beloved parental objects to the intrusion of hostile sibling rivals*. If so, this phantasy is not specific to autistic children but *may also relate to children who early in their life suffered abuse and neglect* (2001, 2008).

Regardless of the reported immense improvement of motivation and skills, Samantha's submissive reaction at the removal of the older foster brother indicates *a lingering tendency for traumatic relapse of reality orientation when feel-*

[138] Intense fear of humiliation linked to phantasies of seeing and being seen by such a terrifying parental couple would be in line with Steiner's thoughts (2011),

ing in risk of losing parental protection. Most likely, her reaction stemmed from anxious identification with Dennis, this feature as mentioned already present at the beginning of therapy. In addition, Samantha unconsciously may have worried so much that she had projected her bad parts into Dennis; with Dennis leaving, she herself left with the necessity to cope with what deep down she experienced as her own terrible badness. The same kind of unconscious reasoning probably contributed terribly to *survivor's guilt feelings;* an inner phantasy that her badness had transformed Dennis so that he had to leave the family. With Dennis out of the way, Samantha herself becoming "*the first foster child to come"*, this might occasion a phantasy that like a cuckoo in the nest, she actually had pushed out Dennis of the family. Hence, probably a mixture of fright, compassion, and guilt contributed to a prolonged sibling-solidarity, preventing her from coming to terms with the fact that since the time when the two children lived together in the foster family, Dennis changed, hardened into a streetwise bully.

The overall conclusion, concerns the importance in both therapy and supportive intervention with children who suffered early neglect and abuse, to *pay close attention to the clinical phenomena related to the differentiation between internal and external reality*.

5.1.3. The therapist as a stand-in for real-life relationships

Klein (1928, 1930a, 1930b) and Bion (1959, 1962a, 1962b) stressed curiosity, the desire to know about one's objects, as the foundation on which all later learning depends; a capacity dwindling, if this impulse becomes restricted e.g. due to an excess of anxious-aggressive feelings. Furthermore, the courage to observe and

explore one's objects and their relationships is considered a necessary precondition for the development of *relational thinking*; the reflexive capacity by Bion termed *thinking,* and by Fonagy et al mentalization , e.g. the ability to grasp the difference between one's own and other people's minds (Bion 1962b, 1970; Fonagy et al 2002a & 2012; Klein 1930b; Sharp et al 2012; Steiner 2011).

To Samantha, a combination of *envy and fear of violently envious objects* seemed at the core of her terror of development, setting in train defensive introjective identification, deployed to modify anxiety against any awareness of separateness. Such anxiously submissive introjection should be differentiated from the normal, early processes of introjection and projection, since not contributing to the building up of good inner objects, but rather keeping the self in schizoid bondage to aggressive inner objects (Gaensbauer 1994, 1995; Klein 1955, 1957; Rosenfeld 1971b, Spillius et al 2011). Anna Freud's early concept of *identification with the aggressor* likewise suggested a tendency for pathological processes of identification based on overwhelming fear (1936).

A related result from this study, the importance that the therapist pays minute attention to the special difficulties of abused and deprived foster children in *working through phantasies linked to an introjected, ferociously violent and fused parental couple*. Samantha's violent behaviour and play as shown strongly suggested adverse early relational experience to have impeded working through of ordinary, developmentally related phantasy. Undigested, distorted and scary bits and pieces of ordinary infantile phantasy apparently intruding upon her consciousness; contributing to severe restrictions not only in relational exploration, but spreading far beyond to any enquiry into the unknown. Hence, in this and other therapies with children, who had suffered early neglect and abuse, I found that

even if grossly distorted and traumatically scary, the child's infantile phantasies contain an embryonic kernel of an ordinary, developmentally related quest for knowledge, needing the attention of the therapist to set free a spirit of inquiry (Grünbaum 1989, 2010a, 2010b). These findings are in line with the experience gathered in the Tavistock Workshop on deprivation, linking sexuality and aggression as intermingled themes in the mind of deprived children (Szur 1983).

It seems immensely important to Samantha's recovery from a shut down state of abuse and neglect that she was able to *explore the mind of the therapist as a live substitute for her real life objects*, engaging in a searching and probing activity, an analogue to the kind of relational exploration that from the earliest weeks takes place in normal development. Picture e.g. a tiny infant from the secure position in its mother's arms and mind exploring her face, hand and breast by looking, touching, tasting. This infant simultaneously is engaged in an exploration of his own self as an agent of experience and change e.g. by initiating or breaking off eye-contact, sensory exploration of the mouth cave, changing the rhythms of sucking, and many other ways of making an impact in its sensory dominated internal world and at the same time on the relation to the external mother. In ordinary development, the infant some months later is ready for active exploration of the experience of geographical and emotional closeness-separateness, absence, and distance e.g. dropping things, playing peek-a-boo games, moving away and towards its parents, experiencing the parents going and coming back, and experiencing the repeated repair of on-off rifts related to battles of willpower.

Samantha apparently found it much safer to divert her anxiousness and hostility from figures of her daily life, instead to focus at the therapist and the therapy. This is in line with a primary claim of psychoanalytic child psychotherapy,

namely that *therapy is mainly concerned with inner reality and transference relationship before external reality*. The finding is of course not independent of my way of working, in tune with my training and experience, teaching me for a start to focus attention on the transference and refrain from addressing too directly the child's real-life relationships, patiently waiting until these issues seems to be emotionally alive in the relationship, almost on the tip of the tongue[139]. One may therefore suspect this finding primarily to reflect *an allegiance factor* (Rosenthal 1966, Sandell et al 2007). However, I am convinced that the evolving dialogue between Samantha and myself was important to the benign result; *her exploration of the why, how and what of therapy and therapist giving her an important second chance to work through intense feelings* felt to be far too risky to bring out in the open in relation to birth and foster parents. As so eloquently formulated by Winnicott, the special thing about play figures is their location in the relational space of the transference relationship, *a creation of a shared phantasy* rather than located solely inside the child's or the therapist (Winnicott: 1967 & 1971; Ferro 1999). While sure to reflect the technical preference of the therapist, and as such an artefact of the applied research method, it also suggests that in time the child's hostile feelings gathered and contained in the transference; space was created in her mind for loving, tender, friendly feelings, which subsequently as reported relieved her external real life relationships.

Summing up, the therapy vividly illustrated *dire consequences of a frozen internal world for the development of a mental apparatus for relational thinking*, any movement felt as releasing catastrophic change; the self at times literally stuck at the doorstep to development. This trapped position, vividly enacted in the

[139] Although in general a sound principle, a more direct approach may be necessary if working in the context of *recent traumatic experience* e.g. related to war and atrocity.

middle part of therapy, seemed to capture the essence of an inner situation, maybe best described as *the borderline position of a self unable to reconcile dependency-separateness dilemmas, stuck at the threshold between paranoid-schizoid and depressive anxieties and modes of functioning*. On the one hand, a terrorized part of the self, unable to enter into development preferring a minus-K state in which any new knowledge avoided or dismantled. On the other hand, *a passionate part of the self*, still alive and unable to stay out of curiosity and longing, however steeped in vigilant, apprehensive hostility, giving rise to complex splitting processes at all levels.

5.2. Reactions to breaks - indicators of change

Samantha's reactions before and after breaks, as well as at session beginnings and endings often had a striking similarity to reported behaviours from early infancy; thus corroborating an assumption that *breaks, beginnings, and endings may especially clearly bring out core object relationship themes*.

In a 2-weekly therapy, the experience of regular breaks implied by the ordinary gap between sessions is part of the setting as an ordinary, recurring experience. Accordingly, one may think about an interesting *parallelism between beginnings and endings*; the hopefulness initially implied in Samantha's eager ways to start single sessions, a similar hopeful note implied at the end of some sessions, Samantha dimly aware of the pain of parting. Taken together with the birth mother's touching capacity even through bad times for keeping up high hopes for the future happiness and abilities of her daughters, this may imply some early ex-

periences of containment in Samantha's relation to birth mother. As an analogy, one maybe could think about watching an infant feed, observing the way it settles at the breast and eagerly goes to work suckling. Observing the way the nursing couple starts and ends; the crucial question being if they can meet and part in such ways that the expectant mood of a good feed prevails; maybe parting can be endured and perhaps even liked. There seems to be a parallel in the whole therapy, starting and ending much more hopeful than the dreadful places we went in the second and third year of therapy, fraught with hostile and explosive states of mind. Hence, maybe the tiny baby Samantha at beginning life saw in her mother's eyes high hopes about getting to know her; only the hopefulness early dashed by terrible disillusionment; an assumption amply supported by case files. However, if this is so, *a related assumption might be, if starting and ending of a therapy goes well; the middle part even if difficult in some ways also may be enriching*.

The decline inside the therapy room in the third year of therapy would be an example. Samantha's characteristic way of beginning the session at this point radically had changed; no longer eagerly entering the playroom, instead in difficult session beginnings *utterly stuck at threshold*. Acutely anxious of what she thought I was going to say; with all her might trying to prevent me from saying anything at all, drowning me out in loud shouting.

A number of authors discussed such stuck mental states. Green metaphorically spoke of *sitting on the fence* unable to say neither no nor yes to separateness, therefore unable to move, not daring any change, since change equals catastrophe (1975, 1977). Rey described *claustro-agoraphobic dilemmas*, the subject caught midways, equalling separateness to terrifying isolation; dependency to suffocation (1975). John Steiner linked the stuckness to avoidance of paranoid-schizoid and

depressive anxiety alike, the subject instead finding a *psychic retreat* (1987, 1993). Rey and Steiner discussed the emotional and existential cost; the evasion of separateness-dependency dilemmas resulting in a kind of half-life; no movement possible because no matter which way you go, pain is threatening. Probably at this stage, Samantha's growing ability to remember at session start the pain and rage of parting that was responsible for the decline. Assuming, her awareness of parting becoming more and more acute, as time went by the frozen state eventually gave way to intense pain of parting; the half-life superseded by passionate, hateful struggles.

The ensuing vulnerability of the patient raises technical difficulties of the therapist in *how to address the terrible pain and anxiety evoked*. Meltzer addressing this dilemma formulated the apt analogy of the extreme sensitivity it takes to get close to a newborn baby without overwhelming and consequently burning the child, who really can only digest the food if teaspoon-fed (1973b, 1976). In this line, it is interesting that even at follow-up Samantha by her expressionless face aroused powerful feelings of precarious uncertainty in two benign adult persons, one of them in the relatively neutral position of her hairdresser. This information is an important part of the external evidence of how powerfully Samantha in moments of anxiety communicated by way of projection into other persons; without words getting rid of some of her anxiety by locating it elsewhere and at the same time conveying just how anxious she was. Presumably, Samantha did not dare show her joy because terribly anxious that somebody might get envious and rob her of the good things; a terror rooted in the hostile links of the internal family in her mind. Further, these reported incidences may have a parallel in the counter-

transference related inability of the therapist to remember details from those rare instances when Samantha really dared confide in her.

5.2.1. Before-break sessions and symbol formation

This brings me to the somewhat mystifying *lack of sibling figures in before-break sessions*. This becomes meaningful, if one assumes that Samantha *at the brink of parting was unable to form a representation of the so much feared and hated sibling-rivals*. The reason probably that she experienced the departing me as equal to a preoccupied mother fused with a preferred violent rival (spouse or baby) and immediately was flooded; her attention narrowed by an excruciating experience of abandonment. It may be that in her imagination there was only room for one baby inside my mind; every break posing the painful and scary question: *"am I alive in your mind or not"*? A parallel *at the end of sessions*, especially in the first half year of therapy, Samantha ever so often appeared profoundly confused; unable to give her suspicions definitive symbolic form, it makes sense to assume a painful process of inner objects falling utterly apart. Samantha's reactions in before-break sessions easily links to Bion's concept of thinking; the ability for relational thinking (the mental apparatus for thinking) dependent on the child's awareness of longing for the absent object and correspondingly acknowledgement of own separateness and dependency (1961a).

Comparing *transference and countertransference in before-break sessions*, a striking result of this study is the *correspondence* between *Samantha's failing ability for symbolic representation of the break as intruding, hostile sibling figures*, and *on the part of the therapist, the experience of cognitive countertransfer-*

ence confusion. At this point, it would be tempting to speculate on what came first; the child's confusion or the therapist's confusion[140]. However, therapy is an ongoing, complex two-way process; both parties deeply involved in each other's minds. It may be more to the point to relate this finding to Bion's conception of *container-contained* as a relationship affecting both parties, under certain circumstances leading to mental growth (1962b, chapter 27). In relation to breaks in therapy, not only the child but also the therapist unconsciously engages in emotional processing of personal experiences related to dependency-separateness, the experience of absence a mediating factor. Thus, *presumably the mental growth of the child (understood as her ability to endure breaks and endings) depends on the ability of the therapist to engage in a mental three-step process of containment, linking and detoxifying both her and the child's feelings and phantasies as stirred up by breaks*.

The continued presence in *after-break sessions* of sibling figures indicates that thoughts and phantasies of hostile siblings were better able to enter Samantha's mind, when the gap of separation was behind us, and she was able to see for herself that I did in fact return after the break, still keeping the baby-her alive in my mind. Correspondingly, *the immediate joy at session beginnings, abruptly cancelled by distancing behaviour* likewise might signify Samantha to become *jealously preoccupied with the thought of whom I might have seen*, when she was not there; hence an increased probability for the emergence of both sibling figures and angry avoidant behaviour.

[140] Jiménez et al (2006) studied breaks in adult psychoanalysis and concluded their findings to support an assumption of the analyst's separation anxiety to influence the patient's reactions to breaks.

In the middle of therapy, Samantha *less confused at session ends,* she reportedly *increasingly was able at night to go to sleep;* important predictors that she had *gained in faith, becoming more aware that to separate before sleeping and at session end may not be forever*. In order to be able to let go and end the session, she still needed to take distance, leaving at an aggressive note or firmly closing the door behind her. *Aggression and self-assertion* thus played an important role to her growing ability to part, but probably also contributed to the dominance of hostile figures right to the end of therapy. It may be as suggested by Winnicott that even in ordinary development some aggression and self assertion are necessary to let go of the object; in which case it must be especially difficult for a deprived and traumatised child to do so without becoming either violent or entangled (Winnicott 1939, 1950, 1969). The more important it seemed that at follow-up, Samantha's ability to cope with her own and other people's aggressions reportedly had improved and still seemed to develop.

Summing up, no matter from which angle the therapy material was explored, before-break sessions stood out as special, highlighting dilemmas of dependency-separateness; how painful and difficult it was for this therapeutic couple to negotiate a workable distance, not too near nor too far away. *Breaks, beginnings, and endings giving rise to jealousy and envy, represented by the eruption of hostile siblings in mind; however separation to come apparently deadening this child's ability for symbolic representation of jealousy and envy in the form of sibling figures*. If this result also is valid for comparable psychoanalytic psychotherapies with similar children, *the appearance of sibling figures in before-break sessions, even if hostile, may be one, very easily evaluated indicator of benign change.*

The study further indicated *severely confused and flooded states, in the first half of therapy especially frequent at session-end and in before-break sessions; in the middle of therapy more often visible at session-start and in after-break sessions; in the last year of therapy diminishing*. If this also holds true for other children in psychoanalytic therapy, who like Samantha had suffered early neglect and abuse, this may be quite important; corroborating and extending Houzel's suggestion concerning autistic children, this result may indicate that the *ability to endure breaks an important indicator of change to diverse groups of children* (Houzel 2008).

5.3. Countertransference and complex splitting

One result not foreseen was to make so very clear *just how important the therapist's subjective experience and states of mind were to understand properly the object related meaning of core themes and breaks*. The crucial role of the therapist's countertransference is of course no news to a psychoanalytic child psychotherapist. Nevertheless, again it seems important to underline the extraordinary strength of the IPA to elucidate and document in a systematized way experiences only dimly perceived by the therapist-in-therapy, here the complexity of the child's and the therapist's contributions to the findings of this study[141].

As is well known, the concept of countertransference has *two possible meanings* (definitions) and accordingly, the findings of this study relate to both meanings, referring to a) *the unresolved personal issues of therapists*; and b) *pa-*

[141] A discussion of the scientific status of countertransference recordings appears below, section 6.1.1.

tients' unconscious projective identifications giving rise to feelings and fantasies in the mind of therapists:

a) *The unresolved issues of therapists acting as blind spots in their field of vision* may interfere with therapeutic stance and understanding; and as shown, the therapist-in-therapy at times became over-involved, indifferent, antagonistic, or in other ways affected and disturbed in her therapeutic function. However, therapists are bound to have a personal emotional reaction to their patients, who very likely will project parts of themselves into their therapists. Thus, countertransference is unavoidable, set in motion in relation to the patient but caused by the state of mind of the therapist rather than by the patient's mind. Accordingly, a continuous task of therapists is to find out within themselves, what is going on, by studying their mistakes getting wiser to what personal difficulties are at stake. This was Freud's and, according to Spillius Klein's view on countertransference[142] (S. Freud 1910; Spillius 2007a; Spillius et al 2011).

b) *The patient's unconscious projective identifications giving rise to corresponding feelings and fantasies in the mind of the therapist*; this additional meaning was introduced by Paula Heimann (1950), who stressed countertransference as a useful therapeutic tool. It became widely accepted, and in contemporary Kleinian theory countertransference unanimously is considered an essential source of information about the patient (Brenman Pick 1985, Joseph 1985, Spillius et al 2011). This meaning presupposes Bion's development of projective identification into a relational model, a primitive form of communication actualizing the patient's unconscious phantasies

[142] See e.g. Spillius summary of Klein's discussion in 1958 with a group of younger colleagues of the clinical value of the concept of countertransference p. 65-126.

through evocative behaviour towards the therapists (Bion 1962b & 1970, Ogden 1979, Spillius 1994b).

The preservation in writing for later scrutiny of countertransference notes related to the above-mentioned problem of differentiation between *countertransference as a source of information about the patient and as mistakes stemming from therapists' blind spots and obsessions* (Britton et al 1994). The vulnerability of therapists is tantamount to the fact that good therapy is a two-way, bi-personal communicative process, with the power to change both parties. So the problem for therapists is how at moments to let go of rational thought, losing the self in the here-and-now process, allowing what Meltzer termed "*areas of ingenuity*" to arise (Meltzer 1973b, 1976 p. 376). In the reality of the playroom, events moving pretty fast, it is no easy task to differentiate between moments of true inspiration and countertransference enactment.

As shown above, Samantha right from the start showed a keen, probably pre-conscious awareness of the countertransference states of the therapist-in-the-therapy, especially those related to availability. This brings to mind suggestions that *even if very distorted, the patient's transference communication contains a kernel of realistic perception* in the here and now of the state of the therapist (Searles 1975; H. F. Smith 1990; Ferro 1999).

It seems important to understand just how complicated are the *formation of the countertransference states of the therapist;* begot by the interplay between *projective identifications of the child, introjective identifications of the therapist, the influence of case history on the child's background and object relationships; the corresponding impact of case file information on the countertransference of*

the therapist; and factors relating to the personality and personal life story of the therapist. The ideal therapist needs to stay open to whatever painful countertransference is stirred up, to the best of her ability differentiating her own feelings from the preoccupations of the child; while also pondering possible links. Far from the ideal, the therapist's differentiation between the child's and her own feelings is so much easier to achieve in retrospect than in real life. The complexity of this task further was demonstrated by *brief visual countertransference images and even bodily states*, relating to a tiny, overwhelmed infant left to its own defensive devices.. Such *primitive, perceptually based countertransference phenomena* helped the therapist-in-therapy keep in mind the vulnerable infant inside the defiant child. Corresponding, but primarily visual countertransference phenomena were reported by Norman (1989).

5.3.1. Three sources of countertransference mistakes

There seemed to be at least three sources of my countertransference mistakes: a) *disturbed containment related to the state of Samantha's inner objects; b) my own anxiety as evoked by being together with a very difficult patient; c) the therapist's inner resistance against the therapeutic task.*

Disturbed containment and the state of Samantha's internal objects

Meltzer (1967a) suggested the evocative conception *toilet-breast container* for the therapist's willingness to function as an object able to keep on behalf of the child the hostile projections for the time being, until such a time that that the combina-

tion of the therapist's mental digestion and the patient's growing capacity for relational thinking makes possible for the therapist to communicate a detoxified version of her original feelings. Working with children who early in their life suffered abuse and neglect, even at best this process is far from smooth, concerning grossly non-empathetic and in general emotionally constricted inner objects. The researcher-after-therapy had to question to what degree this specific therapist's vigilant apprehension and related difficulties of distance were rooted in primarily her own personal past or introjective identification with Samantha's projective identifications of disastrous early object-experiences. In the countertransference, at certain moments not recognizing my own therapeutic self, the therapist-in-therapy felt compulsively identified with an invasive caricature of an overwhelmed mother/therapist flooding her child with never-ending words and erratic limit setting; this bringing to mind Heimann's concept of countertransference feelings as communication stemming from the patient (1950). A more complex understanding of how such introjective identification may take place was offered by Gianna Williams (1997c), describing a *reversal of the container-contained relationship*, the infant becoming a receptacle for the mother's anxiety and projections. In a reversed care relationship the experience of receiving nourishing care/appropriate mirroring/sweet milk from a good mother/breast/therapist is prevented, the baby rather relating to the experience of an unstoppable, overflowing and invasive kind of tap, pouring bad and wrong stuff into it, endlessly going on and on.

The real problems experienced at the start of this therapy, getting it securely launched probably contributed to my fragile faith that eventually it would get going. Most likely this countertransference reservation was strengthened by a chilly

introjective identification with uncaring, envious or indifferent objects, resonating depleted aspects of my own mind, e.g. setting off a defensive inability afterwards to recall especially meaningful details of verbal dialogue. Such cognitive counter-transference disturbances probably relates to anxiousness, maybe an anxiousness that somebody else would interfere, becoming envious, spoiling my good work e.g. an envious foster mother not able to forgive either me or Samantha, should I be able to help her in ways other than she herself. Similarly indifferent or envious countertransference states when working with severely deprived and traumatised children are well known and were first described by Gianna Henry (now Williams), who coined this mechanism *doubly deprived* (1974). This tendency ever so often sadly contributing to wrecked relationships and broken off foster placements of these children further was detailed by other writers (e.g. Sutton 1991; Bell 1998; Emanuel 2002).

The understanding and non-understanding of the therapist came and went, illustrative of an important dynamic aspect of the transference relationship. In singular moments of true understanding, Samantha suddenly took the lead, in her own words movingly particularizing a theme tentatively suggested by the therapist, e.g. passionate, jealous longings for love, phrased in terms of being the first child to come. At the opposite, sad moments of non-understanding often gave rise to defensive reactions similar to the distressed, flooded or shutdown state of a tiny baby, giving up on the maternal ability through reverie to contain and mirror tolerable versions of indigestible feelings.

From differing theoretical perspectives, Winnicott (1952); Bion (1963, 1970); Williams (1997c); and later Fonagy et al. (2002a) described similar prob-

lems of understanding, relating these to two different kinds of *disturbed mirroring in the container-contained relationship*:

1) *Disturbances in which the container (a maternal object's or the therapist's psyche) becomes flooded by the infant's passionate projective communication*. The maternal mind unable to contain the projected parts of the infant's self, in amplified (instead of modified) form returning to the infant its own passionate feelings; the infant re-introjecting an overwhelmed state together with the experience of being flooded by an overwhelmed object – paving the way for difficulties of differentiation between inner and outer reality.
2) Disturbances in which *the container misunderstands the nature of the categorical feeling projected* and consequently gives back to the infant a misperceived version of its inner reality; the infant left with no other choice than to introject this as a foreign, indigestible body inside its mind together with the experience of a misunderstanding object – paving the way for the development of a false self-experience.

The therapist's personal anxiety as evoked by a very difficult patient

Samantha often was difficult to contain, entering her sessions in a pent-up, bad tempered condition, posing real problems of management. However, also true that the power of a patient's projections depends on the possible resonance in at least some parts of the therapist's personal inner world. Therefore, a question arises to what degree my therapeutic function at times was impeded by my own personal brand of catastrophic anxiety, amplified by the very real difficulties in keeping this violent and difficult child in therapy without harm to me or her. I believe the

sources in my own psyche to be located at *two different levels of experience*, namely partly as related to *my here-and-now experience of a difficult patient;* partly related to *resonance at a deeper level:*

1) *The here-and-now experience of the therapist-in-the-therapy, vis-à-vis the violent unpredictability of Samantha* contributed to countertransference states of forced helplessness and related despair. This was especially vivid in the beginning of therapy; in session after session fighting to contain my own hateful feelings, aroused as an unprepared and too naïve child part of me repeatedly was exposed to Samantha's violent attacks, often felt released out of the blue nowhere.
2) *A diffuse awareness of resonance at a deeper level in my own psyche in certain moments entered my conscious mind*; the therapist-in-therapy not able to make this any clearer. The researcher-after-therapy pondering the notes of momentarily paralysed countertransference states, realised in the misty dual twilight of childhood and countertransference memories a link to not quite welcome childhood memories of being an afterthought child in a big unruly group of siblings traumatised by war and related separation.

The therapist's inner resistance against a difficult therapeutic task

One may question whether the therapist's not quite conscious, inner objections against the necessity of the therapeutic task of introjection and containment is at all a kind of countertransference, however in Freud's original meaning of the term, it must be (1910). Obviously, as a therapist one positively wants to be avail-

able to the patient with all it takes of one's mental resources. However, there also is a negative side to this ideal model, as it is not without personal inconvenience to take into one's own psyche another person's disowned projections of despair, agony, and hate. Maybe it should be noted here that as Samantha's (and in the resonance of countertransference also my own) frozen state began to thaw, not just the memory of unmet needs was evoked; evoked was also the live, agonising moments related to the experience of loss and deprivation. The therapy thus took us both to some most distressing and painful places, and it should not come as a surprise to anyone that the psyche of the therapist-in-the-therapy may not quite agree to the necessity that introjection of unpleasant feelings and awakening unbidden personal memories are part of the work task.

Writing this I found myself wondering whether more frequent sessions would have eased the pain. However, to the researcher-after-therapy this appears as a belated countertransferential dream of perfect nurturing rather than belonging to real life. What was and is likely to be available to disadvantaged children like Samantha is at best a twice-weekly therapy, which after all is much better than no therapy. Hence, O'Shaughnessy's statement of the reality of separation from the external object also seems relevant to the countertransference of the therapist, stating the importance that in the end both participants must endure the pain of parting, the therapist also working on her own ability to let go of the child (1989).

Comparing this to Samantha's way of reacting at the end of sessions, in the first years of therapy at times in such a terrible pain, akin to the description given by O'Shaughnessy in 1989: *"...because of their lack of an internal good object, these patients feel little capable of bearing singleness. They must be in a state of projective identification with another object. ... singleness is not yet even a dy-*

namic, .. .the oedipal story begins there – (as) cast out. This after all, is where the original myth began: Laius cast out Oedipus" (p. 149). In this therapy, the problems encountered in the countertransference often were about *the therapist's ability to grasp Samantha's catastrophic experience of separateness*, an issue also stressed by Joseph (1985, 1992) and Alvarez (1992).

5.3.2. Distance-related countertransference - a signpost to pain

Several therapists before me struggled to find an appropriate location from which to address a patient with impaired or restricted abilities for introjection and containment. Meltzer (1976) probably was first to point out the link between distance-related difficulties and a terrific vulnerability in the patient. Suggesting minute attention to emotional temperature and distance as experienced in the countertransference, he recommended therapists closely to monitor their mental position vis-a-vis the patient e.g. *turning up or down the heat of emotionality* by the wording and music of the voice (tone, rhythm, volume, timbre etc.). Likewise recommending the therapist to consider to *which part of the patient's personality* interventions may be addressed, regulating the experience of mental distance (e.g. talking to dependent or separate parts); further, evaluating in which *context of time* the intervention is most likely to be taken in (e.g. past, present, future tense).

As a scientific endeavour, good psychoanalytic child psychotherapy builds on the therapist's close observation of the child and the fate of her interventions; in each single therapy learning anew by experience just by which degree one

should talk directly or indirectly to this unique child; e.g. when to refer directly to Samantha herself; to a generalised child; or to anybody. As beautifully exemplified by Anne Alvarez (2010), it is not easy to strike the right balance between being experienced as too intense and therefore intrusive, or too distant or frail and therefore non-available; e.g. assessing to which degree the intervention may detail the child's feelings or, as phrased by Alvarez, just simply describe the "*whatness*" of the experience.

The case of Samantha illustrates a point stressed by Brenman Pick (1985), namely that the patient's projective identifications attain their power on the therapist in a far from simple way. Samantha apparently did not just project into me, but as illustrated in several of the cited sessions seemed unconsciously prone to project exactly into such particular aspects of my mind, liable resonating loss and catastrophic anxieties. Like Meltzer, Brenman Pick stressed the importance that the therapist is in touch with this resonance in her own mind, giving thought to the timing, emotional atmosphere and wording of her interventions, always aiming at facilitating a move from the paranoid-schizoid to the depressive position. From the perspective of an ego-psychological tradition, Fred Pine addressed much the same questions, pertinently suggesting that interpreting in the face of unbearable mental pain will be no go if striking while the iron is too hot; better to wait patiently until things have calmed sufficiently down for the patient to be able to listen (1985).

O'Shaughnessy (1981) and Alvarez (2010) both stressed the importance that the therapist is minutely attentive to the child's reactions in the relationship, as the only possible way to differentiate levels of communication from different parts of the child's personality e.g. omnipotent sadistic identification from terror-stricken

paranoid panic. Close attention to one's countertransference states is important to be able to recognise the state of a child about to drown in terror-stricken panic, accordingly easing the pressure, turning down the emotional heat, not addressing vulnerable spots too sudden or too directly.

An important finding from this study relates to *the therapeutic potential inherent in the complex interaction between on the one side Samantha's painful dilemmas and on the other side the therapist's distance-related countertransference states*, which like an especially fine-tuned instrument seemed able to *capture issues of dependency-separateness at stake in the here and now*. Thus in the mind of both participants, important understandings dawned, as Samantha suddenly came closer to awareness of the existential problems in her life; the therapist correspondingly gaining new insight in the resonance of these in her own life experience.

Collapsing distance - the therapist under attack

In this therapy were found quite complex links between on the one hand fluctuations in the therapist's ability to monitor distance; on the other the child's attacks on the setting and the therapist. Going back to Daldin's before mentioned study of children's assaults on their therapist, two separate groups of children were identified, one primarily motivated by struggles of dependency-separateness, another re-enacting sadomasochistic parent-child relationships (1992). In the same line Waddell & Williams (1991) described assaults as related to a perverse attraction to sadism and excited power struggles. In this context, Anne Alvarez's (1985) view on therapeutic neutrality seems relevant, defining this as "*the achievement of*

sufficient distance from the impact of the patient to think, yet not so much distance that empathic sensitivity and counter-transference receptivity get lost" (pp. 88). She stressed that therapists working with children felt to be in destructive narcissistic or psychopathic states of mind in order to uphold an ability to think may need to adopt an attitude of "*fortified neutrality*" (1985, 1999). The therapist aiming at an attitude of proper balance, firmly upholding an incorruptible realism and limit setting towards willfully destructive behaviour, but then just as vigilantly keeping up an open mind, safeguarding possibilities for containment, understanding and reparation.

In this specific therapy, the motivational background of assaults apparently quite complex, *overwhelmed states of paranoid anxiety alternating with denigrating sadism*; glimpses of both visible already in the first session. Running as *parallel strands through therapy*, gaining ascendancy at different times; anxious struggles of separateness-dependency most prominent in the first half of therapy; in the second half, sadistic enactment increasingly powerful. This compound background became especially clear in the third year of therapy; *violent attacks often a culmination of flooded states, rooted in a painful and therefore explosive mixture of persecutory and depressive anxieties.*

At the depressive end, contributing was probably a yet immature Samantha, not able to reconcile loving and hateful feelings. She seemed at this point *doing her very best precociously to behave and reserve all good feelings for the foster parents and the birth mother*. But accordingly, she was forced to direct all bad feelings onto therapy and school, there becoming more and more flooded and uncontained.

At the paranoid-schizoid end, a commanding primitive identification with the violently shouting, fighting couple of early life probably contributed; this identification linked to *a powerful tendency towards denying and dismantling any K-related thoughts and feelings* (Bion 1962b and 1970, Meltzer 1975c, 1976). The selfsame dismantling tendency at certain points also affected the therapist through introjective identification; probably playing a part in my countertransference mistakes concerning distance and recurring inability to remember the most meaningful parts of the dialogue.

In line with this, Glasser (1994, 1996, and 1998) conceptualised violence as belonging to one of two types, or a combination of them, namely self-preservative and sadomasochistic violence. Based on psychoanalytic research into violent acts of adult, male perpetrators, he linked self-preservative violence to unconscious core complex anxieties of annihilation and abandonment; operating in all present and past relationships as well as in the transference. Thus, self-preservative violence occurs because the perpetrator perceives the victim a threat to psychological or physical survival, what matters is the imagined threat to the self, and the reaction of the victim plays no role. By contrast, sadomasochistic violence assumed a result of a lustful sexualisation of aggression, distinguishable because the response of the object is essential, the aggressor getting pleasure from watching the sufferings of the victim. According to Glasser, when sadomasochistic violence fails it may regress to self-preservative violence, an assumption consistent with the experience from the present study that within split seconds, these states might alternate

Recapitulating this therapy's manifold dilemmas of distance, it seems easier said than done to follow Alvarez's admirable axiom concerning neutrality and

distance. Thus coming too close, Samantha felt engulfed, trapped in tremendous pain at the risk of being left again. Keeping my distance, life immediately drained out of the session, Samantha withdrawing into *an empty shutdown state* reminiscent of the listless infant observed by the health nurse; shortly to re-emerge into a manic frenzy, getting a kick out of mean aggressive behaviour bound to make me come close again. Action language the only available idiom, these assaults seem analogous to a tiny infant's *desperate attempts to communicate a violent inner breakdown*, demolishing not only links to good inner objects but also to feeling alive. *At a fundamental level*, the *lifeless state might have been the point of entry for manic-sadistic violence, a perverted form of staying mentally alive;* Samantha, at the brink of detrimental shut-down, closely holding onto the excitement of abusive and violent objects. In the language of Hinshelwood's psychodynamic formulation (1991a), conceived as a defensive strategy, *manic-sadistic identification and related violence, emanating from the terror of a shutdown, mentally dead state.* Difficult to keep in mind when the going got rough, this (belated) counter-transferential imagery of the researcher-after-therapy seems in line with Steiner's model of pathological personality organisations (1987)[143] .

This explanation would fit with the therapist's development of *hypersensitivity to invasive noise; a spot-on perceptual pointer linking Samantha's explosive states to the therapist's paranoid-schizoid countertransference experience of auditory flooding.* In the hindsight of the researcher-after-therapy a connection appears, between on the one hand a therapist-in-the-therapy, profoundly flooded by unbearably noisy, high-pitched shouting; on the other hand Samantha's disowned needs for a listening ear, able to contain and share the dreadful phantasies

[143] This assumption fits the early play scenarios of a mistreated infant vis-a-vis brutal objects.

evoked by disturbing sounds emanating from the ongoing veiled, extremely noisy and destructive fight between hostile parental objects. This specific transference-countertransference constellation seems linked to what Hunter working with similar children appositely coined "*the struggle to close the bedroom door"* (2001, p. 85). Presumably, this auditory cue was an important precursor for the turning point of the therapy, an unconscious process leading up to the awareness that enough was enough – and surely not before time to get this door closed. This process took place at a primitive perceptual level, not mentally digested; the hypersensitive countertransference state maybe akin to a pre-stage of Bion's *selected facts;* the unconscious mind-ear of the therapist listening intently to fragmented strands of thoughts and sense impressions until suddenly able intuitively to intervene with a transformative interpretation related to the need for change (1962b, 1963).

The primacy of the countertransference problem is about how one is to *survive as a therapist* when under malicious attack, provoking one's most savage tendencies. This *transcends a discussion of mere technique*, because it has to take into account the personality of the therapist as a determining factor. One may e.g. think about the very different accounts given by Hunter (2001) and Canham (2004), both struggling to contain comparably provoking and sadistic behaviour. Hunter at times found it necessary to protect her sanity and the survival of the therapy by ending the session early (chapter 5, pp. 74-77). Canham on the contrary found it vital to hold the situation, not to break off but to go on working in the setting, even in face of the most evocative pouring out of destructive enactment, which obviously would stretch anyone's capacities for containment to the utmost limit. The amazing thing is that despite the *huge difference in technique,*

the compassionate understanding is quite similar, both therapists presenting substantial session material evidencing the children in time to introject and identify with the therapeutic relation, from this developing improved capacities for containment and symbolic thought.

5.3.3. Countertransference crisis and turning points

The countertransference crisis of the third year of therapy culminated in a confrontation, in hindsight a benign turning point. The therapist-in-therapy at this point worn out by Samantha's ever-escalating violence verbally confronted her with the reported fact that outside therapy she had changed considerably for the better and needed to change inside therapy. The importance of this intervention relates to the therapist's understanding that any lasting change presupposed Samantha to change not only outside therapy but also in her internal world as communicated in the transference. At this intervention, apparently Samantha was so astonished, her brick-like defenses suddenly down, and she started thinking "I have developed". However, as so often with these children, at the core of contemptuous sadism was a fierce borderline dilemma; hence any thinking about change immediately evoked separation anxiety, mounting to catastrophic paranoid anxiety. The thinking part of Samantha's mind seemed very well aware that she needed the help of the therapist to stop the inner destruction of all goodness - the madman broken loose in there. At the same preconscious level she seemed aware that her defensive armour - the knight - prevented her from taking in the good parts of the policeman-therapist. However, since her fear of change was equal to her fear of the thinking mind of the therapist, she accordingly hurried to negate

the I-think-Samantha by mobilizing the I-couldn't- care-less-Samantha. Similar destruction of any dawning awareness, linking inner and outer reality was repeated every so often in this therapy. I assume this destructive link due to the above mentioned basic split between the thinking (K) and the non-thinking (-K) parts of her personality, ever so often making a muddle of her mind (Bion 1962b, 1963).

The realization that I could not forever go on, shielding Samantha against her violent self, seemed of vital importance to subsequent positive development. Thus at a certain point it is necessary firmly to address omnipotent sadism and destructiveness, putting across to the child the necessity to make use of her own capacities for containment of anxiety and rage. Pondering how to know when this certain point is ripe, in retrospect I believe that although this critical intervention partly was instigated by *the child's material*, the decisive part more likely was the necessity implied by *the mounting intensity of the therapist's countertransference feelings;* at the desperate height of a countertransference crisis one really does not feel one has much choice. However, had I at the time been more aware, I might have recognized precursors to this crisis in preceding sessions; Samantha telling me about her nightmares, dimly aware of the terrible destruction going on inside her. Unconsciously, she seemed in pain about the repeated catastrophes caused by the inner madman's destructive and nightmarish attacks on the dependent parts of the self. In this sense, the playing children in the castle may be understood as representing the vital existential choice between group and gang; the dolls playing with each other equaling siblings acting as a gang, keeping out the part of the therapist-policeman able to help.

Thus *in conclusion*, I conceive of the policeman-therapist entering the scene as a small but nevertheless helpful contribution to method with children liable to

violent assaults at the therapist. Working through with violently abused children like Samantha not only concerns the therapist's ability to help the child come to terms with terrible pain of loss and separation; it also concerns bringing to the child's attention *the need for a regulatory, firmly paternal state of mind, putting a stop to mindless enactment of violent identifications*. Thus in line with Houzel, I assume a paternal element needed in order to regulate out of hand remains of early phantasy of an endangered self violently pushed out by rival sibling figures of the assumed maternal nest of plenty (Houzel 2001, 2008; Tustin 1972).

Carlberg studied *turning points* in a study of a number of child psychotherapies; showing these to play an important part in therapists' systematization of complicated interactional processes in the transference relationship (1997; 1999; 2009). He defined a turning point as "*a session in which the therapist notices that something qualitatively new may be identified concerning the behaviour of the child or the child's way of showing her/his inner world, or in which something new enters the interplay between the child and the therapist"* (1997 p. 237). Among conclusions of the study, what for a start may look like negative turning points, later on often turned out to be part of a process leading to benign change.

In this therapy, the described *countertransference crisis played an unavoidable, probably essential part* created by an intensive concentration of Samantha's projective identifications; in her phantasy more and more equalling between the therapist and violently hostile objects wreaking havoc in internal and external relationships. Bothered as I was by her violence, nevertheless the intensely dramatized transference-countertransference roles of this crisis seemed to offer *a chance for a second working through of difficulties of introjection and containment*. As noted, during the same period Samantha's relationships outside therapy reportedly

greatly improved, apparently in a lasting way, which seemed to bear out that important changes did in fact take place in her inner world.

This comprehension implies *a certain parallelism to Freud's original notion of an intensive transference crisis*, the relationship gradually intensifying until reaching a peak; the patient with a new desperate intensity repeating rather than remembering his subjective infantile sufferings and conflicts, for a time experiencing these as originating in his relationship to the therapist. Questions of whether and how such a notion may or may not be applicable to psychoanalytic child psychotherapy have been widely discussed; however, it takes me too far off the point to go further into this possibility (A. Freud 1927; S. Freud 1917d, Klein 1927a, 1955a; Sandler et al 1980).

5.4. The triangular structure of change

The therapist mentally had to stand in for Samantha's whole family in order to create a relation in which she might work through the painful issues at the core of her violent behaviour. Especially during the countertransference crisis, central dilemmas related to mental survival of an infant in a grossly violent family reworked; the crucial feelings worked through repeatedly in relation to the therapist, who in this process had to take upon herself the differing roles as experienced in family life.

This probably was what Freud essentially meant by the term *"working through"* (1914). Working through core object relationship issues has a parallel in normal early development, as the baby and its family, especially mother and fa-

ther, again and again go back to the same issues, covering the same ground, working through over and over again, at times despairing like e.g. "will this child ever be able to sleep all through the night". Samantha was offered no such possibility of working through in infancy, and so in the therapy these parallel issues recurrently had to be repeated, as they kept popping up and in ever more intensive ways forcing the therapeutic couple to go back and have yet another go at working through.

The child's preoccupation with the relation to the therapist makes possible working through *the specific conditions for oedipal development of fostered and adopted children*. This include e.g. phantasies and thoughts about being rejected by birth family; taken in by foster family; confusion about who is to blame for the disillusionment relating to family romance; as well as related phantasy about how would life be as a child in the family of the therapist. Canham (2003) linked such preoccupations to the working through of the Oedipus complex; suggesting particular difficulties because the parental couple in the mind of these children often are unable to make space for a third, containing the psychic reality and feelings of their infant-child; therefore not able to allow this child's separateness. Samantha's inability at session beginnings to look at me may be an indicator of such oedipal phantasies; presumably representing awful phantasies of an infant scared stiff and all eyes, from an abandoned distance watching the veiled sight of a self-preoccupied, terrifyingly violent parental couple. Thus at the core of oedipal phantasies of fostered and adopted children may be an abandoned infant, *unable to inspire the look of love in the eyes of the parents, instead inspiring abuse and rejection.* This understanding would corroborate Canham's suggestions, linking the oedipal phantasy of fostered and adopted children to the paranoid father of the

infant Oedipus, in the myth abusing his baby, leaving him helplessly to die at a mountainside (Canham 2003).

Quite early in this difficult therapy, reported events occurring outside therapy indicated the emergence of more hopeful oedipal phantasies e.g. Samantha collapsing in the foster mother's arms, genuinely and disconsolately sobbing for her lost daddy figure. This crying in the arms of the foster mother for her absent birth father seemed reminiscent of reports from infancy, the residential institution describing the 2-years-old Samantha securely placed at the lap of her beloved first special teacher, pining for birth father. A similar instance might be the reported fantasy of the self in unison with her birth sisters rescuing from drowning the good birth daddy. These events probably heralded the early beginning of a capacity for relating to the foster parents as a couple, a budding capacity for reparative phantasy occurring in a context of splitting as evidenced by Samantha's concurrently fierce rejection of foster father. Presumably, these events also show Samantha outside therapy quite early able effectively to communicate unconscious hopes for a secure and close position not only in the foster mother's mind, but also in the mind-space created by a benign parental couple (Britton 1989, 2001).

I have elsewhere described a quite similar situation; another child who likewise had suffered early abuse and neglect reported early in her therapy at home collapsing in her mother's arms; while vehemently sobbing for a gone-away family member, quite ready to be comforted in the arms of the available parental figure (Grünbaum 2010b). Hence, in line with Gaensbauer (1995) I assume such events to signify the ice about to break, the child at this point ready to experience and communicate to real-life loving parental figures the full force of traumatic loss and desolation. The event of mother and child able to share the genuinely

comforting experience of a containing relationship seems so terribly important to their future relationship.

Concurrently with this benign development, an increasingly fierce splitting process began, presumably in line with the bi-triangular pseudo-oedipal structure described by Green (1975, 1977). Here may be remembered the infant Samantha's reported tendency to go astray seeking out strangers during the long summer break of the third year of therapy, shortly reappeared as a risky tendency to approach male strangers. At this point, Samantha's relation to the foster father and the couple much improved, she was still terribly anxious; inside therapy completely identified with a split-off all-bad daddy-parental couple. In the therapist's absence, Samantha unable to get relief from early memories of terrifying violence, she presumably unconsciously relapsed into looking for a containing daddy-therapist outside the foster family; maybe in a depressive attempt to spare the good foster father and couple[144].

The triangulating role of teamwork

Maybe the most extraordinary result of this study is the finding that to this child, who early suffered abused and abandonment, the identification with a father apparently did not appear from within therapy; rather *the first precarious beginnings of the early Oedipus complex originated in Samantha's external world, from the outside as reported by her external network.*

[144] This finding is consonant to findings of academic child psychology that a tendency for uncritical relationships in infancy are extremely perseverant and difficult to change, often persisting long after attachments to adoptive or foster families have developed (Chisholm 1998).

In *conclusion*, the huge importance of work done in *the network* not only extends to keeping the therapy afloat through rough periods of splitting; rather its scope is much more complex. At its best, a dedicated, creative teamwork effort may *function like a powerfully shared parental mind-space*, until such a time that the child unconsciously is ready to let go of horror-stricken identifications with violent parental figures. At this point, *the containing function of the external network became pregnant with the wishful possibility not only to have a father, but also to have a good father with whom one may need to identify*. The thinking of Henry Rey may contribute further to this understanding, suggesting that simultaneously with the infant's early paternal identification, the father comes to play an essential role in the baby's growing abilities for representation, symbol- and language-formation (1994). To cite Rey himself: *"As father gradually becomes an important object, symbol-formation becomes in part linked with father, or in Lacanian terms, with "the name of the father"* (p.5). In accordance, a very important strengthening of Samantha's explorative urge, testing and mourning the reality of her personal past, followed triangulation early in therapy.

As a therapist, I learned so very much from this difficult therapy. Going through rough periods, at times the process was so very painful to live through and tempting to give up. So what made it worthwhile for me to go through the ordeal of psychotherapy with this child? I believe part of the answer to be given above, *the rewarding experience of real turning points illuminating why and how one manages to stay on as a therapist*, even with very difficult patients.

To this end, *the work done in the network is of paramount importance as a potential source of supportive reality testing;* e.g. to keep up courage when you feel the therapy to hit rock bottom, it helps to be made aware of the improvement

outside therapy as reported by the child's daily relationships. The most important thing however, probably was that Samantha and other children like her taught me how marvelous it is to see real change happen. Hence, at one level this report is about the recovery of a child, but at another level it also is about the recovery of a therapist; as implied by the complex task of how to learn from the experience of such a burdensome therapeutic effort. I learned so much about myself from the mental work necessary to survive as a therapist i.e. as a separate being, able to differentiate myself from the therapy, and in the end to let go of a dear child that by now fully has joined the human family of reflecting, loving and therefore longing individuals relating to each other[145].

A parallel, even more amazing fact was that people in the network around Samantha never gave up, but were able to keep up their interest in her for long stretches of time. This was so from the therapist-after-the-therapy doing this study; the foster parents still having her 2½ years later at follow up; and even to the community worker who almost miraculously turned out to be the same as before, when I decided to research this case. It is highly unusual for children like Samantha to produce such faithful continuity in the professional network; and it may very well serve to illustrate the amazing resilience of this child, she herself doing such a tremendous effort to recover loving resources, crumbled and buried beneath the smoldering embers of crushing disillusionments.

[145] This of course does not mean that one believes the child to be entirely without problems from now on, see chapter 4.5.

6. IPA IN THE PSYCHOANALYTIC CASE STUDY – IMPROVEMENT OR LOSS?

In this section the merits and problems of the applied qualitative case study design and methods are discussed.

Box 25: Research question **IPA and the psychoanalytic single case study**
Whether the scientific credibility of the psychoanalytic case study may be improved by a systematic application of qualitative research methods, to be exact the strategy of Interpretative Phenomenological Analysis as applied for the inductive analysis of part of the clinical data in combination with deductive analysis performed on other parts of these data.

In general terms, this work followed Yin's definition of a case study as *"an empirical enquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident"* (1994, p.13). Such an inquiry is characterized by complexity, coping with clusters of interrelated variables rather than clearly circumscribed, unambiguous data points; consequently relying on multiple sources of evidence, data collection and analysis guided by theoretical propositions. Elliott et al (1999) described the aim of qualitative research as understanding and as far as possible to represent from the perspective of those being studied *"the experiences and actions of people as they encounter, engage and live through situations.."* (p. 216). The ideographic nature of qualitative research is concerned with the unique experience of the subjects to be studied; in a sense the researcher inventing and reinventing applied methodology, customizing afresh the chosen approach to suit the

individuality of the single project and the researcher. Accordingly, no consensus is possible among qualitative researchers concerning appropriate evaluation criteria. The set of criteria presented are this researcher's personal adaptation of suggestions from a number of qualitative researchers (see 3.7. and box 12 below).

Box 26: Evaluation criteria adopted for this study

1) A clear vantage point, specifying the researcher's relationship to the case and sensitivity to context
2) An observing, reflective state of mind
3) Transparency and rigor of data collection, sampling and analysis
4) Procedures aimed at checking and triangulating the credibility of interpretations
5) Reflections on applicability, relevance and implications for the field of study

The aims of the below discussion are multiple; firstly from this platform to elucidate the trustworthiness of this study; secondly to relate to the initial research question posed (Box 13 below), discussing merits and problems found in this attempt to integrate qualitative research methodology and the psychoanalytic single case study. A summary of conclusions and recommendations appears at the end.

6.1. Vantage points, reflectivity and transparency

A fundamental dimension of the researcher's truthfulness concerns whether the study was carried out in a sufficiently reflective state of mind; throughout keeping up *an attitude of relative neutrality, appropriate cognitive doubt and reasonable*

freedom from unacknowledged researcher bias and allegiance. Since we all have to stand somewhere, pure objectivity not possible, the best way to approach this ideal state of mind is squarely to own up, not only to the aims and research questions of the study but also being as clear, specific and sensitive as possible about the context of the study and one's position vis-à-vis the problems to be investigated. Part of this already was provided in *section 3.1-3.3*. There is however no getting away from the uncertainty arising from the fact that in this study, *the therapist-in-the-therapy was also the researcher-after-the-therapy*. I have done my best to keep up *truthful neutrality* between on the one hand a hopefully disciplined, but still *subjective immersion* in the fine details and emotional imagery of the therapeutic process; on the other hand regularly *taking a huge step or more back* in order to contemplate the relation between myself and the case. But there are of course still plenty of risks that personal ambition and tendencies for losing oneself in the attractive regions of imagination may lead to fanciful interpretations not solidly grounded in the actual therapy. To domesticate these temptations, I checked myself by in various ways as described below.

This study led to valuable personal and professional insight, mitigating a supposed rift between *the neutrality of a conscientious qualitative researcher and a trained psychoanalytic child psychotherapist*; the learning that a common kite mark of quality to both are what Leuzinger-Bohleber et al called "*an attitude of exploration*" (1992, p.2.). The child psychotherapist learned to observe and let be, to let the child lead the process, from her observations making inferences about what interventions are needed from the child's point of view; tentatively trying these out, and observing the child's and her own emotional reactions. This is a circular, experiential process of cognition, the therapist all the time revising her

ideas in face of the child's reactions (Emde 1994). As so eloquently pointed out by Tuckett (1994a, 1994b), this inductive-deductive approach is the basis of psychoanalytic psychotherapy, the therapist in a state of contemplation tentatively formulating hunches, trying out in interpretative practice such intuitive strands or ideas coming to her mind. At certain points the intuitive strands may adhere, becoming what Tuckett designated "*clusters of observed clinical facts*" (1994a, p.1161).

The process of child psychotherapy implies a constant circular movement of cognition, tentatively trying out ideas, then checking these by observing the child's reaction; in this ongoing process producing still more empirically grounded and refined hunches again to be tested out in the face of new data. This is the fundamental principle of psychoanalytic child psychotherapy; it seems to me very similar to the analytic principle behind inductive-deductive strategies like e.g. grounded theory and the IPA. The emphasis of both on conclusions firmly rooted in empirical reality but also conceptually processed so as to allow for development of theoretical propositions. Therefore, I propose qualitative research and psychoanalytic therapy alike to build on a self-reinforcing process of exploration and context-dependent learning; along the way of discovery the researcher and the therapist getting more and more confident in her hunches. The researcher-after-therapy confronting the same ontological necessity as the therapist-in-therapy; the need mentally to separate herself from preconceived notions, approaching the data material from a neutral position, a reflective state of mind dependent on her ability to bracket preconceived classifications and constructs imposed on her perceiving, holding in abeyance memory and ambition, thus enabling a spirit of enquiry to arise (Bion 1967; Yardley 2008). At least a hint of impartiality suggested by the

ability of methods applied for this study to produce certain results not previously thought of by either the therapist-in-therapy or researcher-after-therapy.

6.1.1. The vantage point of countertransference recordings

The status of countertransference recordings as scientific preconditions for psychoanalytic case studies may appear dubious, at best highly complex. An obvious difficulty for the research process of this study – probably for any research process performed by the therapist herself - is the premise stated above; the nature of most countertransference phenomena in practice applying both to *unresolved issues of therapists acting as blind spots in their field of vision* (Freud's original vision of 1910), and to the *patient's unconscious projective identifications giving rise to corresponding feelings and fantasies in the mind of the therapist* (Heimann's later development of 1950). This is so because the therapist's personal vulnerabilities inevitably lead to a special receptiveness to the correspondent parts of the patient's problems. The highly subjective nature of a therapist's recording by memory of her own countertransference reactions can of course not be denied; and neither can the complications of a researcher-after-therapy investigating her own countertransference notes.

The writing down apparently had containing functions, applied when the therapist-in-therapy felt at risk of losing her mindfulness. Therefore, the researcher-after-therapy felt it a legitimate claim to consider the *notes concerning countertransference states clinical facts relating a first-hand-account* of what took place at certain critical moments in the mind of this specific therapist-in-the-therapy (O'Shaughnessy 1994). Relating to Bion's model of thinking as a premise for this

study, the researcher-after-therapy conceived of these countertransference notes sometimes to capture something more akin to hitherto disconnected experiences, separate strands at certain critical moments of the therapy coming together as meaningful interrelated understandings in the mind of this specific therapist-in-the-therapy. I therefore propose that countertransference notes are indispensable in certain moments intuitively gathering together, what in Bion's terminology may be considered *selected clinical facts* (Bion 1962b, p. 72-75; Riesenberg-Malcolm 2001).

A sine qua non both of psychoanalytic child psychotherapy and qualitative research is the need for their practitioners to be sensitive to their own position and the context (relationship) of which they are a part; the qualitative researcher e.g. recommended to keep *an ongoing self-reflective journal* possible to share with other researchers (Morrow 2005). The diary-keeping state of mind seems comparable to the child psychotherapist's careful recording of session process, especially the meticulous notes of countertransference. Apart from the obviously important function to keep up the containing state of mind of the therapist-in-therapy, with a view to research methodology it seems equally important that in this study, countertransference notes enabled the researcher-after-therapy to get distance to the therapist-in-the-therapy; furthermore making possible a detailed kind of auditing enabling the clinical research supervisor to get a comprehensive insight into the relational nature of events.

A limitation to the validity of this argument may be the *basic contradiction* in terms between a therapist's ability to stay in touch with the *intense emotional experience of countertransference and the approach of the researcher*, meticulously sifting through the details of the recorded notes. This work gave rise to a

kind of double identity which at times, I found quite disturbing, in some moments resulting in a quite unproductive rumination on details. Thus, a tendency not captured properly in the above analysis of countertransference findings is *a triple resonance of repetition compulsion on the ability of the researcher-after-therapy to write and formulate* concepts. While writing up this report, it dawned on the researcher-after-therapy just how much the tendency for repetition compulsion were part and parcel of the material resonating in her mind, e.g. to be able to write this thesis I had to fight ever so hard to contain a tendency to chew endlessly on the same bits of information, quite similar to the tendency described by the foster parents for Samantha to ruminate endlessly on the same bite of food. In fact *the conceptual differentiation* applied throughout this report, *distinguishing the therapist's perspective from the researcher's was begot while struggling to keep at bay the futile echoes of repetition compulsion*; this distinction offering a position of some mental distance to the therapist's immersion in subjective experience.

This process of discovery took place at *three levels of cognition*; i.e. *in the mind of* 1) *the therapist-in-the-therapy;* 2) *the therapist-between-sessions recording her memory of countertransference;* 3) *the researcher-after-the-therapy scrutinizing the written countertransference facts.*

The *first level* consisted of *what took place in the mind of the therapist-in-the-therapy*, at such moments inside the session when hitherto separate strands, ideas, feelings and thoughts about her own state of mind suddenly popped up as a whole experience, sufficiently integrated to be available for memory and thinking, about how this new discovery in one way or another might be linked to the therapeutic relationship and process.

The *second level* consisted of the *therapist-between-sessions recording her memory* of remembered countertransference. At this point the discovery (unconsciously) slightly altered, whether in the direction of further integration, or at the opposite end in the direction of fragmentation as e.g. evidenced in my tendency to forget the verbal dialogue of especially significant moments. There may be a general risk related to the ordinary human tendency for the creation of narrative meaning, the mind of the therapist unconsciously retrospectively adding cohesive meaningfulness. This tendency is however also a precious gift to be taken care of, according to Flyvbjerg a sine-qua-non for any case study researcher, as without this ability to comprehend and create narrative links we would not be able to grasp the complexity of any case worthwhile the study (2006).

At the *third level*, *the researcher-after-the-therapy scrutinized and pondered the written countertransference facts*. At this point, the concluded therapy existed both as a memory in mind of the therapist-cum-researcher and as a written text-document in its own right, including the original process notes. Time lag and the altered mental position from therapist-in-therapy to researcher-after-therapy offered a unique possibility of second thoughts, admittedly still of a highly subjective nature, epistemological rather than logical in their implications. However, as I hope this work to evidence, nevertheless able to come up with a few worthwhile new discoveries of the complicated nature of transference-countertransference dialogue.

The retrospective information of countertransference notes is indispensable both to the psychotherapeutic process and the psychoanalytic case study, opening up reflective vistas of new doubts and understandings to the researcher-after-therapy. As mentioned one such realization concerned *the implications of a con-*

taining function of countertransference notes, which at least to this child psychotherapist seemed to safeguard my mindfulness and ongoing awareness of the state of my inner space. This may seem a banality but important broader implications for the training of child psychotherapists are evident. If the containing function is valid also for other child psychotherapists with very difficult patients, this constitutes a strong argument to demand students meticulously to record detailed process notes; a tradition in the field of psychoanalytic child psychotherapy but for the time being running upstream to a certain preference among some (maybe solely Danish) psychology supervisors for introducing more technological solutions like e.g. videotaping sessions. The manifest argument presented for this, often is an idea of objectivity in research or personal feed-back to the students. Videotaping useful for certain research purposes; however as a tool of supervision (and for research into countertransference), the risk is that the focus on the interplay of subjective states of patient and therapist is displaced onto observable interaction; entailing the risk that richness of details inherent in the therapist's dual focus for observation is impoverished.

6.1.2. Transparency of selection and data analysis

In quantitative research, reliability concerns the demand that irrespective of the individuality of the researcher, a competent study if repeated with identical research questions, subjects, setting, and methods must yield identical results. Such literal repetition obviously is impossible to a qualitative single case study like the present, both because of the ideographic nature of the data (i.e. the therapeutic relationship as depicted in process notes) and the qualitative data analysis; neither

of which may be accurately reproduced, not even by the same therapist-cum-researcher. Even so, any scientific enterprise is concerned with the possibility to infer from a specific example more widely applicable knowledge and learning; this study no exception. Therefore, it may be asked whether this study was carried out and described with *sufficient care and transparency, enabling other trained child psychotherapists-cum-qualitative researchers to carry out comparable qualitative studies of the impact of breaks in psychoanalytic child psychotherapy*. To this end, as recommended by Tuckett (1994a) and Hiles et al (2007), research questions, design, selection and analytic procedures were described in details (see chapter 3); including a disquisition of the inductive-deductive analytic process of the IPA. Included also was a discussion of the scientific nature of recorded process-notes and the double roles of the therapist as researcher of her own case. I will not repeat here these rather wordy explanations, just mention that their aim was to provide as far as possible an insight into how I got from raw data of the case to conclusions.

An area of special concern to the rich individuality implied by qualitative research methodology is whether the study contains *empirical saturation of interpretations and categories*; findings and conclusions sufficiently garnished with relevant examples (Smith et al 2009). This is especially so in a psychoanalytic single case study, in which rich case information is vital to give the reader a chance to make up his own mind about the interpretations of the case (Edelson 1985; D.P. Spence 1994b; H. Spence 1994; Leuzinger-Bohleber 2006).

At the same time, it is necessary to keep balance between the researcher's interpretations and supporting quotations from case data and interviews. An over-reliance on researcher-interpretations leaves the reader in doubt as to their credi-

bility; but then an excess of quotations achieves the same result, the reader lost in details (Morrow 2005; McLeod 2011).

The solution applied in this study is to allow in the text relatively few direct quotations from session notes; more often providing a reference to corresponding session numbers; the full quotation of relevant relationship episodes to be found in the appendix[146]. Somewhat more quotations from the follow-up interviews are included in text; the full transcripts appear in appendix together with schemes depicting shortened time sequenced extracts of other case file documents. The comprehensive effort of documentation means that the appendix swell, creating another risk namely that critical information needed by other similarly preoccupied case study researchers disappear in the bulk of details. I hope this did not happen here.

6.2. Credibility of interpretations and conclusions

The corresponding concern of quantitative research is validity, referring to a consensus among researchers stipulating unambiguous procedures by which sets of scores are compared in order to establish the truth value of a study. Since qualitative researchers compare words and concepts rather than scores, procedures to affirm credibility are more indistinct, in large measure depending on transparency and rigor of applied methodology as well as plausibility of results. In the end it comes down to a matter of trust, i.e. if the personal integrity, honesty and relevant

[146] Similar recommendations of documentation in the appendix may be found at *www.pnarchive.org/docs/ppt/Assessment_criteria_CA.ppt (© Copyright 2011, The Higher Education Academy Psychology Network was based at the University of York between 2004 and 2011; Latest download July 16th 2013).*

skills of this child psychotherapist-cum-researcher is to be trusted by informed readers, in this case other trained child psychotherapists and qualitative researchers interested in psychoanalytic single case research. However, truth value established solely by listing a number of people in agreement with a certain point of view has its limitations as evidenced in continuing discussions concerning the credibility of psychoanalytic theory and research (Edelson 1988; D.P. Spence 1994b; A. Grünbaum 1997; Fonagy 2009)[147]. Keeping a balance between trust and suspicion; a discussion of credibility must include topics related to efforts of *triangulation by reviewing data from multiple perspectives*[148] (Yardley 2008). These efforts included:

1) A set of *longitudinal data* covering the life span of the child from infancy to 12 years of age; these data *gathered at different times; in different ways; from different sources*. The nature of these data was already detailed and discussed.
2) *Presence of other trained minds* in the analysis of data.
3) *Disconfirming case analysis*.
4) *Systematic exploration of the process of change.*
5) *Comparison to similar research designs.*
6) *Affinity between conclusions and the general body of psychoanalytic theory and method* is considered an important criterion for the validation of psy-

[147] Morrow (2005) referring to *intersubjective or social validity* recommended qualitative studies to include a researcher-as-instrument statement. In this study, section 2.1.1. may be considered part of such a statement, specifying the therapeutic experience and attitude of the therapist; of relevance to previous qualitative research experience may the researcher's publications of a number of qualitative studies, most but not all psychoanalytic single case studies (Grünbaum 1977, 1993, 1997, 1998, 2010a, 2010b; Grünbaum et al 1989).
[148] *Triangulation* as defined in section 3.7.

choanalytic case studies; this item has broader implications and will be discussed in the final section of this chapter.

Relating to *triangulation by the presence of other trained minds*, one may question why coding were not checked by one or more external researchers. This question is discussed below. The *crucial role of supervision in the psychoanalytic case study* already mentioned, it may be appropriate here to recapitulate its meaning in relation to the described turning-point of this therapy; the therapist-in-therapy confronting the child that she had developed an increased ability to contain her feelings and therefore might behave herself (sess. 178 above). The full implications of this intervention were not at all clear to the therapist-in-the-therapy; even the researcher-after-therapy not fully grasping its importance before made aware by the supervisor of the research process. Illustrating a point by Greenberg (1994), this brings to mind the importance in psychoanalytic research to be aware that the differing vantage points of therapist, supervisor and researcher foreground certain parts of the therapy more than others. The therapist-in-therapy at times is bound to become lost in the rich details of the sessions; although reviewing the data from the distance of time, certain countertransference issues still reverberating, in addition the researcher-after-therapy needs the triangulation offered by a trained supervisor.

6.2.1. Disconfirming case analysis

Marshal Edelson (1985, 1988) advocating a point of view largely derived from Karl Popper's dictum of falsification, suggested any serious case study researcher

to make a real attempt of placing at risk her interpretations of assumed links[149]. Thus, it is not conclusive to show the preferred assumption to offer a good explanation of the observed events; one must also formulate a plausible rival hypothesis and show that given a genuine possibility for success, the rival assumption is less able to explain these observations.

In relation to breaks, as showed in the theory review, abundant case studies provide examples of breaks in therapy to be preceded and followed by increased anxiety in the patient. At the outset of this investigation, in line with most authors writing on breaks I assumed these reactions to be caused by the absence of the therapist stirring up separation anxiety in the mind of the patient. However as shown above, since my design included an exploration of the therapist's reactions to breaks, it was possible also to check an obvious rival assumption, namely that at least this therapist also contributed. In exploring this, I discovered that although both the patient and the therapist reacted in ways easy to capture in before-break sessions; their reactions were of a widely different nature, suggesting a complex two-way relationship. Thus in this instance, checking a rival hypothesis in fact led to a third, more complex understanding. Not in itself conclusive, I hope the findings of this qualitative study to contribute to stimulate further studies into the complicated effect of breaks on the relationship between therapist and child.

Also other attempts at falsification were integrated in the research design. Possibilities to show breaks to have no discernible impact thus were part of the research design, as inspired by the symptom-context method developed by Luborsky and colleagues (Luborsky 1997, Luborsky and Luborsky 2006); this

[149] The dictum that a general theory cannot be proven true; but if a prediction derived from such a theory can be proven false; then it may be concluded that the general claim of this theory is false; just like the observation of even a single black swan effectively will falsify the assumption that all swans by necessity are white (Guba et al 1994; Ponteretto 2005).

possibility was systematically checked by comparing breaks and no-breaks in a time-sequenced selection of data material. The construction of a primitive version of the Likert scale, including opposite behavioural categories offered some possibilities for falsifying deductively derived assumptions concerning expected and unexpected behaviours on the relational themes of the IPA. Finally, the initial assumption that hostile parental and sibling figures would increase in numbers and intensity before and after breaks were falsified through systematic frequency tallying of figures appearing in relationship episodes (see below).

The *extraordinary ability of the IPA to produce unexpected results* contributed much to the credibility of this study; the researcher-after-therapy at the outset of this exploration not even dimly aware of the relationships to be uncovered. Thus, among surprising results were the central role played by hostile sibling figures in the mind of this abused child; the emotional quality of parental figures as decisive for the eruption of hostile sibling figures; the functions of distance related counter transference reactions; the affinity between breaks and session beginnings and endings; and the special status of before-break sessions to unearth the complex relationships between symbol formation in the mind of the child and the therapist's experience of cognitive countertransference confusion.

The truth claim of a qualitative single case study relates to *which kind of truth* this may represent. In line with the reasoning of Flyvbjerg (2006), I suggest that the present case study may be considered *a critical and an extreme case*. It seems a *critical case* in the sense that the results (if to be trusted) falsify any assumption that to all children, sibling relationships have a developmental line independent of fundamental care relationships. It seems an *extreme case*, in the sense that since abandoned foster-children may be assumed to have a specific sensitivity

to neglect and inattentiveness, this case study may be assumed especially clearly to elucidate the emotional quality of the lived but not necessarily conscious experience of breaks in the therapy (Ponterotto 2005).

6.2.2. Systematic exploration of the process of change

The inclusion of data which covered the whole therapy made possible *a systematic sequential analysis of* sessions. These were selected according to a theoretical point of view and regularly spaced in time thus enhancing possibilities that variations found were not produced by accidental variation (McLeod 2011). This systematic approach made *the construction of the relational mapping chart* possible; and thus enabled a systematic exploration of in-session change. This e.g. showed hostile parental and sibling figures although common in the same relationship episodes right through therapy; in time the in-session chains of hostile relationship episodes disappeared as did also the therapist's distance-related countertransference responses.

The inclusion of certain *frequency tallies* made possible an assessment of *common versus outlaying phenomena,* i.e. systematically counting the frequency of certain phenomena, assessed as central to conclusions from a theoretical point of view (Yardley 2008). This presented an opportunity to challenge the notion that the most frequent also is the most important aspect of the data; e.g. as relating to purely good parental figures, who were very seldom seen but whose presence even so seemed to have important protective functions, evidencing some more ordinary abilities for splitting, idealization and longing. Another example was the

turning point in this therapy, singular and significant to the process, however occurring only once.

Such counting essentially belongs to a quantitative tradition and may be considered an irrelevant, disturbing avenue to pursue; even so, some counting seemed appropriate in order to provide internal credibility checks. To give an example, the emerging assumption that the emotional quality of parental figures to a large degree was decisive for the appearance and quality of sibling figures was derived from the IPA on the basis of a chain of events in specific sessions. I might have delimited my checking of this by searching for confirming session examples in later Christmas break-sets; however since a certain doubt of the credibility of this reasoning kept returning to mind, I decided to check if this pattern also would appear obvious in a quantitative analysis of session data; therefore counting parental and sibling figures, as occurring in relationship episodes alone or together through the time sequence offered by the 24+24 selected sessions. This convinced me that disconfirming events, sibling figures standing alone with their own quality practically were non-existent.

It might have been possible to endow such frequency tallies with more formal procedures to check the credibility of coding; letting one or more independent researchers code the data, comparing their codes to determine statistically the level of inter-rater agreement (reliability) between codes. *External raters* were e.g. part of Moran et al's seminal studies of the effect of interpretation in psychotherapy with diabetic adolescents (1987, 1991); and also part of Philps' study of depressive versus paranoid-schizoid phenomena in the therapeutic process with children in temporary foster care (2003, 2009). Statistical procedures like these provide assurance that the recording of the phenomena in question was performed

in a systematic manner that may be repeated by another coder (Yardley 2008). There are several reasons why I decided not to supplement this study with similar methods. One reason, this kind of statistical analysis requires simple codes that can be easily and strictly defined, which would pose a problem to this primarily qualitative study. Another reason related to the extra resources needed to enlist other qualified researchers in this quest as compared to the possible gains for this primarily qualitative study. Even more important were the consideration that following the principles of qualitative research, I was not looking for the frequency of specific circumscribed content but rather for more general themes, links or meanings occurring across the different kinds of material included in this study (i.e. the therapist's process notes, the reports from daily caregivers and the transcripts of follow-up interviews). The counting thus were but intermediate steps in the analysis; something done to check my fancy, providing a kind of baseline before allowing myself to engage into further qualitative sifting and ordering, aimed at the identification of themes and patterns; this process of qualitative rumination that in McLeod's words may lead to a "*massive expansion of the text*" continuing to "*a point of frustrated overwhelmed despair*" (2011, p.79)).

6.2.3. The child taking the lead – essential personal experience

To the researcher-after-therapy, sifting through the detailed process notes at times gave rise to something like *a eureka-experience*; probably corresponding to the phenomena Bion called *selective facts* (1962b, p.72), hitherto fragmented strands

of feelings and ideas by an intuitive, unconscious process suddenly linked into meaningful conceptual themes. The critical question of general importance to the psychoanalytic case study is how to distinguish between such selected facts and over-cherished ideas (Britton et al 1994). I believe the differentiation to rest on the precondition that the researcher has access to a sufficiently detailed richness of session notes; including meticulous descriptions of the therapist's countertransference and the child's response to the interventions of the therapist.

As described above, the child psychotherapist's way of working includes an ongoing circular process of cognition; getting to know the child's experience by tentatively checking out her hunches, then observing the next move of the child. This two-way communicative process contains certain *moments* in which the therapist's intervention gets a distinct answer; *the child in her own language responding to an interpretation by adding new, genuinely unique dimensions of personal experience, thereby spontaneously enriching the understanding of the therapist*. Several examples of this were provided in chapter 4; e.g. quite early in the therapy, Samantha in a clear and detailed way stating a wish to be "the first child to come" to mind of the therapist; at the end of this session in detailed play communicating a fervent wish to take in good, nourishing aspects of the relationship, playfully pretending bit by bit to eat up the therapist. Another example occurred in the turning point session, Samantha in her own words admitting to ferocious nightmares, thereafter playing at a policeman needed to stop the madman in the castle making a muddle of good experiences.

I suggest that on the condition of sufficiently dense descriptions of session notes, with some confidence such moments may be taken as internal checks on *the credibility of the therapist's intervention*; this *validated on the spot by the child's*

uniquely detailed response. The implications of such *genuinely mutative moments* are immensely important to grasp in any serious training of child psychotherapists, facilitating their awareness of children suddenly taking in an interpretation as something to grow on, taking the lead, detailing the issue in question by adding new aspects in their own language (Strachey 1934, Pick 1985).

6.2.4. Comparison to a mixed methods study

Another strategy to increase credibility may be to compare the research strategy of this study with other psychoanalytic single case studies combining a qualitative, inductive identification of therapeutic themes with a subsequent deductive assessment. The mixed method design of the above-mentioned predictive study by Moran et al (1987) may be an example. The researchers inductively identified 18 clinical dimensions in a condensed summary prepared by the therapist on the basis of treatment records from the psychoanalytic treatment of an adolescent with diabetes brittle. Ten of these themes were operationally defined; their appearances rated in the therapist's weekly summaries of sessions, prepared on the basis of notes concerning the single sessions. The ratings was performed by external raters first reading the therapist's overall summary of the therapy, then rating the ten themes in 148 weekly summaries according to the operational definitions. The strength of appearance measured on a five-point Likert Scale as ranging from "definitely present" to "definitely not present", the middle value "possibly present"; inter-rater reliability of scores calculated. Among results were *a quantitative time series analysis measuring the rated treatment variables against the varying blood sugar levels of the patient*; this achieving a quite concrete measure of

change, especially pointing towards *interpretation of conflict as strongly associated with improved diabetic control*.

Taken on face value, some similarities between this approach and the method applied in this study seem obvious, especially the inductive identification of themes defined in behavioural terms; their presence/absence in the material assessed. From a quantitative point of view, a serious shortcoming of the present study is the absence of a systematic validation of codes to be used by independent external raters combined with proper statistical procedures to assess reliability and significance. The choice of a three-point Likert-scale as compared to a five-point scale also may be considered problematic because weakening of power to differentiate. However, from the standpoint of qualitative research, there is a fundamental difference between on the one hand a *hypothetical-deductive model and a probabilistic, quantitative approach* and on the other hand *a qualitative model and an Interpretative-Phenomenological approach* e.g. in aims and questions; the way raw data material are selected and processed; the analytic principles; and the applied checks of validity/credibility. A discussion of the proposed dissimilarities appears below.

Selection and processing of raw data: The fundamental choice concerns selection and analytic strategy, working with raw session notes or prepared summaries; specified or unspecified principles of data analysis. Moran et al extracted therapeutic themes from highly prepared data material, namely a summary of the total therapy prepared by the therapist; their chosen themes afterwards rated in weekly summaries i.e. essentially the same material. The present study worked inductively with the original, detailed process notes, a sample of the first 24 sessions (sample A). Each session in sample A qualitatively perused in accordance

with principles of IPA, the analysis slowly moving from raw data to keywords to emerging themes and at last to a final masterlist of relational themes; from start to end closely linking to the empirical evidence of the process notes. In contrast, Moran et al did not specify the applied analytic principles of the extraction; the themes decided upon were highly infused with psychoanalytic theory, links between the final list of themes and raw data undisclosed, as were attrition rates of original session notes and weekly summaries.

Applied checks on validity/credibility: Both studies operationally defined the therapeutic themes, assessing their presence-absence by the use of a Likert scale. In the present study, coding performed by the therapist-cum-researcher herself; in Moran et al's study performed by external raters. The operationalized themes were studied in quite different kinds of material. Moran et al again used prefabricated data material; weekly summaries prepared by the therapist, a quantitative time-sequence of the strength of occurrence of operationalized themes established. The present study assessed presence/absence of themes in five different data pools, among these two different selections of the original, detailed process notes:

1) The original data of 24 first sessions (sample A);
2) A theoretically informed new selection of a time-sequenced sample of another 24 sessions (the Christmas break-set sample D).

Since themes from the therapy were formulated in general everyday language their presence in reported everyday relationships could also be assessed, and accordingly three further data pools were included, namely

3) Case file documents of early relationships (Sample B)
4) Network reports of concurrent daily relationships (Sample C)

5) Transcripts of follow-up interviews with birthmother and foster parents (Sample E).

Qualitative analysis of time-sequenced patterns or statistical calculation of time series co-variance: The present study coded each therapeutic theme into mapping charts, depicting for this theme the occurrence of positive, negative, and neutral incidences in relationship episodes of the single sessions; the new sample D and the initial sample A both charted, creating a time-sequenced overview of each theme in the two samples. These overviews of themes were subsequently studied, looking for clusters, patterns and change in patterns over time, singling out specific points of interest to be qualitative investigated. The thus selected original session notes of the two samples once more perused and compared. By contrast, Moran et al assessed a quantitative measure of intensity of themes, by a statistic time-series analysis ingeniously comparing the fluctuations between themes and a weekly index of blood-sugar levels.

Credibility or validity: Thus all in all, the present study established credibility by the inclusion of detailed session extracts, documentation in appendix, transparency of selection and analytic methods, triangulation by multiple perspectives and informants; and looking for disconfirming evidence. Moran et al primarily documented validity by assessing statistical inter-rater reliability and significance of co-variation.

Notwithstanding the efforts of *both studies* to include procedures to enhance trustworthiness, and in the qualitative study efforts of including contradicting examples; the method in both studies are open to criticism that the researcher always will be able to find, what she looks for (A. Grünbaum 1997). The inclusion of

external raters and a five-point Likert scale in the present study might have improved internal validity of causal inferences drawn from one part of the case study to another part. However, such refinements of the measurement instrument will improve neither the fundamental validity of the scheme nor decrease the risk of begging the question in a circular way. The solid anchoring of Moran et al's study in the undisputable, external reality of biochemical measurements of blood sugar level is highly ingenious. However, in respect of the validity of what did in fact happen in the psychotherapy, this was weakened by the fact that Moran et al based both the inductive and the deductive analysis (looking for themes and trying out themes) on the therapist's summaries of sessions. Thus even if external raters were used, this doesn't do away with the problem that building the analysis on prefabricated data, a condensed paper and weekly summaries, will decrease transparency of selection and analytic procedures and increase the risk of an allegiance related bias, the therapist telling you what he thought he did rather than what he did.

6.2.5. Qualitative methodology – enrichment or depletion?

The common concern of qualitative studies is people's grasp of the world and their lived (but not necessarily conscious) experience (Ashworth 2008; Giorgi et al 2008). From this perspective, the psychoanalytic case study may be considered one among many different qualitative approaches to how this grasp may be conceptualized and investigated. Accordingly, this psychoanalytic child psychotherapy case study may be considered an *enquiry into the subjective experience of relational phenomena taking place inside the playroom between a child and a psy-*

choanalytic child psychotherapist; the relation governed by the "laboratory conditions" of the standard setting and principles for the practice of psychoanalytic child psychotherapy (Michael Rustin 2001, p. 79).

In some respects this case study followed the tradition of the psychoanalytic case study; in other respects principles adopted from IPA were applied. Partaking of the tradition of psychoanalytic research, a precondition for the study was the *subjectivity of the researcher-cum-therapist;* the researcher also the therapist, main part of included data was her own detailed session records of what had taken place in the sessions. Another characteristic common to psychoanalytic case research concerns the *research motivation*, psychotherapist-researcher most often concerned with her relationship to the specific case or class of cases. The motivation for most of my own former case studies thus were closely *linked to the experience of something unfinished, unusual or especially trying staying alive in my mind, giving rise to specific questions to be explored for the benefit of my own professional development*, but hopefully also to the development of the professional field. The motivation for this case study was no exception.

However, apart from these basic characteristics relating to the nature of data and research motivation, the principles of qualitative method were observed. In accordance with the principles of *IPA*, this study combined an initial inductive with a deductive investigation in which the meaningful concepts, derived from the inductive part were given further meaning by being sought for and further elucidated in other parts of the case material, obtained from different informants.

A necessary question concerns the consequences for the psychoanalytic case study of the importation of a foreign methodology like the IPA, adapted from an academic rather than therapeutic tradition. There may be a risk that the combina-

tion of psychoanalytic and qualitative rigor yields an impoverished, oddly composite result not unlike the sad mock turtle of Alice in Wonderland, forever bemoaning its loss of genuine richness, sophistication, and coherence. This question really can only be answered by the evaluation by other trained psychoanalytic child psychotherapists.

However, from *my own previous experience as a psychoanalytic case study researcher*, it seems to me that at the basic level of cognition, more similarities than discrepancies are apparent between the approach of the psychoanalytic case study researcher and the basic requirements of qualitative methods. Generally speaking, both approaches demand the researcher to keep an open mind, in a spiral movement numerous times going back and forth between hunches and their empirical (clinical) basis; in several readings comparing the original, unprocessed empirical case data to the formulation of ever more refined conceptual links, attentive to all aspects of the process notes, keeping at bay preconceived ideas and theoretical assumptions until rather late in this process. This personal conception of psychoanalytic case research is in line with recommendations by Tuckett (1994a, 1994b) and Edelson (1985, 1988) to ground clinical concepts and conclusions in a solid body of raw case data, not foreclosing investigative procedures by mixing up theoretical constructs in the observations of the consulting room, making an effort to identify observable, non-theoretical occurrences of the phenomena in question. This study convinced me of *two central advantages of the integration of IPA methodology in the psychoanalytic case study*, namely 1) *systematization of the explorative search strategy* and 2) *the transparency of selection and analysis*:

1) *The systematization of explorative search strategy*: In my previous case studies, the unfinished business the motivation for the study, this became quite a goal-directed aim, a preconceived lens narrowing my readings of case notes. With this in mind, I primarily looked up related topics in session data; scrutinizing these, to gain further understanding of their meaning in the context of my own interventions and their relationship to the child's needs. In this way, researching, learning, and writing up several case studies e.g. concerning the relationship between early trauma and blocked or merged states of mind (1989); containment of a workable child psychotherapy setting for children in severely traumatized families (1998); and frozen silence in psychotherapy with severely traumatized children and adolescents (2010a, 2010b). The risk implied by this method relates to the delimitation posed by the initial unfinished business on the outlook of the researcher. Paraphrasing A. Grünbaum (1997), this method entails not only a risk but rather a certainty that even if the researcher may unearth valuable insights, she will not be able to find links that she did not go looking for. Thus *an important learning gained from the use of IPA is its amazing power to establish quite unexpected links*, of which the researcher before the study was quite unaware (see below). This truly exploratory state of mind implied a painstaking, sometimes painful quest for knowledge, difficult to uphold in the face of unwelcome discoveries but nevertheless immensely enriching, *enabling me to really learn by my mistakes*.

2) *Rigorous demands for transparency of selection and analysis*: the demands of IPA forced the researcher to contemplate and document each conceptual step taken, from keywords to the last version of a masterlist, complete with documentation. This enabled a splendid overview, linking specific conclusions and

session examples; at the end of the study providing *a firm rooting of conclusions in empirical documentation*. One may question if such slow, time-consuming step-by-step procedures of inductive analysis really are worth the effort. I trust the results of this study to speak for itself, the master list not only providing *an easy overview of categories and related examples* but also providing a tool for further analysis; *a multipronged instrument of relational themes against which change as relating to breaks might subsequently be studied.*.

Proceedings of *the second, deductive part of the study* were much *closer to the usual psychoanalytic case study approach*, since here my reading of case notes was guided by preconceived notions. However also here, procedures imported from general qualitative methodology played a helpful role; stimulating my search for *outlaying and possibly disconfirming examples*.

6.2.6. Unexpected links congruent with psychoanalytic theory

The credibility of this case study not only depends on the therapist's commitment to the transparent rigor of qualitative methodology and a truthful depiction of her observations in the play room. It also depends on whether these observations are compatible with the general principles of psychoanalytic thinking and if not that a substantial explanation of the proposed divergence is offered as well as an elucidation of consequences. In this perspective it seems important that *fundamental, unconscious themes or dilemmas related to dependency-separateness were singled out as giving rise to a host of defensive phantasies and relationships*. The

investigation kept coming back to these questions, no matter from which angle or by which method I started; hence part of the credibility of this study is located in the psychoanalytic literature. The dependency-separateness themes in general terms may be thought of as common to all human beings, dilemmas more or less to be unconsciously reconciled through development. One aspect of related contradictions linked to *wishes for dependency versus fear of rejection;* another to *wishes for autonomy versus fear of separateness.* Neither from a Kleinian nor from a developmentally related self-oriented point of view will these themes come as a surprise; both assumed to represent unresolved existential dilemmas relating to *object dependency-separateness* (Glasser 1996; Klein 1957, 1963; Blass et al 1992; Blatt et al 2009)).

At this point, another critical question concerns whether the vantage point of the psychoanalytic researcher-after-therapy in some ways foreclosed the investigation, e.g. the researcher's assumption that the child's *early reactions in therapy might be informative of her later reactions to breaks*. From a Kleinian point of view one may assume the early transference relationship, if not the very first sessions to reveal if not all, then at least the most central unconscious relationship themes. This assumption was in fact part of the historical Freud-Klein controversy, namely *if unconscious transference tendencies are present from the start of therapy or first to form later on* (Klein 1955a; A. Freud 1966; Sandler et al 1980; King et al 1991). The IPA of the first 24 sessions did in fact point towards *very early occurrence, even in the first therapy session, of a recurring distance-closeness dilemma and predominantly hostile parental and sibling figures*. So how far was this the consequence of a researcher not able to find anything else than her pet theory? Of some importance here, this specific question was not in-

cluded in the investigative purpose of this study, and furthermore, the implications of these early strands had not been grasped by the therapist-in-the-therapy, first occurring to the researcher-after-therapy, several years after its end sifting through the bulk of impressionistic notes and keywords.

Other unexpected results, compatible with psychoanalytic developmental theory were related to a *close link found between parental and sibling figures*. This link was quite unforeseen by the therapist-cum-researcher; it was early predicted by the IPA of the 24 first therapy sessions, but deliberately set aside by the researcher, only to reappear surprisingly clearly in the subsequent analysis. This result of the IPA, the lack of distinction between parental and sibling figures, most convincingly substantiate the scientific rigor and power of the IPA-procedure. Thus leaving aside psychoanalytic theory, emerging as a conceptual link was the same lack of distinction between parental and siblings figures that later could be documented through narrative verbatim examples from the process notes. Furthermore, this link could be given a meaningful theoretical explanation in accordance with psychoanalytic theory. The detailed analysis of session data further elucidating just *how central a theme was the hostile quality of sibling figures in the inner world of this child*, who had suffered severe early abuse and neglect. Furthermore, among unexpected results also were decisive links between the desperately *hostile feelings stirred up by breaks, and the capacity of the transference-countertransference to transform these feelings into symbolic representations depicting sibling figures*.

One further interesting, not at all predicted find, even in a qualitative single case study like this it may be possible to come up with data corroborating the above mentioned *sleeper effect of psychoanalytic child psychotherapy*. Thus at

follow-up, 2 ¾ years after the end of therapy, this child was reported not only to have developed even further since the end of therapy, but reportedly still in the process of continual improvement. This effect might have been given further solidity if like in the above mentioned studies of depression and turning points, the qualitative analysis of reports and interviews had been supplemented by a simple quantitative before-during-after-and-later design applying validated rating-scales or psychological tests.

Taking seriously the exploratory nature of the IPA method – the results had to change my further course of action. Thus if taken seriously, the explorative aim and open nature of the IPA-analysis in its wake has to bring new learning to the researcher. To me this approach brought a number of quite new, imperative hunches or assumptions; a quite new level of understanding of the problem of breaks, which I had to test against the empirical data of my clinical case. There is an important point concerning the psychoanalytic case study method to be taken from this study, namely that just as is the case in the therapeutic process, *when something unforeseen turns up, case study researchers need to be able to change their perspective and therefore course of action*. The surprising results of the IPA, namely an in-depth analysis of such aspects of the transference relationship that I was not even remotely aware of before the study *in it confirms the immense, fruitful value of the systematic application of a rigorous qualitative method in preparing for a psychoanalytic case study.*

6.3. Research design - Relevance and applicability

This study a single case study, the resulting findings are concrete and context-dependent but hopefully may stimulate further development of the psychoanalytic case study method. Below, specific areas of possible significance to other psychoanalytic case study researchers are summarized and discussed.

The applied methodology combined the explorative powers and systematic rigor of IPA with the subjectivity inherent in the psychoanalytic case study. This brought about a surprisingly rich transformation of the raw case material (the clinical case file) into a coherent, detailed web of meanings, bringing forth themes well suited as the backbone of a psychoanalytic case study. The results made good sense from the point of view of both psychoanalytic theory and the experience of this particular psychoanalytic child psychotherapist. The *overall conclusion* therefore must be that *the application of qualitative rigor improves the cohesive, detailed texture of the psychoanalytic case study, giving it a firm and transparent anchoring in the therapeutic data from which it is constructed*.

The *surprising ability of the IPA to bring forward unexpected findings* was a striking, not foreseen result. The unexpected results brought out in details psychoanalytic meaningful core themes, decisively enriching both to the understanding of the child, the therapeutic relationship and what took place in the mind of the therapist. This design thus seems to facilitate new discoveries inside the psychoanalytic method; a result which hopefully may contribute to *the development of the tripartite unity of psychoanalytic theory, child psychotherapy practice, and psychoanalytic case research*.

Hence, through this study I learned with emotional impact the necessity that *the case study researcher-after-therapy approaches the case data in very much the same spirit of inquiry that they were collected by the therapist-in-therapy,* keeping an open state of mind, focusing attention on the descriptions in process notes of relational events of the playroom. The most difficult part of this was in the spirit of Bion (1967) to set on stand-by the preconceived knowledge, ideas, memories and personal ambitions of the therapist-in-therapy; the researcher-after-therapy doing her very best to let the clinical data as reported speak for themselves (Bion 1967). As mentioned, this demands the psychoanalytic researcher *to hold on to a rather split and impersonal state of mind;* the researcher approaching the process notes as if these were conceived by another psychoanalytic child psychotherapist.

Hence, the distance-closeness dilemmas experienced by the therapist-in-therapy apparently reverberated in the mind of the researcher-after-therapy, challenging her ability to maintain appropriate mental distance from which to gauge the meaning of recorded case data. Important learning arose from the complexity of keeping one's balance between therapeutic commitment and the necessity of the researcher at certain points taking a huge step back in order neutrally to contemplate possible meanings. I am still amazed of the close similarity between a research state of mind and the introspective state of mind of the child psychotherapist scrutinizing in detail her own countertransference response. At the bottom line of this, a conclusion might be that *qualitative research methods* in the mind of the researcher-after-therapy may function as a benignly *triangulating third*, facilitating mental *distance and neutrality, enabling the transformation from therapist-in-the-therapy to researcher-after-the-therapy*.

The specific design developed; maybe appropriately named a *core-theme break design* combined an exploration in early sessions of core-themes whose later manifestations might be studied around breaks in the therapy. This design implied a possibility for a time-sequenced comparison of phenomena, allowing *causal inference*; e.g. falsifying an assumption that the emotional quality of siblings in mind in general may be independent of the emotional quality of parental figures in mind; this shown not to be true at least to the child included in this study. The specific nature of this child's early adverse relational experience may of course contribute to this finding.

An important finding was the development in reactions to breaks taking place over time; indicating the *core-theme break design* to be *a feasible method for the validation of therapies in ordinary private therapeutic practice*. Thus it seems that *ordinary breaks as occurring in any therapy may function as a convenient window, looking through which the therapist may be able to assess the state of core object relationships, thus keeping up a running evaluation of change*. If this finding holds true also for other trained child psychotherapists working with similar children, this design may provide a kind of time sequencing that makes it quite easy to evaluate change without the painstaking effort of going through the entire session material.

In this connection must be stressed the promising potential of the *relational mapping chart* as developed in this study; as an analytic instrument to single case study researchers presumably well suited for *a systematic mapping of the occurrence of almost any relational phenomena observed in a therapy session*. The relational mapping chart may offer an easy overview of both intra-session and inter-session change; exploring the development of a specific theme, it may be

used to pinpoint which sessions qualitatively to analyze in details. It may even easily be adapted to mixed methods combining inductive exploration with quantitative measurement and statistical comparison of the phenomena researched. The real inventor of the idea of a mapping chart was Philps (2003, 2009); the version here presented much simpler, making easier the overview but excluding the rich details presented by Philps. My hope is that this simpler version may be further tested and explored by other psychoanalytic single case researchers.

A final reflection concerns the *time consuming aspects of my design,* other case study researchers possibly discouraged by the effort of first doing an IPA, then constructing a mapping chart of relational themes to ascertain which part of the remaining data material to study closer. Presumably, *the initial number of sessions included for the inductive study might be cut considerably down*. Thus, in further studies of breaks it might be immensely valuable to try this out. In a quite impressionistic way, I informally experimented with this, inviting a small number of child psychotherapy trainees in supervision inductively to explore the first 5 sessions and an early and a later break in their therapies. The admittedly few and very local mini-projects left the impression that through the IPA it is possible even in such a delimitated material to find some corroboration that very early sessions points towards central relationship themes and related defensive organizations. After all, why should it not be so? However, it might be of huge interest if other researchers took this question further.

6.3.1. Questions for further research

The applied research design, for convenience called a *Core Theme Break Design* (CTB-D) combined an inductive exploration of core themes in early sessions with

a deductive study of later manifestations of these themes around breaks in the therapy. This inductive-deductive design made use of highly transparent, *strategic data sampling* allowing for a systematic *time-sequenced comparison of phenomena*, allowing *causal inference*. It may be adapted to qualitative or mixed-methods studies, thus allowing for nuanced methodological approaches being integrated. Thus from the dual perspectives of the psychoanalytic single case study and the study of breaks, it would be of major interest for the CTB-D to be *tried out by other case study researchers on comparable psychoanalytic psychotherapies with children with similar and different troubles*.

Another major methodological result of this study is the indication that a simplified version of the *CTB-D may enable child psychotherapy practitioners to assess their ordinary daily practice, keeping up a running evaluation of change*. Thus, breaks as occurring in any therapy may function as a convenient window, looking through which the therapist may be able to assess progress/backlash in the state of central relational themes. In this study was included quite an extensive bulk of session data, too comprehensive for ordinary use. Preliminary probing points to the possibility that *the number of sessions included for the initial exploration of core themes may be cut down considerably*. Hence, the possibility to include a smaller number of initial sessions with fewer break-set sessions should be tested more systematically and compared to other assessment methods. In this connection, it would be of some interest to investigate the affinity between the concept of relational core themes and the instruments applied for measurement of therapeutic alliance in child psychotherapy (Kjærgaard et al 2013; Shirk et al 1992).

On important result of this study was the development of the *relational mapping chart*; the potential of which should be further studied as an analytic instrument well suited for *a systematic mapping of the occurrence of almost any relational phenomena observed in a psychoanalytic therapy session*. The relational mapping chart thus may offer an easy overview of both intra-session and inter-session change; exploring the development of a specific theme, it may be used to pinpoint which sessions qualitatively to analyze in detail. It may even easily be adapted to mixed methods combining inductive exploration with quantitative measurement and statistical comparison of the phenomena researched.

Further testing out of different ways of linking psychoanalytic and qualitative research methodology seems to be of major importance to the future development of psychoanalytic case study research. In this study, the IPA showed a surprising ability to combine qualitative rigor (firmly anchoring the detailed texture of the psychoanalytic case study in the therapeutic data from which it was constructed) with the power to bring forth new and unexpected discoveries, congruent with psychoanalytic theory. Thus the personal learning gained from this project was the recognition that qualitative research methodology in the mind of the psychoanalytic researcher-after-therapy may function as a much needed triangulating third, enabling transformation from therapist-in-the-therapy to researcher-after-the-therapy. It would be of immense value to the field, if other psychoanalytic case researchers would take this challenge further.

More research into *different ways to assess and check credibility of the psychoanalytic case study* is needed. In this study, among several well-known methods applied were disconfirming case analysis, systematic exploration of the process of change, comparison to information from other data sources, comparison

to similar studies, and comparison to relevant aspects of the universe of psychoanalytic theory. In addition, a result from this study was that certain moments of the single therapy sessions provided an internal check on *the credibility of the therapist's intervention*; this *validated on the spot by the child's uniquely detailed response*, the child responding to an interpretation in her own language by adding new, genuinely unique dimensions of personal experience, thereby spontaneously enriching the understanding of the therapist. The precondition for this, the quality of process notes from therapy sessions, the detailed elaboration of which must be so as to provide sufficient specimens both of the therapist's interventions and subjective states of mind and of the child's distinct answers.

The nature of *central relationship themes and related defensive patterns in psychotherapy with children who suffered early abuse and neglect* need further research. This study indicates that among the consequences of early exposure to domestic violence, abuse and gross neglect may be early development of *a prevailing phantasy, ascribing loss of parental care to the presence of hostile sibling rivals, preferred by parental figures*. Since this result corresponds closely to Houzel's suggestions concerning central unconscious preoccupations of autistic children (2001, 2008), it is of importance to investigate if this inner scenario may be specific to these two groups of children or rather a more general disposition of children in psychoanalytic psychotherapy.

A quite convincing result from this study concerns *the primacy of hostile parental figures as compared to hostile sibling figures, whose appearance and emotional quality seemed heavily contingent on the appearance and quality of parental figures*. This seems highly relevant to an ongoing psychoanalytic discussion, whether the development of children's perception of the parental couple and

their perception of internal-external sibling relationships may be considered separate developmental lines or rather stepping stones on the same path of normal early object related emotional development. Further study into this problem apparently would be important; also to investigate the meaning of same-session relationship episode chains of hostile sibling-parent figures

Another salient result concerns *the relationship between the quality of caregiving relationships and the early development of ability to tell apart internal from external reality*. This result concerns the early development of abilities for symbolic thinking (mentalization) and may have important practical implications for the understanding and intervention in relation to the often massive difficulties of learning in children who have suffered early exposure to domestic violence, abuse and gross neglect.

This study documented a pronounced need for further *systematic, empirically grounded research into the impact of breaks on therapeutic process*. Among the importance of further research already was mentioned the importance of further investigation into *the proposed power of breaks, beginnings, and endings quite early in therapy to bring out central aspects of core object relationship themes*. Further research into the *ability to endure breaks as an important indicator of change* seems important, since results from this study are in line with Houzel's research into autistic children's reactions to breaks (2008), pointing to the possibility that this is valid also for other children in psychoanalytic psychotherapy. In this connection, it seems especially important to investigate *the presence/absence and quality of sibling figures in before-break sessions,* since in this study, the child's ability for symbolic representation of jealousy and envy in the

form of sibling figures at the brink of parting (i.e. at session endings and in before-break sessions) seemed to crumble away.

Further, there seem to be a need for further study into proposed *close and complex connections between the child's painful struggles with dependency-separateness dilemmas and parallel subjective experience of the therapist.* Thus, a parallelism of themes seemed to resonate at several levels in the mind of the therapist. Further research into possible links between the occurrence of a *countertransference crisis and turning points* in therapy seems important. Important to study in other therapist-child pairs also are the role of the *therapist's subjective inner imagery and states of mind* in as indicators of the emotional meaning of central relationship themes left by early, preverbal trauma and gross neglect.

Another important finding from this study relates to *the therapeutic potential inherent in the complex interaction between on the one side Samantha's painful dilemmas and on the other side the therapist's distance-related countertransference states,* which like an especially fine-tuned instrument seemed able to *capture issues of dependency-separateness at stake in the here and now*. E.g. fluctuations in the therapist's ability to monitor distance seemed linked to the child's assaults on the setting and the therapist. At the same level, further study seems indicated into instances of *temporal concurrence* between a *failing ability* of the child for *symbolic representation of the break* as intruding, hostile sibling figures, and the *therapist's experience of cognitive countertransference confusion*.

Finally, an important result of this study indicates that to this child, who had suffered early abuse and abandonment the identification with a benign, regulating father apparently did not appear from within therapy; but rather the first precarious beginnings of the early Oedipus complex seemed to originate in *the*

professional network. Thus further research indicated into the role of the professional network in effecting benign change by introducing *a triangulated, regulating third perspective* in the minds of the child and the therapist.

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