Beginnings of Psychotherapy with Adopted Children and Young People: A Grounded Theory Analysis

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Abstract

This thesis focuses on the beginnings of psychotherapy with adopted children and young people, since to date there is no empirical data available concerning an in-depth look at beginnings of psychotherapy with this group. It aims to shed light on the process of beginning of psychotherapy for adopted children and young people, to understand the emotional ramifications of beginning therapy, identify the common themes, and explore the therapeutic technique used in these initial encounters. Beginnings is a key theme in adoption, as a significant number of adopted children and young people have had distressing early life experiences of neglect, loss and abandonment.

Methods: Nine sets of process notes (notes written by psychotherapists after the session to record what happened in it) from three sequential 50-minute psychotherapy assessment sessions belonging to three patients, were analysed using psychoanalytically informed grounded theory. A literature review was also performed.

Findings: The literature search revealed a significant gap, finding no current publications into beginnings or opening sessions of psychotherapy for adopted children and young people. Analysis of the sessions identified six core categories of findings which include: establishing the framework and practical setting; difficulty in relating; alterations of technique; embodied unspeakable communication; patient and therapist being nice to one another; and feelings of exclusion and deprivation. The most frequent therapeutic techniques identified involved using an active, enquiring and non-challenging manner.

Conclusions: This study identifies some of the challenges of getting to know someone at the start of therapy, particularly fears of rejection and elements of confusion. It shows how attention should be paid to the beginnings of psychotherapy for adopted children and young people since depth and meaning can be gained from them. This understanding has the potential to benefit the rest of the therapeutic process.

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Chapter 1 Introduction

1.1 Background to Research Study

My interest in beginnings of psychotherapy for adopted children and young people evolved through my experience of working and training in a Child and Adolescent Mental Health Service for adopted children, adolescents and families. In particular, it was through my own professional and personal experiences of therapy beginnings, and the issues I encountered in clinical work that helped me to evolve my research interest. The central question I want to address is: what can be learned from looking closely at beginnings of psychotherapy with adopted children and young people?

A significant number of adopted children and young people have had distressing early experiences, both in utero and early life, and may have suffered significant losses, deprivation, and in some cases 'exposure to substances in the womb, affecting brain development and emotional intellectual capabilities' (Roy, 2020: 5). Edwards (2000) refers to the beginning lives of adopted children as 'characterised by its instability, lack of continuity and often its potential for significant harm, where no enabling relationship is available to process events' (p. 354). This was often reflected in my beginning work with adopted children, which felt extremely complex and challenging. In particular, there was often a painful struggle to establish contact and communication with these children, whose early lives and development have been seriously affected. I often reflected on 'the something more than interpretation' (Stern et al, 1998) that was needed and I was curious to look at this with greater detail and focus.

A small number of national audits undertaken have shown continuing high levels of disturbance and complexity amongst adopted and looked after children entering psychotherapy (Rance, 2003). Psychoanalytic literature repeatedly illustrates the complexities of working therapeutically with this group and the technical difficulties encountered. Specifically, in a UK wide online survey, Midgley et al. (2017) found that the initial stages of assessment with looked after and adopted children were 'typically complex in nature' and 'compounded by many of the children's difficult presentations and histories' (p. 264). A further look at the characteristics of looked after and adopted children seen for psychotherapy revealed them to be 'hard to reach' and 'highly defended', and that 'they can test the therapist's capacity for fidelity in the face of

intense projections.' The study also reported a need for the therapist to be 'more psychologically robust as children are likely to be more mistrustful and testing boundaries' (pp. 265-266).

1.2 Motivation and Aims of the Study

To date, there are no empirical studies that provide an in-depth look at beginnings of psychotherapy with adopted children and young people, a group with adverse beginnings and severely compromised attachment histories, nor has this topic been previously explored using a Grounded Theory approach. In fact, much of the key research and literature focuses on the middle phases and moments of change in psychotherapy. I hope to address this gap with this qualitative study by exploring beginnings of psychotherapy treatment and the clinical experience of beginning work with adopted children and young people, drawing upon close observations of beginning experiences of psychotherapy, along with a fine-grained analysis of the rich material that process notes can provide. Specifically, I aim to shed light on the process of beginning of psychotherapy for adopted children and young people, to identify the common themes and emotional ramifications, and to explore the therapeutic technique used in these first contacts with patients.

Chapter 2 Literature Review

This chapter will review current studies that investigate the beginnings of psychodynamic psychotherapy with adopted children and young people. This is followed by an overview of relevant clinical papers and case studies for adopted children that briefly focus on the beginnings of psychotherapy, where significant themes are highlighted and gathered together. The second section of the chapter considers the background literature on beginnings of psychotherapy, specifically of the psychoanalytic literature. The third section reviews technique in psychodynamic psychotherapy; the concepts of interpretation, transference and counter-transference are explained, as well as an exploration of the alterations of technique specifically when working with adopted children and young people.

2.1 Literature Search

The aim of the literature review is to find studies that represent findings about therapy beginnings and first encounters in psychoanalytic psychotherapy for adopted children and young people. This meant searching for detailed accounts of the initial phases of when the child and therapist are getting to know one another and building a relationship within psychotherapy. Certain research databases were used in order to achieve this such as *Psyc*INFO and the PEP Archive, and databases from the Psychology & Behavioural Sciences Collection and Google Scholar. The search terms used were: 'initial', 'start', 'assessment', 'beginning', 'adoption' 'LAC', 'foster' and 'Looked After Children.' In addition, searches were expanded to other psychological therapy disciplines with adopted children and young people.

There are other abbreviations to describe the word beginnings such as 'start' and 'initial', as well as other forms of beginnings in psychotherapy such as the 'psychotherapy assessment' where the clinician may not be offering ongoing therapy but will undertake initial exploratory work with a child or young person. This is why the search was expanded to these broader terms. Furthermore, the term Looked After Children (LAC) was included in the literature search as, like adopted children, looked after children have experiences of abuse and neglect and loss of birth family. The method of combining the literature search for looked after and adopted children,

reflects the majority of research in the field, where they are often grouped together. In fact, the literature review identified a similar lack of systematic research into beginnings in psychotherapy for looked after children as adopted children.

2.2 Beginnings in Psychoanalytic Psychotherapy with Looked After and Adopted Children

The literature review conducted identified no research within the psychotherapy domain which focuses on the beginning of psychotherapy with adopted children and young people. This indicates that this research project represents a significant addition to the body of knowledge of psychotherapy with adopted children and young people. Similarly, there is no systematic research published into beginnings for adopted children and young people in other psychological therapy disciplines.

The research identified a UK National survey and two single case studies which featured the beginning of psychotherapy with Looked After and Adopted children. However, this is not the main emphasis of the papers, and therefore does not directly address the research aim of this study.

In a UK wide online survey, Midgley et al. (2017) 'sought to examine child psychotherapists' working practises with looked after and adopted children, including the types of activities undertaken and the therapist's views on this work' (p. 258). He designed an online survey to gather this information from members of the Association of Child Psychotherapists (ACP), which is the regulatory body for child psychotherapists in the UK. The survey included both pre-defined categorical and open-ended questions about assessment and direct psychotherapy work with Looked After and Adopted Children. The data were analysed by quantitative (Chi-square tests of independence) and qualitative (thematic analysis) methods in order to offer both statistical comparisons and provide a further in-depth understanding into the views of the therapists' work. There were 215 responses with a vast majority working directly with looked after and adopted children (87.9%). The remaining respondents worked with either the foster carers and adopted parents or provided consultation work with the professional network that surrounded the child.

Most relevant to this study is the qualitative data on therapists' views of their direct work with looked after and adopted children at the initial stages of assessment. Key

themes were found that mainly centred on the ‘level of difficulty’ (p. 265) and complexity presented by these children when establishing a therapeutic relationship. Key features included the therapists reporting their sense that their patients had high levels of mistrust and testing of boundaries, as well as experiencing the child as 'hard to reach' and 'highly defended' (p. 265). The therapists also reported needing to tolerate ‘disturbing and erratic behaviours’ and ‘intense projections’ from the child (p. 265). The ‘role of attachment and early adversity in the development of epistemic trust’ (p. 273) is described within the discussion section of the paper. Epistemic trust is referred to as ‘the capacity to trust others as a source of knowledge’ (p. 273). Midgley describes that the survey results support recent findings that trauma and maltreatment in the child’s early life impacts their capacity to establish trusting and secure relationships. Midgley (2017) states that ‘the very children that may benefit the most from establishing such a relationship seem to have marked problems in this area’ (p. 273).

Despite these difficulties, Midgley found that many of the therapists viewed the psychotherapy setting as a suitable environment for treating the mental health difficulties of adopted children: ‘They felt that the emphasis on a safe, reliable, predictable setting lent itself to these children’s need for consistency’ (2017: 266).

The literature search also identified two single case studies by Vorus (2004) and Nillson (2000) that pay particular attention to beginnings of psychotherapy with adopted and looked after children. Vorus (2004), in his case study 'Treatment of an Adopted Child: the case of Roger', details ‘a series of vignettes’ (p. 391) from the psychotherapy ‘of an 11-year-old boy who was adopted at birth’ (p. 391).

Vorus describes Roger as a sweet and expressive boy, who spent the first few weeks of his therapy wanting to play chess, ‘draw, or play with action figures’ (p. 392); but mostly wanting to talk about his favourite basketball players. He spent a lot of time talking about players that had been traded by the “Yankees” and those who were allowed to stay in their home team. Vorus argues that at the beginning of therapy Roger resisted bringing his true self and identified with 10-foot-tall basketball players who were the stars of the NBA.

Nillson (2000), in her case study 'The Doll's House: Dream or Reality', follows the progress of a girl called Anna who was in foster care. She was aged four at the start

of her therapy. Nillson refers to Anna's first session as 'a violent one' (p. 84), in which painful emotions were acted out and noted a 'strong tendency towards regression' (p. 83). She describes Anna rushing into the room, often becoming aggressive and throwing things. In the early stages of the therapy she mostly used the dolls' house, to attack it.

Roger and Anna show very distinct experiences when first meeting with their therapist. It appears that each child had developed their own unique ways of managing the experience of deprivation. However, there are some common themes across both studies.

These include the theme of abandonment in which both children, right from the start of treatment, expected to be rejected and given up on by the therapist. They each employed this in different ways. Roger, as seen in his play of the basketball trading, felt that people gave him up. He showed characters being painfully 'traded away', or 'kicked out' (p. 392). Vorus argues that this can reflect Roger's earlier experiences of abandonment, being the only child placed outside of his biological family.

Anna showed her experiences by physically enacting out her feelings of rejection, attacking everything in the room and not giving the therapist a glance or notice.

Both case studies also showed how the child expected the therapist to be insufficient in managing their feelings. This led both Anna and Roger to deploy their own ways of handling their feelings and felt they needed to rely on themselves. For example, Vorus, argues that Roger was unsure if the therapist could survive his more difficult behaviours.

> 'Can we play chess?' As we began to play, he told me he wasn't going to play hard and would go easy on me. He said this in several ways, and I finally pointed out that he seemed worried about whether he would be too much for me. He said, very excitedly, "Yeah! I can be very dangerous!" I said he sounded excited by this, but also a little scared. Maybe he wasn't sure what would happen to me. Roger said nothing but quickly took my knight' (p. 392).

Additionally, Vorus argues that Roger was very praising of the therapist and only wanted to bring to the therapist things that were positive about himself. Vorus said that

this was because Roger was worried that the therapist would not keep him if he brought more negative things.

> ‘In terms of his relationship with me, Roger had long avoided bringing in things that he worried I might find disappointing, like his difficulties at home. Instead, he bragged about the impossibly difficult athletic feats he said he performed at school. After a long time, and many interpretations about his worry that I would trade him unless he were absolutely perfect, some of this began to change. He started talking more openly about the things he wasn’t so good at, and sometimes about things he felt ashamed of. At the same time, he became openly critical of me on occasion. This was something he had steered clear of during our first year of working together, and I felt that in some way I had been preserved, much as his birth parents had been in his mind” (p. 396).

In turn, Nillson articulates that Anna had a ‘powerful disappointment’ (p. 84) in her relationships who she felt would not be there for her when she needed them. Nillson argues that this is rooted from her early experiences of never having a ‘…good reliable object, a base from which Anna could discover the world. Anna’s image of a greenhouse was a house in which insufficient care and nutrition were given’ (p. 87). Nillson uses the analogy of a greenhouse to describe what the doll’s house may have represented for Anna, in which ‘young plants, with care and attention, can grow’ (p. 86).

Nillson (2000) and Vorus (2004) both highlight the technical difficulties and alterations in technique that were encountered in the early stages of therapy. Nillson describes how inaccessible Anna was to contact and how interpretations of her phantasies would lead to uncontrollable anxiety. This meant that Nillson would use positivity and reassurance alongside her interpretations to Anna (for further background on technique see page 25).

> ‘One of my problems in the initial stage of therapy was that Anna reacted with uncontrollable anxiety when I tried to interpret her phantasy. It was as if she experienced my interpretations as intrusive. I decided to give her ego support, encouragement of the positive and reassurance. Several times I had to stop her activities when she, for instance, tried to damage herself, or to carry her from the therapy room when she was not able to end the session. Although she

> panicked at every parting, I felt I could not say that she might be afraid that something terrible would happen to one of us during the break. Instead, I reassured her that we should meet again and I told her that I understood her feelings of not wanting to part' (p. 87).

Similarly, Vorus alerts us to the way he had to choose his words most carefully, as Roger found it difficult to endure too much talking. Roger said his previous therapists would just talk and talk to him and his brain would feel like it was exploding and everything was being destroyed, as if the words were too much.

Kenrick (2004) in her 'Commentary on "Treatment of an Adopted Child: The Case of Roger" argues how Roger at the beginning of therapy felt more comfortable when feelings were placed in the basketball players and not in Roger himself or in the transference relationship. She describes in her commentary how the therapist was not able to explore with Roger more directly his feelings of abandonment and loss and instead felt it was 'safer to work with him in the transitional arena of the basketball scenarios' (p. 403). It was only in the later stages of the therapy that Vorus felt more comfortable to explore his countertransference feelings with Roger and made more links 'between the play, Roger's birth parents, and his adoptive parents' (2004: 394).

Rustin (2004) in 'Assessment in Child Psychotherapy' draws attention to the task of meeting adopted and looked after children for the first time who have experienced severe deprivation and loss. Rustin refers to the ways in which such children enter new relationships in response to their repeated losses, for example, they may resort to a 'superficial relationship …rushing into premature but shallow involvement and enthusiasm for the therapist' (p. 76) when meeting them for the first time. Alternatively, Rustin refers to defences such as appearing 'frozen and guarded as a defence against hurt' (p. 76), and therefore may seem unreachable when first encountering them.

Additionally, there is an abundant literature including papers and single/multiple case studies for adopted children that briefly mention beginnings in psychodynamic psychotherapy but again do not specifically focus on them. Papers by Kenrick (2000; 2005); Edwards (2000); and Hopkins (2000) all stress the difficulties inherent in making new attachments with adopted and looked after children in therapy who have experienced repeated separations and losses. They also note that children who have been in care and who are 'typically burdened with unassimilated and traumatic

histories' (2000: 345) are resistant to forming new relationships. Hopkins describes one of the difficulties of adopting a child from care is that they may 'perpetuate their deprivation by rejecting the loving care offered to them' (p. 333). In addition, for many adopted children, relationships and intimacy can signal danger rather than safety. Hopkins argues that the attachment systems of children who have experienced 'loss and neglect as well as exposure to frightening or frightened parents' (p. 337), is not of protection and security. She explains that the inherent expectation of attachments being safe and secure has been violated by their disorganised/disorientated attachment patterns in infancy.

Similarly, Edwards explores the ways in which earlier experiences of absence and loss can stir up defensive dread of allowing another to become close. She argues that the development of new relationships will inevitably be slow as research has shown that 'children in long-term foster or adoptive care retain strong feelings for their birth parents and their siblings: these ruptured relationships may remain an internal preoccupation' (p. 352).

The authors all point to the characteristic of precariousness that is present at the beginning of therapy. This includes the way the child enters therapy with an expectation that they will not find something in the place where they left it, that nothing will stay the same, and anticipating being pushed out or moved on to somewhere else.

Kenrick (2000) refers to this precariousness as reflecting the precarious attachments and life conditions of children in foster care who experience numerous changes, losses and who have had little continuity in placements. She states, 'in the Adoption and Fostering Workshop at the Tavistock Clinic we have had children who have had twenty or more different placements before they reach secondary school age, often moving at very short notice, real ripping out' (p. 394). Kenrick highlights how the experience of multiple losses for many looked-after children, leads them to have little hope that relationships can endure.

Furthermore, Edwards (2000) describes Gary, a 6-year-old adopted boy at the beginning of therapy, who threw himself around the room and somersaulted onto his head. Edwards links this to Gary's precarious early life which was 'fragmented and often chaotic' (p. 353) having been born to a birth mother who was a heroin addict and as a result, Gary was treated in intensive care for drug withdrawal himself. His

attachment patterns were ‘fraught with instability, comings and goings and toings and froings’ (p. 353) in which he was passed round to different family members. Edwards argues that this may create in a child’s mind ‘huge uncharted areas of confusion and doubt’ (ibid).

Papers by Canham (2004), Kenrick (2000: 2005), Hindle (2000) and Lanyado (2017) address issues of technique at the beginning of therapy with adopted and looked after children. They describe how the child was violent and aggressive towards the therapist and the setting, which meant that any thinking in the sessions became impossible. Canham (2004) argues that this is because ‘children from backgrounds of deprivation and abuse use the most primitive modes of expression to communicate the nature of their experiences’ (p. 143). Canham uses an example of a patient who was severely physically abused and ‘would kick or hit’ him in the exact ‘parts of the body where they were hit themselves’ (p. 119). Kenrick points out that many traumatised children have real difficulty in tolerating and making sense of their experiences and so all they can do is grossly act them out.

Hindle turns to Boston’s idea that ‘unsatisfactory early experiences, of violence, abuse, and neglect, unmodified by loving and supportive reality experiences, may leave residual memories and feelings which are difficult to assimilate and digest’ (1983: 60, cited in Hindle, 2000). Likewise, the authors all draw attention to the real difficulty or deficit for adopted and looked after children in making links and connections in their mind. Lanyado (2017) illustrates how the ‘therapist uses this understanding substantially in their response to the technical challenges and adaptations’ in psychoanalytic technique (p. 210). For example, verbal interpretations are shown to be seen much less in the beginning phases of therapy and rather it is the therapist’s attentiveness to the patient’s anxieties and projections that is needed at this early phase of treatment with adopted and looked after children.

Canham also draws attention to the experiences and attachments of looked after children that are often concretely re-enacted in the consulting room and projected onto the therapist. This is specifically at the start of therapy where ‘the risks of enactment are huge’ (2003: 145), that thinking can become impossible for the therapist if the child is hitting or throwing things. Likewise, Hindle, describes the way her patient Hugh re-enacted and ‘dramatized’ experiences that he could not remember or understand: ‘His

being up high, outside or in a dangerous position was often frightening and difficult to bear. I found myself veering wildly between sympathy and exasperation with him' (p. 388).

Specifically, papers by Canham (2004) and Kenrick (2000: 2005) illustrate ways in which the child at the beginning of therapy is resistant to confronting something real and painful about themselves and allow for any 'chink' to appear in the sessions such as exploring their feelings or connecting to aspects of their early history. Canham describes the way his patient Eddie would sing songs continuously to make it impossible for him to speak and prevent thought in the session. Likewise, Kenrick argues that adopted and looked after children 'may need to develop defences of not thinking or of flight to action against experiences' (p. 395). Kenrick turns to Bion's concept of container/contained (1962) that distress and trauma hugely affect one's capacity to think and reflect. She describes how the mother, or carer acts as a container for holding or containing the thoughts and projected feelings of the infant until the infant 'has taken in and acquired a space within himself for thinking thoughts' (p. 395). Kenrick states that 'many deprived and abused children have had little of this developing and interactive experience in their early lives' (ibid).

This section identified key themes in the literature on beginnings of psychotherapy with looked after and adopted children who have had significant experiences of separation and loss. This included the defences used by adopted and looked after children when entering therapy in response to their repeated losses, such as appearing distant or overly enthusiastic. Another example was that patients expected, and feared, rejection and abandonment by the therapist, and had high levels of mistrust.

Difficulties with the analytic frame was also highlighted as a key theme, this included, patients physically enacting their experiences due to difficulties for adopted children in mentalising their thoughts and feelings. There was also a lot of avoidance of thinking about painful feelings.

Lastly, the authors highlight the alterations of technique that are needed in these early stages of therapy. Examples of this included using positivity and reassurance alongside interpretations, providing ego support, and describing the patients' feelings

without directly attributing them to the patient themselves, for example, as they could feel easily overwhelmed and anxious by them.

2.3 Psychoanalytic Literature on Beginnings of Psychotherapy

This section details psychoanalytic literature found in relation to beginnings of psychotherapy. The literature within the field of psychoanalytic child psychotherapy is vast, however literature on beginnings is limited. In fact, Thompson (1994) remarks on how ‘few books on psychoanalysis actually discuss the beginning of treatment. Most of them concern the territory between the beginning and end, and there is no shortage of debate concerning the meaning and handling of termination’ (p. 155).

This literature review identified a small number of writers who wrote about beginnings within a variety of contexts such as individual and multiple case studies, and theoretical books.

Freud (1913) in his series of technical papers wrote specifically about starting psychotherapy in his paper 'On Beginning Treatment'. He compared the beginnings and endings of psychotherapy to the game of chess, ‘wherein the novice who seeks advice from reading books will soon discover that only the openings and end-games admit of an exhaustive systematic presentation and that the infinite variety of moves which develop after the opening defy any such description’ (p. 123). Freud is suggesting that the beginning and end of treatment can only start and finish in a limited number of ways and variations, unlike the middle phase, in which there are infinite possibilities for what could happen between the patient and therapist.

Exploring this in more detail, Thompson (1994) writes about his curiosity for why the beginning of therapy is so scarcely explored compared to the middle phases of therapy. The irony for Thompson is that with an exhaustive list for the beginning of treatment, more well-defined data can actually be found, unlike the middle phases, in which the data will remain ambiguous and so precise data is harder to find. He further writes that ‘this is such a vital question for the psychoanalyst to ponder’ given that Freud’s paper on beginning of treatment is ‘undoubtedly the most important and by far comprehensive paper’ (p. 155) in terms of technique.

Klein in her book ‘Narrative of a Child Analysis’ (1961), gives a detailed account of her work with Richard, a 10-year-old boy who was so frightened of other children he was

not able to attend school. The therapy took place in Scotland in 1941, which lasted four months. Richard is described as a very frightened child; ‘hypochondriacal’; who had frequent ‘depressed moods’ (p. 15). His anxieties had said to increase due to the outbreak of the war in 1939. It is important to note that this clinical work does not reflect modern practise, nor does it consider the difficulties inherent for adopted children and young people who enter therapy. However, there are some emerging themes in relation to the beginnings of psychotherapy.

Klein kept notes of each session, describing the day-to-day course of the analysis. For the purpose of this study, I will be looking at the first three sessions with Richard. In the notes Klein refers to how she opens the first session by explaining to Richard the reasons for why he was having treatment. She states that ‘it is not unusual for a child in the latency period to ask why he is coming to analysis’ (p. 22). Klein reports that she found this useful for a child who is not able to put the question to himself though obviously desiring information. She also reflected on how this then helped Richard to start talking about his worries.

In terms of technique, Klein uses interpretation in the very first session, and openly interprets Richard’s worries, which Klein said he ‘looked surprised and frightened’ by (p. 21) She further highlights how there are different views among other analysts as to when to interpret the transference and feels that there should be no session without interpretation.

Klein’s notable emphasis on immediately analysing his anxieties in the very first session has been met with considerable debate. In particular, Anna Freud in ‘Introduction to Psychoanalysis’ emphasised the importance of establishing trust and a therapeutic alliance with patients before beginning any therapy with them (1922-1935). She introduces the need for a ‘preparatory period’ at the beginning of therapy, in which ‘everything undertaken in this period still is far removed from real analytic work; that is to say, there is yet no question of making unconscious processes conscious or analysing transferences and resistances’ (p. 7), rather it is about letting the child become familiar with the new surroundings. Unlike Klein, who appears to go deep into the unconscious, concentrating on Richard’s hostile feelings and the negative transference that emerges, very early on.

Klein describes her first aim in analysing children is to analyse the anxieties that are activated but this cannot be done without also recognising the defences which operate against them and which must in turn be analysed. She describes how for others like Anna Freud, analysing anxieties are to be left for a later stage in the therapy. However, Klein makes it clear that she does not agree with this view.

Furthermore, Klein refers to how Richard at this early stage in the therapy tries to 'split off a part of himself so as to keep good feelings safely apart from hostile ones' (p. 30), an example of this is how Richard often disagreed with the part of the interpretation that focused on his destructive feelings of wanting to attack his father and his feelings of jealousy and anger. He did not want to admit to having such feelings at this stage or reveal the more negative parts of himself. He said he 'would never do such a thing' and felt relief when Klein explained that 'he would not really carry out such an attack' (p.28).

Wittenberg attended a great deal to the experience of beginnings in her renowned book 'Experiencing Endings and Beginnings' (2013) which depicts the depth of emotions evoked by beginnings and endings. She states that 'life is full of beginnings and endings, constantly facing us with having to deal with change' (p. 183). She argues that beginnings and endings are closely connected, they are 'inevitably concomitant of moving through the life cycle' (p. 2).

Relevant to this study is Wittenberg's descriptions of the common feelings encountered when facing a new beginning. She details the excited and hopeful feelings 'invested in new experiences that make us look forward to them and seek them out' (p. 196). However, she also recognises the difficulty of beginnings, and draws attention to the fact that starting something new may make us anxious; taking the risk to face the as yet unknown and new experience.

Furthermore, she describes the hopes and fears connected with beginnings. These include, feeling nervous and frightened; lost, confused and alone; as well as excited. She refers to how new situations can evoke feeling 'lost in the unknown situation but … also fear that we are lacking the capacity to manage' (p. 567).

Most relevant to this study is Wittenberg's argument for how beginnings within any context bring earlier experiences to life. She draws attention to how early experiences

are significant: ‘they are deeply embedded in our soma and psyche, shaping our physical, emotional, and mental development; they influence the way we relate to others and react to contingencies life brings with it’ (p. 436). Wittenberg turns to Freud’s idea that ‘nothing is ever lost, that traces of what we have experienced in the past remain in the depths of our mind, in our unconscious’ (p. 15). Likewise, she also turns to Klein (1957) who refers to “memories in feeling” in which ‘every ending, every beginning, therefore arouses, to a greater or lesser extent, the physical, emotional, mental states that we experienced at the beginning of our life’ (p. 440).

Finally, Wittenberg argues that children who have experienced severe neglect and disappointments in their early life, compared to children who have had ‘good enough’ experiences will struggle more to feel able to reach out and explore new experiences. She turns to Bion (1962a) who states that ‘if the preconception of someone who meets our needs finds realisation, that is, is confirmed by actual good experiences, it will crystalise in time into a concept of goodness- a good mother or parts of her in the first instance – which can be reached out to and linked with’ (p. 23). Indeed, children who have experienced neglect will therefore not trust or even have a concept of someone reliable, and therefore it may stop them from asking for help or engage in a trusting relationship.

Relevant to this study is Meltzer’s chapter on ‘The Gathering of the Transference’ in his book ‘The Psychoanalytical Process’ (1967). He describes his experience of the initial phase of the psychoanalytic process with children, which he calls, ‘the introductory period’ (p. 17). He believes that the child is ‘relatively easy to induct into the psychoanalytic process’ as the child will enter immediately into a transference relationship with the therapist from the outset (p. 18). Meltzer explains that this is because children are ‘forced almost constantly to seek new objects.’ He describes the way a child has a readiness to appoint ‘a new repeatedly encountered adult’ as a substitute for their ‘internalised objects’, which are mostly the parents, in particular the mother (p. 19).

Despite these indications Anna Freud disagreed with this notion. In ‘The Psychoanalytical Treatment of Children’ (1946) she concluded that the child does not immediately form a transference relationship with its analyst. She states: ‘The analyst enters this situation as a new person…but there is no necessity for the child to

exchange the parents for him, since compared with them he has not the advantages which the adult finds when he can exchange his phantasy-objects for a real person' (1946, cited in Likierman, 1995: 320).

Meltzer argues that the child unconsciously experiences two contradictory sets of impulses when starting therapy. The first is the wish for a new relationship and experience, where the 'the child is impelled by drives and anxieties to extend the boundaries of self and to engulf every new object' (1967: 107). He states that a child may want to enter into a new experience as they 'wish to please parents' or to obtain 'gratifications of secret yearnings' or are wanting some 'relief for current distress', all of which propels them towards the new experience (p. 16). Alternatively, the second is the child's fear of 'over-extension', that is, of extending too far away from what is familiar and comfortable to them, and therefore getting lost; it is for this reason that the child will want to keep a close distance to the parents when meeting the analyst for the first time. Meltzer referred to this as the child maintaining a 'defined perimeter' (p. 16).

Furthermore, Meltzer refers to how the parent plays a big part in the initial stages of therapy, for example, the way the parent introduces a new person into the child's life and how the parent has prepared the child and presented the need and purpose of therapy. In addition, Meltzer writes about the way the child can 'size up' (1967: 16) the therapist in relation to their parents, watching their interactions closely and measuring how friendly they are to each other, in the moments of meeting. Indeed, he relates this to children who have a lack of capacity for introjection and who are not yet able to separate the parental figure and the therapist, and see them in isolation from one another. Meltzer highlights that children who have particularly persecutory or oedipal negative emotions need less intimate exchange between the parent and the therapist at the beginning of therapy, so as to not heighten rivalrous and competitive feelings about being excluded from a 'couple'. Meltzer writes: 'what is needed is a brief chat with the parent before turning attention to the child with a degree of physical as well as emotional contact' (p. 107).

Meltzer also draws our attention to the technical problems of the setting that are largely dealt with in the early phases of therapy. He argues that this takes various forms; denigration and destruction of the setting by the child, such as stealing, leaving before

time and going to the parent in the waiting room; all of which is dealt with by tightening of the technique of the setting.

Furthermore, Meltzer describes the rhythm and pace at the early stage of therapy, as being ‘haphazard’ (p. 22) compared to other later stages. Meltzer believed that this is because the transference is particularly intense at this stage of therapy, in response to the setting and the first weekend separation. He states: ‘all the devices known to the child, of greater and lesser omnipotence, are tried out in turn, discarded, tried again- and eventually abandoned in favour of a more consistent use of the only infallible defence against separation; massive projective identification. This is the essential sequence in the deepening of the transference which sets going the analytic process, with all its autonomous power’ (1967: 21).

Furthermore, he states the ‘tempo’ of this phase is largely based on the ‘technical skill and clinical judgement’ of the therapist, unlike the later phases where the ‘working through goes on largely at its own pace, determined more by the patient’s structure and constitution’ (p. 395).

Similarly, Betty Joseph (1998) in ‘Thinking About a Playroom’ describes the importance of the setting and the setting up of a playroom in psychotherapy. She believed the aim for psychotherapy is ‘that of providing an environment physical and psychological where the individual can feel able to bring all of himself - hopes, fears, impulses, anxieties, etc., into treatment’ (p. 360). She describes the way analytic work can depend ‘largely on action rather than words’ (p. 360) - particularly for young children which means ‘the room has to be suitable for this’ (ibid), for example, she describes a very disturbed patient who would make a pirate ship out of the playroom furniture and chairs; tear strips of wood off the table and throw the furniture around to express his aggression. In addition, Joseph refers to children who use play as communication; using the room to throw a ball to-and-fro or to play a game of hide and seek. In this way the playroom needs to be equipped to deal with whatever the child brings to, or does to, it.

The ‘Short-term Psychoanalytic Psychotherapy for Adolescents with Depression: A Treatment Manual’ (2017) provides some literature and guidance around the early sessions of short-term psychoanalytic psychotherapy in the context of the Improving Mood with Psychoanalytic and Cognitive-Behavioural Therapy study (the IMPACT

study). The Improving Mood with Psychoanalytic and Cognitive-Behavioural Therapy, published in 2011, is the largest randomised controlled relapse prevention trial involving 540 patients. The aims of the IMPACT study were to explore the effectiveness of three therapeutic interventions: Short Term Psychoanalytic Psychotherapy (STPP), Cognitive Behavioural Therapy (CBT), or Specialist Clinical Care, in the treatment and relapse prevention of depression in young people.

Most relevant to this study is the chapter on, 'The Early Stages of STPP' which suggests some of the important 'tasks and techniques' (p. 85) at these early stages of treatment. These include 'establishing the framework and setting'; 'understanding the nature of the young person's difficulties'; reflecting on 'internal experiences'; 'establishing the therapeutic alliance' - in which building up trust is said to be crucial, and 'one of the main aims of the early stages of treatment' (p. 97) as well as the most challenging; examining the transference and counter-transference; 'exploring the young person's feelings about entering into a therapeutic relationship, which will inform the rest of the therapy' and 'exploring the young person's capacity for curiosity and reflection' (2017: 87-97)

In addition, the manual argues that in the early sessions 'the therapist must strike a balance between allowing the young person to take a lead if he or she is able to do so and making sure that certain areas have been discussed' (p. 90). This involves the therapist gathering important information about the young person's 'external life context' such as home, school and friendships 'with offering a space in which he or she is invited to focus on internal experience: whatever comes to mind in the session, dreams, and fantasies, hopes, fears, and feelings of all sorts' (p. 90).

In addition, the manual points out that in these early stages, the therapist should be looking out for what is needed technically in order to 'elicit meaningful emotional engagement from the young person' (p. 88). Indeed, relevant to this study, the manual makes claim for the way very depressed young people or adolescents involved in problematic or delinquent behaviour, will need particular help to find ways of expressing themselves as a feeling can be communicated through anger or 'actual physical enactment (acting out)' (p. 194).

The setting up of therapy and the therapeutic setting is given particular attention by the Treatment Manual at the early stages of therapy. The manual refers to all the

external factors that enter the therapy at this stage and the way the ‘therapeutic setting is being drawn on all the time, providing a boundary around all aspects of the therapeutic work’ (p. 91). These include establishing various practicalities such as, the room; and confidentiality; and breaks. In addition, the frequency, length and time of sessions, and arrangements for contact between sessions which may be needed occasionally. The manual states that ‘this will establish the idea of a consistent setting (the same room and the same time each week, except when a change is unavoidable), so that disruptions can be kept to a minimum’ (p. 88).

Significant value is therefore given to the practical framework for the therapy from the outset, which helps to build a therapeutic setting that is reliable and constant. The manual stresses how this is felt especially important for depressed adolescents who ‘…have had experiences of significant loss, so the therapist will be implicitly communicating an understanding of the importance of presences and absences’ (p. 89).

The manual includes a direct quote from Wilson (1991):

> ‘The primary task of a psychoanalyst (early on in treatment) is to ensure conditions of work that facilitate communication, and enable both psychotherapist and patient to observe and think about what is happening within and between them’ (pp. 450-451).

2.4 Technique in Child and Adolescent Psychoanalytic Psychotherapy

This section of the literature review will firstly look at technique in psychodynamic psychotherapy; explaining in turn the concepts of interpretation, transference and counter-transference. It will then explore the issues of therapeutic technique specifically when working with adopted and looked after children.

Psychotherapists in case studies with adopted and looked after children have explored the technical difficulties when working with adopted and looked after children. For example, touching on the child’s difficulties for mentalisation and thinking, particularly at the early stages of treatment (Fonagy, 2002; Henry, 1974; Kenrick, 2000; Marsoni, 2006).

In terms of technique, some psychotherapists posited the ‘need to have different levels of interpretation for different patients at different times’ (Kenrick, 2007: 27), particularly for patients whose development has been greatly impacted on by significant deprivation and disturbance in their history. Specifically, Alvarez in ‘Live Company’ (1992) extends thinking about technical dilemmas to groups of children with massive deficits. She refers to the common psychoanalytic task of interpreting a child’s feelings, but argues that for some children they may need help first to recognise and name emotional feelings.

Many psychotherapists also report on the difficultly for adopted and looked after children to reflect meaningfully on their experiences rather than acting out by running away, hiding or attacking the room. They also noted that such children were not able to take in interpretations (Hunter-Smallbone, 2009; Robson, 2014). Other authors such as Goren (2020) describe how ‘some traumatised children may not be ready to productively engage in the classically understood transference relationship and make use of interpretation. The neuro-physiological impact of past relational trauma is too present in the here and now to make this manageable’ (2020: 164).

Hoxter (1977) and Joseph (1988) have detailed the physical setting of psychoanalysis as a space in which is offered to the patient at the same time and place each week. As stated by Sandler ‘the constant setting, the regular hours and its somewhat ritualised external trappings, provides the patient with a feeling of safety, a sense of being held' (2004: 95). In addition to the physical setting, Hoxter and Joseph highlight about the mental setting, such as the importance of the 'receptivity of the analysts mind' (p. 209) and the therapists non-judgemental and enquiring manner. Joseph (1998) describes what a mental setting should look like; whereby ‘the therapist can think and feel freely and thus be able to observe what comes from the child and what is stirred up in him or herself’ (p. 360). She also turns to Klein (1955) who argues that an aspect of the setting ‘consists in understanding the patient’s mind and in conveying to him what goes on in it’ (p. 362). Thus, ‘the physical and psychological is key in creating a receptive physical and mental setting and which the individual can feel able to bring all of himself- hopes, fears, impulses, anxieties, etc., into treatment’ (Joseph, 1988: 360).

A further aspect of technique lies in how the therapist and patient communicate with one another. The IMPACT manual outlines helpful indicators for Short-Term Psychoanalytic Psychotherapy (STPP) in relation to these aspects of technique. These include allowing the young person to lead, empowering the young person to explore their feelings, and exploring the transference dynamic between the patient and therapist. It also describes the fundamental source for 'free association' in which can be equivalent to the child or young person playing and drawing freely, as well as leading the conversation. These will be explored in more detail below.

2.4.1 Interpretation

The literature on the nature and use of interpretations in psychoanalysis is vast. According to Klein, the purpose of interpretation is to reveal to the patient their unconscious phantasies and anxieties, as well as their feelings for the therapist. She believed that interpretations can help the patient to feel understood. She states: ‘it is in fact striking that very painful interpretations- and I am particularly thinking of the interpretations referring to death and to dead internalised objects, which is a psychotic anxiety- could have the effect of reviving hope and making the patient feel more alive. My explanation for this would be that bringing a very deep anxiety nearer to consciousness, in itself produces relief. But I also believe that the very fact that the analysis gets into contact with deep-lying unconscious anxieties gives the patient a feeling of being understood and therefore revives hope’ (1961: 100).

Strachey (1934) stresses that interpretation is a vital tool for psychoanalytic psychotherapy. He argues that a useful interpretation must refer to the patient’s feelings and anxieties at the exact moment when it emerges from their consciousness.

He refers to a ‘mutative’ interpretation which is an interpretation that brings significant change in the patient, and it has two phases. He states:

> ‘First, then, there is the phase in which the patient becomes conscious of a particular quantity of id-energy as being directed towards the analyst; and secondly there is the phase in which the patient becomes aware that this id-energy is directed towards an archaic fantasy object and not towards a real one’ (1934: 73).

This is linked to ideas of transference, in which Strachey states that ‘original conflicts, which had led to the onset of neurosis, began to be re-enacted in the relation to the analyst’ (1934: 68). It is through interpretation that these conflicts of the remote past can be ‘revivified’ (p. 68) in order to work through them and are no longer repressed.

Furthermore, Strachey brings attention to analysts who bring too much into the patient’s consciousness by way of interpretation. This refers to the way the analyst can interpret the patient’s repressed material too promptly and deeply, material that is distant or inaccessible to his ego at the early stages of therapy; thus, bringing such material to consciousness, is likely to arouse anxiety and can lead the patient to break off treatment. As Strachey states:

> ‘The question whether it is “safe” to interpret such material will, as usual, mainly depend upon whether the second phase of the interpretation can be carried through. In the ordinary run of case the material which is urgent during the earlier stages of the analysis is not deep. We have to deal at first only with more or less far-going displacements of the deep impulses, and the deep material itself is only reached later and by degrees, so that no sudden appearance of unmanageable quantities of anxiety is to be anticipated’ (p. 77).

Rosenbluth (2007) also refers to Strachey’s phases, stating that ‘the first should enable the patient to become aware of his feelings and impulses towards the therapist, and the second should make him aware that this impulse is directed towards a phantasy object and not a real one’ (2007: 78). Thus, a sense of reality in the patient plays a crucial part. This therefore helps the patient to ‘contrast phantasy with the reality of the therapist’s behaviour’ (p. 78).

Joseph (1985) refers to interpretations as central to psychoanalytic technique and is the therapist’s formulations of the patient’s conflicts, fantasies and defences. She states that interpretation ‘…must resonate in the patient in a way which is specific to him and his way of functioning’ (p. 478).

The ‘Short-term Psychoanalytic Psychotherapy for Adolescents with Depression: A Treatment Manual’ (2017) defines interpretation as ‘any intervention in which the therapist makes explicit latent aspects of the material, particularly with reference to unconscious processes’ (2017: 62). The manual discusses the variety of

interpretations which could be made by the therapist, such as interpretations about the patient's defences against anxiety; transference interpretations; interpretations in displacement, in which feelings are attributed to ‘characters in their play, without immediately relating them to the child and the therapist’ (p. 63); and process interpretations, in which the therapist observes ‘the nature of the process in a session rather than the content of what is being said’ (2017: 64).

The manual also considers the timing of interpretations; arguing that interpretations need to be well timed so that the patient does not feel too threatened by it. Meltzer (1976), considered the different lexical levels and timing for interpreting the therapists’ thoughts without causing ‘alarm, erotic excitement, or confusion in the patient, for which he called ‘modulations of temperature and distance’ between the analyst and patient (p. 377). For example, he considers the ‘realm of the emotional music of the voice’ (p. 379) for which particular attention is given to the analyst’s voice in terms of tone, rhythm and volume in order to modulate the temperate of communication. He also describes ‘modifying the distance by not addressing the part concerned in our formulation at, but rather, talking about that part to another, or by ruminating aloud in the presence of the patient, leaving it to his choice to listen or ignore.’ (p. 378).

Furthermore, Winnicottian ideas highlight the significance of more non-interpretive interventions such as the use of playing, which in itself is transformative and therapeutic. Unlike the Kleinian approach, which traditionally gives priority to interpretation, Winnicott (1971) stresses that it is experience over interpretation that is crucial; thus, the focus should not be on the content of play in order to interpret it, rather it is the shared experience that is of significant value.

2.4.2 Transference

Freud in his earlier works, particularly in the case of the ‘Rat Man’ (1909), noticed that patients experienced strong opposing feelings towards the analyst, mostly of intense hatred or love. Freud, initially felt this to be a burden to the work, however, he soon came to believe that these opposing feelings towards the analyst belonged to the patients’ past relationships applied to the present therapeutic relationship. Freud in his ‘Fragment of an Analysis of a Case of Hysteria’ (1905 [1901]) described transference as follows:

> ‘They are new editions and facsimiles of the impulses and phantasies which are aroused and made conscious during the progress of analysis, but they have this peculiarity, which is characteristic of their species, that they replace some earlier person by the person of the physician. To put it another way: a whole series of psychological experiences are revived, not as belonging to the past, but as applying to the physician at the present moment’ (p.116)

Freud believed that the transference was an ‘obstacle’ (p. 116) and should be removed by revealing to the patient that his feelings concerning the therapist did not belong in the process of analysis. However, transference is now seen as a central tool of psychoanalysis. According to Klein, working through the transference is crucial as it ‘opens up roads to the patient’s unconscious, his past (in its conscious and unconscious aspects)’ (1952: 433). Klein described how the patient ‘transfers their early experiences, object relations and emotions’ (p. 443) onto the therapist, which then help the patient to deal with their ‘deepest conflicts and anxieties which have been reactivated’ (ibid).

Klein refers to a positive and negative transference which originates in feelings of love and hate towards early objects. She describes the ‘interconnection between positive and negative transferences which are the early interplay between love and hate, and the vicious circle of aggression, anxieties, feelings of guilt and increased aggression, as well as the various aspects of objects towards whom these conflicting emotions and anxieties are directed’ (1952: 436).

Klein’s work, in particular, has deepened and extended the understanding of transference, by using her interest in locating the transference in early object relations and what is transferred from the earliest periods of life, which she calls the ‘total situation’. In her paper ‘The Origins of Transference’ she states: ‘It is my experience that in unravelling the details of the transference it is essential to think in terms of total situations transferred from the past into the present as well as emotions, defences and object relations’ (1952: 55).

Rosenbluth (2007) refers to the transference as becoming ‘part of the continuous stream of unconscious phantasy accompanying all libidinal and destructive impulses, with the therapist now as their object’ (2007: 74). She believed that when the transference relationship becomes more evident in the therapy ‘the situation at home

usually becomes relieved, as the baby relationship needs no longer to interfere so much with the present relationship between the child and his parents' (p. 85).

2.4.3 Counter-transference

Transference, as explored in the previous section, has been defined as the process by which a patient transfers their feelings onto the therapist which originate from earlier relationships in his life. Counter-transference therefore is said to be the analyst's emotional response and feelings towards his patient, which then gives insight into the patient's unconscious world.

Freud initially considered countertransference as a hindrance: he writes 'we have begun to consider the countertransference, which arises in the physician as a result of the patients influence on his unconscious feelings and have nearly come to the point of requiring physician to recognize and over-come this counter-transference in himself…we have noticed that no psycho-analyst goes further than his own complexes and resistances permit; and consequently we require that he should begin his activity with a self-analysis' (1910: 144-145). Therefore, Freud seems to believe that the therapist's countertransference feelings are the analyst's own pathology. However, Freud later acknowledges the importance of counter-transference describing it as a 'receptive organ towards the transmitting unconscious of the patient' (1912: 115).

Heimann in her paper 'On Counter-Transference' (1950) describes countertransference as the analyst's 'emotional response to his patient within the analytic situation' (1950: 82), thus she suggests that countertransference is the response to the patient's behaviour and extends 'all the feelings which the analyst experiences towards his patient' (ibid.) Heimann felt that the countertransference feelings experienced by the analyst is the 'patients' creation, it is part of the patient's personality' (ibid.: 84). She describes how it correlates 'to the nature of the patient's unconscious impulses and defences operative at the actual time' (ibid.: 85).

Money-Kyrle (1978) in his paper, 'Normal Counter-Transference and Some of its Deviations', considers the two features of countertransference, one that is engrained in the analyst and one that is in the patient, as correlated with one another. He describes countertransference as having two phases, introjective and projective, whereby the therapist becomes 'introjectively identified' (p. 360) with the patient. As

stated by Money-Kyrle, ‘as the patient speaks, the analyst will, as it were, become introjectively identified with him, and having understood him inside, will reproject him and interpret’ (1978: 331). He goes on to say that the analyst is most conscious of the projective phases, in which 'the patient will inevitably represent something that corresponds to the analyst’s own ‘unconscious phantasies’ and ‘damaged objects’ (p. 360). He argues that if this is understood by the analyst, it can be successfully treated by interpretation and the analyst’s countertransference feelings can be used to empathise with the patient.

Furthermore, Money-Kyrle describes the occurrence of abnormal countertransference, which is when ‘the patient corresponds too closely with some aspect of the analyst, which he has not yet learnt to understand’ (p. 331). With a lack of understanding, conscious or unconscious anxiety is said to be aroused in the analyst, which further diminishes an understanding of the patient.

2.4.4 Alteration of technique with adopted and looked after children and young people

Authors such as Lanyado (2017); Hunter (2001) and Kenrick (2005) and Alvarez (2012) draw attention to how the therapist needs to adapt their technique when working with looked after and adopted children. Hunter (2001) in 'Psychotherapy with Young people in Care: Lost and Found' argues that psychotherapy for children in care 'requires modification of therapeutic practise' (p. 1) and that 'the process has to be adapted to reach these otherwise unreachable children' (p.1). Lanyado, Hunter and Kenrick all highlight the need to slow down interpretations and hold the child’s projections for longer; while Alvarez suggests offering more reassurance and encouraging aspirations for deprived and abused patients.

Hunter (2001) describes needing to bear ‘negative transferences with equanimity’ (p. 7) and hold the child's unwanted feelings for longer before making interpretations about them and getting the child to own their feelings themselves.

Similarly, Alvarez (2012) in her book ‘The Thinking Heart: Three levels of Psychoanalytic Therapy with Disturbed Children’ writes about the child's need for hope, rather than focusing on anxiety and loss with children who have suffered so much adversity. She refers to interpretations of fears and painful truths, that can feel

particularly threatening for deprived patients unless they are carefully phrased. She highlights the 'technical issues that arise when working with borderline patients who have limited ego capacity and are too overwhelmed by despair or persecution to benefit from interpretations that seek to remove defences against painful truths' (p. 1). She argues that children who have suffered very early on in their lives, and who have little ego development and confidence to fall back on, need to be reminded of their strengths and aspirations and not just of their sad and frightening realities. She emphasises the need to 'carry for them, their hopes and aspirations' (p. 1), rather than just interpret their mental states as omnipotence or manic defences.

Similarly, Kenrick draws our attention to the timing of interpretations:

> '…the therapist should hold the projections and projective identifications within herself and should explore them there before returning them even modified to the child. This is particularly important for the very deprived child who may have had much too little of an object capable of attending to the child's communicative projective identifications with much alpha function. The child may have experienced an object who returns them in an unmodified form so that he experiences them as retaliatory, persecuting and malignant' (2005: 29).

Likewise, Rosenfeld (1987) cautions that transference and countertransference interpretations by the analyst can be damaging to deprived patients that may remind them of a narcissistic object. Similarly, Szur (1983) highlights that for traumatised children in psychotherapy, feelings can be difficult to face, where words and interpretations made by the therapist can be experienced as 'torture' and hard to bear (1983: 54). According to Segal (1957) words may be experienced as an attack, 'being felt in a concrete fashion and are therefore unavailable for purposes of communication' (p. 395). Hopkins adds that 'clinical tact is needed to find acceptable ways to verbalise what needs to be understood' (2006: 106).

Kenrick (2005) argues that interpretations need to be very delicate for looked after and adopted children. She states: 'For fostered and adopted children, not being understood could, almost literally, have been a matter of life and death, or of a malignant misunderstanding; but being understood too well can in itself be persecuting or can put them in touch too poignantly with early deprivation' (p. 38)

Lanyado (2017) also draws our attention to the work of interpretation when the therapist reveals to the patient their unconscious feelings and anxieties. She argues that at the start of therapy, children with severe neglect and trauma are ‘a long way away from the developmental level at which interpretation can be used, the insight gained from within the transference-countertransference relationship often needs to remain within the therapists mind rather than being interpreted’ (p. 210).

In addition, Goren (2020) describes how children who have suffered terrible adversity in their early lives could not make effective use of having their experiences reflected on: ‘These children attacked, hid, broke things, dissociated and ran. Attempts to interpret the meaning of such behaviours mostly fell on deaf ears’ (2020: 153). Goren goes onto claim that this is a ‘common experience for child therapists working with adopted and looked after children’ (p. 153). He refers to ‘needing to bear the unbearable and manage the nameless dread that drives it until the child is able to bear a little and think a little’ (ibid).

Likewise, Boston and Szur (1983) describe the need when working with severely deprived children to hold on to the ‘projections of feelings that the child finds intolerable’ (p. 129). In particular, they refer to the therapists’ containing function and containment of psychic pain, as most crucial at the beginning of therapy.

Henry (1974) describes how it is not enough to just interpret phantasies with adopted and looked after children; interpretations for them seem to be treated as mere background noise. She noticed that her patients needed something more instantaneous, by way of holding and containment. Likewise, Marsoni (2006) suggests when working with adopted and looked after children the therapist limits themselves to ‘naming and describing’ feelings and what is happening in the room (p. 314). She felt that using interpretations can escalate anxiety and destructive behaviours. For her patient Luke she states: ‘My function at this point was to make myself emotionally available to these feelings, experience them on Luke’s behalf and simply to name them to him; anything more was too much for him’ (p. 314). She describes similarly to Bion's concept of the 'alpha function' which is to contain all the child's emotional experiences.

Edwards (2000) also stresses the delicate nature of interpretations for looked after children, particularly at the initial phases of therapy, where interpretations do not help to hold the child. She describes the physical experience in the room with her patient

Gary who needed a more immediate experience of actual holding and catching, where he would ‘leap dangerously from table to chair’ and ‘lower himself slowly head first onto the floor’ (p. 359).

Lanyado and Horne (2007) describe departing from more traditional techniques with deprived children when needed, for example, being ‘playfully responsive’, especially with children who cannot play (p. 6). They suggest that the therapist’s playfulness alongside something that is hard for the patient to digest, can be a ‘powerful antidote’ for the defences that patients have put together against emotional pain (p. 140).

Furthermore, the therapist as a new or ‘developmental object’ is also considered when working with adopted and looked after children. This refers to the therapist as an object which the patient can relate to in a new way that leads to experiences of mentalisation and change. This is separate from the transference object, in which is the therapist as representing the patients’ early experiences of deficit and object relations. Lanyado and Horne argue that ‘children who have lacked the experience of an interested maternal object first need the experience of someone who can notice and respond to their need, before they can experience loss and deficit’ (2007: 48). They argue that the therapist is more ‘evidently themselves’ in this developmental role (ibid.: 116). This includes, being more creative in timing and technique, taking a role in the child’s play such as ‘the role of the feared or longed-for inner objects’, as well as ‘externalising aspects of the child’s self’ (ibid.: 116).

The above authors all draw attention to the different changes in technique needed for the child psychotherapist with looked after and adopted children. These have included the need for the therapist to be a containing function for the patient and provide them with immediate emotional holding; to slow interpretations down and instead bear and hold the child’s unwanted feelings for longer; how clinical tact is needed with interpretations so as to find appropriate ways to verbalise their feelings; the need to remind the patient of their strengths and carry hope and reassurance; and to be playfully responsive and a new benign object for the patient to relate to.

2.5 Summary of Literature Review

The literature review identified key findings related to the process of beginning of psychotherapy for adopted and looked after children, while also covering more general psychoanalytic literature on beginnings of psychotherapy.

It shed light on certain states of mind of adopted and looked after children at these beginning stages of therapy, for example the high levels of mistrust and fears of abandonment and rejection in response to their earlier experiences of repeated loss and discontinuity.

The review found that difficulties with the analytic frame and alterations in technique had been given considerable attention in the literature. For example, the limited use of interpretations offered in these early stages was needed due to the struggle by adopted and looked after children to engage in self-reflection, resulting in the therapist needing to draw upon other approaches.

It also showed how beginnings, such as beginnings in therapy, bring earlier experiences to life (Wittenberg, 2013), an insight which can help the therapist understand the complex histories and trauma that adopted children and young people bring to the beginning stages of therapy. Authors also brought attention to how these beginnings phases of therapy differ from later stages, for example having a different rhythm and tempo (Meltzer, 1967). Furthermore, it identified particularly significant elements to beginning phases of therapy such as information finding, establishing the framework, and establishing practical settings.

Finally, the literature review identified a significant gap in the literature, in that there are no publications which focus on and investigate the beginnings of psychotherapy for adopted children and young people. Therefore, the main aim and rationale of this thesis was to start addressing this gap.

Chapter 3 Methods

This study explores the process of beginnings of psychotherapy with adopted children and young people using process material gathered during assessments for child psychotherapy. The process material is limited to the therapist's own clinical notes; therefore, the experience of the beginning of psychotherapy of the patients comes from the psychotherapist's perspective.

The purpose of a psychodynamic assessment is to explore patients' current difficulties and establish their suitability for psychotherapy, these typically take place over three 1-hour sessions. The aim of the study is to shed light on the process of beginnings of psychotherapy for adopted children and young people, in order to understand the emotional ramifications of beginning therapy, identify common themes, and explore the therapeutic technique used in these first contacts with patients. The purpose of grounded theory as the research method of data analysis is therefore to examine data from psychotherapy assessment sessions in order to capture the process of beginnings of psychotherapy for this group, who have severely compromised attachment histories, and from these to facilitate hypotheses about the nature of this work.

3.1 Epistemology

This is a qualitative study which aims to draw upon close observations on the process of beginning of psychotherapy for adopted children and young people. An inductive method will be used for coding, as the study aims to discover theory from data, as opposed to testing existing theory. It will be used in order to systematically find theory grounded in specific instances which then moves from specific observations to broader generalisations. Furthermore, this research is rooted in an interpretivist philosophy which recognises the researchers position as consequently central in analysing the data, as Deniz and Lincoln write, 'all research is interpretive; it is guided by the researchers set of beliefs and feelings about the world' (2005: 22). Charmaz (2006) argues that what we bring to the study, strongly influences 'what we see as significant in the data' (p. 47). It is important to acknowledge, that the analysis of the data was informed by psychoanalytical theory. Indeed, as Bursnall (2004) states 'every researcher, equipped with the basic premises of grounded theory methodology, goes

on to develop their own variation of grounded theory technique, adapted to the context and purposes of the study and the individual's mind-set' (p. 81, cited in Wakelyn, 2011).

3.2 Ethical Considerations

Full ethical clearance was obtained for this study by Tavistock and Portman Trust Research Ethics Committee (TREC) and the Research and Development department within the Trust of where the patients received their treatment. Permission was sought and obtained from each of the parents of the patients in this study (see appendix A) and not with the patients themselves. This was so participants would not be approached or included in the study directly as one of the aims of the study was to have no impact on participating patients and their treatment; thus, the study did not require changing clinical practice or treatment from accepted standards. Given the age of the patients used for this study it was possible to gain consent from parents only.

This study has made sure that the identity of all three patients and their families is anonymised; pseudonyms are used for all names and locations, as well as any identifying features.

3.3 Research Design

Data from psychotherapy assessment sessions is analysed for this study. The data comprises of the process notes from three sequential 50-minute psychotherapy assessment sessions, pertaining to three patients each. Process notes, typically used by psychotherapists to record their work, are central in clinical supervision. Rustin (2019) describes them as 'post-sessional write-ups from memory of clinical sessions, and such "process records" have been one of the major resources for the clinical grounding of psychoanalytic discoveries' (p. 150). Process notes describe sequentially what happened in a session between the therapist and patient, re-counting what they said and did, as well as capturing the therapist's internal thoughts and emotions during the session. They are written up straight after the session has finished and are from memory.

Grounded theory analysis was applied to detailed process notes that were written up after each session and are the same process notes used for clinical supervision. Therefore, the process notes were not written specifically for the purpose of the study,

however they were obtained post acknowledgment of the study and written with knowledge of this study in mind.

3.4 Sampling

The key criterion when sampling was that of adopted children and young people under the age of 18 who are open to CAMHS (Child and Adolescent Mental Health Service) and whom have been referred for a psychodynamic psychotherapy assessment. There were no exclusion criteria. In so doing, the study aimed to reflect the wide range of complex cases that come into the service. This is a small sample and so can limit generalisation in terms of making theoretical inferences to larger populations. Further limits for generalisation are the unique individual experiences and presentations of the child/young person. However, the aim of the study is to explore in depth the process of beginning of psychotherapy for adopted children and young people through the intense analysis of the data.

3.5 Data

Nine sets of process notes from psychoanalytic psychotherapy assessment sessions were used as data for the study. These consist of the first three sequential sessions of a psychoanalytic assessment that is part of the treatment service with three individual patients. The main purpose of a psychoanalytic assessment (usually over three individual sessions but can be extended in certain circumstances) is to establish the suitability of psychotherapy for the patient. Rustin and Quagliata (2004) in ‘Assessment in Child Psychotherapy’ highlight the key aims of a psychotherapy assessment, some of these include; to produce a detailed formulation of the child’s internal state of mind, this comprises of the child’s developmental difficulties and internal defences and conflicts; to determine if the child can make use of a psychoanalytic treatment approach which involves suggesting ‘the mode (individual, group or family), intensity and optimal timing of the treatment required’ (p. 6); and ‘to establish whether there is someone who can reliably support the treatment of the child’ (p. 6). The assessment sessions typically take place weekly and are on the same day and time each week.

The assessment was conducted by myself as the researcher, a female psychoanalytic psychotherapist in my final year of training. The sessions studied aimed to cover the

early part of the therapy and therefore they were chosen specifically. The three patients whose sessions were studied were two females and a male and were different ages; the two females were 7 and 13 and the male was 11. As the therapist of the sessions, I typed up the sessions straight after the session had finished on the Trust computer laptop. The process notes are all from memory and nothing has been recorded during the sessions.

3.6 Research Method

The qualitative method of grounded theory (Glaser and Strauss, 1967) was used. This is an 'inductive' method which facilitates the generation of theory. This method was chosen so as to capture the lived experiences of beginnings of psychotherapy for adopted children and young people. Rustin (2016) explains that grounded theory analysis 'allows the researcher to capture the complexity of the data presented and for inferences to emerge from the encounter with the material itself' (p. 189). Grounded theory has been chosen for this study as it is a 'naturalistic' method, where meaning can emerge from the clinical data with little preconceived notions about the research topic (Anderson, 2006). Glaser and Strauss (1967) confirm that Grounded theory is a 'discovery of theory from data – systematically obtained and analysed' (p. 1).

When using grounded theory, no hypotheses are initially formed about the research topic which seems a fitting methodology for an open exploration about beginnings of psychotherapy with adopted children and young people. The aim of grounded theory is to allow the theory to emerge from the data. Strauss and Corbin (1998) highlight that 'theory derived from data is more likely to resemble the 'reality' than is theory derived by putting together a series of concepts based on experience or solely through speculation' (p. 12).

As mentioned previously, psychoanalytical theory was used as a framework for this study. Anderson has highlighted that psychoanalytic research is well suited with grounded theory as it can provide 'findings that are translatable to routine clinical practise' (2006: 34). In addition, the method of grounded theory can facilitate the 'generation of new knowledge in the form of theory' (Birks & Mills, 2015: 17), therefore grounded theory has the potential to make a contribution to the topic of beginnings of psychotherapy for adopted children and young people, that is barely studied and deserves research effort.

Grounded theory involves various stages, starting with generating initial codes that are produced by looking at the data through 'microscopic examination' (Strauss & Corbin, 1998: 58), or otherwise known as 'line-by-line' coding which involves naming each line of the data in the material before moving through to more focused codes. Gerund-based coding is used to form the initial codes, which involves looking for 'gerunds' in the data (Glaser, 1978), a noun formed from a verb by adding -ing. This gerund-based coding can help to create descriptive initial codes that express what is closely present in the data.

Focused, axial and theoretical stages then follow, which analyse the data to a higher level of coding. This is the process by which the researcher only looks at the most significant initial codes from the data and relates these 'to their subcategories, termed 'axial' because coding occurs around the axis of a category, linking categories at the level of properties and dimensions' (1998: 123) This leads to the further development of major categories and subcategories and are 'integrated to form a larger theoretical scheme that the research findings take the form of theory' (1998: 143). It is important to note, that according to Charmaz (2006) not all the stages of grounded theory will be essential and can be modified in accordance with what is relevant in the data.

The coding process encompasses memo-writing, which are 'written records of analysis' (Strauss & Corbin 1998: 217). They attempt to capture the researcher's thoughts and theoretical ideas about the data as the study develops. Memo-writing can take many forms, such as 'code notes, theoretical notes, operational notes, and subvarieties of these' (1998: 218).

Consistent with the grounded theory method is 'theoretical saturation' (Glasser & Strauss, 1967) which seeks, through a rigorous examination of the data, to continue adding to the categories until no new codes or information emerges from the data. According to Strauss and Corbin (1998) it is when 'no new properties, dimensions, conditions, actions/interactions, or consequences are seen in the data' (p. 136).

3.7 Analysis of Data

Grounded theory was applied to an analysis of the process notes that is based on the first three sequential psychotherapy assessment sessions for each patient. Each session was individually analysed in order of occurrence, thus starting with the first

before moving on to the second and then third assessment session. The application of line-by-line coding (‘gerunds’) was used for each session, thus ‘lines’ were the unit analysed. This was felt to be the best form of coding in order to capture every feature of the data that could later elaborate the concepts or categories. This helped to achieve full theoretical coverage (Strauss & Corbin, 1998). The example below demonstrates this initial coding process from Patient A:

Key: Highlighted text = Process notes; Purple = Line-by-Line code

I collect A from reception.

Therapist collecting patient from reception

She is sitting with her hands carefully folded on her belly and her legs crossed.

Patient sitting with hands carefully on belly and legs crossed

In a much-closed position.

Patient sitting in a closed position

I say hello and she looks at me with lots of curiosity but with a sweet and endearing smile.

Therapist saying hello to patient

Patient looking at therapist with lots of curiosity

Patient smiling sweetly and endearingly

Mum says hello too and I invite them both to come in and lead them to the room.

Therapist noticing mum too and invites them to room

Therapist leading the way to the room

As noticed in the extract above, the material analysed was not contained in a chart, which is typical of grounded theory analysis. This was because a chart appeared to lead the initial codes away from the process material and created too much of a distance between the codes formed and the material that it related too. This created premature theories and assumptions about the material analysed, as well as losing a clear geographical location of where the codes sat in relation to the process material. In its place, a line-by-line coding that was conducted within the original process material, was developed. This analytic technique is therefore confident that the initial codes generated, closely reflect the process material.

Memos were captured during this process in a separate document. The memos helped to later inform the theoretical stage of the analysis of the data.

Before moving to the higher-level of coding, I had to revisit what I may have missed in the initial coding stage. This was because certain tensions arose when analysing the data, including assumptions I may have made during the initial coding process because I am the therapist in the session material it is therefore likely that I assumed what the therapist felt which was not indicative of what was in the text. In order to mitigate this effect, I used the third person pronoun to keep in the position of researcher when analysing the data (this is explored further in section 3.9.1).

Focused coding was a multistage process, which developed through a recurring of initial codes, this being that they needed to have frequently reoccurred in the data to be determined as a focused code. The initial codes were then subsumed under the same umbrella to form focused codes. In addition, each initial code was colour coded so that you could see which patient it belonged to. The example below indicates the added focused coding process:

Key: Highlighted text = Process notes; Purple = Line-by-Line code; Orange = Focused code

I collect A from reception.

Therapist collecting patient from reception

Therapist collecting patient

She is sitting with her hands carefully folded on her belly and her legs crossed.

Patient sitting with hands carefully on belly and legs crossed

Patient uses closed body language

In a much-closed position.

Patient sitting in a closed position

Patient uses closed body language

I say hello and she looks at me with lots of curiosity but with a sweet and endearing smile.

Therapist saying hello to patient

Patient looking at therapist with lots of curiosity

Patient smiling sweetly and endearingly

Therapist introducing themselves

Looking at therapist and being curious

Patient being sweet and endearing

Mum says hello too and I invite them both to come in and lead them to the room.

Therapist noticing mum too and invites them to room

Therapist leading the way to the room

Therapist includes parent in the first session

Therapist being hospitable/welcoming

The focused codes were then extracted to a separate document and individually numbered. For each focused code, examples of the initial codes that the focused code stemmed from, were put underneath for each patient. This helped provide transparency in where codes originated from and a coherent narrative for what was happening in the data as the analysis evolved. I have given two examples of focused codes:

Key: Orange = Focused code; Green = Patient A; Blue = Patient B; Red = Patient C

Patient uses closed body language

Patient wrapping her arms around her belly

Patient sitting with hands carefully on belly and legs crossed

Therapist thinking patient is sitting in a closed position

Patient keeping her arms wrapped around her belly

Patient crossing over her legs and doesn't want to show any skin and then places note pad on it to draw

Sitting in a much-closed position

Patient continuing to sit in a closed position keeping arms folded and legs crossed

Therapist saying hello to patient but patient avoids eye contact with the therapist by putting his head down

Patient getting up and hides in the tent that is in the waiting room

Therapist saying to patient that he wants to hide himself

Therapist seeing that patient wants to shut himself inside the tent as he tries to close the door

Patient smiling then looks at therapist and then hides her face behind mum all embarrassed

Therapist thinking, she looks like a turtle as she buries her head and then brings it out again

Key: Orange = Focused code; Green = Patient A; Blue = Patient B; Red = Patient C

Patient being sweet and endearing

Patient smiling sweetly and endearingly

Therapist feeling patient is shy but also sweet

Patient speaking to therapist in a sweet voice

Therapist thinking there is something vulnerable about the patient and cannot help but adore him

Therapist thinking there is kindness in the patient

Therapist feeling patient looks like a little princess

Patient smiling then looks at therapist and then hides her face behind mum all embarrassed

Patient smiling cutely at therapist and squishes her face

Patient smiling cutely to therapist many times

Patient continuing to smile cutely at therapist

Patient smiling sweetly to therapist

Patient looking at therapist in the eyes and smiles cutely

Patient smiling sweetly at therapist and shows some teeth

Patient giggling and looks all cute to therapist

The focused codes then helped to inform the generation of core categories. At this stage I looked at the most significant focused codes; those that occurred in all three patients and for all three assessment sessions, as well as focused codes that had significant meaning in the data. I then decided to write each of these focused codes on separate strips of paper and played around with organising them ‘into discrete

categories, according to their properties and dimensions' (Strauss & Corbin, 1998: 19). Identifying theoretical categories in this way helped to make links and comparisons for different categories.

3.8 Reflexivity

It is important to acknowledge the researcher's role and position as integral in the data analysis, in which the researchers own set of beliefs, opinions and biases can cause the focus to shift away from what was indicative in the data. Therefore, my own psychoanalytical orientation may have influenced the data analysis and findings. The original grounded theory analysis 'proposed that investigators should engage with their research questions and their data without theoretical preconceptions' (Rustin, 2019: 173). However, Rustin writes, 'psychoanalytic researchers using grounded theory have usually chosen to work within a psychoanalytic frame of reference from the start, while remaining open to new conjectures' (2009: 46). Whilst approaching the data with a set theoretical framework could limit the generation of new knowledge, given that the research is set within a psychoanalytic process, it was important to hold certain psychoanalytic values in mind, specifically, transference and countertransference elements that can reveal hidden aspects of communication in the data and take account of conscious and unconscious processes.

3.9 Limitations of Study

This study has a small sample size comprising of nine assessment sessions from three individual cases and relies on the work of one psychodynamic psychotherapist, that being myself. Therefore, the findings may not be generalisable. Since the research material is limited to the psychotherapists set of clinical notes, the patients experience of the beginnings of psychotherapy comes from the psychotherapist's perspective, rather than the patient themselves. Furthermore, it does not investigate experiences and differences from other individual therapies or therapists and their process notes. However, focusing on a small sample has meant that each session has been rigorously studied and analysed with significant depth.

Although the plan was to carry out weekly sessions, this was only possible in the first three sessions for Patient C. For Patient A, the third session was cancelled by the patient as they were unwell, resulting in a two-week gap between the second and third

assessment session. For Patient B, he was not able to attend the third assessment session before the Christmas break due to disruptions at school, resulting in an unplanned five-week gap between the second and third assessment session.

There are two central limitations regarding this research project, which are; the dual position of being both the psychotherapist and the researcher in this study, and the role of process notes as research material as described below.

3.9.1 Dual position of psychotherapist-researcher

It is possible that being both the psychotherapist and the researcher in this study may have influenced the data analysis. For example, due to having memory of later sessions since all three cases were still ongoing during the duration of the study, the researcher had knowledge of how the patients and their therapies developed at the same time as analysing the data. I therefore needed to work hard to keep that in the back of my mind so as to not influence the interpretation of the data of the initial three sessions.

Furthermore, being both researcher and psychotherapist in this study makes it more difficult to take an unbiased view of the data. Where researching one's own clinical material can create a lack of objectivity in the data analysis. For example, as discussed previously, it is possible that my knowledge of the patient, and experiences with them, influenced the codes I used, rather than the codes being purely based on the material itself.

3.9.2 The role of process notes as research material

As mentioned above, focusing on my own process notes limits the data set to my own set of experiences and case studies. Therefore, this study would have been strengthened by including data from other therapists' process notes to limit the impact of any subjectivity. Furthermore, using process notes, which is the therapists account of the sessions, results in the interpretations of the session being heavily influenced by the therapist's point of view and not that of the patient themselves. Therefore, it is not possible to claim that these reflect the patients' perspective and experience of the beginnings of psychotherapy. Similarly, Rustin (2019) talks about the limits of clinical process notes which are the 'therapists own retrospectively written-up account of it' (p.151) and the potential errors of what is 'remembered and selective' (p.151). Thus,

a different therapist may have seen different elements in the sessions analysed. Conversely, O'Shaughnessy (1994) in her paper 'What is a Clinical Fact' describes process notes as giving 'privileged access to the patient's interiority. Inner life emerges with a detail and depth not elsewhere accessible' (p. 170), and therefore suggests that insights into the patient's internal world can be gained from them.

It is also important to highlight the limitations of using process notes as reliable data. Whilst process notes can provide significant insight into the therapy process, the central problem of subjectivity is stressed, in which process notes are heavily influenced by the therapist's feelings and opinions.

The reliability and validity of process notes as research data has been debated by several authors. For example, much of this data relies on clinicians' memory of what has taken place and accuracy of recording on the clinician's behalf (Creaser, 2019). As Rustin (2019) states: '…there has also been a question latent in this procedure-namely, how accurate is the record-from-memory of an analyst, and how liable to omission or distortion may it be?' (p. 150).

Chapter 4 Findings

The purpose of this study is to shed light on the process of beginning of psychotherapy for adopted children and young people with adverse early life experiences and severely compromised attachment histories.

The grounded theory analysis generated six core categories from codes seen in all three sequential sessions and in all three patients. These include:

1. Establishing the framework and practical setting
2. Difficulty in relating
3. Alterations in technique: active and enquiring and non-challenging technique
4. Embodied unspeakable communication
5. Patient and therapist being nice to each other
6. Feelings of exclusion and deprivation

This chapter is accompanied by a brief overview of each category finding and what it forms from. To illustrate this, I will give examples by directly quoting from the clinical material: the therapist's process notes from all three patients (a further discussion of these findings can be seen in chapter 5).

This study's findings come from process notes from three sequential psychotherapy assessment sessions for three patients – here called patient A, B and C. Patient A is a 13-year-old girl, patient B is a 11-year-old boy and patient C is a 7-year-old girl. All patients were referred for a psychotherapy assessment in a Child and Adolescent Mental Health Service. All names used are pseudonyms.

4.1 Establishing the Framework and Practical Setting

This category refers to the therapist establishing the therapeutic frame and the technical issues of the setting. This category stems from focused codes such as 'introductory processes', 'establishing why patient is here' and 'patient wanting to take items home from the therapy box'.

This study has shown that the therapist introduces the patient to the frequency, place and length of sessions at the start of the work together.

For Patient A, the therapist introduces why she is there and the time and place of sessions:

> *"I ask mum if she has told A why she is here. Mum said we told her a little and that she is here to help with her challenges and things she finds hard. I say about a space here to have for herself to help with the things she is struggling with and what she is finding difficult and that I could help with these things…I talk about the same room each week and the 6 sessions and the time and about a review after Christmas with parents. A is nodding and listening very attentively" (Patient A, 1st Session).*

A further example demonstrates the same point:

> *"I talk about the time and day of sessions and the box of toys. C is smiley and looks over at me and hides her face a little behind mum all embarrassed" (Patient C, 1st Session).*

Establishing confidentiality and trust are also seen to be important for the patient, as demonstrated in the extract below:

> *"C directs me to another page of her diary that is about her friend who told her other friend something and she was angry and upset that she was not able to keep it to herself." (Patient C, 1st Session).*

The sessions studied draw attention to technical issues of the setting, specifically patients wanting to take items home from the therapy box. Typically, in psychotherapy practise, patients are encouraged to keep the things made in the therapy within the therapeutic setting. This was seen most clearly for Patients B and C, who each wanted to take an item home from the therapy box. As demonstrated in the extracts below:

> *"She fixes the bobbles on both our bracelets so that they are now matching. It is time and I talk to C about needing to keep them here and the things we do here. I explain why I think it is important to do this and she is resistant to taking hers off and wants to show mummy. I allow her but also aware of the boundaries and needing possession and taking things home." (Patient C, 2nd Session).*

> *"B asks if he can take the fidget spinner home. I say about maybe when B next comes, I can bring out the fidget spinner so it stays in his box" (Patient B, 1st Session).*

Another technical issue for Patient B was not being able to stay in the room for long without his mum and wondering the corridors, as seen in the extract below:

> *"He then says he needs mum. He moves to the bean bag and places himself down and then gets up and says how he needs mum again. I ask if he knows why and he says no I just need her. He goes towards the door and wonders where she is. He says he wants to find her and suddenly goes out the room*

and looks for her. I say I think they will be in reception and try to help manage him wondering around the corridor." (Patient B, 3rd Session).

4.2 Difficulty in Relating

This category identifies the difficulties for the patient in relating to the therapist. It is generated from codes relating to a dichotomy of two distinct forms of relating to the therapist: a 'too close' form of relating and a 'too distant' form of relating. This category stems from codes such as 'therapist feeling too close to the patient', 'patient using closed body language' and 'patient finding it hard to open up about feelings.'

This category thinks about the patient managing the beginning relationship with the therapist – either by relating to the therapist too closely or holding self at a distance. In this way, the patient aligns themselves in a polarised way of relating. In the sessions studied the two distinct forms of relating coexisted together and were operative at different times for the patient.

Relating too closely was revealed in a number of ways. For Patient A, relating too closely is by staring intensively at the therapist which felt to be intrusive, so much so, that the therapist felt a lack of space between them and the patient. As seen in the following two extracts:

> *"Patient looks at me and then behind me at the wall. She watches my hand closely as I go to scratch my neck which becomes a little itchy. I feel like she has a lot of watchful eyes on me. I feel it is quite hard to feel a sense of space between me and her like I am drawn in to staring at her and I struggle to find myself taking my eyes off her very much. Because of this it feels like the rest of the room I haven't much looked at and my eyes become quite heavy because I am so drawn to looking at her and feel very fixed on her." (Patient A, 2nd Session).*

> *"She smiles at me and looks at me intensely and it feels quite intrusive." (Patient A, 2nd Session).*

Likewise, the extract below demonstrates how quick and intense it feels for the therapist with Patient C:

> *"She fixes the bobbles on both our bracelets so that they are now matching... I did feel a conflict of whether I can take my bracelet off in front of her but I do and put it in the box. Something I felt was feeling quite trapped by this bracelet - as if I am now in something very final and permanent that I can't get out of. Like some sort of pact or feeling quite entwined, tangled and trapped in something very intense very quickly." (Patient C, 2nd Session).*

Furthermore, strong feelings of love are already expressed by Patient C towards the therapist in the second session, which the therapist is surprised by:

> *"Patient looks at my hand as if maybe seeing if I have a ring on it perhaps. I wonder if she is wondering who is my family or who loves me in my life. She says well one of the people is me. I say she loves me. She nods yes. I am taken aback by this as we are only into the second session." (Patient C, 2nd Session).*

Similarly, the therapist feels surprised at Patient B, who has already attached some emotional feelings to the therapy after just one meeting:

> *"I say it is time and patient say's oh and puts on a sad face. I feel surprised that patient already feels sad about leaving after only meeting with me once. He is unable to get up right away and his mum says come on. He eventually gets up and looks sad." (Patient B, 1st Session).*

In conclusion, there is an overall sense of shock felt by the therapist for all three patients at the intense enthusiasm and emotional link already made at the beginning of therapy.

Conversely, relating at a distance was seen in a number of different ways. Patient A, kept at a distance by a closed body posture. This was by "*sitting with her hands carefully folded on her belly and her legs crossed"* (*Patient A, 1st Session).*

She also spoke about not sharing much of herself with others:

> *"I'm not very good at sharing things with people like I either just get angry or I take myself away from people" (Patient A, 1st Session).*

In the extract below, it is possible to see Patient A's rationale for what drives her to being distant - her fear of losing others and being left by them which the patient links to her earlier experiences of abandonment:

> *"…She says she knows that she doesn't really share much with her friends or tells them much and maybe that's why. She tells me that she fears like losing her friends and them going away. She says she thinks she is like that because of you know when I was very little and what happened to me" (Patient A, 1st Session).*

Furthermore, Patient A talks about her mistrust of others:

> *"She says I don't really trust people that well. She says I have a friend who I tell stuff too but she is someone who has been through something similar to me before so I feel I can tell her stuff." (Patient A, 1st session).*

Likewise, Patient B is distant from the therapist by hiding and avoiding:

> *"Patient puts his head down and avoids eye contact with me…he suddenly gets up and hides in the tent that is in the waiting room. I say that he wants to hide himself. I can see him trying to close the tent door" (Patient B, 1st Session).*

Furthermore, in the second session, Patient B wants to leave, after the therapist tries to talk to him about him feeling that he is in therapy because he is bad. This demonstrates the patient not letting the therapist get close enough to his feelings, as the extract below demonstrates:

> *"B stands up and repeats that he is bad... I say do you think you are here because you have been bad? Mum says that B can think that a lot don't you. I say that I wouldn't want B to think this and how he is not here because he is bad and he is not here because of good or bad. Before I can finish B says he is confused. I can see him getting up and he starts to move around and opens the door. He says he is hot and wants to go out. His mum helps him back in by pulling him in... B says that he doesn't like feelings, he doesn't want to talk about feelings." (Patient B, 2nd Session).*

There are times when the therapist also modulates some distance between them and the patient. This is by not sharing interpretations, as seen in the extract below:

> *"She says her hands are getting quite fidgety so she's going to open her box and use something. She says she finds this button hard to open the box and how she found this difficult the last time she came here. I think of how she might be referring to the difficulty to open up here. I don't say this. She opens the box and takes out the notepad and a pencil." (Patient A, 2nd Session).*

The therapist's reluctance to share her thoughts with Patient A, can indicate something about the therapist's own experience at the beginning of therapy; that they too are unsure how close or how distant to be (this will be further explored in the subsequent category).

It is evident from the process notes that all three patients are distant by not sharing much or keeping things to themselves, a way of relating which seems to exist outside therapy and which others can find frustrating, as seen in the extract below for Patient A:

> *"I don't know she says she just gets on with boys whereas girls always argue. I ask if she can remember when she had an argument. She says she doesn't know. I ask what it was. She says oh I don't know something about that I wasn't like telling them everything and they find it annoying, like I was keeping stuff to myself. I don't know." (Patient A, 2nd Session).*

4.3 Alterations in Technique: Active and Enquiring and Non-challenging Technique

This category identifies the technique that the therapist uses for all three patients in all three assessment sessions. The findings identified two key aspects of the therapist's technical approach towards the patient; firstly, an active and enquiring manner and secondly, a non-challenging manner. This category is formed from focused codes such as 'therapist reassuring the patient', 'therapist helping the patient out to start', 'therapist not being too challenging', and 'information-finding'.

This category forms several components and sub-categories in which a diagram has been used to illustrate this more clearly, as demonstrated below:

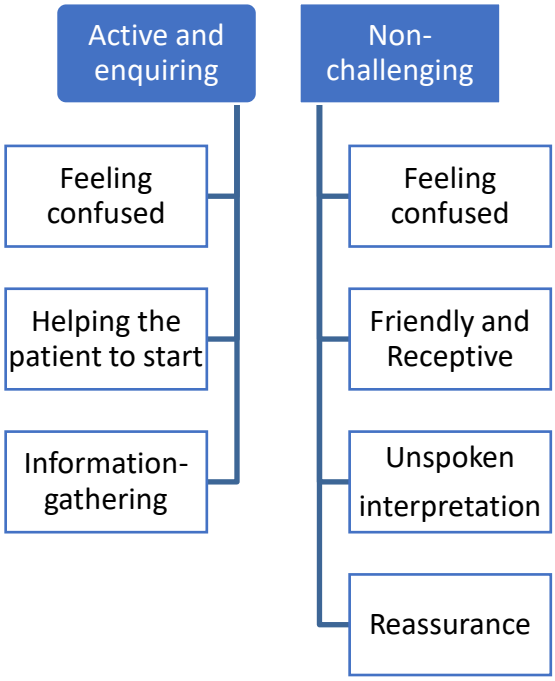

Figure 1: An illustration of components and sub-categories of the therapist's use of technique.

4.3.1 Active and enquiring

As seen in figure 1, the therapist uses an active approach to help the patient to start, as well as to get more information from the patient by asking questions.

Helping the patient to start

The therapist helps Patient A to start the session, as seen in the extract below:

> *"Once we are alone, there is silence. Patient looks at me and smiles and makes a short high pitch sound, a sort of nervous pitch to her voice and a giggle. There is silence. I help patient out as I feel she might struggle to start a conversation with me" (Patient A, 1st Session).*

Further on in the clinical material, the patient suggests that not being given anything to do in the session leads to fidgeting which conveys anxiety and not being comfortable. As the extract below demonstrates:

> *"Patient says I am just moving all the time and need to fidget; I find it hard to sit still. I say well in terms of today it may be because you are a little anxious meeting someone for the first time and being somewhere new and not knowing what to expect or what it is going to be like. She says yeh. She says yeh like and not having any activities. She says she use to have a social worker who she used to play games with a lot when she saw her" (Patient A, 1st Session).*

Likewise, the therapist uses an active approach to help Patient B who is struggling to get to the therapy room. In this instance, the therapist brings various toys to the waiting area to help him transition to the room, as seen in the extract below:

> *"I say that maybe he would like something to help him get to the room. Mum says this is a really good idea. She tells me B likes fidget spinners and do we have one of these. I say we do that I can bring some things from his box in the room to show him what we have. B is looking at me and half puts his thumb up from the tent. Mum says I think that might be a yes. I go and get a fidget spinner and a soft teddy that I have put in his box" (1st Session).*

<u>Information-gathering</u>

This is when the therapist asks questions to gain information from the patient, which shows they are being inquisitive.

This links, in part, to times when the therapist needs to gather more information, as the patient is not being very open or sharing much, as seen in the extract below for Patient C:

> *"I ask her about school and she says that she is having her last day of school today so she is off now. I say that school is closing and things are changing around her, she says that yes, her other activities she does is stopped as well and named a few things. I say how the things she has enjoyed doing are stopping and she can no longer do them for a while. C nods. I ask how she is feeling about that. She says hmm and thinks for a bit, she says she doesn't know the word but she thinks annoyed". (Patient C, 3rd Session).*

There are also times when the therapist asks questions in order to clarify something as they are confused by what the patient is trying to say, as demonstrated in the extract below:

> *"He says at school his friends called a pizza restaurant. B talks very fast and explains how he called them and he said over the phone what you talking about and then hanging up to tease them and then saying what you want and then hanging up. I ask if this was at lunch time and he says yes when he was with his friends. He laughs as he tells me. I ask if they wanted to order pizza to school and he says no we just thought it was funny to call them." (Patient B, 3rd Session).*

4.3.2 Non-challenging

This sub-category identifies the therapist as not being too challenging towards the patient. This is made up of three elements, 'friendly and receptive', 'unspoken interpretation' and 'reassurance', as techniques used by the therapist for all three patients.

Friendly and receptive

For Patient A, the therapist does not allow for many silences as they do not want the patient to feel uncomfortable, as seen in the extract below:

> *"I realise that I am not really allowing for much silences, which usually I am ok with doing. I find myself needing to feel gaps and silences or I can't allow for them for very long… She feels nervous and I feel worried a little in my countertransference about what she will make of me and if she will like me. There is already a feeling for me of loss and if she will come back and stay. (Patient A, 1st Session).*

In the above extract, the therapist adopts a non-challenging approach that appears to stem from a place of anxiety – in that the therapist is worried the patient will not like them and will not return if they are too challenging on them.

Again, in the following extract, the therapist is very compliant to what the patient wants to do in order to help them to stay:

> *"He says that he doesn't like feelings, he doesn't want to talk about feelings. I say that we don't have to and maybe you would like to play a game perhaps to help you stay. B says yeh let's play. He begins to get the bottle and the game is to flip it so it lands on an end and is standing up" (Patient B, 2nd Session).*

Here the therapist does not challenge the patient to talk about their feelings, instead, they allow them to play a game. This seems again to come from a place of anxiety in the therapist, in which the patient will leave if they are too challenging.

For Patient B, the therapist uses a less challenging technique of 'displacement' to address the patient's fear of coming to the room on their own. This is where feelings are ascribed elsewhere and not in the patient himself or in the transference with his therapist. In this instance, feelings are directed to the soft toy, as seen in the extract below:

> *"He looks up briefly at me and then spots teddy in my hand. He says yey teddy is back. He is smiling and seems very pleased. He continues to be on his phone. I say that teddy is still a little scared and worried so he will need your help coming in today would you mind helping him. B nods yes smiling" (Patient B, 2nd Session).*

Unspoken interpretation

In the sessions studied, the potential negative transference does not get shared with the patient. Rather, the therapist keeps a lot of their transference and countertransference interpretations that they are thinking to themselves and is not said in words with the patient. This seems related to the therapist feeling worried that a direct transference interpretation may be too threatening to the patient, as demonstrated in the extract below:

> *"I think of isolation soon when we are about to say goodbye and maybe her sense of separation and loneliness. I don't say this as I am unsure how she will be able to manage more darker thoughts like this" (Patient A, 2nd Session).*

Likewise, the therapist does not interpret their thoughts to Patient B about his feelings of rejection, as seen in the extract below:

> *"I ask if they wanted to order pizza to school and he says no we just thought it was funny to call them. He says that we even called dominoes and then said hello pizza express. I think about something the patient is trying to tell me about feeling unwanted or rejected and not wanting him but someone else. I think about how maybe he feels I hanged up on him during the summer. I don't say any of this. Instead, I think of something B is telling me about teasing and confusing them. B says yes." (Patient B, 3rd Session)".*

Reassurance

In the extract below, the therapist reassures Patient A that her drawings will not get rubbed out, as seen in the extract below:

> *"She rattles through her school blazer pocket. I say I can hear a whole world in there. She giggles and says yeh she has a lot. She starts drawing out lots of items mostly pens and pencils. She says oh yes here we are, she shows me two erasers that are mouse tip ex pocket mice. She says she has them so she can erase her doodles. I say well unlike school, here is different and how it is somewhere that her drawings won't be rubbed out and will stay in her box to think about them." (Patient A, 2nd Session).*

Likewise, the therapist reassures Patient B when they struggle to get to the therapy room, as seen in the extract below:

> *"His mum tries to pull him out of the tent a little and I say that its ok if he wants to hide, there is no rush we can take our time as I can see mum trying to stop him- but I wasn't sure if I wanted him not to be able to hide when he might need to." (Patient B, 1st Session).*

The therapist also reassures the patient by saying, "*today is going to be just to say hello" and "I say about just coming in to meet me and to play a game that he would like." (Patient B, 1st session).*

4.3.3 Feeling confused

A third strand relative to this category are feelings of confusion felt by the therapist; this is mostly in relation to technique. This thinks about the therapist negotiating how to be with the patient in terms of technique, such as how active or passive to be and how challenging or non-challenging to be.

For example, in the first session, the therapist initially takes a passive role when Patient B is refusing to come to the room and watches from a distance as mum tries to manage it, however, the therapist later shifts their approach and becomes more actively supportive.

As described in the preceding sub-category, there is confusion in the therapist's technique about whether to share interpretations to the patient or whether to hold back and not say anything. This implies a tension in the therapist's technique for how they should be relating to the patient.

There are also times when the therapist feels confused by the patient and does not understand them, as seen in the extract below for Patient A:

> *"She continues to play with the playdough. She says that it is like imprinting her fingers on the playdough. Like finger prints. She says it reminds me of like a burglar you know and if they cover it with something so they don't leave an imprint. It is hard to make sense of what she is saying. I say she is leaving imprints on the playdough. She says yeh like but if I wore gloves you know that it won't leave a mark. She says she doesn't know why she is so fascinated by all this. She says probably because I like art so much." (Patient A, 3rd Session).*

As seen in the extract above, the therapist finds it hard to understand what the patient is saying. Likewise, the patient is also confused about what she is bringing up.

Similarly, the therapist is confused by Patient C:

> *"There is something in this moment that I feel for C which is that I am confused by her but also how easy it is with her" (Patient C, 3rd Session).*

4.4 Embodied Unspeakable Communication

This study found patients using a lot of bodily and unspeakable communication. This category relates to three key areas: one that focuses on how the clock is used in the sessions. The second area is psychosomatic presentations – this stems from codes concerning 'how the patient is feeling itchy'. It is important to highlight that the clock and body seem to relate to anxiety and are used to convey discomfort. The third area, relates to how the patient is acting young or remembering when young.

4.4.1 Psychosomatic presentations

In the sessions studied, there are various psychosomatic effects in all three patients, such as itching, rocking and feeling hot. These all seem to relate to anxiety and feeling ill at ease.

For example, Patient A rocks herself back and forth, which the therapist understands as the patient feeling nervous and worried that they will not be liked:

> *"A continues to stay in the same position and rocks little forwards. She feels nervous and I feel worried a little in my countertransference about what she will make of me and if she will like me." (Patient A, 1st Session).*

Furthermore, Patient A's fidgeting conveys a sense of anxiety and not being comfortable following a difficult conversation about friendships:

> *"I say maybe this conversation is difficult and maybe friendships are what she finds most hard. A says yeh she just finds it hard to keep friends and she does get upset. Like her parents know when she has had a bad day or something*

> *and it is mostly to do with friendships and I don't tend to want to speak about it, I just want to hide away or I get angry and just shut down really. I say maybe you are thinking don't make me speak about this now. She smiles a little and says maybe. She says her hands are getting quite fidgety so she's going to open her box and use something." (Patient A, 2nd Session).*

In addition to fidgeting and rocking, there are also examples of Patient A itching:

> *"A says her hand is itching and tells me about eczema that she gets. She then says her nose she feels she is about to sneeze and then says her eye is itchy. I say something is happening to her body lots of itching, first her hand and then her nose felt all itchy and now her eye. She says yeh it's strange" (Patient A, 3rd Session).*

Likewise, Patient C also experiences itching, specifically in her hand, head and eye, as seen in the extract below:

> *"C seems to be itching her hand and I comment on this. She then itches her head and I comment on this too. She says yeh because I think I might have nits. She says well maybe not nits or a scab that has like white eggs there. I suddenly think of her not so cute really. Her hand is also a little red and itchy and notice this part of her. She then itches her eye." (Patient C, 3rd Session).*

Similarly, Patient B's hunger conveys a sense of anxiety about being in the room on his own without mum:

> *"He says he is hungry and goes to his bag and takes out a cereal bar. He bites a big mouthful and then stuffs another cereal bar in his mouth. I say he seems to have a lot in his bag. He says yeh it is for school and has all his school things inside. It looks as if the front pocket of the bag is full of snacks to eat. He then says he needs mum. He moves to the bean bag and places himself down and then gets up and says how he needs mum again." (Patient B, 3rd Session).*

4.4.2 Clock watching

There are many times when Patient A looks at the clock during a session. For example, *"She looks at the clock and then around the room a little before looking at me." (Patient A, 3rd Session).*

Again, Patient A looks at the clock following a difficult conversation about social workers that do not stay and being left by them, as demonstrated in the following extract:

> *"She says, its fine I am use to having lots of social workers as I have had loads when I was very little. I say so she is use to people going and new people and maybe it doesn't feel too strange. She says no she has had so many and is used to it. Something feels very sad about this and I start to wonder if meeting*

> *me for the first time maybe doesn't feel so weird after all. That I'm another new person she is meeting and wonders how long I will stick around for. A, looks at the clock." (Patient A, 1st Session).*

Likewise, Patient C looks at the clock during a session as something to fix on:

> *"She gives a big squeeze of the playdough again with her hand putting all her strength and might into it. She looks over at the clock and fixes and looks at it for some time." (Patient C, 1st Session).*

Furthermore, Patient C looks at the clock after a difficult conversation about her birth mother, as seen in the extract below:

> *"There is a page in the diary that she wants me to read that says about her birth mum who loves her and remembers her and misses her. Mum says she wrote that to C in response to her note before which was that she thinks her birth mum doesn't' love her or remember her. C looks at the clock again ". (Patient C, 1st Session).*

Similarly, Patient B looks at the clock during a session:

> *"B doesn't make much eye contact with me and has looked at the clock a couple of times." (Patient B, 1st Session).*

4.4.3 Acting young or remembering when young

The sessions studied capture moments in which the patient is presenting as little or are idealising being little. This category forms from codes such as 'patient acting young' 'patient recollecting on times when they were young' and 'therapist feeling patient is very little'.

For Patient A, this is seen by her reminiscing about things they used to love doing when little, as demonstrated in the extract below:

> *"She beams again and says how much she loves this playdough. It feels so nice in her hand. She remembers when she was little making things out of the playdough. She says it is so squishy and it has gone all warm now, it's nice. I say maybe she likes it so much as there is something about how she prefers being littler. She says it's true. I do think I prefer being a little one, she says she misses being a child. I ask what she misses about it. She says she misses like you know when you do a piggy back and you were carried everywhere." (Patient A, 1st Session).*

Furthermore, there are times when the therapist thinks Patient A is acting young, for example:

> *"A rolls the playdough around in her hand and she likes the feel of it in her hand, she smiles as she plays with it, like a small child getting much delight. I say she is happy with the playdough. She says yeh, she likes it, and it makes her think of when she was little." (Patient A, 1st Session).*

Likewise, the therapist picks up on 'little' aspects of Patient C, such as her "little voice", "little princess", and "cute little giggle".

Similarly, Patient B appears little to the therapist because he does not use many words:

> *"B feels very little and doesn't use much dialogue." (1st Session).*

Furthermore, the therapist notices how little Patient B becomes when he is anxious about going to the consulting room, like a sudden regression:

> *"I move a little to the opposite side of B so he can see me a little and I say hello, I think you are not sure if you want to come in, that's ok I can understand it's a new place and you're meeting me for the first time. B looks so little and puts his legs up to his chest. He says no and tells his mum he doesn't want to go in. He looks so vulnerable. Mum says come on you can do this. B says no and shakes his head. He now looks very little and sounding little too, he says hide. He suddenly gets up and hides in the tent that is in the waiting room." (Patient B, 1st Session).*

4.5 Patient and Therapist Being Nice to Each Other

This study has found that both the patient and therapist appear overly nice to one another in the beginning phases of therapy. This category stems from codes such as 'the patient being sweet and endearing', 'patient being agreeable and polite' and 'therapist and patient wanting to make a good first impression.'

In the session's studied, Patient A presents as overly nice with the therapist by appearing 'sweet' and 'endearing', as the extract below demonstrates:

> *"I say hello and she looks at me with lots of curiosity but with a sweet and endearing smile." (Patient A, 1st Session).*

Likewise, Patient C presents as 'sweet':

> *"She is smiling very sweetly at me like she is a little princess." (Patient C, 1st Session).*

Furthermore, Patients A and C are often 'giggling', 'smiling' and 'agreeing' a lot with the therapist.

Patient B, also gives off an appearance of being ‘adorable’ to the therapist:

> *“I come back into the waiting room and B is standing up. There is something vulnerable about him that you can’t help but adore.” (Patient B, 1st Session).*

Also, Patient C is very complimentary of the therapist and presents as ‘cute’:

> *“She draws a face with big black eyes with small dots inside of them as if they are glistening. It is a girl and she is smiling. I ask who this is. C lowers herself very close to the paper and writes my name. I say oh it is me. She hands it to me and I am wearing a dress. I ask what she thinks of me in the picture. She smiles and says she is cute…C looks at me in the eyes and smiles all cutely (Patient C, 2nd Session).*

Likewise, Patient C appears to want to please the therapist and give them a good time. The therapist understands this as the patient wanting the therapist to like her so that they will not reject her, as demonstrated in the extract below:

> *“C finds the ball in her box and starts to throw it to herself. She gets very excited and is clumsy with the ball not catching it and laughing as she misses it. She then looks at me and throws it at me. I say she wants me to join her now. We throw back and forth, C being clumsy with the ball, sometimes dropping it, sometimes catching it. She giggles and is very excited which I comment on. She has somehow become livelier and has more energy. She then tells me that she thinks she drops the ball because it is funny and she is trying to make me laugh and find it fun. I say she is trying to make me laugh and have a good time with her and give me a good time and make me happy. She shows the ball landing on one of the cut out pictures and says it prefers this one it has picked this one as it likes it the most. I talk about her needing to be liked here so maybe I will pick her and she will keep coming here. Her eyes lighten up and says she wants to come here every day!” (Patient C, 3rd Session).*

Furthermore, the therapist too wants to be liked by the patient and not have anything negative shown about themselves; this is perhaps driven by the therapist fearing the patient will not stay, as seen in the extract below:

> *“There is already a feeling for me of loss and if she will come back and stay. I feel determined to not have anything too negative about me and for her to like me in the first session.” (Patient A, 1st Session).*

The therapist also notices patients only bringing in pleasant things and the more unpleasant aspects seem to be split off from them, as seen in the extract below:

> *“She then looks at the poster behind me and says she doesn’t know why but she keeps looking at the poster. I say she does look at it a lot when she comes. She says yeh I like looking at it. She points out the nice blue colours she likes on the outside and how it reminds her of the sea. She says she also likes the*

> *middle bit, like that spiral shape thing, it kind of reminds me of a flower. I realise about all the other bits on the poster that has blood and sword men and A doesn't seem to want to acknowledge these parts on the board. There is something very sweet, good and kind and clean about A, that if there was anything bad or disturbed or contaminated about her, she would worry." (Patient A, 3rd Session).*

Also, the therapist notices how Patient C wants to appear cute and tidy for the therapist, as demonstrated in the extract below:

> *"I talk about her maybe feeling that she needs me to think a certain way about her, that she is cute and loveable and friendly and that I like her work and creations that she is doing here. C smiles sweetly at me showing a little of her teeth and appears a little shy. She tidies up around her keeping everything very neat and tidy and just keeps out the cut-out pictures all lined in a row." (Patient C, 3rd Session).*

4.6 Feelings of Exclusion and Deprivation

In the sessions studied, patients have shown feelings of exclusion and deprivation. This is mostly in relation to being deprived from lasting relationships. This category stems from codes such as 'temporary nature of relationships', 'patient wanting to take things home', 'patient finding it difficult to leave and say goodbye' and 'being left.'

The sense of feeling deprived from lasting relationships is seen most clearly for Patient A. As seen in the extract below, she expresses how her relationships often come and go:

> *"Like I think I find it hard to talk about because my friends they sort of friends one minute and then not the next and they sort of come and go" (3rd Session),*

Furthermore, she describes her experience of being left by social workers:

> *"She tells me that she doesn't see her social worker anymore because she had to leave. I ask how she felt about that. She says it did affect her and was upset. She says its fine I am use to have lots of social workers as I have had loads when I was very little. I say so she is use to people going and new people and maybe it doesn't feel too strange. She says yes she has had so many and is used to it" (Patient A, 1st Session).*

This study has also identified patients wishing to have a relationship that lasts and does not break, as demonstrated in the extract below which the therapist understands as representing her wanting to have a lasting connection:

> *"How maybe you would like to find a way to imprint here, to have a place here that you can stay and for it to be yours and no one to take it away. A says yeh very silently and smiles" (3rd Session).*

Likewise, for Patient C, the wish for a lasting relationship is understood to be represented in the friendship bracelet that the patient made for the therapist:

> *"I talk about wanting something that is just ours that keeps us together. I ask what about when we wear it and other people see it and those people who do not have one. She says that's the point is that they will know that we have made a friend. I think of something wanting very exclusive and close, idealised a bit and I talk about C maybe wanting us to be close and have this special relationship together where nothing can take us away from each other that is strong and lasting." (Patient C, 3rd Session).*

Feelings of exclusion and being left out recur in very concrete forms. As demonstrated in the extract below:

> *"He has some conversations with mum that are sometimes hard to follow because they are about after school or what he wants to do at home, either way they are not things that involve me. I wonder about my sense of B thinking about things after therapy that is without me. B then takes some time to leave when it is time and wants to play one more game" (Patient B, 3rd Session).*

In the extract above, feelings of exclusion are in relation to the patient and therapist doing things after therapy that does not involve the other. Feelings of exclusion are shown to be enacted concretely, by the patient then not wanting to leave so as to not feel left out.

Furthermore, feelings of exclusion are seen to be concretely enacted by wanting to take something home, as demonstrated in the extract below:

> *"B seems a little uninterested and I think the clock and ending has come to most of his attention now with 5 more minutes as I say this. B says oh and I say he looks sad about this. I say maybe he has had a nice time. B asks if he can take the fidget spinner home." (Patient B, 1st Session).*

Likewise, Patient C wants to take something home and come every day, as demonstrated in the extract below:

> *"I say it is time and she wants to take one of the cut outs to show her mum, I agree but say how we do need to keep the things we make in the box. We go back to mum and she shows mum and then hands it back to me. She says how much she enjoys it and wants to come every day. Mum seems unsure what to say and says well we can make some of these things at home too C." (Patient C, 3rd Session).*

Similarly, Patient A talks about her experiences of being left out from her friends:

> *"She said, I felt she was ignoring me…she just prefers to be with other people than me I think. I ask why she felt she was ignoring you. She said because she used to be friends with me…we no longer really talk and I feel she is ignoring me. She says that they are leaving me out. I say that it feels like you are feeling left out. A says yeh looking sad. I say that I know last week we didn't see each other and how it might feel like she has gone unnoticed and maybe felt left out from me." (Patient A, 3rd Session).*

Interestingly, feelings of exclusion are also felt by the therapist. This is in relation to the therapist feeling worried that the parent might feel excluded when they leave the room and the therapist and child stay together without them. As demonstrsted in the extract below for Patient A:

> *"We say bye to mum and I highlight that mum will be in the waiting room and will come if A feels she needs you. There is always a feeling of awkwardness for me in this moment when mum leaves as if someone is always left out and excluded." (Patient A, 1st Session).*

Likewise, for Patient C:

> *"Mum says right I think I will go then. Mum seems a little hesitant but eventually I reassure her that we will come to reception if needed." (Patient C, 2nd Session).*

It is striking how the therapist reassures the parent that the patient still needs them; this can indicate a powerful undercurrent from the therapist of feeling that they are pulling the child away from their parent and replacing them.

Furthermore, all three patients show that they want more time with the therapist, which comes from a place of deprivation. As seen with Patient C:

> *"Her eyes lighten up and says she wants to come here every day! I say every day. She nods yes. She says she likes it here it is fun…I say maybe you are telling me that coming once a week doesn't feel very much and you want more and waiting a whole week is a long time then. She nods yes." (Patient C, 3rd Session).*

4.7 Connections Between Core Categories

The data showed that each of the core categories manifested from different levels of mistrust and fears of rejection or abandonment, as illustrated in figure 2 below, which also gives examples of presentations from each category. The levels of mistrust, fear

of rejection or abandonment, and the associated core categories were all encompassed by earlier experiences of rejection, loss and discontinuity, as so commonly found in the histories of adopted children and young people. These links are explored further in the discussion section.

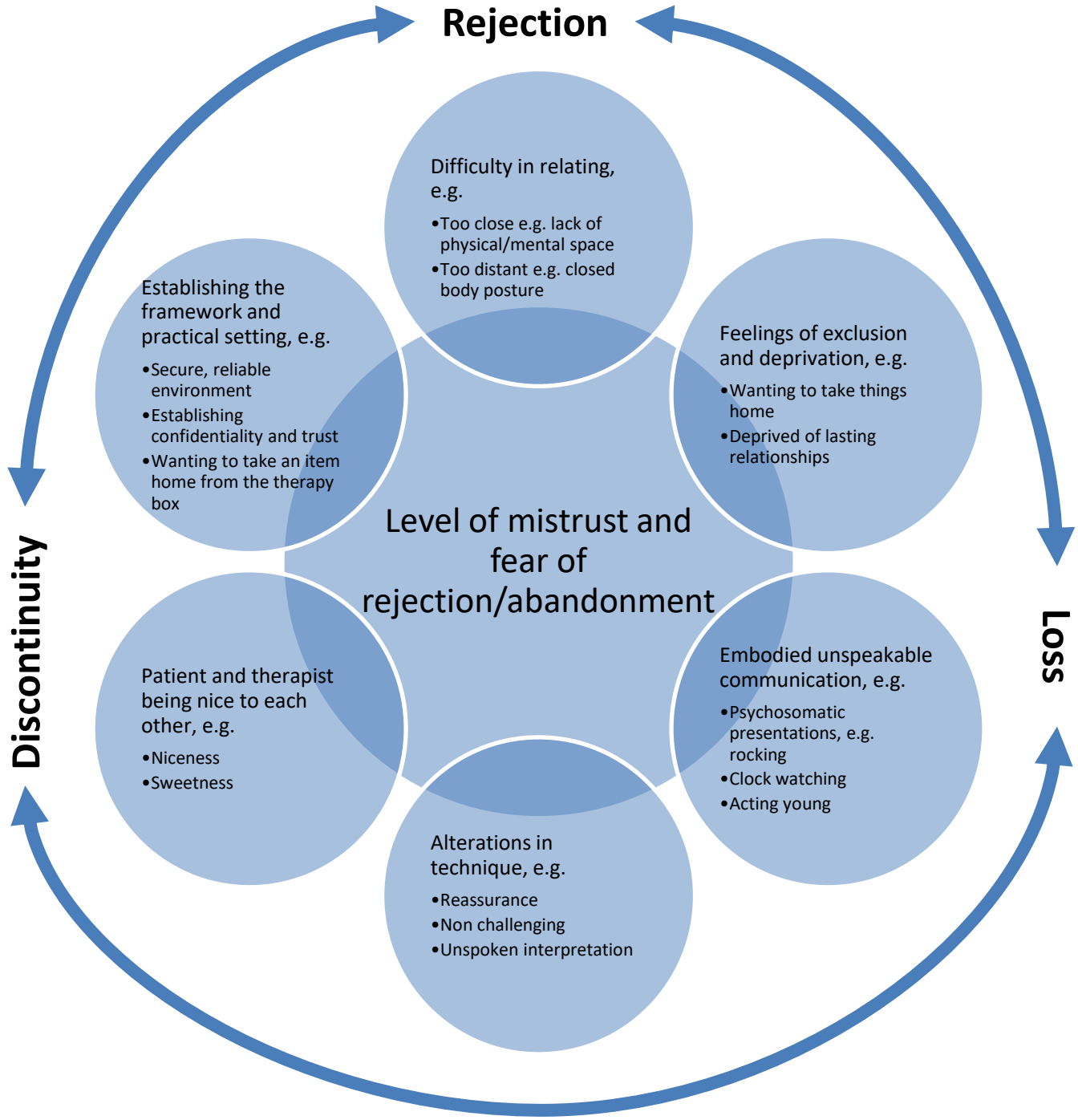

Figure 2: an illustration of core categories, examples from each, and their connection

Chapter 5 Discussion and Concluding Remarks

5.1 Study Overview

This study has explored the process of beginning psychotherapy with adopted children and young people using process material gathered during assessments for child psychotherapy. The aim was to shed light on the process of beginning of psychotherapy for adopted children and young people (as recorded in the therapist's process notes), in order to understand the emotional ramifications of beginning therapy, identify common themes, and explore the therapeutic technique used in these initial encounters. Psychoanalytic informed grounded theory was used to shed light on the process of beginning of psychotherapy for adopted children and young people. The findings in this study were relevant to all patients and sessions analysed.

Analysing the data using grounded theory led to six core categories. These are, establishing the framework and practical setting; difficulty in relating; alterations in technique; active and enquiring and non-challenging technique; embodied unspeakable communication; patient and therapist being nice to each other; feelings of exclusion and deprivation.

5.2 Summary of Key Findings

This study suggests that adopted children and young people enter a new relationship with the therapist in a dichotomised way of relating - being either 'too close' or 'too distant'. This is similar to earlier literature which found that a significant number of adopted and looked after children entered a new relationship with the therapist by either rushing into an intense involvement or appearing guarded, distant and unreachable (Rustin, 2000, Kenrick, 2000; 2005; Edwards, 2000; and Hopkins, 2000).

Relating in a way that was 'too close', was seen most clearly for Patients A and C. Patient A would stare intensively at the therapist or fixate on them. This caused the therapist to feel intruded on and felt a lack of space between them and the patient. Similarly, Patient C, expressed that she 'loved' the therapist after only the second session. A 'too distanced' form of relating was seen most clearly in Patient B, who would hide away from the therapist: *'patient puts his head down and avoids eye contact with me'.*

Further research is needed to explore whether either too close or too distant is specific to adopted children and young people, or whether this can be generalised to non-adopted children and young people. However, in relation to adoption, it can be assumed that aspects of 'too distant' and 'too close' could stem from an underlying lack of trust (see figure 2). In terms of 'too distant', this can be because they cannot trust or acknowledge they need someone and risk closeness when there has been so much rejection, humiliation and uncertainty in their earlier life experiences. Similarly, 'too close', can also be linked to a fear of abandonment (see figure 2), in which there is a lack of trust that the therapist will not leave.

In terms of relating in a 'too distant' form, previous literature has extensively explored the difficulties for adopted children in therapy to coherently form new attachments due to their early experiences of repeated separations and losses (Midgley et al, 2017, Wittenberg, 2003; Kenrick, 2000; 2005; Edwards, 2000; and Hopkins, 2000). In particular, Wittenberg (2003) refers to how early experiences are crucial in shaping how we relate to others. Children with early severe neglect, have been shown to struggle to trust and engage in a new relationship as they fear getting hurt or have little hope that the relationship will last. This highlights a contemporaneous theme from the beginning of therapy for adopted children and young people, which indicates the different levels that are operating all the time for the adopted child - being afraid to be close to someone and not wanting to trust the therapist, fearful the relationship cannot last, but also wanting the relationship. As seen with Patient A, who described how her fears of rejection and abandonment due to her earlier experiences, had led her to not trust people or open up to them: *'she says, she doesn't really share much with her friends or tell them much…She tells me that she fears like losing her friends and them going away. She says she thinks she is like that because of you know when I was very little and what happened to me…'* Whilst Patient C, made matching friendship bracelets for her and the therapist, which was understood by the therapist as wanting to have something *'close' and 'entwined'* so that nothing could take them away from each other.

The theory of 'adhesive identification' can provide some explanation for the 'too close' mode of relating seen in this study. Adhesive identification is described as wanting to identify with another in an adhesive way, specifically in this study, this refers to the entanglement or lack of separation that the therapist felt between themselves and the

patient. This phenomenon is closely related to Bick's observation, in 'The Experience of the Skin in Early Object Relations' (1968), where she describes how a baby holds itself together by sticking to an object in an adhesive way in the absence of a containing object. Alternatively, Tustin (1981) describes the use of adhesiveness as a defence against fears of separation. Meltzer (1992) also refers to adhesive identification in the 'claustrum' phantasy, in which a relationship is marked by intrusive projective identification, a 'claustrum' rather than a container-contained relationship. Melzer refers to the way a child who has had repeated experiences of neglect by a parental figure may try to force a way inside of them, rather than feel they belong within a containing object. This concept of the claustrum phantasy can be seen most clearly in Patient A, when the therapist felt, the patient was trying to *'get inside'* of them.

This study identified two key aspects in which the therapist seemed to regulate temperature and distance between them and patient (Meltzer 1976): firstly, an active and enquiring manner and secondly, a non-challenging manner. An active-enquiring manner involved the overt desire from the therapist to help the patient start the session, as well the therapist asking questions, either to gain more information because the patient was not being very open or the therapist was attempting to clarify something the patient said. For example, for Patient A, the therapist felt that they needed help to start and so suggested what topics they could talk about: '*I say well we could speak about something she has thought a lot about before coming or maybe something about her week.'* With Patient B the therapist used an active approach to help the patient who struggled to get to the therapy room, bringing various toys to the waiting area to help him transition to the room. For both patients A and B, the therapist asked questions in order to get more information, and to clarify what the patient was saying.

The desire to be helpful and ask questions seemed to stem from the therapist's observations of the patient feeling anxious and struggling to talk openly. This is different from the 'free association' approach typical of psychoanalysis, which can be challenging for adopted children and young people who struggle to engage in self-reflection (Alvarez, 2010; Music, 2014). Such children may require more direction and guidance at the beginning stages of therapy.

A pro-active technique, as seen in this study, is supported by an abundance of literature on technique with adopted and looked after children; with writers emphasising the need for the therapist to be active and responsive, providing actual holding rather than a more representative or symbolic transference object (Lanyado, 2017; Canham 2004, Kenrick, 2005 and Alvarez (2012); Hurry, 1998).

The second aspect in which the therapist regulated temperature and distance between them and patient was a non-challenging approach. This involved being friendly and receptive, not allowing for too many silences and using little direct transference interpretations. This study identified that the therapist was hesitant to use interpretations as they feared that the patient would struggle to cope with connecting painful aspects of their history. This was seen most clearly for Patient A, when the therapist was hesitant to link the patient's ambition to their own life experiences of neglect.

Clinical literature by Kenrick (2005); Goren (2020) and Boston & Szur (1983) all draw a similar conclusion, demonstrating that the therapist uses limited direct transference interpretations with looked after and adopted children. They show how interpretations need to be very delicate for looked after and adopted children, as it can be too persecuting to put them in touch with early deprivation.

The findings of this study support previous psychoanalytic literature which states that a change in psychoanalytic technique may be required to reach adopted children and young people (Lanyado, 2017; Hunter, 2001; Kenrick, 2005; and Alvarez 2012). However, a slightly different conclusion can be drawn from the findings of this study - that the use of a non-challenging approach is not only related to technical implications, but also stems from the therapist's anxiety about the patient not returning if they are too challenging on them. Where, giving too formed an interpretation and making too many links to their early history seemed to evoke a feeling in the therapist that they run the risk of frightening the patient off. In relation to adoption, it can be hypothesised that this anxiety from the therapist may be a countertransference feeling from the patient, which stems from the adopted child's expectation of rejection and discontinuity due to their early experiences of multiple losses and abandonment (see figure 2). This confirms the literature by Lanyado (2017) who describes how the child enters therapy with a lack of expectation of continuity due to their previous lack of continuity of care

and numerous separation traumas. The therapist's fear of the patient not coming back after the first meeting may also be connected to the powerful feelings related to rejection and loss when starting work with adopted children, possibly related to the patient's experiences of loss. This is seen most clearly for Patient A, where the therapist is very clear that '*there is already a feeling for me of loss'* and is doubting if the patient *'will come back and stay'.*

A further adaptation in the therapist's technique is the use of reassurance, as seen for Patient A, where the therapist reassured the patient that the therapy space will last, in response to the therapist worrying that the patient might feel they will get rejected or *'rubbed out'* by the therapist. An explanation of this could be that this is a response to the therapist having a sense of the patient's past experiences of abandonment, knowing that their experience of secure early attachments has been severely compromised. It seems that the therapist therefore wants to actively challenge the child's expectations, to counteract the internalised model. In light of this, the helpful and reassuring response by the therapist to the patient perhaps stems from a wish by the therapist to alleviate their early deprivation. The desire to be reassuring may also stem from a conflict evoked in the therapist of wanting to give the patient a good experience and leave a good impression. For example, as seen in Patient B, the therapist allowed the patient to play a game or be on their mobile phone, instead of pursuing talk about feelings, which they found uncomfortable.

As we saw, the therapist's anxiety about the patient not sticking around might be linked to this 'niceness' seen at the beginning of therapy, which can be understood as the therapist being overly nice in order to get the patient to stay. Similarly, the patient was also overly nice to the therapist as they were worried the therapist would reject them (see figure 2). This was seen most clearly with Patient C, who gave the therapist compliments and tried to get them to laugh and have a *'good time'*. This was interpreted by the therapist as the patient *'needing to be liked'* so that they will want them to *'keep coming'.* This gives rise to the hypothesis that niceness comes from a place of anxiety and not a place of trust, it is something that is 'performed' by both parties to prevent the relationship from breaking. The fear of rejection is present for both the patient and therapist, and its impact on the beginning of therapy is significant.

An alternative explanation for the therapist being non-challenging and fearing the patient not returning, may be marked by the therapist in this study's own position as a trainee and the pressure of needing to keep patients to fulfil caseload requirements, rather than relating to any specified adoption explanation. Although all three participants used in this study were patients who already needed treatment, it is naïve to assume that there was no additional pressure felt by the therapist to keep these patients in relation to the success and completion of the study.

As discussed previously, this study identified feelings of confusion felt by the therapist in particular, confusion about technique. For example, the therapist is often negotiating how to be with the patient such as, how active or passive to be with them and how emotionally close or distant to get to them in terms of use of interpretation and opening up of feelings with the patient. It, therefore, appears that the therapist at the beginning of therapy can feel unsure of their 'place' in relation to the patient.

The analysis of the data suggests that there is confusion for the therapist in navigating a process of being in a room with someone you do not know. It is important to ask if this is in relation to dealing with doubt and unknowns at the beginning stages of therapy, particularly aspects of technique, in which it is the therapists first time being with the patient and is therefore unsure what aspect of technique will work with this child or young person. This confusion can also be explained in terms of the primitive and concrete styles of expression that adopted children and young people use to communicate their experiences, which the therapist can find it hard to make sense of (Canham, 2004; Kenrick, 2000,2005). This is seen for Patient B, who covers and hides himself in a tent to show that he is scared, which the therapist was unsure how to respond to. Thus, it is not just the patient who is responding to being with someone they do not know but the same process is happening to the therapist. It is important to acknowledge that this confusion may relate to the therapist's level of experience, which is limited due to being a trainee. Therefore, further studies with more experienced therapists might be needed to test this.

This study suggests that establishing the therapeutic frame and setting is important at the beginning of therapy. This is probably true of all patients, but it may have particular aspects for adopted children and young people. This was seen in all three patients as the therapist introduced the patient to the frequency, place and length of sessions at

the start of the work together. This is consistent with the study by Midgley et al. on ‘Child Psychotherapists Working Practises with Looked After and Adopted Children’ (2017) which emphasised creating a secure, safe and reliable therapeutic environment.

The therapeutic frame may need to be particularly strong for this client group because of the fear of rejection and loss arising from their early experiences. This was most evident for Patient A, who missed a session due to illness, but was not contacted by the therapist to acknowledge this as they did not have their contact details. As a result, the patient felt rejected by the therapist. In response to this, the therapist got the patients contact details from the parent.

Although patients rarely directly address this fear of rejection, there was ample evidence of patients managing this anxiety through somatisation. This was most marked by psychosomatic presentations such as ‘itching’, ‘rocking’ and clock watching. This indicates that patients engage physically, which was more obvious in the children than the adolescent. Thus, these psychosomatic presentations relate to feelings of anxiety and discomfort in the patient, in which the somatic symptoms seemed to follow on from difficult conversations. Patient A for example, rocked herself and itched her skin following an uncomfortable conversation about friendships, which demonstrates how the body is used to convey discomfort. These findings show how powerful these unspeakable communications are, therefore it is important that the therapist focuses on both the physical and emotional worlds of the patient.

Clock-watching was frequent in the sessions for all three patients, although each patient used the clock in different ways. At times, the clock seemed to be a fixture in the room which the patient focused on. At other times, the clock was used in moments of discomfort, and on occasion, it was used to check how much time was remaining of the session, as seen with Patient A: *‘there is some silence and A looks at me and then turns to the clock. She says about 25 minutes to go.’* Canham (1999) suggested that many fostered and adopted children reveal significant difficulties with time in analytic work, since they have not yet developed a clear sense of time. This is because ‘many of these children come from backgrounds where their lives have not been characterised by rhythm, but rather by its opposite’ due to ‘erratic and unpredictable parenting’ (p. 161). Furthermore, he suggests that fostered and adopted children can

often feel they are not in control of time and that it either ‘passes excruciatingly slowly, or bewilderingly quickly due to the countless waits for suitable homes’ (p. 164).

It could be hypothesised that clock-watching is a way to try to distance oneself from painful feelings, like abandonment and loss, or as a way to hold oneself together when talking about it. For example, Patient A looked at the clock when speaking about ‘being left’ by others. Likewise, Patient C focused on the clock following a difficult conversation about her birth mother in which she doubted if she loved and remembered her.

Bick’s concept of ‘second-skin’ defences (1968) can provide an explanation for these body-based behaviours and clock-watching. She suggested that a failure in early skin containment can lead the infant to use substitute objects, such as looking at a light or a clock in this study, against falling apart. These substitute objects ‘can hold the attention and thereby be experienced, momentarily at least, as holding the parts of the personality together’ (1968: 56). This need to hold themselves can give insight into the patients experience of these beginning sessions, since starting therapy may be scary and bring anxiety. It is clear from the findings that patients focus on physical things to manage this beginning experience.

The category of ‘niceness’ could be a form of second-skin phenomena, in which the patient uses ‘niceness’ to counteract discomfort. For example, Patients A and C only wanted to bring in something ‘sweet’ and ‘pleasant’, whilst the ‘darker’ aspects of themselves seemed to get split off. Specifically with Patient A, the therapist observed that the patient only noticed the nice things decorating the room, such as the picture of the ‘blue sea’, whilst seeming to dismiss less pleasant elements in the room such as the picture of ‘blood’ and ‘sword men’ that got unacknowledged. It seemed that the level of awareness of violence and aggression was significantly understated, whilst awareness of ‘niceness’ was emphasised. This introduces the idea that niceness has two purposes, with the patient using niceness both to counteract anxiety about rejection and perhaps to counteract more unpleasant feelings such *as ‘isolation’.* This was seen for *Patient A*, who, prior to referring to the pleasant pictures on the wall at the end of the session, spoke about the difficult experience of being sent to an isolation room at school as a disciplinary penalty. The therapist linked this to feelings of seperation and loneliness experienced at the end of the session: *‘I think of isolation*

soon when we are about to say goodbye and maybe her sense of separation and loneliness.'

In relation to psychoanalytic theory, 'niceness' can be seen as the defense mechanism splitting, which aims to keep apart two opposing feelings/thoughts (see page 20 of the literature review). According to Klein (1946), splitting is a primitive defense charactersitic of the paranoid-schnizoid position, which actively keeps apart contradictory feelings and experiences of the self and signifiant others,'the frustrating and persecutory object is kept widely apart from the idealised one. However, the bad object is not only kept apart from the good one, but its very existence is denied.' (p. 7). Fagan has argued that many abused and neglected children 'have relied on splitting to manage overwhelming feelings, the capacity to make links between different parts of their personalities is extremely impaired' (Fagan, 2011: 132). This study confirms that both the patient and therapist at the beginning of therapy, are wanting to be on the 'good side'of the split. However, it is not fully clear, if 'being nice' is a normal experience for everyone when they meet someone new and if specifically comes from a fear of rejection. The factors that make the difference between these for adopted and non-adopted children would be important to further explore in future research.

Exclusion and deprivation are common feelings identified across all three patients. The data suggested that the patients felt deprived of lasting relationships and wished for a relationship with the therapist that lasts and does not break. This was seen most clearly for Patients A and C. For Patient C, the wish for a lasting relationship was demonstrated in the form of a 'friendship bracelet' that the patient made for both of them, which the therapist felt was an expression of the patient wanting something lasting and exclusive with them, whilst Patient A, shared with the therapist her experience of relationships that come and go. The patient later talked about 'imprinting' and demonstrated this by marking her fingerprints into the playdough, which the therapist interpreted as wanting to make a permanent and lasting connection.

The patients' feelings of deprivation could be linked to a feeling that they were not getting enough from the therapist. Specifically, the patients each expressed wanting more time and sessions with the therapist, as they felt they were not getting enough,

thus projecting the deprivation of their early object relations into the relationship with the therapist. According to Boston & Szur, ‘this can be one of the sources of pain for the therapist - how can a limited amount of therapy ever be enough for children who have been deprived of permanent parents?’ (1983: 8). In addition, feelings of exclusion were seen across all three patients. This could be enacted concretely, by wanting to take something home from the therapy box or not wanting to leave, so as to not feel left out of the therapy, or counteracted as patients talked about what they were going to do after the therapy which did not include the therapist, as seen with Patient B. This is also seen in relation to the parent of the child/young person in which the therapist felt worried that the parent might feel excluded when they left the room, leaving the therapist and child together without them.

The study acknowledges that it is not possible to make a specific link to adoption and that feelings of being excluded are because they are adopted and have experienced signficant amounts of loss and placement breakdowns. However, a link between the two is suggested. The strong thread running through many adopted children’s histories are the precarious attachments and life conditions of children in foster and adoptive homes who have had significant losses and little continuity of relationships (Kenrick, 2000; 2005; Edwards, 2000; and Hopkins, 2000).

Previous literature has identified feelings of exclusion for the patient in therapy, whilst this study has also indentified these feelings in the therapist for all cases investigated. This manifested itself in the therapist as feelings of awkwardness and worry when the parent left the room, leaving the child and therapist together without the parent. The therapist attributed these feelings to concerns that the parent may feel left out and excluded from the relationship.

In the context of this study, feelings of exclusion can be seen to be inherent in adoption. This can be due to the systemic nature found in adoption in which many families are involved, this includes the adopted family, birth family and foster family. The sensitivity felt by the therapist at parents being excluded, can be linked to this adoption process of one parent replacing another, which means that in adoption, the coming together is always at the cost of a rupture elsewhere.

Finally, this study has indicated that all three patients presented as little or young as indicated in the category ‘embodied unspeakable communication’. This was mainly

shown by infantile behaviour such as crawling, hiding, and putting on a ‘baby voice’, which involved using shorter sentences and repeating words such as, ‘*shy teddy shy teddy, aww’ (Patient B).* Patients also showed that they idealised being little, for example Patient A reminisced about the things they loved doing when little such as, *‘making dens’* and *‘piggy back rides.’* There are several possible interpretations of this presentation. Firstly, it can be hypothesised that this may have been used to appear ‘cute’, which can be linked to the category of ‘niceness’, so that the patient feels less likely to be abandoned (see figure 2). Secondly, presenting as little can be explained as a defensive function of regression, particularly in moments when the patient is trying to manage fear, anxiety and nerves. Thirdly, is that the patient is bringing the infantile transference to therapy. This is where early relationships, which is often where the trauma lies, becomes transferred to the therapy quite immediately in order to be gathered and bought to bear in the therapy. A final possible interpretation is that being little could be wanting to be a *baby* so that the patient can rescue that time in their lives. This links to Winnicott’s (1955) idea which refers to the tendency towards regression as a way to master an anxiety-provoking situation or to have ‘a renewed experience in which the failure situation will be able to be unfrozen and re-experienced…in an environment that is making adequate adaptation’ (p. 281).

5.3 Conclusions

The purpose of this study has been to shed light on the process of beginning of psychotherapy for adopted children and young people, in order, to understand the patterns and technical implications that are present at the beginning stages of therapy for this group. I believe that this study has achieved this and has made a meaningful contribution to the understanding of these areas.

This study has developed insight into some of the challenges and anxieties of getting to know someone at the start of therapy, and navigating a process of being in a room with someone you do not know. In particular, the fear of rejection at the beginning of therapy, which both patient and therapist are carrying, as well as elements of confusion. Important questions have arisen in light of this, such as, how do we manage not knowing the other person, does confusion get sufficiently acknowledged, is this confusion more heightened with adopted children than children in their family of origin,

or is it a natural confusion that is more present than expected from normal relationships?

This study has highlighted that the patient brings a lot of history and trauma to the beginning stages of therapy. It has shown that the therapist may react to this history and trauma, and even adding to the complexity of the beginning by bringing their own fears about starting a new relationship. Together, this highlights the important role that both the patient and therapist play in the beginning process of building a relationship in therapy.

5.4 Future Work

There are many important and interesting avenues for future research: firstly, a study that contains a larger sample size, and secondly, a study that includes gaining a boarder range of therapists' experiences of beginning work with adopted children. It would also be important and interesting to investigate the patient's perspective on their beginning experiences of psychotherapy, for example through interviews and feedback evaluations from routine outcome measures in CAMHS (Child and Adolescent Mental Health Services).

As discussed earlier, in this study assumptions and hypotheses have been made linked to adoption, however we cannot be sure that these findings are directly linked to adoption or would be present with children living in their families of origin, and this would need further testing. Therefore, one next key investigation required is to perform a study with a control group of three children with birth parents compared to children who are not. This is particularly important to see whether all the data findings come up in all data sets or some that are specific or more marked in adoption.

This study represents a significant addition to the body of knowledge of psychotherapy with adopted children and young people. This is because the literature review conducted found no published research within the child psychotherapy domain which focuses on the beginning of psychotherapy with adopted children and young people. This research has therefore addressed this gap, by drawing upon close observation of the process of beginning of psychotherapy for adopted children and young people.

Finally, this study points to the depth and richness of meaning contained in the opening sessions of psychotherapy, in which both patient and therapist are negotiating the

painful process of getting to know one another. With such richness and meaning to these early sessions, they are deserving of having more attention paid to them in terms of future practise and research.

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Appendices

Appendix A

Research Project

Beginnings in Psychotherapy with Adopted Children and Young People

Dear parent,

As part of my training as a child and adolescent psychotherapist, I am doing research that will be looking at beginnings in psychotherapy with adopted children and young people. The beginning of life is incredibly compromised for adopted children and young people and this can often be reflected at the start of therapy where beginnings and meeting new people can be meaningful as well as challenging for them. Looking at this with greater insight can help to identity the main challenges that are faced by your child entering treatment and improve access to appropriate services.

What are clinical notes?

To look at this I will be analysing my clinical notes from the first three psychotherapy assessment sessions with your child. This involves looking for specific themes that may emerge from the notes. Clinical notes are an ordinary part of clinical practise that are written up after each session and describe sequentially what happened in the session. They are used to help the clinician have a record of each session and are used in supervision to further think about the patient's behaviours and communications. Clinical notes and any additional data generated in the course of the research will be retained in accordance with the NHS Data Protection Act.

Does the research have any impact on my child's treatment?

No. This research is all done in the background and is routine to clinical practise. Therefore this research will have no impact on your child's assessment, treatment and service use and your child will receive treatment as normal. This research does not change anything to your child's clinical treatment or require your child or myself to do anything differently outside of the usual therapeutic relationship. In fact, looking in detail at clinical notes can help to further enrich my clinical thinking about your child and provide a deeper understanding of your child's internal world, which is of much benefit for the success of the treatment.

What will I do with the research?

When the research is finished, I will be writing a paper as part of my qualification. Direct quotes from sessions may be used in this paper but these will be completely anonymised so that all names, facts and places cannot be identified. It is also possible

that this paper, or parts of this paper, could go on to be published in academic journals to contribute to the understanding of the therapeutic relationship in working with adopted children and young people. It is likely that some parts of this paper will be presented to other clinicians so that they can learn from any findings.

This study is being supported by The Tavistock & Portman and has been through all relevant ethics approval (TREC).

If you have any questions or would like to discuss further you can contact me on (*). Alternatively, any concerns or further questions can be directed to my supervisor: (*) Or Dean of Postgraduate Studies at the Tavistock: (*) and Head of Academic Governance and Quality Assurance (*).

I (name) _____confirm that I have read and understood this information sheet for the research carried out by Gabrielle Gandz regarding beginnings in psychotherapy with adopted children and young people.

Signed: ……Date: …… ☐

I (name) _____confirm that I give consent for Gabrielle Gandz to use clinical notes from the first 3 psychotherapy assessment sessions of my child as part of the research described above.

Signed: ……Date: …… ☐

I (name) _____confirm that I understand that I can withdraw my consent at any point during the first 3 psychotherapy assessment sessions and up to one month after. ☐

Signed: ……Date: ……