A CLINICAL INVESTIGATION OF IMPAIRMENT IN THE DEVELOPMENT OF HEALTHY AGGRESSION WITH REFERENCE TO THE WORK OF HENRI PARENS

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Abstract

This thesis investigates how impairments and arrests in the development of ordinary healthy aggression interfere with development in general. I review the literature on aggression, particularly in relation to Henri Parens' concept of a spectrum of aggression. I describe two cases seen in a general CAMH service. The clinical material from the first year of therapy for each case is subjected to Grounded Theory coding to ensure that aggression has not been prejudiced over other significant factors. I describe the two cases using Anna Freud's Diagnostic Profile and Developmental Lines to trace the development of aggression within the broader context of more general development. I compare their respective progress with reference to Parens' work, using his spectrum to hypothesise that in some children there is a confusion of ordinary healthy aggression (or developmental assertiveness) with destructiveness. I suggest that this confusion inhibits development across several areas. Finally I discuss some possible implications for clinical practice.

Contents

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Introduction

Many children and young people are referred to mental health services with difficulties around aggression. It is a concern not just for clinicians but for families and all those working with children and young people. In recent times aggressive and/or destructive behaviour in the young is frequently flagged up by the media as a growing problem in society at large. We have become used to reports of anti-social behaviour, hoodies and asbos, knife crime and gang culture. The widespread rioting and apparently wanton destruction of property in August 2011 led to a renewed public debate about the causes of such behaviour. Whether this was an isolated phenomenon, a group response to a particular set of circumstances, or whether destructive aggression is in reality on the rise, children and young people who cannot regulate their aggression appropriately are adversely affected. What led to this investigation was, however, not so much a question of *dis-inhibition* but rather the effects of *inhibition* of ordinary aggression.

My particular interest in the early development of aggression began with a child, Jimmy. I saw Jimmy three times a week for psychotherapy when I was training as a child and adolescent psychotherapist. On our first meeting, Jimmy, an angelic looking five year old, swept the books from the display in the corridor, dropped the small dolls down the stairwell then broke the hinges on the dolls' house, dismantled the portable sink and screwed the handles from the cupboard. His mother was bemused and troubled: 'Why does he do this?' I felt unable to provide an adequate answer to her question. This little boy's gleeful destructiveness was a puzzle, his diagnosis of an autism spectrum disorder making it expectable but no easier to understand. Later, after several months of intensive therapy and a comprehensive network of support, a different, more ordinary kind of aggressive behaviour emerged. Normal development was evident: rivalry with his mother's much-loved pet led Jimmy to shut the family cat in a drawer; in his play a hungry dinosaur came to the fore, roaring and biting, the omnipotence of a small boy, his pride in his sense of agency and his worries when this failed or was threatened.

In discussion about this little boy a colleague made reference to Parens' thinking about a spectrum of aggression. I was interested in this idea but did not pursue this further at the time. Some years later I embarked on the doctoral programme. My first intention

was to explore more fully the function of fantasy for one particular patient, one of the subjects of this current research. His fantasy world is very rich, totally absorbing to him and quite compelling for those who come into contact with him. However, in beginning to think more about this boy I found myself asking *why* he was so caught up in these other worlds. *Why* was I required to play out being his mum, his travelling companion? I recalled this notion of a spectrum of aggression, at first to my surprise because he was such a timorous boy. It had not been in my mind, but, now that it was, this 'spectrum of aggression' had more obvious application to thinking about another small patient who was as outwardly aggressive as the child lost in fantasy was excessively timid. They seemed to have very little in common. However, this idea remained in my mind in relation to the timid child and I pondered on what the connection might be. He was caught up in a world of fantasy, often threatening and violent but he could not say boo to a proverbial goose, and should a goose say boo to him he would have crumpled. There were clear links in his personal history which might account for his anxiety about aggression: a violent father and family breakdown, which he felt responsible for. My other small patient had responded very differently to the social and emotional deprivations of his background: he had come out fighting. He met the world with such aggression the world re-coiled, his siblings and peers avoiding him or hitting back. Both children were isolated by a failure to harness aggression appropriately. I considered how the contrasts between the two boys might be understood and wondered in particular whether there might be some *confusion* about when and how aggression/assertiveness might be really creative and life-enhancing and when it might be destructive. Although Parens does not identify this confusion, he offers an empirical research-based metapsychology for his spectrum of aggression that provides a framework for my hypothesis and that helped me crystallise my research question, as set out below. I had little idea at the outset how difficult it would be to immerse myself in Parens: his writing is dense and at times convoluted. However, his data is always linked back to observation and what he means becomes clear when he describes the child or infantile behaviour that prompted his complex theoretical description.

The Research Question

My interest in the development of aggression in children began, as described above, with a little boy I saw during my training in child psychotherapy. He had been diagnosed with autism and had all the developmental difficulties associated with this disorder, including what appeared to be a wanton destructiveness. A discussion about this child alerted me to the work of Henri Parens and the notion of 'a spectrum of aggression'. Later, when I had an idea that perhaps some children might confuse the assertiveness necessary to negotiate developmental steps with destructiveness, I looked to Parens.

Parens and his team, as described more fully later, were engaged in a longitudinal study of child development. Parens' interest in the development of aggression arose unexpectedly in the course of the team's observations. He was taken aback by the behaviours that he and the team observed which challenged his theoretical understanding of what constitutes aggression. The subsequent analysis of material led to the hypothesis of a spectrum of aggression including non-destructive and destructive aggression. At one end of the spectrum there is non-destructive self-assertiveness and mastery and at the other end there is hostile destructiveness and rage. Parens' spectrum provides the background for my question:

might there be a *confusion* of destructive and non-destructive aggression that inhibits the ordinary development of healthy aggression?

And if this were to be the case, to what extent does the confusion of destructive aggression and non-destructive aggression affect the healthy development of the child more generally?

A secondary research objective is to consider the usefulness of my posited refinement of Parens' hypothesis and its possible application to the understanding and treatment of children and young people presenting with difficulties in the development of healthy aggression.

CHAPTER 1

The development of aggression and the work of Henri Parens: A review of the literature

The literature on aggression is vast and wide-ranging[1] (for overviews see Perelberg, 1999; Harding, 2006; Yakely, 2010) and leads to continued debate about its origins and its nature: whether it is a drive, whether it is fundamentally an expression of the death instinct, whether it is reactive to environmental failure, what the connections are between aggression and violence; the significance of aggression in the development of individuation-separation and so on. In this chapter I aim to give an outline of the research project and findings that led Parens to his re-formulation of the development of aggression with reference to the theoretical tradition he was working from. I shall briefly describe Mahler's stages of separation-individuation which he employed as a framework on to which to map his findings. I shall summarize the main areas in which Parens' theory converges and diverges from that of his predecessors and contemporaries. Lastly I shall consider a more recent developmental perspective and relate it to Parens' work.

Both the subjects of the case studies are children looked after by foster carers. This is inevitability very pertinent to their development and there is a particular field of literature concerned with children who do not live with their birth families (see Anna Freud and Burlingham, 1944; the Robertsons, 1989; Hunter, 2001). I have not attempted to cover this literature in the review for two reasons. Firstly, I wished to focus on the development of aggression rather than the looked-after status of the children. Secondly, in the presentation and discussion of the clinical material, the impact on development of early deprivation and trauma, characteristic of many children in the looked after system, is considered with reference to literature on recent research in neurobiology and attachment, object relations theory and so on.

The Early Child Development Project

[1] I have followed Sandler et al (1997: 22) in using the terms “instinct”, “drive”, “instinctual impulse” and “instinctual drives” synonymously.

Parens' interest in the development of aggression came from the work of the Early Child Development Program at the Medical College of Pennsylvania, Eastern Pennsylvania Psychiatric Institute. Along with colleagues Parens developed a project with the aim of attempting to correlate the development of adaptive functions in children with qualitative aspects of the mother-child relationship.

Fifty mothers, encouraged by their positive experience of a programme of activities provided by the social service department of the same institution the summer before, volunteered to take part in the project. The team selected ten pregnant mothers with the intention of studying the children's development from birth. None of these children were first babies. The group were all from the lower socio-economic locality and were, co-incidentally, of mixed race with a split between Caucasian and African-American ethnicity.

The group of mothers, their pre-school children and their babies met twice weekly for two hours with the researchers for the following seven years. Several other babies were born during the course of the study. Over the course of the project attendance was 75%. The original and primary focus of the group was to study child development and subsequently to produce training materials and programmes to encourage positive parenting. The method of collecting data was based on the observer-participant model of infant observation. The researchers found, however, that the mothers were very interested in both what the researchers observed and how they understood their observations. The mothers became increasingly interested in their children's development. The experience of being part of the research group had a positive effect on the continuing development of the children. Follow-up studies of the project were carried out at 19 and 32 years. The infant subjects of the study achieved better academically, more went on to further education and fewer were involved in crime than their peer group (Parens *et al*, 2006).

Parens became interested in the question of aggression when he was faced with clinical observations that did not match his theoretical Freudian understanding of it. As Freud did himself, Parens began to modify his theoretical view, in this case of the origin and development of aggression, in the light of clinical experience.

Parens started from a Freudian view of an inherent death instinct and was working in the tradition of Hartmann, Kris and Lowenstein (1949). In this view the adaptive function of aggression comes with the mitigation or neutralizing of the death instinct by the binding qualities of libido/love. Parens, from the postulate that 'the somatic source of aggression is the musculature' (1979: 39), observed children demonstrating what he perceived to be (non-destructive) behaviour relating to aggression at an age where such secondary (adaptive) function would not, according to Freud's second instinct theory, yet be in place. This led him to question whether the inherent aggressive instinct is all destructive: 'The earliest manifestations of aggressive behaviour do not support the hypothesis that the contributions of aggression to adaptation and self-preservation are secondary only.' (1979: 42) Parens' research led him to consider that there is 'a continuum' (1979: 39) of distinct polar trends of aggressive impulsivity. That is there are distinct non-destructive and destructive currents which may derive from the same source.

Parens describes his findings as essentially a re-ordering of Freud's first instinct theory, taking into account some of Freud's thinking from both the first and second instinct theories. His observations led him to distinguish four categories of aggression which he saw as representing trends or strands on a continuum of the aggressive drive.

To understand Parens' line of thought it is helpful to recall the theoretical background he was drawing on. Parens' work was informed by the American ego-psychology of his training, in particular Greenacre, Spitz and Hendrick, and by Winnicott's ideas. In his research methods he drew on Mahler's work but in his analysis of the material he went initially to Freud.

Freud's First Instinct Theory

Where to place aggression in relation to the instincts was a continuing problem for Freud, and a continuing problem for his reader in trying to follow the shifts and re-formulations of the theory.[2] For my purposes here I shall outline Freud's thinking about aggression up to his most complete statement of the first instinct theory in *Instincts and*

[2] For an historical account of the development of Freud's thinking about aggression in relation to instinct theory see Edgcumbe (1970), Meissner (2000).

their Vicissitudes (1915) (although even then Freud was on the point of reconfiguring his theory in the light of his thinking about narcissism [Gillespie, 1971]).

In the first theory Freud identified two instincts: the sexual and the self-preservative. Aggression is present in both, in the sexual as the aggressive component of the libidinal drive and in the self-preservative as the instinct to master. Freud thought of the muscular apparatus as being the source of the instinct. Where stimuli provoke excessive unpleasure, the aim is to get rid of it. Whether it comes from inside or outside, it is experienced and treated as if it is coming from the outside. This is the first source of hatred. In *Instincts and their Vicissitudes* Freud thought of aggression as originating in the self-preservative instincts. Up to this point, however, aggression had been conceptualized as a form of mastery over the world and mastery was not confined to the self-preservative instinct. In the service of the sexual instinct it became sadism, the mastery of the object necessary for the preservation of the species. Sadism has a particular pertinence for Parens' formulation. I shall return to this.

Freud's Second Instinct Theory

In Freud's second instinct theory Eros, which includes but is not coterminous with the sexual instinct, is in opposition to the Death Instinct. Aggression is conceptualized as the manifestation of the death instinct turned outwards away from the self towards objects. There is a residual quantity of the death instinct that remains directed towards the self. The residual death instinct fuses with the libido to become primary masochism. Aggression as the manifestation of the death instinct turned outwards in the service of sexual function becomes sadism. Freud felt that these two instincts are not seen in isolation from each other except perhaps in the case of melancholia which he described as 'the pure culture of the death instinct' (1924). Instead he introduced the concept of fusion in which aggression is mitigated by Eros. Initially this happens in terms of environmental provision: for the neonate the auxiliary ego of the caretaker provides this function until the infant is able to internalize the mitigating capacity for itself.

Freud's theory of a Death Instinct has led to continued debate throughout the psychoanalytic community. It raises questions such as where the self-preservative instincts, assertiveness, non-destructive aggression, are placed. Black (2001), for

example, although believing that Freud was mistaken in his proposition, recognizes the usefulness of the concept. He points out that rejecting the death drive has tended to lead to a rejection of violence as fundamental in human behaviour and motivation: 'There is a tendency among decent people to drift towards underestimating the pervasiveness of our cruelty, malice, envy, hatred and violence, our capacity to revel in destructiveness or be terrified by fears of annihilation. The clinical value, as opposed to the truth, of the death drive has been that it gives a simple banner under which to rally all these forces: it helps us to keep them in mind and to think about them...it will not be easy to find another single term to replace it that unites this wide spectrum of motives.' More radically, Lear (2005) questions the premise on which the theory relies, that the aim of the repetition compulsion is the repetition itself. Lear contends that the compulsion to repeat is a disruption in normal functioning, a failed attempt to move forward through mastery. For Lear the actual aim is progressive not regressive and conservative as it was in Freud's view that the compulsion is towards restoring an earlier state and that 'the aim of all life is death' (2005: 196). Lear goes on to argue that in Freud's conceptualization of aggression human beings are aggressive towards each other 'because they deflect outwards an internal tendency to decompose' (2005: 162), making aggression a secondary defensive phenomenon. In Lear's view, 'What is needed is a psychodynamic account of the role of aggression in psychological and social formation' He sums up: 'Freud never succeeded in giving aggression its due place in the psychoanalytic interpretation of life; and it is the death drive that got in the way. It is a challenge for future generations to develop a distinctively psychoanalytic account of human aggression and destructiveness' (2005: 162). Parens, writing some time before Black and Lear, found himself concerned with the same problem.

Parens' version of the Aggressive Drive

For Parens (1979: 58), following Hartmann (1948), Freud's second instinct theory and his postulation of the death instinct highlighted the significance of the aggressive instinct in relation to libido: 'This new duality is strongly compatible with structural theory (Freud, 1923) and solves well the problem of self-preservative instinctual trends as against the task of self-preservation which is assigned to the ego'. However, he contested the view that the primary nature of the aggressive drive is solely destructive. Parens states: ' The most significant problem deriving from the second instinct theory

for our present findings from direct infant observations is that destructiveness pre-empts the aggressive drive. The inferences which we derive from observations do not confirm that assumption.' (1979: 57). He concluded that hostility, observable from the very early months, was not inherent but reactive, challenging Freud's proposition of a death instinct:

'In the infant under six months, at no time were we able to assume from its phenomenology a rage discharge occurring *spontaneously*. We found that a unique condition seemed required for rage to appear: *the internally-felt experience of excessive, sufficient, unpleasure.* Not only could a cause of excessive or sufficient unpleasure be ascribed to be the instigator of rage, but we could confirm this to be the causative factor by altering the environment not to gratify the rage but to arrest the underlying, known or inferred, cause of the unpleasure.' Hence the view that 'in the first four or so months of life, the unique condition of *sufficient unpleasure* – experienced first in somatopsychic irritability – is the sine qua non of the infantile rage reaction, the first clear manifestation of hostile destructiveness in the human child.' (1979: 109)

Sadism and Intent

Parens' observations led him to conclude that hostile destructiveness did not arise spontaneously but arose from 'the internally-felt experience of excessive, sufficient, unpleasure' (1979: 109). He doubted whether, for example, the excited pounding of floor and toys in a seven month old was evidence of a destructive trend. Similarly Edgcumbe and Sandler (1974) make a distinction between what appears to be aggressive behaviour and the aggressive *wish*, implying intentionality and a developmental achievement of differentiation of self and object. Parsons (2006: 42) cautions against the 'danger of equating adult behaviours, feelings and phantasies[3] with those of children. Something may look actively destructive to our adult eye, but we should not assume that destructive intent (as we know it) is necessarily in the young child's mind. The child's capacity for mental functioning is limited at every developmental stage by his awareness of himself and his knowledge of the world around him. Does the tiny baby who screams and kicks have destructive intent or is he

[3] Susan Isaacs (1948: 318) proposed that 'the two alternative spellings fantasy and phantasy should be used to denote 'conscious daydreams, fictions and so on' and the primary content of unconscious mental processes' respectively. .

in some primitive bodily way trying to get rid of intolerable feelings?' This is consistent with Freud's view in *Instincts and their Vicissitudes* (1915: 128): 'Psycho-analysis would appear to show that the infliction of pain plays no part among the original purposive actions of the instinct. A sadistic child takes no account of whether or not he inflicts pains, nor does he intend to do so.' The language is confusing. Freud uses the term sadism both loosely to refer to ‘violence whether or not it is accompanied by sexual satisfaction' and 'sadism proper' (Freud, 1924: 163) where violence against others and sexual pleasure are linked. As Laplanche and Pontalis point out, the danger of this dual usage of 'sadism' 'is that it encourages an unjustified conflation of sadism and aggressiveness' (1973: 401). In the passage quoted it would seem that Freud is describing the pre-stages to “sadism proper” which have much in common with Winnicott's notion of 'pre-ruth' (1954: 265). Freud adds that 'feelings of pity cannot be described as a result of a transformation of instinct occurring in sadism, but necessitate the notion of a *reaction-formation* against that instinct' (1915: 129). “Sadism proper” for Freud is dependent on the self experiencing pain and excitation (masochism) which can then be turned outward towards an object in the form of sadism: 'When once feeling pains has become a masochistic aim, the sadistic aim of *causing* pains can arise also...The enjoyment of pain would thus be an aim which was originally masochistic, but which can only become an instinctual aim in someone who was originally sadistic [in Freud's looser sense].' (1915: 129) The theory of masochism changed with the second instinct theory but at this stage of Freud's thinking the origin of 'sadism proper' is a reaction to masochism. Parens became convinced that sadism was the result of too-much unpleasure, an impingement, secondary not primary. Aggression, however, he held to be an instinct, not the death instinct of Freud but a separate trend, interlinked with libido and encompassing both the destructiveness of Freud's second instinct theory and the assertiveness, self-preservative aggression, of the first instinct theory: 'while there is evidence from earliest infancy of innate destructive trends in humans there is another trend in the aggressive drive which seems to be innately *non-destructive*'. (Parens, 1979: 17)

In some respects Parens' view seems to straddle the two groups of psychoanalytic theory on aggression described by Likierman (1987: 144), the one deriving from Freud's proposition of a death instinct, taken up by Klein et al, and the other seeing aggression as a reactive phenomenon in response to a primitive frustrating environment. Winnicott

is of this second school of thought, although not without his own reservations:

'It is thought by many that the primary excited impulse is not destructive, but that the destructiveness enters into the imaginative elaboration through anger at frustration. Part and parcel of this theory, however, is that of the omnipotence of the infant, so the result is the same. The infant becomes angry since adaptation to need is never complete. Nevertheless I consider that this theory, although it is correct is not basic, since this anger at frustration does not go early enough. At the present time I find I need to assume that there is a primary aggressive and destructive impulse that is indistinguishable from instinctual love appropriate to the very early stage of the development of the infant.' (Winnicott, 1988: 79)

Winnicott, however, in a departure from Klein, held that it was not possible to infer intention to hurt, for example, in the infant chewing the mother's nipple. Such intention, and subsequent guilt, he proposed, could only occur when the baby had moved from a state of 'unintegration' to a state of integration. That is, the baby needs to know an inside distinct from an outside and a mother as a separate object before it has the capacity to begin to own intentions, and to have concern. Winnicott consistently refers to the necessity of the fusion of what he describes as the two roots of instinctual life, the erotic and the aggressive. He links aggression with motility and spontaneity, 'Prior to integration of the personality there is aggression and original aggressiveness is almost synonymous with activity' (1950: 215). The aggressive component has an essential role in the distinguishing of the infant's self from its mother. 'When the Me and the Not-Me are being established, it is the aggressive component that surely drives the individual to a need for Not-Me or an object that is felt to be external.' (1950: 215) Whereas the erotic component at these earliest stages does not conflict with the sense of the infant and mother being one, Winnicott suggests that the aggressive component, in the service of the developing self, requires an external opposition. It is when that opposition becomes excessive that it is experienced by the baby as an impingement. It is the mother's job to provide a responsive opposition, as a collaborator not an accomplice or adversary, to enable the infant to harness aggression in the service of development and differentiate himself from his mother.

In Parens' terms Winnicott's conceptualization of motility becomes a component of the non-destructive current of the aggressive drive. In an elaboration of Winnicott’s (1950:

216) notion of a 'life force' (aggression arising when opposition to spontaneity or impulsiveness is encountered) Parens suggests that 'opposition leads to intensification of primary aggressive trends at the level of self-assertiveness; sufficiently persistent opposition leads to mounting unpleasure and the mobilization of hostile destructiveness' (1979: 72). Parens proposes that the psychic organization which facilitates this 'mobilization' starts from the premise that 'the unpleasure-valenced, aggressive-ridding impulse is the first and most primitive hostile destructive impulse and the neo-nate is capable of experiencing it' (1979: 116). In the 'getting rid of it', the hostile aggressive impulse is discharged and becomes attached, in Mahler's terms, to the outer rind of the autistic self (that is the neonate in the 'normal autistic' phase). In the phase of symbiosis, if there is excessive unpleasure, this hostile aggressive impulse becomes attached to that part of the outer rind of the self that is part of the symbiotic dyad. When the other partner (the mother) in the symbiotic dyad becomes a libidinal object, at the beginning of the separation-individuation phase, attachment of the hostile destructive impulse becomes attached to that object. This forms the model for future object relations: 'the hostile destructiveness invested in the earliest object- and self-representations becomes the fountainhead of hostility in the psyche.' In this way, according to Parens, 'hostile destructiveness becomes part of repetitive, automatic, patterned modes of functioning in intrapsychic dynamics and in object relations.' (1979: 117)

Parens' Spectrum of Aggression

Compelled by the unexpected manifestations of aggression in the children of his original study Parens investigated more closely, the research following the model of the Master's Children's Center Early Child Development Project (Mahler, Pine and Bergman, 1975). From the careful analysis of the written and later video-recorded observations of the child subjects of the study Parens (1977, 1980) distinguished what he described as four trends of aggression:

- first: the *non-affective discharge of destructiveness* (such as sucking and chewing), 'the aim of which is destruction of animate structure for the purpose of self-preservation';
- second: the *non-destructive discharge of aggression',* the aim of which seems *not* to destroy but to assert oneself, to control and master self and environment';

- third: the *unpleasure-related discharges of destructiveness* (the kicking and yelling associated with the infant's attempts to 'get rid of' pain/discomfort). 'Excessive unpleasure (pain or distress) seems to be the precondition for such discharges which more often than not are stopped not by the child's destroying but rather by the mother's arresting the unpleasure that caused the infant's rage' (1980: 97).
- fourth: the trend of *hostile destructiveness*, 'the aim of which, whilst self-preservative in origin, can become the inflicting of pain, harm upon, and destruction of the object'; the *pleasure-related discharge of destructiveness* (the teasing and taunting that predate sadism) a variant of hostile destructiveness.

Later Parens subsumed the third trend into *hostile destructiveness* (Parens, 1989: 114-117; 1991: 79). He observed the teasing and taunting that emerged around the beginning of the second year as usually preceded by psychic pain. He interpreted the teasing to be a delay of an unpleasure-related destructive discharge, modified by the ego's developing capacity to delay and inhibit aggression, displacing it into a 'game' through 'presublimination'.

Parens observed irritability and rage from birth onwards, with anger and hostility emerging in the second half of the first year, and hate organizing during the second half of the second year (Parens, 1991: 82). He used Mahler's theory of symbiosis and separation-individuation as a framework against which to consider the emerging conception of a development of aggression.

The phases of psychic development hypothesized by Mahler and associates provided a useful structure for mapping the emergence of aggression alongside other developmental landmarks. I shall recap Mahler's formulation. Initially Mahler conceptualized the first 'phase' of infant mental life as the 'Normal autistic phase'. This describes the first few weeks of life as monadic, an objectless phase in which the infant is detached and self-absorbed. Although, in the light of her own and others' clinical experience and research, she later revised her view on this (see below), Parens used this notion of a normal autistic phase as the earliest stage of development. Mahler's next 'phase' is the 'Normal symbiotic phase' in which, for the infant, the infant and mother are a seamless dyad with no differentiation between the two. The dissolution of this state

arises at around 5 months as the infant begins to differentiate itself from its mother along with ego development and the beginnings of a sense of separate identity in the Separation-Individuation phase.

Mahler further divided this significant development into sub-phases. The first of these she described as 'differentiation' or 'hatching' – as the infant emerges from the symbiotic 'cocoon' relationship with the mother into the larger world. There follows an extended phase of 'practising', from about 10-12 months to 16-18 months when the now mobile infant/toddler gains new motor skills and can begin to explore the world. Then comes the phase of 'rapprochement', which has three stages. The first stage is characterized by the desire to share discoveries with the mother. A crisis then occurs as the infant is faced with the opposing pulls to be safe and secure with the mother or to be autonomous and independent of her. The individual solution to the crisis is worked out for each child with the development of language and the superego.

Mahler, using Hartmann's term, and placing the development at a later stage than Anna Freud, described a last phase, referred to as 'object constancy' or 'toward object constancy'. In this phase (for Mahler occurring at around about three years of age, for Anna Freud in the latter half of the first year) the relatively stable, permanent relationship with the mother is internalized by the infant and the internal representation can then be drawn on in the absence of the actual presence of the mother. Psychoanalytic conceptualizations of aggression continue to change. Mahler's 'normal autistic phase' of this sequence has since been widely debated (Stern, 1985, 1991; Pine, 1985, 2004; Alvarez, 1989; Gunsberg, 1994; Blum, 2004; Weinberger and Smith, 2011). Shortly before she died, Mahler herself withdrew her theory of “normal primary autism” (Tustin, 1994: 1307). But Pine (2004: 532), whilst recognising the limitations of Mahler's concepts, contends that with modifications they are still clinically useful.[4]

Parens used Mahler's developmental stages and his own categories of aggression to order and then analyse the mass of data accumulated. 'Outline developmental profiles' were produced for each of the children of the study. These are inevitably a simplification. Recognizing the limitations of these charts they nevertheless give a

[4] Alvarez (1989: 15), with reference to Stern (1983), suggests that conceptualising the infant's experience in terms of 'state' rather than 'developmental phase' is a solution to the theoretical disputes and makes retaining the richness of different approaches possible.

useful overview. As might be anticipated there is no neat correlation between Mahler's phases and the emergence of Parens' trends in aggression but there are many interesting overlaps. There is, for example, strong evidence of non-destructive aggression in the exploratory activity and strivings for autonomy in the 'practising' sub-phase whilst there was weak evidence of the discharge of non-destructive aggression in the first few weeks, Mahler's 'normal autistic' phase.

Critiques of Parens' hypothesis

In her extensive review of the literature on aggression Perelberg (1999) remarks that Parens' work has been the most widely debated. Parens' proposition of a spectrum of aggression, and his re-working of Freud's drive theory prompted several papers in response. Gedo (1982) apart, all welcome Parens' notion of a spectrum of aggression and find his categories clinically and theoretically useful although various reservations are raised. Lichtenberg (1982: 229) recognizes Parens' research findings as 'a major contribution...to the field of child development and psychoanalytic theory' but draws attention to the possible contributing factors in the development of aggression that are not considered within the study, i.e. the environment beyond the observation setting of the nursery and in particular the role of the father. Lichtenberg (1982: 221) also suggests that Parens' adherence to Mahler's framework is overly restricting. In his view reference to other child development researchers, such as Stern, Emde, and Brazelton among others, would have enhanced the conceptualization of the interplay between the internal and the external. Lichtenberg's interest in other child developmentalists leads him to bring the child's cognitive development more prominently to the discussion. For example, Parens interprets a particular behaviour as defensive: a small child's ambivalence at being close to or separate from her mother is managed through a game of throwing away and then retrieving a doll. Parens views the game as evidence of an attenuation of a discharge of hostile destructive impulses. Lichtenberg (1982:228) prefers to see the game as symbolically meaningful, the child's developing self 'as director utilizing increasing capacities and affective controls'. (Gedo [1982] agrees that this is evidence of symbolic play but offers quite a different reading, inferring from the behaviour that the child wished her mother to get rid of her new baby sibling.) Lichtenberg (1982: 219-220) takes issue with Parens' deliberations (Parens, 1979: 334) over the mechanism by which aggression is transformed from one category to another.

He proposes that the problem disappears if the toddler's cognitive capacities are taken into consideration. If we accept, for example, that a toddler can recognize the source of his frustration and pain, his response would be directed with intentionality and feeling so that the 'mechanism' of the transformation is the growing child's mind. Lichtenberg suggests this would also free Parens from the constraints of the labels he gives to the categories of aggression - he finds the distinctions helpful but suggests that the descriptions are more about what something isn't rather than about what it is. He prefers, for example, 'the rage reactions of infants in distress' to 'unpleasure related discharges of destructiveness' or 'sucking and chewing patterns' to 'non-affective discharges of destructiveness'.

Osofsky (1982) concurs with Lichtenberg's view of the general usefulness of Parens' ideas and the generation of new theory. She too considers that the narrowness of the frame of reference was likely to impact on the wider reading and application of the research across other disciplines. Unlike Lichtenberg, Osofsky approves of the Mahlerian framework but questions the validity of the research in other respects, the predominance of girls, for example, in the group, the different ages of the children observed. Gedo (1982) also complains about Parens' frame of reference but his objection is Parens' failure to acknowledge theoreticians in the field of psychoanalysis itself. Gedo takes issue with Parens' definition of aggression, preferring the much narrower Freudian 'unpleasure-related' and 'pleasure-related' destructiveness. Whilst appreciating the usefulness of the categories of observable manifestations of aggression, Tyson (1984) questions some of Parens' assumptions. He holds (1984: 682) for example, that Parens infers an unwarranted degree of psychic structuralisation from birth. Likewise he challenges the pre-supposition that aggression manifest in later life is epigenetically related to aggression in the earliest years. Grotstein (1982) acknowledges that different theories arise from different psychoanalytic techniques of observation. He describes Parens' and Mahler's techniques as 'detached', more anthropological in nature, whilst in his view Klein's theory of aggression follows from 'empathic' as well as 'detached' observation. (1982: 102) Grotstein finds Parens' lack of attention to self-destructiveness and the adherents to the Death Instinct who followed Freud a significant omission. However, he finds a complementarity between Parens, Kleinian, Object Relations and Kohutian theory. The surge in non-destructive aggression that Parens observes at around 6 months which he correlates with the shift from Mahler's symbiotic

to the separation-individuation stage coincides, for example, with Klein's move from the paranoid-schizoid to the depressive position.

Shane and Shane (1982) explore the links with Kohut further, along with comparisons with Piaget and Stoller. They find little evidence for Parens' non-affective destructive aggression from Parens' research or beyond. However, they find much in common between Kohut's theory of aggression and Parens' non-destructive aggression. They also present Piaget's research, focusing on cognitive development, as consistent with Parens' observations: 'Parens' documentation of (non-destructive aggression), unlike Piaget's, demonstrates the means by which such non-destructive aggression can become conflictual....What begins as non-destructive aggression, or, in Piaget's terms, the need to function in order to learn, is inevitably met from time to time by a resistant environment, and conflict as well as compromise and adaptation ensues. Parens' findings, therefore, elucidate Piaget's epistemological theory and pave the way for permitting a keener appreciation of the role of aggression in both facilitating and interfering with the learning process.' (1982: 245) Turning their attention to Parens' fourth category, pleasure-related hostile behaviour, Shane and Shane consider Kohut's and Stoller's different theses on hostility and libido. They conclude that whilst Parens does not necessarily agree with Stoller that hostility is an essential component of all sexual excitement, they concur that the hostility in sexuality is reactive. They find themselves convinced by 'the confluence of data explicating peremptory, aggressively tinged sexuality: Parens' category of pleasureful destructive aggression which is reactive to frustration; Stoller's concept of sexual excitement as an expression reactive to anxiety and humiliation; and Kohut's isolated sexual drives as breakdown products of a fragmenting or endangered self reactive to severely unempathic reception. What this striking merger of three divergent theories would point to is the likelihood that hostile aggressive sexuality is best conceptualized as reactive rather than primary.' (Shane and Shane, 1982: 248)

Parens (1982) made a long and detailed response to the critiques, elucidating some of the finer points of his thesis, clarifying, for example, his definition of non-affective discharge of destructiveness, making a distinction between 'excessive unpleasure' and frustration, re-stating his thinking on non-instinctual neutral ego energy being viewed as non-destructive aggression. He is appreciative of the attempts at comparison with other

theorists discussing where he feels his findings converge and diverge such as with Piaget, Kohut and Klein. For example, Gedo argues that other psychoanalytic schemata of the drives, such as Basch's (1976) view on the affective storms of infancy, encompass Parens' observations. Parens' response is that such a view of rage reactions is not wrong but insufficient to answer his question: 'the view does not address what I am looking for, namely, their...motivational, inner-driven, and peremptory nature. Yes, a rage reaction is a communication; it is a reactive communication. But I ask: *What activated* that communication? And then, being comfortable with drive theory, I ask: What fuels that reaction? What force is at play in this reactive communication?' (1982: 287) Parens' objections to Lichtenberg's attempt to resolve the problem of the mechanism of the transformation of one strain of hostility into another is in a similar vein. The fine and important distinctions, to his mind, are lost: 'the point is missed if a paradigm exemplary model “becomes simply” the entire spectrum of phenomena it is used to illustrate.' (1982: 298). Similarly he comments on Piaget's conceptualization of accommodation and assimilation: 'While accommodation tells us something about *reactive motivations* it does not address *primary* sources of motivation.' (1982: 296) And again, although acknowledging, with some surprise, the parallels the Shanes draw with Rochlin's and Kohut's work, Parens finds their 'propositions do not go far enough to account for the place of hostility in human aggression.' (1982: 314) Parens diverges from Kohut in his belief that non-destructive aggression and hostile destructiveness are both components of one instinctual drive whereas Kohut only recognises reactive hostile destructiveness as a drive.

Parens soundly rejects the suggestion that his research findings were determined by *a priori* assumptions, reiterating at several points (1982: 284, 298) that his interest in aggression arose unexpectedly from the behaviours observed in the research setting and that these observations challenged his confidence in the classical formulations on aggression which he was familiar with. He also addresses the questions about the nature and reliability of the research methods. He cites other researchers, Anna Freud and Burlingham, Brazelton, Spitz, Mahler, Fraiberg amongst them, who have 'employed the method of longitudinal direct-infant observation of a psychoanalytic kind'. (1982: 307). Parens finds there is more that can be known about from this approach than Gedo believes but less than Klein proposes. In his response to Grotstein's comparison with Klein, Parens remarks, 'from my empathic stance – and I insist on that – I did not find

the data nor could I infer the hypotheses that Grotstein tells us were found and inferred by Klein...I still find Klein's postulations on the schizoid-paranoid position too far in the direction of ascribing cognitive capability and differentiated psychic content than I can infer from observing the children's behaviours.' (1982: 292) However, he acknowledges that 'as we observe more a number of us seem to be finding phenomena emerging at an earlier age than our earlier observations suggested ....estimating maturational progress is an open issue.' (1982: 290) Parens recognizes some of the limitations of his research: for example, despite the regularity and length of the observations the children were not observed across settings and fathers figure very little. He agrees with Osofsky that there is a need for controls in order to draw conclusions, but from a psychoanalytic research perspective Parens finds, for example, that 'the constitutional endowment of the child and the qualitative aspects of the mother-child relationship' (1982: 312) to be more significant than the educational level of the parents, numbers of subjects.

The significance of the father has attracted more attention in recent years. Perelberg (1999: 42) notes that the father's role in the development of aggression, in creating a space between the child and mother, and the impact of the actual or emotional absence of the father is a theme for all the contributors of the collection of papers on violence and suicide.

A Contemporary Developmental View of Aggression

Anna Freud saw aggression as an inborn drive necessary to the development of the mind and assertiveness, mastery and self-preservation. She recognized that libidinal development was also dependent on a measure of aggression and, along with Winnicott, she emphasised the need for good, consistent loving relationships to facilitate the essential fusion of aggressive and sexual urges. More recently writers such as Glasser (1979), Davis (1979), Fonagy, Moran, and Target, (1993), Downey (1984), Fosshage (1998) and Karush (2006) have all added to the literature. Glasser's conceptualization of the 'core complex' (1979), for example, has been influential in thinking about the development of aggression and the relationship between aggression and violence, including suicide (see Campbell [1995] Laufer [1995]). Although he does not offer an explicit developmental framework, he sites the core complex as fixated at very early developmental stages, reminiscent of Mahler's 'symbiosis' and 'separation-individuation'

stages (1979: 280). Karush offers a useful reminder that there is still an ongoing debate about constructive versus destructive uses of aggression (2006: 18).

Building on the work of Freud, Anna Freud and Winnicott, Parsons (2006) gives a current developmental view of aggression in which the earliest form of aggression is perceived as the baby's efforts to get rid of unpleasant sensations, coming from the environment or from the baby's own body. The baby kicks out and yells. In time as the baby begins to develop a sense of itself as separate from its mother the cries become a signal to alert her to its needs. If the mother's response is not experienced as adequate the baby experiences too much frustration and can feel overwhelmed. In a well-attuned mother-infant couple the baby will begin to internalise the managing function of the mother, her love. Small children continue to express aggression (hatred) through their bodies, often directed towards the perceived source of frustration or disquiet. In due course the child is able to experience but not act on aggressive feelings, and with the acquisition of language aggression can be expressed through words. In healthy development the child will develop a capacity to be assertive but not destructive and to channel aggression more appropriately. What is essential in this process is the fusion of hatred and love. 'The libido has the task of making the destroying instinct innocuous, and it fulfils the task by diverting that instinct to a great extent outwards – soon with the help of a special organic system, the muscular apparatus – towards objects in the external world.' (Freud, 1924)

Parens view is broadly in line with this account, though it is typical of his careful attempt to reconfigure a metapsychology of aggression in the light of his observations that he offers subtle and important distinctions. For example, Parens (1979: 308-309) makes a distinction between the role of the libido and of the ego in the neutralization of aggression, concluding that 'the danger of losing the newly structured libidinal object leads not just to activity of the libido but particularly adaptive (defensive) activity on the part of the ego. The libidinal activity is *fusion*, the ego activity is *neutralisation'*. But these fine distinctions should not be allowed to obscure the fact that, as Perelberg (1999:43) points out, the majority of writers on aggression make distinctions between healthy assertiveness and intentionally hurtful or humiliating destructiveness. However, Parens' attempt to tease out the underlying metapsychology is arguably the most conceptually detailed. Most significantly the theory is derived from direct observation.

Parens' notion of a *spectrum* of aggression is observable. In the therapy room and outside we observe children's assertiveness tipping into destructive aggression. An example would be the child, who enjoying his capacity to make a mark on paper, makes wide sweeping lines of colour, pressing increasingly hard, making increasingly deeper marks until he is gouging the paper, tearing it deliberately and with pleasure and then perhaps with upset, perhaps with defiant triumph. Another instance would be a child painting, going over the edge of the paper onto the table, accidentally perhaps at first, and then excited by this, deliberately getting paint on the chair, the walls and so on. The shift from non-affective to destructive aggression is most evident in the fun fight that becomes a real fight. We recognise the inevitability that a particular action beginning in exuberance is going to escalate into spoiling, in the predictive ‘It’ll end in tears'.

Parens' research-based conceptualisation, and in particular his detailed distinction of *non-destructive* and *destructive* aggression, provides the background for my research question which is essentially a refinement of Parens' application of his theory within a broadly contemporary developmental view of aggression.

CHAPTER 2

Methodology

In this chapter I shall briefly consider the appropriateness of 'the case study' to the research question. I shall describe the context in which I came to be working with the two boys who became the 'case study' subjects of this research. I shall describe the methodology adopted and the reasoning behind the particular approach selected. I shall explain the nature of the data and how it was gathered. Possible limitations will be discussed. In conclusion I shall consider the trustworthiness of the research study, its scope and limitations. I shall give an account of the ethical issues and how these have been addressed.

My inquiry is informed by psychoanalytic theory, especially the developmental point of view of Freudian metapsychology. The theory, as previously described, is rooted in Freud's work, further developed by Anna Freud, Margaret Mahler, Winnicott and the Object Relations school who extended the developmental view of aggression to take account of the earliest weeks and months of an infant's experience. The emphasis of this line of psychoanalytic thinking is on normative development against which divergence into pathology is measured. The theory is derived from close observation of infants and children. Such observation is at the heart of psychoanalytic practice and at the centre of Parens' research.

As described earlier, Parens' theory came to my attention in relation to a particular child whose treatment raised a question concerning a possible confusion between destructive and non-destructive aggression. I subsequently began to think about this 'confusion' in relation to other clinical cases against the background of Parens' 'spectrum of aggression'. I decided that a closer examination of two of these cases would be an appropriate way of exploring this further. As the research question was one concerning metapsychology an experimental research method or the broader sweep of a quantitative approach would not have produced the raw data necessary for the investigation.

This is a study, then, comparing two single cases, investigating the development,

healthy or otherwise, of aggression.

The case study

The value and place of the case study in research is a broad topic. I shall restrict myself to some considerations in relation to this research. Midgley (2006:127) categorises the criticisms of case study as research into three main areas: the data problem; the data analysis problem; and the generalisability problem. I shall consider this research in relation to these categories in more detail later. Hammersley (2008:3), discussing the value of qualitative research in the field of social science, perceives a current crisis. His contention is that qualitative researchers in this field have written in the main for fellow academics with a hope that the research results might be read, and perhaps taken up, more widely. This leaves them vulnerable to an external pressure to demonstrate practical value in terms of application and policy making. The current demand to provide an 'evidence base' is very familiar in the field of psychoanalytic psychotherapy. There is a clear link between research and practice as most of those engaged in psychoanalytic research draw on their own clinical practice and write in large for fellow practitioners. Drawing on case studies to formulate, debate, refine and re-formulate theory has been the main approach to the psychoanalytic investigation of the mind from Freud onwards. Every case potentially confirms or dis-confirms hypotheses and consequently influences clinical practice and further research. However, there is also a lively debate in child psychotherapy research which Midgley (2006) summarizes in his paper on the 'inseparable bond between cure and research′. Psychoanalytic child psychotherapy is a relatively small field within the relatively small arena of psychoanalytic research. Although research in the area is generally generated by and for clinicians the need for recognition of its relevance in a broader setting, for example in public health services, is a pressing concern.

There are common criticisms levied at the case study such as the problem of generalisability: what can be inferred for a wider population from such narrow research? One counter argument is that the depth of the case study, in comparison to, for example, survey research, yields richer data. Or the question of objectivity: what does it mean for the researcher to have an independent point of view? How does the method of collecting the data or the researcher's personal viewpoint affect objectivity? There are also

particular criticisms when it comes to *psychoanalytic* case studies. The challenges to child psychotherapy research, relying largely as it has done on case studies which might be seen as anecdotal and unscientific, have been met by some with moves to data-gathering methods borrowed from other disciplines such as the social sciences. Others argue that this is reductionist. Midgley (2006: 140) proposes a more rigorous approach to the case study and argues that 'while the report of a psychotherapy treatment may not, in itself, be sufficient as a way of doing research, this is more a matter of *degree* rather than *kind*, and there are ways in which the clinical case study may be set on a firmer research footing.' An area where there might be particular demands for more rigour, or perhaps more explanation, is in 'objectivity'. The conscious processes of social interaction, such as described by social science researchers as 'processual complexity' and the capacity for 'reflexivity' (reflecting on processes whilst actively engaged in them and adjusting behaviour in the light of those reflections [Hammersley, 2008: 42]), are recognised by qualitative researchers across disciplines. In psychoanalytic research there are also the unconscious processes to take into account – and to account for, both in the generation and the analysis of the data. This is the area where psychoanalytic research, by its very nature, has something different to offer. There is an extensive literature on the challenges and problems this presents, such as the reliability of reporting, the use of transference and countertransference and so on. The nature and limitations of my research data are outlined below with reference to some of the literature. Developing a capacity to reflect on unconscious as well as conscious processes is integral to psychoanalytic trainings and is a central aspect of clinical practice. Developing a capacity to reflect on oneself, on ones own internal world, through personal analysis or psychoanalytic psychotherapy is also a prerequisite of the training. This should make members of the profession well-placed to consider their own contribution to any given interaction. In terms of this piece of research my own experience, for example of aggression and assertion, will inevitability have impacted on the work. It is part of our clinical responsibility to be aware, or to become aware through supervision, and take account of these influences.

Another common question about the case study is the number of cases or the size/complexity of the case. The number of suitable cases available for this study was determined by my case load. Although I see and have seen several children who have difficulties managing their aggression I decided to focus on the two cases mentioned

earlier and described in more detail below. I could have restricted myself to a study of the first child, Philip, but the research question arose from wondering about the similarities and contrasts in relation to the second case. I am therefore examining the two cases, comparing both against a normative framework and then with each other. At the outset the intention, as stated in the proposal, had been to extend the study and consider a third case in relation to the research question. The third child offered some similarities, a latency aged child in the looked after system and an important difference as this child was female. Although this would potentially bring another dimension to the study, this child was seen only for an extended assessment which did not continue into direct treatment. For this reason it was agreed early in supervision that the data available from this case was not easily comparable with the data from the work with the two boys and that the research should compare the two cases. It is important here to add a word about comparative method. Hammersley, Gomm and Foster (2000: 239) argue that the strongest comparative research method is experimentation with cases created or recruited to test out a causal claim. The case study researcher has to search for cases that are suitable for comparison. In my case the research question arose from the casework: the cases found the researcher rather than the researcher having to seek out the cases.

Before turning to the content of the case studies it is perhaps helpful to have a description first of where the clinical work took place.

The context of the study

The two cases were drawn from my case load in a Looked After Children's service in which I work as a child and adolescent psychotherapist. We are a multi-agency service with a multi-disciplinary CAMH (Child and Adolescent Mental Health) team working alongside our Local Authority education and social work colleagues and other health teams such as Drugs and Alcohol and Sexual Health.

Children and young people are referred into the service by a variety of professionals, usually their social worker. Referrals to the CAMHS team are discussed in team meetings and allocated to one of the various members of the team according to the needs of the child or young person. Most of my work is ongoing psychotherapy. I work, as stated above, from a psychoanalytic perspective and see my psychotherapy cases in

that tradition: once a week, at the same time, in the same room. The number of sessions is unfortunately dictated by resources, in some instances two or three sessions would be clinically preferable. For children living with their families a psychoanalytic psychotherapy intervention would usually also involve parent sessions for one or both parents to support the child or young person's therapy. The situation is more complicated for children who are 'Looked After' by the state within a system of 'corporate parenting'. In this case the support for the therapy is to the network, through review meetings with the social worker and foster carer and/or attendance at Care Team meetings. A number of professionals will be involved in the 'Care Team' around the child. The child or young person's social worker is a key figure. It falls to the social worker, as the representative of the Local Authority, to make decisions about the child or young person (informed by the Care Team and with reference to their own professional code of conduct and management structure). Most significantly decisions will be about foster or residential placement, contact with birth families but also, for example, about changing schools. However, social workers frequently change their jobs and foster carers manage the day to day care of the children and young people, it is the foster carers who will decide what is for dinner. In a long term placement the emotional attachment for the child or young person develops, if all goes well, with the foster carer. It is a complex and multi-faceted situation – both organisationally for the professionals and emotionally for the children and young people.

Methods used for gathering and analysing the data

In the spirit of Midgley's call to a more rigorous approach to the case study I have used research tools (the Diagnostic Profile and Diagnostic Lines) that have been developed, tried and tested within child psychotherapy along with an approach (elements of Grounded Theory) developed in the wider field of research as a 'check' against which to measure findings.

In Grounded Theory terms the data gathered might be described as 'extant texts' (Charmaz, 2006: 37), that is they have not been generated for the purpose of the research. Charmaz poses a series of questions for the researcher, exploring the nature, usefulness and limitations of extant texts as data. Midgley (2006:127), as mentioned earlier, categorises the criticisms of case study as research into three main areas: the

data problem; the data analysis problem; and the generalisability problem. It is useful to consider the data in relation to these categories with Charmaz's questions in mind:

The Data

The data drawn on for this research are the background information and the process notes from the first year of therapy of two children whom I shall call, for the purposes of this research, Philip and Lenny. Both boys were in the 'Looked After' system and both were referred to the CAMH service in which I work, with behaviours which disturbed and challenged those around them.

It is important to state at this point that I was unfamiliar with the detail of Parens' research and the question of a possible confusion of destructive and non-destructive aggression was not in my mind at the time of recording the process notes under scrutiny, but only in retrospect. The selection of notes was not pre-determined, that is, by an interest in applying a hypothesis.

The nature of the data is of two kinds. Firstly there is the background information, gathered from Social Services reports submitted with the referrals and/or gathered from discussions with social workers and foster carers and other professionals, for example teachers, involved in the respective child's care. Most of this information was garnered at the assessment stage but there were occasions when, for example, the foster carer might pass on some news about ordinary events in the child's life or want me to know about some difficulty that had occurred. The second source of data, the process notes from psychotherapy sessions, is of quite a different nature. These are notes of once a week, ongoing therapy, written up as soon as possible after the sessions.

The usefulness of the background information is evident: a picture of the child's current functioning across several settings, an account of extended family and the child in relation to various family members, a history of known events in the child's life. Some of the limitations of this kind of information are also evident. The histories of pregnancy, birth and early emotional experience are often absent or sketchy, there is rarely any detail of the mother's state of mind. There are many reasons for the inadequacies in the information. The parents are usually defensive, invariably socially,

and generally educationally, disadvantaged, with complex histories of their own. They may have mental health disorders, addictions, learning disabilities. Their capacity to give accurate information may be in doubt, or, in their interests of keeping their child at home, they may consciously or unconsciously withhold, distort or give scant or selected information. Shame, guilt or a failure to perceive their child's distress might shape their reports. The information from professionals is also subject to discrepancies. The initial information gathering and recording will be affected by the social worker's own competence and internal and external pressures. Some of the relevant details may be known by one social worker but not passed onto the next – there is a sadly well-recognised rapid turnover of social workers. Information from schools and foster carers is invaluable but will also be subjective to some degree. There is a tendency, for example, to attribute all a 'Looked After' child's difficulties to his or her early experiences, pre-care, and to ignore the impact of the current environment or the foster carer's own history and experiences of being parented and parenting. What the school or foster carer report and how they understand the child's presentation depends on their own value systems and knowledge of child development in general in relation to the child in question in particular.

To turn to the second source of data: the process notes. These notes were made as a record of intervention, in line with the clinical governance policy of the NHS Trust in which the therapy was taking place. However, the primary purpose of such note taking is to record the interactions of the session in order to process and make sense of the child's emotional experience. Fonagy, (2003), Midgley, (2006), Rustin (2003) discuss the use of a therapist's own process notes as primary data in clinical case study research. They draw on earlier debates on the nature, scientific or otherwise, objectivity, subjectivity and reliability of process notes (for example Klein, 1961) and the question of what is a clinical fact (O'Shaugnessy, 1994).

The overarching debate of the 'data problem' will continue. However, working on the premise that the arguments so far are persuasive enough to legitimise process notes as an acceptable data base for research, I would like to consider the particular data 'problems' of the process notes in this research. These notes are not those of training cases, written up in detail with a supervisor in mind. They are the day to day recordings, made as soon as possible, within an ordinary, very busy, working day. (The quality and

quantity of the notes was discussed at both the proposal stage and in early supervisions and agreed as fit for purpose). The difficulties of recording verbatim accounts, the therapist's responses, the body language, the nuances of the session are well documented from Freud onwards, as is the inevitability of the therapist 'selecting' details in the writing up. Midgley (2006: 128) quotes Klumpner and Galatzer-Levy's criticism (1991: 727) that ‘undue reliance on narrative and brief vignettes obscures analytic experience and supports received theory'. It is inevitable (and proper) that, whilst maintaining 'free floating attention' and remaining open to surprise, the therapist will be inclined to be more alert to interactions, play, vocalisations, transference and countertransference, which are already manifestly known to be appertaining to the patient's history. A therapist will be mindful, for example, of expressions or defences against feelings of intrusion where it is known, either through external information or through the therapy, that a child has experienced abuse. This will be reflected in the process notes. Whilst accepting that other things might be learnt about the child if there were more extensive or supplementary information (e.g. video recordings), this 'selecting' might be viewed as mirroring a step in the process recommended in the grounded theory analysis of material, a form of unwitting 'coding'. Charmaz (2006: 57), referring to Glaser (1978) describes 'focussed codes' as 'more directed selective and conceptual word-by-word, line-by-line, and incident-by-incident coding'. Likewise, for the therapist, whilst remaining open to whatever the child brings: once a preoccupation or feature, be it an action, a reference to something, an attitude comes into the therapy it is more likely to be noticed the second and third time it appears, quite possibly at the expense of either noticing and/or recording something else. I became aware, for instance, each time Philip, the child preoccupied with Dr Who, made some reference to the programme, and then I became aware that there were references to father figures. References to other father figures in other fantasy were then noted as part of a pattern. My own knowledge also had an impact here, I was 'tuned in' to the Dr who references, having watched it myself. I was much less sure of the references to 'Chicken Little', a film I hadn't seen. I would know from the patient's movements that he was adopting David Tennant's depiction of the Doctor but I did not have a similar field of reference for the ‘Fish-Out-of-Water' character he sometimes became. I had to rely entirely on other ways to understand the significance of this character, for instance the role I was required to play and how the child related to me. The information was gathered in these two examples in different ways, from observation and through transference and

countertransference one with and one without a frame of reference. Both have their advantages and disadvantages.

Data Analysis

How best to analyse the data in relation to the research question has been somewhat taxing. Rustin (2003) has argued that the psychoanalytic process is in its nature an arena of ongoing research, the consulting room being the equivalent of the laboratory. Some analysis is implicit in the process itself, but, as Rustin and others acknowledge, (Midgley 2006, Fonagy and Moran, 1993), employing other research methods produces research more recognisably robust beyond the confines of child psychotherapy and psychoanalysis. 'What is needed is a means to enhance the internal validity of the data gathered in the clinical setting, so that the canons of scientific objectivity can be met, while at the same time preserving the subtlety and complexity of clinical phenomena' (Fonagy and Moran, 1993: 64). I have adopted some aspects of grounded theory, alongside using Diagnostic Profiles (and Developmental Lines), to this end. Since my research starts out from a hypothesis, rather than using grounded theory to generate one through coding and categorising, 'pure' grounded theory approach is not appropriate to it. , Pure grounded theory ‘is about theory generation not proof' (Anderson, 2006: 330). Although Glaser (1978) recognises that there may be a research interest prior to data analysis, he nevertheless maintains that research should start out 'theory-free'. The starting point for my research is somewhere between testing out existing theory and the possibility of generating new theory. My research question extends Parens' hypothesis of a spectrum of aggression, within a psychoanalytic framework. I have chosen to use a hybrid methodology, employing the techniques of coding, in addition to the Diagnostic Profiles, as a check that my hypothesis has not biased my analysis of the data. , As Rustin (2009:46) suggests, 'Innovation, when it occurs, usually has a methodological as well as a substantive dimension. Such hybridisation has already been taking place in psychotherapist researchers' use of ‘grounded theory’, who, contrary to Glaser and Strauss's original prescription of a theory-free inductive approach, have usually chosen to work within a psychoanalytic frame of reference from the start, while remaining open to new conjectures informed by it.'

Grounded Theory

Midgley (2006: 132) points out, 'such an explicit approach (as Grounded Theory) to data analysis is likely to prevent any one 'over-valued idea' (Britton and Steiner, 1994) from dominating the clinician's mind as she attempts to build up an understanding of the clinical material'. The coding and categorising processes of grounded theory can provide a very useful 'check' that that is not what is happening. The data, including the process notes, were collated pre-hypothesis, with a hypothesis emerging from a re-consideration of the material. I have then subjected the process notes to the focussed coding described by Charmaz, noting emerging categories and themes in order to confirm or dis-confirm the validity of the focus of the hypothesis. Had the results dis-confirmed the hypothesis a new hypothesis would have been generated by the process. The emerging 'categories' also provide a context and a frame of reference for the focus on the development of aggression. In studying more closely the hypothetical 'tree' it is clearly very important not to lose sight of the 'wood' in which it grows. 'Substantive' theory relating to the data and 'formal' theory which has a wider application may or may not materialise with the analysis of the data.

Applying Grounded Theory: Coding the raw data

Initial coding

Charmaz (2006: 48), agreeing with Glaser (1978) that whilst researchers come with their own knowledge and expertise, states, 'initial codes are provisional, comparative, and grounded in the data. They are provisional as (the researcher) aims to remain open to other analytic possibilities and create codes that best fit the data'. I have attempted to code the raw data with this in mind, putting the research hypothesis and any other pre-conceptions to one side as far as possible. The process notes did not lend themselves to word by word coding as they were not verbatim records of the sessions. Coding a case at a time, I started with six sessions, randomly selected, coding line by line. Sample line by line coded sessions were discussed in supervision and further ideas and notes generated. The remaining sessions were then analysed coding session to session, in line with Charmaz's 'incident to incident' coding. (2006: 55). Finally, through 'focussed' coding, using the most frequent and/or significant codes generated by the sample line by

line and the session to session analyses, new codes emerged and other codes were modified/expanded to better fit the data. (For examples of coding see Appendix A)

Results

For the first case, Philip:

As expected there were references to fantasy in every session. The content of the fantasies both created and fell into different codes. As his fantasy life was so predominant I also tracked Philip's changing preoccupations with different fantasy figures (see Appendix B). The codes that emerged most strongly, that is that were evidenced most frequently, were as follows:

Anxiety about aggression
Therapist as carer/parent
Fathers
Association between parents and death
Loss of sense of reality
Fear of aliens/monsters/own creations
Concern for/caring for vulnerable/infantile others

For the second case, Lenny:

The focussed codes that were generated by examining the raw data in this manner for Lenny were dominated by aspects of aggression and the need to be in control. However, healthier development was also apparent in the material, such as instances of sustained play/playful activity. The aggressive behaviours emerged in different groupings:

Expulsive aggression: throwing, biting, kicking, hitting, knocking over
Of these there was a predominance of biting (inanimate objects) and kicking
Excitement becoming aggression or excitement as the result of perception of destructiveness
Aggression linked with bodily function, oral, anal and phallic
Moderation of impulsive behaviour using another

Self-moderation of impulsive behaviour

Taking control

Self-reliance v dependency

A gap thrown up in the coding for both cases was the lack of information about language development. I had anticipated there may be more evidence of this as Philip has a speech impairment and Lenny's language development was delayed. Although I was aware that each boy had difficulties in this area I had not registered that it was an area of difficulty in common until I was writing the research proposal. The third child considered in the proposal also had both a speech impediment and language delay. It is a pointer to a deficit in the material for the purposes of this research and a reminder of the selection process that goes on all the time in recording. Had I been aware of this correlation earlier on in the work I would have recorded more detail of their speech. [5]

Anderson (2006: 339), using grounded theory methods from a psychoanalytic perspective describes organising clinical data under headings in readiness for analysis. The headings, generated by the data, also include, for example, the child's history, the family history, and emotional environment of the child. Interactions in the clinical space and counter-transference data are also included. Another method of gathering and ordering data, concerning the external and the internal, psychological world of the child, that has been a research tool for some years is the Diagnostic Profile (Anna Freud, 1962, Nagera, 1963). The data determine the emerging categories in Grounded Theory whereas the categories of the Diagnostic Profile are necessarily set – this is a major difference. However, the coding and categorising of Grounded Theory and the organisation of material within the framework of the Diagnostic Profile have a surprising amount in common, most particularly that the data determines the organisation of the material rather than the framework determining the organisation of the data. For example, in coding the sessional material for the second child activity a category was generated for 'Takes control of ending session'. The same activity would

[5] Interestingly, in Philip's sessions there were few overt references to a desire to be female, or for being responsible for damage. It is clear from his history and the referral that these were significant areas of concern. However, unlike language development, there was no, or very little, evidence available for collection or that could have been collected. Charmaz (2006: 54) urges the grounded theory researcher to value intuitions even if they do not match the material. The assumption, however, is that the covert meanings will become apparent later. This does not take account of unconscious processes such as defences. However, the metapsychological frame of the Diagnostic Profile and Developmental lines (as described below) offers an opportunity to examine the material not otherwise readily available.

be distributed under several headings of the Diagnostic Profile, in particular, the section of the development of the ego and super-ego detailing the status of defence organisation.

Diagnostic Profile

'The Profile is meant to be an extremely dynamic and alive picture of a given person. This requires the selection of relevant clinical material, which will convey meaning and imbue the Profile with liveliness. For those who want to achieve this, an important warning must be given: this is not to work from the headings to the material, a procedure which will never make a Profile, but rather the other way round, from the clinical material to the headings. Working in this way the clinical material will tend to classify itself whenever it is a relevant piece of information under a given section. Frequently, the same piece of material will "place itself" under several headings, making a different and valuable contribution to each and throwing light on the particular personality being examined. This makes the Profile meaningful, dynamic, and alive.' (Nagera, 1963: 535)

The Diagnostic Profile for children was developed at the Anna Freud Centre in research groups and has gone through several revisions and adaptations to particular client groups. It was designed as a method, from a metapsychological perspective, of organizing clinical material within the psychoanalytic frame of reference. It encompasses all relevant information available, clinical or otherwise, to gain as complete a picture as possible of a given personality at a given moment of development. Gaps in the available information are highlighted by the process and then filled or, in the absence of the relevant information, taken into account.

Developmental Lines

Parens, in his research, used Mahler's stages of separation-individuation as a frame against which to map out his findings, there were some interesting correlations and diversions. I have used some of the 'Developmental Lines' of the Anna Freudian school, with additions, as a frame for considering the development of aggression in each of the two boys against developmental expectations in ordinary health. The lines are a

development of Anna Freud's work in the Hampstead war nursery. In 1965 she listed six 'lines' of development which she regarded as prototypes, 'ladders leading up to every one of the expected achievements of the child's personality' (1974: 63). The lines describe the steps and stages of each developmental area e.g. from dependency to emotional self-reliance and adult object relationships.[6] Considering a child's development against this framework, it is possible to see how a child is progressing along any given line and whether development is consistent across various lines. The emphasis is on observable behaviour but the internal, psychological development required to achieve each step is also taken into account. For example the move from breast or bottle feeding to solid food is not just a physical but also a psychological achievement, part of the process of the infant's growing sense of self.

Anna Freud continued to add further lines of development and her colleagues, Yorke et al, (1989), Kennedy (1979), Edgcumbe (1981) formulated others. The lines devised later in her work are described in less detail. Edgcumbe (2000:132) suggests this is a reflection of Anna Freud's intention that the lines should not be used as rigid scales but for 'exploring how the myriad small areas of interaction combine over time in a complex and initially fluid way to produce an individual's character. As maturation and development proceed, those areas gradually become more fixed, sometimes rigid, in recognisable aspects of normal and pathological personality development.'

The Diagnostic Profile provides an overview of the whole of the child's current development, a 'snapshot' of how he or she is functioning at a particular point in time. The Developmental Lines provide a longitudinal view, a history of the small steps, including psychological, along any given developmental path, showing how the child made each achievement or how close he is, or not, to the next. Used in conjunction, the developmental focus of the lines and the metapsychological focus of the profile become a useful 'tool-kit' in moving towards gaining a comprehensive picture of the child. Taken together with grounded theory, the Diagnostic Profile and the Developmental Lines guard against skewing the analysis in favour of aggression. The Profile and Lines provide a wider developmental picture and grounded theory a coding check. [7]

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[6] The six 'lines' are: From dependency to emotional self-reliance and adult object relationships; From suckling to rational eating; From wetting and soiling to bowel and bladder control; From irresponsibility to responsibility in body management; From egocentricity to companionship; From the body to the toy and from play to work.

[7] For example, playful activity emerged from the coding exercise. The nature of the capacity for play at the assessment stage is described in the Diagnostic Profile under the heading ‘Play’ in the

Generalisability

Midgley (2006: 136-139), addresses the question of whether it is possible to generalise from the single case study as opposed to the 'statistical inference' that can be made from larger group studies. Referring to the long tradition from Freud to more current research in neuro-psychoanalysis, Midgley discusses the 'aggregated single-case study' 'where a theory is built up on the basis of the understanding that emerges from a series of case studies'. Midgley refers to Phelps' (2003) comparison of the aggregated single case-study to the development of 'case law' in which 'incremental conceptual refinements and reformulations' are made. He acknowledges the possible pitfalls, e.g. the selection of cases for comparison is often unsystematic and more likely to confirm rather than challenge the emerging analytic understanding. However, he suggests that more systematic selection might aid researchers in establishing the extent to which the findings from one case study can be generalised to others and lead to 'the sort of 'generalisation' that is clinically significant' (2006: 139)

This leads to the question of how systematic the selection was of the two cases of this research. To some extent, as mentioned earlier, the case 'selected' the research. The cases were identified in response to a question in my mind about the first case, Philip, in relation to Parens' research findings. The second case provided an obvious contrast, another latency aged, 'Looked After' boy but with an openly and excessively aggressive presentation compared to Philip's inability to express aggression in an ordinary manner. I would argue that the comparison of the two cases of this research and the building on Parens' research (conducted with a group of children but analysed and presented as a series of case studies) are in line with the 'aggregated case-study' approach. I have already found the idea of a confusion of destructive and non-destructive aggression useful to have in mind in my clinical practice. It may be that the analysis of the material of these two cases leads to a reformulation or 'an incremental refinement' of Parens' theory and perhaps even a generalisability that is 'clinically significant'.

Trustworthiness

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context of, and in relation to, several areas of psychic functioning. Development in the capacity to play (and its relationship to aggression) over time is tracked using the Developmental Line as a framework.

I have discussed some of the limitations of this research earlier such as the inherent problems of the case study and the implications for objectivity in the generation and analysis of the data. The impact of my own role in relation to the clinical and the research work has been considered.

I have limited myself to a thorough investigation of the process notes of the first year of therapy with the exception of reference to material from one of Philip's later sessions.

The decision to do this was to ensure that the data was not current and therefore less likely to impact on the ongoing treatment of the boys.

The Diagnostic Profile is used by clinicians working in the tradition of the Anna Freud Centre as part of assessment and monitoring. It is quite a rigorous exercise and the clinician has it in mind from the outset of the work with the child. Therefore there will be extensive information for the clinician to draw on when writing up the Profile. This will include noting the significant absences of some features, for instance, defences. I have applied the Profile in retrospect. I did not have it in mind at the time of my assessments with the two cases. The information I had was not of the same quantity as one would ordinarily expect for a Profile report and it was gathered without that proforma in mind. The absences in my material are in part due to having a different focus in mind at the assessment stage as well as a paucity of information available, and not necessarily an indication of an aspect of the child's presentation.

The small numbers, just two cases, has been acknowledged. A strength of this research is that it fits in the tradition of psychoanalytic research and debate accommodating new data and evolving theory. There is a community of people working in this way resulting in a slow accretion in the literature. It would be possible to test out the research questions further with close observation in small groups of children, such as in Parens' original project, or through more case studies.

Ethical Considerations

The background material and the notes of the psychotherapy sessions that form the data of the research were gathered within the code of ethical practice of my professional

body, the Association of Child Psychotherapists.

As the two subjects of the study were still in therapy the local NHS Trust Research and Development unit deemed the work 'research' rather than 'audit' and therefore subject to approval of the appropriate ethics committees. As part of the process of seeking relevant agreement to conduct the research Caldicott approval was obtained. My Trust Research and Development Committee agreed to sponsor the research and approval of the proposal was subsequently sought from, and granted by, the National Research Ethics Service and the University of East London Ethics Board. The NHS National Research and Ethics Committee required some minor alterations to information sheets. This was to be expected but I was surprised by the recognition that the stories of the child subjects of the research were distressing. The Committee sought confirmation that I would have adequate support. I understood this request to be a concern for the researcher's welfare but also a recognition of the possible impact of the therapist's state of mind on the children in any ongoing therapeutic work. Fortunately I am well supported by my multi-disciplinary team and through supervision.

As the children were in the care of the Local Authority consent to use material relating to them lay with the Head of Safeguarding and Children's Care, acting *in loco parentis*. Although it took some time (as the personnel changed between gaining verbal and requesting written agreement) this consent was given. Consent from the foster carers was not theoretically required. However, this raised a question about where the day to day parental *function*, as opposed to the legal parental *responsibility* lay. Both the children were in long-term placements and had an emotional attachment to their carer which was reciprocated. Each child's social worker would make decisions on behalf of the Local Authority but it was the foster carers who were at the centre of discussions about the children's difficulties, well-being and progress. Foster carers were therefore advised of the proposed research. I discussed the study with each of them and gave them written information including an independent contact in the event of a complaint. In order that they had time to absorb the information and voice any reservations they felt unable to address with the researcher they were directed to their designated Supervising Social Worker before responding. Both foster carers were interested in the research and happy to sign a form to acknowledge they understood and had discussed the study. Had either of them refused an alternative case would have had to be considered.

The children were not asked to give consent themselves as they would have been unable to fully understand the nature of the research in order to give informed consent. Ordinarily there is a requirement to inform even if consent is not sought. However, as the children were still in treatment introducing the idea would have been un-analytic and likely to have a confusing or adverse impact on the therapeutic relationship.

There is a central concern from the Ethics Committees reflected in the questions asked in the application for approval about how the research might affect the participants, and most particularly whether there is risk of a negative impact. In this case, the raw data of the research, that is background information and the notes from the first year of therapy, are all retrospective. Any ongoing treatment would not be affected except in as far as the study may lead to a better understanding of the nature of the difficulties of the respective children. If this were so the only impact on the participants would be a positive one.

All data collected have been anonymised, names changed and identifying features omitted or altered. Storage of data have been according to Trust policy, files kept in lockable cabinets in the workplace and anonymised data kept in lockable cabinet at place of study.

It has been important to consider carefully the use of material relating to the foster carers themselves. This is information given in meetings to discuss the child's therapy or in other contexts such as Care Team meetings. Whilst parents might be open to thinking about their own histories and the impact this might have on their children there is a tendency for foster carers to attribute all a child or young person's difficulties to their early environment, pre-care. They might give information about their own pasts when they are talking about their reasons for deciding to foster or how they come to have their own particular parenting style. However, they are unlikely to expect to reflect on their own emotional worlds in relation to the emotional development of the children they are fostering. Although the foster carers of the two boys of the study may not regard their pasts as significant there clearly has been an impact on their charges. In the interests of not revealing unnecessary information about the carers I have included only those details where omission would affect the understanding of the material.

In Summary

I have stated the theoretical perspective underpinning this research. I have outlined the choice of methodology and described the scope and limitations of the research. I have explained that I have used aspects of grounded theory coding as a check to ensure there that a prejudiced idea was not driving the research without due attention to other factors, and to provide a context in which the research idea can be thought about. I have considered the trustworthiness and ethics of the research. I have produced a Diagnostic Profile of each child from material available at assessment to provide a metapsychological overview and offer a 'baseline' point of reference. I have given a summary of the first year of therapy for each child with a fuller account available as Appendices C and D. The material from the Profile and the sessions is discussed with reference to developmental lines. I have then compared the results of the investigation of both cases in relation to the research question and, in conclusion, suggested some clinical applications of the research findings.

The Setting

At the time of the clinical work presented here I had my own room in the CAMHS clinic, an old house which had once been used as a residential unit for children and young people at a nearby special school. Reception and the waiting room were on the ground floor. The therapy room was on the first floor. It was a sunny room, furnished with two armless easy chairs, a desk and chair. There was a cast iron fireplace against one wall, a built in cupboard in the corner, a locked filing cabinet and a portable sink such as one might find in a caravan. The children's boxes were stored in the cupboard. There was a dolls' house with wooden furniture, a pile of brightly coloured, plastic-covered foam blocks which the children and I referred to as 'softplay', and a fleece blanket/rug. There was an abstract print above the fireplace and two, rather curious, wooden panels on the partition walls, perhaps replacing glass. It seems a previous use of the room may have been for staff to observe/monitor the resident children in the adjoining rooms.

CHAPTER 3

Case 1: Philip

Philip was ten years old when he was referred for psychotherapy. He was in the care of the Local Authority, living with a foster carer and attending a special school for children with learning disabilities.

In the spirit of the Diagnostic Profile, as described in the Methodology, I have worked from the clinical material to the profile (Nagera, 1963; W.E. Freud, 1968), organising the material from the assessment stage according to the helpfulness of the categories in this particular case. I have used the most recent model of the profile with some reference to the earlier model (used up until 1998). The picture emerging from the Diagnostic Profile provides a baseline for considering the first year of the therapy that is summarised and discussed later.

Sources of information for the Diagnostic Profile:
Assessment sessions
Reports from and discussion with Social Services, teachers, clinical psychologist and foster carer

DIAGNOSTIC PROFILE:

Philip, aged 10

Statement of the Problem

Philip was living in a fantasy world which disturbed him, his peers and adults caring for him. There was considerable concern from his foster carer, teachers and the school clinical psychologist that Philip's preoccupation with being someone else was interfering with his social and educational development.

Family Constellation

Birth family: mother
father (whereabouts unknown)
sister 12 (adopted)
Philip 10 (in foster care)

James 9 (in foster care, not in same placement as Philip)
sister 8 (adopted)
sister 7 (adopted)
sister 4 (conceived after the older children were taken into care, living with mother)

Foster family: foster carer
foster carer's older daughter (25, employed, living at home)
foster carer's younger daughter (23, unemployed, living at home)

Referral

Philip was referred for psychotherapy by his school's clinical psychologist. She reported that Philip had been a very labile child and although his crying had diminished he remained a very anxious boy who retreated into a fantasy world, often drawing other children into it with him. He had become fixated with Harry Potter and then Doctor Who. He had appeared to lose all sense that his imagined worlds were 'pretend' and would become frightened, distressed and desperate in the fantasy,[8] disturbing his peers and worrying the adults around him. Those involved in Philip's care were also concerned about Philip's sense of guilt. He had told his carer and teachers that it was his fault his younger brother had been seriously scalded in a bath, and he could not be dissuaded from this belief. And lastly there was Philip's wish to be a girl. This desire often got lost from the professionals' minds and did not worry his foster carer.

Philip's agitation had earlier been diagnosed as a symptom of ADHD by the Community Paediatrician who prescribed Ritalin. His foster carer was unconvinced by the helpfulness of the medication although it did make him calmer in the mornings and more able to access the school curriculum. She later, with the paediatrician's agreement, stopped giving Philip the medication.

Philip did not think there was a problem in being Dr Who but he was aware that he 'got upset'.

Description of the child

Philip was a dark- haired, slightly built boy. He had a rather pale complexion, a thin face and large dark eyes. He presented as an odd, nervous child, younger than his years. Philip was born with microcephalus giving him an odd appearance. He had a speech

[8] With reference to Susan Isaacs' distinction between fantasy and phantasy (1948:318) Philip's use of fantasy is conscious although it has meanings of which he is not conscious.

defect, a rather gangling gait and some difficulties with co-ordination and spatial awareness. His oddness was immediately apparent from his physical appearance and reinforced by his muttering to himself or to invisible companions, although he could sit quietly in the waiting room with his foster carer where he chose, or was directed to, books that were appropriate for a much younger age group. Philip was attending a special school for children and young people with moderate to severe learning difficulties. His development was delayed across many areas, including cognitive, emotional and social. His special-needs teachers maintained that his difficulties were due to a very marked delay rather than a learning disability *per se*. Schore (2001: 209) describes the impact of 'chronic relational trauma' during critical periods of right brain development on the infant's capacity for 'socio-emotional learning'. Although there was apparent agreement about Philip's needs there was a divergence of opinion about his capacity. Whilst his teachers did not expect Philip to catch up with his peers they appeared to see more potential for development than his carer who was more inclined to accept, support and protect him from his deficits. There was another difference of perception around Philip's difficulty in concentrating. Whereas the community paediatrician diagnosed ADHD both teachers and foster carers attributed Philip's difficulty to his preoccupation with his fantasy life. Philip's speech impediment was quite marked, his words often indistinct, sometimes indecipherable. However, he had an unexpected level of sophistication: he could use language to delay or substitute action, talk about time, explain, instruct, express his feelings and imagine. He was embarrassed if he was not immediately understood and would not repeat what he said, muttering, 'Nothing' or 'It doesn't matter'.

Philip was always neatly dressed, usually in school uniform. He was very polite, winning the affection of the receptionists in the clinic, his teachers and other adults whom he came into contact with. Other children and young people in the waiting room tended to be wary of him or studiously ignore him but his teachers reported that his peers at school liked him. The only difficult relationship mentioned was with his brother, James. Philip was initially very anxious about being in the therapy room alone with me. His foster carer reported that he found any change difficult.

Family Background and Personal History

Philip was the second of a sibling group of five children. A sixth child was born two years after the older children were taken into care. There was scant available history of his mother's pregnancy, her state of mind or the family's circumstances. It was known that Philip was born with microcephalus which may be caused by drug or alcohol use during pregnancy. The earliest information available was from when Philip was four, at the point he was taken into care after his younger brother, James, was badly scalded in a bath and admitted to hospital. Social Services found that Philip and his siblings were severely neglected. Both parents were drug users and the children had witnessed violent behaviour from their father towards their mother. Philip and his older sister had been frequently left to care for the three younger children.

Initially Philip was placed in foster care with his two youngest siblings. Philip's older sister was placed on her own. James remained in hospital for some time and when discharged was placed separately. In Philip's first placement there was a further trauma when his foster father was killed in a road accident on his way to work. The children, Philip and the two younger siblings, were moved again. Philip at this time was reported to have cried hysterically, frequently and for hours. The foster carer could not manage his distress and the children were moved to a third carer. Philip's oldest and two youngest siblings were eventually placed for adoption in two families. He remained with his third carer. Whenever his view was sought Philip stated a wish to stay with his foster carer and her extended family. The family was predominantly female and Philip went to another female foster carer for occasional respite stays. His carer had recently had some health problems of her own. She tended to play these down and focussed instead on Philip's needs and her younger daughter's various physical conditions that required medical attention.

James remained in foster care and attended the same special school as Philip. At the time of the assessment the boys had a conflictual relationship. Their teachers and respective foster carers encouraged joint activities but supervised them closely. Both boys saw their mother and youngest sister under supervision several times a year. They no longer saw their father who disappeared several months after they were taken into the care of the local authority. His whereabouts were unknown but there was an idea in

the professional network at the time that he may in fact be dead. (This view was subsequently revised after several unconfirmed 'sightings' of his father selling the Big Issue). Philip's foster carer supervised early contact meetings with his parents and spoke positively of the children's father, of his warmth and capacity to play with them. Philip was reported as taking the contact visits with his mother in his stride, appearing to react neither negatively nor positively.

Possibly Significant Environmental and Non-Environmental Factors

Historical factors:

1. Microcephalus: The problem is usually identified at birth or soon after when the baby's head is routinely measured. Philip's parents' response to their baby's small head, why he might have failed to develop in utero, what the implications for his continuing development might be, and so on, were unknown but likely to be of significance. Microcephalus is sometimes, but not necessarily, associated with developmental delay and learning disability. It is likely to have contributed to Philip's difficulties. Philip was still being monitored by doctors and it is probable that this interest in his head and in his capacities will have affected his sense of himself. It may have contributed to the cathexis of himself as an oddity and to his identification with non-human or distorted human forms e.g. the Doctor and Sharkboy.
2. Early deprivation: although there is limited information Social Services' reports indicate that the older children, Philip and his older sister, were often in care-giving roles in relation to their younger siblings. The children reported violence from their father towards their mother.
3. The drug use of Philip's parents inevitably impacted on the capacity to care for their children. The children are likely to have experienced unpredictable behaviour from their parents and quite possibly altered states of mind. Drug taking may also have fuelled violent behaviour, for example the throwing of furniture which Philip referred to. Philip's preoccupation with an unreal fantasy world may have been influenced by his experience of his parents' drug induced states.
4. Parental neglect: Philip expressed his feelings of responsibility for James's

scalding, telling adults that he had turned on the tap. James was extensively burnt and has been permanently scarred. This was the incident that led to the children being taken into care and in effect the permanent dissolution of the family structure.

5. The sudden death of Philip's first foster father was a further trauma, possibly confirming Philip's ordinary Oedipal 'murderous' fantasies as reality and reinforcing his sense of his own dangerousness. As well as losing a substitute father-figure Philip also lost another mother -substitute figure when he had to move foster placements again. His huge distress was very evident in his constant crying – it is of note that Philip made no reference to this event.
6. The loss and break up of the sibling group: Philip subsequently lost his three sisters when they were adopted. Philip was regarded as unplaceable for adoption. Along with the loss of his sisters this may well have compounded his feelings of being different and not as good as his siblings/other children. As it was the girls in the family who were 'claimed' whilst the two boys, Philip and his brother, remained in foster care, his wish to be a girl may have been reinforced.

Current factors:

7. Philip had daily contact with his brother, James, perhaps keeping alive his guilt about the scalding.
8. Lack of male role models: Philip was in an all female household, staying with another female carer for occasional respite and attending a special school that was predominantly staffed by female teachers and assistants. His social worker and clinical psychologist were also female. There was plenty of opportunity for Philip to identify with females and little challenge to his explicit wish to be a girl, with scant opportunity to explore his own masculinity through an identification with an appropriate male.
9. Foster carer's attitude to aggression: Philip's foster carer talked about her own temper, a surprise to me as she was consistently calm and apparently unflappable. She described having seriously lost control in the past and having learned to keep her anger and aggression under wraps. There was a question about how much aggression she could tolerate and what impact any negation or denial of Philip's negative feelings might have on him.

Current protective factors:

10. Continuous contact with a caregiver: There had been no major disruptions in care since Philip's placement with his third carer and no threats of disruption to this placement. The Care Team had also remained unusually consistent: there have been no changes in staff and Philip's social worker, the clinical psychologist and the teaching staff met regularly.
11. Philip's capacity to evoke care-giving: Philip elicited positive responses from adults, ensuring he was noticed and his needs responded to.
12. The relationship with his foster carer and her family: Philip was clearly loved by his foster carer. She had a long-term commitment to him, providing care, affection and security. She talked about her daughters as being like grown-up sisters to Philip. She was a very solid figure, both physically and in her attitude. She talked about Philip's early experiences with great concern and described her feelings of wanting to comfort, wrap him up and protect him from the world. Philip was very attached to her, stating that he wanted to stay with her.
13. School: Philip's teachers were disturbed by his agitation and preoccupation with fantasy worlds but they also had a more hopeful attitude in terms of his capacity to change. They viewed his difficulties as predominantly due to massive developmental delay rather than as due to an organic learning disability. Special school was a haven to Philip though it may also have served to protect him from the need to be more in touch with the ordinary world.

Psychic Development:

A. Object Relationships/Object Relations

Philip was clearly very attached to his foster carer. This was evident in the interactions between them around the beginnings and endings of sessions. Philip would look to her for reassurance on leaving her and she would encourage him to go with me, telling him she would be in the waiting room when he got back. She was a source of security for him. As previously mentioned, Philip demonstrated attachment seeking behaviours and had a capacity for invoking care. He seemed able to rely on his foster carer to be a constant and consistent provider, meeting his physical needs and offering interest in and affection to him. His foster carer had a protective, 'mother hen' attitude towards him,

using terms such as 'chick' or 'tuppence'. She described him as seeking physical affection from her, enjoying a cuddle. There was a warmth between them and she described Philip as having a sense of humour. However, new situations were anxiety-provoking and he was unable to make use of his carer as a secure base from which to explore the world. There was scant evidence at this stage of Philip's interest in his foster carer beyond relating to her as an immediate need-fulfilling object as he made little reference to her in his assessment sessions. His foster carer tended to dampen down the expression of any aggressive feelings in Philip, aiding his retreat from his own aggression and possibly from his libido (see sexual development below).

Philip made few references in the assessment sessions to other people with whom he currently had active relationships, such as his teachers, classmates, social worker and his carer's extended family. The fictional characters that caught his imagination were all isolated from their loved ones: Sharkboy[9] from his father, the Spy Kids[10] on a mission without their parents, Marnie[11] from her dead mother, the Doctor from his family and his travelling companion, Rose. Philip made anxious references to his brother and to his adopted sisters, although significantly he forgot the name of one of his younger sisters at one point. His foster carer reported that Philip became very agitated if he heard a baby crying, for example on the bus. She interpreted his distress as being related to his experience of being responsible for his baby siblings and unable to manage. That is, his distress was evidence of his own feelings of being overwhelmed, and perhaps of his infantile self not being adequately attended to, rather than expressing a capacity for concern for another/the actual crying baby.

Philip seemed unable to relate to me as having a status independent of his fantasies. There was a pull to join in his fantasy games, to step into something I didn't understand, into chaotic and confusing worlds full of threat and unpredictability. He ignored anything that I said unless it was determined by him: I only seemed to exist in as far as I

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[9] *Sharkboy and Lavagirl* is a Disney film. The central character, Max, a ten year old who escapes from his experience of being bullied at school and his arguing parents through creating an imaginary world of his own, finds himself recruited by his own creations, Sharkboy and Lavagirl, to save the Planet Drool. Sharkboy was washed away to sea and brought up by sharks, growing shark-like fins and so on His mission is to find his father.

[10] *Spy Kids* (2001) depicts two children who take on adult roles to rescue their parents and combat evil.

[11] *Shoebox Zoo* is a television drama for children. Eleven year old Marnie, following her mother's death and a move to a new city, finds herself in possession of a shoebox with four wooden animals. The animals unexpectedly come to life and Marnie inherits a quest to find the 'The Book of Forbidden Knowledge'.

was part of his world. He cathected me at the level of an anaclitic need-fulfilling object. He could, for example, use me within the sessions as a model-maker, making things *for* rather than *with* him.

Philip did not seek to communicate but to inhabit a hermetically sealed private world. What looked like play was actually used to preserve a distance between himself and the other. There was no sense of sharing. The objects we made (that is, I made on his instruction) were not used in the service of development but rather were used by Philip to stay in the same place. There was an unconscious symbolic value to the objects, as in the phallic screwdriver, but no invitation to play, raising questions about Philip's capacity for symbolic functioning (see below, Play, section D). Philip's version of the Doctor's screwdriver, for example, which had magic qualities that gave him immense control over the environment could not be given up at the end of the session. The ordinary parameters of make-believe were not observed. He talked all the way back to the waiting room as if he were still in possession of the powerful screwdriver. His foster carer and teachers agreed that Philip appeared to be playing out his fantasies in his head even when he was supposedly engaged in more ordinary activity. Philip had the capacity to be alone *despite* rather than *in* the presence of another (Winnicott, 1958).

Superego Development

Philip expected to be told off and criticized all the time by an internal as well as an external voice. He projected bad and angry feelings into father figures who were censorious or Dalek figures that attack. His internal world was exacting and punitive, ambivalent at best. Dangerous father figures were good and bad. In adopting the Doctor persona Philip identified with the good father figures by identifying with the superego-heroes who killed off the baddies/bad father figures. It was a split that reflected the two contradictory aspects of his father that he had been unable to integrate and may well have been reinforced by his foster carer's requirement that he be a gentle boy.

Fixation Points/ Regressions/ Arrests

There was not enough material at this stage to determine whether the retreat to wishful hallucinatory thinking was a regression or an arrest. It was clear that Philip's carer encouraged regression in other respects and that Philip happily complied. Philip's insistence that he was the Doctor was possibly an attempt at mastery in response to

repeated trauma, the most evident trauma being the scalding of his brother, followed by the sudden death of his foster father. However, there were likely to be earlier traumas. It is not clear whether Philip had achieved, in Fonagy and Target's (1996) terms, the integration of the psychic equivalence and pretend modes of relating internal experience to the external situation and has regressed from this position, or whether he had not yet reached this stage of functioning and the result was an arrest in development (see Discussion 1.2). He lacked a facilitating environment in his early years but his siblings appear to have fared better. A constitutional vulnerability may well have contributed to developmental arrest or regression in the face of repeated trauma as well as a lack of adequate developmental help.

B. Self

Self representation

Philip had very low self-esteem. He relied heavily on his carer and teachers for direction and reassurance. He was anxious about having an impact on anything, as if he would make a mistake, concretely demonstrated in his worry about making a mark on paper. In order to feel competent he identified with an all- powerful fantasy figure. There was a vast gap between the omnipotent persona he adopted and the very anxious, vulnerable, dependent boy who he was otherwise. His identification with Shark-boy, a 'mutant' boy, might reflect his perception of himself as not whole or not well-formed whilst at the same time offering a 'super-human' defence against such feelings of inadequacy. (See 'Defence organisation' below)

Development of self representation

Perhaps inadvertently re-enforced by his foster carer's desire to blanket and protect him, Philip tended to think of himself as a much younger child than his ten years. His foster carer encouraged a regression to a more dependent state, feeding Philip's fear of developing a sense of agency. Whilst his teachers had a more active sense of his capacity Philip's special school peers also had varying degrees of developmental delay and learning disabilities. He had little contact with children of his own age who were developing at a more ordinary rate and fashion. His stated desire to be a girl indicated his confusion and anxiety about ordinary phallic aggression. He could only be in touch with more phallic aspects of himself in displacement – as the Doctor with the powerful screwdriver. Far from bolstering his sense of maleness this had the opposite effect.

Self/other representation

It was very difficult to know about Philip's identifications outside his fantasies. There was scant evidence of identification with living people. Philip presented little in the sessions that was discernibly from the world outside. In fantasy his concern appeared to be with father figures. Mother figures were largely absent from his play at this stage. It is possible that Philip was identified with the shut-off drug-induced world of his father, the Doctor representing the good aspects of his father as a defence against identification with the frightening aspects of his father. The result was an endangered and dangerous self.

Self in relation to others

Philip rarely referred to other people although he occasionally expressed likes and dislikes about people. His interest was in the characters that populate his fantasy world, his internal world. He did have an idea about friendship and sought out the company of two particular boys. Both the boys he played with joined him in Dr Who scenarios so it may be that they functioned for Philip as an extension of his internal world, as in his use of me in the assessment sessions where I was allowed no independent existence.

Theory of mind

Philip was so caught up in fantasy and so often so closely identified with the 'others' he talked about that it was difficult to be clear whether he had a sense of other minds or if all 'others' referred to were extensions/versions of himself. It seemed that the self-object barrier was still very permeable for Philip. His lack of interest in other people suggested little theory of mind beyond experiencing them as potentially dangerous figures from whom he had to keep a distance, or need-fulfilling objects whom he could use. However, his capacity with language raised a question about how much sense he might have of another mind/listener. Although often caught up in his internal world he could listen to his teachers and take in information. Philip appeared to have great difficulty distinguishing what was in his mind and what was outside but progress at school suggested some, if very limited, sense of another (for example a teacher) who might know something that he does not know.

C. Relationship to Bodily Self and Drives

Use of the body

Philip inhabited the body of whatever character he took on, adopting the mannerisms of, for example, David Tennant's Doctor, striding energetically about the room with a purpose and fluidity of movement which was quite different from his own awkwardness. This was also quite at odds with the little-boy body that his foster carer talked about, for example in relation to his eczema. Philip was still pre-pubertal but his carer expressed her anxiety about how he/she would manage changes in his sexual body that would be out of kilter with his emotional development.

Sexual development and psychosexual status

Philip presented as a timid, gentle, not yet phallic boy, the kind of child who might be described as a 'Mummy's boy'. He sometimes referred explicitly to female characters such as Lavagirl, and implicitly to Marnie, the girl destined to save the Shoebox Zoo, but he was more identified with male characters, Sharkboy, and in particular, the Doctor. It may well be that his passage into a more phallic identity had been inhibited by his fear of being identified with a destructively aggressive father and possibly by murderous oedipal impulses being confirmed by the death of his foster father. It is perhaps because of this fear, of the castrated/castrating male, that 'from very early on' he told his foster carer that he wanted to be a girl, a desire that may have been reinforced by the all female foster home he found himself in. Philip's foster carer's own anxieties about male aggression may have confirmed his own fears of male aggression. However, the major source of threat for Philip appeared to be internal, originating from trauma which he was forever trying to master in fantasy (see Discussion **1.**2). He was so busy protecting himself from fears from within and without that there was little room for healthy narcissistic investment in his body as a boy. There was some evidence of more phallic interest in the 'screwdriver' but it was not an object of pride to be exhibited and admired. Instead Philip used it as an instrument of control, expressing his need to be the Doctor in a way more suggestive of anal stage functioning.

Aggression

There was very little evidence of aggressive activity from Philip *as Philip*. He was excessively timid, almost all aggression being expressed through fantasy. He did worry about people 'throwing chairs' in the secondary (special) school he was expecting to

move to the following year but his anxiety was based not in reality nor, as far as is known, in stories told by other pupils, but in an internal anxiety. His solution was to protect himself with a 'magical' object (the Shoebox Zoo model). There was plenty of aggression in the fantasy situations. Any aggression meted out by Philip was in response to external danger and justifiable, that is in the service of protecting/saving the weak and vulnerable as in the Doctor saving the human race. The aggression was physical - fantasied Daleks exterminating - rather than verbal. Philip threw himself around the room, avoiding laser fire, operating the tardis and so on. Despite his harsh superego there was no evidence of turning aggression against himself.

D. Ego Functions/General Development

Physical apparatus subserving ego functions/Cognitive development

Philip had a speech impediment and an odd physical presentation. He was born with microcephalus which may account for some of his developmental delay and difficulty in learning. (Health and special education professionals have repeatedly stated that he does not meet the criteria for a learning disability diagnosis.) He had difficulties with spatial awareness, fine and gross motor control. He could not, for example, draw a circle. He was at the beginning stages of reading, recognizing single words and short phrases.

Basic psychological functions

Philip had a poor sense of time. He suggested, for example, that it had taken me five and a half hours to assemble his box of toys. It was difficult to assess his long-term memory as he did not mention anything in the past because it was forbidden territory. He had a very good capacity for remembering from session to session, no time appeared to elapse between them. He remembered minute details of episodes of Dr Who and other favourites. Philip's carer and his teachers could sometimes persuade him to chat in a more ordinary fashion but his capacity to function appeared much greater when he adopted the role of an 'intelligent' being, such as the Doctor (see Discussion **1.**4). Then he used language fluently and effectively but resisted using it reciprocally: he communicated *to* rather than *with*. He could narrate, instruct, warn, describe but did not debate or converse.

Philip's capacity to reality test seemed to fluctuate from week to week and within the sessions. He appeared to have little sense of time and considerable primary process

functioning was in evidence. He spent almost all of his time, including the short journeys from and back to the waiting room, in imaginary worlds. Given his developmental delay, his chosen scenarios were not inappropriate, the favourites of many latency aged children: Dr Who, Shark Boy, Shoebox Zoo. However, his role-taking and his complete immersion in the fantasy game would ordinarily belong to an earlier developmental stage. Philip felt like a pre-school child, of perhaps three or four years old. At times there was no sense of 'as if' about his play, no 'suspended disbelief'. The markers for the end of the game, for example the end of the session, leaving the room, walking along the corridor past other people, were ignored by Philip. He would still be in character, and troubled by, his imaginary world en route to his foster carer. At the end of the third assessment session, for example, having made a paper 'Wolfgang'[12] for the Shoebox Zoo, he told me on the way back to the waiting room that Wolfgang was saying something to him, he, Wolfgang, kept saying the same thing over and over. Philip was very agitated by this. The experience for Philip appeared almost hallucinatory, losing almost all sense of 'as-ifness'. However, I did not feel that he would actually try to open a door with the paper screwdriver. He would be far more likely to act 'as if' the screwdriver had worked and he were then on the other side of the door. He had a secret, or not so secret, parallel world that he could just side step into.[13] His play had an impenetrable quality that kept me at a distance (and posed a technical problem). My attempts to introduce some reality were futile as with the tardis model where he avoided an acknowledgement that we were pretending and instead incorporated it into the fantasy. Philip invested some of the made objects with a talismanic quality, as with the converted tissue box which became the 'Shoebox Zoo'. Philip insisted he would have to take it with him to his new school (to serve as some protection against the chairs that might be thrown around the room).

Play

There was little sense of playfulness in Philip's role-play. 'As-ifness' was not much in evidence. His play-acting was very repetitive and rigid. The same or similar scenarios were 'played out' with no room for negotiation. He was very controlling about what was

[12] Wolfgang and the other animals are students of an alchemist-wizard, the writer of 'The Book of Forbidden Knowledge'. They are trapped in their animal forms and further trapped in a state of inanimation until the book can be located by Marnie, the eleven year old central character of the drama. Wolfgang dies during the story, thrown into a fire, becoming human again in the moment of death.

[13] Fonagy and Target on psychic reality and pretend modes are helpful on this, see below in discussion of clinical material

happening in the game, who said or did what. He became caught up in fantasy, leaving me quite confused about what was happening. There was no sense of his fantasy 'play' affording mastery over his anxieties. On the contrary, it impeded his capacity to relate to me, the potential playmate. There was some indication of a capacity for companionship – Philip mentioned two friends who were leaving his school in a few weeks. School and foster carer confirmed that Philip did play with these two boys. His capacity for reciprocity, however, was not constant and there were some anxieties about Philip drawing the two friends so far into his fantasy games that they became uneasy and upset. He took a parental role in relation to the card K9, reassuring the robot dog that he was there that he would look after him. This brought to mind Philip's role of carer to his younger siblings together with his sense of failure in that task. His solicitous attitude to the cardboard dog, a robot completely under his control, may have been evidence of an attempt at mastery. The K9 dog has qualities of servitude and unquestioning loyalty to its master. Philip did not endow it with an independent character of its own.

Safety

Philip's foster carer and teachers provided an external source of safety but there was little evidence of his having internalised this. In his fantasy worlds Philip was permanently under threat of attack or abandonment. He created an atmosphere charged with a potential pervasive danger. The 'play' was about the threat of annihilation. The real world often became part of his imaginary world in a frightening way. When a car alarm went off outside Philip looked out of the window up at the sky, telling me with great seriousness, and alarm, that the Daleks were in the sky.[14] There was little distinction between what was inside his mind and what was outside, leaving him vulnerable to intrusion and attack. Philip experienced a fear of excessive drive activity. In his non-fantasy life he had to be passive, but the external world was easily perceived as internal (as with the car alarm). He then had to defend against it in his fantasy life, becoming manically re-active in order to stave off the threat of annihilation.

Defence organisation

Philip needed through fantasy to protect himself against feeling small and vulnerable; he needed to feel big and powerful and in control. When he mentioned his brother he

[14] Winnicott (1971: 3) writes that it is 'the hallmark of madness when an adult puts too powerful a claim on the credulity of others, forcing them to acknowledge a sharing of illusion that is not their own'. It is not surprising that Philip's teachers were concerned about him and his vulnerable and suggestible peers being drawn into his disturbing world

would reassure himself that he was older than James and that he could get the better of him. However, he could not just be Philip and brag and boast about his own prowess and authority. Instead, he had to adopt a powerful, extraordinary persona and use special external 'aids' like the paper screwdriver.

Philip had much to defend against: the loss of his parents and siblings; the feared identification with the violent aspects of his father; his odd looks and his learning difficulties. His omnipotent fantasies served also as a defence against acknowledging the gap between ego and ego ideal together with the shame and low self-esteem that come with that gap.[15]

Philip's defences were largely maladaptive. His 'denial in fantasy' served not only to keep him at a (safe) distance from others but also to configure the world as he chose, not as he found it, absorbing and adapting any challenges to fit his view of how things should be or how he needed them to be in order to feel safe. He deployed excessive projection and splitting in attempts to achieve this but this was only partially successful at best as Philip was still subject to massive anxiety.

Philip had created a defensive character of a much younger, vulnerable child. It was interesting to note that the teaching staff felt his learning difficulties were primarily due to massive developmental delay rather than an organic learning disability. He presented as unable to read, to write, to form any but the most rudimentary shapes (he could not draw a circle or a square). He seemed exceptionally anxious about making a mark of any kind on paper, convinced that he wouldn't be able to do it or he would get it wrong. Philip's unclear speech gave the impression of a boy much younger and intellectually less able than he was.[16] As a result of presenting as a small child he elicited tenderness and concern and sometimes help from those around him (foster carer, teachers, reception staff at the clinic), leading to a secondary gain that would be difficult for him to relinquish. Philip's early years were spent in a large sibling group without adequate

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[15] Sinason (1986: 132) writes, 'The normal can slowly cope with the narcissistic injuries that life provides, the wish to be Bardot, Newman, Einstein, Beethoven. The normal can reduce their horizons to realistic levels. However, those whose horizons are organically or internally attacked and reduced — what happens to them if they become more aware of differences?

[16] Sinason (1986:135) distinguishes three categories of handicap as a secondary defence, the third being handicap used in the service of protecting the self from unbearable memory of trauma.

parental presence, in which, despite being very young himself, he took on a caring role towards his younger siblings. His character defence may be based on a reaction formation, which protected him against his fear of what it means to grow up or to be seen as more grown up.

Philip's attempt at mastery may seem in some respects to be in stark contrast to the defensive vulnerability he took refuge in, unless both are viewed as attempts to adopt a protective character. In this case the character defence, whether it draws on the Doctor, Sharkboy or a Spy Kid is benign. Aggression was used to protect or rescue from or wipe out *sadistic and destructive aggression*. In the midst of his mastery he remained a little boy lost in fantasy, his choice of the Doctor, who finds himself in the same situation time and time again, being particularly apt. Philip's/the Doctor's repeated attempts to stave off disaster and rescue humanity may be seen as instances of the failed attempts at repair that Lear (2005) sees as characteristic of the repetition compulsion. This repetition served Philip well in as far as it kept him in the same situation, safe from frightening development but it did so at the cost of not adapting to reality and cutting him off from ordinary 'going on being' in the world. It restricted his functioning in key areas. In terms of object relations Philip's defences against the fear of ordinary drives impeded his capacity to direct both affection and aggression appropriately. His retreat to fantasy affected his capacity to play and to learn. Practically he was 'otherwise engaged' and not able to attend properly to what was going on around him. Psychologically his impulse was anti-growth, to remain in an enclave where he was in control of the environment. Aggression remained split off, unavailable to the 'binding' influences of the libido.

<u>General characteristics</u>

Philip's frustration tolerance was low. His teachers described him as being frequently in a 'fragile and volatile emotional state' and his foster carer described 'tantrums' when he 'loses it'. Philip relied on his carer and teachers to regulate his feelings for him. Although he was independent, able to clothe, feed and bathe himself, he was treated as if much younger and still in need of close supervision or actual help. School had a stronger sense of his autonomy, trusting him, for example to take the register from the classroom to the school office. Philip had a surprising sense of humour, enjoying, for example, the slapstick of cartoons. He elicited affection and was liked by his teachers.

He appeared interested in age appropriate (given his developmental delay) fictional characters but could not successfully sublimate drive activity through them. Philip got caught up in the game rather than being able to use the game in channelling aggression and libido creatively. He had a difficulty with symbolisation: he could not be Philip pretending, playing at having a magic screwdriver, he had to *become* the Doctor who has the magic screwdriver.

Diagnostic Statement

Philip was a 10 year old boy whose early experience, deprivation and cumulative trauma[17], and organic disability (microcephalus) had distorted development and psychological growth.[18] The context and impact of Philip's birth and infancy on his emotional development could only be surmised. The details of Philip's early life were sketchy. Given his parents' own difficulties and the number of children in the house it is likely that Philip's needs were not adequately met from birth.[19] He was adamant that he did not want to leave his foster carer, and unlike the majority of Looked After Children, he never stated a desire to return to his mother's care. However, he generally appeared to be undisturbed by the contact visits, still supervised, with his mother. His carer and social services staff supervising the earlier contact visits, when his father was still attending, reported Philip's father as showing warmth and affection and a capacity to play.

Philip managed in his special school setting, being generally liked by his teachers and peers. He is likely to have experienced some degree of developmental delay given his background and the microcephalus which is associated with developmental delay in some but not all children affected. However, his strengths, relatively sophisticated

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[17] Masud Khan (1963) argues that breaches in the mother's function as a 'protective shield', that is, a maladaptation to the infant's anaclitic needs, result in cumulative trauma. He stresses that these 'breaches' are qualitatively and quantitatively different to the intrusions resulting from the mother's acute psychopathology. They may not be experienced as traumatic at the time but have the quality of a 'strain' and the effect on the child is cumulative.

[18] Schore (2001: 232), drawing on research into the impact of social stressors over non-social stressors, identifies ensuing trauma as 'relational trauma' and the associated stress as 'ambient' not 'single-event' but 'cumulative'. He continues, 'Because attachment status is the product of the infant's genetically encoded psychobiological predisposition and the caregiver experience, and attachment mechanisms are expressed throughout later stages of life, early relational trauma has both immediate and long-term effects, including the generation of risk for later-forming psychiatric disorders.'

[19] Baradon (2010: 164) describes the unwitting contribution of the parent as 'relational trauma' , placing 'the parent/caregiver centre-stage as a potential source of trauma, through the parent's state of mind and – often unconscious – feelings and intentions towards her infant.'

language, capacity to elicit affection and help, and his sense of humour, suggested, at least in some lines of development, a regression in response to trauma rather than an arrest. Philip was singularly ill-equipped both internally and environmentally to make and sustain ordinary developmental progress. The scant detail of Philip's early life contributed to the difficulty in ascertaining whether his developmental immaturity was due to arrest or regression to a fixation point. His development might best be described as atypical. He had achieved along some developmental lines, for example in management of his body, but had not achieved the ordinarily expected stages of the developmental line from play to work. His developmental delay was likely to be due to a combination of both arrest through lack of appropriate care-giving and regression in the face of trauma. His carer unwittingly discouraged development through her infantilisation of him.

Despite his carer's best efforts there was no evidence in Philip's presentation of an internalised protective mother figure. This may indicate, along with his lack of stated desire to be with his mother, a lack of early maternal investment in him. There was more evidence of father-figures. Philip's experience of his father is complex. The warm and playful positive aspects of his father, as observed at contacts, were a contrast to the frightening father-figures of Philip's imaginary and internal worlds, and to the documented violent and self-destructive behaviours of the man. These differing aspects of the father inform Philip's unresolved dichotomous feelings about fathers which were likely to impede, or at least complicate, attachment to father figures. This background left him vulnerable to feelings of threat to his very survival.

Philip's defences against unmanageable distress have further compounded his difficulties in relating in an ordinary, age-appropriate way to peers and significant adults. He spent much of his time in a fantasy world that has the appearance of play. For example Philip cast me as an ambivalent figure or the baddie in his fantasy world. I could have no independent existence in the external world or in his internal world. Working with Philip posed a problem of technique. If I joined Philip in his fantasy world I felt to lose all autonomy. He decided who I was, what I did, what I said. He resisted any independent contributions I might make to the 'game'. If I remained outside his fantasy world, the therapist in the room with him, he ignored anything I said. This challenge, of how to be separate and communicate with Philip shed light on the heart of

his difficulties. Early deprivation and cumulative trauma have severely affected his capacity for object relationships. Philip's ordinary oedipal aggression in fantasy towards his father and siblings was confirmed for him as damaging in reality first by the scalding of his brother and then by his siblings being taken into care. His brother was badly hurt, irreparably scarred, his sisters and his parents lost, links between the family members broken. The sudden death of his foster father served to confirm his destructiveness. Given such environmental failure it is not surprising that Philip had not yet achieved object constancy, his terror preventing him from making this developmental step (see Discussion **1**.3). He protected himself against turning his aggression towards others and the feared consequent loss of his objects by remaining in a narcissistic world in which he could control his objects. This served the dual purpose of keeping his objects safe from his aggression and from having an independent existence that might allow them to abandon him.

Recommendations for Treatment

Philip's difficulties were very entrenched and long term psychotherapy was advised. In an ideal world at least twice weekly psychotherapy sessions would have been recommended. However, service constraints determined that weekly psychotherapy sessions be offered to Philip, supported by regular meetings with his foster carer and therapist's attendance at Care Team meetings with school and other professionals involved.

Philip: a summary of the first year of therapy

For a fuller account and commentary see Appendix C
See also Appendix B for a list tracing Philip's interest in various fantasies

This summary of the first year of Philip's therapy reads more like a series of 'episodes' than a continuous story, a reflection of his state of mind and how stuck he was in repeating the same scenario. My staccato notes of sessions (see Appendix C) reflect the sudden changes in Philip's focus, but they perhaps, inevitably, fall short of capturing the atmosphere of the sessions. They could feel like being in a maelstrom. Philip's tone and movement was often very urgent, as if a matter of life and death. It was hard to keep up with what was happening when he was shifting from one scenario to another, both in terms of the content and the reason for the sudden changes. In calmer sessions the maelstrom diminished to a muddle of what was real, what was fantasy. Philip's indistinct speech and his extreme reluctance to clarify anything also contributed to the confusion, sometimes leaving me guessing what he had said. He hardly used any of the items in his box but we frequently made three-dimensional representations from card or sugar paper, usually of aliens or props such as control 'switches' for K9, Daleks or the TV. In fact Philip instructed and I made. Philip was reluctant to try to make anything himself because of his lack of confidence in his impaired capacities. His fine and gross motor skills are considerably impaired and he has difficulty manipulating tools such as scissors, pens and pencils. Coupled with massive deficit in confidence about his ability to make a mark. Occasionally I drew pictures, sometimes at Philip's direction, sometimes in an attempt to illustrate something he had asked me to explain.

The assessment sessions are covered in Philip's Diagnostic Profile. I shall however, recap briefly on the content and atmosphere of these meetings since they set the scene for the therapy.

Philip's preoccupations, described in the referral, were evident from the first assessment session. The fifty minutes were peopled by Dr Who, Sharkboy, Spy Kids, all characters without parents who have to take on the role of combating a superpower. It was often unclear to me, and perhaps to Philip, whether he was talking about himself or a fictional character. He told me Sharkboy was looking for his father but he, Philip, hadn't lost his father. His father was just far away and he doesn't see him. Sharkboy would be able to

solve all his problems. He had had to leave his family. He hadn't known that would happen. He thought 'they might chuck chairs at you' at the school he was due to move to the following year. He made references to his youngest sister and to his brother's scars. He cut up card into small pieces which he stuck together with sellotape and then discarded, talking all the time. It was a confused, confusing and fragmented flow.

On reflection (confirmed by the coding exercise) there were themes emerging: the difficulty of holding boundaries, between reality and fantasy, or between one fantasy and another; Philip's worry about the whereabouts of his father; an anxiety about the unpredictable; a concern about 'difference' – are Daleks and Cybermen human?; an interest in superheroes and an anxiety about violence. His capacity for tenderness and concern and his need to control, to master, to have supernatural powers were also to become familiar aspects of the therapy. Philip's resistance to acknowledging reality and his capacity to absorb anything into his view of the world became very apparent. For example, in the third assessment session he asked me to make a life-size tardis. He was undeterred by the lack of resources that I pointed out, or a place to keep such a large construction even had we been able to make one. I made a model tardis. Philip turned it into 'the power source', the energy at the centre of the tardis, and the therapy room itself became the tardis. In the months to come, time travel, as an escape from Philip's own history, was a major activity.

Philip started weekly psychotherapy sessions in September, following the summer break. He came into the first session agitated by his conviction that his friend's 'evil' sister had stolen his white Dalek during a summer play scheme for children with special needs. He was immediately immersed in his fantasy world, he was the Doctor, tracking down a Dalek and talking about his family being sucked into a black hole. In an attempt to follow the material I tried making a family tree. Philip was uncertain about the make up of his birth family. In the following months he avoided looking at this piece of paper. At the end of the first session his foster carer told me that he had been very upset when her daughter had tried to apply cream to his eczema. He behaved as if he were being attacked (see Discussion **2**).

As in the assessment, Philip required me to play a role and resisted any variation or challenge to the script. He was usually the Doctor, I was often his travelling companion.

He ignored me or expressed irritation if I called him Philip. He told me that his teachers were worried about him being the Doctor but he wasn't. It was apparent that I was supposed to know his mind without being told (see Discussion **1.**3).

Philip made several references to his brother's scalding, stating that only he (Philip/the Doctor) could save him. He was invariably agitated when he spoke about his brother, at one point declaring that Daleks had got into James' head.

Philip's carer had forgotten that I had a prior engagement in the third week and he was disturbed when he came to the clinic and I wasn't there. The strength of his conviction that K9 (little more than a cardboard tube) had disappeared was such that I found myself doubting that I had put it away in his box. I had. (see Discussion **1**.2; **1**.3). He spent the session making a Dalek father. The boundary between fantasy and reality was very fragile and he held a powerful belief that the sugar paper Dalek could be 'activated'. Death and disaster were imminent. He told me that Philip had been exterminated. However, he also demonstrated a sense of humour, affection (towards K9) and a capacity to use me as model-maker (see Discussion **1**.3).

Philip behaved as if no time elapsed between sessions, picking up exactly where he had left off. Ambivalent parent figures were often in evidence. His creations, Cybermen and werewolves and so on, often became too frightening and he had to convert them into 'goodies' or get rid of them – as in Session 6 when he decided not to have the werewolf as it might eat people. In the same session Philip adopted a new persona. He became Fish-Out-of-Water[20] and regressed to a pre-verbal toddler-like state (see Discussion **1.**4). I was cast as Chicken Little's mother, a kindly, benign maternal figure. Philip required me to be a need-fulfilling mother figure, intuiting his/Fish-Out-of-Water's babbling and providing gently scolding comments. Philip moved between being Fish-Out-of-Water and translating for him (see Discussion **1.**3). He asked me to make many items, among them a card TV with Spongebob on the screen.[21] The 'TV' became a frequent retreat from anything that got too worrying, a source of mindless self-distraction. For several weeks Philip flipped between being Fish-Out-of-Water and the Doctor, at times playing

[20] *Chicken Little* (2005) Disney. The plot is based very loosely around the traditional tale of the sky falling on Chicken Licken's head. Fish-Out-of-Water is a goldfish who wears a scuba helmet filled with water and lives on the surface. He is one of Chicken Little's misfit friends. Fish is unable to talk properly, communicating more through his actions.

[21] *Spongebob Squarepants* is an American animation for television, the title character is a childlike enthusiastic and energetic character

out a fantasy within a fantasy. Sometimes I would become a frightening figure, as in Session 6, when Philip became anxious that I (his therapist? Chicken Little's mother? I was not sure whom he had cast me as) had brought the Cyberman back to life. There was scant distinction between reality and fantasy. In Session 8, for example, Philip, as Fish-Out-of-Water, told me about a dream which featured Philip (see Appendix C). In Session 9, with my gentle insistence, he managed a little reality testing. He had to acknowledge that there was a limit to the space I could provide for his ever-multiplying models. He also accepted a modification to his script when he grudgingly accepted that I was going to sit and not stand (see Discussion **1.**3).

By Session 10 darker fantasies predominated again. Philip talked about Sharkboy and Lavagirl, and there were references to isolation and megalomaniac tyrants. Philip expressed his anxiety about genetic transmission of destructive aggression (already evident in the assessment - see Diagnostic Profile **B.**3 and Discussion **1.**4). He was also much exercised by the cat-nurse characters of one Doctor Who story line.[22] I was the cat-nurse who had chained up the good D10 Dalek. I was exterminated in due course. That same session there was a fleeting moment of ordinary play when we made 'cookies' and Philip reminded me that they were only pretend (see Discussion **1**.5).

A couple of sessions later a sense of pretend was completely lost again. Philip was terrified of a very formulaic drawing of a gun and very afraid of the werewolf in the cupboard. It was clear that for him naming aloud made it real[23] (see Discussion **1.**2). Whilst the Doctor remained central, Philip continued to move between fantasies. He was briefly interested in the population of the Hundred Acre Wood[24] (especially 'Lumpy', a small elephant), Harry Potter[25], Open Season[26] and in Session 14, the character Mumble from Happy Feet[27]. Mumble is separated from his parents by a schism in the ice. Philip asked me to draw this but the line between penguin-child and parents was too much for him and he asked me to draw the parent penguins beside their

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22 'New Earth' (2006) featured the Sisters of Plenitude, ambivalent figures who both nursed and meted out disease.

23 J.K. Rowling uses this primitive fear to very good effect in the terrifying Voldemort character - 'He who shall not be named' - which Philip would have known about

24 A.A. Milne (1926) *Winnie the Pooh*, Disney (1966)

25 J.K. Rowling (1997) *Harry Potter and the Philosopher's Stone*

26 *Open Season* (2006) computer-animation. The story centres around woodland creatures who team up against their hunters.

27 *Happy Feet* (2006) Warner Brothers. Mumble is a misfit penguin who has no 'Heartsong', necessary for finding true love. He does however have a talent for tap-dancing. In the film Mumble has an accepting mother and a father who is aware of his penguin son's deficits.

offspring. Philip spent some time being an exuberant penguin-chick, skittering excitedly around the therapy room (see Discussion **1.**3).

This particular excitement and fear of separation arose towards the end of the first term. Philip was very anxious about the break. His activity in the preceding sessions was frantic. There had been a tornado in London, widely reported on the news. Philip felt to me as if he were caught up in a whirlwind and I drew a picture of a tornado for him, talking in displacement about another child, but the picture worried him and he didn't want to know about it. He had his Christmas contact with his mother and little sister. His mother gave him Star Wars toys. He made no mention of the meeting except indirectly. He neutralized frightening things as far as possible. He wanted me to tell him about the 'good people' not 'the Dark Side'. He converted buttons from a Dalek model into Christmas tree decorations.

Philip returned after the Christmas break full of short-lived bravado. He declared he was no longer afraid of Daleks, but was soon anxious about potentially dangerous pipe-cleaners (see Discussion **1**.2; **1**.7). In the second session after Christmas he made 'Robotti', a powerful baby robot that resembled a spider. Robotti killed X10, a father-figure robot who had become bad, this worried him.

About this time Philip's older sister's adoptive placement broke down. Although he was not told about this, he began asking his foster carer and teachers about his father. As mentioned earlier, there was an idea in the network that Philip's father may be dead. He had been admitted to hospital with a serious drug overdose, thought to be accidental, and had left hospital still very unwell and unstable. In a meeting with his foster carer I learnt that Philip had asked his mother at the Christmas contact about what had happened when he was small. She also told me that Philip was being aggressive, towards James at school and at home where, when he was upset, he held his fists up. This worried her. I was reminded of her own history, of her violent father, her fear of her own aggression which she had learned to manage.

In Session 20 dying fathers were present in the guise of, what at the time I heard as, 'Phase Ball'. Much later I realised that Philip was talking about 'The Face of Boe'.[28]

[28] 'New Earth' (2006) The Face of Boe. An ancient being, represented as a huge wrinkled head with tendrils, is apparently dying.

Philip told me that the dying figure was Robotti's father. When I asked what Robotti felt about his father dying Philip placed the robot-baby in front of the card TV screen. Philip was particularly agitated for the next few sessions, I was unsure when he was the Doctor, the only one who could help the Face of Boe, or when he was Philip, being protected by the Doctor from Dalek attacks. In Session 22 he sent Robotti in a 'future box' to his past when James was scalded. He was distressed. He told me that Robotti was sick and frightened and he promised never to send him there again. In the same session Philip was interested in my surname. He became aware that he shared his father's first name and surname. He told me that if he wasn't the Doctor he was useless and couldn't do anything. He was worried that when he went to his next school he wouldn't be able to see me. He mumbled something about me being his mother.

At this time Philip became very anxious about one of Robotti's legs, checking it at the beginning of each session, worrying that it was bent (see Discussion **1.**7).

There was murderousness and death in the material over the next few sessions. Philip continued to be interested in Robotti and a larger version of the baby-robot that became Robotti's father. There were also faint signs of a move towards integration of aggression and affection. Philip asked me to make another spider-like model, Charlotte from E.B. White's 'Charlotte's Web'.[29] He identified with Wilbur, the pig being fattened for the farmer's table. He was disgusted by Charlotte's arachnid habits such as drinking flies' blood, but he was also puzzled as he recognised this character as good and protective. He asked lots of questions about birth and death. He was intrigued by Charlotte's babies, wondering if they were all girls and at one point shouted out joyfully, 'Mummy, Mummy, look, I've been born!' (see Discussion **1.**5). Later in the session he boldly stood on two pieces of softplay and called to me to look at him. He got down almost immediately, afraid that he would fall and hurt himself. This session was close to Easter and there may well have been themes of death, birth, sacrifice and regeneration in school assemblies which keyed into Philip's very particular experience.

Philip came back from the Easter break looking for Charlotte's babies but quickly began to talk about the Doctor (Session 25). This was a very significant session. He was

[29] E.B. White (1952) *Charlotte's Web*; animation (1973) Hanna-Barbera Productions for Paramount Pictures; computer-animation (2006), Paramount Pictures, Walden Media, the K Entertainment Company and Nickelodeon Movies

travelling with, rather than being, the Doctor. He told me he wanted to change what had happened in the past when James had been scalded. Then he told me he had changed the future. I was confused and asked Philip to help me draw a picture so that I could understand better. He instructed me where to draw himself and his brother in relation to the bath. When I asked if there was anyone else in the room he told me to draw his mother in the doorway, putting her, quite concretely, 'in the picture' for the first time (see Discussion **1.**5; **2**).

The following week I was cast as the neglectful and culpable Jacky, Rose Taylor's mother. I was punished by having my daughter taken away by the Doctor. Around this time Philip's foster carer was expecting a hospital admission for routine surgery. Her daughter was going to look after Philip in her absence.

In May, Philip became caught up in a wartime story line in Doctor Who,[30] broadcast two years previously. He wanted me to make a model of the lost child in the gas mask who wandered the streets calling plaintively, 'Mummy, Mummy'. He was afraid of the model, fearing that when we attached the gas mask he would become 'the Mummy-gas-mask-man' as he came to call him. Although Philip resisted my attempts to make links, he then made links with his own experience, telling the Mummy-gas-mask-man that he understood what he felt because he too did not live with his mother. He cast me as the older sister who turned out to be the lost child's mother. The child itself was a frightened and frightening figure, the substance of the child having disappeared leaving an empty shell. Anyone in physical contact with the child became 'empty', the face transforming into a gas mask. Philip was very afraid of becoming the Mummy-gas-mask-man and made various attempts to distance himself from it or turn it into something benign/ineffectual (see Discussion **2**). He decided the gas-mask-man was his brother, that his father had died some years ago in the war, that 'they' had looked for him but had not found him. In the session before the half-term break Philip told me that he always wanted to see me. He was solicitous towards the Mummy-gas-mask-man who had become a baby, and he, the Doctor/Philip, its father. He called out, 'Mummy, Mummy' with happy expectation. He played out the sacrificial death and reprieve of Wilbur the pig from Charlotte's Web.

There was a break of three weeks. Philip had his first residential trip away with school,

[30] 'The Empty Child' (2005)

to London, followed by the half-term holiday and a week when I unexpectedly had to cancel a session. He returned as if no time had elapsed. His carer prompted him to tell me that he had had a good time in London and that the two family cats had died. Philip wanted to know if I had seen Doctor Who.

Philip's defence of converting the frightening Mummy-gas-mask-man into a vulnerable baby was not sustainable. In Session 31, talking for the little figure, he then felt persecuted by the constant enquiry of 'Mummy?' Eventually Philip shouted at it: 'Your Mummy's dead!' This was too frightening. He decided I was the Mummy-gas-mask-man-baby's mother, brought back from the dead, and then that he/the Doctor would protect it. The atmosphere was one of urgent confusion. The following week he shifted from one Doctor Who scenario to another. He was particularly interested in the Lazarus machine[31] which, designed to ensure immortality, malfunctioned and transformed people into monsters. He also talked about 'the little Master',[32] wondering what had made him bad. Philip listened when I suggested that he, like the Doctor, had done everything he could to stop something terrible happening but he still felt bad that he hadn't been able to do more. He told me he was Philip *and* the Doctor. He explained to an imaginary little Master why he hadn't managed to save their parents and planet. He dashed to find the picture of the scalding incident and declared with high drama that, 'James was the little Master!' When I suggested people turning into monsters or becoming bad might be worrying, Philip told me I was beginning to worry him.[33]

At school much of the focus was on the imminent transition to secondary school. He became very guarded. He was the Doctor in the 'Family of Blood'[34] story line, very appositely for Philip, hiding his identity from himself. (The Doctor had become John Smith and had no cognisance of his own true identity.) He was inaccessible to anything I might say. In the middle of the Doctor Who fantasy he announced that his pig, Wilbur, had died and so had Charlotte.

In the penultimate session the distinction between fantasy and reality was very fragile (see Discussion **1.**2). Philip talked about the Mummy-gas-mask-man being at a friend's

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31 'The Lazarus Experiment' (2007)

32 'The Master' is another Time Lord and the Doctor's old adversary

33 In a later session Philip asked me to draw a picture which referred back to this session and the shared history of the Doctor and the Master (see Discussion **2**).

34 'The Family of Blood' (2007)

house. He was very preoccupied with the recent Family of Blood episode, wondering why Martha, the Doctor's companion, had slapped him to bring him to his senses. He could not understand why Martha would want to dissuade the Doctor from the belief that he was John Smith. He was cross with me for talking about his own family. Philip was convinced that his friend's sister, Shelley, was an evil alien. His conviction was so strong that I was concerned about his capacity to distinguish the real from the imagined Shelley. I contacted his carer. She told me that Philip now knew that his older sister was in contact with their mother (see Discussion **1.**3).

In the last session of the year. Philip asked me to make a 'stone angel'[35]. The weeping angel, actually a malevolent alien, moves when not observed, it can kill in the blink of an eye. Philip continued to talk about Shelley. He gave a confused account of the alien Shelley (identifiable as such by her antennae) taking James whilst Philip managed to escape in the tardis. He smashed the stone angel with the tardis model and then became very anxious asking me, 'I'm not a murderer...you don't think I'm a murderer do you?' He found it very hard to finish and could not leave his fantasy world to acknowledge the break and say a temporary goodbye.

Philip resumed therapy three weeks later.

[35] 'Blink' (2007)

Discussion

In general Philip's presentation in his first year of therapy was consistent with the picture that emerged in the assessment sessions as described in the Diagnostic Profile. The themes identified in the coding run through the material: anxiety about aggression, therapist as carer/parent, fathers, association between parents and death, loss of sense of reality, fear of aliens/monsters/own creations, concern for/caring for vulnerable/infantile others. These themes might all be thought about in relation to Philip's capacity to establish and maintain a self-object boundary, his capacity for object relatedness, his pre-occupation with a fantasy world and the links between these. The seriousness of the impact of Philip's fantasy life on his ordinary development was not in doubt. As Winnicott stated, 'fantasying[36] interferes with action and with life in the real or external world, but much more so it interferes with dream and with the personal or inner psychic reality, the living core of the individual personality' (1971: 31). During the course of the year Philip remained staunchly in his fantasy world but there was some, if limited, developmental progress. I shall discuss the clinical material outlined in the Diagnostic Profile and the summary of the first year of therapy, as stated earlier, with reference to the literature, using Anna Freud's concept of 'developmental lines' to consider 'where Philip is at' and Parens' theory of a spectrum of aggression to consider 'why he is there'. As stated in Chapter 1 the profile and lines, taken together with grounded theory, couch the development of aggression within a broader developmental picture. In addition to the lines described by Anna Freud, I have referred to the 'lines' proposed by Yorke and Wiseberg (1976), who offer a line from pervasive to signal anxiety, and Parsons (2006) who describes a line for aggression. Even though they might depart in some respects from Anna Freud's thinking, these authors are broadly rooted in the same tradition. I have suggested in addition that Fonagy and Target's conceptualisation of 'mentalisation' and Stern's development from core self to self-representation might be conceived of as 'lines'. Other concepts that are relevant across various lines, such as 'fantasy as defence', I have discussed under the 'line' most pertinent to the clinical material. For a discussion of development across the lines, and a comparison with the second case, see Chapter 5.

1 Where is Philip at developmentally?

[36] Winnicott is referring to fantasy as a defence, as Anna Freud does in her concept of denial in fantasy.

Aspects of Philip's ego functioning, such as memory, reality testing, synthesis, motility, speech, secondary thought processing are referred to here under various developmental lines. I shall focus particularly on Philip's capacity for reality testing, with reference to Fonagy and Target's 'line' describing the development from 'psychic equivalence' to mentalisation.

The developmental lines are couched implicitly in Freud's drive theory. They describe the growing capacity for mastery determined by the strength of the developing ego in relation to an average expectable environment. Impairments in, or paucity of, early good-enough care-giving relationships affect attachment and hinder or curtail development. Establishing where a child is along any given line can inform consideration of what constitutional, environmental or pathological factors have impeded or interrupted development. As might be expected development along the various 'lines' is uneven. We do not know in detail about Philip's early development but he had achieved the milestones from 'suckling to rational eating' and from 'wetting and soiling to bladder and bowel control'. However, in other respects Philip's development was considerably delayed.

1.1 *From irresponsibility to responsibility in body management*

Philip presented as much younger than his ten years in almost all respects. As with many children with special needs he was more physically dependent on his carers than might be expected. Philip's tendency to evoke care-giving chimed with his foster carer's inclination to be a care-giver. Although Philip was gangly and awkward and his fine and gross motor skills were impaired, he did not have a physical disability which would prevent a reasonable degree of self care: for example he had difficulty using a pencil but did not need help with eating. However, his carer was still brushing his teeth for him and washing his hair in the bath. Philip complied, appearing to abnegate responsibility for his own bodily care. For instance, he did not object when his carer asked him, in the waiting room in front of other children and young people, if he needed to go to the toilet or asked if he had washed his hands, as if he were a much younger, or less physically able, child. Anna Freud (1965: 76) proposes that progress along the developmental line 'From irresponsibility to responsibility in body management' is dependent on advances

in ego functioning 'such as orientation in the external world, understanding of cause and effect, control of dangerous wishes in the service of the reality principle'. Given his extreme aversion to reality testing it was unsurprising that this was a possible fixation point in Philip's development. Whatever his development to the point at which the trauma occurred, his little brother's scalding, and quite likely his mother's guilt projected into him, is likely to have led him to regress to a wished-for state of being cared for, leaving behind a sense of agency and responsibility. We might conjecture that Philip's care-seeking could be a return to an earlier experience of eliciting his mother's care on the basis that, at the times when she was more available, she might have been more responsive to her children when she felt needed by them. Where there is ego regression, as in Philip's desire to return to a dependent state, ego functioning is also negatively affected. There can be a shift back from secondary to primary processing. Philip was capable of secondary processing but whilst he had one foot in the real world he shifted all his weight to the foot that was firmly in his fantasy world, to the extent that he could quite ignore reality. Fonagy and Target's work is very pertinent here.

1.2 From '*psychic equivalence' to mentalisation*

Fonagy and Target (1996) make a distinction between 'psychic equivalence' and 'pretend' modes of experiencing psychic reality. The shift from psychic equivalent to pretend, to an integration of the two modes, and eventually to a capacity for mentalisation[37] might helpfully be thought of as another 'developmental line'. Working from the widely accepted premise that for the young child inner experience 'is equivalent to and thus mirrors external reality' Fonagy and Target (1996: 219) propose that 'the subjective sense of oneness between internal and external....is a universal phase in the development of children. Indeed, movement forward from this phase inevitably gives rise to conflict, and may therefore be fiercely resisted.' In normal development Fonagy and Target suggest the anxiety arising from such conflict acts as a push towards integration of the different modes of experiencing inner and outer reality, the child then becoming more able to distinguish between the two. They emphasize the need to keep the distinction between the psychic equivalent and the pretend: when something pretend becomes too real it is potentially very threatening. The successful integration of 'psychic equivalence' and 'pretend' modes leads eventually (around about the fourth or fifth

[37] That is the ability to make and use mental representations of one's own and other people's emotional states.

year) to a capacity for a reflective or mentalising mode of experiencing psychic reality. Philip had very little, if any, capacity for making or maintaining a distinction between psychic equivalence and pretend: for him the paper screwdriver *is* the Doctor's powerful tool, indeed most of the time Philip *was* the Doctor. When we made the model of the 'Mummy-gas-mask-man' (see Appendix C, Session 28) he feared that when he put the sugar paper gas mask on the body he, Philip, would become the Mummy-gas-mask-man, the empty, alien child. As was evident in his history and in the clinical material, this state of mind had profound implications for his capacity to develop healthy relationships with others. Segal (1991: 102) points out that 'The capacity to play freely depends on the capacity for symbolisation. When the symbolic function is disturbed it may lead to inhibition....A disturbance of symbolisation can also lead to forms of play which preclude learning by experience and freedom to vary play....When the toy is symbolically equated too concretely with the object symbolised, it cannot be used imaginatively.' Playfulness was very rare in the sessions, but it is difficult to determine whether this was a developmental regression or arrest. There was no available evidence either way to determine whether Philip had achieved a capacity prior to the traumas resulting in his coming into care. When his teachers and carer described him as playing they referred to the times when he involved other children in his fantasy world.

Fantasy as defence

Philip's terror prevented development. He created a world where he was in total control - and which impeded his capacity to relate. Philip's self-enclosed narcissistic universe was of a different order to the omnipotent thinking and wish-fulfilling fantasies of the magical thinking of ordinary childhood experience. It was all encompassing. Philip had no curiosity about the world around him. For example, he did not comment on the unusual panels in the wall in the therapy room, normally a matter of interest to children. Fraiberg (1959: 22) reminds us that in health the child 'can maintain his contact with reality while he maintains his imaginary world. Moreover...the child's world is *strengthened* by his periodic excursions into fantasy. It becomes easier to accede to the demands of reality if one can restore himself at intervals in a world where the deepest wishes can achieve imaginary gratification.' In ordinary circumstances fantasy is a useful and creative defence against anxiety and childhood anxieties and fears. Once anxiety and fear are mastered the fantasy dissipates. If anxiety and fear seem to be confirmed by reality, fantasy is a much less effective defence. For Philip the use of

fantasy was maladaptive as a defence.

There was almost no flexible movement between reality and fantasy, such as Fraiberg describes, which created a technical challenge: maintaining an independent voice within the fantasy was impossible, but remaining on the 'outside' meant Philip would, for the most part, completely ignore my existence. It was very easy to get drawn into Philip's fantasy world. Why he chose particular fantasies and what that might tell us about his functioning is fascinating, as is discussed in more detail later. The rare points of development that I noted tended to be in those sessions where Philip was being Fish-Out-of-Water, who appeared a month into therapy (see Summary p.71/Appendix C, Session 6), or thinking about Charlotte and Wilbur, whom Philip began to talk about in late March (see Summary p.74/Appendix C, Session 24). Generally it was easier to maintain a foot in reality when Philip was engaged in a fantasy other than Doctor Who. These other scenarios felt closer to play and I was usually cast as a benign parent figure. The mood of these sessions was lighter and there was occasional humour between us. There was some, albeit fleeting, hope of development. Conversely The Doctor Who fantasy, enthralling as it was, provided no opportunity for growth. The Doctor Who world was seductive to me as well as to Philip. It was tempting (and in practice ineffective) to become caught up in tracking the parallels between his fantasy and his own experience, and to offer interpretations in the hope of him seeing those links too and then, eventually, moving on.[38] It was less easy to keep in mind the fact that he could not/did not want to relinquish this world. Fonagy and Target are helpful on this:

> The young child, attempting to make the developmental step between a dual and an integrated mode of psychic reality, is in a highly vulnerable state. The integration of the pretend mode (in which the child splits thought and feeling from ordinary reality) and the mode of psychic equivalence (where there is an equation of internal and external reality) confronts the child with particular difficulties when a thought, felt to become real, signals danger. While the worlds of pretend and reality are separate, the child's psychic reality can include fantasy representations that would be highly conflictual if their truth or falsity were to be examined in conjunction with the world outside (1996: 225).

[38] As with 'The Family of Blood' story line when the Doctor took on another character to hide his own identity from himself (see Summary p.7/Appendix C, Session 34) Interestingly Philip did make his own links in relation to his brother and the little Master but only within the Doctor Who fantasy.

Fonagy and Target propose that successful integration is dependent on repeated experience of three factors: the child's 'current feelings and thoughts, these mental states represented (thought about) in the object's mind, and the frame represented by the adult's normally reality-oriented perspective' (1996: 220). They emphasize the importance of this 'frame': an adult or older child who can join in playing with the fantasy so that the child can experience the fantasy in the mind of an 'other'. The child re-introjects the shared fantasy into his or her own mind and it becomes a representation of his/her own thinking. Philip suffered early loss, rejection and trauma and retreated into a psychic equivalent mode of functioning. He was without an interested helpful adult who could help him integrate psychic equivalent and pretend modes.[39] Philip's severe delay in achieving object relatedness impacted on his capacity to make use of the 'frame', to use the help on offer from his foster carer and teachers or from his therapist. This explains in part why it was so difficult to help Philip but it still leaves the question of why he was so resistant. It would seem that the degree of trauma and the threat of disintegration were too great. His fantasies had been confirmed in the scalding of his brother and the death of his foster father – which brings me back to Henri Parens' work and the central question of the thesis: **is it a confusion of aggression with assertion that has impeded Philip's development, that prevents the integration of psychic equivalent and pretend modes of reality?** I shall return to this later.

1.3 *From dependency to emotional self-reliance and adult object relations*

Philip's early experiences and his defences in response militated against the development of ordinary healthy object relationships. Philip had progressed beyond the total dependence of the first stage of this line[40] and did relate to people: his teachers, his carer, her family, his peers. However, his capacity to maintain a positive image of those important people in their absence was doubtful. Philip at ten years of age was functioning somewhere between stage 2, relating to significant others as part or need-fulfilling objects, and stage 3 of this particular developmental line, in which a positive

[39] Music (2011: 66), considering the transmission of 'attachment', links Mein's mind-mindedness (the capacity of parents to be aware of their children's states of mind [2001]) with Fonagy's concept of mentalisation.

[40] Anna Freud's prototype 'From Dependency to Emotional Self-Reliance and Adult Object Relations' (1965: 64) describes the stages of development form the newborn's total dependence, through the part-object or need-fulfilling anaclitic relationship, object constancy, the anal-sadistic, the phallic-oedipal, latency, pre-adolescent, and adolescent stages to the emotional and physical self-reliance of adulthood. The latency child would ordinarily be beginning to move towards 'the pre-adolescent prelude' and to 'the adolescent revolt'. This stage is characterised by 'a return to early attitudes and behaviour, especially of the part-object, need-fulfilling, and ambivalent type' (1989: 66)

inner image of the object can be maintained. He did not appear to have yet achieved object constancy, which Anna Freud proposed would, in normal health, be achieved in the latter half of the first year.

Development of object constancy

For Anna Freud the term refers to the stage at which the child maintains 'a positive inner image' (1965) of the mother, or 'libidinal object' (Spitz: 1946, 1965) whether she satisfies or frustrates the child's needs. Other theorists offer different perspectives, for example Piaget's (1937) emphasis is on cognition and evocative memory, placing the permanence of an object concept in which the child can maintain and recall a mental representation of the mother at around eighteen months. Mahler, as outlined earlier in Chapter 1, described a sequence from symbiosis to separation and individuation. Mahler focuses on internalization of the mother and the function of this representation. Object constancy has been achieved when 'at times of mother's absence the representation continues to provide sustenance, comfort and love' (1968: 222) (as in Freud's observation of the *fort da* game). P. Tyson (1996) suggests that Mahler's formulation, whilst offering a more finely tuned and thorough understanding of the concept, perhaps encourages a blurring of the cognitive and structural aspects. This is a helpful distinction with respect to Philip who had the cognitive capacity for the recall Piaget describes but had a great deal of trouble with affect regulation. His teachers and foster carer were greatly concerned by his outbursts. Tyson, drawing on Hartmann (1952), is interested in the links with ego functioning and the capacity for affective self-regulation. She draws attention to the child's capacity to perceive and identify an affect associated with danger and adapt accordingly, the affect then having a signal function, as a developmental achievement rather than an automatic reaction. If the mother is not overwhelmed herself by her young child's distress and can help her child regain control and a sense of equilibrium ('contain' in Bion's terms), the child 's internalisation of her, in time, will include her regulatory responses to danger. However, 'without timely intervention and the mother's comforting, regulating, and reorganizing responses, the toddler easily feels desperately helpless and defensively angry.' (P. Tyson, 1996: 102). Along with fellow theorists working from drive theory, including Spitz, Hartmann and Anna Freud, Mahler viewed the neutralization of the libidinal and aggressive drives as a pre-requisite for object constancy and the development of a coherent sense of self. By

this she does not imply the abnegation of aggression, rather that 'the object is increasingly invested with predominantly libidinal and neutralized energy'. Such 'neutralization' depends, in part, on the mother being able to help the infant to distinguish and organise inner and outer stimuli. (Mahler, 1968: 224) Philip's mother was not well placed to provide that.

Early on in the work the indications were that Philip did not perceive me as a separate object. I found myself asking whether Philip had a sense of my 'going on being' (Winnicott, 1956: 304) in his absence. He was distressed by having come to a session (see Summary p.71/Apppendix C, Session 3) and not finding me there. He asked me to feed the cardboard K9 in his absence. Did this constitute a sense of my independent existence? Did he have enough sense of me to want or need me to 'keep him in mind'? Or were these indications of his omnipotent thinking, his capacity (born out of need) to conjure up his own version of the world. No doubt his distress was connected in part with the very significant changes and losses in his past which I was aware of and acknowledged in that session. However his perturbation was perhaps less about missing me as the therapist-person he was getting to know, and anticipating spending some time with, and more about a challenge to his perception/wish for me to be ever-present, an extension of his own world. Philip was not interested in my independent existence. He demanded that I stay in role in his fantasy and feed the cardboard K9, ready to pick up where he had left off. Feeding K9 had a different quality to the 'pretend mode' of playing along with small children's fantasies, such as looking after loved soft toys whilst a child is at school. It was different too from the anxious demand that the therapist should look after and protect the child's possessions from other children who might come to the clinic. It was much closer to the 'psychic equivalent' mode Fonagy and Target describe.

In the transference to me as a 'functional object'[41] I was required to do Philip's bidding. Then countertransference experience confirmed Philip's use of me as an aid, an extension of himself not as a whole and separate object, I felt to be 'an adjunct', a 'spare part', his 'slave'. It felt as if Philip would play out his fantasy whether I were present or not. I was useful to him solely as another body to 'be' one of his imagined characters and

[41] Tähkä (1988) suggests, 'Depending on whether the mother's respective function is gratifying or frustrating, she is experienced by the child as "all-good" or "all-bad" with a corresponding and/or compensatory mobilization of the inner images about her. In the child's experiential world this early object is not yet somebody with functions but a much less differentiated somebody who is the function she is performing at a given moment'.

to make the props. As in Anna Freud's second stage in the development towards companionship I could be 'related to as a lifeless object.....sought out, and discarded as the mood demands' (1965: 78). From a Kleinian perspective, his need to control, an omnipotence rooted in very early wishes, might be understood in terms of Philip having projected his angry feelings at my absence into me and then becoming fearful of those projections coming back at him and so that he must convert the bad-part-object into a good-part-object (one who will feed K9) to keep himself safe. There was little evidence of a capacity for concern for another or reparation to a damaged whole object.

Philip's identification with the infantile 'Fish' character (see Summary p.71/Appendix C, Session 6) was further evidence that he had not yet achieved object constancy. He was still at a stage of part-objects, demanding an ideal, need-fulfilling mother who would instantly provide whatever he required, a stage in which object cathexis is temporary, extending only until satisfaction of desires has been achieved. There were, however, intimations of the 'hatching' and 'practising' phases of Mahler's model of separation-individuation in the Fish and Mumble (the small penguin) figures in relation to me.

Illusion and disillusion and separation/individuation

This enactment of a situation of needs-being-met, or not, raises questions about Philip's early experience. Winnicott (1971: 12) states, 'The mother, at the beginning, by an almost 100-percent adaptation affords the infant the opportunity for the *illusion* that her breast is part of the infant. It is, as it were, under the baby's magical control....omnipotence is nearly a fact of experience. The mother's eventual task is to disillusion the infant, but she has no hope of success unless at first she has been able to give sufficient opportunity for illusion.'

Philip was hanging onto/recreating a state of illusion with great tenacity. It is unlikely that his mother would have been able to provide 'an almost 100 percent adaptation' to her infant son who arrived in the world with his own difficulties: in the form of microcephalus. The question of the extent to which this likely failure of adequate care-giving might have impacted on Philip's capacity for *disillusionment* has implications for technique. It was very difficult to introduce a gentle challenge to his omnipotence. Philip's use of a need-fulfilling object confirms 'object-seeking' (Fairbairn

1941) and there was also some evidence of (grudging) object recognition. In Session 9, for example, he expressed irritation with limits, the limited space in the cupboard, his concession about my sitting. It raises the possibility that he had retreated to a need-fulfilling object relationship out of anxiety and that there may be some capacity that he could draw on when he was more settled. The failure of his therapist/need-fulfilling-mother to provide absolutely and instantly what he wanted was a reminder, unwelcome but to some extent acknowledged, that he and she were not one and the same. The task of disillusionment, of helping the baby to move on from the early stage of the illusion of being the creator of the breast and unity with the mother, through gradual lessening of adaptation, is an essential pre-cursor to weaning and separation. Winnicott (1971: 17) points out that this process of disillusionment continues to be a task of parents and teachers. However, timing and readiness are imperative for the frustration to be manageable. 'Like the baby with the mother, the patient cannot become autonomous except in conjunction with the therapist's readiness to let go, and yet any move on the part of the therapist away from the state of being merged in with the patient is under dire suspicion, so that disaster threatens' (1971: 126). Towards the end of the year Philip had retreated somewhat and again experienced any threat to his illusory state as a rupture. In the then-current Doctor Who story line, the Doctor, so aptly for Philip, was hiding from himself in the guise of 'John Smith'. In Session 35 (See Summary p.77/Appendix C) Philip *wanted to know why Martha had slapped John Smith* and could not understand why the Doctor's companion should want to disillusion 'John Smith' and face him with his real identity (the Doctor). I had wondered if Philip experienced my thoughts about his own wish to hide in another character as a similar 'slap'. The timing of my attempt to bring him back to an unwelcome reality was certainly unproductive and perhaps unhelpfully caused him to retreat further into his fantasy world, quite convinced that his classmate Shelley was an alien. His insistence was so great that, as mentioned earlier, I felt it wise to alert his foster carer, in case the real Shelley be in danger of Philip's projections and possible defensive attack. His anxieties had a primitive quality, linked I think, to his 'black hole' experience, a fear of annihilation (Tustin, 1988), raising questions about Philip's very early experience which I shall return to later. Within the limits of whatever sense of self he had, Philip had good cause to hide from the self, or aspect of self, he perceived as dangerous. Stern is helpful on this: building on his work on the development from the core self we might consider a further developmental line:

1.4 *From the core self to self-representation*

Stern (1985) locates the epigenesis of a 'core' self in the affective attunement and intersubjectivity in the infant-mother relationship. As the infant experiences and internalises other intersubjective relationships other, more complex 'selves' develop and an internal representational world is established. Stern describes the development of the 'emergent self' over the first two months to a 'verbal' sense of self at two years. From round about two to seven months the integration of the 'self-invariants' – self-agency; self-co-herence; self-affectivity; self-history – lead to a unified core sense of self. A sense of 'other' emerges in parallel. The infant gains a sense of self and, or with, another. A sense of 'subjective self' follows and eventually, at around about two years of age, a 'verbal self' is established. Stern diverges from Mahler, Winnicott et al in his proposition that the infant achieves a sense of self much earlier, and that a sense of self precedes the experience of fusion or merger with an other. With that important distinction in mind, building on Stern, a developmental line leading to self-representation might start with an initial dependence on the object to facilitate the 'emerging' process, moving to an internalisation of the *function* of the object, towards a process of identification and eventually a more stable self-representation and the achievement of both self and object constancy.[42] A step along the way is Stern's 'self-history', the invariant that relates to Winnicott's sense of 'going on being'. Philip had plenty he could not or did not wish to remember. We can only conjecture about Philip's early stages in this line of development but his presentation indicated that his sense of self was fragile. There were times when Philip managed better, when he could talk in a more ordinary way about something that had happened in the past, recounting for example, with encouragement and prompting, the events of the school trip to London (see Summary p.76/Appendix C, Session 28-31). However, there was a question about his sense of 'going on being' when he avoided being in touch with reality, with the people around him, and with the passing of time.

Identifications

Self-representation is gradually established through the child's identifications with

[42] Akhtar (1996) emphasizes that self- and object constancy continues to evolve throughout childhood and sometimes in adult life.

introjected objects. Some of these identifications are temporary, some remain to become part of the structure of the personality. Philip's development was arrested in this respect. He was terrified of identification with his father, a fear which kept him in infantile omnipotence, affecting his capacity for object relationships. The draw of the identification with the Doctor as a defence is discussed below in more detail, along with some thoughts on Philip's response to possible projections into him of his mother's guilt about the scalding.

As mentioned above, Philip flitted between temporary identifications that were fleeting and unstable. He inhabited various roles, each representing aspects of himself but they were unintegrated so that his sense of self remained incoherent. His identification with the infantile Fish and Mumble characters were chronological-age inappropriate. Something similar should have occurred in his infancy but Philip had not had a consistent helpful adult to foster his growing sense of self. The therapeutic relationship provided the potential facilitating environment for such identifications to be belatedly tried out. However, there were questions of whether Philip was able to use what was on offer and whether it was enough or too late to effect real and lasting change. Philip's capacity to identify both with the pre-verbal Fish and the more competent aspects of himself as translator (see Summary p.72/Appendix C Session 7) suggested that his capacity was only partially impaired. Stern (1985: 164) proposes that as well as being subjectively experienced, a representation of the self as an objective entity is a pre-requisite for the acquisition of language. Stern (1985: 163) also observes that 'language causes a split in the experience of the self'. Divergent directions appear: 'language as a new form of relatedness and language as a problem for the integration of self-experience and self-with-other experience.' Stern is referring to the possibility of failures in communication, misunderstandings but also to language as a tool 'to distort and transcend reality....create expectations contrary to past experience...elaborate a wish contrary to present fact' (1985: 182). It is interesting that Philip's speech was much more fluent and he was much more articulate when he was immersed in his Doctor-self and his speech impediment was much more apparent and disabling when he was not (see Diagnostic Profile **D.**2). This suggests that establishing an integrated sense of self was more complex and more challenging for Philip in relation to his self-with -others.

1.5 *From egocentricity to companionship*

Philip was inclined to live in a fantasy (rather than the real) world with 'companions' in imagination rather than real friends. It was tantalizing work with Philip. It often felt akin to attempting to coax a small, very timid, creature to venture out of its burrow. A mere glimpse of the outside world was enough to send it scurrying back in again. Change rarely seemed to be maintained but there were indications of some development. Session 10 provides an example. Philip was still some way from object constancy at this point but there were some occasions when we were playing together and a degree of object-relatedness was beginning to be tolerable. The cookie making was more of a joint effort with Philip adding the felt- tip 'chocolate chips' and reminding me that they weren't real. There was collaboration and a sense of pretend. (Fonagy and Target, 1996). There was recognition of an other in this interaction, possibly even concern for me as the other – it would harm me to eat paper. Making pretend cookies with Philip was like being with a three year old, but such moments of ordinary, if very early, play were fleeting (see Summary p. 72/ Appendix C Session 10). In healthy development a nursery aged child would have achieved 'the fourth stage which equips the child for companionship, enmities and friendships of any type and duration', recognising other children as separate and autonomous, towards whom he can have a range of feelings, 'whose wishes he acknowledges and often respects, and with whom he can share possessions on a basis of equality' (Anna Freud, 1965: 78). Philip appeared to be some way from joining in, turn taking, reciprocity, pretending along-with (not just alongside) another, taking pleasure in being in another's company. He was functioning somewhere between treating his therapist as a needs-fulfilling object and as a helpmate with no autonomy.

1.6 *From play to work*

Anna Freud ascribes the beginnings of play to the baby's pleasurable (erotic) experience of his or her own body through touch, mouthing, seeing, and the baby's experience of his/her mother's body. As the baby develops, the bodily qualities, softness and so on, are transferred to a soft toy, a blanket, a transitional object, (Winnicott, 1951) which is invested with both narcissistic and object libido. Gradually there is a broadening interest in a wider range of objects which have symbolic value through which small children can

express their ambivalent feelings without fear of retaliation. Cuddly toys become less important, except at bedtime. The pleasure of 'task completion' develops leading eventually to a pleasure and satisfaction in work.

Interestingly, as mentioned earlier, Philip showed very little interest in the toys and materials provided in his box, the animals, fences, paints and so on. He was more concerned with making props for his fantasy world. When we made models he did not stand back and admire our creations, he moved straight on to incorporate them in his narrative, becoming frightened of them and sometimes destroying them if they became too invested with his own fears.

Potential space and and transitional phenomena

I was tempted on occasion to see progress that was not sustained over time, for example, to see Philip's use of K9 as a transitional object, the not-me object that is an aid to the negotiation of 'the intermediate area between the subjective and that which is objectively perceived' (Winnicott 1971: 3). However, Philip's attachment to K9 does not meet Winnicott's criteria of a transitional object (1971: 10) in that it doesn't appear to stand in for a relationship with another/the breast but rather a projected part, the vulnerable baby part, of himself. Philip' is trapped in the 'narcissistic milieu' (Hoffer, 1950), at the subjective end of Winnicott's 'intermediate area' and he keeps his therapist there with him. His play is not playful and he is a long way from moving to reality. A potential space has to be established first: 'Through the mother's empathy with her infant and the therapist's empathy with the patient, the infant/patient is able to internalize and feel safe from dependence to autonomy. Only through this reliability and trust does a potential space start to occur.' (Abram, 1996: 325) Philip's mother was unable to provide the prerequisite 'holding' (Winnicott, 1960: 44) for Philip to achieve object constancy and he was very resistant to development in therapy. However, over the year there were some developmental gains and indications that a potential space might emerge. For example, another, more optimistic, reading, of the K9 material implies a degree of separation and concern, that is if leaving K9 with me was in some sense keeping an eye on me, keeping me safe from disappearing down the black hole of his aggression. There had been a worry, for example, about where I was (and what had happened to me?) when he had come to a session and I wasn't there (see Summary p.70/Appendix C,

Session 3). The 'down to earth' explanation that I was on a course was very important to Philip. His teachers were sometimes away on courses so he could understand that. I hadn't disappeared. It was unclear how differentiated Philip and I were in his mind, but if I were perceived as an extension of himself there was at least a recognition that I was an extension worth worrying about. In terms of this developmental line Philip appears to have not yet fully achieved, or to have regressed to an early stage, suggesting less than satisfactory early experience of his own and his mother's bodies. There is an absence of phase dominance and my uncertainty about how Philip related to me in the transference may be a reflection of instability of development along the various lines.

Later in the year Philip's interest in Charlotte's Web and his identification with Charlotte's babies (see Summary p.75/Appendix C Session 24) appeared to be an opportunity for some healthy exploration. Philip was asking questions about Charlotte and wanted to know what I had to say. He was faced with the possibility that a mother figure might have both positive and less attractive attributes (kindness and the unappealing habit of eating flies). Philip's interest in Charlotte preceded a significant shift. In the last session before the Easter break, Philip was excited about Charlotte and the new babies. He *took one 'baby' to 'Charlotte' shouting, 'Mummy, Mummy, look, I've been born.'* There was something very hopeful about this – a small creature, a baby part of Philip, unfettered by the Doctor Who world, full of potential. He followed this with climbing on some softplay, a very daring act for him, asking me to look at him. I felt I was, very briefly, looking at him, at Philip, and not at Philip in one of his roles. He was scared, however, and got off quickly, in case he hurt himself. At the moment when he asked me to 'Look at me' he was making a clear distinction between himself and me, we were separate objects. He had a sense of himself, a fleeting moment of healthy exhibitionism (Mahler's 'practising subphase'). But it was so precarious that in asking me to look it drew his attention to his separateness – and his vulnerability. Or did he see something in my eyes? Pleasure? I was pleased. Did that frighten him? Was that a reminder of something good and lost in his mother's eyes, or a painful contrast with an absence or something more malignant? There was something too frightening about the experience and Philip was unable to use me as an auxiliary ego, or self-regulating other (Stern, 1985) to help him manage the affect, the intensity of the contact. He hastily retreated. The 'potential space' between infant and mother, child and therapist disappeared again. Although at the time this seemed to be a tentative move forward, just

before the summer break Philip declared that both Wilbur and Charlotte were dead. This is likely to have been a response to the break, something hopeful cut off.

In his writing on vision and separation Ken Wright (1991) draws attention to the importance of actual space between infant and mother in the development of a sense of self in relation to others. Looking, he suggests (which is dependent on some distance between subject and object) is the precursor of action, of doing. And touching is the precursor of looking – and '*the nucleus of the real*' (Wright's italics). 'Touch', states Wright, 'is the primary modality – what *touches* is real; what is *only seen* might be real or might not be real' (1991: 57). Philip was in retreat from painful reality and avoided touch, didn't take any chances. Seeing me was disturbing enough and he kept his distance. I realised that Philip very rarely looked directly at me except when he was the Doctor. Then he could hold, demand even, my gaze. On leaving his carer in the waiting room he would give her a stiff hug but without looking at her. Philip's avoidance of gaze is interesting: what was his early experience of his mother's gaze? What did he see in her eyes when she was drugged up? Was he persecuted by her look or by her vacant eyes? The only direct reference to his mother was in the first session after the Easter break, following the sessions about Charlotte's babies (see Summary p.75/Appendix C Session 25). He let me know that (in actual or psychic reality) she was in the doorway of the bathroom, present in the background but not intervening when James got scalded. Philip contemplated her guilt, at least temporarily, in his Doctor Who world. His mother/I (as 'Jacky', 'Rose's mother') was punished for failing to look after her/my daughter and therefore not allowed to see her/my child. Is this a talionic punishment? Is the mother who looks but does not 'look after', who does not keep her child safe from internal danger (his rivalrous possibly murderous feelings towards his sibling) and external danger (the hot water), being punished by having her child removed from her sight?

I was aware that he configured me as his mother, that in fantasy I was not really his therapist but his mother in disguise. Occasionally he told me he wanted to see me forever and in Session 20 *He mumbled something about me being his mother* (see Summary p.74/Appendix C. Session 22). However, I was only there once a week and saw other children too, better perhaps to conjure me up whenever he wanted.[43] It

[43] In a session some time later I found myself hearing in my head Gene Pitney's 'all I have to do is dream...'. When I told Philip the lyrics and asked him if that was what he did, he replied, 'Of course',

seemed he didn't trust himself and/or he didn't trust me enough to make another step towards me. The sister-mother figure in the Mummy-gas-mask-man episodes was another ambivalent mother figure resonating with Philip's experience. The mother has been unable to claim her child, she claims to be his sister and is afraid of the child.[44] The Doctor is alone in the world. We do not know what lay behind Philip's mother's drug use but her lack of lively availability, her cut -off state of mind, echoes a milieu described by Andre Green (1986) in which the mother is 'absorbed by a bereavement'. Green suggests that the infant is subject to fears of annihilation and defends himself by decathecting the maternal object and identifying with the (to him) dead mother. The effect of this is a psychic hole opening up in the structure of his ego and object relations, into which meaning disappears. I shall return to this. What we know of about the centrality of mutual gaze between mother and infant in the development of a secure sense of self (Farroni, T. *et al* [2002]; Farroni T. *et al* [2003]; Fonagy, P. and Target, M. [2007]; Winnicott, D.W. [1956], Wright, [1991]) suggests that if Philip saw blankness or nothingness in his mother's drugged eyes he would be subject to such anxiety.

1.7 *A developmental line for aggression and Parens' perspective*

Like Parens, Anna Freud did not find an easy fit for the epigenesis of aggression with the psychosexual model of Freud and Abraham. However, she did not describe a developmental line for aggression. Instead she was interested in how the strength and distribution of libido and aggression promote or inhibit progress along the various developmental 'lines'. Kohut (1977), holding like Parens that destructiveness is reactive, conceived of aggression as developing along different 'lines'. Parens' (1979), concerned with the first two to three years, hypothesized a single drive for aggression with a continuum between the two 'trends' of non-destructive and destructive aggression rather than a line. However, both Parens and Kohut, who came to very similar conclusions, insisted that aggression develops. As discussed in Chapter 1, later writers of the Anna Freudian school make the distinction between violence and aggression. Parsons (2006: 41) traces a 'developmental line for normative healthy aggression' from the bodily to the symbolic, extending her account into adolescence. There is much in common with Parens' position. Parsons starts from the view that the earliest forms of aggression result

and was irritated when I drew his attention to the next line: 'Only trouble is, gee whizz, I'm dreaming my life away'.

[44] A further resonance with Philip's history is that his sister, although not much older than him was the 'big one' and is likely to have had some measure of a parental function for him.

from primitive anxieties and not from innate destructiveness, a need to get rid of unpleasant or painful sensations, arising internally or externally. She concurs with Anna Freud that at this stage it is aggressive love, the biting of the mother or toys, and not hatred that threatens destruction. There is a need for a good enough mother to respond, to alleviate distress, not to retaliate. The empathic attunement between mother and baby leads to a sense of basic safety and trust. In time the baby internalises the protective function of the mother. 'Repeated experiences of optimal frustration in the context of empathic mothering help (the infant) learn that he can survive feelings of helplessness without being overwhelmed. This promotes the development of healthy aggression' (2006: 45). As the child grows, expression of aggression through the body continues, in the form of biting, hitting, throwing or through shouting and screaming, until a capacity for processing frustration and anger develops. Winnicott (1963a) reminds us that some level of cruelty, along with aggressive love, is usual at this stage. Challenges to the child's omnipotence, loss of the object or feelings of abandonment or engulfment might provoke aggression. As the ego develops, a broader range of defences are adopted, reaction formation amongst them. Parsons points out the civilising influence of this, for example of converting cruelty into kindness. However, if this defence against aggression is used too readily it can be maladaptive leading to 'pathological self-sacrifice, perfectionism and obsessionality' (2006: 46). The distinction between reality and phantasy is not yet firmly in place leaving the toddler-aged child vulnerable to experiencing his angry wishful thinking as actually causative. This leaves the child unsure of what 'activities are really destructive or aggressive, and which are potentially useful and creative? In normal development the child gradually arrives at some kind of working definition that allows him to distinguish between those of his actions which are actually harmful and those which are not.' (Edgcumbe, 1976: *x*) Progress along the 'line' continues with a conflict of ambivalent feelings towards the object, the child loving the mother when she gratifies and hating her when she doesn't, whilst dependency creates the need to please. Anal aggression is common at this stage. The well-enough adjusted, well-enough resourced mother will manage her child's ambivalence and attacks without retaliation, providing a function that can then be internalised by the child. The child learns to accept limits. At nursery school age sexuality comes to the fore and aggression is more likely to be triggered by loss of love, jealousy, envy and castration anxiety and affronts to narcissism. New defences are adopted: externalisation, and projections. The child is ordinarily negotiating a greater degree of separation at this time and a degree of

aggression is necessary in the service of this development. Physical expression of aggression is still present but language is an increasingly important channel. As the child moves into latency physical aggression is more directed, through games for example. As superego formation strengthens cheating diminishes and the child adheres more easily to the 'rules', not just of the game but of social living. As the ego and superego continue to develop instinctual urges are sublimated into language, competitive games, sports. With puberty and adolescence the growing child/young person, defending against fears of regression and dependence, may react with aggression. Adolescence is a precarious time, the developmental tasks are demanding: working through unresolved areas of earlier childhood, re-negotiating libidinal and aggressive relationships with parents, re-directing libido and aggression towards the peer group. Where defences are maladaptive or not sufficiently robust aggression may be directed away from the object and towards the self. In health aggression can now be turned constructively outwards. In Parsons' terms with the use of language in the form of 'biting wit'.

This achievement of the healthy development of aggression is dependent on the integration of loving and hating feelings (Anna Freud [1949], Winnicott [1950], Zaphiriou Woods [2010], Parsons and Dermen [1999] Parsons [2006], Yakely [2010], Perelberg [1999]). Philip has not achieved this. He was a long way from the sublimation of aggression into games, or conversion into language. On this line, as described above, he was functioning at a pre-nursery school stage. His developmental delay was the result of a failure in integration leading to a situation where 'omnipotent and magical thinking will persist unmodified, the power of love to tame destructiveness will be diminished, and the child's belief in the enormity of his aggression will be unchecked' (Parsons and Dermen 1999: 333). Philip's early years were punctuated with violent eruptions between his parents. Fonagy and Target (1999: 70), in their discussion of the role of the father in the psychic development of violent individuals, write that 'the child has a second chance to foster a secure psychological self through relation to the father, even when the mother has been unable to support this and separate successfully.' Philip's violent and unpredictable father did not provide this second chance, he contributed to his vulnerabilities. Perelberg (1999: 87) proposes a 'core phantasy' in some patients of a violent and destructive primal scene and Harrison (2006: 95), in her paper on the effects of the memory of a violent father, describes the child's perception of

the father as 'damaged and damaging, impossible to identify with as a sexual male'. Given his early history Philip may have had a 'core phantasy' that he was the product of a destructive and violent coupling. Along with the later trauma at the oedipal stage, this would have impeded Philip's sexual development. In therapy our models of Charlotte and the baby spiders bore a close resemblance to 'Robotti', the vulnerable/potentially ruthless and destructive baby robot but whereas Charlotte and the babies were female or genderless, Robotti was definitely male. Philip became very anxious about whether one of Robotti's legs was straight or not, a displacement of some phallic anxiety. This was positive, although threatened and less than perfect – the bent robot leg in need of repair – Philip could be concerned at some level about the in-tactness of his penis/masculinity. However, it threw Philip into a dilemma as for him phallic equated with destructive, the vulnerable baby 'Robotti' becomes a killer. Philip was interested in whether Charlotte's babies were all girls. There was no evidence of a spider-father with whom to identify. The girl spiders with only a mother imago and without the dangerous phallic quality of Robotti were perhaps more free to grow up than the baby robot. Being a girl, or at least not being a boy, would be a solution for Philip.[45] Although the shift was small it suggests the possibility of development from the anal to the phallic stage: Philip's concern about the penis-Robotti leg was a development from the interest in the magical, powerful screwdriver at the assessment stage and he could enlist my help, or at least instruct me to attend to the perceived damage. A very optimistic reading of this would be that this was an indication of some rudimentary binding of the aggressive with the libidinal.

We might conjecture on Philip's foster carer's unwitting role in maintaining fear of aggression and therefore impeding the integration of love and aggression. Her own defence against her own aggressive impulses was to deny them or dampen them down. She was unperturbed by Philip's desire to be a girl and far more anxious about managing his outbursts. She could voice her anxiety about him becoming a big physically strong man and whether she would have to restrain him in the future. However, any anxieties about his becoming a phallic male were not available for thinking about. Phallic equated with danger for his carer: it was less problematic for her if he were a girl. Her care of and affection for Philip was not in doubt and he had developed capacity for care-taking.

[45] It is unsurprising that Philip's development is severely impeded, as Akhtar (1996: 134) points out: 'The oedipal experience requires a unified self with a capacity for intentionality, and objects that are experienced as distinct from oneself and whom towards ambivalence can be tolerated.'

He was very solicitous of K9 and Lumpy and Robotti who represented younger vulnerable aspects of himself. But because his carer could not adequately bind the libidinal and aggressive in herself or in him, he echoed her unspoken fears that if his 'baby parts' grow they might 'become bad'. He could not countenance development. In Session 22, for example, Robotti, the powerful baby robot, is dependent but could unleash destruction on the Daleks. As time has gone on it has become more apparent that Philip's foster carer is reluctant to encourage his independence of her, or to help him engage in age-appropriate interests, perhaps reinforcing his anxiety about what happens when you grow up. Alongside the shared fear of masculinity, her tendency to (unconsciously) inhibit development may well have strengthened Philip's marked lack of curiosity. Shane and Shane (1982: 270), referring to the innate exploratory drive which Parens believes to be fuelled by aggressive rather than neutralised libidinal energy, suggest that 'curiosity may be equally well conceptualized as a form of aggression. Therefore, inhibitions of curiosity, which are often clinically associated with forbidden sexual and sex-related aggression (e.g., primal-scene curiosity), might instead, using Parens' data, be quite as accurately connected with an inhibition of healthy aggressivity and self-assertion, which inhibition only later gets tied to sexual curiosity'. They add that when such curiosity or self-assertion is blocked by the environment, hostile aggressivity is provoked, which further disguises the non-hostile origin of the activity. However, that was not the case for Philip.

2 <u>What is impeding Philip's development: the confusion of non-destructive and destructive aggression in relation to Parens' 'Spectrum of Aggression'</u>

In terms of the research question and Parens' theory of destructive and non-destructive aggression: Philip's ordinary development of healthy aggression was severely impaired by a conviction that aggression in fantasy (his rivalrous or murderous oedipal feelings) was in reality destructive and led to loss of the object. This then prevented him from being able to harness aggression in the service of developmental assertiveness and inevitably affected his capacity to relate to others and his capacity to learn Parens (1979: 278) proposes that the mother's prohibitions and boundary setting, frustrating the child and so evoking negative feelings towards her, lead to 'the libidinal object also (becoming) the first object qua object of the infant's destructive impulses'. The mother's

response to her infant's anger will determine whether its compliance derives from a wish to regain her affection, or whether it derives from fear of retaliation. The mother's failure to respond will leave the infant at the mercy of his feelings which later might include fear of its own destructiveness. Snippets of information, such as the social worker's report of the visit to the house when Philip was three, confirm that there was little active parenting at times. Philip and his sister were reported as running wildly around the house and as having 'trashed' their bedroom. It is not clear whether the pejorative language accurately describes deliberate destruction. What is clear, is that there was too much excitement spilling over into destruction and an absence of an auxiliary ego to help the children manage excess pleasure/unpleasure. Parens gives an example of the shift from non-destructive to hostile destructive action from the team's observation of infants at around about six months. Several of the observed infants, at different times, insisted on taking objects from each other, even when they already had the same object themselves. 'From the non-destructive current comes the exploration directed at the thing...as does the impulse to control that thing, to assert oneself over it. As external resistance against the self taking possession occurs, a greater investment of aggression is instigated; and if sufficient resistance persists, unpleasure will mount and hostile destructive impulses will be mobilized' (1979: 279). The mother's response to this situation is crucial. Parens emphasizes the calming effect of 'positive affects (libido)' on over-assertiveness and anger. However, if the infant's over-assertiveness is met with 'hateful affects', or if such a response is feared, or if there is no response, aggression may not be modified but merely inhibited. Philip did not have a reliable external object nor as a consequence did he have an internal capacity to mitigate his aggression – he is left to his own devices. His un-regulated activity is read by the social worker as aggression. It is likely that his earliest experiences of discharge of unpleasure were also understood as destructive aggression by his mother. Philip's mother was absent, whether physically in bed, or emotionally and psychologically unavailable through adversity and/or drug use. He may well have experienced her failure to meet his needs as a rupture (Winnicott [1963b], Tustin [1988], Ogden [1989]). Winnicott (1963:222) points out that such maternal failure at a point where a sense of self has been firmly established would lead to loss of the object. If the failure occurs at a point where the baby is not yet equipped to manage such a 'sudden startling awareness of separateness from the mother's body' the impact is more in the region of annihilation anxiety. As Tustin puts it: 'These children have terrible fears that they will fall apart, or

that parts of their body will drop off, or that they will spill way and cease to exist' (Tustin, 1988: 41). If an angry discharge of unpleasure is not mitigated or bound by the mother the child can experience it as 'an explosive amputation of the connecting link with the mother brought about by his tantrum'. Tustin (1983: 126) was concerned specifically with psychogenic autism and the anxiety of 'black holes', but she was aware that she was describing phenomena not unlike those observed by Mahler, or by Winnicott as 'psychotic depression' and Balint in relation to 'the basic fault'. Kohut (1977), concerned with self-pathology and a fragmented sense of self, describes extreme frustration in the environment as leading to what he terms 'isolated destructive aggression'. Parens' equivalent of the black hole is 'infantile depression', an unmitigated hostile destructiveness towards the self, 'however the self is experienced in these primitive syndromes' (1982: 192). Philip was not autistic but his retreat into fantasy might well be described as an autistic-like retreat, a shell protecting him from the impingements of reality and his fear of annihilation. He responded in a paranoid-schizoid way by projecting his fear out into the black holes of his Doctor Who world. However, the black holes threaten to engulf him - he felt attacked by his foster carer's daughter when she applied cream to his eczema (see Appendix C, Session 1).[46] He needed to be the Doctor to escape, but there was no real escape. His explosive projection served to perpetuate his sense of a black hole within that he must constantly defend himself against. He was trapped in a dread-ful entropy Tustin (1969: 38).

The cumulative trauma that Philip had been subjected to left him without the internal resources to withstand the later traumas he experienced. It also impaired his development. As Parens points out (1979b: 397), in the absence of a sufficiently nurturing environment, non-destructive aggression turns inward, along with destructive aggression, making non-destructive aggression unavailable for developmental assertion. Philip has had to fight on two fronts, protecting himself from the threat of annihilation and protecting his objects from his destructiveness, as well as being unable to assert himself to develop. This impasse has had wider implications for his progress along various developmental lines, especially for his capacity for separation, object relationships and curiosity. Philip could not bear to know about his trauma (both cumulative and specific traumas) and his aggression. His fear of them has become an

[46] See Esther Bick (1968) 'The experience of the skin in early object relations' *The International Journal of Psychoanalysis,* 49: 484-486

impediment to knowing about anything leaving him reliant on various defensive manoeuvres, with varying degrees of success, central to which was Philip's identification with fictional characters, in particular the Doctor.

Why Who?

As the Doctor, Philip was caught, forever fighting off impending danger from within and without, whist never making any ground. If there were an audio-visual accompaniment to Philip's internal world we would hear the compelling, adrenalin-pumping theme of Doctor Who and see the swirling vortex, Philip being sucked in, spiralling into the depths and the Daleks spinning out at us, with their sensor-weapon aimed straight at us. Philip feared that his aggression, experienced as destructive, would create a black hole that would suck him and everyone around into it. Winnicott (1963c) believed that fear of breakdown was the fear of breakdown that had already happened. Philip already knew about this black hole experience as a result of his upbringing and projected his black holes into aliens. In the session material the black holes were evidenced as his paranoid fear of alien attacks, his fear of the Davros/Dalek aspects of himself which threatened both himself and his objects. He has had to manoeuvre desperately to combat the enormity of his fear of his destructive aggression, as in his identification with the Doctor, the only one who can prevent the end of the world as we know it.[47]

The Doctor is an extraordinarily apt vehicle for Philip. Rustin and Rustin (2008) point out that the doctor's capacity for 're-generation' leaves the production team plenty of leeway to explore different aspects of character. In the new series the re-generated Doctor is a more complex character. The Rustins propose that the Doctor is moving, in Kleinian terms, from the paranoid-schizoid to a more depressive position where the internal world is not so black and white: 'The Dalek turns out to be not wholly the opposite of the Doctor, but similar to him in respect of having lived with the knowledge

[47] So why 'Who' and not 'Harry Potter'? Philip did talk about Harry Potter a little but this character did not have the same hold for him. Like the Doctor, Harry is marked out as the only one who can save the human race. Like the Doctor he is not an ordinary human being and like the Doctor he has extraordinary powers. Both have been, like Philip, separated from their families. However, Harry's parents are benign figures, his mother self-sacrificing in death. They are positively present in Harry's mind, represented by the smiling, waving figures in the photo frame. Philip's actual experience and internalised parental figures are ambivalent at best. It is the bathroom door that frames the image of Philip's absent or perhaps accusing mother. Both story lines arise from wish-fulfilling superpowers in the face of loss but Harry has to rely, to some extent on adult support. The Doctor is autonomous, his omnipotence is greater.

of the destruction of his entire kind' (2008: 9). Philip's identification with the Doctor is an attempt to deny in fantasy his destructiveness and to remain in the paranoid-schizoid position. The more developmentally advanced Doctor represents a challenge for him. The Doctor of earlier series might have more reliably kept the bad, evil elements located firmly elsewhere. Occasionally Philip was faced with the integration of positive and negative coming together, as in the drawing described below. However, he resisted this and his use of the Doctor was selective. He identified with particular aspects of the character. For example, he identified with the Doctor as the only being who can stop Davros and the Daleks destroying humankind. The Doctor is himself defined by the existence of Davros: without his enemies he has no purpose. He is constantly embattled with threatening alien forces and there are casualties along the way, but the war is never won. This resonated with Philip's experience. Another way in which he could identify with the Doctor is in his being destined to be alone. The Doctor is set apart by his task, to save the world from destruction, and by his nature, being a Time Lord he is different from other people. The Doctor has, like Philip, lost his family and his home, the world as he knew it. In a later session (echoing the material in Session 32) this link was clearly illustrated when Philip asked me to draw and annotate a version of what happened to the Time Lords' planet. This was also a point at which there were cracks in the cast-iron defence, exposing Philip to the (fleeting) knowledge that he was his own worst enemy, a parallel with the Doctor's other great constant enemy, the Master. Philip, in some significant respects had been the little Master in his family home. He was the oldest son, sharing his first name with his father, and, according to Social Service reports, along with his older sister, took on the role of caring for his younger siblings. He was, in the ordinary way of things, usurped by another, smaller Master with the birth of his brother James. We might imagine that ordinary jealousy was not managed well in this household. Philip asked me to draw a picture of 'The Time Lord's Forgotten Universe'. He directed me to draw mountains and two figures, the Doctor and the Master when they were young. He said, 'I was him when I was little.' He asked, 'How did the Doctor's mother and father die? Did they get exterminated?' I was confused at first whether Philip meant he was the Doctor or the Master, it became clear that Philip was both. For the second 'frame' of the story Philip directed me to draw a parental couple, their son in front of them, the family looking outwards. He asked me to write: 'When the Master was a little boy and he looked out at the universe he saw so much and it was so big and so amazing that he went mad. He wanted to rule the world.' The story

ended with, 'The Master must have been angry because his parents were killed.....his planet was destroyed'. As an afterthought he added, 'Reason he can't listen to the Doctor'. His identification with the Master could not be sustained, he had to disown his identification with the Master, placing the unwanted anger and fear of his destructiveness into his brother. Philip dictated a postscript, 'The family of blood wants to kill the master', and at the end of the drawing he reminded me that 'James is the little master'.

Philip was terrified of his own omnipotence which sends him mad: 'He wanted to rule the world'. And he is terrified of retribution: the family of blood, his birth family, 'want to kill him'. Philip needed to distance himself from the mad, angry, powerful aspects of himself. He projected onto James who becomes the bad one, the one who needs to be stopped, who deserves, asks for punishment. (Philip's carer and teachers had noted that he shifted between expressions of guilt about the scalding to attacking James. On occasions his teachers felt the need to ensure that Philip and James were not in the same space unless very closely supervised.) In Session 31 (see Summary p.74/Appendix C), when he first declared that his brother was the little Master, Philip went straight to the scalding picture with his mother in the doorway looking on at the scene of the crime. Ferenczi (1949) describes how the sexually abusive adult projects his guilt into his victim. Philip's mother did not sexually abuse him but his shaky sense of self and his negative rivalrous feelings towards his brother offered fertile ground for her to project her intolerable feelings into him. It seems likely that this is what happened, leaving Philip carrying his mother's projection of guilt. There were occasional hints that his mother's representation of him as guilty had passed into his self-representation but this view of himself was intolerable. In his own defence Philip had to identify himself with the rescuing, healing saviour-Doctor.

Like the Doctor, Philip exists in a different world. When the doctor arrives on earth he is 'just visiting'. In order to protect himself against turning his feared aggression on others and the consequent loss of his objects Philip must remain in a narcissistic world in which he can control his objects. This manoeuvre served the dual purpose of allowing him to keep his objects safe from his aggression and rendering his objects unable to leave him since they have no autonomy. When this defence was threatened Philip was terrified, as in his identification with the Mummy-gas-mask-man, the child bringing

destruction to his loved ones. This was a very poignant identification to observe, and a potentially terrifying one to adopt. The child with the blank gas mask face (the internalisation of the blank gaze of the mother?) has already disappeared into a black hole. As a defence against the threat of annihilation the identification has failed and is ineffective as a defence against threat to the objects. (See Summary p.75-76/Appendix C, Sessions 28-31) Philip has to insist all the more on the Doctor's omnipotence. In this instance he took the role of caring adult towards the Mummy-gas-mask-man, investing it with liveliness and divesting it of its power and potential destructiveness. In so doing he managed to occupy both the role of psychic-equivalent Time Lord and pretend father figure: the Doctor and a more ordinary dad. I was cast alongside as the mother figure. The situation mirrored the four year old brother/father Philip caring for his younger siblings, alongside his six year old sister/mother. The task however, had been too great when he was four and in fantasy, despite his Time Lord defence, he was once again overwhelmed by the demands: *The Mummy-gas-mask-man was plaguing Philip. Philip spoke for it, inquiring of Philip, 'Mummy?' Philip eventually shouted at it, 'Your Mummy's dead!'*

Philip's defences do not hold at that point but the following week he was nevertheless able to tolerate my thinking and to make a link with his own experience, dashing off to find the picture we had made of the scalding incident. He could only manage this, however, in the role of the Doctor, explaining the picture to an imaginary 'little Master'. Even this was short lived. He then turned to the paper computer and another fantasy scenario. On the most optimistic reading, in Winnicott's terms we were in the very early stages of the development of a capacity to play, the therapist taking the place of the mother in 'making actual what the baby is ready to find' (1971: 47). Philip was not ready to 'find' very much very often. Fonagy and Target, however, emphasise the need for repeated experience for the child of the helpful other in the move towards integrating psychic and pretend modes. Disentangling Philip's confusion of destructive and non-destructive aggression, to free him from the dread-ful entropy and facilitate emotional development, would depend on his capacity to eventually integrate and make use of a new developmental object.

CHAPTER 4

Case 2: Lenny

Lenny was a five year old boy in the care of the Local Authority. He was living with a foster carer and her husband and three of his siblings (his older brother and sister, who are twins, and a sister from his mother's first marriage). He attended a mainstream school with additional support. He was referred for psychotherapy because of his aggressive and impulsive behaviour. As with Philip, the Diagnostic Profile covers the assessment stage and provides a point of reference for considering the clinical material that follows on.

Sources of information for the Diagnostic Profile:
Psychotherapy assessment sessions
Reports from Social Services and other professionals
Discussions with Lenny's social worker and foster carer

DIAGNOSTIC PROFILE:

Lenny, aged 5

Statement of the Problem

Lenny was born into a large, chaotic family known to Social Services for many years. He was the sixth of his mother's eight children, the third of his father's (the three older children having a different father). The children were taken into care when Lenny was four following ongoing concerns about the level of neglect, poor housing conditions, poor school/nursery attendance, failure to attend medical appointments and health checks. The children had witnessed domestic violence. Lenny's development was significantly delayed. His siblings seemed to have fared better than he had. The older siblings looked after themselves and the younger children and their mother was more able to attend to the needs of her youngest two children. When Lenny arrived at his foster carers he was still eating with his hands and would perch with his feet on the seat of the toilet. He did not like to be touched and it was six months before he sought a

cuddle. His language was very immature. He was putting two or three words together, but he 'could swear like a trooper'. He was unable to play with his siblings or other children, constantly disrupting their games. At school he attacked other children, biting, hitting and kicking and occasionally 'strangling' his classmates. The Social Services' 'care plan' did not initially identify Lenny as having therapeutic needs, recommending a nurturing foster placement and extra support in school. Lenny responded to care, affection and the clear boundaries of his foster carers, but, a year later, he continued to present with very challenging behaviour. His foster carers wondered whether they could continue to care for him.

Family Constellation

Birth family: mother
father
half-brother 20 from mother's first marriage
half-sister 19 from mother's first marriage
half-sister 11 from mother's first marriage in placement with Lenny
brother- twin 9 in foster placement with Lenny
sister-twin 9 in foster placement with Lenny
Lenny 5
sister 3 adopted
brother 3 adopted

Foster family: foster carer
foster carer's husband
foster carer's daughter and partner who lived close by and also fostered (babies)

Referral

Lenny was just five when he was referred to CAMHS by the Education Welfare Officer following a multi-professionals meeting. Lenny had been in care for a year at this point. He was displaying disturbing and aggressive behaviour in school and was at risk of

exclusion. He had already been excluded from one nursery. He was described as 'an extremely angry little boy [who] does not know how to control himself'. Lenny had poor communication and social skills, immature use of language and little capacity for making or sustaining friendships. Unknown to CAMHS, Lenny's foster carer, who was convinced that Lenny had ADHD, sought a parallel referral to the community paediatric team. Lenny was diagnosed with ADHD by the community paediatrician and prescribed Ritalin between his third and fourth psychotherapy assessment sessions. We only became aware of this when a letter from the community paediatrician arrived some weeks later. Lenny's carer and the paediatrician were not alone in missing the latent nature of the sort of behaviour that he displayed. Fraiberg (1982: 625) describes a group of children who present to services with challenging behaviour. The underlying anxiety and defensive nature of the behaviours are not properly recognised and the children are often (wrongly) labelled hyperactive. However, in retrospect this was also one of many instances of the foster carer doubting the professional advice and instead being determined to follow the course of her own inclination, a tendency which had implications for Lenny in terms of capacity to trust and depend on another.

Description of the child

Lenny was a slight child, small for his age. He had very blond, short-cropped hair, pale skin and wide-spaced eyes. He appeared hyper-vigilant, his body tense and his eyes darting about. He wore his school sweatshirt tucked into his trousers. He had a ready scowl. Although he was well cared for by his foster family he had the look of a very deprived child.

Professionals did not warm to Lenny. Reports from his teachers emphasised his very challenging behaviour and their concern about his impact on the other children in his peer group. All strategies they tried failed and Lenny continued to exhibit the same difficult behaviour. His concentration span was low, for example, he could not sit on the carpet with the other children to listen to his teacher. His behaviour was impulsive and aggressive. He spat, bit, swore at and scratched the other children. His teachers and foster carer reported him as sometimes 'strangling' other children. He could not take turns. Lenny was not taken on any school trips as staff felt they could not guarantee his or the other children's safety. His foster carer reported similar behaviour at home. Lenny

could not play with his siblings: he was aggressive towards them and spoilt their games. He was 'very demanding' and 'always on the go'. She described him as 'feral' when he arrived, and although to her mind he had greatly improved, his behaviour remained so challenging that she was unsure whether she would be able to look after him in the long term. However, with a reputation of her own as something of a belligerent campaigner, she was more inclined to rise to the challenge of Lenny. She spoke of him and to him with affection.

In the therapy room Lenny flitted from one activity to another. He responded to any attempts to engage him or to extend an activity with 'You do it', and a move away to something else. His carer described him as having great difficulty in 'keeping a lid on things'. (She had wondered whether Lenny had Tourettes syndrome.) His impulsive aggression was very evident as he kicked and punched the softplay, threw it towards me and shouted out. He had to be reminded of limits: not to drink the water from the sink, not to climb onto the back of the chair and so on. He stopped when reminded but then wanted to leave the room.

He needed to be in control. He did not want any help, for example with tidying up, and he put everything back in his box at the end of the session. He needed to be the one who decided how long he was going to stay. Lenny did not 'appeal' to adults. He had neither the engaging smile of more confident children nor the curious reticence of shyer children which elicit warmth or concern. He struck me as prickly: a small, fierce, frightened and unpredictable child. Even in moments of calm I was aware that he might erupt at any moment. No doubt he had experienced the world as a dangerous, frightening and unpredictable place.

Family Background and Personal History

Lenny was from a family with a history of intergenerational neglect, emotional abuse and impaired attachments The children's mother had been in the care of the local authority herself as a child. Both parents abused alcohol and there were incidents of domestic violence from the father towards the mother. Maternal alcohol use during pregnancy may have been a contributing factor to Lenny's difficulties but there were no references to foetal alcohol syndrome in his documentation and early developmental

records were not available.

Lenny was the third child in a sibling group of five. He had three older half-siblings from his mother's first marriage. The two oldest half-siblings left the family home around about the time Lenny and the younger children were taken into care. They had been frequently left in charge of the younger children. The oldest girl had an entangled relationship with her mother. Her partner, a drug user and dealer, had an acrimonious relationship with her step-father (Lenny's father). Lenny's older brother worked long hours as a chef. Both older children were willing but unable to be adequate substitute parents to their younger siblings. The younger group of children was composed of a girl (Lenny's half sister), followed by twins, then Lenny. Two more babies followed Lenny, a girl and then a boy.

The family had been known to Social Services for some years. The house was unkempt and in disrepair. Social work reports described the children as scavenging for food in the house and roaming about the locality. Interventions at various points to support the parents to be more active in the care of their children, take their children to school, attend clinic appointments only proved to be helpful in the short term. When the youngest child was found, semi clad, wandering in the street the children were taken into care. Lenny's sister, then aged 9, reported seeing young adults having sex in the house at her ninth birthday party. Her parents were not in the house, their adolescent sister had been left to supervise.

Lenny's half-sister and the twins settled into the foster placement and school with relative ease. Both the girls needed extra academic support. The girls were both passive in their presentation. Lenny's brother was quiet and withdrawn. Lenny appears to have had more difficulty than the others, perhaps because of some additional constitutional vulnerability. Lenny's mother reportedly managed better with small babies, and was less able to meet their needs as they grew. Lenny and his younger sister were observed to be body rocking on visits to the home and at Sure Start appointments. This persisted some weeks into their respective placements. Lenny slept well but suffered from nocturnal enuresis.

When the children were taken into care Lenny, at just four, was young enough to have

been adopted but his behaviour was so challenging that it was deemed very unlikely that appropriate and willing adopters would be found. A decision was made for a long- term foster placement. Lenny had weekly contact with his parents along with his siblings, supervised by a social worker. These contact visits were described as chaotic and distressing to Lenny. Lenny told his social worker that there were 'noises in [his] head' that made him hit the car seats on his way to contact with his parents. The social worker described Lenny as the child who received least attention from parents. He reported that whilst Lenny swore readily at his mother he did not swear at his father and was closer to him. When the plan for permanent foster care was agreed in court the frequency of the supervised visits was reduced to every six to eight weeks. Their father gradually stopped attending the contacts and their mother's attendance became erratic.

Possibly Significant Environmental and Non-Environmental Factors

Historical factors:

1. Parental neglect: Lenny's parents failed to provide adequately for their children either emotionally or physically .
2. Parental alcohol abuse
3. Loss of father: Lenny's parents' relationship had broken down in the months before the children were taken into care. Their father moved from the immediate locality and dis-engaged from the family and services.
4. Loss of younger siblings: when the children were taken into the care of the Local Authority Lenny's two younger siblings were placed together with a different foster carer with a view to adoption. They were placed with adoptive parents shortly before Lenny's referral to CAMHS.
5. Place in the family: Lenny was very much 'in the middle', the third of his full-sibling group of five. The twins had each other and the older children offered some caring for the youngest. It may be that Lenny was not the youngest for long enough to benefit from the caring attention from his mother or older siblings.
6. Temperament: Lenny was a very active child with a very low tolerance of frustration. This behaviour was not shared by all his family as some of his older siblings were much more passive. Lenny's difficulties may have been in part

constitutional as well as reactive.

7. Poor attendance at nursery school

Current factors:

8. Contact with mother: the children had supervised contact with their mother six times a year. Her attendance, however, was sporadic and unreliable. Lenny did not seek her attention at these meetings, but his challenging behaviour at school and home escalated around these planned visits.
9. Lenny had an unfortunate capacity for eliciting negative feelings in the adults caring for him: his impulsivity and inability to manage his aggression led to an angry hopelessness in teaching staff. As a result school was not entirely 'on side'.

Current protective factors:

10. Lenny's foster carer was combative and often took on authority figures or institutions. If she could harness her determination not to be beaten and decided she could continue to care for Lenny she would fight his corner, ensuring that he had access to whatever services he needed. But her pugnacity had its downsides, such as her insistence on a referral to the community paediatrician for a diagnosis of ADHD and medication outside the CAMHS assessment.
11. Positive male role model: in contrast to Lenny's father, his foster father, a down-to-earth, even-tempered man, played an active role in parenting. He was a long-distance lorry driver and therefore away from the house at times, but when at home he spent time with the children, particularly the boys, playing football and taking the dog for a walk.
12. Still sharing home with familiar siblings: although Lenny's relationships with his siblings were not easy they did provide him with a continuity of experience and a shared history. The older children missed their mother but had also adapted to their foster carer's home, providing a helpful model for Lenny.
13. Contact with extended family: Lenny and his siblings had contact with their older brother and sister. Their sister and her partner had recently had a baby whom the children also got to see. These meetings were described very positively by the children's social worker and their foster carer.

14. Lenny was now attending school and receiving extra support. Several agencies including Educational Psychology and the Behaviour Support Service were involved. A Statement of Educational Needs was in process.

Psychic Development:

A. Object Relations/Relationships

Lenny had great difficulty relating to peers. His siblings tolerated him at best. He was unable to make good use of his teachers and classroom assistants, tending to push them away with his aggressive and challenging behaviour. His carer reported that Lenny gravitated towards male figures: for instance he followed her husband around, seeking his approval. He was relaxed in the company of his male social worker. His carer also remarked several times on how gentle he was with the baby in foster care with his carers' daughter. This was possibly on the basis of identification with the baby rather than evidence of tenderness toward another.

Although very young Lenny appeared fiercely independent, relying on no-one. His foster carer was an exception. Lenny looked to her for support but did not yet have a secure internal representation of her. If he remembered his carer was out of the room then he would want to go to her. He managed twenty five of the fifty minutes of an assessment session on his own. He had wanted to leave after ten minutes. When I acknowledged that he wanted to find his foster carer he was then able to stay for the remaining fifteen minutes, but the following session he wanted his carer to come with him to the room. His foster carer reported that Lenny did not seek a cuddle for his first six months with her and resisted physical contact, even holding hands with an adult when crossing the road. Although Lenny did not seek physical proximity – his behaviour was not 'clingy' – he was more at ease when in his foster carer's presence. In the first assessment session there was evidence of Lenny keeping his object safe from his impulses. He had wet sleeves from playing in the sink. He clearly did not like the feel of this and flapped the wet sleeves at his carer. She told him not to, a warning tone in her voice. He moved his arm slightly as if to hit out at her but pointed instead to a Disney character on her sweater. His carer followed his lead and talked to him about the Disney characters. His capacity for concern for an other/his carer was very limited. However, what control he did manage to exert over his impulses was in the interests of his safety, and even this may only have been possible in the context of his carer

providing an auxiliary superego function. In the third assessment session, for example, Lenny was very unsettled and agitated but he responded to his carer's pre-emptive directions: 'Don't throw the crayon', 'Put the paper in the bin', and so on. Her tone was one of firm instruction, rather than critical. It would appear that Lenny was beginning to identify with his admonishing foster carer as a pre-stage of superego development. This was evident in his awareness of danger and capacity to voice it. Watching a skip lorry from the window of the therapy room he voiced his concern that it was in the middle of the road, a car could crash into it. Indicating the window ledge, he talked about what might happen if one were to 'stand on the roof': 'you might fall and hurt yourself'.

Lenny was aware of me as another person in the room. He drew my attention to things as he moved from one thing to another, asking me to, 'Look', or naming the object whilst looking in my direction. He was less responsive to my suggestions/attempts to engage his interest but he did join in – with colouring in, for example. Lenny's directions were at least as much about controlling me, an unknown adult, as they were about engaging me. I was tolerable as long as I didn't impinge upon him too much. He responded to my boundary setting, scowling at me but nevertheless complying with my injunctions to refrain from drinking the water, putting the crayons in his mouth, and so on. I noted also that he had a sense of my existence beyond his contact with me. He asked, for example, whether I had tidied up the dolls' house.

Lenny had a very muddled sense of where he fitted in his family. In the diagram we made, with his carer's help, of who was living in the carer's house, Lenny directed me to put 'Mum' and 'Dad'. It was unclear if this was a reference to his birth parents or his foster carers, but his wish to be part of the foster family was evident. He insisted on being called Lenny Brown, his foster carer's daughter's married name (perhaps indicating a wish to be the baby cared for by her). His carer told me that Lenny would like to call her 'mum' but she insists on the children using her first name, reminding them that they have a mum.

Lenny's first attachment figure, his birth mother, provided erratic care. All we knew about the family suggested that his mother would have been unavailable, at times, to the demands of many children through her lack of her own emotional resources and her

resort to alcohol. Her care-giving would have been unpredictable at best, resulting in 'relational trauma' (Baradon, 2010: 164) and contributing to the 'cumulative trauma' that Khan (1963) and Schore (2001) describe. The neglectful aspects of Lenny's mother made her a dangerous figure to a small infant dependent on her ministrations. Lenny fitted into the description Fraiberg (1982: 625) offers of those children who have bucked the biological trend of turning towards their mothers. In the face of maternal deprivation and neglect, these infants are exposed to extreme and prolonged feelings of helplessness. They become avoidant, turning away from the source of distress and danger. Such babies may go on to exhibit challenging and aggressive behaviour 'fighting against the danger of helplessness and dissolution of the self feelings which accompany extreme danger'.

Lenny's foster carer provided a very different attachment model. She was consistent, predictable and a provided a continuity of care that he had not experienced previously. Although warm and responsive she did not require physical affection from Lenny. At times she doubted her family's capacity to maintain the placement but would not, I think, have seen a decision to end the placement as a failure of her own capacity. In this she was markedly different from others, such as teachers, in whom Lenny's capacity to elicit negative responses stirred up a sense of professional failure. It is likely that his carer's attitude towards him, and the emotional distance she tolerated, was a particularly helpful quality to Lenny. She did not require too much close affection that might lead to feelings of dependence and vulnerability, and so did not arouse his aggression. Lenny was more able to tolerate the phallic mother figure his carer presented. Given his fear of dependence her attitude was clearly helpful at this stage. Nevertheless, it also posed a question for his future development, since to move beyond his fear of dependence he would need an emotional environment to support attachment on the basis of trust and affection. The tender feelings he did have, such as towards the baby, may have been frustrated and then fed his aggression.

Superego Development

Superego development was delayed but there were some signs of pre-stages such as his interest in police cars and his response to his foster carer's cautions and advice. Sandler, with Anna Freud (1985: 382), describes identification with the aggressor as a common stage in the normal development of the superego. 'By identifying with the parental

threat of punishment, the child takes an important step in superego formation through internalizing the criticisms of others'. Repetition of this internalization of the critical qualities of adults is 'superego-forming material'. However, it does not become self-criticism yet. First criticism is turned outwards in a projection of guilt. Only then is it turned inwards, and subsequently the ego has to tolerate self-criticism and guilt. Lenny had very scant internal control and did not show remorse – there was no evidence of guilt. His capacity, such as it was, to protect his object, in this case his foster carer, was indicative not of a capacity for concern but for survival: he had to keep his caregiver appeased and available to meet his needs . Lenny did use projection, but he projected feelings of vulnerability rather than guilt. As already noted, he could make use of the auxiliary super-ego function of others. When I verbalised his aggression, his 'punchy feelings', the effect was to 'bind' his aggression which then diminished. The material suggested he was at the stage of repeatedly internalising the criticisms of others but he had yet to experience guilt so that he was some considerable way off the transformation into self-criticism.

Developmental Arrests

In general Lenny's delay appeared to be due to developmental arrest, through lack of care and stimulation. He had had very inadequate care-giving and insufficient developmental help. The 'scaffolding' to support the child with affect regulation had been absent in his early months and years.[48] He had not internalised a self-regulatory function and there had been a subsequent arrest of development in the regulation of impulses. Lenny's difficulty in putting a delay between peremptory impulse demands and action affected his development in many areas: his social, cognitive, linguistic development were all significantly delayed. This was all the more evident at times of particular stress. When Lenny's carers took a holiday (planned before the children were placed with them) Lenny and his brother were placed together with a respite carer. Lenny's difficult behaviour escalated at school and in the placement and his aggressive attacks and swearing increased.

Orality was predominant and Lenny was still exploring, or perhaps beginning to explore the world through his senses rather than words. He had a tendency, for example, to put things in his mouth such as crayons and pipe cleaners from his box and the small

[48] See McCrory, De Brito and Viding (2010) for an overview of recent research on the neurobiology and genetics of adversity and maltreatment.

wooden toilet seat from the dolls' house. His foster carer, Educational Psychologist and teachers also reported Lenny 'putting everything into his mouth'.[49]

Lenny did not talk a great deal and mostly used language to name things or to make demands/give directions, 'Get the key!' 'Open it'. It was clear from Lenny's history that he would have had neither the proto-conversations with a mother attuned to his needs (Stern (1985), Wright (2009), Trevarthen (1979)) nor the attentive 'motherese' that Bateson (1971) describes, both of which facilitate the development of language. In health the infant takes in the libidinised naming of objects and affects from his attentive mother (Furman, 1978), gradually internalising this function. The social worker described the children's mother as shouting or speaking roughly to the children. Lenny likewise could 'swear like a trooper'. Hobson (2002: 2-3) states that 'social engagement is what provides the foundations for language. Not only does it serve as a motive for language to appear in the first place, but, in the structure of what is exchanged between one person and another, it also provides enough – just enough – to begin to shape grammar.' Lenny's speech was immature and difficult to understand at times, both because there was a lack of clarity in his enunciation and because he often used odd substitutions, as in 'Harry Potter' for 'helicopter' or 'it's melt' to describe small dints in the wall of the therapy room. At five a child would ordinarily have at his command all vowels, most consonants and a vocabulary of about 5000 words. Speech would be completely intelligible, despite problems with articulation. She/he would ordinarily be using fairly long sentences and some compound and some complex sentences. Speech on the whole would be grammatically correct.

'Shut up!' 'I'll kill you': Lenny uses language as action to discharge excess energy and uncomfortable feelings and/or to ward people off in the face of possible impingement. It was difficult to tell what the external triggers were to such outbursts and whether they were object-directed (in this case towards me). I was not speaking when Lenny shouted 'Shut up'. Referring to recent research on genetic vulnerability, McCrory, De Brito and Viding (2010: 1087) report, for example, increased risk from one particular genotype which 'is related to hyper-responsivity of the brain's threat detection and reduced

[49] Hoffer (1950) describes the very early stages of ego development as beginning with the establishment of the 'mouth ego'; 'With the help of the hand the oral-sucking drive undergoes a transformation from an instinctual demand to an ego-controlled activity. In the course of this process the hand, like the mouth, is perceived as part of the self and the differentiation between self and not-self is thus carried forward. All these processes have so far been confined to the oral phase of instinct and ego development'.

activation in emotion regulation circuits, as well as to structural differences (in males) in key regulatory regions'.[50] Perhaps my thoughtful silence was perceived as me getting too close, an impingement, or perhaps the shouting out originated in an internal discomfort, leading to an expulsion of 'unpleasure' rather than the words themselves being more object-related. Or perhaps Lenny was using language to establish a self-object boundary.

This level of delay was an indication of Lenny's insecure sense of himself as being separate and had clear implications for the development of his capacity for healthy object relations. His making and sustaining of friendships was inevitably affected. He could join in an activity with an adult and he could play on his own in the presence of another but he had difficulty playing alongside another child and could not manage 'playing with', spoiling any games.

B. Self

Self- representation

Lenny had a very fragile sense of himself. He adopted a tough guy, not-to-be-messed-with attitude but underneath there was considerable vulnerability. He was not yet secure in the phallic phase and was still predominantly driven by infantile impulses. Orality was still predominant. Although his precarious representation of himself as tough echoed his father's personality, it stemmed more fundamentally from an environmental failure that had impeded his development of healthy narcissism. He had not experienced being consistently held in mind, nor had he benefited from consistent confirmation that he was wanted and loved. In contact visits with his parents it was noted (as above) that Lenny received the least attention. His fragile sense of himself left him beset by anxiety about his very survival. He defended himself aggressively against such fears (see below). His lack of confidence brought with it an uncertain sense of agency. Sometimes his injunction, 'You do it', occurred when he was not interested in an activity but at other times it expressed his lack of confidence in his own ability, as when, for example, he asked me to draw the police car.

Development of self representation

[50] Of course, we do not know whether Lenny has a genetic pre-disposition which would make him vulnerable to stress reactivity. The authors themselves sound a note of caution in drawing inferences too readily from the gene-environment interaction research to date. (2010: 1079)

Lenny's carer reported significant changes in Lenny's sense of self in the time that he had been living with her. He was beginning to take pride in his achievements – as she was – as he learned to manage a knife and fork, get dressed, recognise words and so on.

The medication Lenny was taking, methylphenidate, is likely to have compounded his fluctuating sense of self. It altered his behaviour and the responses of others to him. When medicated he was more compliant, less challenging, and more tolerable and adults and peers reacted differently towards him. His medication was also likely to have made him feel different, less excitable, more able to concentrate, but less like the self he experienced himself to be when not on medication or when the effects of the medication wore off.

Self in relation to others

His very aggressive presentation was likely to be the result of internalising parental hostility – there were 'noises in (his) head' – as well as a more primitive 'discharge of unpleasure' and a reaction formation against fragility. Although he attacked his siblings and peers Lenny was also consistently affectionate and gentle with the babies he has encountered. He was particularly drawn to the baby cared for by Sarah, his foster carer's daughter. He was fond of the foster carer's dog. His foster carer had reported that Lenny was affectionate towards babies from coming into care. This capacity for warmth and concern seemed to suggest a more positive identification of a nurturing nature. It was tempting to think that there was perhaps some good, albeit not good-enough, care-taking at the earliest stages of his life or that his tenderness towards babies was the result of an identification with his mother in relation to his younger siblings. However, it was more likely that his apparent tenderness resulted from projection of his needs onto, and an identification with, the baby.

Although Lenny experienced himself as a nuisance, unwanted by his peers he could use his foster carer as a source of affection as well as to help him moderate his own behaviour. He wanted to call her 'Mum'. In the clinic he showed a capacity for shared attention, for example, looking at books with his carer in the waiting room, watching the skip lorry with me, investigating the pipes under the sink with me. At the same time he had a sense of resources being unavailable to him, imagining the locked cupboard to be full of toys that were not for him, just as his mother reserved all her attention for the

other children. His feeling that good things were withheld fuelled his aggression.

Theory of mind

Lenny appeared to have a rudimentary level of self-other differentiation. In keeping with this there was no evidence of a capacity for empathy. He struggled with dyads and there was no sign of a 'third' person in his mind. At school he sometimes failed to respond to instruction or to his name. He acted without reference to others, as, for example, in leaving an area of the classroom without telling his teacher or classroom support assistant.[51] Such behaviour may indicate a lack of awareness of other minds or may indicate an unwelcome awareness and avoidance of others whose wishes are in conflict with his own.[52] At five Lenny might be expected to have more ordinary interest in others, but such interest as he has appears to be closer to a 'vigilant awareness of other minds...tuning in to someone out of anxiety or a desperate need to know' (Music, 2011: 55). Music points out that this anxious awareness of others' minds can result from the child having to monitor unpredictable parents and is a very different form of understanding from 'one derived from more benign and enjoyable forms of joint attention seen in secure children'. The function for Lenny may be closer to using the other to define the self-object boundary. Tähkä (1984: 139) proposes that when 'the experience of a self is still entirely dependent on the object's existence, preserving and protecting the ... differentiation [is] ... a central task for the infant's developing personality.' He goes on to describe the use of primitive introjection, projection and denial to maintain the as yet precarious self-object differentiation. He adds that these primitive mechanisms 'belong to the normal functioning of the primitive psyche and become “defence mechanisms”[as they do for Lenny] only in conditions under which the preservation of the primary differentiation seems to require their pathological accentuation.'

C. Relationship to Bodily Self and Drives

[51] Tähkä 's (1984: 144) concept of a 'functional object' is of interest here: 'This prestructural object represents lacking parts of the child's personality and is experienced as existing self-evidently only for the child's sake and thus belonging to his possession. It is “functional” in the sense that it is not yet experienced as a separate person with functions but someone who is the function she is performing at the given moment. Therefore, the object's affective colour, its “goodness” or “badness”, depends entirely on whether its respective function is experienced as gratifying or frustrating, and consequently the child's image of the object is bound to oscillate constantly between “all good” and “all bad”.'

[52] Fraiberg (1982: 618) describing 'avoidant behaviour in small infants observed that, 'if (the mother) is for the moment outside the baby's visual field and she speaks to the baby or calls to him, there is no automatic turning in the direction of her voice, and there is no alerting or signs of attention.'

Use of the body

In general my experience of Lenny in the assessment sessions was that he did not often feel relaxed in his body. At times Lenny felt tightly coiled, ready to spring into action, not in exuberance but against possible attack. He held himself together, tucking his sweatshirt tightly into his trousers, worrying about his shoes being properly fastened. He felt 'buttoned up', anxious about what might spill out and about what *did* spill out, when he could not hold everything together. I am reminded of Tustin's button image, the nipple in the mouth of the child, holding the child together in the face of disintegration (1988: 40). Unsurprisingly Lenny was still experiencing nocturnal enuresis although this had improved over his year in his foster placement.

However, this was not his only mode of being. When he was playing in the waiting room, in the presence of his carer, Lenny appeared unaware of himself. Similarly, putting things in his mouth seemed more developed than a 'plugging the hole' reaction to primitive anxiety. It too had an exploratory quality. Although he tended to be restless, moving from one thing to another, he could let his guard down sometimes, for example, to investigate the pipes under the sink.

Sexual development and psychosexual status

A very mixed picture emerged with respect to Lenny's psychosexual development. Alongside very active orality, as above, there was also phallic material. Masculinity was almost certainly viewed as superior in his birth family and masculine qualities were prized in his foster family. Lenny's ordering me about was an expression of his need for control but might also be indicative of some phallic aggression. Lenny's curiosity was limited. He looked at the toys in the box but did not play with them, he moved from one thing to another. However, he did have a fleeting curiosity about the inside of things: he investigated the pipes under the sink and wanted to know what is in the cupboards (Klein, 1923). Lenny was very aware of himself as a boy. We had to use a blue crayon for his name and to draw the police car. His carer remarked repeatedly on Lenny's admiration for her husband. However, his statements about being a boy were defensive and anxious. There was little evidence of his seeking admiration in the service of healthy exhibitionism/phallic narcissism with the exception of the gun which he showed me he had made.

Lenny's phallic aggression might also include identification with the phallic aspects of

his foster carer which would have implications for his psychosexual development. What impact might she have on his oedipal development? There was no evidence of Lenny managing triadic relationships. Would she, for example, inhibit his engagement in a triadic relationship? Might she also exacerbate Lenny's castration anxieties? He was very determined not to 'let anything hang out': he kept his top well tucked into his trousers.

Aggression

Lenny's mother was not able to provide him with a secure attachment and help him regulate his emotions and impulses. This had left him at the mercy of primitive fears for his own survival.

Lenny's aggression, particularly his attacks on other children, was the main cause of concern for his carer and teachers. His attacks on other children often appeared to be more in the vein of lashing out, a discharge of unpleasure, or fear, as opposed to aggression as a self-preservative defence. His experience in the real world would have been frightening and unpredictable, amplifying his internal fears and uncertainties. Professionals commented that Lenny's violent behaviour was unpredictable, making it very difficult for them to pre-empt an incident. However, some triggers that frequently provoked outbursts were identified: being asked, for example, to end an activity before he wanted to, or being refused something he wanted (such as being first in line). Teachers also observed Lenny reacting with shouting or pushing to jostling or accidental contact with peers.

Lenny's first interaction with me was to show me, with great excitement, the gun he had made in the waiting room. In the assessment sessions Lenny's aggression was often accompanied by excitement, as in forcefully knocking down the tower of softplay blocks. His kicking out and shouting abuse was explosive.

The overall impression was one of impulsive hitting out, kicking and punching, whether the softplay in the therapy room or in seemingly unprovoked attacks on children at school. But there were examples in the assessment sessions of Lenny exerting some control over his aggressive impulses. He stopped himself from hitting his carer. She helped him divert his movement towards her into something more constructive. At other

times Lenny managed to moderate his aggression himself. For instance, on opening the door of the dolls' house Lenny saw a small fixed wooden panel at the top of the staircase. He punched it swiftly with his fist, saying, 'Punch' as he did so. However, he controlled the degree of force he exerted so that he did not make destructive contact with the wood. When I commented on his 'punchy feelings' he nodded and began to explore the dolls' house. It was not clear whether Lenny felt provoked in some way by the wooden panel, his punch being reactive. Did he perceive it as an obstacle blocking his access in some way? He was very agitated by the locked cupboard door. Or might he have noticed the small dents in the wood, perceiving them as evidence of previous aggression which then stirred up aggressive feelings in him?

D. Ego Functions/General Development

Physical apparatus subserving ego functions/Cognitive development

Lenny had no physical disabilities but he was very small for his age. He was undernourished at the point of being taken into care and is likely to have received inadequate physical care from very early on. His learning was significantly delayed and he may have had a more permanent learning difficulty. The paediatrician's assessment on entry into the care system concluded that Lenny was 'globally delayed in all areas relating to his speech, retentive memory, concentration skills and hand-eye visual co-ordination.'

An Educational Psychology report, conducted when Lenny was four years and seven months, concluded that his receptive vocabulary was at the age equivalent of a child of two years and seven months and his picture naming was at the age equivalent of a child of two years and ten months. Lenny scored better on visual and thinking skills, achieving an age equivalent level of four years.

Lenny could draw rudimentary figures. He enjoyed looking at books with his foster carer.

Basic psychological functions

Lenny was a physically very active little boy, climbing and jumping with confidence. He had reasonable control over art materials and good control over the small cars. Lenny's memory of place was good. He remembered the clinic and the contents of the

therapy room from week to week. He remembered and talked about looking out of the window at the skip. As previously noted, Lenny's language and social skills were immature. He had a capacity for symbolization (as below). Lenny was confused about the relationships between members of his birth and foster families. This was unsurprising given his age and the complexity of his family. No doubt his confusion was amplified by the chaotic nature of his family life, its lack of boundaries, the subsequent dispersal of the family unit and the pain and conflict that it aroused in him. The boundaries between internal and external objects seemed to be confused.

Play

Lenny's capacity for developing play and/or playing with others was significantly delayed. He was still at a stage of sensory exploration, enjoying the water in the sink in the therapy room, putting things in his mouth and so on. According to his foster carer and school, Lenny had no friends. His foster carer described him as choosing to play, usually with cars, in his room or in a room apart from the other children. He had little capacity for turn-taking, was aggressive towards peers and spoilt his siblings' games. Lenny was interested that there were toys in the therapy room but he did not play with them. However, he did have a capacity for shared attention, looking at picture books and so on, and he could engage in some activity such as moving toy cars around quietly by himself as in the waiting room before the session. As yet he was unable to develop anything into more elaborated and sustained play. He could construct and symbolize – he proudly showed me the gun he had made on our first meeting. He asked me to draw for him, recognizing my sketch as a police car. He knew that the letters making up his name signified him.

Safety

Lenny's teachers and foster carer reported that he had no sense of risk or consequences. His behaviour was certainly very impulsive, potentially destructive and provocative. He hurt other children without thought about possible retaliation or repercussion. His attacks were perceived as intentional and hostile but closer observation would suggest they were reactive to impingements, physical or psychological (jostling in the classroom and so on perhaps being perceived as a threat to his self-object boundary). As mentioned, in the therapy room he climbed on things, jumped off things, drank the water from the sink, put things in his mouth. However, he did demonstrate some

awareness of danger – such as noticing that the skip lorry might have caused a crash and remarking on how precarious the roof/window ledge would be as a place to stand. Given the lack of 'scaffolding' and a secure attachment, the external dangers he identified probably correlated with his internal sense of his own dangerousness and precariousness.

Defence organisation

Lenny fell into Winnicott's (1969: 259) second 'category' of babies i.e. those who have not been 'held' by the reliable 'silent communication' of an attentive mother. He was one of those babies who have experienced an environmental failure. 'These babies carry with them the experience of unthinkable or archaic anxiety. They know what it is to be in a state of acute confusion or the agony of disintegration'. They are subject to the 'nameless dread' that Bion (1962: 116) describes. Lenny defended against feelings of vulnerability and dependence through various mechanisms, predominantly turning passive into active through identifying with the aggressor. He had not had dependable parental figures in his early years and had learnt, very prematurely, to rely on himself. His basic needs such as having enough to eat may well have depended on this. The lack of a secure attachment left him vulnerable to states of panic and the defences he mobilised were often inadequate. His development was affected across all areas. At times he projected his feelings of inadequacy onto others, as when he asked me to draw the police car and then drew attention to my failure to colour in the corners which he did for me.

Aggression served a defensive function, an expulsion of excess unpleasurable feelings and a defence against impingement. The cost of Lenny's defence mechanisms was high: other children avoided him and his siblings didn't want him around. He failed to adapt to social settings such as school where a level of conformity was required. His learning was disrupted by his aggressive outbursts and his exclusion from education as a consequence.

Anxiety

Lenny, as noted, had been subject to cumulative trauma (Khan: 1963). His need to be in control, to keep himself tucked in, literally held together, was a response to primitive anxiety, a threat to survival. Internal and external impingements threatened to

overwhelm him and he took an active stance in defence, fists at the ready. In Kleinian terms Lenny remained in a paranoid-schizoid state of mind, looking out for attack. In Ogden's terms he appeared closer to the autistic-contiguous mode of experience, in fear of 'impending disintegration of one's sensory surface or one's 'rhythm of safety' (Tustin, 1986) (Ogden, 1989: 68). His awareness of particular dangers suggested progress toward signal anxiety (the skip lorry could crash, it is dangerous to stand on a roof) but he was hyper-vigilant and subject to quickly tipping into a state of more pervasive anxiety.[53]

General characteristics

Lenny was functioning at approximately two years behind his chronological age in language and social communication skills. He had a very low level of frustration tolerance. He managed anxiety by being active. This may have served him well in the context of his birth family, ensuring he got some, if not his fair share, of the physical and emotional sustenance available. However, it was maladaptive in the wider world where his impulsivity and aggression impeded his development.

Diagnostic Statement

Lenny was a five year old boy presenting with aggressive behaviour towards his siblings and his peers. He was a middle child from a large family with a trans-generational history of deprivation, neglect and domestic abuse. The absence of adequate emotional scaffolding had left Lenny vulnerable to primitive anxieties of disintegration and had a negative impact on his capacity to develop healthy object relationships and a secure attachment. Lenny's aggression derived from his need to protect himself. Intolerable frustration led to frequent discharges of unpleasure and he reacted to external impingements with self-preservative attacks. Significantly there was no evidence of sadism. His attacks appeared to be a defence against primitive anxiety. He was excited by aggression but did not appear to take pleasure in controlling his objects. He did not hurt smaller children, and he was actively kind towards babies and animals, particularly the foster home dog. Lenny relied on auxiliary-ego functioning but feared dependence. His dependency needs were all the greater because his development was delayed across several areas: cognitive, social, and emotional,

[53] Recent research suggests that some maltreated children 'remain hyper-vigilant to potential social threat in their environment, possibly at the expense of other developmental processes' (McCrory *et al* (2010: 1085)

including psycho-sexual identity.

Lenny's development was arrested around separation/individuation. He had largely had to parent himself whilst making use of what parenting was available from his mother or his older siblings. Dependence on others provoked unmanageable feelings of vulnerability and was experienced as an impingement. Lenny responded defensively, attacking dependence in others and/or those who made him feel dependent. Lenny's carer's 'hands off' parenting style had been useful to him. He had been able to accept help from her without excessive fear of impingement. She provided a warmth which could form the basis of a more secure attachment. However, her difficulty in tolerating opposition might hinder the development of object constancy. In contrast to his unpredictable and violent birth father, Lenny's foster father was a stable and emotionally predictable man, a potential source of healthy identification. He could help Lenny with some of his anxieties with masculinity. However, his job required him to be away from home for several days at a time, limiting his capacity to support Lenny's development both directly and as a 'third' who might helpfully come between Lenny and his foster mother.

The network had hoped that new environmental help would be sufficient to address Lenny's needs and to change his developmental trajectory, but despite his very determined foster carer, considerable resources in school and medication, he had made limited progress. Lenny attended mainstream school but found the structure difficult to manage. He remained in a disregulated state for much of the time. Lenny's cognitive and linguistic delay hindered any developing capacity for recognising and naming feelings, leaving him unable to differentiation between affects. Rooted in an environmental failure to help him relate, this further exacerbated his difficulties in relating to others.

<u>Recommendations for Treatment</u>

If it had been possible I would have recommended three times a week therapy for Lenny (the maximum our service could offer), extending the session length and increasing the number of sessions gradually as he found it difficult to manage more than thirty minutes in the assessment sessions. A good foster placement and education

package had proved to be not enough to address Lenny's developmental needs. He needed different help to facilitate his development of healthier object relations. There were indications that a window of opportunity was still open: Lenny was beginning to internalise his carer's attitude and capacity to care for him. He was beginning to verbalise his feelings and worries and anticipate danger. The degree of emotional deprivation coupled with his age indicated intensive work. In their extensive review of outcome of treatment in psychotherapy Fonagy and Target (1996) found that in general children presenting with anxiety fared better in treatment, but disruptive children showed equivalent gains to emotionally disordered children when given intensive therapy. However, his foster carer was adamant that she could only commit to bringing Lenny once a week. She was solid and reliable but not very psychologically minded. She wanted a diagnosis, of ADHD or Tourettes, and medication alongside some behaviour management. In addition, given the constraints within the service, I would have had to argue, with little hope of success, for more sessions. Taking all this into consideration, I decided to provide weekly psychotherapy sessions for Lenny and support his foster placement by building a good working relationship with his social worker and teachers.

Lenny's school and foster carer perceived a benefit from the methylphenidate. We made a pragmatic team decision and did not challenge the Community Paediatrician's diagnosis and management plan of ADHD. Although the team psychiatrist would not have recommended medication in the first place, she took over the prescribing.

Lenny: a summary of the first year of therapy

For a fuller account and commentary see Appendix D

Lenny began therapy at the start of the autumn term, five weeks after the end of the assessment. His foster carer wanted help for him but made it clear that it was on her terms. There was some considerable compromise as she insisted she could not bring Lenny to appointments, or arrange for anyone else to bring him, during school holidays. Other appointments, if she felt they were of more importance, took precedence over Lenny's therapy. Lenny's social worker, a young man, both admired and was somewhat in awe of her. He tended to follow her lead rather than challenge.

Lenny's carer reported that they had had a good summer because she had kept all the children busy and Lenny closely supervised.

Lenny could not manage full sessions in the first few weeks, usually declaring he had 'had enough' after about 25 minutes. He came on his own to his first session, reluctantly leaving two cars with his carer. The first thing he noticed in the therapy room was the locked cupboard which became a source of frustration when he was convinced that I was keeping a myriad of toys from him. Although anxious and vigilant Lenny made some contact with me. There was an interesting exchange about biting which I shall return to in the discussion. It was clear at this early stage that Lenny had not yet securely achieved object constancy, and in the next few sessions he needed to bring his carer with him to the therapy room. His carer proved to be a good collaborator. She was a reassuring presence for Lenny but did not seek to engage or direct him. Lenny's capacity to play was still under-developed. He liked driving toy cars around a sugar paper 'road map' that we made but he appeared to have little imagination and he was unresponsive to suggested ideas or possibilities. For example he took all the cups and saucers out as if to play at having tea but then put them all back again. Lenny rarely asked for help, avoiding feeling dependent. As in the assessment stage, he put all the items back in his toy box at the end of sessions and liked to tuck his sweatshirt securely into his trousers. However, he was also exploring the environment in toddler-like fashion, investigating the boundaries of the room, interested in the noises he could make with the door chock and the feel of different surfaces.

Lenny's tolerance of frustration was low from the beginning. His lack of regulation became more evident as the sessions proceeded. There had been some throwing in the second session, some of it directed towards his carer but there was also evidence of a capacity to moderate his actions in response to an external caution. By the third session his excited aggression was much more evident, with kicking, biting and punching, largely directed towards inanimate objects. Over the year Lenny gained much more control over his impulses, although he regressed at times of increased anxiety. At this early stage Lenny felt easily overwhelmed by excess excitation which led to wild lashing out, but there was also evidence of some self-regulation. In the third session, for example, his kicking was almost transformed into a game of football. At times there was an admixture of aggression and affection (see Discussion **1.**7). Biting other children at school continued to be problematic. His carer linked these outbursts to the supervised contact meetings with his mother. She was anxious about his educational development and at odds with the teaching staff when Lenny was excluded from activities and from school.

By Session 4 Lenny was willing to come on his own to the therapy room, running ahead to play the first of many games over the coming months of 'hide and seek'. This session was also the first time that he could let me know directly that he was frightened, telling me about scary monsters, fighting dinosaurs and pinching crabs. Lenny also demonstrated his prowess in counting and enjoyed my acknowledgement of his skill. He was very aware of being a boy, as in Session 5 when he wanted to paint the water bottle blue (for boys). He was adamant that he was not a baby (although babies also evoked tenderness in him). Masculinity of a rather 'macho' nature was important in both Lenny's birth and foster families. There was evidence of phallic anxiety in his agitation with 'bent' pipe cleaners (see Discussion **1.**6/Appendix D, Sessions 6 and 7). Lenny adopted a deep guttural voice, that I imagined was mimicked from a television character although I never knew the source. He often used this voice when he was throwing insults at me. These were usually genital and/or anal, for example, 'Sexy Punkyhead' or 'Fatty bum-bum'.

Lenny's carer continued to be very anxious about his poor academic performance at school. There was a very real possibility that he would have to move to another school. Very encouragingly (Session 9) Lenny was able to express some of his own anxiety

through play (see Discussion **1.**6). His symbolic play was developing and there was a leap forward when he began to use the glove puppets (on my hands) as a participating audience (see Discussion **1.**2, **1.**5). There was a change in the nature of his biting when he seemed to be using his teeth to 'put his mark' on something – a magazine in Session 10 (see Discussion **2**). As we approached the Christmas break his aggression escalated. Excited play quickly became attacks towards himself or me/the puppets.

There was an extended break at this point in the therapy as Lenny's foster carers took him and his siblings on a trip to Disneyland, Florida. Lenny had asked for a dinosaur and play-doh before the break. On his return his pleasure at seeing me was mixed with aggressive attack: affection for the puppets led to hitting them/my hands. There was a lot of material about separation in the first session after the break (Session 14) and about coupling the following week (see Discussion 1.**2**). There was then another two week break for half term and a Speech and Language appointment. The Speech and Language Therapist was considering recommending that Lenny be transferred to an Additionally Resourced Centre for children with communication difficulties .

Following this second break there were small but significant shifts. Lenny asked me to tidy away for him, there was evidence of the beginnings of a capacity for reflection (see Discusson **1.**3) and of a greater degree of self-regulation. Lenny was managing in school much better although his teachers were asking for slow release methylphenidate. Lenny's foster carer, pleased with his progress, requested shorter sessions. On this occasion I managed to persuade her that this would be short-changing Lenny. She was unable to bring Lenny for his next session but agreed to ask if his social worker could. Lenny had his session, but he clearly missed his carer's presence and needed to bring the small garage from the waiting room (See Discussion **1.**3, **1.**6). From Session 17 the dinosaur, or rather Lenny's identification with the ferocious aspects of the dinosaur, became more important (see Discussion 1.7). Lenny was boisterous but less aggressive as his capacity to play and symbolize continued to develop. The last session before Easter (Session 19) coincided with his sixth birthday. He was very proud of being six. The Lenny-dinosaur stomped and roared but also sang, talked and slept. The distinction between fantasy and reality was very blurred in this session and Lenny became convinced that there was a dinosaur in the cupboard (see Discussion **1**.7).

Lenny returned happily from the Easter break. By now he was no longer being considered for a place in the Additionally Resourced Centre. He made (brief) reference to a 'Mummy' character in his play (see Appendix D, Session 20). His capacity for reciprocal play, his toleration of mess, and his social skills had all continued to develop. His foster carer was less anxious now about his educational levels of achievement as she could see that he had the capacity to learn. He was no longer excluded from school trips. Generally he was much less aggressive towards other children, with the exception of his sister and his carer's grandson. The first session after the break (Session 20) was characterised by creative, focussed play. Although the following sessions were characterised by much more excitable, aggressive, explosive play, he was more able to make use of my efforts, for example through drawing, to help him name and understand his feelings (see Discussion **1.**4/Appendix D, Sessions 21 and 22).

In the ensuing sessions there was a lot of oral aggression in Lenny's play: for example, eating up his monkey puppet (Session 26). There was also care-taking. Lenny wanted to know if I would take the puppets home and bring them back safely, with seat belts on. Excitement still spilled into aggression but he was better able to respond to external help. Wild kicking, for example, could be converted into a game with rules and turn taking. Lenny had a big fright at the end of Session 24. He rushed down to the waiting room to find that his carer was not there. (She had gone to the toilet). In the next session he played out an apocalyptic scene in an attempt at mastery (see Discussion **1.**2; **1.**4).

In the proceeding sessions there was phallic material along with the oral and anal material that was more commonly present. Lenny began to use the little fences in his play, for example to separate the wild from the domestic animals (see Discussion **1**.7). In the penultimate session before the summer break he used the joined-up fences as a giant ruler, measuring up the therapy room and its contents. In his last session his frustration about the locked cupboard – he had imagined that I was withholding toys and his anxiety – the roaring dinosaur that might be inside – gave way to interest and curiosity. His play became excitable and attacking but he stopped himself when I told him it was time to finish. He tucked his sweatshirt into his trousers, something he had not done for some months and poured a beaker of water carefully into my bin. I felt he was leaving his mark in a very primitive way. He asked to take a small car from his box. I suggested he might bring it back after the holiday. He left telling me that he wasn't

Lenny any more, he was Spongebob. (See Appendix D) Lenny came back six weeks later, with the small car.

Discussion

As in Philip's case, the codes that emerged from the coding exercise of the first year of Lenny's therapy sessions, were in evidence from the assessment stage. They were:

Expulsive aggression: throwing, biting, kicking, hitting, knocking over
Excitement becoming aggression or excitement as the result of perception of destructiveness
Moderation of impulsive behaviour using another
Self-moderation of impulsive behaviour
Taking control
Self-reliance v dependency

Although the predominant themes of the therapy were there from the beginning for both Philip and Lenny, their initial presentation and their progress were very different. Where Philip's fear of aggression inhibited assertiveness, Lenny was overtly and excessively aggressive. Both boys had difficulty with object relationships. However, over the year Lenny achieved a greater degree of synthesis in ego functioning which facilitated his general developmental progress. Before comparing the two cases further I shall consider Lenny's developmental achievements, arrests and/or regression to fixation points. As with Philip I shall use the developmental lines as a framework. In addition to 'lines' already referred to I have included a line, mentioned earlier, from pervasive to signal anxiety, proposed by Yorke and Wiseberg. I shall discuss different aspects of 'attachment', as did Anna Freud, under the appropriate developmental lines but in particular under the line from dependency to adult object relations. To consider more fully how Lenny's aggression impacts on his development I shall refer to Parens' hypothesis of a spectrum of aggression. Progress or otherwise across the lines is explored further in Chapter 5. For more detailed session material refer to Appendix D.

It is important to bear in mind Lenny's very early history in considering his presentation in relation to the developmental lines. As described previously, Lenny had a poor start in life, without a constant, consistent mother/primary care-giver to rely upon. Lenny's father was not only ill-equipped to fill this gap in positive maternal functioning or to intervene on Lenny's behalf but had a further negative impact on his development. His

violence towards Lenny's mother traumatised her, creating an atmosphere of violence and fear in which both parents were subject to heightened levels of arousal, impacting on their capacity to relate to, and protect, their children (Baradon, 2010: 133). This environment was a significant factor in Lenny's cumulative trauma (Khan, 1963; Schore, 2001).

1 Where is Lenny at developmentally?

1.1 *From irresponsibility to responsibility in body management*

By the time Lenny came into care he had learned to look after himself. He could feed and dress himself. He had urethral and bowel control during the day although he was still subject to nocturnal enuresis. He had not, however, adopted the niceties of ordinary communal living. The effects of the lack of parenting at key stages of development, as described in the Diagnostic Profile, were evident: he ate with his hands, perched on the toilet seat and so on. His advances in self-care had been made through the need to survive. Anna Freud (1952: 79) describes some children who are temporarily or permanently without mothers as identifying with the lost maternal function in relation to their own bodies: 'Far from enjoying the freedom from anxious motherly supervision (as the observer might expect from the mothered child's revolt against her care) motherless children proceed to care for their own bodies in an unexpected manner.' Anna Freud describes an observation in which 'it was difficult sometimes to prevail upon a child to shed his sweater or overcoat in hot weather; his answer was that he "might catch cold."' Lenny anxiously kept his sweatshirt on, tucking it in tightly, and he worried about his sleeves getting wet, or the uncomfortable feeling his socks gave him (Session 6). In ordinary health the mastering of bodily functions is concomitant with significant stages in ego development and a gradual detaching of the child's body from the mother's towards the child's possession of his/her own body. Loss of independence, of control over one's own body 'means an equivalent loss in ego control, a pull back toward the earlier and more passive levels of infantile development' (1952: 71). For children who are defended against passivity and dependence any enforced regression is fiercely opposed. Lenny resisted holding hands to cross the street, refusing help of all kinds. In the less guarded hours of sleep Lenny could not control his bladder. This symptom was greatly alleviated during his first year in foster care and improvement continued over

the following year in therapy as his anxiety reduced and he gradually became more able to be dependent without feeling overwhelmed by threats to his survival. In Session 15, for example, I noted that Lenny had not tucked his sweatshirt in (although he had brought a rescue vehicle with him). By Session 20 he was not bothered about getting wet and messy. In general Lenny's self-care represents a form of premature ego-development. His particular tendency to tuck in his clothes as if keeping himself together, places him in the region of Bick's work on second-skin formation and the relationship between the physical and psychical need to pull oneself together in the face of primitive fears of falling apart. Bick proposes that where there is an inadequate containing object, either in reality or as the result of fantasy attacks on the object, introjection of the containing function is impaired. A 'second-skin' may form, with dependence on the object substituted with 'a pseudo-independence, by the inappropriate use of certain mental functions, or perhaps innate talents' (1968: 484).

1.2 From dependency to emotional self-reliance and adult object relations

Lenny had not experienced the ordinary good fortune of physical and emotional dependency. The natural line of development is from dependency to self-reliance, but Lenny had had to learn aspects of physical independence prematurely. With the attention of his foster carer he caught up quickly in the practical areas where he had lacked parental input, using cutlery, dressing, brushing his teeth and so on. His emotional development, however, was more significantly compromised. As described earlier in the Diagnostic Profile, the nature of Lenny's relationship to his foster carer at the assessment stage was one of a need-fulfilling object (Stage 2 on Anna Freud's 'line'). His carer provided sustenance and safety and Lenny responded to that, mindful of the need to please her – such as when he refrained from hitting her with his wet sleeves. (For a fuller description of the theory behind this line see Chapter 3.) By the end of the year Lenny was functioning somewhere between Stage 3, with the ability to maintain a positive image of his carer in her absence, and 'the ambivalent relationship of the preoedipal, anal-sadistic stage' (1965: 65) of Stage 4.

Lenny made progress over the summer break between the assessment and the start of therapy. At the outset of therapy proper, it was clear that he had not yet fully achieved object constancy, frequently needing to return to his carer after twenty minutes or so for

the first few weeks. In Session 2 he acknowledged he didn't want to go to school because he wanted to be with his carer. He was, as yet, unable to maintain a positive inner image of her in her absence. However, there had been a change in his presentation from the assessment sessions, his interactions had a different quality. He was already able to make use of another to explore the world rather than purely meet his needs. For example in his first session Lenny was interested in the clicking noises he and I could make with our nails against our teeth. I noted ' a *moment of real connection'* as over the next few minutes we explored this experience together. This progress was followed the next week with a step back and the need for the reassurance of his foster carer's presence. Perhaps he feared that without external help he might revert to biting rather than exploring. In the same session Lenny's conflictual feelings towards his object were evident when he nearly hit his foster carer, though he was able to use me as an auxiliary object to help him moderate his aggression. Given his early start in life his ambivalence was not surprising – and very disruptive to his development of healthy object relationships. His presentation suggested that he both desired and feared his mother. Any ambivalence in fantasy would have been compounded by ambivalence in reality.

Progress was evident fairly early on. By Session 4 Lenny was enjoying hide and seek and wanting to be found. But dependency was very threatening. He continued to need to be in control, tidying up by himself, deciding when the session had finished, wishing he was a grown up 'who didn't have to wear socks' (Session 6). His language was punctuated with demands, commands and sometimes threats, as in Session 11: *'I want the garage. Get it now. Go downstairs. I'll stab you.'* His violent language was perhaps in part an identification with his violent father, a defence against feelings of being small and vulnerable. On occasion he could use help but resisted dependence. In the same session, for example, he enjoyed shaking the rug together but as soon as he didn't need me to complete the task I became redundant. Getting close and having to move away was repeated frequently. His language in Session 14 indicated the conflict between libido and aggression, *'Sexy Punkyhead'* was one of the insults/endearments he threw at me. Lenny made contact with me through typically aggressive behaviour, blowing raspberries and spitting in my face, behaviour which also served as an attack, keeping me, at the same time, away from him. He then had to make sure there was a divide between us, building a wall of softplay. I was an ambivalent object for him: he wished to be close but also feared me, perhaps as retaliatory. This conflict was apparent in the

following sessions when Lenny coupled cars with sellotape and then pulled them apart. Lenny's sadistic control over his object/me, attacking but not destroying me was his solution to his ambivalence. It remained to be seen whether it might become a step along the way to integrating loving and hating and towards object constancy.

Winnicott (1960) offers his own gradations of dependence/independence. He suggests three broad categories: absolute dependence; relative dependence; towards independence. He equates the stage of relative dependence with the 'graduated de-adaptation' that promotes emotional and psychological growth in the infant. This is also the stage at which the infant becomes to some degree aware of dependence: 'When the mother is away for a moment beyond the time-span of his (or her) capacity to believe in her survival, anxiety appears, and this is the first sign that the infant knows' (1963: 87). Lenny's anxiety was extreme at the (early) end of Session 23. When his foster carer was not in the waiting room he ran from the building in panic. He seemed somewhat sobered by this experience, and perhaps reassured by his carer's steady assertions that she would not abandon him. He was calmer the following session. Winnicott describes the next stage of 'relative independence' as a point of development when the infant knows its mother is necessary. Lenny's use of his carer as a need-fulfilling object had been evident for some time but his distress at her absence and the nature of the reunion with his carer was perhaps an indication of a stronger attachment forming.

The hand puppets were significant in respect of Lenny's development of object relationships. They had a transitional function for Lenny but did not have quite the usual status of transitional objects – although my hands barely disguised as the puppets took quite a hammering. The puppets served as a stepping stone towards me/his object allowing him to tolerate my presence through the puppets as intermediaries. Whilst keeping a safe distance Lenny could enjoy the interest of another, feeding a healthy narcissism. For example, Lenny loved it when I talked through the puppets about him, how old he was, how he went to school, who he lived with. This 'transitional space' perhaps mirrored the measuredness of the relationship with his foster carer who kept her distance and did not encroach, gradually allowing Lenny to approach and invest in her. By Session 17 Lenny clearly missed his carer when she was unable to bring him. He liked and felt safe with his social worker but it wasn't the same. In Session 19 Lenny asked if I went to my house in his absence. An indication of his awareness of my

separateness but also a wish that I would return (and an example of a developing representation of me that could serve him in my absence).

Given his history Lenny may be unlikely to achieve his full potential but there was evidence over the year of a capacity for internalising a new developmental object. Responding to the regulatory functions of his foster carer, his teachers and his therapist, Lenny developed a capacity for moderating his own impulses. Previously he had been unable to sustain or generate a game and his impulsive behaviour frequently escalated into wilder more destructive activity, as in Session 26 when Lenny was kicking, shouting and thumping. However, his aggressive-libidinal feelings were now also manifest in his play. In the same session Lenny ate up the puppets and the dinosaur ate the play-doh man. Khan's description (1979) of how perverse adult patients use the other as a quasi-transitional object there to be attacked but never destroyed is a reminder of a possible unhealthy trajectory for Lenny if he should become stuck in this way of functioning.

Schore (2010: 28) states that ordinary good-enough mothering serves to 'scaffold and support an expansion of the child's right-brain regulatory coping capacities and underlie(s) the developmental principle that secure attachment is the primary defense against trauma-induced psychopathology.' There is a growing body of research[54] that supports the view that early emotional deprivation has long term consequences, setting the child on an adverse trajectory. Schore (2010: 30) describes the move from a state of hyper-arousal to a dissociative state in which the young child withdraws to maintain homeostasis. He emphasises that both are states of 'extreme emotional arousal'. Lenny is more usually in a state of hyperarousal but we know from social services records, as noted in the Diagnostic Profile, that as a small child he had resorted to auto-regulation, self-soothing rocking In his therapy sessions a feeling of too-muchness would typically be followed with a statement of, 'I've had enough' and a withdrawal from the session/relationship with his therapist/the activity. It is evident that early adverse experience has delayed Lenny's development. What remains unclear is what kind of recovery he might make, given the appropriate environment. Although the odds are stacked against children such as Lenny who have been exposed for several years to neglect, violence and deprivation, Hodges et al (2003) research on adopted children is

[54] Grossman, Grossman and Waters (2005); Sroufe (2005)

more encouraging. McCrory et al (2010: 1087) conclude from their review of recent research that 'positive environmental influences, such as social support, can ameliorate genetic and environmental risk for psychopathology and promote resilience.'[55] McCrory et al (2010: 1088) also suggest that the hypervigilance that maltreated children develop, although maladaptive as a defence later, could be viewed as adaptive in the context of adversity and implicitly a possible indicator of resilience.[56]

1.3 From the core self to self-representation/verbal self

Lenny had lacked a facilitating environment in which to develop, in Stern's terms, a sense of an 'emerging self' (see Chapter 3, 1.4). In the early weeks, as discussed above, his sense of self in relation to others was fragile. However, he made significant gains during the year.

Focussing on the interplay between structural development, object relationships and language, Edgcumbe (1981) outlines five early stages of a developmental line for the acquisition of language which emerged from a study group on language at the Hampstead Clinic. The development of language is described in the context of the baby's relationship with the mother and there is an emphasis on pre-linguistic communication. Development begins with the infant's innate capacity to attract his mother's attention alongside the cries and noises of discharges of tension. It is vital for the child's development that the mother attributes intention to the baby's noises. Her responses reinforce the infant's vocalisations and gestures and differentiate them for the child. In stage 2, with the early stages of structural development, the baby develops a range of sounds linked with specific inner experiences. There is a growing capacity for anticipation and the primitive beginnings of an inner representational world. The mother's voice and gestures help the baby to tolerate frustration. The baby vocalises when content and responds with pleasure to friendly advances. This is the stage of proto-conversations (Beebe et al 1997). In stage 3 the baby begins to use noise and gesture with intent to obtain gratification of wishes as well as to communicate inner experience and interest in the external world. At stage 4 the infant's capacity to understand far outstrips his capacity to use language. The infant internalises the

[55] Freud's 'constitutional' roughly equates with today's 'genetic'.

[56] Interesting clinical studies on resilience include Veronica Machtlinger's investigation of the child survivors of Tereszin concentration camp (2006, unpublished) and Michael Rutter's longitudinal study of the children of the Romanian orphanages (English and Romanian Adoptees Study).

language of others, contributing to the development of ego functioning and object representations and in turn to internalised relationships. His mother's words can comfort, reassure and direct him. At stage 5 the small child can use words and gestures to comfort and reassure himself as well as to express feeling and attract attention. He can convey increasingly complex ideas and experiences and ask questions. Words may be used independently of action. The verbal prohibitions of the parental figures are used by the child, reinforcing the development of the superego.

Edgcumbe is reluctant to state at how many months an infant might be expected to attain any particular stage. The study group found considerable variation in development across the children. However, their findings are roughly in line with those of other research studies in the field.

Stern (1985) suggests that a 'verbal self' is established at around about two years of age. As mentioned earlier in the Diagnostic Profile, the Educational Psychology report, conducted two months before Lenny's assessment for psychotherapy, indicated that he was functioning at about two years behind his chronological age in terms of vocabulary. Lenny continued to use language to demand, to keep at bay, or as a means of ridding himself of excess uncomfortable energy. However, he also used language to explore and explain sensory experience (Edgcumbe's stage 3). His language structure was changing. In Session 5 he told me I should buy a new 'bottle' (water container) for the sink, and I should *'paint them blue, not pink, because boys don't like pink'*. He gave an instruction, stated a preference and a reason (as well as implicitly conveying something of his anxieties in relation to gender). Katan (1961) observes how verbalization leads to an increase in mastery of the ego, giving the child more control over himself in relation to his environment.[57] Rather than acting on feelings, action is delayed and feelings put into words instead (Freud, 1900, 1923, 1933, Rapaport, 1950, Bion 1962). An increase in a sense of security and educational advances are generally sequelae. Around about Session 16 Lenny was being considered for the Additionally Resourced Communication Centre. In therapy at this time (Session 16) there was evidence of a capacity of some self-awareness when he began a statement which he did not finish. He observed, *'Sometimes I...'* and subsequently refrained from pouring water into the bin.[58]

[57] Karen Weise (1995) tracks the reduction in aggression in a small boy as he acquires language and moves from primary to secondary processing.

[58] It would have been interesting to track Lenny's use of the personal pronoun in relation to his emerging sense of self. However, as mentioned in Chapter 2, my process notes lacked extensive recordings of

Encouragingly, by Session 19 he no longer met the criteria for specialist provision and the recommendation became mainstream education with a high level of support. In Session 21 with my words and actions he was able to become more aware of his explosive feelings. Having crashed and banged his way through the session he joined in drawing an erupting volcano and then applied himself very seriously to a picture of himself. He had a strong sense of himself as a boy, really wanting blue paper but managing to compromise with brown. He wanted to depict himself with a smile and was very proud of the result. Lenny is functioning at Edgcumbe's stage 4, able to use his mother-therapist's language to understand something of his own experience and to help him tolerate a degree of frustration.

Verbalisation also serves to distinguish between wishes and fantasies and reality (Katan, 1961: 188) which in turn is helpful in the resolution of the oedipal complex. This is very pertinent to Lenny who had great difficulty relinquishing his omnipotence. Barnett's (1983) research in nursery settings raised the question of the connection between language difficulties and lack of intimacy. The limitations of the verbal exchanges that she describes in her research, often restricted to prohibitions or instructions and rarely elaborated or creative, echo the language observed between Lenny's mother and her children. Wright (1991: 135), writing about the pre-requisite 'gap' between child and primary care-giver in the child's acquisition of language, emphasises the centrality of the relationship with 'the Other': 'In the child's experience it is the Other – the mother, the father, other people – who bring words to the child.' The sounds of language gradually become attached to shapes and faces. 'Then they acquire a magical power to control other people and bring things to them. Only gradually and much later do they come to 'mean', to symbolize.' Lenny had little chance to develop symbolic language in his birth family where he encountered transgenerational emotional and subsequently linguistic impoverishment.

1.4 From pervasive to signal anxiety

Yorke and Wiseberg (1976, 1989) suggest a developmental line 'from the earliest somatic experiences, through early psychic concomitants, through pervasive psychic anxiety, and finally to signal anxiety' (1976: 111). They emphasize the shift from

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speech.

somatic to psychic in relation to mentalisation, containment of anxiety, changes in quality of anxiety and the change from a maladaptive to an adaptive function of anxiety. They describe the first kind of mentalised anxiety as 'automatic', primitive psychic panic, total helplessness, that can only be alleviated by help from another.[59] Further development of mentalisation and ego structure equip the child with rudimentary defensive measures which restrict the anxiety, although it remains pervasive. In ordinarily good-enough circumstances, with further development along the various lines, the latency-stage child is able to use danger signals to protect himself against pervasive anxiety. These capacities become more firmly integrated into the psychic structure during the latency years but the adaptive control that has been achieved is threatened again with the onset of adolescence. The regressions of normal adolescence are eventually superseded by the attainment of adult mastery. The authors stress the interplay between the lines of development, which will promote or hinder progress towards signal anxiety. They cite as an example the adverse impact of unsatisfactory object relations and awareness of outside dangers which are likely to fill the individual with helplessness and overwhelming anxiety. A very apposite example in terms of Lenny's history.

As discussed in the Diagnostic Profile, from his earliest weeks Lenny was subject to diffuse anxiety arising from both internal sensations, hunger, discomfort, and so on and from the privations and trauma of his external environment. His mother was unable to contain and provide a regulatory function for his emotions and/or to offer the ordinary help in developing a capacity for mentalisation. His father could not compensate but instead fuelled an atmosphere of violent tension and arousal. At the assessment stage Lenny was still largely subject to pervasive anxiety but there were indications of a move towards signal anxiety (as in his thoughts in the assessment session about the lorry that might crash). As with development along other lines, there are advances and regressions. His fear of disintegration was evident in his need to be in control which continued throughout the year. In Session 16, for example, he was perturbed by the drop of the stairwell in the dolls' house, a reminder of the threat of automatic anxiety and his existential terror of falling through space which Tustin (1986, 1988) describes. However, concomitant with development along other lines, including development towards object constancy and his increasing capacity for acquiring and using language,

[59] McCrory et al (2010) offer an overview of recent research in neurobiology and early adversity and stress.

he made progress towards regulation of affect. Yorke and Wiseberg (1979: 8) propose that once speech and secondary-process functioning are established signal anxiety begins to operate. In Session 9, for example, there was evidence that symbolisation had a regulatory effect. There was considerable anxiety around the possibility that Lenny would have to move school. The threat of such change would previously have tipped Lenny into a state of extreme anxiety but at this stage he was able to express his worry through play. Symbolisation, like language and thought, introduces delay between impulse and action. This was a shift towards signal anxiety, although this was far from being established. In Session 21, as described above, there was an instance of Lenny responding to his therapist's containment, helping him to internalise a capacity for regulation of his own emotional states. He calmed down when I drew his explosive feelings as a volcano. Progress was far from constant and Lenny was overwhelmed by anxiety at times. His carer noted that Lenny's challenging behaviour and his seemingly unprovoked attacks on other children escalated around contact with his parents and during the week when he was in respite care, separated from his carers. As mentioned above his panic at the loss of his carer was demonstrable when he got to the waiting room and his carer was not there (Session 24) and he tipped back into a state of pervasive anxiety. However, by the end of the first year Lenny was showing signs of managing much better. He appeared to be exercising a degree of mastery over his anxieties about the forthcoming break: he took stock, measuring up the room, checking it out for other potential occupants, and he took a bit of the room with him, a small car.

1.5 From egocentricity to companionship

At the start of therapy Lenny was functioning at around stage 2 of Anna Freud's developmental line. He had no friends and his siblings barely tolerated him. Lenny could demand that someone must do something for him and he could manage to do some things alongside others. A major frustration for his siblings, as previously noted, was his inability to join in with rule-governed activities and his tendency to spoil or disrupt their games. Anna Freud (1965: 83) points out that a degree of adaptation to reality and a level of frustration tolerance must necessarily be achieved before a child can successfully join in such activities.[60] Given Lenny's vulnerability to becoming

[60] This is an example of cross referencing between developmental lines: Anna Freud addresses 'games' in the line from 'The body to the toy and from play to work' but emphasises a child would need to have reached Stage 3 on the line 'From egocentricity to companionship' before managing the 'symbolic and highly formalized expression of trends toward aggressive attack, defence, competition etc.' of game

overwhelmed with pervasive anxiety and his necessary, if maladaptive, defences against this, it is unsurprising that his development along this line was particularly delayed. His hypervigilance, poor impulse control, and delay in object relations development and language all militated against progress in relating to his peers. However, as he experienced the ongoing predictability of his carer his anxiety began to have less of a hold on him. He moved towards object constancy and began to internalise the regulatory function of his carer and other significant adults, developing a capacity for moderating his own impulses.

By the end of the first year of therapy he was still some way off regarding other children as partners and objects in their own right but he had made progress and was functioning at stage 3. The puppets, which stood in for other children/potential playmates, had shifted from alternating between being admiring audience and whipping boys to also being of interest to Lenny. He took pleasure in shared activity such as drawing, throwing and catching games. He was included in school trips and managing the day to day interactions with his peers at school.

1.6 From the body to the toy and from play to work

At assessment and for some weeks into the therapy Lenny did not develop or sustain play. He would get toys out of his box only to put them back again. An exception was the little cars that Lenny would take from his box and drive around the road map I had made. His use of objects for play was consistent with a toddler-aged child, such as the door chock used to explore the sounds and textures and boundaries of the environment. Lenny appeared to have missed out on the earliest experiences where play begins, the erotic pleasure of the child's own body and the interplay with the mother's and then the transferring of those properties to a plaything (Anna Freud, 1965: 79). There was no indication of Lenny having, or having had in the past, a transitional object.

Lenny's capacity for symbolic play continued to develop. There was evidence, for example, of symbolic functioning in Session 6 when he had been very agitated by the bends in a pipe cleaner (see Appendix D). The following week the pipe cleaner became a 'man' in play. In Session 9, as mentioned above, Lenny explored his situation through

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playing (1989: 83).

play with his road map and the broken parking space. He could make good use of his therapist as an admiring audience of his prowess, as evidenced in the healthy demonstrations of phallic exhibitionism. In Session 17, for example, when he became 'the blue dinosaur with sharp teeth' stomping happily around the room. Although he was a long way off managing games (see above) there were indications of his potential for joining in and abiding by rules as early as Session 3 when kicking the softplay almost became a game of football. There was notable progress during the year. Some toys were invested with transitional qualities. He expressed both affection (libido) and aggression towards the glove puppets. He used the garage as a link with his carer in her absence (Session 17) and took a car from his box to keep with him over the summer break (Session 30). By the end of year Lenny was engaged in some aspects of Stage 4 (d) at which toys serve in the expression of masculine or feminine trends and attitudes in solitary play, in relation to the oedipal object and in group play. However, he was only just beginning to join in group play at school and his development was disrupted by his excess of aggressive feelings. Anna Freud (1965: 80) describes the use of play materials as serving ego activities and the underlying fantasies, identifying at Stage 4 (c) 'building materials offering equal opportunities for construction and destruction (in correspondence with the ambivalent trends of the anal-sadistic phase)'. Lenny was far more driven to destruction than construction and although this compulsion lessened considerably over the year it remained a problem. In other respects he progressed more freely along a healthy trajectory.

1.7 A developmental line for aggression

As outlined earlier in the discussion of Philip, the proposed development line towards healthy aggression begins with the infant's need to be rid of primitive anxieties rather than an innate destructiveness. Lenny did not have a 'good enough mother' who could alleviate frustration and help him to internalise a basic sense of safety and trust. Love, consistent care and affection, was in short measure. His father only worsened the situation. His emotional environment was singularly ill-equipped to mitigate the 'aggressive love' Winnicott identifies as belonging to the infant. Violence characterised the relationship between the parental couple and Lenny's mother spoke roughly to her children, mixing affection with insult or reprimand. Lenny's capacity for processing frustration and anger was severely delayed and he continued to express his frustration

through his body. There are numerous examples in the clinical material, of the smallest impingement, internal or external (the uncomfortable feeling of his socks, the presence of the softplay) provoking kicking, biting, spitting, shouting and verbal abuse.[61] Challenges to a child's omnipotence or sense of integration, loss of the object and fear of abandonment ordinarily provoke an aggressive response. Challenges to Lenny's omnipotence were felt even more keenly as, lacking reliable parental figures, he had in reality to depend on his own limited resources and loss and abandonment were an actuality. Lenny was still functioning at an early stage with a limited range of defences available to him. An early, not very successful, attempt at managing his aggression involved projection – the crabs and monsters at the beach (Session 4). However, there are also many instances of a growing capacity for self-regulation during the course of therapy as he internalised his foster carer's attitude, which was reinforced by school. For example, Lenny's ambivalence towards his object was very evident in Session 3 when his excitement, as often happened, spilled into aggression and *he gave me something between an embrace and an assault.* Affection and aggression were often confused as in Session 13 when he hugged and thumped the hand puppets/my hands. In Session 16 there are signs of a shift: Lenny, throwing his toy cars into the room, hit me with one of them and then changed the direction of his throwing. As he gradually acquired a firmer sense of object constancy, and concern for his object, and as his use of language and his capacity for play developed, Lenny could begin to symbolize his aggression – he became the blue dinosaur with sharp teeth. He was more able to respond to limitations and to accept help without having to defend himself aggressively against feelings of humiliation. Towards the end of the first year there were indications that Lenny was more aware of the impact of his aggression and the need to protect himself and his objects against it. In Session 23 Lenny had attacked the Monkey and Elephant puppets soundly and then wanted to know if I would keep them safe – by taking them home and bringing them back with seat belts on. In Session 27 he separated the dangerous from the vulnerable animals with fencing. Then he decided the wild and the domestic animals should all be friends in an externalisation of his attempt to bring together the wild and domestic elements of himself.

There are other aspects to Lenny's identification with the 'growling monster' (Session

[61] Balbernie (2001: 247) , in his paper on the neurobiological consequences of early relationships, describes how the growing brains of babies are affected by maltreatment. 'Such babies become children and adults with an instant exaggerated threat response, reacting to events which others would not notice, as a result of the reactivation of previously sensitized neural networks. The past is not lost.'

13). As with his violent language there is likely to be an aspect of identification with his father. Fraiberg (1959: 18), discussing early childhood fears, suggests that a 'very satisfactory approach to the tiger problem is to become a tiger'.[62] However, she points out that a child who has met danger in reality is much less likely to be able to overcome fears through the imagination. 'In extreme cases, and especially in the case of delinquents, a world view is formed on the basis of these early real and unmastered dangers, a view in which the world is populated with dangerous persons against whom the child must constantly defend himself.' (1959: 19) Anna Freud notes the similarities between turning passive into active and identification of the aggressor as a defence but she also makes a distinction between them. She points out that the child becomes the aggressor in order to protect himself, for example, if the child becomes a ghost he will not be frightened of his fellow ghosts. However, this identification does not necessarily lead to the child directing his aggression towards the former aggressor (1985: 386-388). Parsons (2006: 49) points out that when an externalising defence extends to projection the child can then fear attack from whoever or whatever he imbued with his aggression. When Lenny stopped being the dinosaur he then became frightened of it, as in Session 19 when he was convinced it was in the cupboard.

2. How might we understand Lenny's development in relation to Parens' theory of aggression?

Parens, as outlined in Chapter 2, hypothesised that hostile destructiveness arose as a response to too much internal or external distress, physical or psychic pain. From his research findings Parens concluded that 'hostile destructiveness invested in the earliest object- and self- representations .... becomes part of repetitive, automatic, patterned modes of functioning in intrapsychic dynamics and in object relations.' (1979: 117). Is this a helpful way of conceptualising Lenny's presentation? Lenny had been subject to external privations and had not had a care-giver attuned to his internal needs. He was a very distressed and angry little boy. Of the four trends of aggression proposed by Parens Lenny was most evidently subject to *unpleasure-related discharge of destructiveness* (the hitting out, kicking and shouting) and *hostile destructiveness* (his attacks on his

[62] Hansi Kennedy and Anna Freud (1985: 388-389) discussing identification with the aggressor recall a child who played at being a 'doggy so doggy don't bite me'. This child had a mother who 'barked at her' and the child herself developed a sharp tone.

siblings and other children. At times his excitement would suggest a worrying shift towards *pleasure-related discharge of destructiveness*, the path towards sadism, but there was relatively little teasing and taunting, his attacks, ironically reassuringly, were generally more direct.

It was Lenny's oral aggression, biting other children, that particularly disturbed those caring for him. At an earlier stage of development biting would have been seen by the same professionals and carers as a response to teething and/or distress but at five it provoked condemnation as primitive, animal-like behaviour. Parens gives some thought to understanding oral-aggressive cannibalistic impulses observed in the research project. 'Our findings suggest that when these biological and psychological developments are occurring (the emergence of teeth and the sufficient structuring of the libidinal object), they simultaneously set the stage for the emergence of cannibalistic impulses directed toward the newly structured libidinal object. At this juncture the hypothetical line between non-affective and affective, between unpleasure-related and pleasure-related destructive impulse discharges becomes at times almost impossible to distinguish.' (1979: 175) This is Abraham's oral-sadistic phase: 'Within the first oral period, the child exchanges its pre-ambivalent libidinal attitude, which is free from conflict, for one which is ambivalent and preponderantly hostile towards its object' (1924: 453). Both Parens and Abraham are referring to an earlier stage of development than Lenny should be at. Given the lack of information available, it is difficult to know whether this is a regression or a developmental arrest, however, his carer had reported that Lenny's biting had been a constant problem, suggesting an arrest. Whilst he does begin to make progress there are relapses at times of stress, such as contacts with mother or staying with respite carers.

Lenny also pondered over the problem of biting. He seemed to be trying to sort out the distinction between 'good' biting and 'bad' biting in his first session when he linked 'food' and the sound of eating with his carer's prohibitive 'no biting' (of nails/children).

He discovered that the little windscreen on one of the cars clicked up and down. He began to chew his thumb and click his nail against his teeth. A moment of real connection followed when I mimicked what he was doing and commented on the interesting noise. Lenny asked why I was biting my nails. I made the distinction between

biting and making the noise. He told me his carer says, 'No biting'. I agreed biting nails wasn't a good idea. Lenny made a connection with the noise of the windscreen and we tried it out. (Clicking the windscreen then clicking our nails against our teeth.) I commented that the nail noise sounded in your head. Lenny said, 'Food'. I repeated, 'Food?'. Lenny said, 'Like eating'. There was eye contact at this point. I agreed it was like the sound of eating in your head.

The interaction started with Lenny's thumb in his mouth, a reminder of the earliest hallucinatory substitute for the nipple. He isn't just sucking but rather chewing at his finger and nail. The breaking down (destruction) of food, taking in milk or comfort from his thumb-nipple is non-affective in Parens' terms. Does the chewing, as opposed to sucking, relate to his early experience as a baby who didn't get enough milk/emotional sustenance? Is this an echo of desperate efforts to get enough or of the infant Lenny attacking the breast/himself? Or exercising his as-yet unbound oral aggression? As Parens observes at times it is almost impossible to delineate unpleasure-related from pleasure-related destructive impulses. Lenny's carer did remind Lenny not to bite his nails but her strongest 'No Biting' was in relation to biting other children. Lenny seems to be reminded of this warning about his own aggressive impulses. He moves from non-affective destruction, the sucking that pre-dates chewing his finger/the breast, to aggression (thoughts about his attacking biting). However, in the context of the therapy session, he moves back to the self-preservative non-affective destruction: he is reminded of the experience of eating food. (Sustenance in his carer's home, in contrast to his birth family's home, was reliable and consistent.) This was an opportunity to offer some developmental help. When Lenny called to mind the 'no biting' warning I took up biting *nails* rather than biting *children* as implicit. That is, his nails/himself as the object of the attack, and his carer's caution as an expression of her concern for him. This emphasized the non-affective destructive impulse. If I had made a connection with Lenny's attacks on other children the result might have been to amplify the hostile destructive aspects that, while originating from self-preservation, can become the inflicting of pain or destruction of the object and in turn lead to sadistic attack.

The convergence of aggression and libido was evident in Lenny's cannibalistic, taking in and making his own/incorporating. For example, in Session 3, Lenny's excited biting on the softplay, my cardigan and so on, reminded me of the lyrics: '*Oh my love...I'm hungry for your touch'* (See Appendix D) and I found myself wondering about

his voracity and his ambivalence in relation to unmet need for his mother's affection (see Chapter 5). Several months later, as mentioned above, (Sessions 23 and 26) Lenny ate up his puppets. In Session 10, when Lenny urged me to *'Kiss your Daddy',* the strange image on the page, there was an admixture of affection and fear. Later in the session there was an example of a more straightforward, assertive laying-claim-to when he bit the magazine saying, *'Mine now'*. Parens proposes that '*sufficient unpleasure* is the determinant which adds to the otherwise non affective destructive impulse its quality of rage and hate in recognition of which we call it a *cannibalistic impulse*' (1979: 175). Lenny's biting of the magazine had no hostile affect [63] but his biting of other children is clearly hostile. The puppet eating is more complicated. Lenny ate them up with relish, it was a very pleasurable activity. Was there an element of sadism? It felt closer to an acting out of an affectionate, post-ambivalent, libidinised desire to incorporate: 'Oh you are so delicious I could eat you all up' as opposed to the hostile intent of a fairytale wolf.

Lenny's exploration of the room, banging the wood chock around the walls and radiator, had the quality of the non-destructive discharge of aggression that Parens associates with Mahler's 'practising sub-phase'. In healthy development this phase would occur between ten to twelve and sixteen to eighteen months of age. There is an upsurge of aggression at this stage coterminous with new levels of assertion, developing autonomy, mastery over self and environment. Where the child is frustrated in his/her exploratory strivings sufficient unpleasure may result in hostile destructiveness. Children with greater capacity for tolerance of frustration manage better. Lenny's delight in building up and knocking down towers of softplay was in contrast to the excited kicking of softplay. The first indicating mastery and the second, in Parens' terms, a manifestation of pleasure-related discharge of destructive impulses that derived from unpleasure-related discharge. Parens noted a 'sweep *toward* destructiveness of the non-destructive trend in aggression' (1979: 191) at this stage of development. Parental help is essential at this point The research inferred that the internalisation of the maternal function of regulation and moderation of aggressive impulses led to the growing ego strength of the children. Needing the approval of the object 'the young ego... begins to internalize dictates from the highly cathected libidinal object and activates neutralisation of hostile destructiveness toward that valued object. Here, therefore, the ego begins to evolve those precursors that will develop into the superego,

[63] Although there was no hostility towards the magazine there was an element of competitiveness – 'it is mine, not yours'.

and takes a further large step in evolving object relatedness.' (1979: 210) Lenny was moving from an oral-sadistic relation to his object/mother to a post-ambivalent state with a new object. With the help of therapy and school, after a very adverse start in life, Lenny was able to begin to make use of and internalise a different consistent, affectionate carer and a maternal regulatory function.

CHAPTER 5

In Summary: A Comparison of Philip and Lenny

I shall briefly re-cap on some of the similarities and differences of the two case studies and consider these in the context of the research question. Philip and Lenny both started life in large families. Philip was one of the older children, expected to take responsibility for his younger siblings whilst Lenny was one of the younger children in his sibling group. They both experienced the cumulative trauma of deprivation, neglect, domestic abuse and parental substance misuse. Philip also experienced acute trauma, his brother's scalding and the death of a foster carer. Both boys had difficulty regulating aggression, Lenny's aggression was turned outwards, Philip's aggression, except on rare occasion, was confined within his fantasy world. Their respective presentations elicited different responses from others: Philip evoked caring from adults around him whilst Lenny evoked rejection. Philip was tolerated by other children and had preferred companions, Lenny was avoided by his peers. Their various defences were self-preservative in origin: Philip ensured his basic needs were met; Lenny protected himself from primitive feelings of disintegration as well as the later vulnerability of dependence. However, these defences, whilst ensuring survival, became maladaptive,[64] inhibiting healthy development.

It became evident over the assessment and first year of therapy that Lenny fared better than Philip. Lenny's development was severely delayed but he began to catch up along several developmental lines. Lenny was placed with a carer with whom there was a possibility of getting beyond his developmental arrests. She encouraged independence, if a little too quickly at times. She was well-placed, at this stage, to encourage assertiveness and mastery whilst helping him to regulate aggressive impulses. (There was a question of how much she would tolerate opposition directed towards herself, necessary for Lenny's achievement of object constancy, as discussed further below).

[64] Solnit (1970: 267) has an interesting take on this, considering the aggressive behaviour not so much as maladaptive but as misunderstood. 'In our studies of children who failed to thrive due to understimulation and neglect, provocative poorly controlled behaviour often appears as restitutive survival and socialization phenomena presenting a paradox of bewildering proportions.' Children placed in foster care from maternal deprivation or institutional care exhibited aggressive behaviour. 'This pattern of recovery, namely, aggressive provocative behaviour, was often misperceived as undesirable wildness. What could be regarded as the child "coming alive" as his drives were awakened by affection and a responsive environment was often reacted to by parents and foster parents as unacceptable, undesirable, and rejecting of the adults. What the psychologically educated observer might view as tumultuous desirable unfolding behaviour is usually experienced by parental persons as intolerable.'

Lenny benefited from having a male role model and a female carer who admired and encouraged his physical prowess, confirming his sense of masculinity. Together his carers actively promoted sublimation of his more unruly impulses into physical games and ordinary competition. Philip's difficulties were more entrenched. There were different constitutional factors: physical foetal impairment, microcephalus, and he perhaps had less innate resilience than Lenny. And in addition to cumulative trauma, Philip experienced acute trauma, leading to a retreat from reality. Where Lenny was guarded and intently aware of his environment, Philip functioned as if it did not exist. Philip's carer provided a refuge from the harshness of life but she had great difficulty in helping him to connect to others and leave the safety of her immediate care - and the confines of his fantasy world. She inhibited the separation-individuation process and inadvertently confirmed his fear of his own aggression and his masculinity, reinforcing a psychic retreat from reality. Philip's object relationships remained under-developed, he made little use of the toys in his box and limited use of his therapist, relating everything to his fantasy world. In contrast, in time, Lenny actively engaged in what was on offer, the resources in the therapy room, his therapist, his foster family. Both boys had started out with marked ego-deficits. Philip remained very limited in ego-strength whilst Lenny made significant gains.

Parens' theory of aggression is a good fit with Lenny's presentation. It has proved to be a useful theoretical framework for teasing out the different trends of aggression and shedding light on the anxieties underlying his behaviour, for example, in considering the epigenesis of Lenny's biting as discussed earlier. Parens' model, whilst allowing for the nuances and subtleties of the constitutional factors and different experiences of individual children, is one of normative development. With (considerable) environmental and therapeutic help, Lenny's arrested development had been kick-started and was back on a healthier trajectory. Although he still had a lot of catching up to do he was making progress. By the end of the year Lenny was developing object constancy; his sense of self was more robust; he was less vulnerable to pervasive anxiety; his capacity for symbolic play was developing and although he had not yet managed to make friends he could be friendly and was included in activities with his peers. There were indications of an attachment forming with his foster carer and signs of a capacity for concern for his object. Lenny was internalising a regulatory function. He was less vulnerable to feelings of disintegration and abandonment. His aggressive outbursts had

not disappeared but were less frequent. There was no evidence of a confusion between non-destructive and destructive aggression in Lenny. However, there was sometimes a confusion in the minds of others, who perceived Lenny's actions as intentionally destructive when in fact his aggressive behaviour was often determined by (maladaptive) defences against very primitive anxiety. Shane and Shane (1982: 271) point out that 'nondestructive aggression, while necessary, valuable to mastery of the surroundings, and important to the development of competence and the cohesive self, does quite often provoke counteraggression and restrictions on the part of the environment, which in turn may lead to destructive aggression and ensuing interpersonal, and later, intrapsychic conflict'. Lenny's hostile aggression was re-enforced by his environment.

Philip's presentation did not fit Parens' theory so neatly. In Parens' model, Philip, exposed to considerable amounts of 'unpleasure', would be expected to show (as Lenny did) tendencies towards hostile destructiveness. However, Philip presented as excessively timid. This raises an important question: does Philip's atypical presentation refute Parens' argument or is this a pathological rather than a normative response, the exception that proves the rule? It is my contention, as I have argued, that in Philip's case there was a confusion of non-destructive and hostile aggression in Philip's mind. Philip's aggression in phantasy, the ordinary hostile feelings towards a younger sibling and the murderous oedipal feelings towards his foster father were confirmed as reality when his brother was scalded and his foster father killed. This confusion was utterly debilitating, affecting his course along the developmental pathway from fantasy to reality which was arrested at the stage of omnipotence and magical thinking. Psychic equivalence and pretend modes (Fonagy and Target, 1996) were not integrated, severely impeding progress along other developmental lines. He was still functioning at a stage of part objects; he had not fully achieved object constancy and was holding onto a state of illusion. There was an inadequate emotional environment to help him with the trauma. He was unable to internalise a protective maternal function and he had not achieved a stable sense of self.

So what happens to normative development, where there is not simply developmental arrest but traumatic impairment? Philip was not readily available to ordinary developmental or therapeutic help. Revisiting the trauma, having someone else help

him make sense of his experience through words or play was unbearable not just because of the threat to his fragile sense of self (the fear of ‘black hole’experience, as discussed earlier) but because it was beyond his current functioning. He was in desperate need of some ego-building but his psychic foundations were insubstantial and shaky. Robinson (2007) describes the use of narrative in making sense of the world and the disruptive impact of trauma on this function: 'massive trauma which floods the psyche with too much affect not only disrupts narrative but is an assault on the very capacity for narrative and the ego development that it subsumes'. The result of such trauma can be a 'psychic hole', a gap in the experience of the self. Philip's ego was immature at the time of the trauma, his sense of self and capacity for narrative not yet firmly established. It is possible that it is not the trauma per se but the particular trauma, that is the trauma of witnessing the scalding and of the projected guilt (from his mother) that has proved too much for him at this early stage of development. He has defended against the trauma by covering over the gap in narrative with a Doctor Who substitute in which guilt is not addressed but avoided. The Doctor, subject to a constant onslaught of invading aliens (projections?), feels responsible for rescuing the world but does not feel to be the cause of the ever impending catastrophe. This defence, as discussed earlier, significantly impedes Philip's development of object constancy. Lenny also had difficulty in achieving object constancy and a closer comparison is called for.

Parens traces the phase specific stages of ambivalence as a child moves towards object constancy. He outlines his use of the term ambivalence as 'restricted to the experience of coexisting feelings of love and hate toward an object (Parens, 1979b: 385). In the course of development it is the stabilizing patterning (intrapsychic structuring) of complementing positive and negative emotions in relationships, each making its independent and interactive contribution to the quality of ambivalence.' He proposes that there are two basic conflicts of ambivalence in early development. The first occurs during the pre-oedipal period with gradual emergence and balancing of positive and negative affects toward the libidinal object. The second conflict, at the oedipal stage, is a reworking in a triadic relationship.

An excess of unpleasure, through marked environmental failure, interferes with this process. Unless there is appropriate environmental response at the right time the infant

experiences an escalation of negative affect: irritability gives way to anger, to hostility and then to rage. Parens describes a sequence from around 5-6 months when 'negatively or positively valenced affects' are directed towards the love object. From about 9 months the infant internalizes maternal dictates, influencing the early formation of the superego. The maternal figure needs to withstand the infant's hostility and at a later stage, around 16 months, engage in the 'battle of wills' that results when she sets limits to the infant's assertive exploration of the world. Fear of the loss of the mother's love, and fear of the destructiveness of his aggression, leads to the infant relinquishing his autonomous strivings. At 16 to 24 months the early affective experiences stabilize into differentiated love. At this stage these are stable and stabilising affects, attached to self-object relationships which are internalised.

Where the mother fails in helping to develop a capacity for self-regulation there is a tendency for the child to rely excessively on external objects for self-regulation. Alongside the mitigation of destructive aggression through experiences of love the child also relies on autonomous ego functioning. In the absence of sufficient help, the child relies further on defences of splitting, denial and so on in an attempt to control the object in the interests of psychic survival. When development is reactivated, through a good substitute parent figure and/or through therapeutic intervention, there is renewed anxiety about destructiveness in line with the conflict of ambivalence. This equates with what we know of Lenny. His 'care package' of foster placement, school and therapy, with his foster carer at the centre of it, was good enough in meeting his needs to facilitate new development as described above. 'An environment that is emphatic, facilitating, and optimally frustrating would encourage nondestructive aggression, thereby promoting the development of healthy aggression and assertiveness and, ultimately, a cohesive self or healthy personality' (Shane and Shane, 1982: 271). But what about Philip?

As previously stated Philip cannot tolerate the experience of object-directed destructiveness. We might conjecture that along with the aggression of sibling rivalry there was an element of autonomous exploration, playing with the taps, in the scalding incident. If this were the case, when his mother failed to provide the protection ordinarily associated with the battle of wills, the non-destructive mastery of his environment would be transmuted into destructiveness. Equally, the carer who fails to

rein in and regulate destructive aggression with love (Philip's mother standing in the bathroom doorway) would compound his feelings of destructiveness related to his murderousness towards his bother and the subsequent projected guilt from his mother. A note on this: Philip is capable of autonomous defence at this stage but the problems inherent in his relationship with his mother impede resolving the conflict of ambivalence. He is not yet able to tolerate hatred towards an object except in fantasy.

As already discussed Philip's foster carer unwittingly maintained this state of play by being unavailable as a recipient of his aggression or hatred. Some years on Philip would still anxiously say, 'Don't tell (his foster carer)', if he felt anything he had done – or said – might in some way be aggressive or destructive. It is important to acknowledge here the strengths as well as the shortcomings in Philip's foster placement. His foster carer offered him love and constant, reliable care-giving. She withstood his extreme distress and accepted his oddities. However, she could not tolerate negative affect toward her and this prolonged his defensive traits: splitting of goodies and baddies, denial and so on.

In conclusion: some thoughts on the implications of the research

Lenny's developmental delay was significant and his aggression was excessive. In Philip's case developmental arrest/traumatic impairment was extreme and his defence unusual. Although these two cases are particularly striking, we are well-used to children presenting to CAMHS with problems with aggression and we see degrees of inhibition, of a lesser order, but frequently, in clinical work. In these cases, sometimes presenting with anxiety or depression, there may be a failure to notice the confusion of destructive and non-destructive aggression in the child or young person's mind. Worryingly this may indicate an unmet need. The quiet, passive children who do not draw attention to themselves, precisely because they are excessively timid, unable to assert their wishes in fear of being destructive, are less likely to be referred to CAMHS. Adult services are arguably more likely to see the results of this developmental failure in patients who cannot get on in their lives, inhibited by the negative impact they fear their success may have on others.

So what does Parens' theory, and my fine-tuning of it, bring to current clinical practice?

With reference to the Diagnostic Profile, Green (1995: 16) outlines the task of the diagnostician of drawing together the information about a child's experience of his internal world, the child's level of functioning and developmental achievements or otherwise. She reminds us 'that development (belied by the simplicity of the term) is an aggregate and synthesis of many strands'. The development of aggression is one of those 'strands'. In the same paper Green (whilst acknowledging the differences in theoretical approaches) draws attention to the findings of Attachment theorists in expanding our knowledge of development. Continuing research in Attachment Theory, and more recently in neuroscience, is adding valuable information to our understanding of risk and resilience. Parens offers another complementary metapsychological view of one particular 'strand', giving the clinician a way of conceptualising a particular child's response to internal and external factors in his physical and emotional environment. In his paper 'Toward a reformulation of the psychoanalytic theory of aggression', Parens writes that 'the search for better models of the mind or of human behaviour is exhilarating but it is also confusing ...neither mind nor behaviour will be explained well enough by a single model...in fact multiple models are needed to enlarge our understanding of mind and behaviour, and...we need bridges in order to move from one to another' (1989b: 83). Parens is not widely read, his theoretical writing is complex. However, he is concerned himself to find common ground with other researchers and to translate his findings into language accessible to parents and a range of professionals working with children.

Parens' spectrum of aggression offers another tool in discerning and describing the precise nature of a child's aggression, the nuances and subtleties of the underlying anxiety, and in turn informs the therapeutic intervention. Being aware of the nuances assists the therapist in supporting carers and teachers to help with regulation of affect rather than respond with harsh punishment or rejection. It is much easier in a therapeutic setting to tolerate aggressive outbursts and to carry on thinking about what is happening and how to respond most helpfully, without the constraints of protecting other children, pets or property from the onslaught. However, helping carers and teachers to recognise that the child's aggression is self-preservative rather than hostile in origin should help to promote understanding and tolerance of the child. For example, understanding that jostling in the corridor might awaken very primitive anxieties in Lenny and pose a threat to him, leading to attacks on other children, should help staff be more alert to his

anxiety and to pre-empt those situations. At those times when he does become aggressive their response to him would hopefully be tempered by addressing implicitly or explicitly his fear and upset whilst continuing to help him manage the demands of school and communal living. In hindsight, Jimmy, the child who first brought Parens to my notice, and his parents would have benefited from my understanding this side of the research, of the non-hostile nature of his gleeful destructiveness.

A recent example of Parens' distinctions between hostile and non-hostile destructive aggressions being clinically useful is of a two and a half year old who was referred with a request for advice to his foster carer. This small child was very destructive. In discussion his foster carer found it very helpful to think about the likely impact of his disrupted early months: time with his parents, time with his grandmother, time with his mother in a refuge before coming into care and then a change of foster placement at eighteen months. In response to his aggression the social worker had organised nursery provision, hopeful that this would give him opportunities to learn how to relate and play. His challenging behaviour continued to threaten the placement and the nursery hours were increased to give the carer more respite. In an assessment session in the therapy room this little boy's observant carer was astounded at his capacity to explore the room, tolerate frustration (when he couldn't get into the filing cabinets), his fear of the spiders he thought might be inside and so on. She was surprised when he fell off a piece of soft play and sought her comfort. We talked a little about the threats to his sense of well-being that he must have faced; where he was developmentally; his capacity to relate to others; what the nature of his attachments might be; his need for boundaries, a 'holding' environment and containment and his capacity to respond to help. And we also talked about the nature of his wild destructiveness and very low tolerance of frustration, what might be self-preservative, whether it was directed at anybody or more like 'spilling out' or expulsion of uncomfortable 'too-muchness'; whether there was a destructive intent or whether the activity was exploratory. It is early days but his carer left feeling that she needed to spend more, not less time with him – for both their sakes.

My proposition of a confusion of non-destructive with destructive aggression is a further refinement of Parens' hypothesis, a concept that I have found surprisingly helpful to bear in mind not only with such a traumatised child as Philip but with a number of cases. Recognising when there is a confusion between non-destructive and

destructive aggression should help with determining what intervention or support would be most helpful. Philip needed help in relation to his impairment with respect to object constancy. It proved very difficult to make significant change. However, other less traumatised children are more available to therapeutic help. Children presenting with problems in asserting themselves are often seen as having a lack of confidence or self-esteem and fearing failure. However, if the presentation stems from a confusion of ordinary assertiveness with destructive aggression the fear might be of succeeding – and so damaging the object/mother – the emphasis of what is taken up in the treatment might then shift. Being aware of this confusion as a possibility would allow the therapist to better understand the implications of the transference countertransfernece phenomena in appropriate cases. A child's compliance might not primarily be a need to appease a dangerous object, it might be a fear of being dangerous and potentially damaging the object.

Although the confusion might be generated at any point of development I have focussed on the stages of ambivalence and object constancy. From the study of the two cases of this research it would seem that the 'practising subphase', in which there is an upsurge of assertiveness, is a stage in development where such a confusion is particularly likely to occur. Further research might explore, for example, whether difficulty at this stage determines the degree and intractability of ensuing confusion between hostile and non-hostile aggression and consequent adverse impact on future development through into adult life.

The usefulness of the concept of this confusion has a wide application. As with many concepts (Winnicott's transitional object or Bion's notion of containment for example) it is not necessary to be completely conversant with all the theoretical underpinnings to make clinical use of the idea. It is a useful concept regardless of the clinician's orientation. And because it makes common sense it easily translates into 'lay' language. Since embarking on the research I have become increasingly aware of instances illustrating how a confusion between non-hostile and hostile aggression might occur, such as in a recent student observation of a toddler. The student described how the small child's zealous exploration was met by his mother's admonishment, her disappointment - and her implicit message that he is damaging when she told him, 'Mummy is really

hurt when you do that'. When colleagues, both working with children and with adults, have asked about the research there are invariably patients who come to mind. It seems obvious. It is this recognition that is affirmation of the research: what has been elaborated is something we have known already.

Finally, an unexpected possible application of this research is in the process of matching children with foster carers. Consideration of the attachment history of potential adopters (Steele et al: 2001; Steele: 2006) is not a new idea. Neither is a capacity to reflect on the drivers of a child's feelings and behaviours (Wassell, 2008). There is an extensive literature, on the desirability of foster carers having a capacity and willingness for self-reflection (see for example: Schofield, 2005; Howe, 2006; Graham Granger, 2008; Steele and Steele, 2008; Walker, 2008). However, a more detailed and in depth understanding of a child's internal world should help further in fine-tuning the decision making, informing placement panels in matching the child with a carer whose parenting style will provide the appropriate 'scaffolding'. It should also help social services to anticipate times that may be more challenging. A carer may be able to meet a child's needs at one developmental stage and need more or different support at another (as do parents). Both Philip and Lenny were fortunate in being matched with their respective carers but both boys would have benefited from their carers addressing their own aggression. Assessing a potential foster carer's willingness to address their own defences and perhaps to change is another question.

Postscript

Lenny continued in therapy for another two and a half years. Although he continued to have difficulty with impulse control at times of stress, he made great progress, becoming a winning, sociable little boy, making friends, remaining (with support) in mainstream and continuing to live with his foster family. Therapy was brought to a close (with a planned but premature ending in my view) as his carers, pleased by his developmental gains, were unwilling to continue to bring him. Lenny continues to see the team psychiatrist to review medication. Lenny's brother became too oppositional and had to leave the placement at eleven. We anticipate adolescence may be a tricky time for Lenny and his foster carer. The upsurge of aggression/assertiveness at this developmental stage and the renewed conflict between the push towards independence

and the pull back towards dependence is often characterised by regression. (Akhtar, 1996: 136) This is likely to be particularly challenging for them both.

Philip continues to come to weekly sessions. He has made slow progress. Philip moved from his pre-occupation with Dr Who to other fantasy scenarios, often requiring me to be his mother. He has since returned to the Dr Who scenario. However, he also talks about a future, sharing a flat with friends, going to college. He has a group of friends at school who join in with his Dr Who games, taking various roles. Philip is Dr Philip. He sometimes has one foot more firmly in reality. On some occasions he is Philip in sessions. Very recently he has begun to talk about not fitting in, expressing an ordinary and realistic worry. His friends are beginning to grow out of role-playing. Philip is in a dilemma – does he dare to grow up with them?

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Appendix A

Lenny	
Session 14 First session after Christmas break and Florida holiday Lenny was pleased to see me, the room with his box of toys and pleased with the new play-doh but wanted dinosaurs	Pleasure, recognition, still needing something else
Lenny played at breaking the play-doh blocks into two and squishing the two halves into one	coupling
He demanded I put the glove puppets on and played a game turning the pile of play-doh into a monster, then a ball, approaching the puppets with pleasure and excitement that became aggressive and attacking	Capacity for play, symbolizing excitement (sexual?) → aggression
He began spitting raspberries in my face, I commented that Lenny had spitty feelings but it wasn't very nice to blow raspberries right in someone's face.	Getting rid of uncomfortable feelings/ including affection? Directing it at me
Lenny went to his box and starting throwing all his cars out across the room and then threw the fences.	My comment is provoking Still needing to discharge but re-directing excess excitable feelings away from me
Lenny built a wall of softplay and toy box between himself and me	Separating himself from object – for whose safety? Fears retaliation? Fears own aggression?
He lined the cars up and made a fence around them using softplay and his box lid to fill in the gaps	Attempting to contain/building strong defences

He made lots of aggressive engine noises with the cars almost bumping into the edges	Managing to stay in control – almost but not quite crashing into sides
The black car smashed all the others one by one in controlled fashion	Destroying in more measured way, not subject to same need to expel uncomfortable feelings
Lenny was cross about the end of the session, he didn't want to finish	
Lenny sang to himself and made lots of funny little noises	self-comfort?
He shouted 'Shut up' a lot at me, called me 'sexy' and ‘Punkyhead’ and 'sexy Punkyhead' in a deep guttural voice. He uses this voice a lot.	Verbalising aggression and directing towards me Sexuality and aggression linked
He insisted on putting everything away himself.	Must tidy away, keep everything together Independent

Philip	
Session 24	
Started (as always recently) with anxiety about Robotti's leg not being properly bent – he asked me to fix it.	Anxiety about things being intact - body/penis?
Philip said he was tired and hadn't wanted to get out of bed.	Unusual - an observation or a communication - does he want me to know?
He was worried about a bear (cub) that had hurt its paw, he was only a baby and Philip hadn't known how he'd done it. There were scratches on backs of (its) hands and around (its) mouth. It had happened yesterday but he didn't know how.	Concern for baby/vulnerable parts (of himself?) Guilty worry re James' injuries?
Then straight into Charlotte's Web. We made a web for Charlotte, two more legs because she only had six, and towards the end of the session we made baby spiders for Charlotte.	Concern re intact-ness. Interest in babies
Philip was curious about life after death. Why did Charlotte have to die? Did Charlotte die for Wilbur? Were all Charlotte's babies girls? Etc.	Curious about life and death and sacrifice. Curious about gender.
Philip took one 'baby' to Charlotte (hanging it from a pipecleaner over the 'web') shouting, 'Mummy, Mummy, look, I've been born!'	Birth, desire to be recognised?
He looked for words on the internet (paper laptop) to put into the web to save Wilbur – nonsense words – or significance lost on me? e.g. 'gast'.	Desperate need to rescue.
He was easily humiliated e.g. when he couldn't get the laptop to 'kneel'; couldn't draw a web; couldn't fit the 'trapdoor' into the stairwell in the dolls' house.	Easily feels small and impotent.
Near the end of the session he stood on two pieces of softplay and invited me to, 'Look at me Katie'. He got off almost immediately, anxious that he might fall and hurt himself.	Desire to be seen. Exhibitionism quickly disappears with fear of falling/failing.
He was aware of the Easter break and talking about when he comes back.	Registering a gap.

Sample session to session coding

Main themes from each session were drawn out to facilitate 'sequential comparison' and track emerging similarities and differences (Charmaz, 2006: 54).

Lenny	
Session 23	
Lenny is pleased with himself – he has sweets. Wants elephant and Monkey to see	Look what I've got!
Oral aggression: roaring, biting, eats monkey up	Oral aggression
Verbal attacks on me. Also cautious affection (rolling playdoh across my back)	Verbal aggression Beginnings of affection/ Reparation?
He gets something in his eye – lets me help him	Accepts help
Enjoys getting playdoh over hands and being a 'blue boy'	Importance of being male
Request for seat belts for monkey and elephant	Concern? Reparation?
Session 24	
Excitable jumping and kicking	Expulsive aggression
Anal aggression mainly directed at monkey and elephant	Anal aggression
Excitable, needing boundaries, responded to help in throwing softplay more gently or divert target from me to chair	Helped by another to moderate impulses
Very aggressive kicking converted, with help, into game of catch	
Excited by water being knocked over – wants to jump from table – negotiates using my hand	Environment stimulates aggression/projection out of 'too-muchness'
Ran out of building when foster carer not in waiting room – became very aggressive – 'Get away from me'	Anxiety provoking extreme aggression; capacity to use another to contain feelings disappears

Appendix B

Session			
Ass 1	Doctor Who		Sharkboy
Ass 2	Doctor Who	Shoebox Zoo	
Ass 3	Doctor Who		
Session 1	Doctor Who		
Session 2	Doctor Who		
Session 3	Doctor Who		
Session 4	Doctor Who		
Session 5	Doctor Who		
Session 6	Doctor Who	Chicken Little	
Session 7	Chicken Little	Doctor Who	
Session 8	Chicken Little		
Session 9	Chicken Little	Doctor Who	
Session 10	Doctor Who	Sharkboy and Lavagirl	
Session 11	Winnie the Pooh		
Session 12	Doctor Who	Harry Potter	
Session 13	Winnie the Pooh		
Session 14	Happy Feet		
Session 15	Doctor Who		
Session 16	Star wars		
Session 17	Scooby Do	Doctor Who	
Session 18	Robotti	Doctor Who	

Session 19	Doctor Who	Robotti	
Session 20	Robotti	Doctor Who	
Session 21	Doctor Who		
Session 22	Robotti	Doctor Who	
Session 23	Robotti	Charlotte's Web	
Session 24	Robotti	A bear cub	Charlotte's Web
Session 25	Charlotte's Web	Doctor Who	
Session 26	Doctor Who		
Session 27	Doctor Who		
Session 28	Doctor Who		
Session 29	Doctor Who		
Session 30	Doctor Who	Charlotte's Web	
Session 31	Doctor Who		
Session 32	Doctor Who		
Session 33	Doctor Who		
Session 34	Doctor Who		
Session 35	Doctor Who		
Session 36	Doctor Who		

Appendix C

Clinical material: Philip's fear of extermination: the Daleks and the Doctor

Note: verbatim extracts from extemporaneous notes (i.e. process notes recorded immediately or shortly after the session) are in italics. Paraphrase of intervening sessions, notes on meetings and commentary are in non-italics. Some footnotes also appear in the main text.

August to Christmas

Session 1

In Philip's first session, a month after the assessment, he was again very involved with the Dr Who world. He repeatedly came back to the fact that his friend Robert was on holiday. Robert is one of the two boys from school whom Philip identifies as his friends. Philip was sure Robert's little sister had taken his white Dalek from Playscheme (a leisure activity programme organised during the school holidays for children and young people with special needs). Philip was very agitated by this perceived 'theft'.

It was very difficult to get any clear narrative or discern what was real and what was imagined.
In his fantasy '44', (a Dalek ?) might have gone to another planet. Philip/the Doctor was trying to track him down. He remembered black holes, everything being sucked in, his family being sucked in.

I asked Philip to help me make a picture of his family. I began to make a family tree. Philip's sense of who is who and who is older than who is very shaky. We agreed it was very difficult to think about. Philip struggled to remember the name of his second but youngest sister.

At the end of this first session Philip's foster carer let me know that Philip had become very upset the previous day when her (grown up) daughter had attempted to put cream on Philip's eczema. Philip had protested and resisted as if she were attacking him.

The confusion between fantasy and reality is there from the beginning, as it had been in

the assessment. There is evidence of Philip's paranoia: Philip is convinced Robert's little sister has taken the Dalek – she later becomes a figure of great suspicion whom Philip generally refers to with the epithet 'evil'; he experiences his foster carer's daughter as attacking him. It is interesting, in the context of Philip's difficulty establishing and holding a boundary between the internal world of fantasy and the external world, that it is another's contact with his skin that upsets him and he experiences as intrusive.[65] Is this a talionic punishment? He has scalded his brother and is now being attacked in retribution? My impulse was to help him begin to think about his family, to 'draw' them together and make something cohesive in the face of Philip's insecure sense of himself in his family. My desire to help him feel more 'grounded' might be thought about as an 'anti-blackhole' force. (I have often thought about the solidity, both physical and temperamental, of Philip's foster carer as providing a kind of emotional 'anchor' for him.)

In my notes of Philip's second session I observed:

Philip was the Doctor today. He was irritated if I addressed him as Philip, telling me it made him confused.
He decided to paint but seemed to have little idea about how to use the paints effectively and quickly gave up the idea. He threw away various pictures from his file and also the box he had asked me to make in the previous session. He retrieved the box from the bin to make a 'remote controlled' K9.
It seemed Philip wanted me to know what he wanted me to make without telling me and again he was irritated when I pointed out that I didn't know without some explanation or instruction from him.
Philip talked a lot about James, his brother, saying, 'He's in trouble....Dalek s have got into his head'. Philip was very anxious about these attacks on James telling me only he, the Doctor, could save him. He made frequent references to James having been scalded. Philip/the Doctor told me that Philip had been present and had been scalded too. I wondered if Philip could tell me any more about this (I wondered to myself if he was he referring to a physical or emotional 'scalding'?) but he didn't want to explore this any further.
He told me that the teachers were worried about his interest in Dr Who, but he wasn't

[65] Esther Bick (1968)

worried, he didn't want to stop thinking about Dr Who.

There is another indication of a problem with self-other boundaries: the Dalek s have got into James' head – or have they got into Philip's?

The third session was a fortnight later. Philip's carer had forgotten that I was going to be away and had brought him for a session to find that I was not in the clinic.

Philip was very anxious about where K9 had gone to. (His anxiety was such that I found myself wondering whether I had mislaid it – it was in his box where we had put it at the end of his last session.) I raised the muddle over the missed session and Philip told me that he had come and I wasn't here, I had gone on a course. I acknowledged how confusing it was when people disappeared and things weren't reliable.
Philip spent most of the session being the Doctor. He was making X's father (I couldn't decipher the name), another Dalek. There was a very real sense that when the last piece was put in place the Dalek would be 'activated' and exterminate anyone nearby.
Philip made a very long 'nose' (his word) for the Dalek's sensor/weapon.
Later he told me that, 'Philip hadn't made it, he'd been exterminated'. And later again, that Philip's father had survived. He explained that the Dalek's father was different from other fathers.
There were moments of contact – Philip used my name to ask me to help with the model making.
He volunteered that James was 'not himself' yesterday and had pushed Philip, he (James) had become 'a Dalek brain' and would never be normal again.
Philip was casting me as 'the baddie', a role I challenged.
He laughed spontaneously when I asked him where to stick K9's head, he said, 'the top'. I said that sounded more sensible than the bottom. (I felt relieved both by the sense of his answer and by his capacity to laugh at absurdity.)
He was very affectionate to the cardboard tube that was already K9 in his mind, making a bed and directing me to feed him in the week.
Philip turned a 'control switch' into a wand (Harry Potter). He wanted to show his foster carer but managed to leave it in the room.

The session started with a boundary, the box in the locked cupboard containing amongst

other things K9, threatening to disappear. On reflection my relief at the shared joke was probably also connected to the shared acknowledgement that it was a model – a more real, less fantasy-driven moment. Generally, however, I felt to be something of a mannequin, a puppet required only to look the part (in Philip's imagination), he could do the rest. I could be related to as 'a helpmate' in terms of making models for him but he was far from accepting that I might have a separate mind: he *wanted me to know what he wanted me to make without telling me and again he was irritated when I pointed out that I didn't know without some explanation or instruction from him.* As if there should be no need to communicate, as if we were of the same mind, no boundary distinguishing one from the other.

In the next two sessions (fourth and fifth), in which Philip/the Doctor behaved as if there had been no time lapse, we encountered ambivalent parent figures: monster/fathers with strong attachments to their sons; alien-bats who turned out to be the Doctor's parents, threatening to eat him but then protecting him from Cybermen. The Cybermen were later converted into 'goodies'. Philip told me about X10[66], a Dalek who was a killer like his Dalek father, 'It's in his blood'. Philip/the Doctor expressed concern about his own/the Doctor's parents, who were no longer alien-bats. Philip told me he/the Doctor had gone to visit them - he didn't play out the visit. (There is evidence here of Philip's anxiety about inheriting parents' characteristics : identifying with a killer-Dalek father would be a very dangerous thing, especially given his difficulties with maintaining self-other boundaries, he could become not just like but actually his father.) He made references to a parallel world and Rose Tyler (me?) helping him. (I wondered if I were in a parallel world, alongside but not with him, but any such suggestions to Philip were ignored as if he hadn't heard them/they hadn't been uttered.) Towards the end of the fifth session Philip asked me to make a werewolf and a cage, a reference to a recent episode of Doctor Who. He told me that I was the werewolf. However, that was a bit too scary:

Session 6

Philip started the session as the Doctor. He told me we wouldn't have the werewolf today, he might eat people. Philip talked about D10's father, still a very ambivalent figure. He was one of Davros' Dalek s and therefore bad, but Philip wasn't sure if this

[66] X10 and D10 seemed to be interchangeable. Philip had one model which he sometimes called X10, sometimes D10. I was unsure if it was one model representing two Dalek s at different times or one model/Dalek whom Philip hadn't a fixed name for.

was true. He wanted to make a Dalek and managed to compromise on the smaller than he wished for Dalek that I was able to make for him.

Philip then became Fish-Out-of-Water,[67]*, a character from 'Chicken Little', a Disney cartoon. He vocalised in a regressed, unintelligible burble for the large part of the rest of the session. Philip wanted me to be Chicken Little's mum. I was to be busy working at household tasks and Philip repeatedly instructed me to urge Fish-Out-of-Water to be patient. Philip/Fish asked me to make a TV with Spongebob*[68] *on the screen. (The TV was a piece of card with a screen drawn on it and a sketched 'Spongebob', propped up against a piece of softplay.)*

Philip/Fish then embarked on a game within a game, playing at Cybermen with the imagined Chicken Little. Philip became anxious about the Cyberman, saying it was coming back to life and
I had brought him back to life. (I was unsure whether I was then his therapist or Chicken Little's/his surrogate mother). Philip made prisons/coffins for the Cybermen.

At the point when Philip is talking about Davros (is he Davros?) he flips to a likeable, very small, vulnerable but fearless, character, who can't even speak properly let alone harm anyone. Philip's defence, his regressive retreat, doesn't hold. In his mind I quickly become someone with fearful powers/malintent who can summon the Cybermen back to life. He has to kill them off again, put them in coffins. In the Chicken Little film aliens looking for their lost child[69] are at first presumed to be hostile. Perhaps this reflects Philip's experience of his sometimes benign, sometimes absent or violent parents. He is then deeply unsure about his therapist-parent in transference.

In the seventh session Philip continued to be Fish-Out-of-Water, speaking in the indecipherable burble that I was supposed to intuit, like a mother a baby, or ask Philip to interpret for me. Philip was able to move between being Fish and being Philip translating for Fish. This was a frantic session with Philip/Fish asking me/Chicken

[67] *Chicken Little* 2005, Disney. The plot is based very loosely around the traditional tale of the sky falling on the Chicken Licken's head. Fish-Out-of-Water is a goldfish who wears a scuba helmet filled with water and lives on the surface. He is one of Chicken Little's misfit friends. Fish is unable to talk properly, communicating more through his actions

[68] *Spongebob Squarepants* is an American animation for television, the title character is a childlike enthusiastic and energetic character

[69] The alien parents are looking for a small orange creature – associated for Philip with his scalded brother? It is interesting that Philip does not mention this aspect of the story at all.

Little's mother to make various and varied articles: a chess board and chessmen, a laptop computer, a bag of chocolates. He asked me to write 'chess' on the back of the family tree we had made during an earlier session saying he didn't want it any more. 'Fish' felt like a very small, pre-speech, pre-ambulant child. Towards the end of the session Philip became the Doctor, making a control for the Dalek.

It was often very difficult to tell whether Philip was telling me about something real or something imagined. Further complicated in the following session when he talked about a dream. I was unsure whether Philip was referring to an actual dream that he had had in which he was Fish or whether Philip was being Fish telling me about an imaginary dream. Philip seemed to switch from one character to another, as he did from one activity/fantasy to another:

Session 8

On the way to the therapy room Philip told me that he'd had a dream about Chicken Little. He began to be Fish en route and it was difficult to get him to tell me about the dream. He said he was Fish (in the dream) and the sky fell on Chicken Little's head. Chicken Little had to go to hospital but he wasn't dead. Philip told me that he, Philip, wasn't dead in the dream either.

Philip was Fish. It was like having a small toddler in the room, requiring me to be a firm but kindly parental figure. (He would instruct me to chide him, bid him be patient etc. whilst he flipped about the room on his knees).

Philip was very resistant to my enquiries about Fish and his fish family.

There was frantic making – Philip demanding, 'Make a TV', 'Make CDs', 'Write on the back' etc. He wanted me to know his mind without having to explain.

Dalek s were incorporated into the activity -X10 was looking for his father/his father was dead. X10 wasn't dangerous/ powerful. Philip decided he didn't like the alien bat – it was human/it was a killer. He threw one bat in the bin and kept the other.

There is evidence again of Philip's desire for a need-fulfilling mother who will know instinctively what it is that is needed and provide just that. In his resistance to thinking

about Fish's background there were echoes of his consistent resistance to any thoughts of his own birth family. And there are the dangerous threatening creatures that get in all the time and have to be got rid of.

In the following session I was more aware of his developmental stage and his need for an 'auxiliary ego', for example by encouraging Philip to sort out the many pieces of paper and models we had made. I was conscious of the muddle, internal and external and an ordinary parental response to help sort out one thing from another including, in my mind, a move eventually to distinguishing between fantasy and reality.

Session 9

The foster carer's older daughter brought Philip. He was Fish. Philip/Fish was very demanding and cross about any limitations. There was a practical problem of storage and I told Philip we would have to fold the helmet we were making (for Fish) when we put it away.

Philip was very resistant to any alteration to his script, telling me, as usual, exactly what I had to say, how and when I said it. He did manage when I insisted on sitting instead of standing as the teacher in Chicken Little.

Philip became the Doctor in a vampire story line.

He managed, on my insistence, to sort out his file and the Dr Who and Chicken Little models so that I could fit them into his space in the cupboard. He talked about being glad that he'd got rid of the vampire bat that was so scary. We talked a bit about Dr Who getting too real and then it becoming too scary.

I was aware of Philip feeling slightly older today, like perhaps a three or four year old.

In tidying up Philip made it clear he didn't want to look at his family tree. I wondered if it wouldn't worry him so if his foster carer and family were on there too. He agreed.

At some point I used the word 'impatient' (I was often required to insist Fish 'be patient'). Philip was upset, hearing it as a criticism but he was able to listen and make a

distinction between criticism and observation.

I was surprised by his reaction, his readiness to hear me as critical and condemning, a projection of his own feelings of guilt. He was able, however, to understand that my tone had been different from the one he had imagined I had used. His continued ambivalence about me is clear in the next session:

Session 10
Philip was the Doctor, then Sharkboy and then Lava Girl. He threw away the scary things, the werewolf and the coffin, talking to himself about them being too scary.

Philip cast me as the cat-nurse[70] *who had chained D10 up. Philip said D10 was a good Dalek, he only exterminated if he was made angry, he couldn't help it, it was in his nature. Philip/the Doctor freed D10 from his chains whilst D10 exterminated me/the cat-nurse. Philip/the Doctor planned to take D10 back to his parents, he phoned D10's mother, because, he said, that was where he belonged.*

We made some paper cookies and Philip reminded me that they weren't real.

The Lava Girl plot was complicated and involved Philip/Lava Girl living on her own in a volcano in conflict with a Mr (indecipherable name) who was trying to take over the world.

Philip flipped between characters. There was evidence of his anxiety about aggression being genetically inherited, a concern about re-unification with parents, isolation and the threat of a tyrannical megalomaniac. But in the middle of all this there is some ordinary (pre-school type) play: making pretend cookies.

Philip continued to present like a young, but less troubled child in the following session. There were no references to Doctor Who. He was interested in Heffalumps and the Hundred Acre Wood.[71] He asked me to make a storybook about 'Lumpy'. He was

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[70] 'The Sisters of Plenitude', the cat-nurses are very ambivalent figures, it is unclear whether they are carers or gaolers.

[71] *Winnie the Pooh,* A.A. Milne (1926), Disney (1966)

demanding, make this, do that, tidy up and so on. He became anxious about painting a tissue box red and wanted me to do it for him. There was another rare moment when Philip was able to make contact with me outside the role he was playing this time as a peremptory infant. I noted *'a lovely moment when Philip laughed with me at how many things he was asking me to do.'* The respite did not last long.

Session 12

Philip was brought to his session by his foster carer's grown-up daughter.

Philip was more open and asked questions: why and how did the Cybermen take over our brains? Why did the Doctor kill the people?

There was a warmth towards me. Philip talked about what he could take with him when he finally left.

He began making a paper gun, became very anxious and stopped himself, 'Guns are bad!' He became perturbed by the locked cupboard (in which I keep his box etc.). He decided the werewolf was in there and then said anxiously that he hadn't meant to say that, it was 'an accident'.

Philip talked about Harry Potter, giving a very lucid account of Harry looking across the lake and thinking that the stag-imago was his father but was in fact Harry himself.

Philip got some red paint on his hands from the top of a box he had painted and became very anxious, throwing the box away. He seemed to understand when I suggested we might find out some day what made him so worried. He comforted himself, getting the paper TV and lying on the floor to 'watch' it.

Philip talked about 'Open Season,'[72] *a film I didn't recognise. He told me the bear kept pelting him with acorns. He seemed to like the idea that he might experience my thoughts/suggestions when I tried to get his attention as like irritating acorns. Later he asked me what I did when people threw acorns at me.*

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[72] *Open Season*, 2006. Computer-animation. The story centres around woodland creatures that are traditionally hunted teaming up against the hunters.

Philip's anxiety about aggression, his fear of his own aggression (the werewolf, for example) coming back at him, was very evident. Even mentioning it becomes dangerous, 'it was an accident' when he remembered the werewolf in the cupboard. (I felt the words had surprised Philip too rather than he had consciously suppressed them.) The Harry Potter allusion is very complicated, and as Philip wouldn't talk about it beyond giving me the account it is difficult to know what the significance was for him. Does he have some sense that the creations of his mind are aspects of himself? In the book Harry can see himself because he has travelled back in time. I had talked to Philip about his wish to be a Time Lord and go back and alter his past. Did he remember this? Everything was very muddled. It may be that there is an association of the gun with the hunters in Open Season, although Philip's account of the bear and the acorns was a much more manageable form of aggression, the acorns were annoying but not life threatening (as Chicken Little's mother reminds Chicken Little in the story: it's an acorn, not the sky). And he asked me how do I respond if people throw acorns at me. The question comes from the fantasy, asked seriously, as if someone throwing acorns might in reality be a problem, but the fact that he asked me a question about myself is significant, as are his questions earlier on about Cybermen. There is a recognition that I might know something that he doesn't and an implication that he perceives me at that point as separate.

Session 14

Philip played out 'Happy Feet', [73] *another animation. He became Mumble, a penguin in the South Pole. Philip's story line changed over the session but there was a consistent element – a seal was attacking the penguins and cracked the ice. Philip had asked me to draw Mumble on the ice. He drew and then repeatedly pointed out the deepening crack caused by the seal. Philip repeatedly made the noise of the ice cracking and held my gaze for a little while when I talked about how frightened Mumble must have been. Philip said his/Mumble's father knew why it had happened. At first Mumble was on his own in the picture. Philip told me his parents had died, then that they were in hospital. Then Philip asked me to draw them beside him.*

[73] *Happy Feet*, 2006, Warner Brothers. Mumble is a misfit penguin who has no 'Heartsong', necessary for finding true love. He does however have a talent for tap-dancing. In the film Mumble has an accepting mother and a father who is aware of his penguin son's deficits.

Philip careered around the room being Mumble, some exuberant energy directed at the softplay. Philip was very demanding, reminding me of a chick, a fledgling wanting to be fed, one, like penguins, that can't fly yet.

There was the frequent pattern of comforting himself with (paper) TV or computer screens.

Philip told me he didn't ever want his sessions to come to an end. I talked to Philip about the Christmas break in two weeks. He seemed to need re-assurance that I would be here after Christmas.

His anxiety about whether I would be there after Christmas was unsurprising in the context of past figures parents, siblings, foster carers 'disappearing'.

Session 15

Philip was very excitable, moving frenetically from one project e.g. making a Christmas tree, to another – making X10 smaller than Davros, making a remote control for K9 etc.

Philip reminded me of a tornado. We talked about the London tornado, on the news that week. Philip asked me to draw a tornado. I told Philip about a boy who'd told me he felt as though he had been in a tornado when something had happened to his family and he found he had to live somewhere else. Philip asked questions about this boy, whether he had seen his parents, whether his father was dead. Philip then declared himself bored.

Later he scribbled out my tornado drawing saying it was frightening.

Philip was anxious about the damage caused, wanting to know if the trees had grown back etc. He asked me to stop talking about tornadoes, it made his head hurt. He told me he'd been off school yesterday, he'd been 'burning up'. That happens sometimes when he's 'really angry'. Philip didn't want to elaborate on this.

He abandoned the Davros figure and used the green Dalek buttons as decorations for his Christmas tree.

Philip tolerates my thinking and talking a little more before declaring himself bored. I was unsure whether he was really bored, which might indicate a rather more mature defence, or whether he was repeating a phrase that stood in for 'I am going to ignore you'. His conversion of the dangerous Davros elements into Christmas tree decorations was more primitive. (And perhaps had significance for him when he was invited to take a decoration from the tree in the waiting room in the following session.)

Philip had had contact with his mother the day before his last session before the Christmas break. His carer reported that Philip had been 'worried' (his word) and pleased by the visit and the presents from his mother. She had given him an R2D2 toy from Star Wars and something related to The Fantastic Four. (Philip's carer was aware that Philip didn't know about/wasn't interested in these characters.)

Session 16

Philip was perturbed that I couldn't construct R2D2 for him. He wanted me to tell him about the good people from Star Wars, not the Dark Side. He was somewhat pre-occupied and more secretive, muttering to himself, about the 'Dark Side' which in some way was associated with a (female) peer in school.

Philip moved from one thing to another, discarded things, cut things up. He threw some card at me.

If I spoke he repeatedly said, 'I don't want to know'.

The session ended with Philip giving me a gift in the waiting room and Philip having a chocolate decoration from the tree at the receptionist's invitation.

This mirrored the exchange of gifts between Philip and his mother the day before. Philip was angry and upset about the break. Like his mother I had been unable to get things right, I hadn't known or been able to provide what Philip wanted. However, there was still a polite exchange of good wishes.

<u>January to Easter</u>

Philip was very excited on his return from the two week Christmas break. He threw away a Dalek model and a picture of a Dalek declaring he wasn't scared of Dalek s any more but his bravado was short-lived - he also threw away the pipe cleaners from his box because, 'They might hurt me'.

Around this time Philip's foster carer learned that his older sister's adoption had broken down and she was back in the care system. There was a possibility that she would come back to her home city. The foster carer was anxious that Philip might have renewed contact with her. Pre-adoption contacts had, in her view, caused him to regress into a carer role in which he would feel responsible for and distressed by younger children and small babies. Philip was not told about the failed adoption but he became upset about the whereabouts of his father, asking anxious questions about where he was. He was told that his father loved him but nobody knew where he was. I was aware of how much Philip had to depend on adults to filter facts, to bring him to his therapy sessions and so on and how, although the intention was to protect him, that might feed a sense of helplessness - and omnipotence in defence.

In the second session after Christmas Philip instructed me to make a baby robot:

Session 18

Philip talked about a small robot from the moment he saw me. We made 'Robotti' (looks like a spider) – a baby robot that was very powerful. There was anxiety about things/creatures becoming 'bad' – Philip reassured himself Robotti wouldn't become bad. He made a bed for Robotti which eventually became a door into a spaceship.

Philip had Robotti kill X10, who had become bad, and then he physically dismantled the X10 model, salvaging some parts to make another Dalek and throwing away the main body.

Philip appeared to be less anxious and the fantasy to have a less strong hold on him.

It is interesting that when Philip is being constructive and caring the power of the fantasy appears to diminish somewhat whereas paranoia and destruction appear to strengthen it.

A meeting with Philip's carer a few days after this session and a care team meeting a couple of weeks later produced some useful material. Philip's carer told me a little of her own history, her own violent father and her fear of her own aggression which she has learned to manage. She reported that Philip was more settled but that on occasion when he had become agitated he had held his fists up. This worried her. Philip was playing football and doing a short judo course. The picture at school was similar: in general Philip had been much more settled but there had been occasions when Philip became upset and volatile. He had been aggressive towards his brother James and had asked about his father, saying that he missed him. He had also asked his social worker to ask his mother to phone his father. His teachers had noted that their 'staying very grounded' seemed to help and that Philip was able to be momentarily in touch with the real world in the middle of being very upset and seemingly out of control. At contact with his mother Philip had been asking about what had happened when he was little. He referred to his brother being scalded and his father throwing chairs. School, at this time, began preparing in earnest for Philip's move into the secondary system.

Philip's concern with ambivalent father figures, who present themselves as good but turn out to be bad, continued. Mother figures tended to be absent (or oblated?), as with Marnie, Sharkboy, Lavagirl, the Doctor, Spy Kids, or benign as in Chicken Little mother.

Session 20

Philip was anxious about 'Robotti', the baby robot. Darius and X10 were very present in Philip's commentary.

Robotti attacked and exterminated monstrous 'Dalek s' – Philip's drawings looked like larger versions of Robotti.

Philip batted off my suggestion that Robotti might be worried about these attacks (from the Dalek s) saying he just gets rid of them.

Later in the session he decided to make 'Phase-ball'[74] *which had something to do with*

[74] I realised, considerably later, that Philip was talking about 'the Face of Boe', a benign, ancient, wise but dying being represented as a disembodied head.

the 'transition' between the two doctors. The end result looked like a bigger version of Robotti. We had to make a cage for Phase-ball. Philip said Phase-ball was dying, he repeated two phrases: 'there's nothing left but dying' and 'dying can wait'. He decided Phase-ball was Robotti's father. When I wondered what Robotti thought of that Philip decided he wasn't his father. 'Robotti' avoided thinking – Philip placed the baby robot in front of the cardboard TV.

Philip's attempts to kill off the worrying father figures, as in the previous session, are ineffectual.

Despite Philip's attempts to get rid of X10, dismantling the model, he reappears. The connection between sons and fathers is very frightening. He momentarily tries out Phaseball as a father figure but, like his father, Phaseball is potentially dangerous, he had to be caged, and he is also dying. Philip retreats into a mindless distraction – the blank cardboard 'TV' screen (onto which he can project whatever cartoon or game he wishes.) Although Philip had not been told, the belief in the network at that time was that Philip's father had barely recovered, if at all, from a drug induced collapse. His whereabouts were unknown and a there was an idea, voiced by the social worker, that he might be dead. It is likely that Philip had a sense that he was not being told the whole truth and that something terrible had happened to his father. It is also possible that this rekindled his guilt about his foster father.

The material in the following session, 21, was very confused and confusing: Philip was agitated about Dalek s wanting to kill him, Philip, and he talked about the Doctor protecting him. Philip had to help Phase-ball who was in grave danger.

Session 22

Philip was the Doctor from meeting him in the waiting room. Philip said he wanted to make a 'future box' (I misunderstood at first, thinking he was saying fuse-er box and meant fuse box).

He was very bossy and agitated, getting a 'gun' to fend off robots etc. He asked me whether they (the robots?) were humans and later whether we had a future.

He sent Robotti in the future box to Philip's past when James was scalded. Robotti became sick and frightened, Philip promised never to send him back there.

Philip became interested in my surname and asked how I had got it. This led to a discussion about Philip sharing his name with his father.

Philip talked a lot about Rose Taylor (the Doctor's companion) wanting to change her past. [75]Philip was able to state that he wants to change his past but quickly slipped into omnipotent magical thinking telling me he can.

Philip stated that if he wasn't the Doctor he was useless and couldn't do anything.

He talked about his new school, anxious that he wouldn't be able to come and see me when he moved. He asked me to talk to his carer about it.

Towards the end of the session he mumbled something about me being his mother.

I was unsure who Philip was referring to in the 'we' at the start of the session. I think it was Philip as the Doctor making a global reference to the human race but it may have signified he and I as a unit or even he and I as separate people.

Around this time Philip started every session with an inspection of Robotti and a subsequent worry that one of his legs was not properly bent, requesting that I fix it. He had an investment of some kind in the therapy and he was recognising that his therapist could be useful and might be an ally, she could talk to his carer. The anxiety about his own potency, if he isn't the doctor he is nobody, ineffectual, was clear, Philip stated it. At some level Philip is recognising his omnipotence as a defence. It might also indicate that if he isn't the powerful force for good he is afraid to act at all.

Murderousness and death were close to the surface in the next few sessions with a continued interest in the vulnerable but potentially destructive Robotti and a new larger model/version that became Robotti's father. There were also signs of a move towards a healthier integration. Philip had seen 'Charlotte's Web' [76] and announced he was going to

[75] Rose wishes to re-write history to change the fate of her father. Meddling in time has drastic consequences

[76] E.B. White (1952) *Charlotte's Web;* animation (1973) Hanna-Barbera Productions for Paramount Pictures; computer-animation (2006), Paramount Pictures, Walden Media, the K Entertainment Company and Nickelodeon Movies

see his friend Fern (the girl in the story), he identified himself with Wilbur, the pig being fattened up by Fern's father for the table. He had lots of questions about why Fern's father should want to kill Wilbur. He talked with concern about Charlotte's habit of drinking flies' blood. He seemed disgusted and quite puzzled (that someone good and kind should do such a thing). We made a 'Charlotte', a sellotaped ball of squashed paper towels with card legs, a sugar paper web and pipe cleaner baby spiders.

Session 24

Philip was curious about life and death – 'Why did Charlotte have to die?', 'Did Charlotte die for Wilbur?', 'Were all Charlotte's babies girls?' etc. Philip took one 'baby' to 'Charlotte' shouting, 'Mummy, Mummy, look, I've been born'.

Later in the session Philip stood on two pieces of softplay and demanded. 'Look at me, Katie!' then almost immediately got off in case he fell and hurt himself. He felt very vulnerable and easily humiliated, but interestingly did not compensate with omnipotence. There was another theme, less pronounced, of Wilbur's perilous situation. Philip turned to the paper laptop, searching the net for words to save Wilbur, the threatened baby. Philip talked about the forthcoming break and when he was coming back.

<u>Easter to Summer break</u>

The next session followed two weeks break for the Easter holidays. The session started with Philip looking for Charlotte's babies but shifted quickly to Doctor Who. Philip wanted to know if I had seen the latest episode but unusually couldn't remember the name of his/the Doctor's companion. Perhaps this was because he started out being with, rather than being, the Doctor. It was a very interesting session, Philip, for the first time, quite literally put his mother in the 'scalding' picture:

Session 25

Philip was travelling with the Doctor. He began to talk about wanting to change what had happened when James got scalded. He told me he <u>had</u> changed the future (did he mean the past?). I was confused and suggested we draw a picture to help me understand. Philip agreed. I drew a bath. Philip showed me where to draw James and

himself. When I asked if there was anyone else in the room he told me to draw his mother, in the doorway. Philip didn't want to think or talk about it any further and retreated to a manic tidying up of the dolls' house.

In the following session Philip cast me as a culpable mother, I was 'Jacky', Rose Taylor's mother, duly punished: *The Doctor had taken Rose away because I (Jacky) had lied and I had to say sorry before I could see Rose again.* Philip was very caught up with the idea of the 'human Dalek ' plotline. Whether beings were human or not was a worry he often returned to.

Around this time Philip's foster carer was anticipating going into hospital for some routine surgery. The plan was that her daughter would care for Philip in her absence.

In May a new figure [77] appeared in the Doctor Who television series and very powerfully, and poignantly, in Philip's sessions. The Mummy-gas-mask man episodes of 'Doctor Who' were broadcast in the following weeks, the content chiming uncomfortably with Philip's external and internal experience. Philip was enthralled, in the strongest sense of the word, and agitated by the 'empty child'. The setting was wartime London, the Blitz. A small child in mackintosh and gas mask wanders the streets calling plaintively, 'Mummy, Mummy'. The audience quickly learns that the child is feared and avoided.

Session 28

Philip (with my help) made a 'Mummy man' from Doctor Who, a small figure in a gas mask, walking bombed London streets, constantly calling, 'Mummy, Mummy' in searching tones. Philip was scared of the model at first, he didn't want to attach the gas mask face, he said he didn't want to become a 'Mummy man'.

Philip talked to the Mummy-boy and explained that he understood what he felt because he couldn't live with his mummy. Later he said that she (his mother) couldn't manage because there were too many of them.

Philip adopted the Mummy-boy as his brother. He told me he, Philip, didn't have a

[77] The title of this story line was 'The Empty Child'

brother and he had to stay in the classroom. (An allusion to an incident in school?) He didn't want to tell me what happened.

He worried about the Mummy-boy going to school. He told the Mummy-boy that his (unclear whether this was a reference to his own or the Mummy-boy's) father had died ten years ago. 'They' had looked for him but he had died in the war.

The Mummy-gas-mask-man, as Philip came to call him, was very present for several sessions. The child calling for its mother caught the imaginations of many children at the time and there were several reports of children re-enacting the child searching for its mother in playgrounds. In the story line the child in the gas mask contaminates others, turning them into gas mask people and is therefore feared. It was particularly poignant for some. Philip cast me as the older sister-mother substitute who looked after the motherless children. He was, as always, resistant to my making any links with his own experience. In the session before the half-term break, extended to three weeks with his first residential trip away with school and an unplanned cancelled session when I was unwell, Philip told me he always wanted to see me. He looked after the small baby/gas mask-child. He became its father whilst simultaneously maintaining his Time Lord status. He changed the tone of the call for 'Mummy, Mummy' into one of happy expectation, as if there were a mother figure who would respond positively. Philip played out Charlotte's Web again, the redemption of the pig and the self-sacrificial death of Charlotte, the mother figure. Philip returned from a very successful trip to tell me, at his carer's prompt, that he had been to London, the two family cats had died and had I seen Doctor Who? He was already in his Doctor Who world with no acknowledgement of the gap. With a lot of gentle insistence he told me a little about going to the theatre, eating at Burger King and so on. He tolerated my interest in the real world but gave only polite, cursory attention to my questions

Session 31

The Mummy-gas-mask-man was plaguing Philip. Philip spoke for it, inquiring of Philip, 'Mummy?' Philip eventually shouted at it, 'Your Mummy's dead!'

Philip tried to convert the persecuting voice into a vulnerable baby, telling me I was the Mummy-gas-mask-man's mummy, or it was under his/the Doctor's control/protection.

The atmosphere of the session was frantic and muddled.

In the following week Philip was a little more able to acknowledge my thinking:

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He worried about the Mummy-boy going to school. He told the Mummy-boy that his (unclear whether this was a reference to his own or the Mummy-boy's) father had died ten years ago. 'They' had looked for him but he had died in the war.

Session 32

Philip was preoccupied with the most recent episode of Dr Who. He wanted an explanation. He was very interested in 'the little Master' and what had happened to make him bad. He rapidly moved from one thing to another, making a model of the monster from the Lazarus machine [78] to the little master and so on.

He was very identified with the Doctor but when I began to talk to him about his own experience he said he was the Doctor <u>and</u> Philip. I linked Philip's early experience with the Doctor. He, like the Doctor, had tried everything to avert a catastrophe (stop something really terrible happening) and even though he knew he was only little and couldn't have done any more he still felt bad. Philip/the Doctor tried to explain to (an

[78] The 'Lazarus machine', from the Doctor Who story line 'The Lazarus Experiment', is designed to rejuvenate but inevitably malfunctions producing monstrous creatures.

imaginary) Master why he hadn't managed to save their planet and prevent his parents' deaths. He said, as if this were a moment of revelation,' James was the little master'. He dashed to find his picture of the scalding incident. He didn't want to explore this much more and said he would check it out on the 'computer'. He was also asking me to make the Lazarus machine monster.

We talked about the story line. Tish, the sister of the current travelling companion, Martha, had been in love with the young Lazarus (who turned into a monster in his attempts to gain immortality?) I said how frightening it was when he became a monster. I suggested it was very frightening when someone you loved and liked was nice and then changed. Philip said, 'You are beginning to worry me, Katie'. And to my, 'Am I?' 'Yes, just a little bit.'

I was unsure whether Philip was worried because I was touching on feared past experience, or whether he feared I might change from nice to frightening, or both.

In the next three sessions before the summer break Philip was aware of the impending move to his new school. He stated that he didn't want to go but he had to. He was caught up with 'The Family of Blood' story line. Again, what seemed like a perfect vehicle for helping Philip think about himself was inaccessible to me as therapist. I was only allowed in to play parts allotted to me. The Doctor has hidden himself from his own self, taking on the form of John Smith, a teacher. The key to his identity is in a fob watch. Philip was very animated about the watch. Whilst playing out a scene involving the watch he suddenly announced that his pig, Wilbur, had died and he didn't have a spider, Charlotte had died too. He sounded sad and wanted to know if I was sorry for him. In the next session the Mummy-gas mask-man made another appearance.

Session 35

Philip started talking about Harry Potter and then told me the Mummy-gas-mask man had been at his friend's house yesterday. Philip had warned his foster carer to keep away or she would become one of them. Philip was very preoccupied with The Family episode – Why did the Doctor hide? Why couldn't he stay John Smith forever? Why did Martha slap him (to bring him to his senses)?

When I linked 'The Family' to real families Philip said he didn't want to talk about his family. He added that he saw his mum and (his youngest sister) but not his other sisters. I said that made him sad. Philip crossed his arms and said, 'Now you've made it worse, I don't want to think about it.'

The material became increasingly confusing as he talked about Shelley, a child who would be in his new class. He said Shelley was an alien and she had taken James away from him. Shelley had scalded James, she hadn't managed to kill Philip yet.

I wondered about the possible connection between the impending break, Philip's slightly more aggressive attitude to me and the worrying escalation in confusion in the material. I contacted Philip's carer after this session, concerned about Philip's capacity to differentiate the real Shelley from the alien-Shelley of his imagination. His carer informed me that Philip had recently discovered that his older sister is now in contact with their mother. I wondered if Shelley was the recipient of his own projected guilty feelings or if she were standing in for his sister in his reconstruction of events. His sister had been the other 'carer' in the family, perhaps he needed to keep his image of her intact, any hint of her complicity in events attributed to an alien girl.

In the last session before the summer break Philip asked me to make a stone angel, the 'moving statue' of another Doctor Who episode. He was very concerned about not blinking, blink and you lose your life. Shelley was much in evidence. At one point he said, 'Philip and Shelley are the same'

Session 36

Philip talked about Shelley being an alien. Philip then became very agitated, looking for his 'dream journal'. He eventually found the book we had made and written in when he was confused about why the Doctor was hiding from the Family of Blood. He said he'd dreamt he was in Shelley's ship then he was here and Shelley took James away. She tried to get him (Philip) but he escaped into the tardis. He had realised that she was an alien when he saw her antennae. He became excited, exclaiming, 'That explains it!' and 'Everything fits!'. He took the (cardboard model) tardis and smashed the stone angel – and then became very worried about what he had done. 'I'm not a murderer....you don't think I'm a murderer do you?'

He found it very difficult to finish the session, wanting to do 'one more thing'. Philip continued to talk all the way down the stairs, unable to leave his fantasy world to say goodbye.

Therapy resumed three weeks later.

Appendix D

Clinical material: Lenny the lion

Note: verbatim extracts from extemporaneous notes (i.e. process notes recorded immediately or shortly after the session) are in italics. Paraphrase of intervening sessions, notes on meetings and commentary are in non-italics.

Clinical material: September to Christmas

Lenny's carer brought him to the clinic, as arranged, in early September, five weeks after the assessment. She reported that the family had had a good summer holiday. She had organized activities to keep everyone busy and occupied and she was now looking forward to some time on her own with the children back at school. Lenny hadn't had much opportunity to get into too much trouble as she had been around to supervise.

In the first session following the assessment Lenny came with me on his own. I had explained earlier that it was generally helpful for children not to bring things into their sessions. His carer instructed him to leave the two cars that he had brought for her to look after. He relinquished them reluctantly. The first thing Lenny noticed on entering the therapy room was the locked cupboard. He quickly wanted the cars/his carer but managed to stay for 25 minutes. I was struck by his development over the summer. As in the assessment sessions, he was unable to settle at first and it was still not possible to develop any play but there was a different quality to his capacity to relate.

Session 1

Lenny was pleased by the tea set. He got everything out as if ready to play then put everything back in the box. He was interested in my idea of a road map for the cars. He briefly joined in drawing some roads on a large piece of sugar paper. He drove the car around once and then returned to his wish to have the cars he had left with his carer. He discovered that the little windscreen on one of the cars clicked up and down. He began to chew his thumb and click his nail against his teeth. A moment of real connection followed when I mimicked what he was doing and commented on the interesting noise. Lenny asked why I was biting my nails. I made the distinction between biting and

making the noise. He told me his carer says, 'No biting'. I agreed biting nails wasn't a good idea. Lenny made a connection with the noise of the windscreen and we tried it out. (Clicking the windscreen then clicking our nails against our teeth.) I commented that the nail noise sounded in your head. Lenny said, 'Food'. I repeated, 'Food?' Lenny said, 'Like eating'. There was eye contact at this point. I agreed it was like the sound of eating in your head.

Contact faltered at this point and Lenny returned to wanting his carer/his cars in the waiting room. I suggested Lenny might manage five more minutes. He looked with me at my watch to see where the big hand would be and decided it was too long. We returned to the waiting room.

Lenny's foster carer had told me that he had managed the first two days at school but had been aggressive on the third day. Similarly he had managed the beginning of the session but he had inadequate reserves of a sense of well-being to stay until the end and needed to go back to his carer for a 'top up'. (To touch base? This might be read as a sign of health that he can make use of his carer and a hopeful indicator that he may develop a secure attachment.) Lenny's references to biting were particularly interesting,

The following week Lenny wanted his carer to come with him to his session. He kept physically close to her, holding her hand as we went up the stairs although there was not enough space to walk side by side. His carer talked, in his hearing, about a meeting the previous day at school when the head had said it was 'make or break this year'. In the therapy room she sat quietly, not instigating any interactions but observing closely. Lenny's anxiety, and his growing capacity to make use of another was evident in the material. He was very quiet and hardly spoke.

Session 2

Lenny got all the plastic crockery out of the tea set box but again didn't play with the cups and saucers.

He urgently put all the cups etc. in the box and tried to close the lid. He couldn't get the lid on. He was so agitated and so focussed on this task he didn't hear/ignored my offers to help but he did eventually notice me and accepted my assistance (without humiliation).

Later in the session:

Lenny threw softplay shapes enjoying the noise of the impact on the floor, watching his carer to check out what she thought of it. He piled the shapes carefully on top of the dolls' house and carefully dislodged the pile. He seemed to enjoy my counting the blocks as they fell. Lenny then threw them into the corner. He crept up behind his carer with a softplay shape in his hand as if to hit her with it. I reminded him, 'Gently'. He threw the shape to the side of the chair. He picked up and threw, with some force, the wooden door stop. I picked it up and began to explain that it was made of wood. Before I said 'wood' Lenny suggested, 'Factory'. I showed him that it was hard and would hurt if it hit someone. Lenny played at banging it on things.

He packed away his box and became interested by the noise the box lid made as he moved it across the table. Lenny found the road map and some focussed play followed. Lenny wanted to take it with him when he left and when I said he should leave it in his box for next week he then wanted to finish the session. Lenny began to say repeatedly that he didn't want to go to school. He couldn't say why. I wondered whether he just wanted to be with his carer. Lenny nodded.

Lenny was like a toddler exploring the room, the sounds he could make. He manages to divert his own aggression to exploration, banging things with the door stop rather than throwing it, as his carer had helped him to do in the assessment when she, following his lead, diverted his attention from hitting to an exploration of the Disney character on her top. He responds to my 'gently' – I had thought he hadn't taken account of how hard the softplay might be and might really hurt his carer. I wondered about his ambivalent feelings, his crossness with her for sending him to school but also his need to protect her. I wondered about his word 'factory' for the door stop. What was the association for him? Was 'factory' an approximation of something else, as in his 'Harry Potter' for helicopter? Did he know about factories? Was it a relatively sophisticated contraction of 'something made in a factory'?

The following week Lenny's aggression and his limited impulse control were much more in evidence. He had been excluded from school for the previous two days for biting children. His carer, at Lenny's insistence, came with him into the session.

Session 3

Lenny bit the softplay. He tried to tear the cardboard packaging from the new cars with his teeth and showed me his teeth several times in the session.

Lenny was kicking the softplay, biting it, throwing things around. He was excitable and explosive throughout the session but there was evidence of internal limits – Lenny didn't hurt his carer, himself or me: he punched the radiator very softly, banged the softplay on the back of his carer's chair softly. He responded to my limits – no climbing on the dolls' house etc. and eventually played with the new cars and the road map.

His excitement was very difficult for him to manage – the new cars and my cardigan, the plastic mat to play on, all provoked more wild biting, punching and kicking (of the softplay etc.) At one point Lenny almost turned the kicking game into a game of football.

Lenny brushed past my face with a car, accidentally, and the idea of hurting me led to excited laughing. Lenny repeated my phrase, 'kicky feelings' but it didn't defuse the excitement. He built a wobbly tower and knocked it down, climbed and wobbled on the softplay but used me to stop himself crashing to the ground. He gave his carer a hug and gave me something between an embrace and an assault. His carer recognised it as a hug ('Oh, you are giving Katie a hug, that's nice.) and Lenny was pleased.

Lenny had wanted to take the cars home but managed to leave them.

There was a general feel of 'too-muchness', the excitement spilling into aggression in the session. Lenny's stimulus barrier is very porous and his efforts to moderate his own behaviour aren't enough. It was easy to see how his teacher might be hard pressed to notice the self restraint, moderation of impulses, that is going on when he is biting children rather than softplay and there is no carer to emphasise the positive in the contact that the recipient child experiences as an attack. In my pondering on the session I found lyrics going through my mind 'Oh my love...I'm hungry for your touch' and a question: Does he want to feed or attack? Does he/did he hunger for his mother's touch/affection?

Later that day I met with Lenny's carer for a pre-arranged appointment. She told me that Lenny still hit his siblings and 'spoils everything we do'. She was still hoping to continue to care for Lenny long term but was requesting respite care fortnightly for one day of the weekend so that she could give the other children some 'quality time'. She wanted one consistent respite carer but doubted anyone would want Lenny more than once. She was anxious about how far behind Lenny was at school, worrying that he had already missed a lot and now he was excluded. She was concerned that if he didn't get adequate help now he would become an aggressive adult. She linked the escalation in his aggressive behaviour with contact visits with his mother. He had bitten two children during the day last Thursday, had a contact visit in the evening and bitten another child the following morning. She talked about the loss of Lenny's younger siblings on adoption, stating the adults had not been truthful about contact with them. Lenny's carer found it very difficult to contemplate that Lenny might need more than a mainstream school could offer.

Lenny came happily on his own to the following session and stayed for thirty five minutes.

Session 4

Lenny ran ahead and hid in the therapy room. He enjoyed my 'seeking' him and gave a friendly 'hello' when I found and greeted him. He started kicking the softplay but it became (aggressive) football. He was mildly cross about his cups and saucers being in his box rather than in their own tea set box. We put them in the right box together.

Lenny instigated a game of racing cars. He was insistent on winning but managed to wait at the starting line for 'Ready, Steady, Go!' He was suddenly very angry when his car fell off the back of the table.

There were three points of sudden anger in the session but Lenny recovered more quickly. Twice he told me he'd 'had enough' and was stroppy in his manner but was easily re-engaged.

There was lots of interest in sounds – he moved from kicking and throwing the door chock to being interested in the different sounds it produced. He was pleased at his own

counting and responsive to my acknowledgement of his achievement. He noticed noises coming from outside and looked for the skip lorry. He noticed a butterfly outside.

Lenny also made several references to 'monster houses' and scary monsters. He talked about dinosaurs fighting and drawing blood and crabs pinching. He said he didn't want to go to the beach.

This was the first time Lenny had let me know directly that he was afraid of something, locating his own aggression in the dinosaurs and pinching crabs. He was proud of his own achievements, his good counting, and he was able to accept praise.

The following week Lenny began again with a game of hide and seek, really enjoying my searching for him. There was further evidence of regulating his aggression and the beginning of sublimation when he began to kick the softplay: saying, 'football' he reduced the force of the kicks. The session continued with a preoccupation with 'boys' and 'blue'.

Session 5

Lenny went to his box, getting out his cars. He made a space for 'the blue one' – the car from the waiting room that he had been persuaded to leave. He seemed to manage his disappointment of not being able to have it. He didn't play with the cars but went to the sink.

Lenny spent a long time with the broken sink, working out what went where. He told me several times I should buy a new bottle (the water container in the sink cabinet). He told me that boys don't like pink and I should paint the bottles blue, not pink, because boys don't like pink. When he realised the paper towels could get wet he moved them very carefully to the top shelf.

Lenny became aware of noises outside, in particular a child crying. He told me it was a baby not a boy because 'big boys don't cry'.

Lenny had wanted to leave after ten minutes but managed a further fifteen minutes before insisting on tidying away. At the end of the session in the waiting room his carer

talked to me about her concern at Lenny's poor literacy and numeracy skills although she recognised his progress in language development. Lenny was also making progress in other developmental areas, with a growing interest in his sense of himself as a boy. Lenny will have already internalised a perception of masculinity as being emotionally tough from his father. Although his foster family is kind and warm they are likely to reinforce the idea that grown men don't cry. Lenny's anxiety about the crying child, not wanting to be in touch with the crying baby bit of himself was clear. I wondered if this might shore up Lenny's need to be the big man, not to need anyone.

Session 6

Lenny was reading a Thomas the Tank 'clock' book with his foster carer when I went to fetch him. He wanted to bring the book with him to his session. He seemed to want to share and show me something. He raced ahead and hid – enjoyed being sought – jumped out and surprised me before he was found.

Lenny sat to look at the book, pointing out the engines, telling me they were very big, all of them, because they'd all eaten their dinner.

Lenny went to the softplay to kick it, kicking it with more tempered excitement than he often managed.

He needed a wee. He came out of the bathroom without washing his hands but was easily persuaded to go back. He said he 'needed' more soap. He had to tuck his sweatshirt in his trousers.

He went to the dolls' house then to his box for the dolls' house people but didn't get as far as finding them. He threw out the puppets onto the floor. He knocked against the tissue box on the window ledge and threw it. He came across the pipe cleaners (in his box) and focussed on them for about five minutes – pulling one out from the bundle and feeding it back in. Taking one out, telling me he didn't like 'the bends', he explored a little with it – putting it in his mouth, moving it around the dolls' house. He became agitated that it wasn't straight. My straightening it wasn't enough and he abandoned it, then becoming concerned about his socks.

He took his shoes off and pulled at the toes of his socks saying they hurt him. He didn't want to leave his shoes off as his socks would get black. He took his socks off – his big toes were red – and put his shoes on without his socks. I told him his shoes would rub and make his feet sore and he put his socks back on again, distressed by the excess fabric at the toes. He refused my offer of help – 'I don't need help'. I suggested even big boys and grown ups needed help sometimes. Lenny said grown ups didn't have to have socks like this.

Lenny said he'd 'had enough' and tidied away. He took the pipe cleaner with him.

His foster carer reported that Lenny had not been able to go on a school trip. She was cross about this and very positive about Lenny. She also told me that Lenny's concern about his socks and tucking his sweatshirt into his trousers was a symptom of ADHD.

Lenny's agitation, his need to tidy up, to tuck everything in and so on continued over the next few sessions. He needed to feel independent, needing help was humiliating, he wished to be a grown up who did not have to wear socks. I wondered about the connection between phallic anxiety and his agitation over the bent pipe cleaner. The following session Lenny confirmed this:

Session 7

Lenny spent a long time, perhaps five minutes, examining the pipe cleaners, looking for a 'straight one'. He was pleased with the sellotape I had put out for him. He instructed me to carefully wrap a piece of sellotape around a pipe cleaner to 'make it straight'. I asked what he wanted to make and Lenny said, 'A man'. He stood the pipe cleaner vertically on the table and I commented that the man was tall. Lenny was very pleased by this and measured his 'man' against another, shorter, pipe cleaner.

Lenny managed a full fifty minutes in this session. I wondered whether this worry about being 'straight' was actually about his penis and/or whether 'bent' was used pejoratively in birth or foster families as defective masculinity.

Whilst he continued to need to be in control, keeping things together, some play was also developing in his therapy. We played cars, making road maps, drawing out parking

spaces, driving the cars around the 'streets'. A 'puppet game' emerged, a ritual that developed when I put the monkey and elephant glove puppets (soft, furry but not cute) on my hands and talked as the puppets about Lenny, wondering what he was doing and so on. Lenny had begun to talk back to the puppets and would often demand that I 'put them on'. (The puppets became important non-critical observers over the course of the next months of therapy.) Lenny had also developed a deep rasping, guttural voice that sounded sinister/threatening. I thought it must hurt his throat to produce the sound. This deep voice also became a common feature in the therapy.

In the waiting room before Lenny's ninth session his foster carer told me that she was unhappy with Lenny's school. She said he had had some 'funny days' at school recently and she thought she was going to have to move him as 'they don't know how to educate him there'. A change of school could not, in fact, be decided on by the foster carer, although she could influence the decision within a care team meeting. Many of her battles were about who had the authority to do what and I was reminded of Lenny's complaint about being small and wanting to be grown up, able to decide for himself about socks and so on. I anticipated an unsettled and lively session with Lenny but his anxiety was expressed in quite a different way:

Session 9

Lenny was engaging from our first contact in the waiting room. He talked about wanting to bring a toy up with him but managed to leave it. He ran ahead to play hide and seek, enjoying being sought and found. He wanted to make another car map and was very focussed on this activity throughout the session. Lenny was very anxious about straight lines being straight and adjoining lines-if the lines didn't meet properly at the corners he became concerned that we should get it right.

Lenny wanted lots of parking spaces, showing me where to put them. He added one to the row I had drawn. Later he commented that this space was 'broken' – his lines were wobbly. However, he did park a car in the space.

Lenny added a beach to the road map. He wanted to colour the sea in but said he couldn't do it. He did begin, though, and then instructed me to help, showing me how to colour 'hard'.

Lenny spent the last five minutes playing quietly with the cars, parking them all neatly and then driving them one at a time around the map.

He was still insistent about tidying up and tucking in his sweatshirt.

At the end of this session Lenny had run ahead and was distressed to find the door through to the waiting room locked.

I was surprised by Lenny's play, expecting his anxiety to be expressed through aggressive kicking and so on. But here was symbolic play about his own situation: he was 'parked' at his foster carers' but now there was an uncertainty about whether he would have to move from his school 'parking space' (the 'broken' one?).

The following session was also different.

Session 10

Lenny brought a magazine from the waiting room with him.

He ran ahead and played the customary game of hide and seek at beginning of session.

He looked at the magazine, very engaged in examining the pictures. Lenny was using a lot of language. He began sporadically to move around the room, go to his box, but constantly went back to the magazine. He said it was his now, he was 'going to bite it' then it would be his. He told me, 'I bite things'. (I had thought when he said this that there was a lexical confusion between 'bite' and 'buy'.) Lenny looked at every page. There were interesting interpretations e.g. Lenny stated, 'Rock goes in the bath' – the bath was superimposed with a crane suspending a rock behind the bath. Lenny was very interested, commenting on several of the pictures. Seeing a male figure – a strange image swooping out/up the page with something black around the head – Lenny said, 'Your daddy, kiss him, kiss him' – a directive to me.

Lenny finished the magazine – the session was finished as far as he was concerned. Lenny bit the magazine and said, 'Mine now'. He tidied away the softplay etc. and

posted the magazine down the back of the radiator.

There were many interesting aspects to this session, his capacity to focus, his associations to fathers, his perception of space, his comments about biting. He was not telling me about the aggressive biting of children that gets him into so much trouble but about an archaic marking out of ones own territory.

The following week Lenny was very angry at the start of the session. In the waiting room he showed me that the little garage was smaller than the big one. He was very cross that I did not allow him to bring the little garage up to the therapy room.

Session 11

Lenny shouted repeatedly at me: 'I want the garage.' 'Get it now.' Go downstairs.' 'I'll stab you.' 'I'm going to get it.' He scowled and pulled the tap from the sink and threw the plug across the room. He tried to get into the cupboard and then into the filing cabinet. There was a very strong sense of me withholding and depriving him of something he really wanted. However, he did not leave the room. He managed to be fleetingly interested in the noises he made with the doorstop and the bent pipe cleaners that he 'walked' across the table.

He demanded that I make him a roadmap. He seemed to have a clear idea of what he wanted it to look like but could not communicate it to me. He was very frustrated. Eventually I produced something marginally satisfactory and he briefly drove his car around it.

Lenny decided he'd 'had enough' and packed away, initially not wanting any help but accepting some. He momentarily enjoyed shaking the rug together but as soon as the task was manageable without my help he was determined to do it on his own.

He left the session happy.

The following week I had to cancel a session. It was pay back time the week after when Lenny effectively cancelled the next one, playing restlessly for a short while, moving the road maps around into different arrangements then tidying everything away and putting his coat on. I had made a chart for Lenny so that we could cross off the sessions

in the weeks leading up to the Christmas break. We had had to cross off two at once due to my absence.

The next session was the last before the Christmas break. Lenny's foster carers had arranged to take the children to Florida early in the new year. They hadn't told Lenny about the trip as they thought the anticipation would be too much for Lenny. (And Lenny's agitation would be too much for them.) Lenny came with a gift for me and was excited when handing it to me. There was a muddle of excitement, affection and aggression in the session.

Session 13

Lenny enjoyed the puppet game but became very excited, pleasure quickly becoming aggression directed towards himself by banging his head, or towards the objects of his pleasure, the puppets/me, thumping the puppets hard. (Hard enough to hurt my hands underneath.)

Lenny then spent some time being a monster. He told me when he growls he's a monster. He had real difficulty managing affection and aggression, both thumping and hugging the puppets. He told me he would like play-doh and dinosaurs after the break.

Lenny really enjoyed taking a chocolate decoration from the Christmas tree (at the Receptionist's invitation).

Clinical material: January to Easter

The break for Christmas, followed by the trip to Florida meant a five week break for Lenny from therapy. On his return Lenny was pleased to see me and pleased to come up to the therapy room. He explored the blocks of modelling clay (the requested 'play-doh').

Session 14

Lenny formed the dough into a rough shape which he said was a monster. He squashed it again and said it was a ball. He approached the puppets (on my hands) with pleasure and excitement that became aggressive and attacking. I commented that

blowing/spitting raspberries in my face wasn't 'very nice'. Lenny went to his box started throwing all his cars out across the room followed by the plastic fences. Lenny built a wall between himself and me, using the softplay and his box.

Lenny lined the cars up and made a fence around them with the fences using the softplay and his box lid to fill the gaps. He moved the cars around, almost bumping them into the edges and making lots of aggressive engine noises. He sang to himself, made lots of funny little noises, repeatedly shouted 'Shut up' at me (I was silent) and called me 'Sexy', 'Punkyhead' and 'Sexy Punkyhead' in his deep guttural voice.

Towards the end of the session Lenny took the black car and smashed all the other vehicles one by one.

Lenny's preoccupation with 'keeping separate' in this session was followed by an interest in coupling in the next. The being apart and coming together had a sexual element but also echoed the separation and coming together again of the break. I wondered about Lenny's experience of separations and comings together – leaving his parents, being re-united briefly for contact meetings, losing his younger siblings, going to a respite foster carer. I was frustrated that therapy had only just resumed and another break was anticipated. This was the last session, only the second since Christmas before another break for half term.

Lenny had been very excitable at the beginning of the session. His enthusiasm for the puppets became too much and he hit them/my hands hard then licked their furry faces and bodies. He threw toys wildly from his box, shouting at me to 'Shut up!'. I wondered aloud about his feeling of wanting 'Monkey' and 'Elephant' to go away. I suggested I make something for him.

Session 15

Lenny's mood changed. He asked me to make a blue car from the play-doh I showed him how to make wheels and we made the car together. Lenny then engaged in quiet, focused play, first with the blue car then with the other cars. He spent a long time trying to hook a car onto the breakdown truck. I made a sellotape 'rope' for him. Lenny then coupled all the cars in pairs with sellotape. He worked out that he could use sellotape

to join the cars underneath to avoid the tape sticking to the carpet.
He accepted my offer to help with tidying away.

Half term was another extended break as Lenny had a speech and language appointment the week following the half term holiday. I noticed when Lenny arrived for his next session that he didn't have his shirt tucked in. He had brought a rescue vehicle from home that, he told me firmly, he was going to take home with him at the end of the session.

Session 16

Lenny demanded I put the puppets on my hands but did not engage with the puppet characters. Lenny was very focussed. He separated the coupled cars urgently, throwing the sellotape to the ground. He played with his cars, the car from home leading the pack into the dolls' house. Lenny was very perturbed by the drop/gap in the stairwell.

Later in the session he played with water in the sink and became agitated in his determined efforts to get the water to run away down the plughole. He asked me to tidy up for him. There were several instances of Lenny moderating his own behaviour. Once when he had accidentally hit me with a toy, he changed the direction of his throwing. On another occasion he was going to pour water in the bin. He said, 'Sometimes I..' and poured it down the sink.

At the end of the session his carer remarked that Lenny's behaviour was 95% improved. She also told me that there was a possibility that Lenny might be moved to the 'Communication ARC' (Additionally Resourced Centre for children with difficulties in communication). She requested that Lenny's sessions be reduced to 35 minutes to enable her to get the foster carer training sessions. She was unconvinced, I think, of the value but agreed, on my insistence, that Lenny was entitled to 50 minute sessions. There were a lot of demands for Lenny's foster carer, four children to look after, two schools to negotiate with, Looked After Child reviews, Care Team meetings and so on. However, I was reminded of Lenny's competition for time and attention from his birth mother, never quite getting enough.

Session 17

Lenny was pleased with the little dinosaur I had brought for him but wanted 'a big one from the shop'. He instructed me to put on the glove puppets. Monkey and Elephant were to watch and admire as Lenny stomped around the room telling me he was a 'blue dinosaur with sharp teeth'.

Lenny wanted me to make a ball with the blue play-doh which became a blue dinosaur 'with noisy legs' and sharp teeth. We made a very basic figure from three pieces of play-doh, a head, torso and legs. Lenny said it had 'noisy shoes'. He stamped around and roared. I responded for Elephant and Monkey with curiosity and trepidation. Lenny was very pleased by this.

Lenny turned the head of the dinosaur into a 'bouncy ball' and 'bounced' it in his hand all around the room, exploring the different surfaces. Lenny found water in the sink, a leak from the base of the tap. We were both surprised by this. Lenny mopped up the water from the leak and then pumped water into his beaker until there was none left. He really enjoyed this activity.

Lenny's foster carer had informed me that she would be unable to bring him to his next session (session 18). At my request his social worker brought him. Lenny likes his social worker who in turn is very warm towards him but he clearly missed having his foster carer in the waiting room. Lenny brought the little garage from the waiting room and played with his cars the whole time. There was very little interaction with me, even through the glove puppets which he had demanded I put on. Lenny seemed bothered by his neck, which he kept rubbing. I wondered if the garage, usually left behind in the waiting room, served as a substitute for his foster carer. This was a short session, barely thirty minutes passed before Lenny felt he had to leave. Lenny's next session, the last before Easter, fell on his birthday.

Session 19

Lenny was very proud of being 6. He was wearing a badge and wanted to know where his 'prize' was.

Lenny demanded I put on the glove puppets and ducked down behind his box. Using the play-doh dinosaur he played a game of being the big blue dinosaur with sharp teeth. Monkey and Elephant had to talk about the noises they heard and then be frightened by

the dinosaur. Lenny asked me to make arms, eyes, nose and hair like his for the dinosaur. I asked how old the dinosaur was. He told me he was 6. The dinosaur made lots of noise, roaring and thumping but also talking, whispering, singing, snoring.

The dinosaur became the bouncy ball again. He waved the plastic carrier bag around (in which the play-doh was stored to prevent it drying out). Lenny enjoyed the noise it made and I used Monkey to suggest it sounded like the wind. Lenny then developed a game of whooshing the ball in the bag around the room. He banged it against surfaces, becoming increasingly excited, almost spilling into aggression. He began to shout out 'Fatty bum-bum' and expel air through his mouth to make the sound of breaking wind.

Later in the session Lenny noticed the key on top of the cupboard (I hadn't pushed it quite out of sight). He wanted to get all the cars and all the dinosaurs and put them in his box. He heard a noise outside as he was talking about the dinosaurs and became frightened, thinking that a dinosaur was knocking on the cupboard door to get out. I drew his attention to the source of the noise, a lorry reversing outside. Lenny was interested but once the lorry was out of sight he wanted to leave – I thought he wasn't entirely sure about the dinosaur in the cupboard.

We talked about the break. I reminded Lenny that I would look after his box, he knew I kept it in the cupboard. Lenny wanted to know, 'You go your house?'

Lenny skipped along the corridor.

Although disappointed that I hadn't provided a 'prize' in the therapy room Lenny was pleased with the birthday card the Receptionists gave him on his way out. Alongside the permeable line between phantasy and reality Lenny also had an idea that I didn't only exist in the clinic but that I might 'go to (my) house'. Around this time the Speech and Language team completed their assessment of Lenny's needs in conjunction with colleagues from school and educational psychology. The team had been unable to conduct a formal assessment earlier due to Lenny's behaviour and inability/refusal to co-operate with the assessment tasks. The general conclusion of the report was that Lenny was making 'great progress' in school. He often now responded well in class, followed adult instruction and could work for unto an hour. Although there was still

'marked delay' Lenny was no longer considered a priority and would not meet the criteria for a place in the Speech and Language ARC (Additionally Resourced Centre). Neither did Lenny fit the profile for the local provision for children with moderate learning disability. The recommendation was mainstream provision with a very high level of support, both individually and when Lenny was in groups. The detail of the report mirrored the development I had seen in therapy.

Easter to the Summer Break

Lenny came back from the Easter break more settled. He seemed very pleased to be back and especially pleased to see 'Elephant' and 'Monkey'.

Session 20

Lenny instructed me to put on the monkey and elephant glove puppets with 'please'. There were lots of 'pleases' throughout the session.

Lenny rolled balls of play-doh to make a body, asking me to help. We both rolled the play-doh – this was very serious activity with Lenny focussed and concentrating hard. Lenny said the smallest blue ball was 'the Mummy one'. He didn't name the others.

Lenny became aware of the marks on the table. He got paper towels and water and cleaned the marked area very carefully. He asked me to take everything off the table and he cleaned the whole surface. This was much more expansive, he really enjoyed playing with the water and was not at all bothered by the blue marks and wet patches he got on his sweatshirt in the process.

His social skills, his 'pleases', his capacity for enjoyment in shared activity, his toleration of mess, were a delight to experience. Later in the week I met with Lenny's foster carer. She was also pleased with his progress. The plan was for Lenny to move up to Year 1 with the current Reception class. She recognised that Lenny still needed to be with a younger age group. His teachers were hoping that Lenny would move into his chronological age group the following year but his carer was doubtful. She was very aware of his delay in acquiring basic skills however she was less anxious now that she could see that he had the capacity to learn. Lenny was now included on school trips and she was no longer greeted by his teacher with a long list of his bad behaviours at the end

of the day. It was her impression that Lenny was generally much less aggressive except towards his sister and her own grandson. She was unsure why it should be these two children that Lenny found difficult. She expressed some concern about Lenny's relationship with his older siblings. Lenny's brother, who had been rather quiet and withdrawn, was beginning to express his upset in more active ways and she felt Lenny was inclined to mimic the older children's behaviours. She also felt that he was talking to Lenny about their parents and that this disturbed Lenny. Lenny exasperated his older brother who found it increasingly difficult to share a room with him. (All the children had been referred to CAMHS during the course of the year. Lenny's brother was seeing the psychologist in the team for weekly therapy. His twin, who was disorganised and had poor concentration, had been diagnosed with ADHD and prescribed methylphenidate. Their older sister's problems were understood in the context of her mild but marked learning difficulties.)

Lenny demonstrated his testing behaviour in the next session.

Session 21

Lenny was sitting quietly in the waiting room when I went to fetch him. He was looking at an outsized book about feelings with his foster carer. He got a drink and walked very carefully to the therapy room. His mood changed as we went through the door. He saw the softplay and immediately began to kick it. He told me it wasn't mine, it was Sarah's (his foster carer's grown up daughter). The first twenty minutes of the session were 'explosive'. Lenny crashed and banged a car around the room, wanting to make marks on walls and surfaces. He was easily diverted to making marks on paper but the explosive activity continued with Lenny banging the car around the dolls' house. I had put the glove puppets on my hands to talk to Lenny about what was happening. He hit me on the head with a piece of softplay, managing to temper the force when I said, 'that was too hard' but then turning his attack onto the puppets on my hands, hitting them with everything from his box. There were moments of humour, for example a piece of sellotape landed on the monkey's face. Lenny giggled and put it in his mouth, he grimaced and then drank and splashed water.

I drew a volcano erupting. Lenny became interested in what I was doing. He joined in, becoming calmer. I asked Lenny if he sometimes felt like the volcano. Lenny nodded. I

wondered if we should draw a picture of Lenny. He liked this idea but was insistent that we used blue paper. There wasn't any blue which was problematic for a while but Lenny managed to compromise with brown. Lenny was insistent that the figure covered the length of the page. He changed the mouth I had drawn to a smile and coloured in the picture carefully. He wanted to take it home. There was a great deal invested in this picture and I agreed that he could take it with him. Lenny carried it very carefully downstairs where his carer greeted him and his picture with interest and approval.

Lenny waved and said goodbye making eye contact as he did so.

Lenny's aggression continued to be very much in evidence in the following weeks but there was development too. Another small patient had managed to wrest one of the opening front panels of the doll's house from its hinge. The damage excited Lenny:

Session 22

On entering the room Lenny gave a little kick to the softplay and was excited by the broken dolls' house door. He told me someone had 'kicked it in'. He mimed kicking in the other panel and breaking the house. Lenny directed physical aggression towards Monkey and Elephant (off my hands) hitting and biting them, he bit the softplay and shouted at the puppets and me 'stupid egghead', 'smelly fartpants' etc. Lenny jutted his bottom out towards me, patting his bottom.

Lenny wanted me to talk to him about him (with the puppets). He really enjoyed hearing about himself – being six, going to school, being in Reception, going into Year 1, who lives in his house. Lenny began to list the extended foster family including Sarah and Sarah's boyfriend. When 'Monkey' added Lenny's name, including his surname, he corrected it to Lenny Brown (Sarah's married name).

Later Lenny played with the sink, he needed to soak up all the water. His play got wilder and I suggested I draw a picture for him. He wanted me to draw Monkey and Elephant fighting (he had played this out earlier). My wrestling picture looked more like an embrace. I talked for the puppets about fighting, really wanting to fight but playing too.

My 'fighting/embracing' picture reminded me of the earlier session when Lenny had attacked/hugged me and his carer had amplified the positive element, interpreting his action for him as a hug. Lenny is much more accessible to the regulating help of another, responding positively to some ego support although the conflict between libidinal and aggressive feelings is very much alive for him, as in the following session.

Session 23

Monkey and Elephant were strongly attacked throughout the session – lots of oral aggression, roaring and biting and eventually incorporation – Lenny put Monkey on a plate and ate him up with a knife and fork. At the end of the session Lenny asked if I would take Monkey and Elephant home and bring them back with seat belts on. There were lots of attacks, verbal attacks towards me and affection – Lenny rolled his blue play-doh ball across my back. He got something in his eye and accepted a wet paper towel from me to soothe it, recovering quickly.

Towards the end of the session Lenny got play-doh over his hands, enjoying the colour and being a 'blue boy', the excitement led to flinging the play-doh around the room.

Later that day I met with Lenny's social worker. He reported that teaching staff were asking for an increase in dose, or slow release, methylphenidate as his behaviour deteriorated as the drug wore off. However, there was also a recognition that Lenny was doing well at school, he was lashing out less and seeking help from his teacher. There were far fewer occasions when staff felt it necessary to contact his carer. Lenny's language was developing and he was increasingly curious. When I described the mixture of affection and attack that I was frequently on the receiving end of, the social worker volunteered that Lenny's birth mother was not affectionate and that exchanges were often characterised by insults such as 'Get up you silly bugger'.

I wondered if Lenny was integrating two maternal figures: his aggressive birth mother and the more affectionate aspects of his foster mother.

The following week Lenny was very excitable and needed plenty of boundary setting, to which he responded with help. He jumped and kicked, directed lots of anal language,

'smelly bum bum', 'poo-face' and so on, towards Monkey and Elephant but he could use me as an auxiliary ego:

Session 24

Lenny re-directed his kicks from the chairs and me towards the softplay and the puppets when I suggested they might be preferable targets. He managed to convert very aggressive kicking into a game of throw, catch, kick, pleased that he got to 5 catches.

He was very excited when a tumbler of water got knocked over. He then wanted to jump off the table but managed to compromise holding my hand and jumping to the floor via the chair.

When I told Lenny it was time to finish he ran out of the room and down the stairs. His carer was not in the waiting room and Lenny ran straight out of the building. I caught up with him to bring him back. Lenny was furious, 'Get away from me'. He wanted to dash into the building and into other rooms, unable to listen to my reassurances that his carer wasn't far away, she had probably just gone to the toilet (as in fact she had). His carer appeared quite quickly, she had heard Lenny's distress and responded with a cuddle, holding his gaze and saying, kindly and firmly, 'Did you think I had left you? I would never do that.'

Lenny's carer's acknowledgement of his fear, that he had been abandoned, and her reassurance, physical and verbal were clearly containing. Lenny was quieter and less excitable the following week (Session 25). Lenny had been talking about more toys and I had introduced a new hand puppet, a squirrel. He was pleased with the new puppet which he insisted I prop up beside the monkey and elephant on my hands. The puppets still stood in as 'whipping boys' but they took less of a beating, at least while they were on my hands.

Session 25

He kicked the door chock saying, 'Kick' but his aggression was much more contained within the boundaries of play. He used a little car he had brought with him to scoop everything out of the dolls' house and then tumbled the softplay on top of the pile of furniture. He wanted to knock the house over but managed when I said we would have

to pretend, enjoying making the noises of the house crashing over. Water – the blue vinyl mat – covered everything and a 'big wind' blew everything out of his box.
The total destruction felt apocalyptic but exciting rather than terrifying and cathartic in effect. Lenny spent the rest of the session carefully cleaning his box, worrying that his crayons and the play-doh were making things messy.

He decided to put all three puppets in the bin, pulled them out in the bin bag and kicked the 'ball' he had made. He then decided to put everything away and leave, 15 minutes early. He tidied up in quite a measured way, proud that he could put the little trap door in the doll's house in place by himself. He told me, again with great pride, that he knew his left and right. As we left the room Lenny told me with importance about the 'work' he had to do at school.

I wondered whether the fright of last week, feeling he had lost his carer, had been a chastening experience. Did he have to please his carer with good behaviour and a serious attitude to work, seeking approval lest she might disappear?

In the next three sessions there was more evidently phallic material, along with the oral and anal material that had been predominant. Lenny's capacity for moderating his own impulses continued to develop. In his play containing fences were appearing.

Session 26
Lenny bit the hand puppets, 'eating them up'. The dinosaur ate the play-doh man, sticking its head into and getting completely immersed in the play-doh Racing cars became rockets Monkey and Elephant/I were required to be an admiring audience. Lenny pushed the dinosaur's tail through a hole in the play-doh which provoked aggressive throwing of the play-doh

Lenny was excitable but biddable – he could keep the play-doh on the mat when reminded. Lenny was enjoying sound, colour, texture, pre-school exploration of materials. There was still lots of impulsive behaviour: Lenny kicked the box, thumped the softplay, shouted out 'Shut up' several times but it did not develop into anything more sustained.

Lenny's capacity to make use of another in the service of his own development is growing. He is relinquishing some of his defensive controlling, becoming dependent enough to internalise a healthier capacity for control over his body and his impulses. There was evidence of this the following week when Lenny had been driving a car around the sink making raspberry noises. He suddenly dashed off to the toilet.

Session 27

He called for me urgently to come in but was happy when I suggested I stand outside with my foot in the door so that it didn't close but no-one else could come in. He said, 'Get out'. I was confused, thinking that he was talking to me but then realized he was talking to his 'poo'. Lenny washed his hands using several paper towels that he then wanted to take into the therapy room. He had some difficulty leaving them in the bin in the bathroom but eventually accepted clean paper towels in their place.

Lenny was very quiet for the rest of the session. He organised the animals into pens. The horses had to be separated from the bulls and hippos that might kill them. He decided the wild animals were friends with the horses. The animals, people and vehicles all went to sleep. Lenny carefully laid out the rug and moved everything across, piling everything into a heap.

Lenny took the vehicles and carefully lined them all up on his box lid. He carefully sorted out his box, putting all his pens and pencils into the black bag from the bin. He was very self contained.

Lenny's social worker brought him to his next session. He had to leave the building but assured Lenny he would be back in time to pick him up. Lenny had wanted to bring the garage up from the waiting room. He compromised with more fences.

Session 28

Lenny spent a long time in very focussed play making a fenced enclosure and putting all the animals inside. He decided all the animals were horses. He then piled them all on the floor, broke up the enclosure and stuffed all the fences into the dolls' house. He put out the mat, spreading it across the floor. He placed each 'horse' carefully, moving them around like chess pieces. He got the people out of his box, began to place them on the

mat and then put them in the house. Frantic activity followed, Lenny putting everything in the house. He went to the toilet. On his return he frantically took everything out of the house. Then carefully packed away his toys. Lenny waited whilst I phoned down to Reception to make sure his social worker had returned and was waiting for him. I talked to Lenny about the time he had gone down and his carer wasn't there. Lenny responded, remembering that he had run out to look for her and that he didn't know where she was.

In the penultimate session before the summer break Lenny spent a long time measuring things in the room. I had provided more yellow fences, of the kind he had brought up from the waiting room. He was pleased by these and made a 'giant' structure. He moved around the room measuring furniture and fittings with his measuring fences-stick. This was very intent, focussed activity. In his surveying of the room he came across an empty roll of sellotape:

Session 29

Lenny was very pleased with his find and hid under the table to examine it. He came out to the sink, soaked the cardboard roll in water and sat on the window ledge to peel it apart. He got off and put all the pieces in the bin. Lenny then climbed onto the window ledge and jumped off. He was cross when I said he couldn't stand on the window ledge. He got the bin bag liner from the bin and collected 'rubbish'. He left the room to go to the toilet, taking the bag with him. He wanted to collect more rubbish. When I said he couldn't empty the bin from the bathroom he was very cross with me. He decided he didn't want to stay any longer.

Lenny's tendency to cut short his sessions was echoed by his carer and his last session before the summer break was a short one. His carer arrived announcing that she had to leave ten minutes earlier than usual. It was a fait accompli and I was aware of (and frustrated by) the unyielding quality in her. I wondered if Lenny experienced her certainty as reassuring or inflexible. We had been crossing off the appointments on a chart for the last few weeks. Lenny seemed to look at the room anew in this last session, perhaps taking something in to remember over the school holidays.

Session 30

Lenny explored the room, he was very interested in the locked cupboard. He looked behind and under all the pieces of furniture and was interested in who else I might see in the room. There were lots of 'fatty bum bum' remarks.

Later in the session Lenny's mood changed:

Lenny made a tall tower with the softplay which he wanted me to admire. He knocked it down and became excitable. He drove a little car around the room, whizzing round. He kicked the softplay, attacked the car with the softplay, attacked the softplay with his hands.

He stopped suddenly and tucked his sweatshirt into his trousers. He agreed when I suggested it felt better sometimes to be tucked in. It was time to finish. Lenny carefully poured his beaker of water into my bin. He took the little black car, putting it in his pocket. I suggested he could bring it back in September, after the school holidays. Lenny didn't remark on this but announced to me that he wasn't Lenny any more, he was Spongebob.

I was struck by Lenny's attempts to manage his own excited feelings, tucking himself in, but also his capacity to rely on another, taking something from the therapy room, the car, to hold onto in the break. I wondered about his decision to be Spongebob, an energetic and optimistic character from an American animation. Perhaps there were reasons to be cheerful, no doubt it was also a defence: maybe if he was somebody else he wouldn't have to contemplate the break.

Lenny resumed therapy six weeks later.