

LIFE BECKONING

**A thematic analysis of change in a deprived boy in
long-term foster care, during intensive psychoanalytic
psychotherapy**

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Abstract

This research is based on a single case study of psychoanalytic therapy with a young adolescent boy in care. It is part of a growing movement to identify research methods for exploring the place of unconscious expectations, emotion and affect, in relationships. It experiments with methods for testing out psychoanalytic theory and contributing findings to evidence, modify or expand theory in new directions.

The patient Simon, had a history of deprivation and showed many features of ADHD and oppositional conduct disorder. The research locates him in a “family” of children who share histories of early traumas and serious behavioural difficulties. Therefore findings, while grounded in clinical material from a single case, and restricted in scope, are of relevance to work with a very needy and challenging population of children, who are often a major cause of concern to their carers, teachers, social workers and to mental health professionals.

The research examines clinical material through the framework of Bion’s theoretical claim that identifies thinking as at bottom an emotional process, and relates symbolic capacity to early emotional experiences of communication and containment. The framework was selected because of its relevance to the particular features of the patient, which emerged through the detailed study of session records. The analysis of patient-therapist interaction follows Bion in looking at thinking and learning, side by side with the sort of internal objects active in the therapeutic relationship, and the emotions connected to them. Through a detailed focus on these aspects of clinical material, the author assesses some current ideas about what interferes with a deprived child’s capacity to think and learn from experience; and what are the factors in a therapeutic relationship that can help a child’s capacity in these areas to grow.

Declaration

This thesis represents my own research and original work. It cannot be attributed to any other person or persons.

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Introduction

This research is based on a single case study of psychoanalytic therapy with a young adolescent boy in care. It is part of a growing movement to identify research methods for exploring the place of unconscious expectations, emotion and affect, in relationships. It experiments with methods for testing out psychoanalytic theory – in this case, Bion’s theory of thinking - and contributing findings to evidence, modify or expand theory in new directions.

The patient Simon, had a history of deprivation and showed many features of ADHD and oppositional conduct disorder. The research locates him in a “family” of children who share histories of early traumas and serious behavioural difficulties. Findings, while grounded in clinical material from a single case, and restricted in scope, are therefore of relevance to work with a very needy and challenging population of children, who are often a major cause of concern to their carers, teachers, social workers and to mental health professionals.

Two questions, framed by theory, lie at the heart of the current project:

Applying Bion’s theory of thinking

- What can be learnt from a systematic analysis of selective psychotherapy records about the internal world of a deprived child, his difficulty forming relationships, expressing himself and communicating with others?
- When such a child improves with therapy, what insight can researching the record provide about what is going on?

The first chapter provides a case history, clinical portrait of my patient, and overview of the therapy. In the second chapter, I review the literature on behavioural difficulties in deprived children, clinical theory regarding them, the evidence base for psychotherapy as an effective form of treatment, and theories regarding therapeutic efficacy arising from such work. The third chapter describes the methodology adopted in the current study, locating it in terms of theorized thematic analysis, and tracking the evolution of a grid for session mapping. I present a detailed narrative account of two sessions from the therapy, based on this grid, in Chapters Four and Five. Chapter Six gives an account of

the research findings. In Chapter Seven, I discuss the relevance of the research for carers and other professionals working with children like Simon.

Chapter One

Case history and description of the therapy¹

In the following chapter, I review the particular features of my patient Simon, as they emerged through his relationship with me in therapy. The description is grounded in an examination of the 72 sessions which were written up in detail during Simon's treatment, for supervision purposes. An extended version of the chapter appeared first in a clinical paper presented for qualification purposes, which formed the starting point for the current research.

Family Situation

Simon came from a white working class family and was the eldest of seven children, two full siblings and four half siblings. His mother separated from his father when he was a toddler. The relationship with Simon's father had been violent and it later emerged that the father had a history of mental health problems, including at least one attempt to kill himself. According to mother, father had been obsessed with Simon as a baby, and had taken over his care, leaving mother to manage the other two children. She ended the relationship with him to move in with Simon's stepfather, taking Simon and his siblings with her.

When Simon was 6, he disclosed that his stepfather had abused him physically and sexually. Mother and stepfather denied these reports and accused Simon of habitual lying. The case went to court on two occasions but without leading to a conviction. Simon's parents rejected him, cutting off all contact, and he was placed in foster care with a white, working class family with children of its own, all slightly older than Simon. Simon became very attached to foster father although he was often aggressive and contemptuous towards foster mother. Both foster parents worked shifts, and there were other fostered children on short-term placements, so there was a good deal of coming and going in the household.

Originally a short term placement, the foster family applied for this to be made long-term so as to keep Simon in the family. They were strong advocates for Simon, supporting him in pursuing legal action against his stepfather and in seeking contact

¹ Names and some personal details of my patient have been changed to preserve anonymity.

with his birth siblings, which was renewed against opposition from birth mum and step dad in the year before Simon started therapy. The foster parents provided continuity through a succession of rapidly changing social workers allocated to his case.

During his therapy, there were further disclosures of abuse from the other children in his birth family, and subsequently all Simon's birth siblings were taken into care. The relationship between birth mother and stepfather broke down, social services tracked down Simon's birth father, and both birth parents made independent applications to renew contact with him. Simon refused contact on both occasions. He remained in touch with his birth siblings although this looked unlikely to continue since all the children were being placed separately for adoption / long-term fostering.

Referral

Simon, aged 11, was referred to therapy by the local Looked After Children's team. His foster parents had been pushing for him to have "counselling", because of impulsive and destructive behaviour which demanded high levels of adult supervision at home and at school. He had been assessed by a CAMHS team aged 9 and concerns about ASD traits had been raised, but no treatment offered, perhaps because of a lack of clinical resource at the time.

Simon's behaviour had been just about manageable while he remained at primary school but things deteriorated with the move to secondary school, and the increased demands on him to manage himself independently. He could not hold on to anything on his own: basic personal and school equipment would vanish, as soon as it was passed into his keeping. He was constantly restless and excitable, needing ordinary, routine information to be repeated over and over again. His foster parents and teachers found him to be extremely attention-seeking, usually in a negative and challenging way. There were concerns about his inability to form friendships with other children, lying and bullying behaviour, and lack of emotional comprehension. His foster parents were requesting that he be assessed for an educational statement, and referred to a residential school.

Once-weekly therapy with me began towards the end of Simon's first year in secondary school, as he was rising 12. However the situation continued to deteriorate over the

summer and following term, with both school and home warning that his placement was at risk of breakdown. When Simon killed one of the family pets in the summer, the foster family insisted on a period of respite care and improved support thereafter. It was then agreed that a substantial and co-ordinated package of support was needed.

Measures included:

- Increasing and stabilising social services support to the family;
- Beginning medication for ADHD;
- Increasing therapy to three-times-weekly sessions, alongside monthly consultations with his foster father and periodic network meetings.

Simon began intensive therapy aged 12, at the start of the spring term of Year 8. He came three times a week for two years, then dropped to twice a week for two terms and a final term of once-weekly sessions. Therapy ended when he was 15, at the end of the Christmas term of Year 11.

Therapy fell roughly into two phases: a repetitive / destructive phase (from the start until about 18 months into intensive therapy = 2 ¼ years); and a phase of change/growth (from 18 months into intensive therapy until the end = 1 ½ years).

Note about the therapist

Simon was one of my first referrals as a child psychotherapist trainee, and became my first intensive patient. As a new trainee, I was reluctant to take on the referral, and questioned both Simon's suitability for therapy and my own capacity to provide it, given his aggression and challenging behaviour, and my inexperience. The inexperience and insecurity that went with it were factors in a rigid, defensive clinging to analytic "rules" through the first phase of intensive therapy. For instance, the session reported at the end of this chapter, illustrates a rigid approach to Simon taking things in and out of the therapy room, and to the therapist responding to personal questions. Such inflexibility contributed to the embattled character of the therapy during Phase 1, as seen in the clinical extract.

First impression

Meeting Simon for the first time, in the company of his foster father, I saw a pleasant ordinary-looking 11 year-old boy who seemed interested in his surroundings and keen to make a good impression. It was hard to reconcile his bright, cooperative manner with the description on the referral of a chaotic, challenging boy. I remember that foster dad's plain speaking struck me as quite critical and controlling at that first meeting: he spoke openly in front of his foster son about Simon's shortcomings and failures, and how unbearable the family could sometimes find him. This was mixed with a protective attitude, however, when he moved on to locate many of Simon's difficulties in Simon's early experience with his birth family and the subsequent failures of health and social services to provide Simon with the necessary support.

I found similar exasperation mixed with real commitment and concern among others – teachers and social workers - involved in Simon's care. As foster dad put it on a number of occasions: *"You find you can't live with him, and you can't live without him."* It seemed to link to an underlying duality in Simon's self image which represented him as victim and abuser simultaneously, and was expressed in his impervious disregard for others, conjoined with extreme neediness and vulnerability. As his therapist I was to become familiar with the powerful conflicting drives to punish and protect Simon, voiced by foster father at that first meeting. It was a perpetual challenge for me, as for the wider network, to steer a course free of the pull towards indulgence and permissiveness, at one end of the spectrum, and rigidity and blame at the other.

Deprivation – appetite and destructiveness

Simon was quick to occupy the space provided for him by therapy. He showed a voracious appetite for resources, time, and information about his therapist and others in the team. His creativity in play was immediate and seemed effortless, capable of improvising endless variations on a single theme. Yet this appetite and activity had an insatiable, restless quality, communicating emptiness – an internal world where people and things were routinely debased, stripped of meaning and value. Sometimes Simon seemed to be showing himself as trapped in this world, sometimes as actively involved in maintaining and promoting it.

His use of play materials is illustrative. Simon showed an acute awareness of the materials in his box, the toys in the room, and materials provided for him. His treatment of these things was often contemptuous and rubbishing, however. Fresh paper provided at the start of each session would be used up and trashed, whatever the quantity supplied. Sometimes the destruction would be undisguised – paper soaked, torn or crumpled so as to put it beyond use. At other times, the destruction was more subtle, connected with creative activity requiring resources on a large scale, which rarely reached completion or turned out to have a destructive intent. Thus, paper planes were made in industrial quantities, tested, and then binned. Numerous sheets of blank paper were turned into “bangers”, which Simon would snap to make a loud “BANG” in the hope of giving me a fright, or disturbing the gulls outside. More poignantly, during many months at the start of therapy, he would begin drawing his name in bold block design, sometimes with great attention to detail, only to abandon or jettison one after another as unfit for purpose. The trashing of his name in this way, which was upsetting to witness, often bore traces of sado-masochistic pleasure, with Simon occupying the position of victim and abuser simultaneously, using me as an audience. It also had the quality of a repetition compulsion, as if Simon was driven to recreate the sequence of his own abuse in this way, positioning me in the role of the adult onlooker who fails to intervene.

The sellotape ball

During the early months, when I was still re-stocking materials on a sessional basis to keep pace with the wholesale rate of consumption, rolls of sellotape would barely last a session, as Simon worked on creating an enormous sellotape ball. This was to be the biggest sellotape ball ever, winning a place for him in the Guinness Book of Records. As it grew in size and weight, outstripping Simon’s box, it served as a formidable missile, posing a threat to me and to the fabric of the room at different times. These moments were common in connection with external disturbances, including breaks in the therapy, when Simon’s sense of deprivation snowballed and was most acute. The sellotape ball’s dimensions and destructiveness then seemed to become a concrete representation of a painfully conflicted inner state, swollen with anger and hurt, which could barely be safely contained.

Attacks on the therapy and sado-masochistic traits

Simon's activity grew increasingly destructive as he confronted the limitations of his therapist and the session boundaries. He showed me that holding the boundary between what was his to claim (my time with him in the room), and what was not his (my time apart from him) was almost intolerable to him. When I failed to respond to his wish to know about my life apart from him, I was experienced as cruelly provocative, taunting him with what he could not have.

My occasional friendly gesture or expression of sympathy in response to a loss or mishap in the play, were for him the mocking actions of a sadistic mother, bent on exposing his loss so as better to humiliate him. He showed a fierce desire to turn the tables, making me the one left out of games, rejected and scorned, and he the hardened one in charge. It could get physical and manic: for many sessions, the room and I were pelted with paper planes, pellets, balls, pencils, and wooden cars. Chairs and tables were drawn on, scratched, kicked over. Some sessions became a kind of orgy of destructiveness, the room turned upside down, littered with toys and paper, with Simon making a triumphant exit at the end.

His tormenting aggression against the depriving mother would sometimes push me into acting in with the role, by depriving him of play materials; or I would be driven to the brink of having to end a session early. There were times when his toy box was almost completely empty because this seemed the only way of limiting his unceasing attacks on the materials and on me. Perhaps most disturbingly, I was frequently pushed to the limits of my own anger during these periods, and there is no doubt that these feelings infected the quality of my actions, providing some basis of reality for Simon's sado-masochistic fantasy.

Sometimes bully, sometimes victim, Simon conveyed the powerful blend of attachment and hatred which pervades sado-masochistic relationships: the pull to merge with me, in his physical steps to get rid of the space between us; and conflicting urge to beat a hostile retreat, and sever contact. He could not isolate himself for long however, and even at his most remote, was keenly sensitive to moments when my attention wandered. Session endings were fraught with conflicting feelings: he had an acute sense of timing and even at his most threatening and contemptuous, would never leave a session early.

Controlling the object

Simon's behaviour was controlling, insisting I followed instructions, and getting very frustrated if I refused. He could be intrusive physically, emotionally and mentally, hammering with questions to get inside my mind and physically to get inside any object whose entrance was denied him. He was constant in his efforts to explore my life outside the room, usually in the form of questioning what I owned, where I had been, what factual knowledge I possessed. Throughout the therapy, he kept up a low-level investigation into whether or not I had a car, and what sort it might be. This enquiry was conducted both inside and outside the therapy room, in conversation with his driver, and via a monitoring of the cars parked outside our building. Similarly, he wanted to know exactly who I knew in his care network and what conversations I might be having.

His intrusiveness often took a concrete form. He showed a peculiar alertness to all the areas off limits to him, especially drawers and cupboards in the therapy room. These could not be locked and I had to "police" them, as Simon attempted to trick or force an opening. He badgered me with questions about what went on upstairs, in the office, and in the staff kitchen, all closed doors to him.

Absence of good objects

There was a barrenness and rudimentary quality to his quest for someone or something good. He expressed a perpetual sense of grievance and complaint which had much more solidity than any contrasting experience of satisfaction. It was, for instance, common for him to rail against the limitations of the play materials. He would spend weeks pressing me to introduce new toys and materials, or to replace old pens with new ones. Yet this would no sooner win a response than the sought-after object would be discarded, and he would bring a new demand. He was also adept at finding surreptitious ways of introducing new materials into the room – bringing in quantities of elastic bands, collected from the post table, and converting his plastic water cups into building blocks, skittles, telephones and the like, with great ingenuity.

Once in his possession, objects lost their value and could not be preserved from one session to the next. So a paper games board, designed and executed with painstaking

care in one session, would be trashed without a second thought in the next. He often appeared blind to the internal and external resources available to him. One day, for example, he was faced with our building's In/Out board, showing his floor of our organisation "In" and the second one "Out"; he immediately homed in on the "Out" sign to conclude I had stood him up. Such expectations continually interfered with his capacity to engage with the complexity of the world about him. It seemed that the hunger and grievance that drove him had no experience of satisfaction to inform it, or help him recognise relationships and opportunities with something to offer him.

The ignorance of what might constitute a good object, and what a relationship with such an object might be like, was communicated in Simon's play. I was particularly struck by the way his considerable inventiveness was narrowed to elaborating variations on essentially repetitive games. These featured endless competitions involving pens and cars, wooden building blocks and plastic cups, games of elimination, complex exercises in obstruction, demolition and collapse. Over many months, it was the sterility of the play which came to stand out, as repetition leached it of meaning and emotional immediacy. Departures in new directions, though full of purpose at the outset, were prone to abort early, like promising paths which peter out after a few yards. Thus, the boy who energetically made telephones from plastic cups, would find himself at a loss when it came to using them, soon drying up and pressing me to improvise the imagined conversation. Likewise, his many paper fortune tellers which looked so convincing from the outside, all turned out to be blank on the inside flaps.

The restless activity had an addictive, deadening feel to it, creating a space where nothing new could ever happen. Interpretations led nowhere.

The difficulty progressing from a latency position

For much of his therapy, Simon appeared locked in a latency position², defending

² 'Latency' names the psychosocial developmental stage between infancy and puberty, corresponding in most children to the period between the ages of 5-6 years and 11-12 years. Waddell (1998) links the anxieties of latency to the process of separating into a world beyond the family. The latency child copes with these anxieties with "*characteristically rigid patterns of defence*", typically a focus on ordering and rule-following, which "*may inhibit the child from exploring and taking initiatives and limit the more imaginative side of the self, resulting in the repetitive and monotonous activities so characteristic of these years*" (Waddell 1998: 74). The repetition and rule-following serves a developmental purpose, providing the child with a means of regulating his very powerful feelings during a kind of transitional period, when external parental function begins to dilute and recede and while internal parental function is still

against anxiety with rigid, repetitive activity and a constant reaching for rule-following play, despite showing many physical signs of puberty as time passed. He grew taller and heavier, his voice broke, his skin developed sudden adolescent rashes. Yet he persisted in squeezing himself onto the child's chair, jamming his knees under the little table in the therapy room, even when this became physically a challenge. At 13 and 14, he was still playing hide and seek and versions of hunt the thimble, flying paper planes, and playing long improvised editions of TV and board games, like Deal or No Deal, snakes and ladders and Monopoly.

His persistence in identifying himself as a latency child, against all the evidence of his own physical development, acquired the flavour of a perverse addiction: he seemed to be showing his deep-seated antipathy to change, or progress, leading in the direction of responsibility and hope. As latency children are relatively exempt from external demands to think for themselves and take responsibility for their actions, so Simon made it clear in his sessions that these functions had to belong elsewhere, habitually retreating from attempts to explore a situation with bored indifference. Despite the displays of inventiveness, he frequently claimed that he had no thoughts and no views about anything, inside or outside the room, he knew nothing, acknowledged nothing. The constant attack on the setting, illustrated in the material below, was also in this respect a defensive manoeuvre, aimed at maintaining his relationships at a developmentally regressed level where he could not be left safely on his own.

Enactment and concrete thinking

During the first eighteen months of intensive therapy, the play was concrete with little imaginative content. Games had a way of taking over the sessions, becoming manic and controlling. We passed many weeks in the therapy playing "Deal or No Deal". Simon would grow very impatient with me, when I commented on this or "*wasted time*" with interpretations. Other play showed him inhabiting a world of mechanical objects with little space for thinking. He talked with fascination about fairground games and one in particular, a machine filled with teddy bears with a robotic claw which the player had to manoeuvre into position in the hope of grabbing one of the bears and swinging it down

primitive. In this sense, the monotonous activities contribute helpfully to constructing a mental space relatively protected from emotional turmoil, where the child is able to think and explore the extending world around him.

an exit chute. Simon would identify himself as the claw, demanding that I take the role of the player, issuing him with a range of scripted instructions, “up, down, left, right” and so on. At one level, his play seemed to represent the way in which his tenderness had become imprisoned behind a defensive screen, and tantalisingly beyond his powers of access. At another, the game, which I experienced as highly coercive, communicated Simon’s stifling internal situation: his defensive identification with a mindless machine without volition, or responsibility, which worked by reducing scope for independent thought and action to a minimum.

There was a lack of interest in thoughts and ideas. While his play and behaviour were often expressive, he would dismiss suggestions that they might hold meaning for us. I toiled away at interpretations, and in more cooperative moments, he would allow space for this, making it plain that he was happy to humour my weird ideas, so long as I didn’t intrude too much on his play time.... And he didn’t have to respond.

He poured out feelings and fantasies but without any curiosity about what might lie behind them. Curiosity of this sort, and thoughtfulness, had to be projected into me. This is not to say he had *no* curiosity since, as described above, he was intrusive in his quest for information, especially when access was denied him. But his curiosity was acquisitive and controlling, disengaged from an interest in personal insight. In the same way, while he showed an aptitude for memory games and often put my memory to the test, his own experience, even when quite recent, seemed lost to him or only available in a fragmentary, disconnected form which could not be shaped into a narrative of any length or depth.

Projective communication

One consequence of the resistance to thinking, was that communication between us was for a long time located in the arena of action and feeling, rather than meaning. Simon showed his indifference to what I had to say while remaining very attuned to the feelings behind the words. It seemed my understanding was worse than useless to Simon, unless he could sense an emotional engagement on my part, or get me to join in an enactment; as if at times the only part of Simon available for contact, was an unthinking self who could enact feelings but not symbolise them, relate emotionally but

not reflectively. The challenge was to find some way of renewing contact with his thinking self, as well as with his split-off infantile feelings.

Very occasionally, Simon would start a session with a piece of dramatic information – always concrete, always factual - from his life outside therapy. For instance, he reported on his foster mother's admission to hospital, the arrival and departure of other foster children in the family, the birth of a new baby. When he received the letters from his birth mother and birth father, he brought these to show me. Efforts to explore or associate to these events were almost always abortive, however. At times, there was a tantalising quality to this – Simon occupying the role of the “teasing” object – but at other moments, his retreat into play was like someone who finds himself in a cul-de-sac, where the only way out is backwards.

He did however show considerable interest in my reactions to his reports. Initially I regarded this further projection as an act of expulsion - a way of splitting and projecting his concern into me, so as to rid himself of it. As the therapy progressed, however, I began to consider that it might have a more communicative and exploratory purpose.

Life beckoning: changes during therapy

Change in Therapist

I became aware that my efforts to interpret Simon's enactments were often serving as a way of keeping him at arm's length, distancing myself from the emotional turmoil he could stir up in me. This did not offer him containment but merely served to increase his frustration and confirm his belief in an unavailable object. I became increasingly concerned with the risks of this position, the more I felt my own sadism triggered by Simon's aggressive and contemptuous treatment. Also, the longer I remained preoccupied with returning his projections prematurely via interpretations, the more extreme he became in his efforts to reach me. I found I had to accept, and in some way acknowledge, the disturbed, sometimes violent feelings, Simon projected into me.

This was not a simple matter, and I doubt I would have found it thinkable without a great deal of help from my supervisor. Too much of an acknowledgement risked becoming a retaliation. It was important to stop trying to relocate the aggression back

with Simon however, and instead free up some space for both of us – for me to do some real emotional processing and containment work in the countertransference; and for him to experience a relationship where his sadistic attacks, and my own destructive responses, could be met authentically and thought about, instead of converting immediately into conscious or unconscious retaliation.

Inevitably, I did not always get it right and then it was important to acknowledge the failure and the feelings stirred up by it. On one occasion, when I had found Simon's treatment of me particularly unbearable, I could hardly wait for him to leave the room at the end of the session before shutting the door on him with unnecessary force. He confronted me with this the following day, and we were able to talk about his provocation and my failure to withstand it, together with the very anxious feelings he was then left with. It proved a moment of real connection, freed of sadism, perhaps one of those "*moments-of-meeting*" described by Stern et al (1998) which "*leave in their wake an open space in which a new equilibrium is formed.*" (Sternberg, 2006: 44)

My language and interactions with Simon grew less constrained and I found myself becoming more creative and expressive with voice and movement. Countertransference underwent a change, as maternal feelings came to the fore and I found myself taking increasing pleasure in Simon's company and play.

Change in Patient

In association with experiences of this sort, new aspects of Simon began to emerge in the therapy, bringing opportunities for a different sort of relationship to develop. One example was the evolution of "aka" Simon, a play persona, who expressed a conflicted dread and pleasure in contact, with lively and experimental playfulness.

Physical proximity became a place for a conversation to develop, instead of an experience threatening hostility or annihilation. He became able to name his very hungry feelings and find them mitigated, not aggravated, by the contact between us. The space for concern and love began to emerge, not in place of, but alongside, aggression and destructive feelings.

The change in the quality of play was striking. It was no longer the mechanical, monotonous activity of the earlier sessions. Both of us showed a new freedom to engage spontaneously and creatively with each other's ideas. Control ceased to be the central issue; humour – so bitter, sometimes wounding, in the past - became a way of developing an idea and bringing it to life between us.

Simon began to play with thoughts which in earlier times could only be enacted. His pleasure in word play suddenly took off and imaginative, interactive play started to replace the repetitive board games. As his “as if” activity increased, it brought him the opportunity to separate from the fantasy of living in a world of mechanical objects and explore how he made it a defence against being alive, owning memories, desires, curiosity: all the delights, limitations and vulnerability of being in a human relationship. In the process, he became more able to bear and have some sympathy for, the vulnerable, hitherto despised, parts of himself and his therapist.

Ending and outcomes

By the end of therapy, Simon was more consistently in touch with both the robotic and the infantile aspects of his personality. With relatedness had come a world of meaning, where words could be played with and joined up in all sorts of different ways: a very different situation from before, when Simon experienced my words as cruel barbs, needing to be drowned out; or meaningless intrusions on a private world of robotic objects. However, his capacity for independent thought remained very underdeveloped and he showed a young child's reliance on his therapist when it came to processing experience in the direction of self understanding and insight.

Ending therapy at this point was a decision taken on several grounds. Arguing for the resources needed to continue was increasingly difficult because of the expense involved. Meanwhile, there were concerns that therapy was encroaching on Simon's time for other age-appropriate and developmentally relevant activities, such as time with peers, and school work. These combined with a concern in me, that Simon needed the impetus of limits³, to pull him free of an addictive flight from reality and abuse of resources in himself and others. In this regard, I think some of the developments in the last six

³Limits, carrying the significance of absence and frustration, work as a “*spur to development*” (O'Shaughnessy 1964: 134)

months of intensive therapy were due to an ending date for intensive work having been agreed.

Therapy continued for another year, with twice weekly sessions for two terms reducing to once weekly in the final term. In the last few weeks of sessions, there were a number of moments when he wanted to review our time together. He reminded us, with some appreciation, of the times when he had succeeded in ‘winding me up’, recognising too his own messy, destructive behaviour. I think this was a communication on a number of levels: an expression of potency; a reminder of his grievance with an abandoning object; but also, an acknowledgement of a relationship where we had undergone a lot together and experienced real contact. The tone was retrospective, companionable as if to say that from such shared experience, we had reached a place where the feelings of hostility had been mitigated enough to be owned, without risking a re-enactment.

At this point, there had been significant improvements in Simon’s behaviour; there were no longer concerns about placement breakdown; he had developed some friendships and was keeping up with his peers academically; he had stopped his ADHD medication 10 months before. School were “delighted” with his progress and he had been off report for a term. He went on to secure a good handful of GCSEs at C grade and above.

Perhaps most notable was the strong relationship he had developed with the baby in the family – the daughter of his foster brother. Simon’s foster parents had been very concerned about leaving Simon on his own with the baby during the first year, but by the final review this concern had given way to a confident trust in his evident care for her.

Clinical illustration of Simon’s presenting features and early patient-therapist relations

The following material illustrates some of the core features of the therapy discussed above, namely: Simon’s appetite and destructiveness; his attacks on the therapy and their sado-masochistic quality; his intrusive, controlling behaviour; the concrete thinking and enactment that dominated the first phase of therapy; the inflammatory impact of interpretations; and my own struggle with rigid, defensive thinking aroused by the sadistic, depriving identifications projected into me.

It comes from a session fifteen months into intensive therapy, during a messy period when Simon was repeatedly trashing materials and breaching whatever boundaries were set. Externally, over the same period, Simon's birth family had been much in evidence, exposing Simon to repeated conflict and upset. There had been disagreement in the care system over the issue of Simon's younger sister, now in care, joining Simon's secondary school. His siblings had all disclosed sexual abuse; his mother, after years of disowning Simon, had written him a letter of apology and asked to see him. And the care network was in turmoil over a letter from Simon's vanished birth father who, located by Social Services, had written out of the blue, inviting Simon and his siblings to visit. Against this backdrop, Simon and I were struggling with the forthcoming Easter break.

The session begins with Simon pushing boundaries by bringing food into the room and protesting my request that he leave it until the end of the session.

He gets out the calendar we have been making and says with a flourish that he's going to mark off his first session – "now there are just nine left before Easter!" I comment that it sounds like he feels that's not much. Simon responds for a moment in a more ordinary voice, saying yeah, actually he can't believe its only nine sessions until the holiday...

He switches to his more hectoring voice to ask me what it was that we were playing the previous session. When I don't respond to this, he persists, louder – "Go on, tell me!" ... Then he follows with another aggressive question – "And did you find out the May bank holiday dates?" I say that I haven't done this yet. "Why not? I bet you forgot didn't you!" I respond that he seems to think that I've forgotten everything, can't remember him today ... Simon has gone back to his nougat bar and now strips all the paper off it. I ask him to leave it alone. ... He picks it up and waves it at me, then breaks it and takes another big bite. I say I will have to take it out of the room if he can't leave it be. He makes a show of biting off another piece. I go and take the bar. Simon struggles, then

relinquishes it, cramming a last piece into his mouth as I take the rest out of the room.

He has already repeatedly smashed his water cup against the table, spilling his water, and now picks a pencil out of his box and hurls it viciously against the far wall. I comment that he really wants to throw and smash things today, it looks like he is choosing things that will make a mess. I link this to him bringing in his nougat bar, knowing that I would object to this, and then going on to make a show of eating it, as if he was perhaps looking to get us into a fight. "Yeah", agrees Simon with emphasis. I suggest he wants to have a go at me today and I wonder what he thinks this is about. Simon replies he just wants to play that's all.

There follows an escalating attack on me with paper planes and pellets.

He orders me not to look at him, to turn my chair round and face the wall. I say I think he finds it very difficult when I look at him or speak to him when he's feeling like this. He comes across the room saying if I don't move my chair, then he will! When he lays hands on the arm, I tell him to leave it be. He gives it a tug and says "Or what, what will you do, uh?" Then walks away.

If I speak, he tells me to shut up, he's not listening, He talks about leaving early – he's got a party to go to at 6.30 and then at quarter to seven – he pauses, "What am I doing at quarter to seven...?" He stares at me, repeating his question over and over again, growing more strident. ..He starts twirling the cars around on the table, smashing them into each other, then hurling them as hard as he can across the room, making a tremendous and violent racket, every now and again shooting me a contemptuous look. "Don't cry!" he jeers, then breaks into a parody of crying, repeating this at different intervals. It feels horribly painful and hopeless.

I am pelted with more, and harder, objects.

I warn him that if he goes on throwing things at me, we will have to finish for today. He turns and throws them hard at the wall, then gets together two pencils. He drops them on the floor, and orders me to "say goodbye to the pencils." When I don't respond, he repeats it louder each time, as he treads on the pencils and kicks them to the door, pushing them underneath. He opens the door to get them back and lined up again, before kicking them outside again. I talk about his feeling that he is getting closer and closer to getting himself "kicked out".

There is a brief return to vestiges of more friendly play which collapses after a few seconds.

He comes across the room and drops onto the cushions beside my chair, with a blanket over him, saying loudly that he's going to sleep now until the end of the session. I'm to wake him up at 3 minutes past 6. "When are you going to wake me up then...? What did I say...?" When I don't speak, he repeats his question, telling me not to ignore him. If I start a comment, he immediately drowns me out, shouting at me to shut up....He begins talking about how many minutes are left, marking time and dates. I wonder if what's been happening in here today is to do with dates, and with us making a calendar for the break.

He spots the wobbly table leg, kicking and tugging it, saying "it's broken, see!" He says any minute now I'm going to tell him it's time, and wants me to tell him exactly how many seconds he has left. When I respond that it's not long and I'll let him know when, he grabs my wrist, forcing it round to see my watch. I tell him to let me go. He jumps to his feet and goes to stand by the door. I tell him it is now time. He picks up some pens off the floor, saying "Freedom at last!", turns to throw them across the room, pulls open the door and turns off the light. I am left in darkness, with everything in the room spilt and overturned.

In this session, I felt I had the experience that Joseph described, when “*in the transference, one gets the feeling of being driven up to the edge of things ... and both patient and analyst feel tortured.*” (Joseph, 1982: 322)

The forthcoming break is powerfully in evidence throughout, with Simon’s attention to the calendar at the outset, and his vigilance regarding the dwindling time left to him, as we get to the end of the session. There is a brief moment at the start when he can register the holiday as a disappointing but tolerable interruption. However this gives way almost at once to his feelings of extreme rejection by an uncaring therapist-mother, as if invaded by the feelings connected to his birth mother’s abandonment. He is then committed to forcing through a re-enactment, where he is cast as the unbearable child and I the cruel mother who has no genuine interest or concern for him. His hectoring interrogations communicate his conviction that he is forgotten, overlooked. My failure to have the May bank holiday dates ready for him, is regarded as evidence of my criminal indifference and neglect. His attack on the setting boundaries and on me, seems bent on dislodging me from an analytic position regarding him, just as later he wants to mess with the position of my actual chair. When I succumb and remove his nougat bar, I unconsciously take on the identity he has assigned me, so “acting in” with his projection, and becoming the hostile, punishing figure, who wants to deprive and expel him. Yet alongside the pain of this, we get the sense that Simon is also excited by the experience. There is sadistic enjoyment in making me witness the expulsion of the pens, and the brutalising use of toys and old games to trash the room. He communicates his rage and contempt for a therapist who has failed to keep the setting safe from breaks, along with his sense of a useless, broken therapy which, like the table leg, is not robust enough to withstand him. But there is a triumphant edge to his exit.

Chapter Two

Literature review

Introduction

In the previous chapter, I concentrated on selected aspects of my fostered ADHD patient Simon, which seemed particularly relevant to understanding his internal situation. These loosely group into three areas:

1. the nature of his relationships with people and objects
 - his appetite and destructiveness, evidenced in a preoccupation with mess and dedication to destructive, repetitive behaviour in therapy
 - attacks on the therapy and sado-masochistic traits, which often lent his activity a cruel, coercive, sometimes excited, quality
 - very controlling use of the setting and relationship with his therapist;
 - absence of good objects and sense of deprivation
 - developmentally-arrested quality of his relationships
2. his pattern of cognitive function and communication
 - marked difficulty developing symbolic play;
 - apparent addiction to mindlessness
 - use of enactment and concrete thinking to take the place of reflective function
 - prevalence of projection over other forms of communication.
3. the character of therapeutic change
 - futility / negative impact of therapist's interpretation over long stretches of therapy (phase 1)
 - need for therapist to engage emotionally with primitive states of mind / be emotionally available to receive extreme projective communications during this phase
 - need for patient and therapist to work through repeated experiences of hostility and rejection before a different solution could be found.

The aim of the current chapter is to explore the literature relating to these aspects of Simon, and the disproportionate number of children in the care system with diagnoses

like him of ADHD and oppositional behaviours (ONS 2003)⁴. While psychoanalytic, theory provides the chapter's primary frame of reference, I also draw on data from a range of research disciplines, including neuroscience, child development, and parent-child attachment studies. What does the literature have to say about the links between ADHD / oppositional modes of relating and early deprivation? Does early trauma or a deficit in early parent-infant relations have consequences for symbolic functioning and modes of communication at later stages of development? Can such difficulties be addressed by therapeutic intervention, and if so how can we make sense of its contribution?

The chapter is structured in three parts as follows:

In part 1, Klein's concept of internal world is used to gather together converging views of how children with ADHD/disruptive behaviours, arising in a context of early trauma / deprivation, come to share specific difficulties around relationships. I argue a cross-disciplinary case for approaching ADHD-type behaviours among this subset of children, as a probable consequence and expression of early emotional damage.

In part 2, I consider Bion's concept of thinking as an emotional process, expressed in the concept of K and -K. His concept is then used to organize converging theories from the consulting room, neuroscience and child development research, regarding the link between deprivation and ADHD-type problems in concentration, mental processing and symbolization.

In part 3, I review the clinical evidence for regarding intensive psychotherapy as an effective form of treatment for deprived, ADHD-type children. I explore different theoretical and clinical accounts of work in this area to argue a need for clinicians working with such children, to be particularly alive to communications at a primitive, emotional level.

⁴ A summary of ADHD diagnostic criteria is given in Appendix 5

Part 1: Internal features of development and deprivation

The child's internal world: a dyadic construct

Many contemporary views of child development, based on experimental research, were anticipated by the early pioneers of psychoanalysis and in particular by Klein.

According to Klein, the mental and emotional life of the infant hinged on the relationship it builds with its first maternal figure - who is both a real external presence for the baby and also develops as a figure in the baby's mind. The infant forms an *internal world* derived from the interaction of infantile phantasy with external reality. Klein theorised that when the infant's first experiences with mother go well (the baby experiences enough emotional and physical satisfaction), the infant is able to internalise and establish over time a good internal object/sense of itself, which helps it withstand difficulties arising from internal or external disturbance, and seek further interactions with hopeful expectancy. Klein referred to the balance of understanding, fears and defences born out of a good enough experience of mothering, as the depressive position, "*a unifying experience for the infant, as the gradually acquired constancy of the internal object mitigates the effects of actual separations, disappointments and frustrations.*" (Wakelyn 2011). Development towards the depressive position is of critical importance in psychic life, allowing infantile anxieties to regroup, to introduce concern for the fate of the internal and external parents, and a gradual differentiation between internal and external reality.

Adverse experience with mother will have an opposite effect – the baby will be left with a bad internal figure/sense of a bad self (depriving, cruel, neglectful) and seek to defend itself – by for instance, establishing an aggressive or idealised relationship to the self, internal and external figures; or by turning away from interaction. Anxieties remain fixed to phantasies of hostile attack or retaliation by figures hostile to the self. Klein named such a constellation of primitive fears and defences the paranoid-schizoid position, because of the persecutory nature of the baby's anxiety and the split quality of its internal figures, between extremes of good and bad.

In one of her last papers, Klein reiterated the importance of the *external* infant-parent relationship for such developments:

“External circumstances play a vital part in the initial relation to the breast. If birth has been difficult ... whether or not the child is adequately fed and mothered, whether the mother fully enjoys the care of the child or is anxious and has psychological difficulties feeding – all these factors influence the infant’s capacity to accept the milk with enjoyment and to internalise the good breast.”

Klein (1957: 179)

The personality and *internal world* thus develop around the early feelings and phantasies towards the parent figure, in interaction with the parent’s response: the quality of the interaction gives rise to particular anxieties and defences which shape our ability to learn, face reality and to perceive accurately ourselves and others.

Klein’s ideas about the centrality to future development, of the mother-baby relationship, were expanded by Winnicott (1952), who went further to argue that there was no such thing as a baby, only “*a nursing couple*”. Winnicott regarded the mother’s capacity to devote attention to her baby and to adapt herself and the environment to meet her baby’s needs, as providing the necessary conditions for infant development to take a favourable direction. His term “*primary maternal preoccupation*” (Winnicott 1956) to describe this state resembles Bion’s concept of “*maternal reverie*”, whereby the mother’s mind provides a receptive container for her baby’s unorganised experience and her multi-layered response – cognitive, emotional, physical – gives the first shape and order to what was inchoate in the baby’s mind.

From the perspective of developmental psychology, attachment theory has contributed a further volume of research establishing the link between early mother-infant relationships and subsequent mental health. Attachment pioneers, Bowlby and Ainsworth, hypothesised that the quality of attachment between infant and caregiver generates an enduring internal working model of the self in relationship to the world, which can serve as a predictor for mental and relational functioning in adulthood. Infants who have experienced consistent, sensitive and responsive parenting are much more likely to become adults with a coherent and adaptive sense of self and reality, than infants whose parents have been otherwise preoccupied.

Trauma and Deprivation in early care: their impact on brain development, emotional functioning and attachment behaviour

Simon, the child at the centre of this research, had experienced a traumatic early history involving parental mental illness, domestic violence, separation at a very early age from a primary care giver, physical and sexual abuse, and subsequent scapegoating and rejection by his birth family (see previous chapter). Deprivation in the early parent-infant relationship – and especially caregiver-induced trauma - has been commonly taken to cover a spectrum of infant experience ranging from intrusive / neglectful parenting to active parental abuse. It may encompass emotional, sexual, or physical abuse of the child by the parent; neglect and forms of parental absence – perhaps a literal physical abandonment; and/ or an emotional absence or failure of parental function in attending to, and containing, the child's experience. In its many guises, it is a principal cause of children being taken into care.

Speaking of its effects on brain development, Schore identifies care-giver induced trauma as *“qualitatively and quantitatively more potentially psychopathogenic than any other social or physical stressor.”* (Schore 2001b: 207). In psychobiological terms, sustained parental abuse and neglect not only deprive the infant of an essential environment for the regulation of stress at a critical period of right-brain development; they also further escalate infant stress and lead to excessive pruning (or parcellation) of neural networks (Schore 2001b).

“Both lack of critical nurturing experiences and excessive exposure to traumatic violence will alter the developing central nervous system, predisposing to a more impulsive, reactive, and violent individual.”

(Perry 1997, cited in Balbernie 2001: 245)

Such children, like my patient, are prime candidates for a later diagnosis of ADHD because of the impulsive, reactive features they have developed. The NICE 2009 guidelines note that among the several aetiologies involved with the diagnosis:

“ADHD has been associated with severe early psychosocial adversity (Roy et al., 2000).”

National Collaborating Centre for Mental Health (2009: 29)

Where deprivation involves caregiver-induced trauma, it is closely associated with later psychiatric disorders, including borderline personality disorder, post-traumatic stress

disorder, dissociative, or multiple personality disorders, and sociopathic personality disorder (Schoore 2001b, Balbernie 2001). It appears that the younger the child exposed to trauma of this sort, and the longer its exposure, the more pervasive will be the effects and the more “hard-wired” the child’s troubling behaviours may subsequently appear. Perry et al (1995) trace how a traumatic experience causes certain neurochemical and structural changes to forge a particular stress response pattern in the infant brain, moving along a continuum from hyperarousal to dissociation, which is then reactivated by reminders or memories of the event. Gradually reinforced in this manner, the response pattern is then generalised to determine behaviour in other contexts (“states” become “traits”, Perry, 1995). Traumatized children may live in neurologically-defined states of permanent low-level hyperarousal or dissociation which closely match behaviours found among children with an ADHD diagnosis.

The first two years of life are particularly important for right brain development and growth (Schoore 2001b), such that infants under two will be more vulnerable to trauma in certain respects than older children. Functions of the right brain include autonomic activation; regulation of primary emotions and the stress response; and procedural and implicit memory. All are functions regarded as core deficits in children with ADHD. Reviewing Perry’s (1995) neurobiological study of childhood trauma, Orford reports similar conclusions:

“Perry’s finding is that children with true ADD/ADHD have established neural pathways on the basis of response to threat or trauma.”

Orford (1998: 260).

It is unsurprising in the light of these findings that there are such high rates of ADHD among children in care, whose early relationships with parents have, like Simon’s, often been disturbed ones. The Office of National Statistics (Meltzer 2003) reports that the prevalence of ADHD and conduct disorders in the population of looked after children is seven times the national average.

The evidence from attachment studies agrees in associating a certain type of disturbed behaviour in children to deprivation or trauma in the infant-parent relationship. Research on attachment behaviour in neglected / abused infants (Egeland and Sroufe, 1981; Crittenden, 1987; Gaensbauer and Harmon 1982), led to the identification of a new, type ‘D’ category, of disorganised/disoriented attachment. Type “D” attachment

was subsequently detailed and formalised by Main and Solomon (1990). Infants in this group seemed to be in the grip of (and disoriented by) conflicting attachment impulses, expressed in: behavioural paradoxes such as approaching the parent backwards; rapid shifts between hyperactive and dissociative states; and extreme dissociation (freezing).⁵

Attachment studies show that although type “D” attachment is not always predictive of maltreatment (Main and Hesse, 1990), 80% of abused infants exhibit type “D” behaviour (Carlson et al 1989). Hindle’s 2000(a) study identified similar attachment behaviours among deprived children with histories of abuse and/or in the care system. As Philps (2003) points out, such children show considerable difficulty in forming relationships with later carers, since the disorganized and paradoxical characteristics of type ‘D’ attachment, signal “*a lack, or collapse, of an organized strategy for maintaining a functional attachment pattern*”, making it “*dysfunctional with regard to maintaining attachment*” (Philps 2003: 17). The rapid shifts between hyperactive and dissociative states, the difficulties organizing and completing tasks, the affective lability which characterize children with ADHD, are all common among children in this category.

Research into co-morbidity in severely deprived children by O’Connor et al found:

"Attachment disturbances ... overlapped markedly only with inattention/hyperactivity. It may be that both forms of behaviour problems frequently co-occur because they derive from a common aetiology, early deprivation."

O’Connor, Bredenkamp and Rutter (1999: 23)

Ladnier and Massanari (2000) argue a case for treating ADHD in some circumstances as *attachment* deficit hyperactivity disorder, linking ADHD-type deficits in self-regulation and relating skills to classic symptoms of attachment trauma in early childhood.

⁵ Closely related to type “D” behaviour is what is now described as “Reactive Attachment Disorder”, where children exhibit either abnormally inhibited or disinhibited attitudes generalized indiscriminately to a range of caregivers / strangers (O’Connor, Bredenkamp & Rutter 1999). Perhaps because of similarities in presentation and lack of conceptual clarity, some researchers have noted a difficulty in distinguishing between these aspects of attachment disorder, disorganized attachment and the consequences of maltreatment (Prior & Glaser, 2006).

Jones (2002) similarly cites research linking the self-regulatory difficulties of a subset of ADHD children to a parallel area of deficit in the parent:

“Because of the dual process of acquisition of affect tolerance (by learning and by identification), children whose parents have difficulty in handling affect also have difficulty in developing effective ways of dealing with their emotions (Krystal 1988). The development of affects and affect-regulating capacities is facilitated early in life by the experience of affect sharing and “mirroring” of affective expressions with the primary caregiver. (Krystal 1988; McDougall 1988; Taylor, Bagby and Parker 1997)”

Jones (2002: 15)

Similarly, a prospective longitudinal study of inattentiveness and hyperactivity in children, (Carlson, Jacobitz and Sroufe, 1995) draws on the attachment paradigm to emphasise the role of parenting in the genesis and development of ADHD symptoms in some children. They summarise the normative part the parent plays in the child gaining a capacity to regulate its experience and control its behaviour:

“A progressive process is emphasized wherein what begins as dyadic control of arousal regulation is transferred, step by step, to the child. At each developmental phase, there is a changing role for the parent, first as a shielding or buffering influence and ultimately in monitoring the child's own regulation efforts.”

Carlson, Jacobitz and Sroufe (1995: 39).

Their research suggests ADHD symptoms are one outcome of a child experiencing “intrusive and overstimulating care” during this process.⁶

Impact on the internal world: the child’s identifications and relationships

Child psychotherapists and analysts in the object relations tradition can lay claim to a long record of work with children with attachment and other difficulties rooted in trauma / early deprivation, many with an ADHD diagnosis or presenting ADHD-type behaviour. Both clinical and theoretical literature abounds with references to case histories located explicitly or implicitly in this clinical population. A literature search restricted to one electronic archive alone found 40 results for books and articles on psychoanalysis and ADHD, of which just over half involved reference to trauma. There

⁶ According to Simon’s birth mother, his early care was taken over by his father, who showed an obsessive interest in Simon, to the exclusion of mother and his other two siblings.

are many more studies describing undiagnosed patients whose troubled relationship with parents at an early stage of development is seen as bound to disorganized, impulsive, emotionally labile and often aggressive behaviour in the consulting room. (Emanuel 1974, Canham 2004, Weir-Jeffery 2011) Clinicians draw attention to the rigidity, concrete thinking, and inability to tolerate frustration or stay with tasks requiring time to complete, which feature in such cases. Of particular interest to the current research, is the detailed attention to the *internal* situation driving the child's behaviour, which can be found in clinical writing.⁷

Internal profile of deprivation: evidence and theory from the consulting room

Writing about therapy with a looked-after boy, Henry (1974) used the term “*doubly deprived*” to represent the way early neglect had had devastating effect on the shape of the child's internal world and mode of operating. Her patient's secondary deprivation “*derived from internal sources: from his crippling defences and from the quality of his internal objects which provided him with so little support as to make him an orphan inwardly and outwardly.*” (Henry, 1974: 16).

My patient too, with his rigid, controlling, sadistic, concrete, and hyperactive mode of functioning, evidenced a mutilated internal landscape. In the previous chapter, I noted that one aspect of his deprivation was a strong sense of grievance, linked with a blindness to what might constitute a good object, and what a relationship with such an

⁷ Typically child psychotherapists focus on exploring the meaning of behaviour, in relation to a highly individual internal state of affairs: the child's internal world. Thus psychoanalytic research has a relevance to building an understanding of the individual interiors of disorders like ADHD, where there are multiple possible determinants. Salomonsson (2004) argues that, while psychoanalysis may not be suited to make claims regarding neurological aetiology, through focusing its exploration in the area of personal, interactional experiences, it contributes core information: “psychoanalysis, as a research instrument, is instrumental in establishing individual ADHD aetiology.” This is particularly relevant for children in care who have been given an ADHD diagnosis since, as Orford notes: ““One of the real problems attending this diagnostic category is that many of the symptoms described are symptoms of other problems” (Orford, 1998, p. 255). Jones (2002) argues that the diagnosis can unhelpfully obscure the contribution made by the child's emotional history: “the current diagnosis of ADHD does not, unfortunately, help us distinguish between those children who may have a true neurodevelopmental deficit and those children who are struggling with conscious and unconscious conflicts, trauma, and/or family problems.” Child psychotherapy offers a method of refining the diagnosis to take into account the part played by emotional conflict and trauma. In so doing, as my work with Simon showed, it can also help the child to develop emotional resilience and less destructive ways of coping with anxiety, ultimately dispensing with the need for medication which remains the most prevalent form of treatment for the condition.

object might be like. Instead, his expectations, as expressed in the relationship with me, seemed to revolve around a cruelly withholding or neglectful internal figure. Throughout Phase 1 of the therapy, it appeared that I was both an object beyond contempt, with nothing to offer, and a figure wilfully withholding what he needed.

Clinical case studies confirm corresponding qualities in the description of the internal parental figures found among children who have been deprived: common attributes range from actively depriving, abusive and cruel at one end of the spectrum; to neglectful, unresponsive, and withholding, at the other. Weir-Jeffery (2011) notes that the 80 severely deprived children reviewed by Boston (1980) revealed a mix of internal parental figures, some abandoning, some sadistic. In her analysis of 15 JCP articles reporting single case studies of therapy with deprived, adopted or looked-after children, she goes on to report a range of characteristics found among children at the start of therapy, taken here to be indicative of the relationship with the internal parent. In some, an absenting, neglectful internal parent was evidenced in the child's repetitive fear of falling, abandonment and pervasive sense of loneliness (Newbolt 1971, Berse 1980, Jackson 2004), lifelessness (Rustin, 2001); or frantic attempts to reach an inaccessible figure (Micanzi Ravagli, 1999). Hindle's case study describes a child expressing insatiable demands, allegations and a repetitive sense of grievance, pointing to the presence of a withholding, untrustworthy internal parent (Hindle 2000b); while the child in Henry's classic case study began therapy in identification with a cold, contemptuous, hard and unreachable parent figure (Henry 1974), as expressed in his treatment of his therapist. Similarly, other children, through play, behaviour in the consulting room, and their attitude to the therapist, evidenced internal worlds of dangerous, chaotic savagery (Bradley 1985, Sutton 1991, Grunbaum 1997, Canham 2004, Marsoni 2006); terror of attack by persecutory enemies (Lykins-Trevatt, 1999); and identifications with a perverse, seductive or sadistic object (Bradley 1985, Rustin 2001).⁸

As these case studies show, the child's relationship to the internal parent pervades its idea of self and its relationships with others. Canham writes:

⁸ A depriving or unresponsive internal parent is also found in some studies of ADHD children. Salomonsson (2004) reports: "According to my experience, children with DAMP and ADHD find no containment for their emotions, which they often experience as 'nobody understands me'. They perceive the environment as rejecting, but what is crucial is their rejecting internal containing object... (the child's) impulsivity and restlessness are, from a subjective point of view, an incessant flight from an external object that threatens him because he has attacked it."

"The relationship to parental figures in the mind is to mental life what the sexual union of parents is to our physical existence."

Canham (2003)

Deprived children who are in identification with a depriving parental figure are apt, like Henry's patient, to treat self and others with similar neglect, contempt or cruelty.

Ironside writes:

"Deprived children can bring a particular and seemingly very destructive quality to their interaction with others, both within and outside, the consulting room. They are likely to 'recreate' their experience of the emotionally and/or physically absent, cruel and abusive parent who could not bear their vulnerability and pain and who left them with a sense that the environment had fundamentally failed them."

Ironside (2001: 20).

Canham likewise worked with a number of physically abused children whose behaviour in therapy was for long periods unrelentingly violent and abusive, often inflicting on the therapist exactly the abuse they had suffered (Canham 2004).

Alternatively, when identifying with the child in such a relationship, deprived children will often exhibit a strong sense of victimization and grievance with others. Henry writes of her patient:

"He appeared to go to great lengths to put himself in a position where he could reproach me of neglect".

Henry (1974: 20).

This occurred particularly at times when he was emerging from total identification with an insensitive mother, and getting in touch with his position as a needy child, which he had previously kept split off.

Linked to traumatic early experiences with care-givers and the loss and uncertainty consequent on enforced separation, Philips draws attention to the prevalence of paranoid-schizoid defences over depressive defences found among child patients in the care system:

"It seems that under the impact and extent of (these) accumulated painful experiences there is often less evidence in the child's material of fragile manic

defences against 'depressive' feelings and more of strong 'paranoid-schizoid' defences of splitting, projection and denial, together with a frequent use of 'Projective Identification', envious attacks on 'Good Objects' (for example, on the foster family) ...(and) a wish for, or fear of appalling, annihilating retribution."

Philps (2003)

Ironside refers to "a particular pathological and pathogenic organization of the personality" among deprived children and "the destructive forces that seem to be at play in the internal worlds of these children". (Ironside 2001: 12)

Core complex fears

Oscillation between cruel contemptuous attacks and bitter complaints of neglect was common in my patient Simon during many months of therapy. I have noted the powerful blend of attachment and hatred conveyed through his physical steps to get rid of the space between us; and conflicting urge to beat a hostile retreat, and sever contact (see previous chapter). He fitted well the description given by Rey of borderline personalities:

"They are demanding, manipulative, threatening and devaluing towards others. They accuse society and others for their ills and are easily persecuted. This may be associated with grandiose ideas about themselves. Their feelings are dominated by fantasies of relative smallness and bigness. When threatened by feeling small and unprotected and in danger, they may defend themselves by uncontrollable rages and various forms of impulsive behaviour."

Rey (1994: 8-9, cited in Philps 23))

Glasser (1996) writes about the internal conflicts for a child who feels itself to be simultaneously dependent on, and threatened by, its parental figures. The child resists separation, particularly where a neglectful or unresponsive object is involved, by seeking to merge with the mother figure. The drive to attach through merging leads to a situation where the self feels threatened by the overwhelming closeness of its object and fears it will be trapped or lost inside it (Glasser, 1996, Meltzer, 1992). The child reacts by taking flight or attacking the object, often in a concrete way, but then suffers with redoubled force the terror of being abandoned by the loved one, or killing it off. Terror

of abandonment sparks a renewed attempt to merge with the object and so the cycle, which Glasser (1996) named the core complex, is repeated.

Writing of a looked-after ADHD child, Kestenbaum observes a similar constellation of anxiety-charged and conflicted impulses around relationship:

“He was reportedly hyperactive when anxious, and his behavior alternated between angry defiance and excessive affection to strangers, clinging to their legs and saying, ‘I love you.’”

Kestenbaum (2003)

The fear of annihilation is likely to be particularly acute when the parental figure is a hostile or unresponsive one, as suggested by cases with an early history of deprivation. As Canham reports of one of his deprived child patients:

“We get a glimpse of ... what lies behind his omnipotent possessiveness – which is a terror of abandonment and collapse, of something catastrophic.”

Canham (2003:14)

Similar fears are identified in connection with borderline personalities in studies by Rey (1994) and Steiner (1993). Rey links it to the phantasy of a prematurely aborted relationship with a maternal figure:

“The borderline patient often feels he has been prematurely and cruelly pushed out of (the) maternal space and attempts to regain his right to reside there.”

Rey (1993: 52-53, cited in Philips 2003).

Sadomasochistic relationship patterns

Simon’s destructiveness and attacks on me and the therapy had a cruel, manic, tormenting edge (see previous chapter). Similar sado-masochistic patterns of relating are common in clinical reports of work with deprived children across the range. Ironside comments:

“Deprived children can come to therapy – or for that matter go to a foster home or school – with a seemingly fixed idea in their minds that the only relation... is that of mutual cruelty and destruction and that the only way to visualize coming together is in a mutually attacking mode.”

Ironside (2001: 21).

Many of the 80 severely deprived children in Boston's study (1983), and in Bartram's more recent report of adopted child patients (2003), were cruelly attacking and destructive towards their therapists, appearing to be driven by a need to inflict pain. Henry's violent child patient, who had been abandoned by his mother at birth, took pleasure in fantasies of hurting his therapist and toying with her fears. Weir-Jeffery (2011) notes that the child in Berse's case study used "*cruelty, revenge as an antidote to depression .. (and) excitement and torture as an escape from despair*" (Berse 1980). Her analysis reports similar features of dangerous behaviour, mixed with sadism and fear, in the accounts of therapy with deprived children by Sutton (1991), Grunbaum (1997), Lykins-Trevatt (1999), Rustin (2001) and Marsoni (2006).

Klein (1946) gives sadomasochistic traits a central position in child development, noting them as active at a very early stage of infancy, when splitting and projection are the dominant features of communication; and when body parts and products are treated as weapons of aggression and control. Ordinarily, the infant's fury and aggression towards the all-important mother when she is absent, is mitigated over time by repeated experiences of her return and evidence of her continuing love, despite her baby's attacks. However, in cases of deprivation, where the child's aggression routinely meets a slap and a push from its parent, in place of understanding, a cruel parental figure is internalized, and sadomasochistic patterns of relating are liable to flourish:

"Instead of gaining a view of relating based on negotiation and give and take, the child learns that there are two protagonists – the attacker and the attacked, the controller and the controlled – and his sense of identity will necessarily encompass both aspects. In order to escape from the position of being attacked, humiliated and controlled, he may identify with the aggressor and take on that role."

Parsons and Dermen, (1999: 334)

In her account of therapy with a deprived looked-after child, Rustin (2001) underscores the defensive purpose of such a position:

"There was only one way to protect himself from psychological pain, and that was to become the person who inflicted it. Put simply, it was a clear case of identification with the aggressor."

Rustin (2001: 273)

Glasser (1996) explains sadomasochistic modes of functioning as an attempt to resolve the conflicts engendered by the core complex, particularly the difficulty of preserving the object from destruction which is threatened by the self's violent aggression towards it. In sadomasochism, aggression is deflected from purely destructive purposes, towards possession and control of the other person:

"The intention to destroy is converted into a wish to hurt and control."

Glasser (1996: 289)

The emphasis on control – very notable in Simon - relates to the other core complex fear of losing the object through abandonment, since there is no confidence that the object will return of its own free will, once attacked; or will bother to seek out the self, who has spurned it. Emanuel's child patient seemed caught in just such a position:

"Because of the violence and cruelty associated with this link, the object seems to be always trying to escape from its imprisonment."

Emanuel (1984: 75)

Implicit is a fundamental belief in an object incapable of perceiving or responding to the needs of the dependent self, and potentially actively hostile to it. Such an object *"is inconsistent and often 'teasing'. This in itself promotes both the anxiety of uncertainty and aggression and can be seen as an important determinant of the subsequent sadistic need to control the object and determine exactly how she feels and responds."* (Glasser 1996: 293) A similar preoccupation with control, tracked back to a state of unpredictable, disturbing object relations, is reported by Gilmore of work with ADHD patients:

"...narcissistic fragility and the need to be in control are very common features of this disorder, deriving from multiple sources but perhaps most intrinsically related to the readiness to experience human interchange as disruptive and disorganizing."

Gilmore (2000)

Psychic retreat

The patient at the centre of this study, as many others described in the clinical literature, often appeared to lose himself in destructive, wasteful cycles of physical activity, which consumed large quantities of time and resources without ever reaching completion. I noted in the previous chapter that his appetite and activity had an insatiable, restless

quality, communicating emptiness – an internal world where people and things were routinely debased, stripped of meaning and value. Sometimes Simon seemed to be showing himself as trapped in this world, sometimes as actively involved in maintaining and promoting it. Later I observed how monotonous and repetitive the activity and play could come to feel: it was its sterility that came to stand out, as repetition leached it of meaning and emotional immediacy. This addictive repetitiveness seemed to tie in with Simon's persistence in identifying himself as a latency-aged child, despite the many physical signs of his puberty and adolescence over the course of the therapy (see previous chapter)

Joseph's analysis of psychologically deprived patients reports a correspondingly repetitive and rigid mode of mental functioning, rooted in early feelings of rejection, failure and guilt, which give rise to "*a type of mental activity consisting of going over and over again about happenings or anticipations of an accusatory or self-accusatory type.*" (Joseph, 1982: 312). She names this process "*chuntering*" and notes such patients give "*the impression of very little real active interest in changing, improving, remembering, getting anywhere with the treatment.*" (Joseph, 1982: 321). The patient communicates with the therapist, not so much to change the internal situation as to extend it, to colonise the therapeutic relationship with it, and so assert external reality claims for his internal world. This position resists new experience, repudiates the unknown, resulting in a deep paralysis, a turning away from relationships with objects which do not conform to the patient's strict specifications. Developing Joseph's ideas, Steiner offers the concept of "*psychic retreat*" to describe the borderline patient's "*withdrawal to a refuge where the patient (is) relatively free from anxiety but where development (is) minimal*". (Steiner 1993: 14). In this position, the deprived child severely limits contact with himself and his objects, preferring to experience "*boredom, uselessness, lack of interest ... (to the) pain of 'true' depression*" (Rey 1994, cited in Philps 2003). He is "*threatened by the possibility of change and, if provoked, may respond with a more profound withdrawal.*" (Steiner, 1993: 3). Alvarez observes a similar tendency in deprived child patients whose play is exceptionally repetitive and monotonous, not in the service of regulating new experience to keep it in tolerable bounds (Waddell 1998), but so as to prevent live contact between patient and therapist, and "*the uncertain pleasures of real relationships*" (Joseph, 1982: 323).

Conclusion

Research across psychoanalytic literature and related disciplines confirms the central role of early care in shaping a child's emotional capacity and internal world. In cases like Simon's, where the parent-infant relationship has been traumatically disturbed, there is considerable evidence to show that children's capacity to form positive attachments and self regulate is likely to be much impaired. Oppositional and ADHD-type behaviours are common in this group of children, raising questions about the complex, sometimes competing, aetiologies of the diagnostic category. Among very deprived children, I argue that clinical case studies identify an association between diagnostic ADHD descriptors and an internal situation turning on the absence of good internal figures, an established system of sado-masochistic defences, and addiction to repetitive, rigid modes of relating to self and others. I make the case for treating deprivation in such cases, as the primary organising and explanatory principle for the behaviours attracting an ADHD/ODD diagnosis.

Part 2: Thinking as emotional process: the K link

Kleinian and post-Kleinian accounts

While accounts of the nature of link between early care giving and the development of symbolic function vary, psychoanalytic theorists are agreed that thinking starts as an emotional process. In Klein's view symbolization is a process emotionally driven by frustration, at a time when the child is becoming aware that the good and bad breast are aspects of one and the same breast. Frustration, and consequent aggression, is now felt towards the absent good object, and leads to fear that the good object will be lost or destroyed.⁹ The child seeks to defend the object from its aggression by substituting another object for it. Such a substitution marks the birth of symbolic function, when one object is taken to stand in for another.

Following Klein, Segal (1957) comments that symbolisation is also an aid for tolerating the absence of the desired object – holding on to the idea of it when it is no longer there instead of having the experience of it being irretrievably lost or converted into its

⁹ Bion points out that earlier the absent breast is experienced as a bad breast, rather than an absent good breast. O'Shaughnessy comments: "*the absent object is a bad object which is leaving the baby to starve and die.*" (O'Shaughnessy 1964:34)

opposite, the bad object. Frustration, which drives the process, is thus also alleviated by it. In this regard, symbolization is both a defence against mental pain and also accompanies the child's progress from an internal world of split-asunder part objects, towards awareness of a self and objects made up of both good and bad aspects. What begins as a defensive manoeuvre thus has a developmental function, since it is through the defensive turning away from mother to mother-substitutes that the child begins to relate to – and get to know – the wider world of persons and objects outside the nursing couple. Kleinians thus regard the sequence of frustration and sadistic aggression as fundamental to children's epistemophilic impulses and development. Klein linked learning difficulties involving disorders in thinking and symbolization, to cases where frustration was too severe, or aggression too extreme, resulting in a retreat to an earlier world of part objects where psychic and physical reality remained confused (Klein 1930).

Building on Klein's related theory of projective identification, Bion stressed the role of the parent in the child's development of symbolic function, communication and thinking capacity. According to Klein, a primitive infantile way of managing disturbing or difficult mental experience was to project it outwards onto objects or people in the outside world, often the parent. Through this process, called projective identification, the baby rids itself of its unwanted feelings by turning them into features belonging to someone, or something, else. With psychic development, and more awareness of inside, outside, self and other, projective identification could acquire more complex functions, to do with avoiding separation, or controlling other people. As the ego matured and was able to tolerate more anxiety and disturbance, it became less dependent on projective identification however, so while Klein regarded it as a constant factor in mental life, it was less dominant in healthy adults than at early stages of development.

Bion expanded the theory to place projective identification at the heart of infantile communication, which is also the baby's instinctual quest for a home for mental experience. In giving her mind to her infant's earliest projections, the mother treats them as actions with meaning, which tell her about her child's internal state. The baby experiences its mother's understanding response as transformative. Its yell of hunger which may first be aimed at physical expulsion of nameless all-encompassing torment, when understood and met by a soothing voice-and-breast, is contained and made

manageable. Bion emphasizes that it is not just milk that the infant then takes in, but an experience of an understanding mind, through whose operation something nameless finds an identity. If the mother gets it right, the baby's need is met – the hungry mouth finds the feeding breast – and then the baby has an experience of satisfaction. Bion described this as the baby's preconception of the breast – which till then has lacked content – meeting up with real breast and so acquiring shape and form for the baby. When a preconception meets with the necessary counterpart, a conception –or thought - is formed. Now the child is able to recognize what it seeks and step by step develops its own capacity to make sense of its experience, and communicate it to others. Isaksson writes:

“When the mother receives and (Bion 1962) works through the feelings the child evokes in her, when she can tolerate and understand them, she can also convey to the child that it is possible to give a shape to an unthinkable anxiety (Winnicott 1962). She communicates to the child the possibility of reflecting on perceptions based on feelings.”

Isaksson (2005)

Fisher observes that, in Bion's view, the epistemophilic instinct is an emotional force in psychic development that stands on a par with love and hate, and is not a derivative of them. Humans are born with an innate drive to find out, which is rooted in the drive to know and be known by another human mind. On this view, *“the experience of knowing someone or something must express an emotional experience that can stand alongside the experience of loving someone or hating someone or something.”* (Fisher 2011: 43). Truth, beginning in the area of such an emotional experience with another, is as important to psychic growth as nutrition is to physical development.¹⁰

“Being deprived of the truth of one's emotional experience is a kind of starvation since truth is essential for psychic health.”

Fisher (2011: 48, paraphrasing Bion 1962b: 310).

Bion describes the process of getting to know and be known by another human mind as the K link. Thinking is thus *“an emotional experience of trying to know oneself or*

¹⁰ My patient Simon's striking persistence in asserting the truth of his abuse in the face of parental denial and rejection, his insatiable, intrusive curiosity, his attunement to the feelings behind my words, are all perhaps expressions of this drive to know in someone who has been denied emotional truth and fed lies at a very young age.

someone else ... If xKy, the 'x is in the state of getting to know y and y is in a state of getting to be known by x'." (O'Shaughnessy, 1981: 178). K develops "*from emotional experiences with a nurturing object, functioning normally on the reality principle*" (O'Shaughnessy, 1981: 180)

On Bion's view, infant thinking is thus contingent from the outset on the emotional quality of the parent-infant relationship. Where containment is "*commensal*", mother and infant "*are dependent on each other for mutual benefit and without harm to either... the mother derives benefit and achieves mental growth from the experience: the infant likewise abstracts benefit and achieves growth.*" (Bion 1962a: 91) The mother's K activity in this situation is internalized by the infant, leading to the growth of a K capacity in the baby. Bion sees such growth to occur within a climate where doubt can be tolerated, and equates it with a developing capacity to learn from experience. It represents "*the state of mind of the individual who can retain his knowledge and experience and yet be prepared to reconstrue past experiences in a manner that enables him to be receptive of a new idea.*" (Bion 1962a: 93) A person in a K frame of mind, centred on a nurturing object, may be open to interactions with another, show curiosity, tolerance of difference and uncertainty, and freedom in associating ideas and experiences.

Impact of deprivation on cognitive and symbolic function: the concept of –K

Where the container-contained relationship is what Bion termed "*parasitic*", mother and infant are involved in interactions characterized by misunderstanding, envious attack and fragmentation. Bion considers many psychological disorders to spring from such an inversion of the K link, denoted –K, when a person is under pressure to use his mind to attack/misunderstand links because these are felt to endanger the ego. –K can end in the collapse of K, when a person's mental activity becomes excessively concrete or fragmented (denoted "*no K*" by O'Shaughnessy 1981).

In a parasitic container-contained relationship, instead of internalising a capacity for tolerance of pain and self-reflection, the child internalises the capacities of a "mindless" parent, who experiences the child's pain as an assault and acts immediately to repel it, often through a counter attack on the offending child. The excessive mental pain of this experience adds emotional charge to the patient's difficulty in thinking, giving it the

quality of active resistance: the patient clings to mindlessness because awareness is too painful.¹¹ Such a patient is not curious to “know” himself or his object in the ordinary way, through “*a human link – the endeavour to understand, comprehend the reality of, get insight into the nature of oneself or someone else.*” (O’Shaughnessy 1981: 181). Instead he substitutes the human link with something mechanical and indifferent; or more extremely, he develops an increasingly violent and bizarre relationship with the world which is imagined as peopled with animist objects hostile to the self¹².

Someone driven by –K, infused with phantasies of a greedy, depriving breast, is likely to be intolerant, suspicious, pedantically argumentative or perhaps intellectually expert in demolishing new thoughts or proving his point: thinking is being deployed to attack difference, or links to the dreaded, envied other (also, disowned parts of himself), in place of exploration. The no K patient, trapped with a destroyed, persecutory object, may appear to inhabit a psychotic world full of fragmented / bizarre objects; or less severely, give the impression of mindlessness through fragmented, impulsive behaviour, an absence of curiosity, and the flatness and superficial quality of his interactions with others.

A clinical example is Edgcumbe’s description of a child patient whose mother suffered from serious depression and resented her baby during infancy:

“Susan suffered not only interference with her ability to communicate with objects, but a disruption of her own thinking and understanding of herself. She demonstrates an extreme stunting of the development and differentiation of affects and of somatic and psychic modes of expression, with severe interference in the building up of representations and capacity for symbolization. Words for her did not serve as symbols of feelings or connections between inner and outer events. Psychic as well as somatic states of tension continued to be expressed via her body.”

Edgcumbe (1984)

Simon, like Susan, showed little interest in words as tools for exploration or for the development of a narrative. His play, as I noted in the previous chapter, was singularly lacking in imaginative or symbolic content, although very expressive. The restlessness

¹¹ Simon’s dedication to repetitive games of chance, and his retreat in sessions to a world of mindless, mechanical objects, had this quality (see previous Chapter).

¹² See the case of Salomonsson’s ADHD patient Anthony (Salomonsson 2004).

and hyperactivity of the sessions had a compulsive feel that both expressed his hunger for something missing while also interfering with processes of linking and symbolization. His language and communications were strikingly limited and two-dimensional. He also showed the difficulty in discriminating between different states of mind which clinicians note to be common among deprived children (and also those who have been sexually abused in secrecy during early childhood). Such children, whose early experience has been routinely denied, evaded or distorted by lies, may show long-lasting confusion and difficulty distinguishing truth from fiction, both in terms of emotional experience and with regard to simple matters of fact. (Canham 2003).

-K can take the form of a retreat to the pathological form of mental functioning, termed “*psychic retreat*” (Steiner 1993, Britton 1998), as a defence against unbearable psychic pain and anxiety.

“..To end uncertainty and the fears associated with fragmentation”, the patient regresses “to a ready-made, previously espoused coherent belief system, D (path).”

Britton (1998: 72).

Not only the fear, but the experience, of things falling apart around them, starting with the earliest parent-infant bond, is the common ground of children in care. It is unsurprising then, that many, like Simon, appear to cling tenaciously to a “*self-righteous state of chronic grievance*” (Britton 1998: 80) which – while severely restricting development - offers a psychic refuge from mental pain or psychic container for holding things together.

The distinctions between K, and –K are schematic and in the normal course of development there is constant oscillation between them. Bion observes that K is a process, not a fixed state of affairs, and attempts to capture or freeze K moments are doomed to failure: insight turns to dogma, “*knowing*” turns defensive, and K becomes – K. K dynamics thus correspond closely with the oscillation between paranoid-schizoid and depressive states of mind, represented by Bion as $Ps \leftrightarrow D$. Expanding this concept, Britton notes such oscillation gives psychic development its structure, and it is when the subject becomes fixed in one or other position that thinking becomes pathological. Ps here denotes the stage of un-integration, where the mind may be occupied by confusing, disconnected, sometimes conflicting thoughts and feelings. D refers to the stage of

integration where thoughts come together in the mind of the subject: confusion acquires shape, turned by containment into meaning. But:

“ the depressive position is no final resting place ... leaving the security of depressive-position coherence for a new round of fragmented, persecuting uncertainties is necessary for development... Yesterday’s depressive position becomes tomorrow’s defensive organization.”

Britton (1998: 73)

Impact on communication: evidence and theorising from the consulting room

Simon, in common with many other deprived, ADHD children whose development has been disturbed at a primitive stage of ego development, favoured projection and enactment over symbolic modes of communication (see previous chapter). In Bion’s terms, projection is the precursor of symbolisation, and a child’s capacity to communicate symbolically develops through its projections finding containment in another mind. The deficit of the deprived child in this area means that projection retains relevance and importance for the child, beyond the age when children would ordinarily shift towards symbolic modes of communication.

Two aspects of projection, as articulated by Bion, remain vital to the deprived child. Firstly, lacking symbolic capacity, he needs a way of ridding himself of unbearable and unthinkable feelings, and through restless, compulsive hyperactivity (projection in its most concrete form), works to expel them out of himself. Action and acting out are for him the dominant modes of self-regulation. Expression remains locked at a primitive physical level and actions are as much about managing internal mental states as about shaping an external environment.¹³

Secondly, such a child relies on projection for the connective, communicative activity, identified by Bion as the most primitive form of K. Lacking the parent’s attentive emotional processing and naming of his experience, the deprived child continues to work at this primitive, infantile level, through creating in the other his emotional experience, in a visceral, immediate way. Therapists like Edgumbe (cited above) note

¹³ Following Fenichel (1945), Greenacre connects such tendencies to: “*high narcissistic need and intolerance of frustrations, the heightened constitutional motility, the presence of severe early traumata (producing a repetitive, abreactive acting out similar to the traumatic neuroses).*” (Greenacre 1950).

that such children show difficulty distinguishing somatic and psychic modes of expression. Canham comments:

“these children often use the most primitive modes of expression to communicate the nature of their experiences,”

Canham (2004: 143).

Ironside observes:

“One of the crucial issues in working with this particular patient group is that of their apparent inability to play symbolically and creatively use this ‘space in mind’”

Ironside (2001: 14)

They are likely to use words not as symbols for communicating complex meaning, so much as emotive acts in a highly charged love-hate relationship with others. Often emotional and psychic states become expressed through the body, while the therapist’s verbal responses appear to go nowhere, or else to frustrate and inflame the child, as my interpretations sometimes did with Simon.

James hypothesises a similar link between his patients’ somatisation of psychic states, and the early absence of parental empathy, forcing premature ego development in the infant.

“The baby is asked to compensate for the adult's failure of empathy at a time when we cannot conceive of a baby apart from a caring adult.”

James (1979)

In this situation, the parent’s lack of attunement to the child’s emotional state leads to a failure to adapt the environment to fit the child’s needs and protect him from external impingements. The child prematurely is required to make its own adaptations and since the body-ego is dominant, these adaptations will take a physical form. Parents will unconsciously drive the somatisation to spiral if, to avoid psychic pain and emotional conflict themselves, they persist in ignoring the emotional aspects of the child’s physical state, focusing exclusively on a physical account of the disturbance.

Isaksson (2005) argues that where there is no faith in internal containment, because of severe disturbance in the early relationship between mother and infant, symbolization cannot progress to provide the child with an alternative means of processing emotional experience from that offered by the body. Edgcumbe’s account (1984) tracks defective

symbolization to a breakdown in parental support around separation and individuation, at a time when the body-ego dominates.¹⁴ In both accounts, the outcome for the child is the lack of a capacity to reflect on its internal state and express it other than through physical enactment. As with my patient, anger with one's object translates in physical attack, emotional closeness and intimacy is confused with physical proximity. Emotionally play for a child in this state tends to merge with reality, symbol lapses into symbolic equation (Segal), and the child can be left in a state of great agitation, unreachable by words alone. Edgumbe observes of such a patient:

"Norma's early deprivation stunted both her object relationships and the ego functioning that depends on those relationships. Without this background words can serve as signals, but have no role in organizing the inner chaos."

Edgumbe (1984)

Where communication takes the form of projection and enactment, clinicians find that words are used more for projective purposes than to symbolize meaning in an evolving intra or interpsychic dialogue. The distinction between acting out and verbalization then collapses, since the primacy of meaning is lost and words become another kind of action in the service of repeating a sadomasochistic pattern of relating. As Boesky observes, in such circumstances: "...not all acting out involves action." Boesky (1982) Salomonsson remarks of his ADHD patient:

"He communicates not so much to make me understand, but to affect me."

Salomonsson (2004)

In the same vein, Pick (1985) discusses patients who "indeed only listen to the mood and do not seem to hear the words at all." (Pick 1985: 36). Greenacre reports:

"Sometimes the speech itself seems, through its own motor qualities of pitch and intensity, to participate in the motor discharge of tension rather than through establishment of communication or any distillation of the situation into thought."

Greenacre (1950)

The communication of a child in this position will have the controlling, acquisitive characteristics of projection, mentioned by Spillius (1992) and linked to avoidance of separation; since it is only when the child succeeds in arousing the matching feeling in

¹⁴ Parental sexual abuse of a young child like Simon represents an extreme breakdown of parental support, when the child's separateness is not tolerated and the body-ego suffers a combined physical and mental violation. The breakdown is further compounded by the parent condemning the child as a liar, when the child tries, like Simon, to voice his experience.

the other, that he has an experience of making contact and being received in the other's mind.

Conversely, words can be used as tools for blocking communication and real contact, as Borgogno observes of: "*communications that may appear elaborate and even suited to the situation, although in reality the patient is profoundly unable to think through or experience as meaningful in any complex way.*" (Borgogno 2004). Gilmore (2000) refers to her adopted ADHD patient's marked preference for rigid and stereotypical interactions and verbal exchanges with her therapist. Although ostensibly engaged in a dialogue, the child "*bristled*" whenever the therapist departed from the child's script, and "*stonewalled*" the therapist's attempts at verbal exploration. Simon's frustration with me when I failed to follow instructions, and deafness to my verbal associations / commentary, also interfered with live contact between us (see previous chapter).

Contribution from neuroscience

Crossing into the region of neuroscience, research shows that dyadic experiences in infancy register not only as new information but play a formative part in brain development, both in imprinting implicit or procedural memory (Gaensbauer, 2002) and in shaping the functional capacity of the brain. Different parts of the brain develop at different times and require different experiential cues to do so. If these cues are lacking or are distorted, development will be affected – sometimes irreversibly. In other words, how the brain develops is use-dependent (Perry 1995, Schore 2001a, Schore 2001b, Balbernie 2001). Balbernie draws attention to the central role of the parent in this process.

"From the infant's point of view, the most vital part of the surrounding world is the emotional connection with his caregiver."

Balbernie (2001: 237).

Emotional communication between parent and baby provides the cue for infant neuronal organisation and connection.

Studies of brain development in children raised in Romanian orphanages reveal substantial areas of deficit related to early deprivation, and lower levels of brain activity in the prefrontal cortex and temporal lobes. The prefrontal cortex is associated with the planning of complex behaviour, differentiation, and direction of thought and action in

accordance with internal goals. The temporal lobes, especially on the left side of the brain, are involved in memory, comprehension, naming and language function. Citing research by Eluvathingal et al (2006), Music records:

“these children had cognitive and emotional impairments, difficulties in concentrating, and in regulating bodily and emotional states as well as neurological deficits.”

Music (2011: 204. My emphasis)

Schore argues that the impact of trauma/deprivation on right brain development has a knock-on effect on left brain development, and consequences therefore for cognitive and linguistic functioning. Interhemispheric organisation is impaired and the capacity for semantic processing of bodily states and emotions is a casualty. Citing research by Cicchetti, Graniban, and Barnett (1991), Schore reports:

“Maltreated toddlers show a dramatic inability to talk about their emotions and internal states.”

Schore (2001b: 242)

Child Development Studies

Studies of infant-parent interaction have richly illustrated these findings.

“The prevailing biosocial perspective on emotional development contends that mother and infant form an affective communication system from the moment the baby is born.”

De Litvan (2007)

Experiments such as those conducted by Tronick detail how *“the operation of this system has a major influence on how well the infant accomplishes his or her goals, the emotions the infant experiences, and infant’s developmental outcome”* (Tronick, 1989). Microanalytic videotape studies of mother-infant face-to-face interactions show the impact of parental attunement on the development of infant attention span and responsiveness (Brazelton et al, 1974; Stern, 1977; Field 2002, Beebe 2006) and on later cognitive, social and emotional functioning (Main, 1991, Ainsworth and Bell 1977, Fonagy and Target, 1998, Fonagy 2002, Leerkes et al, 2009). Attunement *“is based in large measure on the mother’s ability to differentiate her child’s needs from her own and maintain an appropriate level of stimulation and need satisfaction for her infant.”* (Beebe and Sloate, 1982). Among other factors, it comprises emotional awareness; responsiveness to the infant’s cues for more or less interaction; intuitive partnering in

imitative, sequential play; and regulating exposure to new experience. Optimally, mother-infant dyads function best in developmental terms where attunement is mixed with mis-matches or “*mis-steps in the dance*” (Stern 1977: 133). Parental capacity to support their infants to “*repair interactive errors*” is demonstrated to be central to the child’s development of resilience, sense of agency, and capacity to mentalise (Tronick & Weinberg 1997).

Fonagy notes:

“The disruption of early affectional bonds ... undermines a range of capabilities vital to the processing of information related to mental states.”

Fonagy (2009: 24)

Longitudinal studies of children of depressed mothers find a link between low maternal attunement and impaired development of cognitive functioning in the child (Murray 1996, Hay 1997). Tronick’s research into dyadically expanded states of consciousness, through micro-analysis of mother-baby interactions, goes further to spell out that the lack of parental containment is not just the absence of a formative experience, it is an experience in its own right and has equal, if opposite, formative consequences for the child (Tronick 1998).

Bick’s classic early infant observation studies add weight to the hypothesis that infants develop somatic forms of coping, when there is no parent available to reflect on the child’s experience, hold the child through successive experiential states, and make an environment for the infant’s sense of self to build and stabilise. These “*second skin defences*” involve the baby in latching on to a physical object such as a light or smell, and using its own bodily activity, to hold itself together (Bick 1968).

Ironside describes how deprived children who have not grown up in the safe environment of protective care are often hyper-vigilant and unable to make space for thinking to develop, because of the need to take care of themselves.

“The child holding onto this protective function might present as not having a long attention span but this might be just because his/her attention is focused but on looking out for signs of danger, looking after themselves.”

Ironside (2001:21).

He adds that children in this patient group may also appear to need constant outside stimulation, associated with premature exposure to having to manage on their own and a consequent dread of finding themselves alone with their thoughts.

Music (2011), reviewing child development studies, observes that children who have experienced excessive early frustration or trauma, accompanied or caused by the absence of a containing parent, will often exhibit thought disorders of one sort or another. In part this will be because they have not been helped, in the attentive company of a thinking, containing parent, to bear the ordinary pains and frustration of separation and development. Such a child has not acquired the capacity to tolerate frustration, which containment brings, and is a prerequisite of thought. The “*affect discharge and impulsivity*”, typical of Simon and other children with a diagnosis of ADHD, may be one consequence, along with difficulties in empathy and attunement, and in understanding one’s own and others’ psychological states (Music 2011).

Fonagy and Target (1998) argue a developmental psychology case for the view that it is through experience of a containing parental mind that children acquire the basic mentalising skills to name and reflect on their own experience, and recognise mental experience in others.

“It is assumed that the parent who cannot think about the child's particular experience of himself deprives him of a core of self-structure that he needs to build a viable sense of himself. We suggest that developmental personality disturbances arise first from the child's failure to find the image of his mind, his experience of himself as a thinker of thoughts, believer of ideas, feeler of emotions, in the mind of the caregiver.”

Fonagy & Target (1998).

The link between mental states and actions is especially hard to make when a child’s experience of agency - where action is intentionally related to feelings, wishes - has been denied: for instance when what the child wants is ignored and he is obliged to act out the adult’s wishes, misrepresented as his own . There is a breakdown in the capacity to identify feelings in self and others, particularly where the child has had the experience of a parent who has used the child as a vehicle for the parent’s wishes or emotional experience. Such a child has repeatedly had the mental states of another

imposed on him, in denial of his own psychic reality. Fonagy and Target note the tendency to violence in such cases:

"The decoupling of self-representation and action because of the disruption of the child's intentional stance is as relevant for violence against the other as for violence against the self. ... violence reflects the absence of a critical precursor of empathy, the capacity to link action and mental state, which normally begets the psychological self."

Fonagy & Target (1998)

As in Simon's case, a similar difficulty with empathy and tendency to impulsive aggression may result in an ADHD diagnosis for many such children (Jones 2002).

Where parental containment has not been available to help the baby develop feelings into thoughts, projection remains the child's primary means of finding a link to another mind. Building on child development research, Fonagy and Target observe:

"Children with limited mentalization or reflective abilities are unable to take a step back and respond flexibly and adaptively to the symbolic, meaningful qualities of other people's behavior. Instead, these children find themselves caught in fixed patterns of attribution; rigid stereotypes of response; nonsymbolic, instrumental uses of affect—mental patterns that are not amenable to either reflection or modulation."

Fonagy and Target (1998)

Conclusion

Evidence from clinical case studies, neuroscience and child development research confirms Bion's hypothesis that cognitive and symbolic development in children have their origins in the emotional experience of being known by, and getting to know, a parental mind. Deficits in the early infant-parent relationship are found to have a significant negative impact on children's capacity to tolerate frustration; be curious about themselves and others; distinguish truth from fiction; differentiate psychic from somatic experience; process and verbalise feelings; remain open to new experience; and develop an understanding of other minds (capacity for mentalisation) and self-reflective function.

Part 3: The relevance of psychoanalytic psychotherapy: evidence and theory

Evidence

Large-scale studies

There are few large-scale outcome studies of psychotherapy with children and the majority are concerned with behavioural treatment. In their major meta-analysis of treatment outcome studies, Weisz et al note:

“Only about 10% of the treatment groups in our sample involved nonbehavioral interventions.”

Weisz et al (1995)

The evidence from such meta-studies has tended to support behavioural over non-behavioural interventions, but the authors acknowledge the limitations of seeking comparisons where there is such an unequal representation of data:

“In the future, it will be important for researchers to expand the base of evidence on the effects of the nonbehavioral interventions that are widely used in clinical practice but rarely evaluated for their efficacy in controlled studies.”

Weisz et al (1995)

Here issues of research methodology are relevant, since evidence of efficacy from clinical practice is often discounted as failing to meet the inclusion criteria governing controlled outcome studies. Eresund notes:

“Most of the research included in reviews concerns cognitive and behaviour therapies, since very few studies of psychodynamic psychotherapy meet the inclusion requirements.”

Eresund (2007: 162)

There is thus an inherent bias in current research in favour of prescriptive, standardized treatments, over the intensive, individual explorations favoured by a psychoanalytic approach.

Two large-scale studies stand out as exceptions. The first, published by Boston and Szur (1980) tracked the treatment of 80 severely deprived children seen in the Tavistock clinic and other clinics and schools in the London area. This study, mentioned in the

previous section of this chapter, offers rich insight into the internal face of deprivation: the difficulties deprived children brought to their relationships, their pervasive “*lack of expectation of any continuity*” (p.8) and experience of being dropped; their splitting between hostile, and idealised parental figures; the extreme force and projective character of their communications; and the painfulness of the therapeutic experience, notwithstanding the steady progress that most of the children in the study were able to make, “*provided the therapist (could) stick it out in the difficult phases.*” (p.10)

The second is a retrospective outcomes study based on over 750 psychoanalytic treatment records from the Anna Freud Centre (Fonagy 1996). This research evidences improvements in 80% of children exhibiting symptoms of a single emotional disorder with high levels of adaptation. Children with pervasive developmental disorders like autism, or severe disruptive disorders, did much less well. Within this latter group, the study notes that children with ADHD also fared poorly, although to a lesser extent. While holding that such results were not unexpected, the authors were surprised to discover that: “*intensive treatment was remarkably effective for some children with relatively severe, long-standing, and complex psychosocial problems, including conduct disorder, given the presence of at least one emotional disorder diagnosis.*” (Fonagy and Target, 1998).

This finding may help account for the continuing debate surrounding psychoanalytic work with ADHD patients, since as noted earlier, it is a heterogeneous diagnostic category which does not distinguish between symptoms originating in neurobiological disorders and those rooted in early deprivation / emotional conflict / trauma (Jones 2002). Hence within the clinical population, there will be children whose diagnosis overlays at least one emotional disorder, and others where there is no such correlation. Fonagy’s study also indicates that the frequency of treatment is a significant variable, since the results of non-intensive treatment with children showing such complex pathology was very poor: “*nearly 60% showed negative outcomes following once- or twice-weekly treatment.*” (Fonagy and Target, 1998). Simon also fared less well with once-weekly sessions: his behaviour deteriorated to the extent of killing one of the family pets at the end of his first term of treatment. It required a considerable period of intensive work before things began to change (see previous chapter).

Three more recent reports offer useful systematic overviews of the research studies that constitute the current evidence base for child psychotherapy practice (Kennedy 2004; Kennedy and Midgley 2007; Midgley and Kennedy 2011). Several of the smaller, and single, case studies recorded by them, in relation to work with deprived and abused children, are referenced in the discussion below.

Clinical case studies

In individual case studies, clinicians report a range of improvements from therapy with deprived children with ADHD and/or borderline features. Philips, using an impartial quantitative tool for measuring paranoid-schizoid and depressive functioning, noted a decrease in borderline features in her studies of two child patients. The first, an abused looked-after boy, *“seemed to emerge gradually from a “retreated” position (Steiner 1993) often split-off emotionally from the therapist in a “Clastrum”-like world (Meltzer 1991)”* (Philips 2003: 316). She observed a growth in his capacity for intimacy, continuous relationship, and sense of self. The second, a looked-after girl, recovered a capacity *“to think about her emotional pain again”* (ibid: 305) in contrast to her split-off, mindless, helpless state at the start of treatment.

Gilmore (2000) describes the outcomes for one very disturbed, adopted ADHD child, whose verbal fluency and expressiveness showed marked improvement after two years of therapy. She also became more resilient to challenges and difficulties, and showed *“much higher functioning on tests of verbal abstraction and comprehension”*. Her relationship to her therapist lost much of its rigidity, although she remained easily distractible. While she could revert to more rigid patterns of relating under stress, she was also able to recover a more adaptive and open stance, as shown when she moved schools and *“after a period of almost dogged resistance to the new curriculum, she suddenly began to make significant gains.”* Similar improvements in behaviour, adaptive self-regulation, and attention to academic work are noted by Newbolt (1971), Kestenbaum (2003), Jackson (2004) and Orford (1998).

Orford's deprived 6-year old ADHD patient arrived in therapy in a whirlwind of rubbishing destructiveness and mess. The increase in frequency of sessions, and

provision of space for mother, resulted in significant changes after 9 months of treatment.

“He does not now spend his time in rubbishing and destructiveness but has developed a story line.... The feeling of a vague whirlwind of danger and destructiveness has given way to a more symbolized awareness of danger.”

Orford (1998: 263-264)

These changes within the child's sessions were accompanied by improvements outside therapy, where the child's behaviour became more ordinary, he was attentive in class and had formed playful relationships with his peers.

Such improvements in attentiveness, reflective and symbolic function are widely noted in case reports spanning psychotherapy with deprived / borderline /ADHD-type children (eg: Emanuel 1994, Eresund 2007, James (1979), Gilmore 2000, Jones 2002, Orford 1988, Henry 1974, Micanzi Ravagli 1999, Lykins-Trevatt 1999). Learning progress is noted by Henry (1974) and Emanuel (1984). Emanuel describes the emergence in his 5-year old patient, of a boy who *“could converse with me, know things, see, learn and listen,” so challenging the “mad, negativistic, destructive, omnipotent means of dealing with the world” which dominated before.*” (Emanuel 1984: 84) With his therapist's containment, came a corresponding decrease in projection and enactment as the primary modes of communication, freeing the child to continue *“using much more verbal means of communication”* (84). James (1979) reports similar outcomes in his work with two deprived boys, referred with somatic symptoms originating in anxiety and aggression towards depriving parental objects. Therapy mitigated the children's physical symptoms, as other modes of expression became available. In the same way, clinicians working with ADHD children report drops in levels of hyperactivity (Jones 2002, Widener 1998, Kestenbaum 2003) related to therapeutic containment. Jones writes about one patient's response to an interpretation:

“Up until that moment in the session, he had been moving about and fidgeting as he always had throughout our sessions. But when this interpretation was made and both his conscious and his unconscious feelings were labelled and understood, the hyperactivity ceased. He became quiet and his eyes welled with tears for the first time since our work began.”

Jones (2002: 18)

Henry's (1974) account of her deprived patient's progress in therapy concurs in reporting a development in the child's affective register and capacity to tolerate mental pain. This corresponds to the increase in emotional tolerance/resilience noted in Gilmore's adopted ADHD patient (2000), the looked after children in Philps's study (2003), and further case studies of work with deprived patients (Miller 1980, Grunbaum 1997, Hindle 2000a, 2000b). In the same vein, Rustin (2001) mentions an increase in emotional self-awareness, echoed by Marsoni (2006). Berse (1980), like Philps (2003), Miller (1980), High (1982), Bradley (1985), describes her patient's new capacity to build reciprocal relationships at the end of treatment.

Theoretical models of therapeutic change

"Psychoanalysis at its core is a relationship form of treatment."

Emde (1994: 44)

There have been varying accounts of the processes underlying change in psychoanalytic treatment of children. Klein and her followers emphasised the importance of the transference relationship between child and therapist, the place of interpretation, and ultimately patient insight. Anna Freud argued that the therapeutic relationship in child analysis was less tied up with transference than with a developmental experience for the child, and that consequently the therapist figured as a developmental, not transference, object. While both schools concurred in viewing therapy as a distinctively relational process, there was disagreement between them about the relative importance of taking up the child's positive and negative feelings towards the therapist. Kleinians stressed the need to address the child's negative feelings towards therapist and therapy, within the total transference; while Freudians emphasised the importance of building on the child's positive feelings for the therapist. However, over time, the distinctions between the two approaches have tended to blur as new debates have formed around, for instance, the role of countertransference in the analytic process; the distinction between containment and insight-oriented therapy; and the challenges arising in work with disturbed, disrupted and disruptive children, previously regarded as unsuitable for psychoanalytic treatment. The growing dialogue with attachment studies, child development and neurological research, has been key to shaping some of the current thinking (eg Stern 1985, 1988, 2000; Shuttlesworth 1989; Schore 2001a, 2001b; Gilmore 2000; Fonagy & Target 1998; Fonagy 2000; Balbernie 2001).

The therapeutic relationship and containment

Bion's ideas about therapeutic containment, further supported by child development research, stress the relational aspects of child psychotherapy. The therapist is seen as bearing many quasi-parental functions for the child in this regard, since Bion takes maternal function as his principal model of containment. Segal, linking the psychoanalytic process to Bion's thoughts on the parent-infant relationship, writes:

"In this model, the analytic situation provides a container."

Segal (1975: 135)

As the mother is needed by the infant to receive unformed or unbearable feelings, digest them in her own mind to return in a tolerable shape; so the therapist must receive his patient's experience, particularly the unconscious aspects of it, using his own mind to name and link experiences which in the child are inchoate, split off, or denied. The therapist must also, like the mother, find ways of returning unconscious experience to the patient, helping the patient to develop tolerance for what could not be borne. Through such a relationship with the therapist's mind, the patient, like the infant, is helped to find a mind of his own for thinking about his feelings and the feelings of others, in place of acting them out.

"The analyst's attitude and verbalization permit the opening of a window on the mental world of self and other."

Fonagy and Target (1998)

He discovers other ways of managing mental conflict without being driven to resort to self-mutilation of one kind or another – splitting, projection, denial – all of which can have disastrous consequences for his capacity to know and relate flexibly to others and the external world.

Alvarez (1992), making use of child development research, further expands on the idea of maternal function, stressing the dimensions of mirroring and partnering emotional experience in the child (eg: Stern 1985, Trevarthen 2004, Zeedyk 2006). Mothers are active through, play, touch, facial expression, voice, words, in regulating their children's emotional and relational experience, and introducing new experiences to the child. Stern observes:

"It is a very common experience for any mother to try to expand her infant's tolerance for excitement or arousal and generally stretch her infant's world."

Stern (1985: 193).

In Stern's developmental map, such activities are core to the child's development of self-other relatedness. Alvarez argues that child psychotherapists too are needed at times to work as "*alerters, arouzers and enliveners*" (Alvarez, 1992: 60), particularly when working with children who have been severely deprived of responsive parenting at an early stage. Schore also stresses the role of psychotherapy in providing: "*an optimal socioemotional environment for the development of internal structures that efficiently regulate affect.... The empathic therapist can enter into dyadic affect transactions with the patient and act as an affect regulator*" (Schore 1994: 465)

Building on such concepts, Fonagy formulates two distinct functions for child psychotherapy, one which is insight oriented, and the other which has "*the recovery of mentalization in the context of emotional arousal at its core*" (Fonagy 2009: 25).

Conclusions from his retrospective outcomes study are that the children exhibiting complex psychopathologies were less helped by insight-oriented interpretations than by interventions which help them track, and put words to, the mental states hitherto expressed in actions or body states; which focus on what triggers minute-to-minute change in the child's internal state; and helps the child think imaginatively about the therapist's mind and thoughts in the context of the joint interaction in the session. Fonagy and Target (1998) further stress the importance of adapting the focus of therapy to match the child's developmental situation, in cases where maltreatment and early deprivation have seriously interfered with the child's mentalising capacity. In such circumstances:

"...the therapeutic intent is to facilitate the establishment of a beachhead, an area of self-other relatedness. Prematurely confronting the patient's defences before this beachhead is established only exacerbates the need for distance, control, or devaluation of the analyst and the therapy."

Fonagy & Target (1998)

Steiner's (1993) discussion of work with adult borderline patients puts forward a similar distinction between containment and insight as sequential goals of therapy.

Jones, like Fonagy, argues for long-term treatment with children suffering mentalising deficits as a result of early deprivation / maltreatment:

“The development of a safe, trusting therapeutic relationship does not happen quickly, particularly for people whose formative environments may have been unpredictable, chaotic, or abusive.”

Jones (2002: 14)

He finds support in Schore’s comment that the chances of *“dyadic interactive repair are expanded in longer term treatment. In the context of an extended relationship, interactive transactions can be internalized, allowing for the emergence of an adaptive mechanism that can, under periods of stress, be accessed for self-comforting”* (Schore 1994: 473). Jones translates this hypothesis to his own work with ADHD patients, noting:

“A therapist’s role in helping a patient with ADHD is most powerfully communicated through empathy, mirroring, and affect regulating interactions. The therapeutic relationship, with its affect regulating capacities, can be internalized by the patient. This results in an internal presence that helps the patient regulate his or her own feelings and behaviors.”

Jones (2002: 17)

Working in the counter-transference

How does the therapist know about the patient’s internal state of mind? In patients with good mentalising function, verbalization and self-reporting is a helpful starting point for accessing at least what is in the patient’s conscious mind. But much of the psychoanalytic therapist’s concern is with the patient’s unconscious life – phantasies and aspects of the self which have been forced underground by the demands of the ego and superego. Freud regarded his patient’s verbal reports of dreams and free associations as essential data for uncovering such unconscious mental states. Klein, with children, developed a technique based on play, observing that a child’s play activities *“... are means of expressing what the adult expresses predominantly by words”* (Klein 1955: 123), and moreover often share the free-wheeling connectivity common to dreams and free association. Flowing from her ideas about projection and projective identification, Bion and subsequent analysts theorized that the feelings evoked in the therapist by the patient – or counter-transference feelings - were also clues to the patient’s internal state:

"..patients attempt to arouse in the analyst feelings that they cannot tolerate in themselves but which they unconsciously wish to express and which can be understood by the analyst as a communication."

Spillius (1992: 62).

Heimann, one of the first to formulate an explicit place for attending to counter-transference experiences in therapy, writes:

"My thesis is that the analyst's emotional response to his patient within the analytic situation represents one of the most important tools for his work. The analyst's counter-transference is an instrument of research into the patient's unconscious."

Heimann (1950)

As a result of such theories, Alvarez notes:

"There is now ... much greater attention paid to the interpersonal relationship between the patient and his analyst, that is, to the patient's changing transference and to the analyst's changing counter-transference – the feelings and reactions evoked in him by the patient."

Alvarez (1992: 2)

The central role of counter-transference is further compounded in cases where symbolization and mentalisation functions are restricted. As noted earlier, children in such circumstances show an inordinate reliance on enactment and projection, both for defensive and communicative purposes. As Alvarez (1992) powerfully describes in her account of work with autistic, borderline, deprived and abused children, it is often only through close attention to her own feelings in response to what the patient is doing, that the therapist is able to tune in to the meanings underlying the child's actions. She notes that seemingly repetitive, monotonous activity can evoke quite distinct feelings in the therapist, relating to the very different internal states and intentions in the child at different times. Where the therapist blocks off awareness of her own responses, these subtle variations will go unnoticed. Conversely, attention to counter-transference can reveal surprising signals of the child's unconscious attunement and responsiveness to the therapist's own state of attentiveness. She reports cases of children like my patient Simon (see previous chapter), where reductions in the therapist's attention provoked subtle shifts in the child's activity geared to recovering the child's place in the therapist's mind /eye. For instance, one of her patients would alter his circular pacing,

widening it to take an oval form bringing him back within range of her gaze, when her attention wandered; then returning to the original circular track when her attention was restored. By attending to her own internal states the therapist is able to track these subtle connections and so help detect the unconscious object-relating aspects of the child's activity. A careful monitoring of counter-transference feelings is thus vital to making sense of what can otherwise appear to be meaningless or disconnected shifts in behaviour.

Joseph (1989) argues that one of the analyst's tasks is to be aware of her patient's disguised, and often unconscious, efforts to "nudge" the analyst into feeling and acting to reproduce the patient's internal object relations. Through her awareness, the therapist acquires a knowledge of the nature of the child's internal objects, self representation, and patterns of relating; his "*unconscious conflicts and defences*" (Heimann 1950). Sandler suggests that attention to the transference counter-transference flow in sessions is moreover needed for tracking changes in the child's self-representation in parallel with changes in his related object representation (Sandler 1994).

The emphasis so far has been on counter-transference as a tool for investigating the unconscious. Closely linked is the view that the transference / counter-transference relationship is a dynamic factor in psychic change. Alvarez shows how the clinician's use of counter-transference to gain insight into children whose symbolic and mentalising capacities are poor, also provides the opportunity for the child to develop an awareness of his own mind, and the beginnings of differentiated awareness of his internal state. Where a child's projections have repeatedly failed to reach their target, the child "*resorts to increasingly intense projective identification, and eventually may virtually empty out his mind so as not to have to know how unbearable his thoughts and feelings are. By this time he is on the road to madness.*" (Spillius 1992: 62) When the therapist becomes aware of the unconscious meaning in the child's activity, she can find ways to alert the child to it. Her mind at this moment both discovers and models something to the child about the meaningful link between mind and action; about minds as digesters and transformers of emotional experience; and about minds as interactive authors and receivers of meaning.

This is a transformative moment, as Borgogno found with his severely neglected patient:

"It was this continuous and sensitive attempt to offer words and affective meaningfulness to orphan M—an orphan, I would say, of parental transformative reverie and representation—that gradually enabled her to acquire first a less painful body and later a personal idiom through which she could express and narrate, at a more conscious level and in first person, the various episodes of her life."

Borgogno (2004)

In Bion's terms, the child has the experience of its projection being received and contained. Thus, the therapist's capacity to consult her feelings to shape a differentiating response, is the spur to the child's own mentalising function to be (re-)activated – the lost link between thought and action has an opportunity to re-establish itself. Fonagy and Target (1998) clarify:

"The relationship with the analyst ... remains central because the clarification of children's feelings about themselves and about the analyst is the most effective route toward acquiring mentalizing capacity."

Fonagy & Target (1998)

Work in the transference / counter-transference can also be key to shifting or amplifying the patient's internal landscape of object relations. In one sense, all a patient's relationships will be transference relationships in that they will all carry the stamp of the patient's internal world. Therapy, because of its overriding, patient-centred preoccupation with the transference / countertransference dimensions of the interaction, offers the patient the opportunity of being in, and simultaneously reflecting on, his relationship as it is forming with the therapist, and as patterned by his, the patient's, unconscious phantasies. This unusual feature, which is distinctive of therapy, makes the therapeutic relationship both an arena for re-enactment of old relationships, but also a space for a new experience. The therapist is both a transference object and a new object for the patient, since it is her job to be available to the patient's "nudges" and projections, without falling in with the invitation to reproduce the object projected into her. She has to be in touch with the projections but also keep at one step removed from them. Box writes:

"The task of the therapist ... is to be available to play a part in his patients' phantasy scenario but, rather than enacting the projections as he is implicitly

invited to, it is to monitor his minute by minute experience in order to try and understand what is the part he is being required to play and to transform it. ”

Box (1986: 192)

For many deprived and abused children, especially, this will challenge an internal situation premised on hostile, retaliatory objects versus idealized, all-sustaining objects, by introducing a new element: *“an inner representation of a receiver, of someone who is interested in getting to know and understand something of his inner world, of the way he thinks and feels, someone who is open to become emotionally touched by him”* (Isaksson 2005); yet also someone who remains separate enough from the emotional contact to be curious and reflective.

Meotti comments:

“Insofar as the transference is a new experience, it represents a mortal threat to the status quo. ”

Meotti (1995: 463).

The therapist’s activity in receiving and reflecting on her patient’s projections, creates a space for the patient to go beyond repetition, to the slow business of working through unconscious conflicts (Freud 1914) – first bringing them to consciousness, and through this experience also finding a new internal position in relation to his feelings and beliefs about self and others. As Britton (1989) describes, the experience of the therapist’s mind, working in this way to stay in touch with her own and her patient’s internal states, without collapsing into them, introduces a dynamic “third” position to what can often be a very static internal state of affairs in the patient. It constructs a triangular inter and intrapsychic space, with *“the possibility of being a participant in a relationship and observed by a third person as well as being an observer of a relationship between two people.”* (Britton, 1989: 86) In developmental terms, this is what opens the doors for the patient to think about his internal states no longer as all-encompassing, but at one remove, as parts of a larger internal and external picture. He can then start to entertain the idea of another reality apart from that of his immediate internal world and begin the task of sorting out what belongs where – work that is fundamental to building a place for himself in the real world.

Rosenfeld (1987) stresses the importance of the therapist being emotionally alive and present to the patient in this process:

“The analyst’s emotional participation is absolutely necessary in order to create a containing environment, and a purely intellectual approach is equal to a complete failure to contain.”

Rosenfeld (1987: 174).

How to communicate such emotional participation is the subject of much debate. I noted some of its pitfalls in the previous chapter with reference to the disturbed, sometimes violent feelings, Simon projected into me. Pick refers to it as *“walking the tightrope between experiencing disturbance and responding with interpretation that does not convey disturbing anxiety.”* (Pick 1985: 34) Heimann, while emphasizing the importance of emotional contact to inform interpretations, similarly draws the line at the therapist evidencing an emotional response to the patient’s communication:

“His (the therapist’s) own emotions are barred from expression”

Heimann (1956).

Referencing Emde (1988), Sternberg counters that:

“The therapist has to be affectively in tune with the patient and be able to show it.”

Sternberg (2006: 45).

Fonagy and Target coincide that:

“The analyst has to teach the patient about minds, principally by opening his mind to the patient’s explorations.”

Fonagy & Target (1998)

The difference of opinion over what is to be communicated of the therapist’s emotional participation, may be more one of emphasis than of substance. Interpretations inevitably are emotionally nuanced by factors such as the therapist’s timing and tonality – the choice of words, the tone of voice, what might be called the mood contours of the utterance. Meltzer relates such *“modulations of temperature and distance”* to two linked but separable therapeutic tasks, one using *“a language of uncertain rumination for expressing exploratory thought (interpretative activity) and one of commitment for presenting metapsychological statements (interpretation proper).”* (Meltzer 1976: 375). The first task aims at engaging patient and analyst in a free-flowing interaction, stimulative to the unconscious processes at work in both, and to the intuitive contact

between them. Communication at this level is as much concerned with projective identification as with symbolization. The second concerns a more definite and symbolically precise formulation of the analyst's ideas concerning his patient's unconscious, in the service of helping the patient gain insight. Meltzer stresses the role of "*musicality*" in the first task, involving tone, rhythm, key, volume, and timbre as means whereby the therapist modulates "*the emotionality of the voice.*" (op cit). Finding such a register with Simon was an important part of the therapeutic process, as noted in the previous chapter.

Meltzer traces his recognition of the therapeutic value of this dimension of communication, to his work with children and very ill adults, implying the relevance of patient pathology and developmental stage to the weighting of one or other modes of communication in any given case. Alvarez makes a similar point in discussing her work with autistic, deprived and border-line children. Drawing on child development studies of parent-infant interactions, she stresses the centrality of the mother's emotional expressiveness, evidenced through touch, voice and facial expression, in the task of providing her baby with the regulation and containment needed for symbolic function to develop (Alvarez 1992, Stern 1985, Zeedyk 2006). She argues that where a child has been very deprived of such maternal function, the therapist will need to give more attention to these primitive aspects of communication, in order to reach the child at all. Such children have missed out on the developmentally-critical experience of an object who can receive emotional states from the child, evidencing receipt in simple, expressive ways, and so allow the child to explore the feelings through the mind of his object. Premature interpretation of projections for a child in this state is experienced as a failure of containment resulting in therapeutic impasse (Alvarez 2000, Joseph 1978, Rosenfeld 1987). Consequently, projection and enactment remain the patient's dominant modes of communication, or intensify. As Bion comments:

"If the mother cannot tolerate ..projections, the infant is reduced to continued projective identification carried out with increasing force and frequency."

Bion (1962a: 115)

Along similar lines, Fonagy and Target's outcome research notes that in cases of more complex psycho-social disorders where intensive therapy has been shown to be helpful, "*interpretations of unconscious conflict aimed at promoting insight – long held as the*

centerpiece of analytic technique – appear to be of limited value” (Fonagy and Target 1998). In single case reports, clinicians working with deprived children stress the need for the therapist to accept the patient’s projections, sometimes for long periods of time, before attempting to relate the unwanted emotion back to the patient. Accepting a projection is first and foremost an emotional experience for the therapist – that is, a counter-transference experience. It means having the feeling on behalf of the child and the child will require some evidence of having reached the therapist emotionally before he can experience containment. This is especially true for children with poor mentalisation / symbolic function, who – like Alvarez’s autistic patient and the patient at the centre of this study - are highly attentive to the emotional state of the therapist at an unconscious level but have very small capacity to receive and make sense of complex symbolic communications from the therapist. Recalling some of the salient features found in the overlap between ADHD and deprivation, these borderline patients are operating in early infantile ways: they “*are concrete, one-tracked, overwhelmed by the singularity of their state of mind, and in danger of symbolic equations and massive splitting and projection.*” (Alvarez 2000: 10-11)

Hurry argues that the role of the therapist at such times is to make a space where the child can “*create or discover an alternative way of relating ... appropriate to their developmental stage.*”(Hurry, 1998: 46). Alvarez concurs, noting the importance of using language and structuring interpretations commensurate with the developmental state of such children. By moving from detached, descriptive interpretations to a grammar of rightful needs, the therapist shows the child *in a way that he can understand*, that she is positioned emotionally alongside him, even while she remains independent of him. As in early parent-infant relations, the therapist’s use of her voice, face and body, alongside the verbal content of her comments also gain in importance to express her emotional awareness of the child, and so create the conditions for containment. Sessions may be more weighted in the direction of what Stern et al (2002) describe as “*local level*” attunement-seeking interaction, than interpretative activity. With very disruptive, emotionally uncontained children, the therapist may also be required to intervene physically to contain the child (Emanuel 1984, Chused 1998, Rustin 2001, Canham 2004, Isaksson 2005). In all these cases, the child requires evidence of the therapist’s own emotional liveliness and involvement, as a prerequisite of meaningful, and later symbolic, interaction: he needs to find in his therapist an

emotionally alive object. Emotional authenticity, spontaneity, and playfulness in the therapist are therefore regarded as essential aspects of therapeutic work (Lanyado 2006; Sternberg 2006; Winnicott 1971), especially where such early deficits in object relations and mentalising function are involved. Equally important to the deprived child, is the therapist's capacity to maintain an analytic position – that is, to emotionally withstand and with time articulate the feelings being projected into them. But this only has meaning for the child if the therapist is seen as an emotionally alive and available object in the first place.

Again following Stern, Alvarez views emotional interplay between therapist and patient as very important to helping deprived children develop their capacity to think and sustain live relationships.

“Both developmentalists and psychoanalytic observers seem to be agreed that if a mind is to grow, it requires a meeting of minds and not too many “missteps in the dance” (Stern 1977) between infant and caregiver – but also not too few – mismatch, disillusion, and separateness are fundamental too to learning about reality.”

Alvarez (2000: 11)

The emotional work in the counter-transference combined with the therapist's relation of this work to the patient's internal situation addresses a developmental deficit, especially when both are accessible to the patient. In this regard, Borgogno (2004) stresses the importance of the therapist frankly owning errors and being authentic in her emotional responses, not only so that the patient may feel understood but also because *“whoever suffers from some form of deprivation will undoubtedly observe our behaviour, mistakes, and anxieties, including how we manage and resolve these.”* I mention the impact of such a moment of acknowledgement and repair between Simon and me, in the previous chapter.

Canham likewise emphasizes the gain for the child patient from an experience of real emotional contact with a containing object:

“My feeling and experience is that if it is possible to remain sufficiently open in order to take in the communication, then a gradual and gentle feeding back to the patient of what you are being made to feel in the counter-transference can be very helpful in enabling them to have a sense of being understood. Not only has

someone been able to withstand and articulate such awful feelings but, in so doing, they have also provided a model for painful emotional feeling states being borne rather than acted upon.”

Canham (2004: 146).

The intersubjective analytic third

Ogden conceptualizes the interplay of patient and analyst in the consulting room as generating an intersubjectivity which he names “*the analytic third*” (Ogden 1994). Related to Winnicott’s idea of the mother-infant dyad, two individuals bring themselves to the analytic setting to form a dynamic dyad, which confers identity on each. The character of the dyad is partly a product of the setting which denotes one member the patient, and the other the analyst, making the relationship an asymmetric one in terms of its focus. Its other aspect derives from the fusion of unconscious thoughts and wishes that occurs when a relationship forms, and which can be experienced by each member of the dyad as a subjective or external force, shaping their interactions sometimes in spite of their conscious intentions towards one another:

“the intersubjectivity of the analyst–analysand coexists in dynamic tension with the analyst and the analysand as separate individuals with their own thoughts, feelings, sensations, corporal reality, psychological identity and so on.”

Ogden (1994).

Ogden recommends the therapist to work with the transference-countertransference towards an understanding of the analytic third and how this connects to the patient’s subjective world:

“The analytic task involves an attempt to describe as fully as possible the specific nature of the experience of the interplay of individual subjectivity and intersubjectivity.”

Ogden (1994)

This requires attending not only to the patient but also to the associations set going in the analyst’s mind by the experience of dyad with this particular patient, so giving access to the unconscious processes at work.

Along similar lines, Sullivan (2010: 14) draws on the Jungian concept of conjunction to characterize the therapeutic process as a joining of analyst and patient to form

“something larger than the sum of the two”. Acknowledging the ideas of Bion, Meltzer, Ogden, and Ferro, she argues that the therapist accompanies the patient to explore his inner world through the “field” of the relationship evolving between them. The therapist needs to enter her patient’s internal world and discover it as a participant in the relational situation so brought into being.

“The therapist watches, unconsciously drawn into the patient’s depths as an emotional participant. She watches his associations and his non-verbal behaviors; she watches her own reverie in all its imagistic, verbal, emotional and physical aspects.”

Sullivan (2010:15).

Like Ogden, the task is to bring to awareness the unconscious aspects of the therapeutic relationship through tuning into the relational field with the analyst’s own subjectivity and reflecting on its unconscious patterning. Sullivan draws attention to the force of resistance to this process of getting to know oneself and another, found in patient and analyst.

“There is always a great temptation ...to (reach) for theory or old knowledge rather than (remain) in the confusion and disorientation of the emotionally charged present.”

Sullivan (2010: 203)

Both partners in the dyad wish to *“hang onto their cherished fictions about themselves”* and fear taking *“a receptive stance.. that centers itself in unknowing, confusion, faith and patience”* (2010:17).

Ferro writes:

“The analyst’s subjectivity .. obviously plays a major part - can he be himself and be creative, or does he need to operate .. with a theory that protects him from the risk of original thinking?”

Ferro (2009: 6)

The “*protective theory*” or “*old knowledge*” is here regarded as a variation of Bion’s – K, giving rise to interpretations that are defensive in function. Where the analytic third features such unconscious –K (at some level, a contest for mastery and resistance to change), there will be a prevailing sense of sterility and impasse. Ogden observes:

“It has been my experience that the language of both patient and analyst is dead (and thinking and communicating cease) when their use of language conveys

certainty as opposed to tendency, knowledge as opposed to a tentative, ever-sliding sense of things, fixity as opposed to movement and transition”

Ogden (1994).

As noted in the previous chapter, Simon, so rigid and controlling in his own thinking, was nonetheless an uncompromising opponent of defensive interpretation, when I used language to keep him at arm's length, distancing myself from the emotional turmoil he could stir up in me.

Conclusion

A large-scale outcome study and multiple clinical case studies concur that intensive therapy is helpful to deprived children with conduct disorders and ADHD-type features arising out of a history of trauma. Outcomes include improvements in emotional register, self-awareness, capacity to build relationships, emotional tolerance, verbal fluency and expressiveness, as well longer attention span and higher cognitive functioning. Drawing on psychoanalytic and child development theory, effectiveness is variously attributed to therapeutic containment, attention to the counter-transference, the emotional participation and expressiveness of the therapist, her acknowledgement and the interactive repair of mistakes, and attention to the intersubjective analytic third generated by the therapeutic encounter. I return to these themes in my later analysis of session material and discussion of the research findings.

Situating the research question in relation to theory

The current research offers the opportunity to explore in a clinical setting: the relationship between the different aspects of Simon detailed at the start of this chapter; and the impact of therapeutic work.

As this review of the literature shows, the very deprived character of his internal world and relationships, his difficulty thinking and expressing himself symbolically, and the importance of projective communication in the relationship with his therapist, are all aspects he shared with many other deprived children. It is common for such features to be associated with an ADHD diagnosis and treated with drugs and a short behavioural intervention. However, Bion's theory of thinking offers an account of how these

features can be aspects of the psychic situation formed by a damaged and damaging early relationship between infant and parent. There is evidence that intensive therapy, through offering the child an experience of containment, can improve the situation.

Turning back from the general to the particular, my question is in three parts:

- can we test out and expand on Bion's theory through a detailed analysis of the clinical record?
- would doing so add to clinical understanding of the patient?
- what might such an analysis contribute to our understanding of the workings of the therapeutic relationship in cases of severe deprivation?

Chapter 3

Methodology

Reviewing current trends in the social sciences, Clarke and Hoggett write:

“The preoccupation with language and cognition has started to give way to an equal interest in emotion and affect.”

Clarke & Hoggett (2009: 1)

An interest in tracking the complex relationship between language, cognition, emotion and affect is at the heart of this study of therapy with Simon. As Clarke and Hoggett observe, the shift in attention has required researchers to explore new methods of enquiry, capable of registering and analysing the emotional aspects of communication.

I begin the current chapter with an account of the ethical principles attached to such research, and consider some methodological issues associated with the single case study as an important area of psychoanalytic enquiry. I then draw on the discussion in the previous chapter to situate my choice of research tools, which are designed to map the clinical process with special attention to the quality of the internal situation expressed through the therapy relationship, and explore how it relates to the capacity to think and modes of communication prevailing at different moments between patient and therapist. Contributions have come from different disciplines, with child development research and psychoanalysis adding core concepts and methods to existing qualitative research methodology. I have drawn on all these areas to construct the present study.

Ethical considerations

My study observes four core principles guiding ethical research of clinical practice:

1. Clinical integrity

The research takes as its base data, records of a completed clinical treatment. Simon received standard clinical treatment determined by a clinical assessment of his needs, and completed prior to the proposal to use the clinical record of the case for research purposes. My study is therefore retrospective in character and did not

impinge on the development of the therapy, or the relationship between therapist and patient within the context of ongoing therapy.

2. Informed consent

The patient's consent was sought as a precondition of the research¹⁵. As Simon was nearly 16 at the time of submitting my research proposal, I approached him directly, and in writing, to allow full opportunity for him to be clear about the purpose of the research and what it involved for him. I explained the research was part of a doctoral programme to learn from work with patients, and share this thinking with other professionals so that they could use what has been learned to help other young people in the future. In view of his developmental position and vulnerability, I also discussed the proposal with his social worker and foster carers. Written consent was received from all concerned before proceeding.

3. Anonymity

It is important to protect the anonymity of research subjects and to this end, the research uses pseudonyms and avoids references which might identify the patient or his care network. Some personal details have also been disguised in writing up the data, to minimise the risk of identification.

4. Regard for subject's rights and welfare throughout the process

Research subjects have a right to know what is written about them, and this was clearly stated in the preliminary information and discussion with Simon and his carers. A protocol was agreed, stating where the research publication could be found, and how Simon could access it. This included an opportunity for Simon and me to discuss such an action beforehand, with due regard to Simon's wishes and best interests, so he could make as informed a decision as possible, about exercising his right.

Choosing the single case study as a research area

The preliminary ideas underpinning the research questions were born from an extended single case study of clinical work. This is in keeping with a long tradition in the natural and human sciences, where intensive studies of individual cases have led to important

¹⁵ Copies of the information and consent forms I used are attached in Appendix 6

developments in theoretical concepts: the single case study has, for instance, played a key role in the development of theory in medicine and neuroscience (Rustin 2001, Fonagy & Moran 1993), as well as in the work of historians and social scientists (Stake 1994). Freud developed many of his theories regarding the structure and operations of the human mind, through close analysis of his work with individual patients, and through his own self analysis. Rustin (2001) describes how the highly detailed studies of individual mother-infant interactions, by Stern, Trevarthen, Brazelton and others, were key to the evolution of child development theory. There is thus evidence to demonstrate the empirical advantage of starting from an in-depth scrutiny of single cases.

As well as holding a well-established place in scientific thought, the characteristics of the single case study make it particularly suited for use in psychoanalytic research. Yin (2009) comments that the case study is relevant when research is concerned with either a descriptive question (what happened?) or an explanatory question (how or why did something happen?). As a professional group, our particular interest is in understanding how our patients think and why they think the way they do. Moreover, the practice of psychoanalytic psychotherapy, like single case study research, involves an intensive one-to-one focus on the individual. Even if methodologically diverse, therapy and single case research can thus be seen to share some principles in common and an interest in the same subject area.

There are epistemological grounds for holding that there are things to be learnt from the study of the one. Stake, in his discussion of single case studies, points out, “*the case study is not a methodological choice but a choice of what is to be studied.*”(1994: 435). The choice can be defended on two grounds: first, that the case under study is regarded as being of intrinsic interest; and second, that the case is chosen because it presents particular features of interest which suit it to be regarded as one of a kind. A similar distinction is made by Smith et al who point to the difference between “*consideration of the individual in itself ... and its consideration as a bearer of a type*” (1995: 65). This distinction is sometimes applied to differentiate between two different starting points for research, and perhaps particularly between practice-based, clinical research (where the case is of clinical interest in its own right), and more selectively-constructed academic studies, where cases are studied for their instrumental (or representational) qualities.

The current study moves dynamically between both perspectives. It originates in work done in a clinical setting, where the purpose was to understand and support a particular child, struggling with inherently individual emotional and symbolic difficulties. The clinical task involved becoming emotionally and intellectually engaged with him as a unique individual of intrinsic interest. Recording and analyzing the interactions between us in supervision was principally a clinical, not an academic, activity, shaped by a therapeutic, not theoretical, interest. Now, however, the clinical record and supervision notes, have acquired a different function, taking on the identity of the data items for the current research. The frame of the academic doctorate introduces a new perspective where the clinical reading of my patient is revisited, and interrogated in a different way. Meanwhile, as I get the distance needed to re-appraise the events in therapy from a non-clinical position, so too does the intrinsic uniqueness of my patient recede and it is his identity as one of a family of children that pushes to the fore. (Understandably this is a complex emotional journey for the researcher, as well as an intellectual one).

The single case study thus comes with the potential to exemplify the dialectical character of scientific enquiry which lies in its constant movement between the general and the particular, the nomothetic and the idiographic. Wherever the researcher begins, and whatever the dynamic shifts in perspective which occur in the process, the strength of single case research relies on the capacity of the researcher to be open to the unexpected as well as the expected, and to be receptive to fine detail. The value of the case study lies in exploring the particular, to gather the data against which competing hypotheses may be developed and tested. Smith et al describe this as the basis for the work of exploring similarities across difference, and differences between the similar, which is the starting point for all science, beginning the “*cautious climb up the ladder of generality, seeking for universal structures but reaching them only by a painful, step-by-step approach.*” (1995: 63, citing Harré, 1979: 137).

Critique of the single case study

The open mind of the idiographic researcher is not the same as an empty mind. Attention to the particular will be selective from the outset: shaped by concepts of relevance (Smith et al, 1995), reflecting theoretical assumptions made on the basis of previous experience and training, as well as the personal and social values of the researcher (Stake 1994). Bromley comments:

“A case study is not exhaustive in its description and analysis of the person and situation: it is selective in the sense that it addresses itself to some issue and ignores others. Thus some facts about the person and the situation are relevant to those issues (and constitute evidence) whereas others are not ...”

Bromley (1986: 5)

This results in a tension where the processes of conceptualisation, which are necessary to identify and locate a case, frame some starting point for enquiry, and draw conclusions, constantly accompany and vie with the stance of free floating attention advocated for the study of the particular. As Stake comments:

“The search for particularity competes with the search for generalizability.”

Stake (1994: 439)

Like other dialectics, science thrives when both opposing strands come together and proceed simultaneously, producing the creative tension needed to generate new ideas or modify old ones. Single case studies are prime examples of this dynamic process in action.

It follows that the single case study, however intrinsic in character, or singular in subject matter, is never a study pursued in isolation. It is inseparable from processes of conceptualisation and generalisation, which are the goals of science. Its weakness, if it can be called such, is that it cannot, on its own, do more than hypothesise the generalisability of its conclusions to other cases. This is what Turpin describes as the “*limited generalisability*” of the single case study (2001:105), taken as a one-off piece of research. However, he goes on to point out that this difficulty can be overcome through adding progressively to the number of single case studies, each of which provides a basis for assessing and refining on the theories put forward in previous studies, with cumulative power to discriminate between findings which can be generalised beyond the particular, and those which cannot. For this reason, an important aspect of the current research was a literature review to articulate its theoretical orientation, preliminary questions, subsequent observations and conclusions, in relation to other work in the field, thus making explicit its place in “the series”.

Critique of the psychoanalytic case study

Common criticisms of the psychoanalytic case study focus not so much on its reliance on single case material, as on its methods of investigation. As Turpin (2001) points out,

within the psychological sciences, the term “case study” has been used to cover a wide array of quite diverse writings, ranging through the anecdotal, the brief case report, to the more formal presentation of clinical material to assess clinical competence. In my case, the current study arose out of a clinical paper prepared for qualification purposes, which belonged to the latter of these categories. While it was grounded in the same clinical material and literature as the current study, it was only in the loosest sense a “research” paper. What then is required for the case study to meet the requirements of clinical research?

In its looser sense, some psychoanalysts have regarded therapeutic practice and research as one and the same – or at least, closely conjoined . Sandler, for instance, who was both a pioneer of psychoanalytic research and a practicing analyst, wrote that, in psychoanalysis, “*the method of therapy is identical with the method of investigation*” (1965: 112). On this view, all practicing therapists are constantly involved in the business of research, since the aim of therapy – like research - is for therapist and patient to arrive at a place of insight into the mind of the patient. It does not matter if the methods don’t comply with general scientific principles – it is enough that the claims to insight are presented for debate and evaluation by peers in the profession, who are best placed by training and experience to judge them (Rustin, 2001).

Representing another perspective, Fonagy draws a distinction between analytic methods of working and scientific research methods, decrying as “*inexcusable ... the thin evidence base of psychoanalytically oriented treatments*” (2003: 130). He warns against a complacent disregard for current research methods which leaves psychoanalytic research and practice vulnerable to marginalisation, in a highly competitive, science-dominated market-place where it is rapidly losing ground to other, cheaper treatments with more widely-accepted evidence bases. Even more serious in his view is that keeping psychoanalysis in the position of an inward-looking, self-authorising knowledge club contributes to an unhealthy culture of “*knowing and certainty*” (2003: 131), at the expense of the critical, questioning thinking required for progress across the sciences.

Spence (1993) summarises some of the weaknesses of the traditional psychoanalytic case study as a research methodology. These include

1. its reliance on anecdote and narrative persuasion;

2. the tendency to single out and build one narrative, without reference to any other possible construction of events;
3. the uniquely privileged position of the therapist-researcher, with regard to the data, which always advantages the author's construction of events over any one else's, and places undue reliance on the therapist's own powers of observation, memory of events, and capacity to distinguish evidence from theory.

Of these, it is perhaps the last which represents the greatest methodological challenge, since it compromises the basic scientific principle, that the evidence for knowledge claims in science should be available to "*public inspection or consensual validation*" (1993: 41). When we read a psychoanalytic case study such as Freud's paper on the Wolfman (1918), we are wholly reliant on his selection and construction of the facts of the case. There is no other data to inspect. We do not know what has been left out and so cannot make any judgements about the completeness of the account, nor the accuracy of Freud's record. In this respect, the case study is in a poor position to defend itself against the charge of being "*anecdotal, selective, consciously or unconsciously self-serving, or biased towards a singular solution*" (Spence 1993: 40). It is perhaps small wonder that its critics have frequently dismissed psychoanalysis as a "pseudo-science" when there has been so much scope for "*psychoanalytic theory ... to fill the role of shared fantasy*" (Spence 1993: 40).

In response to these criticisms, there have been some attempts to import single case methodology from other branches of science, into psychoanalytic research studies, so as to strengthen psychoanalytic knowledge claims and the capacity to communicate these convincingly beyond the boundaries of the discipline. Midgley (2004), Fonagy & Moran (1993) and Spence (1993) suggest some important principles for such an enterprise. These include:

1. Setting stable base lines against which to measure change
2. Triangulating data from multiple sources to support conclusions
3. Keeping systematic, durable and accessible records which clearly distinguish between the phenomena under scrutiny, and parallel or subsequent theorising
4. Formulating clear hypotheses which are specific enough for data and counterdata to be identified consistently by different observers.

I return to these principles at different points in the next sections, where I describe the data and data analysis methods used in the current study.

Data corpus of the current research

The data corpus of the current research is the body of records held in the clinical case file. Given the retrospective character of the research, the data stands independent of the research aims, rather in the same way that historical records are free-standing of the historical research which investigates them. Although partial, subjective, sometimes contradictory in content, and unsystematic, the records have the virtue of being, in this one respect, an “uncontaminated” source, since data collection which is structured around a particular research question, introduces from the outset a confounding variable into the research process which must then be carefully controlled for.

The records are from various sources and consist of:

The researcher’s own notes

Detailed written records of

selected sessions during intensive therapy (about 1 in every 4 sessions = 65 in total)

3 sessions before the start of intensive therapy

4 sessions following the end of intensive therapy.

Brief supervision notes on detailed session records.

Brief notes of individual sessions with the patient.

The researcher’s own summary reports on the therapy dated at periodic intervals during therapy.

Triangulating data from multiple sources

Reports from other professionals, produced independently prior to the start of therapy, with information on the patient’s history and functioning at the time of writing.

Reports on the patient from other professionals during, and following the end of, intensive therapy.

Colleague notes of network meetings held during the course of therapy.

Colleague and the researcher's own correspondence with other professionals during therapy.

Colleague notes on monthly consultation meetings with the patient's carers during therapy.

Supervisor's notes on selected sessions.

Base lines and triangulating data within the data corpus

Fonagy and Moran (1993) describe some of the difficulties for psychotherapists in setting stable base lines for measuring treatment effects, pointing out that most psychoanalytic studies begin as the patient enters treatment, so there is no opportunity to gather pre-treatment data sufficient to identify and control for random fluctuations within the treatment period. They do however cite an interesting study of psychotherapy with children with brittle diabetes (Fonagy & Moran 1993), where the researchers used physical indicators as a measure of treatment outcome and were able to access pre-treatment health records to establish a base line. This highlights the interest and relevance of collaborative research, correlating cross-disciplinary data, advocated by Fonagy & Moran (2003) and Rustin (2001) among others. It is also a useful illustration of triangulation as a method for constructing the evidence base for a hypothesis. There are opportunities to triangulate data within the discipline too, using for instance patient records, consultation work with carers and others in the patient's network, supervision records, peer ratings of session records, etc.

In the current research, independent social work, paediatric and school reports on the patient from before the start of treatment are useful, if limited, base lines from which to measure treatment effects. Follow up reports from these professionals punctuate, and continue after the end of, intensive treatment, providing points of triangulation for my own assessment of the patient's situation at different points in treatment. They are further supplemented by the views of the patient's carers as noted during regular consultation sessions with an experienced colleague.

Subjectivity in the data items

Inevitably the detailed written records of therapy sessions which constitute the data items of this research are subjective accounts of the interactions in the therapy room. Much attention has been paid to data collection procedures within psychotherapy and suggestions of ways to improve them. Spence discusses the work of the American Psychoanalytic Association (Klumpner & Frank 1991) which recommended the adoption of systematic conventions for recording session notes, which distinguish clearly between patient and therapist, non-verbal and verbalised behaviour, approximate descriptions of utterances and verbatim records, with multiple columns allocated to later comments and thoughts – of the therapist, and then of subsequent readers. These recommendations do not do away with the problem of an over-reliance on the therapist's observation and memory in data collection, but they do point up the need to introduce some rigour and system to the record which can help to make the balance of different types of observation more visible, while identifying blind spots and limits in patient's and therapist's attention.

Within the current study, session records have not obeyed the conventions outlined above but they have been routinely and rigorously scrutinized by the experienced eye of a senior colleague to whom I brought the patient for weekly supervision during the period of intensive therapy. Thus built into the therapy process, there has been an external check on the therapist's subjective understanding of the patient, and reading of interactions in the therapy room, including her own countertransference experience. In this regard, as Rustin (2001) points out, supervision, which forms such a part of the psychoanalytic method of enquiry in the clinic setting, is also a resource for qualifying the inherent subjectivity of the therapist's account noted by Spence, in the academic arena.

In addition, during the research process my detailed analysis of the two sessions in the following Chapters was closely read and examined by two senior psychotherapy colleagues acting as research supervisors, and a third independent training analyst. Their questions, comments and contributions, have been integrated to inform the final version produced here, representing a collaborative, rather than purely individual, reading of the material.

Nor is it possible to discount “subjectivity” in psychological research as a simple negative. Increasingly the literature on research traditions within the human and natural sciences have discriminated between realist and constructivist approaches, depending on the subject being researched (Rustin 2001, Urwin et al 2009). Where the interest is in establishing the *meaning* of human events and actions, subjectivity is both the object of research and tool in the research process. From within the psychoanalytic tradition, O’Shaughnessy comments:

“When I make a truth claim, I do not claim to know the truth, or all the truth, but only a truth.”

O’Shaughnessy (1994: 941).

She emphasises (as a strength) the fundamentally personal and individual character of knowledge and learning. The subjectivity of the therapist is here regarded as an essential resource for discerning and communicating inter and intrapsychic meaning.

Data analysis

Formulating the research question with thematic analysis methodology

Where the subjectivity of the data items is a valued given, qualitative research methods for analyzing data bring helpful systematisation, particularly as regards procedures for clear hypothesising and classification of data. Within qualitative methodology, hypothesizing and classification can be regarded as the starting point for research or an essential aspect of the research process. At one extreme, it requires that “*categories should be defined explicitly enough for the reliable allocation of clinical material to categories by independent judges*”, and “*the set of categories should be exhaustive, so that every instance belongs to a category.*” (Fonagy & Moran, 1993: 67).

Psychoanalytic thinking is rarely as uniform or unambiguous as this, however. A plurality of perspectives is traditionally regarded as fruitful and is characteristic of clinical thinking and discussion. It is thus common during psychoanalytic work for a number of views of clinical material to co-exist, both between different clinicians and within the therapist’s own mind. This open-ended approach is however perfectly compatible with the qualitative research methods described by Midgley, which entail “*a detailed, but systematic approach ... with the aim of developing hypotheses or theories that are grounded in the data itself, derived from a constant interplay between*

observation and understanding” (2004: 92). With the benefit of hindsight (see Findings Chapter), I would now add that such an approach is also epistemologically congruent with new scientific paradigms, which formalise concepts of “emergence”, paradox, and non-repetitive, interactive, self-organising patterning, as aspects of natural process.

The current research takes some of its general methodological principles from thematic analysis:

“a method for identifying, analyzing and reporting patterns (themes) within data.”

Braun and Clark (2006: 79).

Thematic analysis has much in common with grounded theory as a methodology, but without the commitment to generate developments in theory out of data analysis. It postulates various stages in the research process, grounded in repeated examinations of the research data with a view to gradually refining a set of themes and the relations between them, with which to structure an analysis and final write-up of the clinical data.

“A theme captures something important about the data in relation to the research question, and represents some level of patterned response or meaning within the data set.”

Braun and Clark (2006:82).

The first stage of this process in the current study may be regarded as the review of detailed session material which resulted in the clinical paper on my patient, written for qualification purposes. I had chosen a case where the experience of intensive psychoanalytic treatment was accompanied by significant progress in the patient’s symbolic communication, a gradual reduction in his controlling patterns of relating, and the eventual termination of medication. In writing the clinical paper, I became interested to explore these developments in terms of the relationship formed in the course of the therapy, trying to identify the key factors which led to shifts in the internal situation.

The clinical paper, based on transcripts of the 72 sessions written up for supervision during Simon’s treatment, thus identified a research focus and what thematic analysis calls a core group of “*candidate themes*” with which to revisit the data items in a more systematic way. I formulated my conclusions into a research question as follows:

What can the application of thematic analysis methods to a single case study of intensive psychoanalytic psychotherapy, add to our understanding of

1. the link between a child's early experience of deprivation and sadomasochistic addictive functioning?
2. how these features relate to the prevalence of enactment and projection over the child's symbolic communication and developmental progress?
3. how these difficulties are addressed by intensive psychoanalytic psychotherapy?
4. the emotional work required of the therapist in the case?

At the same time, I identified the first candidate themes for tracking developments over the course of the therapy. These concerned attention in the following areas:

- The patient's very controlling use of the setting and relationship with his therapist;
- his preoccupation with mess, and dedication to destructive, repetitive behaviour, which often had an excited, coercive quality;
- his marked difficulty developing symbolic play;
- my strong emotional reactions to his behaviour and repeated sense of being coerced by him to take up a part in a punitive, destructive relationship.

Sampling the data items to refine themes

As many other researchers have found, confronting a substantial data corpus numbering many data items, I early on faced the task of finding a way into the material as the second step towards refining my candidate themes. I followed the advice of my doctoral supervisors, selecting two sample sessions to get the process started. These sessions were chosen not at random, but because they were representative of the sorts of behaviour and interactions I had identified, from among the 72 sessions reviewed for the qualifying paper, to contrast therapy at the beginning and end of treatment.

Features were coded in three areas: the nature of Simon's relationship with his therapist and objects in the therapy room; his pattern of cognitive function and communication; the quality of the therapeutic relationship. In Session 1, I was looking for a session featuring the distinctive qualities of the first phase of treatment in these areas, as

represented by the categories grounded in my earlier detailed session-by-session review. The criteria for this session were as follows:

Session 1 coding:	
Code	Sub-categories
Nature of relationship with therapist and objects in therapy room	
	Appetite for materials combined with destructiveness
	Preoccupation with messing and spoiling
	Repetitively destructive play
	Attacks on the therapeutic space/setting
	Controlling, coercive attitude to therapist, allied with cruelty and sometimes excitement
	Sense of deprivation and grievance with therapist
	Developmentally regressed relationship with therapist
Pattern of cognitive function and communication	
	Marked difficulty sustaining play
	Absence of developed symbolic play
	Driven quality of physical activity
	Enactment and concrete thinking
	Absence of reflective function
	Marked use of projection
Quality of the therapeutic relationship	
	Negative impact of therapist's interpretations
	Repeated experience of hostility and rejection
	Embattled quality
	Restricted emotional availability
	Primitive, non-reflective states of mind

Figure 1

The criteria for Session 2 were similarly grounded in the features of the last phase of therapy as identified in the qualifying paper. These were as follows:

Session 2 Coding	
Code	Sub-categories
Nature of relationship with therapist and objects in therapy room	
	Moments of non-controlling curiosity
	Limits accepted
	Concern expressed
	Enjoyment, satisfaction with therapist
Pattern of cognitive function and communication	
	Periods of sustained play
	Symbolically developed play
	Attention to meaning, exploration of meaning
	Moments of reflective function
	Development of language
Quality of the therapeutic relationship	
	Creative exchanges – spontaneity
	Emotional engagement
	Open, receptive states of mind
	Interpretation tolerated

Figure 2

Using these criteria, I selected two candidate sessions, the first occurring two months after the start of intensive therapy within the phase 1 period of therapy; and the second a couple of months before the end of intensive therapy, in the phase 2 period of therapy.

My selection was approved by the case supervisor, a senior child psychotherapist with detailed knowledge of the patient. I reasoned that a study of the themes emerging in each of these sessions would then provide a useful template for approaching other sessions from the data items.¹⁶

Originally I planned a third stage of the research which would involve again broadening out the sample of sessions to be studied with the template from stage two. The aim was to create a sample which would cover the entire period of intensive therapy, permitting

¹⁶ Retrospectively borrowing from Mandelbrot set theory, such selection might be considered a “fractal” approach to the data, on the theory that zooming in on any point of a complex, irregular phenomenon, will reveal the same (though never exactly repeated) emergent pattern, and contributes vital understanding to more macro analysis of the phenomenon as a whole.

me to map shifts in my patient's internal state over time. However, the restrictions on research time and length of the concluding research report, have led me to defer the third stage for the time being and limit myself to constructing a research tool thoroughly grounded in the two sample sessions first selected. I reasoned that although this might limit the generalisability of my conclusions, in much the same way as the single case study suffers from limited generalisability, nevertheless there was a stand-alone quality to the revised research plan. I would learn whether systematic analysis of clinical material with such a tool, could produce evidence to support theory, add to clinical understanding, and construct robustly-grounded hypotheses for further enquiry.

Measuring the internal situation

Following Philips' example, I employed peer ratings of session material to substantiate in general terms, my reading of the internal situation of my patient in the two selected sessions. Like Philips, I found the Personal Relatedness Profile a useful tool (Hobson, Patrick and Valentine 1998). It provides a rating scheme based on Kleinian concepts of the paranoid-schizoid and depressive positions, to measure a patient's dominant mode of psychological functioning at any one point of time:

"The Profile has thirty items in three scales of ten items each, representing paranoid-schizoid and depressive states of mind...Each subject is rated on each item on a five-point scale and an overall single score is obtained. A higher score indicates a greater degree of depressive rather than paranoid-schizoid functioning."

Philips (2009: 60).

I applied the PRP to produce my own ratings. I then removed dates from the session records and assigned them random identifiers, before approaching three professionally qualified child and adolescent psychotherapist and asking them to use the same tool to score each session. The results are shown in Appendix 1 and discussed further in the Findings Chapter.

I further considered using the Child Psychotherapy Q-sort which offers a very useful tool for describing types of functioning in patient, therapist and the therapeutic relationship, using atheoretical behavioural descriptors which nevertheless are easily related to psychoanalytical concepts. I am indebted to Celeste Schneider who

constructed the tool and was very generous in guiding me through its application to the two sessions in the current study. (Results are shown in Appendix 4). It is a considerably more complex tool than the PRP however and my own inexperience in its use, coupled with the lack of child psychotherapists well enough acquainted with it to act as peer raters in the UK child psychotherapy network, led me, with some reluctance, to set it to one side for a future project. It merits more thorough use, particularly in research where the therapist's contribution and the character of the therapeutic relationship are included in the investigation, since these areas are not covered by the PRP. Also, because of its atheoretical character, it is well suited as a tool to bridge the gap between psychoanalytical theorizing and other research disciplines.

Constructing data extracts

“Data extract refers to an individual coded chunk of data, which has been identified within, and extracted from, a data item.”

Braun and Clark (2006:79).

I wanted the map of each session to track, for external inspection, the detail of interactions in the therapy room, and be a means of following the conscious and unconscious processes at work between patient and therapist. Philps refers to similar aims in her search for *“a method for mapping transference, countertransference and outcome episode in process recordings for child psychotherapy sessions.”* (Philps 2009: 56). Her exploration developed into a particular method which I have drawn on freely in my own research, building on the ideas of Emde (1994) for defining *“psychoanalytically meaningful units of experience”* (Philps 2009: 65). In thematic analysis terms, the record of such *“units of experience”* correspond to data extracts out of whose study, research themes emerge and develop an identity.

Following Philps, I therefore divided each session record from the data set into a number of episodes of interaction between patient and therapist. Each episode comprises an act (or short sequence of acts / communications) from the patient, evidencing his internal state at that moment (transference), and sparking an internal reaction, response (or sequence of these) from the therapist which may or may not be registered consciously and communicated back to the patient (countertransference). The

sequence has an outcome which can be read in what happens next between the two – ie, the content of the subsequent episode.

Analysis of data extracts

Using this method, data analysis began with a summary description of each episode or data extract, in terms of transference and countertransference, as illustrated in figure 3.

<u>EP#</u>	<u>Data extract</u>	<u>Summary</u>
3	There is a pause while he stands at the table and skids paper balls down it and into the bin. He adds a few planes, giving me a look and asking me if they are going in the bin.	P retreats to play, testing / checking T's readiness to follow him. Can T provide containment?
	I say that some are and some aren't. I add that I think it is very hard for him, not knowing how long he is going to be able to come here, and perhaps he thinks I'll be making these decisions without thinking about it with him, as if he'll have no say and could be just chucked out from one day to the next.	<i>T registers the play but makes bid to return focus to uncertainty of therapy, and P's doubts about her commitment to holding a space for him.</i>
4	His response is to round on me with a familiar question about who's the boss here, is it Mary or me or Jane? I say it's important to him to know who's in charge – he chips in to say Babette has told him Jane's in charge of one side of things, and Mary and I work on the other, so is that right?	P rejects T's redirection and signals issues of trustworthiness need to be addressed. Who's side is T on?
	I say I suppose it is about people doing different things and it all working together, but I think for him, he does feel someone has to be in charge.	<i>T acknowledges importance to P of someone being in charge but misses link to here and now uncertainty.</i>

Figure 3

The summary description involves employing psychoanalytic theory to read beneath the surface of the interactions, to hypothesise the more or less hidden transference and countertransference layers of meaning below. In this regard, the current research exemplifies the theoretical branch of thematic analysis, where analysis is driven by a well-specified theoretical interest in the area, in contrast to the more inductive process of purist grounded theory. Its purpose is to examine the latent content of the data through an interpretative lens, such that “*the analysis that is produced is not just descriptive, but is already theorized.*” (Braun and Clark, 2006: 84)

Once the episodes had been clearly summarized, a secondary layer of themes could be examined in relation to the data.. As the interest lay in examining the dynamic interplay of transference and countertransference states of mind, both patient and therapist aspects of each episode were classified . To start with, I used categories derived from Philips, who helpfully provided notes for elucidating them (Philips 2009 personal communication). My first matrix, which slightly expanded on hers, was as follows:

<u>Patient</u>	<u>Therapist</u>
Acting out	Observation
Verbal	Reflecting and/or mirroring
Behavioural	Linking
Play	Actively supporting defence
In identification with object	Explaining
Merging with object	Questioning
Projecting object	Partial interpreting
Splitting / projecting unwanted feelings	Full interpreting
Reflective reporting	Acting in
Defended...available	Defended...available

Figure 4

However I felt that this approach missed some of the very primitive emotional dynamics of the interaction between patient and therapist, which had been noted as a candidate theme, and which often seemed to be occurring at a pre-verbal level, involving the therapist as much as the patient. I went on to experiment with a second matrix (Figure 5), informed by child development research and the work of the Boston study group.

			FEELINGS	RESPONSES	
LOCAL DYNAMICS	feeling distant	EMOTIONAL DYNAMICS	distant	push away, reject	reflecting / mirroring
	mirroring - feeling		close, in touch	cut off	linking
	pushed away		feeling charged	intrude, invade	supporting defence
	emotionally hot		pushed away	bully, punish	acting in
	good fit		kept at arms length	play	explaining, scaffolding
	trying to join		attacked	laugh, joke	questioning
	pushing away		bullied, punished	mess	interpreting
	backing off		deceived, betrayed	back off, avoid	projecting back
	cutting off		useless/powerless		owning countertrans
	keeping minimal contact		deprived	take charge	using countertrans
	asserting limits		damaging, cruel,	attack	acting out
	contesting limits		hostile	hold back, withhold	in identification with object
	resisting other's lead		lost	keep min contact	projecting object
	accepting, ratifying other's lead		wary	test	denying / projecting feelings
	offering new direction		uncertain, anxious, vulnerable	explore, describe, reflect	evacuating feelings
	interested guessing		valued, accepted	accept	owning feelings
	suspicious guessing		friendly		defending
	mixed feelings-oscillation				reflection
	controlling				
	mistaking				
					THERAPIST PATIENT COMMUNICATION

Figure 5

This sought to track the local dynamics of each episode in terms of the unspoken, emotional, attunement-seeking activity described by infant observation research in mother-baby interactions. The Figure 5 matrix was helpful in evolving a language for capturing what was going on between patient and therapist and also the same categories were applied to both members of the dyad, so capturing the dance-like quality of the interaction. Yet trying to convert the nuanced variety of positions, feelings, defences and communications into a finite list of descriptors - a complete vocabulary for any interaction in the relationship – was not helpful. I realized I needed an approach which allowed for flexibility, nuance and could capture the multiple levels/meanings, not always pointing in the same direction, of any one action and communication in the interplay. This involved abandoning fixed descriptors as sub-categories. Instead I turned to thinking about a matrix which could be broad and abstract enough to encompass a range of multi-dimensional interactions, yet provide enough of a structure for the different strands of my research question to be studied in relation to one another. Such a matrix would function much as linguistic grammar which provides a structure in which words can take on a vast variety of meaning. Retrospectively, I would add that an open matrix of this sort fitted methodologically with the research subject, that is: the study of therapeutic interactions presenting the emergent character of a complex, adaptive, interactional system, as set out in scientific complexity theory discourse. However, this only became apparent to me towards the end of my study.

The basics of Bion's theory of thinking appeared to provide the appropriate conceptual foundation or organizing principles for such a matrix. In the consulting room, his theory places thinking – his K and –K activity – in dynamic relation to the patient's emotional experience with his therapist. The aspects of my patient which had emerged as candidate themes were well organised by this approach, since it conceptually articulated a link between Simon's destructive repetitive behaviour, his difficulty in thinking and symbolic representation, his use of projection to communicate, and need for his therapist to engage at a primitive emotional level to provide containment. I decided my analysis should therefore follow Bion in looking at thinking in sessions side by side with the sort of internal objects active in the therapeutic relationship, and the emotions/defences connected to them (that is, Simon's internal world as constructed by his early emotional experience). These elements joined to form the tabular grid illustrated in Figure 6.

Each episode in the session is thus studied in relation to five categories:

1. a summary of the interaction for P and T (as described in Figure 3).
2. dominant self and other identifications in the process
3. the primary emotional state active in P and T during the interaction
4. the responses / defences employed by P and T during the interaction
5. the K content of the interaction.

The purpose of the tabular grid is to provide a framework to study how internal narrative (1), identifications (2), emotion (3), defence in the therapeutic couple (4), relate to their capacity for K (5) – the process of getting to know the self and another – at different moments in a session. Such mapping aims to provide a basis for identifying patterned links between different modes of communication at particular moments during the therapy, and relating these to the shifts in my patient's internal state in the interval between the start and end of intensive therapy.

The grid gives me a way of capturing and organising data regarding the four salient features of this particular patient, namely: his harsh inner world, persecutory feelings and identifications (1,2,3), paranoid-schizoid defences (4), and limited symbolic function (5). At an intrapsychic level, I have an opportunity to view the processes in each area unfolding side by side through a series of contemporaneous “snap shots”, and

thus a tool for finding repeated associative patterns, linking for instance shifts in P's emotional state or object representations, to variations in his symbolic function from moment to moment. By including a corresponding focus on the therapist, it allows me to consider the interpsychic dimension: that is, the therapist's part in reinforcing or challenging the patient's position, and how aspects of her own internal emotional, defensive, and K processes were active in shaping her patient's capacity for K at different moments. It is possible to pick out the different sorts of containment and projective identification active between therapist and patient, and how these emerged in the modes of K link from moment to moment.

As mentioned above, a secondary function of the framework is to apply, in simplified form, Bion's theory of thinking to a clinical case study. In so doing, I hope to situate the current research in a broader context, using it to examine the theoretical claim which identifies thinking as an emotional process, relates symbolic capacity to early emotional experiences of communication and containment, and regards efficacy in therapy as deriving from the gradual formation of a relationship providing containment for the patient's states of emotional disturbance.

Session 49 - Episode	memo	identifications		feelings	defences	K content
		patient	therapist		responses	
There is a pause while he stands at the table and skids paper balls down it and into the bin. He adds a few planes, giving me a look and asking me if they are going in the bin.	<i>P retreats to play, testing / checking T's readiness to follow him. Can T provide containment?</i>	rubbished child or rubbish child?	container or rubbish bin mother?	abandoned, pushed out, unheld - wanting more	turning to messy play. Trying to engage T	early K - uncs exploring if T's K can receive, hold his experience? Or is T's K a rubbish bin to evacuate into?
<i>I say that some are and some aren't. I add that I think it is very hard for him, not knowing how long he is going to be able to come here, and perhaps he thinks I'll be making these decisions without thinking about it with him, as if he'll have no say and could be just chucked out from one day to the next.</i>	<i>T registers the play but makes bid to return focus to uncertainty of therapy, and P's doubts about her commitment to holding a space for him.</i>	vulnerable, rubbished child	container mother	pushed out, deflected, rubbished	linking back to unwanted feelings, keeping minimal contact with play	K carrying traces of sado-masochistic identifications
His response is to round on me with a familiar question about who's the boss here, is it Mary or me or Jane? I say it's important to him to know who's in charge – he chips in to say Babette has told him Jane's in charge of one side of things, and Mary and I work on the other, so is that right?	<i>P rejects T's redirection and signals issues of trustworthiness need to be addressed. Who's side is T on?</i>	deceived child and anxious child	unreliable, lying parent	raw, exposed, unsafe. Punitive	testing framework, shifting to attack on T's competence, contesting control	between weak K and -K. exploration mixed with wish to expose, punish T
<i>I say I suppose it is about people doing different things and it all working together, but I think for him, he does feel someone has to be in charge.</i>	<i>T acknowledges importance to P of someone being in charge but misses link to here and now uncertainty.</i>	hostile, abandoned child	beleaguered mother, bad mother	inadequate, under pressure	retreat to generalities	K weakens - becomes concrete, literal - then more reflective
						Figure 6

Addressing subjectivity in data analysis

Both the PRP and the tabular grid described above can be counted as systems of data classification which address the unique privilege of the therapist's position, in the construction of a clinical account, by making his reading of events available for external scrutiny and consensual validation. They provide a clear demarcation between thoughts in the session, and the later reflections of the researcher, such that a helpful line is drawn between the clinical material and the possible theorising around it, allowing space for alternative constructions to emerge, in place of a single narrative. As a result, the researcher is in a better position to engage with challenges to his necessarily subjective account of events, and a meaningful debate with others can get going.

The current research has benefited in two principal ways. First, detailed debate of emerging themes with professional colleagues has been key to refining a conceptual tool for mapping the emotional dynamics of clinical data. Second, both PRP and grid have made it possible to triangulate my interpretation of the data with the views of others, through the peer rating of session material in the data set in the case of the PRP; and through close inspection by highly trained and experienced colleagues of the contents of grid, which comprise the building blocks of my analysis

Chapter Four

Analysing the therapeutic process: first session

Two sessions follow, representative of two very different moments in the therapy, with a narrative analysis of each episode based on an application of the five categories to the clinical record. (The full grid of each session is reproduced in Appendices 2 & 3.) I conclude the detailed narrative analysis of each session with some discussion of the findings.

In the first, Session 49, patient and therapist are operating in a restricted psychic field, animated by powerful paranoid schizoid objects, thinking, and defences.

Episode 1

Coming down the stairs with my earlier patient, I hear Babette's voice and find her with Simon in the waiting room. She is chatting to the little girl's father who holds a large baby. I say a brief goodbye and return to collect Simon after a further 15 or 20 mins, during which I have needed to cross the waiting room doorway a few times, going backwards and forwards.

In the room, he sits and when I am sat down, says "So ... did you do anything nice over half term?" He sounds flat and uninterested. I remind him that we had met on Friday and wonder if perhaps today it feels like he is back in the old routine – "back to school". I add that today feels rather different from Friday when he had come full of the meeting with his brothers and sisters the day before. He gives a token nod and tells me that Fred's shed is nearly finished, just needs painting and the tools moving in. I say this sounds like the process of reshuffling people round the house is now underway, in preparation for the new baby. He nods with a distracted look, then says he was going to say something and now has forgotten it. "Perhaps there is a feeling that I am talking too much today?" I hazard. For a few moments, I am silent while he continues to look at pains to remember something, then shakes his head, saying he can't remember it. I respond that I can see something has got lost and perhaps it feels worrying, not being able to hold onto his thought. (His feeling I take something away from him?)

The session is jump-started by the patient arriving early and coming across another child with his therapist. As he enters the room, he appears flat and uninterested in his therapist – as if she has become a distant, and insignificant object to him, scarcely worth remembering. The patient is communicating through projecting his feelings of disappointment and insignificance into the therapist: she feels forgotten, as he feels the presence of a rival child proves she has forgotten him. He experiences her as an indifferent mother, who does not hold onto him and replaces him between sessions; he experiences himself as unwanted, unable to attract or sustain a parent's interest. The experience is too disturbing to reach consciousness for long – it is repressed and displaced away from the present, into outside events, concerns which the patient associates unconsciously with the present situation: so he talks about the preparations at home for the arrival of a new baby. At the same time he registers that something (the repressed thought) is lost to him, has moved out of reach, and tells his therapist about this.

The therapist is receptive to the feelings of disappointment and inadequacy projected into her; she notices something is different today and struggles to locate this. As a first-time therapist, she moves from uncertainty to identification with the disappointing, inadequate mother projected into her. In turn, she experiences the patient as hostile and rejecting, her anxiety making her unreceptive to the hurt and need buried in the patient's flat attitude. Her link to the earlier session, featuring material about the patient's siblings, shows that unconsciously she is on the right track: connecting today's forgetfulness and flatness to "sibling" matters (representing the rival therapy child). Like the patient, she is unable to bring this thought to consciousness at this stage, only sensing that the "lost" thought may have as much to do with something she is doing as with what is happening in the patient's mind.

Both therapist and patient are trying to get to know each other in this episode but both are in the grip of identifications and projections which limit their curiosity and openness to explore the thoughts around. The patient makes his identifications on the basis of early deprivation and acts defensively to ward off mental pain by splitting and projection (pushing unwanted disappointment / inadequacy into the therapist); and displacement (repressing the immediate disturbance from consciousness and relocating it elsewhere). The therapist's anxiety is also a powerful factor, appearing in her rush to

make sense of the patient's communications which limits the space for his experience to unfold and be explored. Her comments seem premature attempts at pinning down something elusive and half-formed; her receptivity is interfered with, and her efforts to evade identification with the patient's disappointing object, push the disturbance caused by her contact with another child, further out of conscious reach.

Episode 2

"So ... am I coming here in the summer holidays then?" he asks, in slightly aggrieved tones. As he speaks, he stands and moves to his box. I reply that I have noticed this has been on his mind as he has asked me this a few times, and as I have said before, there will be a break coinciding with the school holidays. "So is that it, do I never come back?" I say that it isn't the end and that he will come back again in September. "But you said something about it changing?" I am perplexed and ask him what he thought I'd said. He says it was something about meeting up until then and then having to see. I respond that it is agreed that he will be coming up until the end of the year, until Christmas that is. "And then what?" I reply that then we will have to think about what happens next.

The patient confronts his therapist about her availability and commitment to him. Unconsciously he may have registered the limits to her receptivity during the previous episode, adding to the distrust stirred up by seeing her with another child. He shows his suspicion of her, as a mother who is not there - leaves him over the holidays, and is liable to disappear altogether after Christmas. He experiences himself as an abandoned, disappointed child. Disappointment and grievance with the unavailable, unreliable mother push out other memories, identifications from earlier sessions when his therapist had shown evidence of thoughtfulness over the question of holiday breaks. His questioning is querulous, edged with aggression. The move to the toy box betrays an impulse to break off connection, push his feelings of deprivation, abandonment into the bad mother.

The therapist identifies with her patient's representation of her as a depriving, disappointing mother, and also picks up feelings of deprivation and disappointment as her patient turns away from her. She experiences him now as a hostile, threatening child, and herself as an inadequate mother, under attack. She defends herself by

reminding her patient that she has had the next holiday in mind for some time and “calmly” spelling out the arrangements again. When Simon raises the question of her continuing commitment – is he stopping after Christmas – her responses remain concrete, she retreats to prevarication, unconsciously acting in with his projection of an untrustworthy, evasive parent.

K in this episode is active but again restricted by identifications with a bad object, and associated feelings in therapist and patient of vulnerability and disappointment. Simon’s thinking has narrowed and closed: he seems a boy with a case to prove against a callous, disappointing object and his attention is all in this direction. The questioning is insistent, concrete, shorn of more exploratory, associative thinking. The therapist’s defensive response to her patient’s attack stops her picking up on the projective aspects of her feelings: she is too far in identification with Simon’s depriving mother at this moment and cannot register her emotional state as also being a communication of her patient’s feelings. Her thinking is predominantly concrete and literal during the episode, betraying her difficulty distancing herself from Simon’s projections.

Episode 3

There is a pause while he stands at the table and skids paper balls down it and into the bin. He adds a few planes, giving me a look and asking me if they are going in the bin. I say that some are and some aren't. I add that I think it is very hard for him, not knowing how long he is going to be able to come here, and perhaps he thinks I'll be making these decisions without thinking about it with him, as if he'll have no say and could be just chucked out from one day to the next.

Simon’s turn away to play includes his therapist: he is not breaking off contact and lets her know that her attention is needed, though the move also suggests contempt for their previous exchange. The messy destructive edge to the play, skidding paper pellets and planes into the bin, communicates an inner state dipping in and out of contemptuous, punitive feelings, neediness, and confusion about himself and his therapist.

Unconsciously, he seems to be looking for a place to put a self in pieces, a jumble mix of odds and ends – both a rubbish and a rubbished child; the rubbish mother therapist

now takes on aspects of a rubbish bin, a place to evacuate into. The need for containment is ensnared within sado-masochistic self and object identifications.

His therapist goes along with the play which seems to offer her space to process feelings from the earlier episodes. She is receptive to her patient's contempt, is now able to experience him as a vulnerable child, and go back to reflect on his earlier questions about his place in therapy and her reliability, as a parent capable of sticking with him, making his needs and wishes a priority. She offers an interpretation which draws attention to Simon's warded-off feelings of vulnerability and worthlessness; her voicing of this interpretation perhaps carries traces of her own sado-masochistic feelings, stirred up by his projection of a rubbish, rubbishing parent into her.

K is active in both Simon and his therapist, though highly coloured by sado-masochistic identifications and impulses. The modes of thinking and communicating are markedly dissimilar. Simon's exploration and communication is almost entirely projective and unconscious: he is in the grip of his jumbled emotions which flood out unprocessed in his play, the reference to his therapist marking the play as not solely an evacuation of unwanted feeling, but one in search of a container. By contrast, his therapist's reflective commentary suggests a conscious processing of his communication which is subtly out of step with her patient's capacity to take in his warded-off feelings, perhaps because infused by traces of identification with a rubbish, rubbishing mother. While ostensibly her interpretation shows understanding of her patient, at another level it works to reproduce Simon's underlying p-s pattern of relating.

Episode 4

His response is to round on me with a familiar question about who's the boss here, is it Mary or me or Jane? I say it's important to him to know who's in charge – he chips in to say Babette has told him Jane's in charge of one side of things, and Mary and I work on the other, so is that right? I say I suppose it is about people doing different things and it all working together, but I think for him, he does feel someone has to be in charge.

Simon responds to the interpretation, and the less conscious feelings involved in it, by moving to question his therapist's trustworthiness. His questioning evidences the

primary persecutory phantasy of an abused, rejected child, who has been forced to depend on a series of changeable, unreliable parent figures who pass responsibility around evasively, nobody potent or committed enough to take charge of keeping him safe. Is his therapist another such parent? Whose side is she on? The questions link to the raw exposed feelings of the unwanted child which have been stirred up by his therapist's previous interpretation: they have a retaliatory edge; they seem both genuinely concerned to establish who is in charge and also to expose the unreliable equivocating mother projected onto his therapist.

His therapist identifies with the bad mother projected into her and struggles with anxious feelings of guilt and inadequacy. She experiences Simon's question as an attack and is also attuned to the feelings of abandonment and betrayal which are behind it: it is the hostility of a child whose object has always let him down.

Simon's K is restricted and compromised by his level of distrust and hatred of the bad mother. His curiosity about the real situation with his therapist, is entangled in a contrary –K activity: a wish to use K to expose and punish the bad mother. His therapist's response begins concrete and literal, pointing to the difficulty she is again having, treating her feelings as a communication about Simon's self and object representations. However the second part of her response returns to explore his question from this second perspective. Perhaps because her unconscious identification with the inadequate mother is so strong, she speaks in generalities and cannot quite make the link to what is going on between her and her patient in the current session – notably, him finding her with another child at the start.

Episode 5

He has started to add small strips of sellotape to his sellotape ball, and now I point this out and wonder if perhaps he wants me to overlook what he's doing. "Whaaat?" he says with a half laugh. I say he doesn't want to remember the agreement we had made about the sellotape. "What agreement?" I describe it again. "Well so what? I don't care anyway." I say that again I'm thinking about all the times when people have let him down by saying they will do something and then not doing it, and that I think by breaking our agreement about the sellotape he is letting me know what that feels like. (only this time, he's not going to be the one to care). He protests that in any case he's had this roll for a

long time and look, it's still not finished. I say he thinks perhaps he's using it up so slowly that I shouldn't notice what he's doing with it, and there's a feeling that I'm being very unreasonable to go on about our agreement, when he is being so careful. "Whatever – I don't care anyway," says Simon and tosses the roll of sellotape away.

Simon's move to add further strips of tape to the sellotape ball is charged with ambiguous feeling. It provocatively flouts an agreement between him and his therapist, made in a previous session, conveying his experience of alienation from her and the hostility alive in the situation between them today: so far it is intended as a communication. At another level, the activity seems to carry acknowledgement of something broken and a need to bind something together – perhaps his own fragmented self, in the space left by a demolished therapist. Where in the earlier episode, his activity with the paper pellets suggested a search for a container, here the sellotape ball appears to have replaced the containing, albeit rubbish-bin, mother, as if the idea of human connection has turned bad on Simon. His defence is to move into identification with a tough, unfeeling, self-regarding object ("So what. I don't care anyway!") – and locate himself in a world of inanimate things: the sort of second-skin defences of an autistic child. He tells his therapist the "agreement" or connection between them is now worthless and no longer matters to him. She is experienced as an object of no value, as he projects his own feelings of being a rubbish, unwanted child into her.

His therapist is receptive to the hostility to her, behind Simon's choice of the sellotape ball, and makes the link to his experience as a child who has been repeatedly let down by others. She feels confused by opposing feelings: hostility to Simon / the feelings of helplessness, rejection projected into her, warring with a concern for her patient and wish to repair the connection between them. The content of the interpretation seems on track but the tone and timing carry undercurrents of the therapist's divided state: she relates back to Simon the feelings he is not able to tolerate, distancing herself from them in the process, so she becomes the calm parent and he the needy child; she re-states the existence of the agreement Simon is trashing, and by implication stresses the futility of his omnipotent bid to eradicate unwanted aspects of himself / others.

Simon's activity seems to hover between –K and no K in this episode. As a vestigial communication, its function at one level is to rubbish the connection with his therapist,

attack the link between them – that is, -K. Truth is discarded: his “Whaaat” claims there is nothing to remember, while his tone – the half laugh – gives this the lie, conveying the impression he is well aware of the agreement he is flouting. At another level, the physical activity with sellotape and ball resembles a sort of no-K body thinking, whose aim is to discharge unwanted, unprocessed feelings in a concrete, physical manner. Simon’s therapist moves between limit-setting (opposing Simon’s shift to -K) and interpretation, aimed at processing his no K flood of feeling through reconnecting Simon’s activity to earlier experiences of disappointment. Her difficulty tolerating the helplessness and rejection projected into her are a limit on her capacity to process Simon’s feelings (K), however, so her interpretation is partly defensive, aimed at warding off projective identification with Simon’s rubbish unwanted child. At an intellectual level, the link to Simon’s immediate cause for hurt, in finding her with another child, is still out of reach.

Episode 6

He gets his felt tips out of his box and stands them upright on the table like skittles. Then he uses the sellotape, rolling and spinning it into them to send them down. I am silent, thinking. After a few moments, I say that I’ve been thinking that another thing different about Mondays is that it’s the day when he sees me saying goodbye to another child.

Simon’s feelings of deprivation and rejection are increased by his therapist’s interpretation in the previous episode. As he starts a messy game, demolishing rows of skittle pens with his sellotape ball, he seems to enact in concrete form, the unconscious conflict going on inside him: between himself in identification with a tough, unfeeling, destructive object (the ball), and a string of critical, weak, depriving parental objects (the skittles) . He appears to have broken off contact with his therapist altogether, retreating to physical activity to evacuate his feelings.

His therapist is once again made to experience Simon’s helplessness and rejection. Her silent reflection suggests there is now more capacity in her to make space to receive these feelings. In this position, she is able to make the link to Simon seeing her say goodbye to another child at the start of the session. Her comment relates the link back to her patient and is gentler, more ruminative in tone, than her earlier interpretations: she is

owning her association for further exploration, rather than making it a statement about Simon.

Simon's activity in this episode is no K – a concrete symbolisation or evacuation of unconscious thinking. His withdrawal from verbal communication points to a failure of containment so far: his therapist's interpretations are missing something important and this in some way confirms his suspicions of his parental object. The concreteness of his repudiation in turn forces his therapist beyond a somewhat superficial, verbal and defended level of responsiveness, to a more genuine emotional engagement with her patient – that is, stronger K. She can receive and reflect on the feelings projected into her, instead of pushing them back prematurely into him. The increase in her empathy is evidenced in the silence and gentler tone of her commentary in this episode.

Episode 7

“What???” he expostulates in tones of disbelief. “I don’t even notice, why would I mind?” I reply that I think it does make it very in his face, the fact that I see other children here as well as him (this feels very cruel to say), and that this can hurt. “What are you talking about? Anyway, I could have left home at 5 and still been here on time...” I respond that added to everything else, he’s had a long wait and it can be very hard to feel like you’re being kept waiting. “No!” I wonder if perhaps he was thinking, why didn’t we start early, seeing he was here at 5 – and instead I’d kept him waiting. “I didn’t care .. I was playing on my phone.. anyway, you can’t do that can you?” I agree that I can’t start the session early, but I still think he may have feelings about it and it might make him angry and upset. Simon gives me a pitying look.

Simon is roused from his isolation by his therapist's last interpretation, and renews contact. While explicitly he dismisses the interpretation, his “anyway, I could have left home at five...” suggests an undeclared acceptance of the therapist's link to his experience on arrival. He is briefly in touch with his hurt feelings and his first response is to deny and repudiate them. His identification with a tough, unfeeling object (“why would I mind?”) is less complete than in the previous episode, however, since the “anyway” which follows expresses awareness / vulnerability. When his therapist responds with empathic acknowledgement of his long wait, he experiences the concern for him as an aggression – the act of a cruel, depriving parent out to expose his

vulnerability so as to humiliate him. This time, he is more vigorous in repudiating his hurt: “I didn’t care ...” The next “anyway, you can’t do that can you...” is rhetorical in tone: his voice is dismissive and contemptuous, as he tries to turn the tables, making his therapist into the helpless one, whose wishes are shown to count for nothing.

The therapist responds to Simon’s first, divided dismissal with empathic understanding: her guilt, in identification with the bad mother, is present but more tolerable – less of a distraction. She is receptive to his feelings of hurt and more genuinely empathic in return, in noticing the cruelty for him of her contact with other children. From his response, she can pick up on his half-acknowledged association to the long wait at the start of the session with compassion. She wants to validate his identification with a hurt child with this comment. However, she struggles with Simon’s defensive rejoinder – his unmitigated identification of her with a cruel, depriving parent, and retaliatory projection into her of his own hurt and helplessness. Her own identifications with these objects begin to colour her next comment: her acknowledgement of the limits restricting her and her patient comes with renewed emphasis on Simon’s warded-off feelings of anger and upset, in unconscious accord with the humiliating parent projected into her. Simon’s pitying look is scornful: she has exposed herself and confirmed his suspicions about the falseness of her concern.

The episode sees Simon at the start, emerging from no K in response to increased K in his therapist. He wavers between a K and –K response to her interpretation about him seeing her with another child: his denial of the link she has proposed is joined with unconscious acceptance and further linking to having to wait for her. Then the force of his identifications with sado-masochistic objects interferes to prevent him exploring further: in the latter part of the episode he tips progressively into –K, at a conscious level denying his vulnerability, and unconsciously projecting to expel unwanted feelings, curiosity giving way to projection for defensive control of his object. (He is not open to any new experiences in himself or his object by the end of this episode). His therapist seems to shift in parallel. She begins the episode in a K position, open and receptive to exploring Simon’s communications. Her comments appear on track and emotionally attuned. By the end of the episode, a split is emerging between the verbal content of her comments and their emotive function. She is unconsciously sliding into

identification with a –K object, who uses language not so much in the service of truth as to control or sometimes punish a hostile other / aspect of the self.

Episode 8

He carries on playing with the pens, then throws me a look: "You carry on thinking then, are you still thinking ... thinking about nothing?" I feel sad and say, I think that to him, it can feel that me thinking about him is like me thinking about nothing – that it can't have any value or purpose. He is taking all the lids of his pens, and now throws them lidless into his box as if they too are good for nothing. He gathers the lids into the sellotape roll and jiggles them, shooting me a look and saying "Don't laugh!" I say that he thinks I'm laughing at him. "You are!" he says, "Like this..." putting on a cheesy grin and saying "hee hee hee". I say it sounds like I can't get anything right today. "Except thinking..." he says disparagingly.

Simon breaks off contact, reverting to play with the pens, but then returns to the attack, deriding his therapist's silence which stirs up his fear of abandonment, while giving further proof of her inadequacy. He is in identification with the bad child who is rejected by its cruel mother. The attack seems to express his ever-present terror of the bad mother deserting him or being driven off by his hatred. Thinking is intolerable to him because it is equated with the persecutory absenteeism of a bad parent. At some level, the thinking space (nothing or no thing space) projectively identified in his therapist's mind, is felt as an act of expulsion, instead of a space for digesting and making sense of experience.

His therapist is able to hear the pain and despair behind his attack and is filled with feelings of sadness and hopelessness, which she communicates back to him in her tone of voice as well as with words. She accepts Simon's hurt and disappointment in her, making fleeting space for him to own and voice some of the more vulnerable feelings he has been denying and evacuating into her. In consequence, he lets her see his fear of being humiliated and laughed at by a bad therapist, who leaves him dangerously exposed (like the lidless pens, tossed thoughtlessly aside). Although consciously he is hostile, his attempt to put words to what he imagines is happening between them, suggests that some hope of making himself understood is active alongside his more persecutory fears.

His therapist is able to hold onto a more reflective K space during this episode. She tolerates Simon's identification of her with a bad mother and is able to use her feelings to name this experience with him. Simon in turn recovers some K capacity, to own his feelings and communicate them to her, though at another level his communications remain hostile, and attacking. His concrete body thinking through the activity with the pens is also much in evidence.

Episode 9

The pen tops are thrown carelessly into the box and Simon goes to the little table, near where I am sitting. He grabs hold of the toy basket and then turns to ask me if the wooden cars are in it. I say I think he is in a better place to see than I am. "No, but are they..?" he wants to know, then turns back to rummage in the basket, complaining that they aren't there. After a few moments, he unearths the red one, then fishes out the blue and the green. I comment on him wanting me to know and find them for him. He pulls some fat felt tips out of the basket and tells me he can send them flying across the room, demonstrating.

Simon moves closer to his therapist, telling her he needs her help to see things. He identifies with a helpless child without resources / capacities. The rubbishing of the pens and rough grab at the toy basket carry an aggressive edge – as his assumed helplessness (he cannot see the toys) holds an accusation against a depriving mother. His therapist has become identified with a parent whom he hopes holds something good for him, overlaid with the idea of a parent who refuses him.

His therapist is sensitive to his resentful, accusatory feelings, identifying with a beleaguered mother figure fending off a demanding, greedy child. She responds concretely with a refusal, missing the real need now symbolically equated with the vanished toys, as well as Simon's hope of finding a helpful parent in her; so unconsciously she falls into identification with the depriving mother projected into her. Simon experiences her reaction as a spurning of his needy self and redoubles his demand. His difficulty finding the toys he wants seems to express the difficulty he is having getting something good from the therapist – does she have something to give

him or not? His complaint that the cars aren't there conveys the grievance of a child whose mother turns out to be disappointingly unavailable to look after his needs, keep things safe over absences. His therapist draws attention to his neediness without being able to link it up with its counterpart – the disappointed hope of being accepted and understood. Simon's anger and despair at the breakdown in communication is evident in his retreat to body thinking, and expulsion of messy destructive feelings in the treatment of the pens which follows.

In this episode, Simon shows his desire for K, which he experiences as lacking in himself and located in his therapist. His therapist's identification with the bad object prevents her picking up on the hope he is expressing and stifles K. Instead she amplifies the splitting and aggression which accompany his projection, treating it as an attempt to expel responsibility rather than an infantile attempt at communication via projective identification. Some fundamental misattunement is apparent between the two.

Episode 10

I talk about so many things getting thrown around today. He sets the cars up on the little table and starts a game, which begins with the sellotape roll crashing into them. When it goes off the table and flies across the room, he asks me to fetch it for him. When I don't obey, he abandons the roll and starts smashing the cars into each other, again and again, until one or other of them is pushed off the table. Occasionally he adds a few plastic or wooden bricks. It is repetitive and empty.

For a moment, the therapist is able to recognise the destructive turmoil engulfing the session, and acknowledge it without immediately attributing it to Simon: something is happening in the room today and observation is all she can offer at present. In response Simon's activity acquires more play-like features – less an evacuation and more a concrete symbolisation of the situation between him and his therapist, a repetitive cycle of battering, collapsing contacts as represented by the sellotape ball and pens. Cutting across this scenario of connective torment between self and object, his request (or is it demand) for his therapist to retrieve the pieces/pens, signals a renewed hope of finding a parent figure who can help him do something with the needy, aggressive feelings consuming him.

The therapist's deafness to the hopes conveyed by his demand show her still in the grip of an identification with a tormented/tormenting mother. Her refusal to meet Simon's demand pushes him back into his primary scenario, where relationship is figured as perpetual entrapment and conflict between a rivalrous, unreceptive self and other. He retreats to a physical bashing/expulsion of toy cars and other objects with only a vestigial resemblance to play.

K appears frail and fluctuating during this episode – the sort of K which might be common at p-s moments in the constant p-s ↔ d motion, which Bion used to describe the process of thinking. The therapist's fleeting K at the start lies in her negative capability to tolerate a situation of emotional turmoil which she cannot read. Simon's responsive K is again operating at the level of infantile projective identification. The strong p-s identifications on either side overwhelm both K moments: the therapist cannot pick up on Simon's K, seeing his play and the demand on her to pick up the pieces as a disavowal of his own capacity to think, and attempt to control her, rather than an effort to communicate and explore an experience through her. Her misattunement demolishes Simon's nascent hope of finding K in his object, as shown by the collapse of his rudimentary game into concrete body thinking, with the mindless, repetitive quality of no K.

Episode 11

I watch silently for a while. After some minutes I comment that in this game the cars are having to push each other out, and I am thinking about Simon talking about his brothers and sisters, how he'd been worried that they would just end up pushing and fighting and instead he'd found that they wanted to be with him and had been thinking about him. But I think today it feels so hard to hold onto that, or to feel – like on Friday – that he has a place in his own family and in Fred's family. Instead he feels he's back having to fight for it. Simon continues to play, as if I haven't spoken. There is another pause while I register just how much I am feeling pushed out by him. I venture another comment, saying that I think he wants me to know what it's like to be dropped out of mind.

The therapist now experiences the helplessness pushed into her and after some moments is able to consider it as a communication to her about Simon's state of mind. She tries to formulate some links between his activity with the toys, his anxious expectation of rivalry and aggression in relationships, and the fleeting moments of acceptance and friendliness which can happen but are all too easily lost from mind. There is greater awareness of the torment involved for Simon in this position, and a parallel increase in her identification with a concerned parent, makes itself apparent in her commentary. When Simon ignores her, she is able to explore her sense of rejection further to notice his need for her to know what it's like to feel himself dropped out of mind.

In this episode, the therapist is less defended and consequently more capable of K. She can bear to acknowledge her disturbing feelings to herself, and stay thinking – that is, she can sombrely own the feelings without being taken over by them and moving into identification with the tormented child. She is able to begin to make links between what is happening in the room, Simon's fragmentary mentions of experience outside the sessions, his conflicted feelings; she is looking for ways of bringing the pieces together. The link to the immediate cause for the turmoil between them is just out of reach.

Episode 12

"What do you mean?" he wants to know. I talk about him playing on his own today, perhaps telling me that he's fine on his own, I'm to feel that he doesn't care if I'm sitting in this chair or not, I'm no use to him. "Yeah why don't you go and sit in that chair over there," he responds. I say I wonder if this has something to do with him seeing me with someone else, feeling dropped out of my mind and kept waiting. And I'm also thinking that perhaps I didn't pay enough attention to the fact that he had to miss his Thursday session last week. (This all feels unhelpfully muddled in my own mind – as if I'm thinking out loud - and I wonder if it's better not to have said anything).

Simon is roused from his isolation by his therapist's sombre interpretation. He renews contact with his questioning: he wants to know what she is thinking and accepts her description of his wish to make her feel useless and unwanted, heaping on the scorn with his "yeah, why don't you go and sit in that chair over there!" The verbal push away is also an acknowledgement of connection but again it seems contact can only be of a

hostile, tormenting nature: the therapist is a figure to be attacked and denigrated, as he feels she has made him feel small and unwanted at different moments in the session.

His therapist is filled with conflicting feelings which seem to parallel Simon's conflictive wish both to spurn her and to keep her with him. Her swift attempt at interpretation, linking his aggression to feelings of rejection from seeing her with another child, has a defensive retaliatory feel. She is pushing the unbearable feelings which Simon has put into her, back into her patient. Unconsciously she seems aware of failing him, as evidenced by her immediate association to a session Simon had to miss the week before. The association arises out of a present feeling of guilt, stirred up by her retaliatory interpretation, which is too disturbing to be acknowledged consciously. She is aware of feeling and sounding muddled, evidence of her divided state of mind and the presence of thoughts/emotions which are being warded off.

The therapist's K in the previous episode succeeds in re-kindling K in Simon. However, his desire for connection and his curiosity are both restricted by the phantasy of a persecutory relationship between self and object. It is unclear whether he is exploring or enacting this phantasy with his therapist in this episode: K or –K? The therapist's K is likewise divided and fragmentary, struggling with –K impulses from her identification with a retaliatory, persecutory figure.

Episode 13

Simon's cars and bricks are now being shoved and thrown into the window sill. I say they are close to the window, then watch until one bangs into the glass and say "Simon ..." in warning tones. He says "sorry" and when I don't hear this and repeat that he may not throw things at the window, tells me "I said I'm sorry", reproachfully. He tosses the bricks carelessly into the basket on the window sill behind him, without looking where they go. Then he returns to the car-bashing game, tearing up one of his paper planes to make a score sheet, dropping the remaining pieces carelessly on the floor. There is a brief turning towards me, when he pushes the score sheet across to me, with the pen, but when I don't immediately respond he takes them back again.

Simon's aggressively-charged activity escalates in consequence of the dominant persecutory phantasy. It becomes hard for patient and therapist to hold the boundary –

his actions risking breaking a window, a concrete attack on the therapy space, demonstrating how unsafe thinking has become for him. Is he unconsciously also seeking to push his therapist to take on the concrete aspects of parenting, which her “thinking” role denies him? The only thinking he shows he can bear is a process of symbolic equation, as if more abstract thoughts – presupposing a capacity to tolerate frustration / states of psychic conflict – are felt as acts of deprivation.

Under pressure to keep the physical setting safe, his therapist cannot hold a thinking space in her mind, so steps into identification with a strict, exacting parent. Actions are the primary vocabulary – words go unheard, as when Simon is deaf to his therapist’s first observation of danger and later, when she cannot hear his ambivalent “sorry”. The state of oppositional misunderstanding between them is very strongly evidenced. Simon’s only refuge seems to be a retreat to car bashing. His attempt to resurrect a game, with a score sheet, is too fleeting, concrete, and ambivalent to get a response from his therapist and they are isolated from each other at the end of the episode.

Neither Simon nor his therapist is able to think symbolically during this episode. Simon’s primitive need for containment, and state of symbolic equation, evokes a concrete response but cannot be identified or understood in relation to his deprivation.

Episode 14

As the cars spill off the table, I occasionally retrieve the ones which land near me. I think to myself about Simon feeling like one of these fighting jostling cars and needing me to pick him up. Out loud I say that there are times when I think he wants me there to pick up the pieces, but this can sometimes turn into making me into a rubbish collector. The cars swing from fairly controlled nudging and jostling, to violent and dramatic clashes which clear the table. I talk about noticing the violence in his play today and this stirs him to ask me what I mean.

In the ensuing hiatus, the therapist experiences a jostling mix of upset and angry feelings, belonging to the rejected, rubbished child Simon is projecting. Also recovering is her identification with a concerned parent, struggling to understand her child’s upset, and this helps her accept the feelings without moving immediately to push them back

into Simon. Unconsciously she becomes more attuned to the arrested, infantile state of his functioning when she acts to retrieve his fallen cars: as a baby needs physical responsiveness from its parent to have the emotional experience of the parent's love and concern, she seems to appreciate that anything less concrete from her in Simon's present state of torment, will be likely to be misread as indifference or worse. Joined to her picking up the cars, she speaks about the angry, needy feelings Simon is showing through his activity with the toys: his need for her help and contrary wish to rubbish any help she offers. Her increased attunement and empathy help her stay receptive to his destructive feelings, when Simon remains unresponsive to this first commentary. With the acceptance conveyed by her observation of the violence in his play, Simon is able to renew contact with her, to ask what she means.

The therapist's recovery of K is evident first in the space for silent reflection at the start of the episode, and then in her subsequent shift to a more grounded, descriptive, observational commentary, coupled with greater flexibility towards Simon's concrete demands. Simon's renewal of contact and wish to explore meaning with her, by the end of the episode, indicates the return of his capacity for K, in relation to the more attuned, responsive figure she is making available.

Episode 15

I describe how things are being thrown around the room with so much force. After another pause, I add that perhaps he is feeling very angry with me and this feels like it cannot be said in words (or thought about). Simon reels off a string of numbers, saying sarcastically: "There you are, I've said it in numbers." He glances at the clock, saying "ten minutes." I agree that we have ten minutes left and I notice he is keeping his eye on the time today. He parodies this, with ostentatious glances at the clock every few seconds, then shoots me a look saying "you've still got to tell me when to stop, you know." I agree that I do need to tell him when it's time and he knows this, but I think he still feels very thrown out when I tell him.

The therapist elaborates to describe the violence she is witnessing in the play, then looks to link it to Simon's anger with her and the problem in finding words to talk about it. Simon's first response is to ridicule her link: the scorn of his rejoinder seems to express his angry hurt with a relationship where words / thinking are regarded as

treacherous substitutes for real care. His unconscious preoccupation with an untrustworthy, arbitrary parent, who picks him up and drops him at whim, is apparent in his next association, when he shows his attention to the approaching end of the session. He defends himself from feeling needy as separation looms, through denigrating the therapist and assuming control of the ending: he will be the one to call time, or if not, it will be his therapist acting on his say so. It is not immediately clear, which aspects of the ending are foremost for him – will it be escape, eviction or act of vengeance against his therapist? His reminder, that his therapist is not to think his attention to the clock relieves her of her responsibilities as a carer, has anxious, accusatory undertones: the contemptible, absenting parent must be held to account and forced into service.

The therapist is made to feel the helplessness, rejection underlying Simon's mockery, and her response carries traces of a corresponding ambivalence. At one level, her interpretation shows understanding of his turmoil around endings, while at another, it returns his projected vulnerability back to him, exposing his defences with scant appreciation of his frail internal state.

Feelings of vulnerability are a pressure on K for both Simon and his therapist during the episode. Simon at the start uses sarcasm to attack K in the therapist, while unconsciously her link is accepted and related to the approaching ending. There is a similar –K twist to his next piece of parody, yet a sense that he is also trying to bring the ending into focus and looking for K in the therapist, fearing its loss to the –K part of him, when he reminds her that she will have to tell him when to stop. Her interpretation shows K is active in her though the speed with which she returns his projection suggests she is under pressure from the more defensive, -K part of herself, which struggles to put up with the experience of helpless rejection Simon is pushing into her.

Episode 16

He continues playing with the cars up until the last couple of minutes, when I tell him it is time to clear up now. He says he just needs to finish this match and find out who the winner is, anyway there isn't any clearing up to do. I remind him there are things to sort out in his box. When he doesn't respond, I repeat that it is time to stop, and when this is ignored, get up and move to the table, putting the felt tips in his box back together. Behind me, he tries to get me back,

saying "Emily, here's the final score." I feel cross with him and continue sorting his box. He comes over, saying "so it's time to go, is it." I repeat that it is time to go. "OK then, goodbye," he pulls a piece of paper out of his pocket, dropping it on the table – it is his scrunpled score sheet. I go with him to the door, where he turns and says goodbye again and that he will see me next week. I return the goodbye, saying that our next session will be on Thursday. "Same thing," he says, repeating his goodbye as if trying to mend something between us.

Simon turns away from the ending, back into his game with the cars. He oscillates back and forth between contrary positions during the following episode. Early on, he tries to ignore his therapist's reminder and blanks the need for attention and preparation, which had overtaken him in the previous episode. His avoidance shows him in flight from the imminent separation, backing off into illusion and denial that has a compulsive, habitual quality. Physical and emotional mess cannot be acknowledged. Feelings of helplessness, anxiety, being unwanted, are pushed into his therapist. Simultaneously, his attention to the score sheet suggests some point scoring may also be going on and his retreat is, at another level, meant to goad: the symbolic equivalent of what his therapist does, when she ends each session and pushes him out, a chapter in the ongoing saga of their tormenting relationship. In this connection, his fear of abandonment resurfaces, he again identifies with the needy child threatened with desertion and embarks on a sequence of counter moves to keep the therapist engaged with him, as when he presses the score sheet on her and refers to the date of his next session. Then the immediate blanking of the Thursday session marks a compulsive return to identification with a heartless parent, who doesn't care enough to notice the length of his child's absence: it's all the same to him. Is there an unconscious association with the Thursday session he had to miss the week before, and his therapist's lack of attention to this? Is he checking her capacity to notice him, be available to him, after so much rubbishing? The final goodbye appears a bid to retract the aggression and avert the rejection he fears will follow.

His therapist experiences his retreat as oppositional and provocative; she feels deliberately ignored and exploited by him, much as he earlier felt her emphasis on thinking was meant to expose and humiliate him. Her increasingly irritable insistence on the time boundary and need to clear up show her back in identification with a strict retaliatory parent, who cannot detect the anxiety in her child's impossible behaviour.

She is warding off feelings of inadequacy and guilt and cannot speak to these feelings in Simon.

This final episode shows the fragmentation of K in both therapist and patient. There are hints that Simon is unconsciously looking for K in his attention to the score sheet, insofar as it is a concrete representation of his wish to organise the events of the session in a readable way; but at the same time it becomes a device for fending off his therapist and her unwelcome insistence on the ending. The wish to be understood (K) seems enmeshed with a contrary wish to blank out or rubbish the ending of the session, and by extension the link between him and his therapist (-K). The therapist's own identification with the bad parent gets in the way of her recognising Simon's neediness: her response is concrete and lacking in attunement to his anxiety and vulnerability. A persecutory separation is enacted, which reproduces Simon's primary phantasy.

Emerging themes

The session usefully captures the problems which brought Simon into therapy: his difficulty tolerating the pains of relationship and way of cutting off, isolating himself at moments of strain; the sado-masochistic quality of his attachments, evidenced here in his moments of messy, destructive, and controlling behaviour towards his therapist; his short attention span, hyper-vigilance and extreme restlessness, allied with a flat, concrete focus on physical needs/objects; his difficulty exploring ideas and feelings at a conscious level; and his restricted symbolic thinking, hence excessive use of projection and symbolic equation in his interactions with others. We can also track (sometimes parallel) difficulties in the therapist: her insecurity as a new trainee and the related moments when she moves into identification with a persecutory/persecuted object; the defensiveness and rigidity which get stirred up in her at such times, limiting her receptiveness to more vulnerable, needy aspects of her patient and making it hard for her to appreciate Simon's real developmental deficit; her difficulty tolerating the feelings put into her long enough to explore them, hence times when she joins Simon in using projection and concrete thinking to ward off disturbance.

The interactions between the pair show how persecutory phantasy formed out of a history of abuse repeatedly interferes with a process of K between two people. In Simon, there is frequent confusion at a very primitive level of functioning, where

preconception (of a loving, nourishing breast) has become bound, through experience, to its opposite (the cruel, depriving breast). He shows his profound distrust of “the human link”: no longer imagined as inviting and benign, but on the contrary, a link which has been perverted to become persecuting and tyrannical. His therapist’s curiosity to know him is experienced as invasive, dangerously exposing, as he shows in Episode 8 when he responds to her attention and attunement as if it were an act of humiliation: “Don’t laugh!” He often appears to be seeking to protect himself from new experience with his therapist, for fear of what it will bring. A corresponding arrest in symbolic function is evident, showing the abused child’s reliance on primitive splitting, projection and symbolic equation to manage his experience, and tendency to avoid more developed awareness of what might be happening to him.

Simon’s partial or complete retreats from contact with his therapist in reaction to moments of disappointment, are frequently marked by a turning away to compulsive, concrete, physical activity – what I term body thinking (eg: Episodes 3, 5, 6, 9, 10, 13). They carry the hallmarks of a habituated, almost “hard-wired” mode of discharging mental disturbance. The activity which takes over is often highly expressive of his internal situation at that moment, yet the unconscious symbolism is kept out of awareness. Attempts by his therapist to make it conscious are attacked and ridiculed by the conscious part of him (notable examples in Episodes 7 and 15).

At another level, his repeated oscillation between contact and retreat, symbolic function and body thinking, suggests an abused child’s ambivalent relationship to truth. Simon’s history records how adults around him repeatedly distorted and denied reality to protect themselves, while attacking his truthfulness, projecting confusion, deceitfulness into him at a very helpless and vulnerable age. He was persistent in trying to get the truth of his abuse acknowledged, despite two failed court hearings. So here, in tension with the part of him which finds the truth of his experience unbearable, there is another part which is actively working, within the limited scope of his primary persecutory phantasy, to establish the truth of the interactions between him and his therapist. He is highly attuned in this session to his therapist’s emotional truthfulness, and responds to moments when she becomes evasive or less than genuine, by becoming particularly insistent and challenging. For instance, in Episode 2, he questions her insistently to expose the limits of her commitment to him, when she has difficulty acknowledging it.

Again in Episode 7, at a more unconscious level, his goading works to expose the retaliatory and punitive feelings she wants to disown. Throughout the session, there seems to be a perpetual struggle between the part of him which rubbishes the truth out of disappointment and the part of him which needs, demands and exacts the truth from her.

Simon's harsh internal world, as revealed through the relationship with his therapist in the session, is populated by figures that lie and distort reality, desert him, punish or torment him, are indifferent or bent on retaliatory blame, humiliation. Sometimes he is in identification with these figures during the session, while his therapist becomes identified by him as the opposite self: the child who is rejected, unwanted, deceived, humiliated (eg Episode 5, and later on in Episode 7). At other times he is at war with an abusive internal figure, projectively identified in his therapist, and more in identification with the unwanted child (eg Episode 2, 4). There are other moments again when the two aspects of himself seem to blur and merge and he shows a confused jumble of conflicting identifications (eg Episode 3, Episode 6, Episode 16). The problem for Simon and his therapist is how to establish a way of exploring such persecutory forms of self and other, in a territory so short on benign figures for identification. It is a problem which both share because it comes with the terrain of Simon's internal world, where relationships are primarily hostile: that is, the link with the other is not one based on openness, curiosity and a concern for truth, but on conflicting sado-masochistic desires – to possess, control, punish, rubbish the other. The therapy relationship of necessity takes on the qualities of Simon's phantasy, as the projections become alive in the room, moving between patient and therapist. On the one hand, this is what makes the therapy meaningful and useful for Simon: anything less would be a sterile affair. But on the other hand, there are numerous times when the therapy relationship collapses into an enactment, sometimes led by Simon, sometimes by his therapist, while the seeds of a different way of being together go unnoticed or are swamped. Moments when a different sort of link is imagined are fleeting and often hard to identify because of the mix of other, contrary and regressive identifications, within and between the pair.

In Episode 7, for instance, a potential K moment occurs when the therapist acknowledges his long wait at the start of the session with empathic concern. In that moment, she is in identification with a figure receptive to feelings of vulnerability and

frustration, and able to tolerate these, validate them, with understanding and concern for what her patient has had to go through at the start of the session. She is aware of having a role in Simon's hurt feelings and also that this is, at some level, an unavoidable position for him and for her. For his part, Simon is quick to experience and respond to her comment as an aggressive act of humiliation: an experience of –K at the hands of a cruel, tormenting object. His own –K identifications are animated, in opposition to the part of him which responds to the truth of what his therapist is saying about himself and her. He slips from ambiguity into a more –K position, where he denies and distorts reality, disparages the link with his therapist, to protect himself from the pain of it. His therapist's contrary identification with the bad parent projected into her then gathers force her so she ends up sliding back under the influence of the projections, instead of trying "*to understand what is the part (she) is being required to play and to transform it.*" (Box, 1986: 192). Thus her interpretation at the end of the episode, while similar in content to the one at the start, has acquired a more exacting, controlling tone: feeling acknowledgement has turned towards competitive enforcement. Examples of this sort of interplay of K and –K, within and between patient and therapist, are dotted through nearly every episode.

We also learn something from the session about the features of K, in relation to primitive paranoid-schizoid modes of functioning. Outside the session, at one remove from the projections, it is possible to begin to distinguish signs of K amidst opposing trends of –K and no K, but because p-s thinking has both a developmental and anti-developmental thrust at different stages, the signs of K in Simon are not always obvious to his therapist at the time¹⁷. In Episode 9 for example, Simon's search for K takes an aggressive and controlling form and his therapist mistakes it for –K. The concreteness of his demand suggests to her a wish to split off and deny his thinking self, forcing the therapist to take responsibility for it. She is unreceptive to the exploratory aspect of his projection and his wish for her help, which in itself is evidence of a new thought, barely

¹⁷ Klein points out that paranoid-schizoid thinking is first and foremost a developmental response of the infant to the torrent of early inchoate experiences which threaten to overwhelm it. It splits and projects in an attempt to organize and distinguish good from bad, protect the self from collapse into chaos. Splitting and projection are in this regard the earliest forms of thinking. They lay the foundations for a later shift in the opposite direction, towards integration, when the ego has grown strong enough to tolerate its powerful, and often competing emotions, without being torn into pieces. The shift towards integration is important for the self to be able to form relationships with, and within, the real world. Continuing to split and project beyond a certain point becomes –K, an evasion and distortion of reality, perhaps because early experience of relatedness has been traumatic and the child now feels compelled to keep reality at bay. Paranoid-schizoid thinking thus always carries a potential for K and –K.

formed, of a figure who might be available for him, help him discover missing parts of himself. Simon is functioning at a level of projective identification and symbolic equation of an infantile kind in this episode, while his therapist is responding to him as if he were a self already formed and in possession of a developed symbolic function. So we find that concreteness, enactment and literal thinking are frequent markers of a collapse of K in the therapist, but often carry seeds of curiosity and unconscious linking in Simon. Her difficulty appreciating this distinction can often be found at the root of the misattunement between them – for instance in Episodes 2, 3, 9, 10. The misattunement takes different forms, sometimes appearing as a blindness in the therapist to traces of more positive identifications in Simon's enactments, as in the episode 9 mentioned above; elsewhere, it is apparent in her timing and overuse of interpretations over other forms of communication, which can often seem out of step with Simon's capacity to relate at a symbolic level. She shows greater awareness of Simon's real developmental position in Episode 14, when she is able respond flexibly to Simon's concreteness by helping him retrieve the spilled cars, and naming the violent play in a simple way, without further linking.

The therapist's understanding and receptiveness are most evident at the moments when she has stopped trying to control and organize the p-s flood of conflictive feelings in the room, and instead has been able to allow space for the disturbance between her and Simon to register with her at an emotional level. These moments are often characterized by her silence and the simplicity of her next comment, which conveys acceptance and more genuinely depressive feelings of sadness, helplessness in response to the destructive, violent state of the relationship. There is silent (often unconscious) recognition that attempts on her part at interpretative integration are falsifying the state of affairs and are worse than useless. Something of this is made explicit in Episode 8 when she says that today, it can feel that her thinking about him is like her thinking about nothing, without value or purpose. She is accepting that this is the real situation and she and he are stuck with it – she does not have an answer for him. Another such moment occurs at the start of Episode 10, when she comments for the first time on his violent play. I describe it as a moment of negative capability when the therapist is able tolerate and name a situation of emotional turmoil which she cannot read. Negative capability, expressed in silent engagement, and grounded, descriptive commentary, emerge as core qualities of K within the context of Simon's fragmented, persecutory

internal world. It is associated with renewed K in Simon, as in Episode 14, when he is able to respond with a shift from self-isolating enactment of perpetual conflict with the cars, back to a position of renewed contact with his therapist, and wish to explore meaning with her. There is a similar link between fleeting moments of emotional attunement, acceptance, in the therapist, and renewed K in Simon, in the sequence linking Episode 6 and 7, again in the sequence between Episode 8 and 9, and midway through Episode 10.

On this reading, the fragmentary, intermittent quality of these K moments is in keeping with the persecutory internal world they seek to know. There are many parallels between the work of the therapist at these K moments, and the care shown by a mother with a young infant, who has to rely on her emotional receptiveness, tone of voice, physical holding, and simple use of words, to communicate her understanding.

What are the criteria that I have been applying to distinguish features associated with a K-state-of mind, from those associated with a minus K or no-K-state-of mind, in this session? My starting point was the broad description of K and minus K as stated in the Literature Review (p.40 and p.41). But reviewing the analysis presented in the current chapter, it becomes clear that some more detailed qualities associated with K and minus K, were taking shape as I analysed the process in the session. I have gathered these in the quadrant graph in Figure 7 below. A fuller account and discussion of this graph, and its session 2 counterpart at the end of the next chapter, are found in the Findings chapter (p.152)

<u>Session 1</u>	
<u>P</u>	<div> <div> <div>K</div> <div> Projection as communication Projective identification Displacement Exploration concrete and literal </div> </div> <div> <div>Tentative exploration Reflective, questioning Tolerant, receptive Silence, waiting, accepting confusion Emotionally-grounded observation / interpretation Owning feelings Flexibility Simplicity</div> </div> </div>
	<div> <div> <div></div> <div> Concrete, literal thinking Speaking in generalities Restricted receptivity Reflection / interpretation also used to ward off feelings </div> </div> <div>T</div> </div>
	<div> <div> <div> Splitting – ambivalent projection K projected into T Restricted receptivity </div> <div> Guarded, restricted exploration, questioning – superficial, verbal, often too soon </div> </div> </div>
	<div> <div> <div> Projection to control, punish Accusatory questioning, blaming Lies, denial Opposing links Rigid, controlling Mockery, rubbishish Body thinking Concrete – physical replaces mental/emotional Evacuation of unconscious thinking in physical action Fragmented thinking Mindless, repetitive, Attacks replace words, attacks on setting </div> <div> Re-projection Accusatory, exposing interpretations – critical, harsh subtext Not authentic – split between surface meaning and underlying emotive quality Rigid, controlling Concrete, literal thinking </div> </div> <div>-K</div> </div>

Figure 7

Chapter Five

Analysing the therapeutic process: second session

In the second session, 270, a different psychic situation obtains. Patient and therapist are more open and receptive to one another, and the play develops fluidly between them.

Episode 1

Simon arrives on time with Derek. He is a moment following me into the room, where he greets me. He says he missed his breakfast today as there wasn't any time. I ask about this and he tells me he didn't wake up until 7.40 – ten minutes before Derek arrived to collect him. He had been watching I'm A Celebrity the night before and had slept through his alarm ... nobody else had woken him. He has gone behind my chair to look out of the window, sort through things in the toy basket. Now he comes back with a load of pens in his hands. He sits at the big table and looks over at me. "So how are you this morning ... are you tired?" I comment on the hurry for him and wanting me to know he is feeling tired, along with also checking up on me .. am I in the same state, tired like him?

The patient signals his awareness of the change in time and the disturbance it is causing him. There is an underlying preoccupation with the danger for him of allowing changes – his delay entering the room expresses his hesitation at stepping away from the familiar, exploring a new situation between him and his therapist. Even while giving himself up to the new, he tells her that his move in this direction is painful, uncomfortable: his links are to pressure (no time), hunger (the missed breakfast), and abandonment (no parental figure to wake him) – all carrying the potential to revive a habitual grievance. He tells her there is a part of him which wants to hold onto the fantasy self/therapist he knows (perhaps the part which gets absorbed in the I'm A Celebrity fantasy), and does not want to have to wake up to reality (the alarm). Another part of him is able to resist retreat however, and be aware of his therapist as someone linked to him but separate, with her own experiences which may or may not be the same as his. Moreover, while his therapist remains at some level a depriving figure, his

complaints also seem addressed to someone from whom he expects interest and tolerance. The presence of this more benign internal figure is apparent in Simon's own interest in finding out about his therapist ("so how are you this morning ... are you tired?"). His enquiry suggests that his identification with a deprived child is mixed here with identification with a child who can afford some curiosity and concern for others.

The therapist's first question communicates an interest and receptiveness to Simon's experience of change. Her later comment moves defensively from exploratory interpretative activity towards defensive "interpretation proper"¹⁸, hinting at her wariness regarding her patient's opening remarks. She picks up on the complaint while missing the curiosity and tentative new identifications buried in it: reflecting her own wariness, her interpretation presumes Simon's enquiry after her is suspicious (checking up on her). Unconsciously, it seems that she remains under the influence of habitual identifications from previous sessions, where Simon was experienced as a tormenting, tormented child and she identified with a beleaguered parent.

Both Simon and his therapist are faced with the problem of how to stay open to the new, in this episode. Simon seems to communicate a tentative and equivocal readiness to allow space for their respective positions to change. The shadow of older identifications on both sides is present, and may act as a rein on the therapist's freedom to discern new directions, and explore these further. Her concluding interpretative comment looks like foreclosing on the space for uncertainty, not knowing, with its potential for something new to develop.

Episode 2

Simon says he made a mistake yesterday – it's the Friday session he wants to drop, not the Thursday one. "What do you think about that then? Do you think we should do that?" I ask what the thinking is behind this change of mind.

Simon says it's so he doesn't have to miss school. I say it sounds like deciding which session to drop is being difficult for him, today there's the thought of

¹⁸ I am using Meltzer's distinction between interpretative activity and interpretation proper: "*a language of uncertain rumination for expressing exploratory thought (interpretative activity) and one of commitment for presenting metapsychological statements (interpretation proper).*" (Meltzer 1976: 375). "*Interpretation proper*" acquires functional meaning from the context in which it is offered: at times, it can be mutative, as in Strachey's account. Elsewhere, it may express a defensive position taken by the analyst, to ward off unwanted thoughts and feelings (eg Rosenfeld 1987).

Friday's missed school, missed breakfast, missed sleep – yesterday he was talking about missing out on Thursday on time with friends. It's like he really feels in two minds and wants to turn the decision over to me at some level. It also seems to be hard for us to think about what might be lost by dropping to two sessions a week....

Simon is uncertain about what change is going to mean – his links are to loss and deprivation. His mention of a “mistake” hints at awareness that he has more than a one-dimensional mind, which can be in and out of touch with reality. Yet at another level, his thought about dropping the Friday session may mark a step back to more habitual, schizoid thinking: it is an attack on the new Friday time, perhaps out of a wish to rid himself of the disturbance that change stirs up in him. Unconsciously he may imagine the change to mean his therapist prefers other children over him. He protects himself by projecting his feelings of rejection into his therapist, as he debates which session he is going to drop. She is to be the one to feel de-selected, while he retreats into identification with a boy who has many better ways to use his time than in therapy. The projection is not only about riddance however: his questioning shows curiosity to explore these feelings through the mind of his therapist.

The therapist is receptive to the feelings of loss and rejection which might underlie Simon's change of mind. She acknowledges that dropping a session stirs up difficult and mixed feelings in him and that he wants to pass the disturbance back to her. She notices that both she and Simon are finding it hard to think about the loss in relation to the dropped session. These ideas appear on track, but perhaps her identification with the rejected parent, dealing with a volatile, avoidant child, restricts her ability to explore the fluid mix of feelings further with Simon: instead she talks a lot. Her commentary crowds together a string of reflections, allowing little space for the thoughts to be digested, processed or developed. The opportunity for Simon to explore his experience of missing someone becomes swamped.

Both child and therapist show curiosity about one another, vying with wariness. Unconsciously there may be a shared phantasy of friendly relations deteriorating into conflict and competition for control, as K (truthful exploration of the experience between them) awakens fears on both sides. K exploration is consequently made muted and ambivalent by opposing defensive tendencies – omnipotence and denial, in the case

of Simon, who communicates his feeling largely projectively in this episode; evasive verbalisation on the part of the therapist, which gives to her interpretative activity an over-quick, and hence avoidant, aspect.

Episode 3

Simon mentions he's got loads of paper today. He is speaking in a rapid slurry way which I find hard to make sense of. After I've checked one or two words with him, he responds jokingly: "What's wrong with you today, have you gone deaf or something?" I agree that it does seem that I'm having trouble hearing him. Simon responds with a yawn and a stretch, "it's probably me that's the trouble really." I say perhaps it is something we both share in then, he's finding it hard to speak and I'm finding it hard to hear ..?

Simon responds to the flood of thoughts between him and his therapist by turning away. He comments indistinctly on the amount of paper there is today – there is a resource present in unusual quantities and it is unclear what to make of it. Unconsciously the paper may stand for the unusual amount of curiosity he is risking today, while his turning away from the discussion and slurry speech, convey his feeling that the therapist is saying a great deal more than he can take in. He is aware of a communication problem, at first accusing the therapist - perhaps unconsciously a recognition of the evasive aspect of her previous commentary. The attack reveals his vigilance regarding his objects, and tendency to read some threat into a departure from the familiar; it is also mitigated by humour (the joking tone) and concern, though unclear whether the concern is on his own behalf or on hers. The therapist appears to be identified with an object of importance, uncertain whether for good or for bad, whose “deafness” needs investigating. When she shows herself open to this idea, Simon feels his experience has been accepted, he is able to own a vulnerable part of himself and acknowledge that some of the communication difficulty rests with him.

Simon's therapist is confused and uncertain at the start of the episode. She struggles to understand what her patient is telling her by his words, manner and change of direction. Interpretation gives way to tentative exploration, perhaps in unconscious acceptance that words just now are part of the problem. She accepts she cannot hear her patient but

is not further deafened by his identification of her with a deaf parent. When Simon points up her difficulty understanding him, she is able to own this and with her later comment share responsibility for it: the comment positions her in the psychic field with her patient, sharing his confusion and vulnerability, rather than somewhere remote and inaccessible.

Key to K in this episode is the therapist's negative capability – her acceptance of her own and Simon's states of confusion and partial deafness. Unlike the previous episode, her questioning and admission of lack of understanding makes space for the confusion to register, inviting further exploration. It is now possible for Simon and her to wonder what part each might be contributing to it. Through the experience of his therapist's capacity to sit with the problem, Simon's curiosity, coloured by habitually aggressive relations with his object, turns from its initial attacking, projective mode, to a brief moment of self reflection.

Episode 4

Simon nods and laughs. I think about him switching from talk about the session we are going to lose, to the thought of having more paper than usual. Perhaps it is hard to stay thinking about what is going to be lost and what this might mean to him. He says he's going to write down .. I can't catch what comes next .. and he's going to take it away with him at the end of the session. This, said with a challenging look at me. As I begin to respond, he says OK then, he'll write it down on a piece of paper he's brought in his pocket. I grasp that he is talking about writing down the pros and cons of dropping the Thursday or Friday session. I say it sounds like he really feels the only way he can hold onto his thoughts is to put them onto a piece of paper which he can carry away with him. He doesn't trust himself to be able to carry them away in his head. He has drawn his school timetable out of his pocket and is now studying it. I make a link to him needing to carry the timetable around with him, to know where he's meant to be. He starts reading through it, linking initials to the names of teachers and trying to get me to guess which names go with which initials. I suggest he wants to get me into a game .. and also perhaps he wants to get me into school, or school into here ..

The therapist unconsciously links the difficulty understanding one another, to a wish to get rid of the thought of loss, wondering aloud if this was the wish communicated by Simon's switch away from the earlier conversation about which session to drop; in this connection, she takes up his reference to the abundance of paper as a defensive manoeuvre to deny loss. The other side of that comment, suggesting his awareness of a deficit made good, or a resource unusually made available, moves out of reach. Perhaps in unconscious resentment of her omission, Simon's response is ambivalent: he apparently goes along with the therapist's invitation to return to think about which session to drop, while at the same time stepping back from further exploration. "Writing it down" replaces the earlier free exchange of ideas, as if K contact with his therapist, followed by her one-sided interpretation, has stirred into life his fear and envy. He seems in identification with a boy who fears he cannot hold onto his thoughts, who is at risk of losing his thinking mind when he leaves his therapist. She, perhaps, has become the therapist who can only hold on to a negative side of him.

At another level, Simon's plan to make a written record to take away with him, may also be a move to exploit his need so as to break a boundary. The plan hints at habitual envious feelings towards the thinking parent whose capacity for thought is experienced as injurious and depriving, by the child who is made to feel his dependence on it. There is a corresponding ambivalence in his therapist, whose subsequent choice of words, especially the use of "really", hints at exasperation with a provoking child ("he really feels the only way he can hold onto his thoughts is to put them onto a piece of paper"); along with acknowledgement of a needy and dependent one ("needing to carry the timetable around with him, to know where he's meant to be").

The K wish to get to know self and other appears to struggle with negative identifications, competing feelings of anxiety, then envy in Simon, and consequent disappointment and exasperation in his therapist. Simon's switch at the end of the episode, to substitute a game for further discussion, suggests a wish to protect their friendly contact from the threat of envy, disappointment – emotions stirred up by the experience of K in the previous episode.

Episode 5

Simon agrees, he wants to play a game, will I play with him ... a lovely pen game? I comment that he wants to turn away from this conversation, it feels much easier to focus on concrete things like breakfasts and paper and pens, than less tangible things like the relationship between us, and how this might be affected by the change ... Simon stands up and tells me to guess how much money he's got with him today – he'll give me a clue, look – and he places a heap of coins on the arm of my chair. If I guess right, I can keep the money. I say this is his way of trying to get me into a guessing game with him so we don't have to go on talking about something getting lost – there seems to be an old idea that he can bribe me to play along with him?

Simon affirms his wish to take them back into a rule-bound relationship, where exploration, contact is carefully regulated and displaced into play. He imagines “a lovely pen game” with a friendly, accommodating therapist. His therapist detects and challenges his avoidance of too personal, emotionally intense, contact, and preference for an interaction mediated through the world of material objects. However, her identifications seem backward-looking, seeing Simon's suggestion only as indicating his renewed identification with a controlling boy in fear of a hurtful object. She does not hear the hint at an anxiety he feels for a nascent relationship with a good object. In response she moves into identification with a restraining parent figure.

It is unclear whether the money he shows her stands for the resources he is bringing with him today, or is a bribe to subvert her into colluding with a retreat into play. Is it good money or dirty money? There may be a buried question about the quality of what he brings, and of what he can take in from her, as well as a more rivalrous thought about a self and object locked in a contest for power. Is she being invited to join him in protecting a friendly relationship or being corrupted? Which way lies K? Following an “old idea”, his therapist attends to the suggested bribery, foreclosing on the possibility of his gesture acquiring meaning in another direction.

The interaction is again shaped by ambivalent cross currents in Simon and his therapist, the shadow of habitual identifications in both cutting across Simon's tentative interest in a different direction. The therapist's refusal to join Simon in play seems to arise out of fear of it turning out to be counterfeit – a case of -K masquerading as K. She wants to avoid becoming the dupe of a hostile and envious attack, but her suspicion stops her

from tuning into early infantile aspects of Simon's interaction: for instance, the way in which his retreat to play might link to a young infant's need to punctuate its lively K interactions with a parent, with moments of disengagement when rest is needed; how repetition (here, a return to a familiar game) features in early play as a necessary and important part of an infant's ability to explore, without being overwhelmed by, a new experience with its object.

Episode 6

"Yes, and you've taken the money so now we can play!" He wants to play I Spy. I say I'm not going to join in the game. He rushes on to the thought of a story game – he will write down lots of words and give them to me to make a story with. I say something about him not wanting to think about our story but he is already scribbling down words. He hands me the sheet and I say again, gently, that I am not going to join him in turning away with a game. Simon begins to write as if taking dictation, copying down what I say. I suggest there's an idea around that anything he or I says is going to be exposed to ridicule. Simon switches to playing the teacher who is setting me a test. It's a maths quiz. He calls out the questions, saying he will only repeat them once, moving on to the next question regardless of my lack of response. I comment on him becoming the teacher and me the pupil. "Yeesss!" he says. I wonder about teachers and the role they occupy – they are the ones who take charge and tell people what to do – perhaps this is what's going on here, he is taking charge, I'm to do what I'm told. Simon agrees with emphasis. He starts checking the answers to the quiz, challenging me for the answers. "What's 7 x 7?" I say I think this is something he can work out. "But I don't know..!" I talk about his fear of making a mistake which gets in the way of him having a go. Simon continues through the quiz, now wanting me to confirm his calculations. "7 x 7 is 49, isn't it?" I agree that sounds right, and say something about how he distrusts his own capacity to sort out problems and get to the answer.

In the following episode, Simon responds to his therapist's refusal by becoming more manic and insistent in his attempts to get her to join him: as if the experience of refusal, so close to deprivation, triggers a flood of ADHD-type defences. He blanks her opposition and appears not to hear her, treating what she says and does as if it is part of his game. There is a frantic feel to his rapid switches from I Spy, to a story game, to dictation, to setting his therapist a school test. It seems it has become unbearable to him

to experience her as separate and independent. Although there are traces of mockery in him scribbling down her words, his play seems ruled as much by a wish to deny separateness, as by the more ambivalent desire to enslave her. His fear of not getting answers, being left with a problem for lack of time, feeling helpless and controlled without being listened to, gets projected into the play with the school test and the role of the child which he gives his therapist. At the same time he may be discovering a role for himself as teacher, with which to play out the anxiety-driven compulsion to control his object, which seems to saturate this sequence of play.

The therapist persists in meeting his demands with a refusal, at first understanding the pressure from him in terms of avoidance and denial (turning from a real story to a make-believe substitute). She notices a wish to strip her words of meaning, turn them into props in a game, so they cannot form part of a two-way conversation. She comments on his wish to rearrange the situation between them, so he becomes the one in charge and she has to do what she is told. The gentler tone of her interpretations contrasts with the exasperation hinted at in Episode 4, and suggests she is unconsciously more in tune with the neediness driving the play. By the end of the episode, she has moved from wholesale opposition to a more reflective position, wondering aloud what Simon's play ideas might be expressing about the situation he imagines between them, and about his own capacity.

The K state of mind in both therapist and patient – their wish to get to know one another – struggles with a cramping anxiety about fallibility and loss. Simon's manic behaviour in the episode (his denial of meaning, resort to physical activity, fragmentation of play), may reveal the –K and no K forces which get activated in him by an experience of refusal / deprivation. Yet at the same time there seems to be a struggle to stay in touch with his therapist and perhaps a buried hope that her capacity to think/stay with him may survive (she will be able to come up with an answer, find a way of telling him in story form what he can't manage to put together of his own experience). In his school play, there could also be an unconscious attempt to communicate and explore an experience, via projection and displacement. While the therapist is not able to put words to the underlying anxiety, she appears active in seeking K contact with Simon: this involves a struggle with her own rigidity (her pre-emptive refusal to play) and shift from an abstinence based on fear, to a more open, exploratory attitude to Simon's activity. At

some level she has begun to appreciate the infantile quality of his resources for taking in experience and communicating with her. As she begins to modify her response and engage with the play, Simon's "Yeesss" conveys a mix of triumph and relief.

Episode 7

He is marking the table and accidentally-on-purpose jiggling the desk drawer open. I say his name, warningly. "Whaaa?" he laughs at me. I say playing with the drawer means we'll have to stop .. it's like now he is making me into the teacher .. he feels we have to keep swapping this role backwards and forwards.

Play slips into enactment as Simon moves to challenge the limitations imposed on him by the therapy setting. He communicates how unbearable he is finding the restricted relationship allowed him with his therapist. His activity shows a mix of early infantile attitudes towards the mother figure that his therapist becomes for him: responding to her separateness with invasion (getting inside the forbidden drawer) and attack (marking the table). At another level, perhaps in reaction to his therapist's increased openness in the previous episode, he may be drawing attention to his need for boundaries, looking for a father figure in her, who will be able to check his attacks. His challenge spills across the boundary separating psychic from physical reality; it seems to be not only a communication but a bid to force an alteration in the therapy relationship, demanding the therapist step out of her role to interact with him in a practical, directive way – ie: become the teacher / strict parent for real.

The therapist is drawn into identification with a paternal figure, warning Simon that his activity risks closing down a place for therapy. At the same time, she seems to be in touch with the child's need for containment that Simon is expressing. She comments on the identification, so indicating that the enactment is something which remains to be understood. Her link to the earlier classroom play evidences a capacity to think is still intact, and has not been overwhelmed by her patient's infantile feelings.

Simon's K in this episode breaks down, symbolisation gives way to physical enactment. Communication occurs at a level of projection, as his feelings are evacuated in physical activity. His "Whaaa?" assumes a lack of comprehension, at odds with the provocative thrust of his actions. In this regard, he appears to move between no K (physical

evacuation), -K (deception, evasion) and a test for missing K (communication, and attention to his therapist's reaction). His therapist's response, combining limit-setting with reverie, is helpful in checking the no K, -K tendencies and defending a space for K, as the next episode shows.

Episode 8

Simon starts talking about the cars outside, sounding like a detective. He reckons I must own the Subaru because that's the only car there which was there at this time the week before. He is surprised – this is a “bad boy racer” car. I ask what kind of car he thinks I should have. He suggests a small Peugeot – something not very fast. Something slow and reliable, I query? Simon agrees with a grin. He wants to interpret my response to mean that the Subaru is my car – “see, you just confirmed it when you said...” I comment that he's got these little pieces of information and he is trying to get them to join together to get a much bigger answer. He laughs and mentions that he saw someone on a bike the other day – it was Babette going up the hill – he'd never seen her on her bike before, she looked tired. I talk about him seeing her on other business – a part of her he doesn't usually see.

Simon is now able to pursue his enquiries about the therapist in a more overt and ordinary way. He is “surprised” to identify her with a powerful, fast car, perhaps a token of the surprise she has given him in the previous episode, by unequivocal and robust limit-setting, joined with K. The desire to know her, get inside her mind, access what he feels she keeps hidden from him, is openly owned, as he takes on the identity of a detective with a mystery to solve. The identification of therapist with withholding, evasive parent is hinted at, in the stratagems employed to trick information out of her; but the freedom of the association which follows his therapist's interpretation, offers a contrast, suggesting that at some level he has got in touch with a containing parent. Perhaps it is the experience of her containment, which allows him to take in her meaning and make a link to another occasion when he had to make do with a fragmentary sighting, seeing his escort on her bike, unaware of being observed. Here Simon shows a rare, un-persecuted awareness of his objects as real and separate people, living lives of their own apart from him.

The therapist is receptive to Simon's curiosity and desire to know her. Her response appears correspondingly attuned to the curious, over the controlling, child. Her own identification with a beleaguered parent, coping by rigid rules, has receded. She explores Simon's fantasy about her car, picking up on the drive to know which gets going when he is faced with the parts of her life which are off limits to him. She registers the novelty for him of seeing people "on other business", outside his relationship with them.

Both therapist and patient appear open to each other's thoughts in this episode, with ideas and associations flowing freely between them. With the experience of containment from a robust therapist, Simon's need to control his object recedes during the exchange, leaving him open to K and free to explore. His therapist's commentary is questioning and descriptive, supporting Simon's flow of ideas. She is able to pick up on, and amplify, the presence of new thoughts, experiences pushing through.

Episode 9

Simon says he's hungry, can't he go and get something to eat or fetch a drink. I say that he needs to wait until the end of the session. He comes over to the cushions beside my chair, grabbing a blanket and saying that he's going to sleep now – bye. He curls up on the chair across the room, as I comment on his wish to sleep through the last bit of the session. He talks about wishing he could go to the kitchen and put something in the microwave – the microwave would say "hello".

For Simon, contact, and the move into new territory, seems to re-awaken (as at the start of the session) an unconscious link to loss and hunger, identified as a physical need (he wants something to eat and drink). He signals his conflicting impulses, as he moves close to, and then away from, his therapist, as if wanting both more and less contact. The pull is to sleep, to exchange the live relationship with her for a more familiar, mechanical interaction, kept at a physical level (the feeding mother turned into a microwave). Yet his words suggest that the familiar may also be subtly changing – the world of inanimate objects is showing signs of life as he imagines the microwave saying "hello". His running commentary shows a wish to keep his therapist with him, hinting

that this might not be a retreat from a hostile object, but more like a rest in the safe care of a benign parental figure.

The therapist is in touch with the needy child Simon, and while holding the session boundary, is not pulled into identification with a depriving parent. She is receptive to his wish to rest. Her commentary is low-key, descriptive, signalling her availability while allowing space for Simon's thoughts and responses to unfold.

Awareness of loss and hunger are present but seem to be contained in the episode; they do not lead to a rupture; with his therapist's help, Simon is able to communicate the feelings in words without immediately evacuating them in action (he wants to go but is able to stay). Likewise, the therapist can tolerate his need to take a break, and follow his lead without defensive, foreclosing interpretation. The shift to more benign identifications, and tolerance of limitations, fosters the capacity for K in both, as evidenced in Simon's fluid, free-ranging associations and his therapist's attuned combination of low-key limit-setting and reflective observation. The emerging attunement between them recalls times in the pattern of early infantile K interactions: the moments where a mother allows and protects a space for her child, to rest and digest between physical-emotional feeds.

Episode 10

I wonder if this has something to do with his wish for a world of talking machines. Simon starts talking in a robotic, dalek voice. I am not to confuse him for a human being, he says – robots aren't human and don't like being muddled up. I ask what robots do, what makes them different from humans? He replies that he cooks, cleans, drives .. as I begin to say these all sound quite human, he adds that he can write a dictionary in a few minutes, and that robots don't have feelings, they aren't curious. He follows this with a robotic question and I point out that it sounds like this robot is curious after all. Simon says robots aren't alive, they are just a jumble of metal parts. He reels off a robot identity number, then adds "aka¹⁹ Simon". I ask what they are, if they aren't alive. He hesitates and then says robots are dead. I talk about them being neither alive nor dead, perhaps? Simon says he is going to sleep until Monday. I think about him wanting to sleep his way over the weekend break, until his next session.

¹⁹ Aka is a common abbreviation for "also known as"

The therapist's opening comment is dreamy, meditative, playful and Simon responds with a fresh flow of associations, keeping the contact going and expanding it. He plays with his own and his therapist's words, to draw out a thought. The play describes and explores the part of him which prefers a robotic identity to human contact; which wants to kill off curiosity and the capacity to feel emotion. Yet the sequence seems to show him in identification with the robot's opposite : a lively, engaging child enjoying play with a receptive, responsive parent figure. The mention of sleep at the end of the episode may be, at one level, a response to the emotional effort of being in a live relationship, moving out of an old identity into unfamiliar territory. The robot's declared renunciation of life and meaning is slipping, and Simon's hesitation hints that he doesn't know what the alternative might be, if not death. Sleep, the giving up of consciousness, with its conflicts and uncertainties, beckons. At another level, the idea of sleep (lasting until his next session) could hold the fantasy of unbroken contact with his therapist, an infantile world where the child falls asleep, dreams, and wakes, out of a certainty in its mother's presence; where he does not have to experience the pain of separation, or of being on his own.

Simon's therapist supports this process with her own reverie, supplying words, questions and associations to scaffold the emerging play. She slips into Simon's idiom of the robot, which flows from her opening association to a world of talking machines. The following dialogue acquires the quality of unfolding make-believe, creating an imaginative space for thought and feeling at one remove from reality. She observes how the Simon-robot is struggling with feelings of curiosity which it wants to disown; that it appears to exist uncertainly in a no-man's land, where things are neither alive nor dead. The therapist's ready responsiveness to the play, evidences her unconscious attunement to the lively child directing it, and her identification with a playful maternal figure. The same attunement is apparent in the ease with which she follows Simon's lead in switching out of the robot identity, to interpret his wish to lose the weekend break in sleep.

The dialogue in this episode is lively with creativity and responsiveness in both patient and therapist. Persecutory anxiety has dropped into the background. They seem thoroughly engaged with one another, the mood is playful, tolerant, allowing ideas to

flow and develop freely between them. K in this aspect is an experience bringing mutual enjoyment. A space has opened up for imagination and symbolic communication, reflected in Simon's new-found power to play with words. Likewise, acting (the make-believe quality of Simon-robot) has begun to take over from enactment. As in the previous episode, the interaction between patient and therapist has traces of the infantile quality of early mother-child explorations and is rounded by a pause to rest.

Episode 11

I call him "aka Simon" and Simon switches to being another robot, feigning ignorance of its predecessor – "Who said that? Who is aka Simon?" I suggest this robot has wiped its memory as Simon does too, sometimes, denying he's ever had a certain thought or an experience we've shared gets obliterated. "No" says the new robot Simon, repeating this to each of my comments. I tease him about becoming a "No" robot, a one-word machine. We play with "no" and "know". I wonder if there's also a wish to be someone who doesn't – can't – make mistakes...?

The play continues in the same vein as the previous episode, as the pair explore Simon's way of cutting off, disowning his own experience and memories, and attacking links. Play offers them a means of displacement so the painful reality can be kept at a tolerable distance. The primary identifications of lively child and playful maternal figure hold good through the episode. The therapist picks up Simon's phrase "aka Simon" and Simon joins her in elaborating its meaning, through acting out the role of a robot that has many guises but no sense of self. A private language is evolving out of the interaction of free-flowing associations. The pair end up with the "no" "know" play, bringing Simon's habitual denial, evasion of relatedness ("no") into humorous juxtaposition with the constraints on his freedom to think and explore ("know"). At another level, it may be that an underlying anxiety around allowing space for mistakes, misattunements – hinted at in previous episodes (2, 6) and active in both Simon and his therapist - is sparked into awareness.

Again the episode is full of active K. The level of attunement and engagement remains high. Issues of control have been replaced by a receptive and creative interplay of ideas, where patient and therapist partner each other, insight and interpretation building off

one another. Symbolic communication is enhanced, words acquire new layers of meaning, and some unconscious aspects of the therapy relationship are made available for reflection in a powerful and immediate way.

Episode 12

I have a sudden thought that Simon has placed the baby doll on the back of my chair – the baby doll has only recently arrived in the toy basket and he did this in a previous session. I think back to when he was looking out of the window at the beginning of the session and going through the toy basket. I stand up to look behind me and sure enough, the doll is lying along the top of the chair cushion. Simon asks me what I'm doing. I collect the doll, saying I had suddenly wondered if it was lying behind me, and sit back down with it on my lap. Simon laughs and abandons his robot persona. He comes across to take the baby from me, alternately shaking / thumping it and showing it precociously walking and dancing.

A new depth emerges to the therapist's identification with a maternal figure enjoying communication with a playful, somewhat teasing, child. Perhaps her unconscious and conscious identifications have come further into alignment, and it is this that produces her state of free-floating, attentive readiness or enhanced reverie, during the episode. She is newly available and receptive – at an unconscious level - to the little boy Simon; an idea forms, joining together different strands of thought and memory: the newly arrived baby doll; Simon at the start of a session; Simon standing behind her; a previous session where he showed a wish to place a baby near her. She moves intuitively to imagine him placing the doll behind her on the chair – an unconscious symbolization of what has been occurring between them, as Simon's play has brought forward the young child part of himself in search of maternal reverie. In collecting the doll and bringing it to sit on her lap, she communicates her unformulated acceptance of both the little boy Simon, and the need for displacement. It is another instance of the pair finding a play language for managing the contact they are establishing, since – like Simon's placing of the baby doll – there are unconscious fears that it will be ruined by exposure, or too direct an acknowledgement.

Simon's response shows his attentiveness to his therapist, and perhaps a relief at finding they are in attunement, she has registered his little boy need for a mother to hold him,

and can pick up on this in a way he can manage. He is released by it from his robot persona. In the play that develops, he shows his mix of tenderness and aggression towards the little boy who needs so much attention – the conflicting wish to silence, punish him and to show him off.

Has K activity in the previous episode created conditions for a deeper shift in identifications and attunement in the pair? On the part of the therapist, a shift may be evidenced by the intuitive accuracy of her reverie, as her thoughts assemble to form a surmise which has been unable to push its way into consciousness until now, and is then shown with the unusual clarity of a reality check, to be on target. The sequence carries the hallmark of what Bion terms the process leading to a “selected fact” – the mental activity, part unconscious, which draws together elements of experience to form a picture around a central organising idea. In Simon, K seems apparent first, in an unconscious attentiveness, or orientation, to his therapist’s mind, suggested by the expectant alertness of his question to find out what she is doing; and then, in his readiness to acknowledge her accuracy, as he joins her with a laugh, to play with the baby doll. Perhaps at some level, she has been able to understand something, know a part of him which can only be hinted at covertly; he conversely, appears able now to accept and tolerate her recognition, the almost unbearable experience for him of a hated, loved, vulnerable part of him being understood.

Episode 13

He glances at the clock and asks me when I realized it was stopped? This was a reference to the Thursday session when he had taken it down and fiddled with it. Now Simon acknowledges he had removed the battery. I talk about his wish to sabotage the clock. Simon denies this – it’s not sabotage, sabotage is when you throw something across the room and destroy it! I question this, saying sabotage can also be quite subtle – like when games and sleep can be used to sabotage his session time. ..

With his glance at the clock, Simon shows an awareness of time pushing into the play. There is perhaps a wish to regulate their engagement, again recalling moments in infancy when a child rests after a period of intense and pleasurable interaction with its caregiver. His next comments suggest that the approaching end of the session is also a

factor, and there is a linked wish to stop time which leads to separation, or to bring it under his control: not sabotage, as his therapist imagines, but a fantasy of never-ending connection. His question shows an interest in minds; is he checking the evidence that, with the stopped clock, he has kept a place in his therapist's mind between sessions? There may also be an acknowledgement of an under-cover, but not he thinks destructive, part of himself.

The glance at the clock and reference to the previous session seem to revive old identifications in Simon's therapist. In her choice of the word "sabotage", there is a reappearance of the identification with a beleaguered, rejected parent with a controlling, hostile child. Her reference in this connection to games and sleep, risks shadowing the earlier play, re-casting it in the mould of previous conflictive encounters. The comment points up the fluidity of the relationship, how easily it can tip from attunement to suspicion, under the weight of the old paranoid-schizoid pattern between them.

The therapist in this episode shows a K activity cramped by paranoid-schizoid identifications, in contrast to Simon who appears to be interested in exploring something new and different. His thinking is active and discriminatory, as evidenced in him taking issue with the word "sabotage" to describe his action with the clock: he wants to challenge his therapist's negative reading and failure to discriminate old from new. This attention to meaning and engagement in verbal discussion, is itself unfamiliar, marking Simon's shift into symbolic function in place of play and projective identification, as the primary means of communication. Enmeshed in old identifications, Simon's therapist cannot at this moment detect and respond to the new aspects of himself that he is revealing.

Episode 14

We begin a bantering exchange around the "aka" label. I say "aka Simon" a few times, playing with the sound of it, hearing it take on the sound of a pet name for a loved child. Simon laughs and plays along, first testing that I know what aka means, then picking it up to talk to "aka baby" doll. I notice his mix of tenderness and aggression with aka baby. I apply it to some of the things he does and says – "let's play a game – aka I don't want to think about that." Somewhere in the middle, Simon says "It's funny, you know, but I don't feel

hungry any more.” I suggest perhaps he has filled up on something in here today – a different sort of meal has been enjoyed.

The therapist initiates a return to mother-infant play which re-establishes the pleasurable attunement of earlier episodes. She is perhaps unconsciously aware of yielding to the older identifications, and looking for a way to nurture and protect the vulnerable, new-born connection, or psychic field, forming between them. Her tone and prosody express the maternal concern and affection of the new identifications the pair has begun to imagine into being. She extends Simon’s term “aka”, to illuminate the way in which his messages to her are often disguised – appearing to say one thing while really saying another. Her interpretation, couched in relation to a needy little Simon, conveys understanding and acceptance, at variance with the suspicious edge to her comment in the previous episode

Simon is quick to respond, showing with his laugh and play, an undiminished enjoyment in relating to a baby part of himself, “aka baby”. A link is made to a feeling of completeness, satisfaction, registered by him as a curious absence of hunger.

The therapist works herself free of the paranoid-schizoid fantasy of the previous episode and recovers some of her capacity for reverie, by recreating a space through play for words to take on emotional nuance. Perhaps it is the unconscious emphasis on mood to give meaning, often observed in early mother-infant interactions, that allows for maternal and infantile feelings to unfold and become available to them both for exploration. Her empathy is enhanced and she is able to make a link to the vulnerability underlying Simon’s controlling behaviour. The emotional climate established through the play appears to scaffold reciprocal K in Simon, who resumes contact with the more infantile part of himself, and becomes aware of something changed inside him (“it’s funny, you know, I don’t feel hungry any more”). The therapist’s interpretations are now tolerable. K is here revealed as an emotionally satisfying activity, allied with increased awareness of warded off parts of the self; enriched communication (words acquiring added meaning and power in the relationship); and relief of very needy, starving feelings.

Episode 15

Simon starts to ask the time – how much longer have we got. I interpret this as “aka, I don’t want to be surprised by the ending ... I want to be the one who says it’s time.” It is time and Simon says goodbye, telling me to “look after aka baby.”

Simon again shows his awareness of time pushing into consciousness and this time clearly links it to the end of the session. The therapist is able to pick up his underlying concern about the ending, his wish to avoid it coming as a surprise, in connection with a part of him which wants to take charge of separation. Her understanding helps Simon stay in touch and express his concern for the little boy Simon (“aka baby”) – perhaps he fears what can happen to him during a separation? There is a hope that this mother-therapist may be able to take care of him and keep him safe.

In contrast to previous sessions, K continues active under pressure of the ending. There is awareness in both of the worries stirred up by separation, but mitigated by the experience of connection they have been sharing which Simon hopes can be kept safe in the gap between sessions. The mix of worry and hope can be acknowledged symbolically in interpretation and play.

Episode 16

I hear him and Derek going downstairs. A minute later, as I am putting things away, there’s the sound of feet running back up the stairs and then a knock on the door. Simon doesn’t wait but pushes his way back in, saying he’s left his money behind – where is it. I remind him he put it away in his pocket. “But it’s not there!” I add it was his shirt pocket. Simon feels and finds it. “Thanks” and is gone.

After leaving the room, it seems that Simon’s feelings of deprivation resurface and are physically enacted. There may be a terror of something important and valuable to him being lost, perhaps because of his excessive projections, whereby he has put much of his thinking, caring self into the figure of the good mother-therapist. Separation therefore is felt as if a part of himself is lost to him – symbolically equated with his money, something that belongs to him.

Simon’s thinking has become concrete in this episode.

Emerging themes

Therapist and patient are contending with two external events in the session: a change in the timing of the session, involving an early morning start; and the forthcoming reduction from three to two sessions a week, planned to follow the next holiday break. Themes of change, new contact, loss and abandonment, are prevalent, often working in counterpoint through the session. Simon's depressive anxieties and mix of paranoid and manic defences concerning loss, stimulated by increased contact with his therapist and awareness of its limitations, are in evidence from the start.

The psychic situation is different from that of the earlier session, although therapist and patient are recognizably the same. Episodes divide into two halves: in the first (episodes 1 through 7), habitual defences and identifications recur in juxtaposition with new influences, giving rise to a repeated backward and forward motion, as therapist and patient move between p-s and depressive positions in relation to one another. In the second half (episodes 8 through 15), the new influences gain momentum and are shown to prevail, the dyadic motion acquires direction, arriving at closer, and more attuned, contact between the pair. There are longer stretches of imaginative play, while symbolization is enriched and takes over from projection and negative capability, as the primary mode of thought and communication.

Signs of new influences in Simon's internal world are evidenced in various ways. During the first half of the session, the figure of his therapist, often experienced as depriving, cruel, indifferent, is mixed with more benign features: someone from whom he expects interest and tolerance (Episode 1), an object of importance whose presence is needed (Episode 3, 6), a thinking parent (Episode 4), a friendly, accommodating figure (Episode 5), a longed-for mother and containing parent (Episode 7, 8). Persecutory fears of hostile deprivation (Episodes 1, 2) vie with envy (the attack on the thinking therapist in Episode 4), and fears of loss of a good object ("what's wrong with you today" in Episode 3; the manic efforts to control in Episode 6). In the last half of the session, a benign, playful, attuned parent is increasingly present in the transference, apparent in the therapist's more spontaneous relationship to Simon, and in Simon's increased responsiveness and tolerance, as he identifies with a benign, curious and lively part of himself. Controlling play diminishes as the good object becomes more securely

established between them, through a process of slips and successful repairs of attunement.

Simon's therapist shows a corresponding alternation between old and new identifications during the session. In the first half, it appears that it is sometimes her difficulty tuning into the cross currents and multiple layers of Simon's communications that acts as a brake on new experience in the dyad gaining ground. The influence on her of old identifications is threaded through the first 7 episodes: suspicions of a tormenting child colour her response to Simon's curiosity in Episode 1, and his controlling behaviour in Episode 4. Her fear of being manipulated and exploited by him is evident in her instant resistance to his invitation to play in Episodes 5 and 6. In identification with a controlling, restraining parent part of herself, her capacity to stay receptive and explore what is happening between her and her patient is inhibited and cramped. For instance, interpretative comment cuts short exploration in Episode 1 when Simon is showing his mix of feelings around change; and again in Episode 5, when the therapist interprets Simon's bid to play as negative, avoidant, missing its protective aspect. A similar moment recurs towards the end of the session in Episode 13, when the therapist is attuned to Simon's wish to "sabotage" his therapy, but does not discern a contrary impulse to prolong it indefinitely, so as to avoid the pain associated with separation.

As the session unfolds, new identifications with a more tolerant, genuinely curious, and benign parental figure come to the fore. Her receptivity to the little boy Simon is enhanced: her tone softens (Episode 6 onwards), the rigidity of her refusal to play modulates into active engagement (Episodes 10, 11, 12 and 14), as she becomes more attuned to the infantile state of his communications. Lively maternal feelings are evinced and voiced in the play, notably in Episodes 12 and 14, in the play with the baby doll and when she plays with the sound of "aka Simon". The therapist's feelings of inadequacy and persecution recede and a new sympathy is evident for the anxiety and vulnerability underlying Simon's tests and evasions – for instance in Episode 8, when she detects the sense of exclusion behind his drive to find out what sort of car she has; and again in Episode 14, when she can acknowledge the wish to evade mental pain, in his repetitive game-playing. There is a corresponding decrease in premature and defensive interpretation, she stops trying to steer her patient and is able to follow

Simon's lead. When, in sessions 7 and 9, Simon challenges the session boundaries, her response is firm without being punitive and a thinking space is preserved.

Analysis of the session reveals moments where the underlying K dynamics are open to more than one interpretation, sometimes missed by the therapist in the moment. In particular, her tendency at the start of the session to take up the defensive aspects of Simon's interactions, at times obscures their infantile character, so infantile K²⁰ is read as an attempt on his part to restrict K or a retreat from the K link. For instance in Episode 5, the therapist refuses Simon's invitation to play, suspecting it is a retreat, when it holds infantile aspects of a young child's developmentally-based need for pauses in interaction (Stern 1977, Tronick 2007), and repetitive play (Reddy 1991). The session-mapping charts the therapist's gradual process of adjustment, to a more developmentally-aligned stance in the latter episodes, where her participation evidences acceptance of Simon's play as an important medium for communication and joint exploration. As with mothers of young children, her adaptation appears to occur outside consciousness, at an intuitive level: she does not notice or comment on it as it happens, for instance in Episode 6, when she stops opposing Simon's invitation to play; and later in Episode 14, when she takes the lead at a moment where rupture threatens, and turns from discussion back to play.

At moments such as these, the K link in the dyad is seen to develop not so much in an ordered, linear manner, as in a looping oscillation between moments of attunement, alternating with misunderstanding, pauses and ruptures. The experience of missing one another's meaning, moving apart or disagreeing, and then finding one another again, is a central motif. Another example is the sequence mapped in Episodes 2 and 3: in 2, the therapist's wordy commentary on Simon's question about which session to drop, gets in the way of exploration and points up the distance between them. In 3, she is able to acknowledge this lack of attunement and consequently they draw closer. A further instance is the sequence linking Episodes 7 and 8, where the therapist sets limits to

²⁰ Infantile K refers to the way in which babies and young children build relationships with others and develop a mentalising capacity. There are grounds for the confusion between infantile K and defences against K. Klein noted the link between important infantile ways of coping with the barrage of early experience, and later psychopathologies – especially psychotic and depressive illness. She argued that what was normal and developmentally significant in a young child would be grounds for a diagnosis if continued into adult life. Music (2011) comments "*what starts as a momentary coping mechanism, something that all infants have to manage, can turn into an ongoing defensive strategy.*" (Music, 2011: 34)

check Simon's disruptive drift, and he responds. While the reparative act varies from moment to moment (here, she accommodates him and shifts her stance, there she checks him and he shifts his) the process of mismatch and repair repeated across the session, emerges as the "shape" of the dyad's progress towards exploring and getting to know one another.²¹ Paraphrasing Sullivan:

"Healing actually flows from the couple working on the damage arising out of (their) tangles and missteps rather than from (their) flawless functioning."

Sullivan (2010: 116)

Mapping the session material in this way, suggests that the emotional quality of K is not a constant, but varies depending on where the dyad finds itself on the Ps↔D spectrum. During the first half of the session, when Ps identifications are strongest, K activity often seems associated with discomfort and a sense of threat. Simon's curiosity in Episode 1 is ambivalent, uncomfortable to him – he is taking a step into a new experience, meeting his therapist in a new way and his commentary on entering the room expresses reluctance, suspicion and feelings of deprivation. Later, in the sequence linking Episode 3 and Episode 4, it appears that a K moment of contact stirs up feelings of anxiety and envy, prompting him to retreat and then challenge the session boundaries. When in Episode 6, he experiences the therapist's desire to know him, through her gradual shift into play, it is a deeply ambivalent experience as the next episode shows – his attack on the table signals the hunger and frustration that contact of this sort stirs up in him. Thus K activity in the dyad over the first 6 episodes appears as a dance composed of brief forays, and staccato retreats. It bears out Bion's account of psychotic reactions to K moments, observed among patients with characteristically p-s defences against psychic pain. Symington & Symington cite an interesting example:

"A woman with a deprived background felt that her sense of deprivation and neglect had been suddenly and deeply understood by the analyst. Then equally abruptly, she felt persecuted ... the experience of understanding and being understood was immediately followed by a sense of persecution, of something being done behind her back."

Symington (1996, 69-70).

²¹These findings reinforce child development studies which argue that parental capacity to support their infants to "repair interactive errors" is central to the child's development of resilience, sense of agency, and capacity to mentalise (Tronick & Weinberg 1997).

During the latter half of the session, the dyad experiences K activity in a different way. By episodes 10, 11 and 12, enjoyment and pleasure are evidently in the ascendant, as shown by the increasing fluidity of the play. Episodes flow easily as Simon and therapist give and take from one another in a stream of imaginative associations. Momentum builds towards an unconscious joining in Episode 12, declared in the co-creation of “aka baby”, to the evident pleasure and satisfaction of each. Simon’s sudden comment in Episode 14, that he is no longer feeling hungry, seems to capture this emotionally nourishing aspect of K – what Joseph terms “*the delights ... of live relationships*”, in contrast to their limitations and uncertainties (Joseph, 1982: 323).

K in its P-S aspect is cramped and restricted by opposing -K and no K tendencies which cut short exploration, or close it down in various directions. The therapist’s interpretations in the early episodes have this quality – they interfere with her curiosity and receptiveness, much as her defensive refusal in Episodes 4 and 5 checks opportunities for K. She has to make the “*affective shift from accusatory interpretation to real listening*” (Ogden 1999, 184) for K in the dyad to lose its staccato gait. Her K activity at this stage of the session takes the form of negative capability – in Episode 3 for example, where she accepts her lack of understanding and in the process makes space for Simon to register his own uncertainty and confusion. Simon’s K activity in this part of the session has a different shape, more apparent in a persistent itch to create an emotional experience in his therapist, and attention to what she does with it – as in Episode 2 when he projects feelings of deprivation and rejection into her, while pressing her for a response, showing his curiosity to explore the feelings through her mind. When she responds evasively, his frustration is evident and though mitigated by her acceptance of responsibility in Episode 3, it resurfaces again in Episode 4 in the threat to make off with things belonging in the therapy room. The persistent questing to get to a nameless emotional experience through another’s mind, is perhaps an immature version of negative capability. In this respect, Simon is like a child who lacks the words for what he wants and can only signal vigorously when the wrong thing is supplied: he doesn’t know what “it” is, only what “not-it” is. This might be the state of mind which Bion describes as a preconception in search of a realization, which lies at the primitive roots of thinking.

In the opposite direction, his low tolerance of uncertainty, frustration, his envy of his therapist, and the fear of his own aggression frequently interrupt or fetter Simon's search for K in the early episodes. So at the start of Episode 3, he turns away from talk out of the frustration with his therapist's misunderstanding in the previous episode; in Episode 4, the substitution of challenging, controlling play for discussion is not only a negative signal of frustration with the misunderstanding, imperfect therapist of Episode 2, but also – as noted above - an envious reaction to the brief K moment at the close of Episode 3. By Episode 5, the push to replace talk with play has acquired an additional protective thrust, as he fears the twin force of his craving and envy may destroy the fragile contact with his therapist.

In the latter half of the session, K activity is more expansive on both sides, seemingly as a result of the increasing attunement in the dyad, realised through the sequence of interactive repairs mentioned earlier. We find that the distinctive features of K are changed with the new psychic situation, so it is evidenced now not so much in the guise of negative capability, as in the spontaneous evolution of ideas and language between Simon and therapist. Paraphrasing Ogden:

“...certainty (has given way) ... to tendency, knowledge ... to a tentative, ever-sliding sense of things, fixity ... to movement and transition”

Ogden (1999: 230).

The therapist has relaxed her rigid grip on analytic “technique” and her use of commentary is no longer controlling but has become descriptive, associative, grounded in emotional experience shared with her patient. She takes up his words, playing with meaning in relation to the history between them, as in Episode 11 when she finds in Simon's robot play, a representation of his compulsion to disconnect and deny shared experience; and again in Episode 14 when his “aka baby” play is linked in her mind to his need to disguise his feelings. Her developing capacity to weave interpretation from the play in an attuned, emotionally grounded way, in keeping with his need for displacement, appears to be one of the factors to free Simon from the staccato rhythm of his previous interaction.

On Simon's side, the shift in K has other markers. The session maps his growing tolerance of frustration (awareness of his own limitations and the external limits

imposed by reality), which is hypothesised by Bion as a pre-requisite for K to evolve beyond its infantile projective mode. Symington and Symington write:

“The most crucial decision on which mental growth depends is whether frustration is evaded, or faced. Encountering a painful state of mind, does the individual immediately engage in one or more of the numerous defence mechanisms readily available, for the purpose of getting rid of the awareness of the frustration, or is there an attempt to remain open to it, to tolerate it and to think about it...”

Symington & Symington (1996: 67).

In this session, the shift begins with Simon’s brief self-report in Episode 3 (“it’s probably me that’s the trouble really”), that follows a moment of negative capability in the therapist. His urgent need to check, repudiate or evacuate the experience of separateness is very present in Episodes 5, 6 and 7, as he grows manic in his attempts to conscript, then invade his therapist; but, in concert with her containment, it swings progressively to moments of acceptance of separateness, observable in the Simon who is capable of noticing his escort on her bicycle without triumph or resentment, but with dawning curiosity (Episode 8). In Episode 9, he can acknowledge and bear with sensations of hunger; the impulse to get food and drink is contained in words, in place of physical action, so preserving a space for mental activity.

Tolerance of separateness and frustration allows the later play sequences time to extend and evolve; there is a corresponding flowering in Simon’s symbolization and symbolic communication. The continuity of play in episodes 10, 11 and 12, is in marked contrast to the staccato rhythm of the early episodes, when differences in meaning and understanding between Simon and therapist often halted an interaction. In the robot and aka baby play, there is an acceptance and enjoyment in their different ways of taking up words, Simon tolerates the therapist’s interpretative commentary and it is elaborated into further play. In Episode 13, he can sustain a lively dispute over the meaning of his play, without immediately turning the conversation or diverting into physical activity.

As in the previous chapter, some features associated with K and minus K that emerge from, and are found retrospectively to have shaped, this description, are summarised in

graph form in Figure 8. A full discussion of the graph is found in the Findings chapter (p.152)

<u>Session 2</u>	
	<u>K</u>
	<p>Curiosity</p> <p>Exploratory play / playfulness</p> <p>Imaginative free association</p> <p>Feelings/intentions owned</p> <p>Free flow and interplay of ideas, creative use of other, enriched communication / language</p> <p>Shift from control to partnering</p> <p>Digestive rests</p> <p>Attentive readiness / orientation to other</p> <p>Accepting of confusion/deficits</p> <p>Projective identification used to explore</p> <p>Active, discriminatory thinking</p> <p>Repetition to repair – sustain exploration</p> <p>Self reflection</p> <p>Increased awareness/acceptance of reality/limits/separateness</p> <p>Increased awareness/tolerance of warded-off parts</p> <p>Symbolisation / acting / “as if” replaces enactment</p> <p>Shift from two dimensional to three dimensional (from splitting to repression?)</p>
	<p>Curiosity</p> <p>Exploratory playfulness</p> <p>Imaginative free association – reverie</p> <p>Feelings/intentions owned</p> <p>Free flow and interplay of ideas, creative use of other, enriched communication / language</p> <p>Shift from control to partnering</p> <p>Tolerance of digestive rests</p> <p>Attentive readiness / orientation to other</p> <p>Accepting of confusion / deficits</p> <p>Emotionally-grounded observation</p> <p>Descriptive, questioning commentary</p> <p>Adaptive pacing, prosody, use of displacement – responsive to P</p> <p>Flexibility</p> <p>Simplicity</p> <p>Tolerant, receptive – open – enhanced empathy</p> <p>Increased alignment / integration of conscious and unconscious identifications</p> <p>Non-persecutory boundary-keeping</p>
<u>P</u>	<u>I</u>
<p>Wary, cramped receptivity</p> <p>Vigilance limits receptivity</p> <p>Tentative equivocal readiness for change</p> <p>Suspicious exploration through projection</p>	<p>Wary, cramped receptivity</p> <p>Vigilance limits receptivity</p> <p>Interpretation to ward off uncertainty, evasive verbalisation restricts exploration</p> <p>Suspicion restricts exploration</p>
<p>Exploration turns literal, concrete to ward off uncertainty / aggression</p> <p>Use of symbolic equation to test for missing K</p>	<p>Rigidity interferes with exploration</p>
<p>Attack on change</p> <p>Denial and projection of disturbance</p> <p>Attack on thinking through physical enactment</p> <p>Envy</p> <p>Manic fragmentation</p> <p>Denial of separateness, via invasion, symbolic equation and projective identification</p> <p>Mockery, ridicule to punish, control</p> <p>Denial of meaning</p>	<p>Accusatory, exposing commentary / interpretation – critical, harsh subtext</p>
	<u>-K</u>

Figure 8

Chapter Six

Findings

This research set out to examine clinical material through the framework of Bion's theoretical claim that identifies thinking as at bottom an emotional process, and relates symbolic capacity to early emotional experiences of communication and containment. The framework was selected because of its relevance to the particular features of my patient, which emerged through the detailed study of session records and writing of a clinical paper for qualification purposes. My analysis of patient-therapist interaction followed Bion in looking at thinking and learning, side by side with the sort of internal objects active in the therapeutic relationship, and the emotions connected to them. I wanted to assess, through a detailed focus on these aspects of clinical material, some current ideas about what interferes with a deprived child's capacity to think and learn from experience; and what are the factors in a therapeutic relationship that can help a child's capacity in these areas to grow.

In this chapter, I discuss my findings, arguing that the examination of sessional material using such a framework, produces a coherent and illuminating clinical reading, expands understanding of my patient's difficulties, as well as further mapping Bion's concepts of K and -K in relation to the primitive emotional states found in deprived children.

The chapter is organised in five parts. In the first, I summarise my findings regarding factors which interfere with, and factors which promote, the process of thinking and exploration in therapy. I emphasise the need for discrimination in differentiating K from -K, across different psychic situations; and the value of attending to two core variables, in this process. I argue such an approach expands understanding of my patient's difficulties which were often misread at the time.

In the second, I discuss the finding that therapy has to be thoroughly emotionally grounded in the countertransference, as well as the transference. I argue that such emotional grounding was of especial relevance to Simon's development in therapy, and by extension may be relevant to other children with backgrounds and features similar to him.

In the third part, I consider how introducing the concept of the analytic third into the data analysis was helpful to illuminate moments of impasse and movement in terms of Simon's internal objects, mode of relating, and symbolic capacity.

In the fourth, I relate results of the research to a theory of mind, and literature regarding differential phases of therapy for young patients with externalising disorders arising out of histories of deprivation. I present some implications of the current study for child psychotherapy practice, in terms of the relevance of long-term psychotherapy to very deprived children, the emotional work required of the therapist and the centrality of supervision.

The fifth part of the chapter outlines some thoughts concerning the place of child psychotherapy research, in terms of what I have learnt from this experience of looking at clinical material and writing from a research perspective. I consider further directions, born out of the present study but leading beyond its scope, towards dialogue with other science-based discourses working with concepts of emergence, contingency, and complexity.

Findings regarding K and -K: value for clinical understanding

The detailed analysis offers a means of exploring what K activity, the exercise of curiosity and a hunger for truth in a patient, looks like in the different psychic situations represented by Klein's paranoid-schizoid and depressive positions. K emerges as a profound emotional experience for both patient and therapist. The hunger for truth, the desire to know and be known by another human mind, and the contrary envy and fear this desire arouses, are shown to be fundamental factors in the interaction. How patient and therapist experience and manage the conflict between K and -K is found to be core determinants in Simon's gradual emergence from psychic retreat and development of mind. The research thus begins to formalise a systematic evidence base for Bion's claim, repeated by Britton and Fisher, that K stands on a par with Love and Hate as a primary, and foundational force, in psychic development.

Britton's paper on the oscillatory path of development between Ps and D states of mind offered useful clarity for detecting K activity in both positions, as Bion suggested in his $Ps \leftrightarrow D$ equation (Britton 1998). As noted in Chapter Two, Britton argues that

becoming stuck in either position involves a surrender of mental development or what might be termed “a *K-state-of-mind*” (Fisher 2011).

I found it useful to study my material in three steps. First, I and three other qualified child psychotherapists scored the two sessions under scrutiny, on the PRP scale which has been used to distinguish Ps from D states of mind (see Appendix 1). The results of seven of the eight ratings showed Simon in Session 1 to score high on the Ps scale, while in Session 2 he had shifted closer to a D position²². That is to say, with one exception there was consensus that data from session 1 showed him to be in the grip of identifications with hostile, tormenting objects, in a controlling, sado-masochistic pattern of relationship; while in session 2, the identifications involved more tolerant, sympathetic objects, capable of mutual concern and a receptive, cooperative mode of relating.

My second step was to gather features of K-states-of -mind and their converse, into a pair of modified quadrant graphs (Figures 7 and 8), corresponding to the two sessions examined in the previous chapters. The graphs are organised around two axes, where the vertical line represents the continuum K to –K, and the horizontal differentiates patient from therapist. The shaded area midway between the K and –K poles indicates the area of slippage which I label “restricted/defended K”: this is the region of ambivalent, two-way-facing communications where K curiosity and the wish to know, jostle for advantage with –K influences (particularly envy and anxiety). It seeks to represent in graphic form the finding that K and –K are not so much separated by a rigid barrier, as processes which can be seen to shade into one another; at times, communications are seen to waver uncertainly between one and the other. In such a state of mind, it is not always easy to know who is doing what, where identifications originate, what is projection with an exploratory purpose, and what is projection as defence. Restricted/defended K emerges as an area of psychic confusion.

²² I was interested that the one exception scored Session 1 high on depressive features, on a par with the same therapist’s score for Session 2. In subsequent conversation, it emerged that it was this therapist’s sensitivity to the *object-seeking* quality of Simon’s activity in Session 1 which underpinned his high “D” scoring of the session. I wonder if this therapist was picking up and amplifying the depressive, object-seeking aspects of Simon’s communication, which could often be drowned out within the strong Ps identifications active between him and his therapist, as I discuss below.

Session 1

		<u>K</u>	
Projection as communication Projective identification Displacement Exploration concrete and literal		Tentative exploration Reflective, questioning Tolerant, receptive Silence, waiting, accepting confusion Emotionally-grounded observation / interpretation Owning feelings Flexibility Simplicity	
<u>P</u>	Splitting – ambivalent projection	Concrete, literal thinking Speaking in generalities Restricted receptivity Reflection / interpretation also used to ward off feelings	<u>T</u>
		Guarded, restricted exploration, questioning – superficial, verbal, often too soon	
K projected into T Restricted receptivity		Re-projection Accusatory, exposing interpretations – critical, harsh subtext Not authentic – split between surface meaning and underlying emotive quality Rigid, controlling Concrete, literal thinking	
Projection to control, punish Accusatory questioning, blaming Lies, denial Opposing links Rigid, controlling Mockery, rubbishing Body thinking Concrete – physical replaces mental/emotional Evacuation of unconscious thinking in physical action Fragmented thinking Mindless, repetitive, Attacks replace words, attacks on setting			
		<u>-K</u>	

Figure 7

<u>Session 2</u>	
	<u>K</u>
Curiosity	Curiosity
Exploratory play / playfulness	Exploratory playfulness
Imaginative free association	Imaginative free association – reverie
Feelings/intentions owned	Feelings/intentions owned
Free flow and interplay of ideas, creative use of other, enriched communication / language	Free flow and interplay of ideas, creative use of other, enriched communication / language
Shift from control to partnering	Shift from control to partnering
Digestive rests	Tolerance of digestive rests
Attentive readiness / orientation to other	Attentive readiness / orientation to other
Accepting of confusion/deficits	Accepting of confusion / deficits
Projective identification used to explore	Emotionally-grounded observation
Active, discriminatory thinking	Descriptive, questioning commentary
Repetition to repair – sustain exploration	Adaptive pacing, prosody, use of displacement – responsive to P
Self reflection	Flexibility
Increased awareness/acceptance of reality/limits/separateness	Simplicity
Increased awareness/tolerance of warded-off parts	Tolerant, receptive – open – enhanced empathy
Symbolisation / acting / “as if” replaces enactment	Increased alignment / integration of conscious and unconscious identifications
Shift from two dimensional to three dimensional (from splitting to repression?)	Non-persecutory boundary-keeping
Wary, cramped receptivity	Wary, cramped receptivity
Vigilance limits receptivity	Vigilance limits receptivity Interpretation
Tentative equivocal readiness for change	to ward off uncertainty, evasive
Suspicious exploration through projection	verbalisation restricts exploration
	Suspicion restricts exploration
<u>P</u>	<u>T</u>
Exploration turns literal, concrete to ward off uncertainty / aggression	Rigidity interferes with exploration
Use of symbolic equation to test for missing K	
Attack on change	Accusatory, exposing commentary / interpretation – critical, harsh subtext
Denial and projection of disturbance	
Attack on thinking through physical enactment	
Envy	
Manic fragmentation	
Denial of separateness, via invasion, symbolic equation and projective identification	
Mockery, ridicule to punish, control	
Denial of meaning	
	<u>-K</u>

Figure 8

The third step was to bring the two graphs into relation with the PRP rating for each session (see Appendix 1) to formulate a view of how basic modes of thinking / communication which carry K, take a different shape depending on the patient's characteristic psychic state and mode of relating at the time. The prevailing mode of

thinking/communication is seen to be markedly different between the two sessions, as shown in Figure 9.

<i>Simon's prevailing mode of thinking/communication in Ps dominated session (1)</i>	<i>Simon's prevailing mode of thinking/communication in D-dominated session (2)</i>
<ul style="list-style-type: none"> • Enactment, projection and projective identification primary means of expression / communication / exploration • Thoughts concrete/literal, 2 dimensional • Fragmentary thinking, conflicted, disorganised, staccato; lack of connectivity in actions/interactions • Attention locked on primitive emotional content of interactions 	<ul style="list-style-type: none"> • Play primary means of expression / communication / exploration • Move from 2 to 3-dimensional thinking – emergent capacity for self-reflection • Free association, creative flow of ideas • Imaginative, verbal exchanges • Attention extended to symbolisation, symbolic content of interactions

Figure 9

From a developmental perspective, the differences in Simon's mode of thinking/communication between the two sessions appear to match differences discussed in Chapter Two, between early, primitive forms of thinking found in young infants / psychotic adults, and the modes of thinking/communication in older children on the way to ordinary adult functioning. In Session 1, Simon behaves as a child who has been so starved of emotional truth that his capacity to experience more than a limited, and largely negative range of emotions, appears stunted,²³ along with his capacity for more abstract, complex communications. Yet his sensitivity and drive to expose emotionally false notes in his therapist, although repeatedly interfered with by cross-currents of suspicion and envy, offers insight into the instinctual questing after

²³ Fisher writes: "It is the K-state-of-mind that makes possible the experience of the full range of human emotions ... paradoxically certain emotions – such as anxiety, envy and hatred – attack and makes impossible the experiencing of other emotions. Actually, rather than envy, perhaps we should put fear at the head of the list of the –K factors, the fear that emotional experience is not survivable." (Fisher 2011: 60)

truth at the emotional level of pre-verbal thought, which is the K-state-of-mind in its most primitive form.²⁴

There is considerable debate in the literature about whether the primitive mode of thinking described in the first column is the product of emotional deficit at an early developmental level (Alvarez 1992), or of a defensive organisation in response to trauma or psychic pain (Joseph 1982, Steiner 1993). The material here does not resolve the debate, and the “hard-wired” quality of Simon’s body-thinking in session 1 could equally correspond to both accounts: at any given moment, an established defensive organisation can be as subjectively overriding and restrictive to the person concerned, as an area of deficit. However, the contrast with session 2, a bare 18 months later, is striking and it might be argued that modes of thinking entirely rooted in early deficit would be more enduring (as in the case of some of the patients described by Alvarez, 1992, 1998).

There is also some indication in both sessions that the ebb and flow of body thinking had a defensive function: perhaps, for Simon, both deficit and defence were in play, and this was one factor adding to the therapist’s difficulty in distinguishing K from –K in the session. My region of defended/restricted K on the quadrant graphs can be read as representing the complex crosscurrents at such times. The hypothesis to emerge from the material is that it was important for the therapist to keep both defence and deficit in mind, since opting for one to the exclusion of the other, appeared to link to the patient not feeling understood. It would be interesting to test this hypothesis further, and see if misunderstanding and misattunement between patient and therapist in other sessions (or treatments), was linked to times when the ambivalent quality of words/ actions was overlooked and they tended to be taken the wrong way – that is to say: one way only, when they were two-way-facing.

²⁴ In such an exchange, Bion argues that emotional truth is as vital to the development of the mind as nutrition is to the body, and is as instinctively sought. But, as Fisher’s commentary on Bion makes clear, contrary forces are also at work in the infant. At odds with the drive for emotional truth, is the child’s equally powerful hunger for pleasure (translated into Bion’s L) and the avoidance of pain (Bion’s H). L or H can override the wish to know because of the pain/pleasure which K brings. We distort reality / truth in order to feel good or avoid feeling bad. Painful truths are denied, and pleasant illusions fostered. An example in the research data is Simon’s repeated wish to deny truths that threaten pain / disturb his habitual object identifications and modes of relating.

As well as providing a perspective on Simon's K-activity in relation to his Ps and D states of mind, the research throws up interesting observations regarding the therapist's role of container and how this too, is seen to vary with the change in the psychic situation between sessions (Figure 10).

<i>Features of therapist's containment in Ps-dominated session (1)</i>	<i>Features of therapist's containment in D-dominated session (2)</i>
<ul style="list-style-type: none"> • Silent, receptive, patient • Thinking conflicted, uncertain, tentative • Inside space for feeling to unfold • attention to emotional content of interactions • Thinking emotionally grounded 	<ul style="list-style-type: none"> • Joining patient in free association – flow of ideas • Integrative, declarative, interpretative commentary • Expansive symbolization and playful exchange • Thinking emotionally grounded

Figure 10

What Fisher names "*the container-in-K*" can thus be hypothesised to vary depending on the mode of thinking / communication dominant in Simon, and by extension his psychic state and mode of object relating. Where Simon is operating from a Ps position, his therapist's containment tends to be associated with her silence and "*patience*" – the word used by Bion to describe the Ps pole of psychic growth (cited by Britton, 1998). Her thinking is uncertain and she does not have answers. She allows space in herself for feelings to unfold. By contrast, in the second session where Simon shows more depressive features, her containment is associated with playfulness, free association, expansive interaction and commentary. Such patterns show primitive K and/or Ps-dominated K to call up a different brand of containment from D-dominated K, and that where there is a mismatch, containment fails.

As can be seen from Figure 10, both situations require the therapist's thinking to be emotionally grounded.²⁵ Indeed, the evidence of this analysis suggests that shifts in the therapist mode of containment cannot be produced formulaically but must be authentic

²⁵ This seems to bear out Rosenfeld's observation that: "*the unconscious intuitive understanding by the psychoanalyst of what the patient is conveying to him is an essential factor in all analyses, and depends on the analyst's capacity to use his counter-transference as a kind of sensitive "receiving set"*". (Rosenfeld 1952: 116)

and stem from her emotional participation in her patient's experience. Such a finding supports and expands on Rosenfeld's view that "*the analyst's emotional participation is absolutely necessary in order to create a containing environment, and a purely intellectual approach is equal to a complete failure to contain.*"

(Rosenfeld, 1987: op cit).

In summary, I would argue that this form of micro-analysis shows K and -K to be highly context-dependent while identifying two core variables which affect the shape of K in a clinical encounter. I suggest these variables concern 1) the nature of the dyadic relationship (is the patient in a Ps position or D position or somewhere in between? what sort of object identifications are organising the interaction? What is the nature of the analytic third?); and 2) the patient's level of mental functioning (his mode of communication and where his thinking processes are anchored on a developmental scale). When these aspects are lost or undifferentiated, perhaps because of the powerful emotions flowing between patient and therapist, the hypothesis to emerge from the current research is that the therapist has lost touch with her patient, is unable to provide containment, communications are liable to be misread or misplaced, and moments with K potential can rapidly slide into mutual suspicion and envious / fearful attacks on thinking.

Emotional grounding of therapy: importance to work with deprived children

The need for work to be emotionally grounded is shown through this form of session mapping, to link to the deprived child's primitive dependence on projective identification to communicate, using an emotional wavelength to transmit and receive, in place of verbal thought. The material illustrates that therapeutic containment of Simon required not only a capacity in the therapist to tolerate the content of his communications – his disturbing feels of hatred, envy, fear and rejection; but also his mode of communication – its projective, concrete quality and demand for a concretely-grounded response. He required her to have his emotional experience not just to speak about it, before words could have meaning. In other words, his predominantly body-ego state of mental functioning was demonstrated to require a response from her at a

concrete emotional level and as long as she denied this, the therapy could not proceed²⁶. Instead, the material shows that her words, though often intellectually on track, were felt by Simon to be, in Bion's phrase, an attack by a "*wilfully mis-understanding object*" (Bion – in Fisher 2011: 53), one who seems determined to "*lay bare the truth no matter the cost and yet cannot or will not take in the emotional experiences that can be the truth of the quest*" (Fisher 2011: 53).

The first of the sessions discussed here makes Bion's point very clearly. Simon shows highly developed attunement to his therapist's emotional evasion in this material, which is often found associated with interpretations which hold him at arm's length. His attunement poses a bewildering contrast to the fragmentary, superficial quality of his verbal exploration of the relationship between them. It evidences the strength, if limited range, of his emotional radar, which appears abnormally developed in one direction and mutilated in the other. The primary, non-negotiable need at this moment appears to be for the therapist to accept and acknowledge his and her negative emotional experience. This corresponds to Bion's thesis that mental development starts in an emotional exchange between mother and child and, without adequate receptivity / containment from the mother, stalls there.

Micro-analysis thus supports Bion's hypothesis that in certain disturbed patients, whose thinking appears arrested at a primitive, concrete stage, projective identification is to be understood as a mode of communication, rather than a simple attack on thinking. We find that with Simon, it is when the therapist is able to allow herself the space to experience what is being projected into her, and tie her commentary to that experience, that communication can get started. In the second session, it is the therapist's enhanced capacity to engage emotionally and communicate this, through adaptively joining the play, her tone and inflection, that appears to stimulate Simon's curiosity, leading not to answers but to "*more seeking, more curiosity*" (Fisher 2011: 61). The material from this session shows that the process is closely connected to Simon's increasing ability with words, powers of symbolisation, and a corresponding decrease in physical enactment.

²⁶ Britton, describing a very ill adult patient, writes of her intolerance of any communication from him which did not express understanding of her subjective point of view. He relates this to early difficulty establishing "*a securely based maternal object through the process of containment.*" (Britton 1998: 41)

From dyadic to triadic thinking: the analytic third

Whereas previous qualitative case studies have focused principally on the internal world of the patient, the current research extends the frame to include systematic tracking of what is occurring in the mind of the therapist.²⁷ This mapping system was designed out of an interest in the part played by the therapist's internal capacity in Simon's therapy, which had grown during the writing of my qualifying paper. I was struck both by how difficult it was to study my own capacity in this way and also, by the evidence of a parallel difficulty at work in the therapy itself, where Simon and I often seemed to end up at logger-heads, arising out of a difficulty tolerating the hostile feelings and identifications flowing between us. This was particularly evident in the first of the sessions studied here and similar states of impasse were frequent throughout the first 18 months of intensive therapy. Our interactions often had a stale, repetitive feel, where words were lifeless and impotent to change the situation.

Studying our interactions in the current research reveals key moments in session 1, where I am briefly able to shift position to one more alongside Simon. One such is recorded in Episode 10: *"For a moment, the therapist is able to recognise the destructive turmoil engulfing the session, and acknowledge it without immediately attributing it to Simon: something is happening in the room today and observation is all she can offer at present."* Similar moments occur in session 2, for instance in Episode 3: *"When Simon points up her difficulty understanding him, she is able to own this and with her later comment share responsibility for it: the comment positions her in the psychic field with her patient, sharing his confusion and vulnerability, rather than somewhere remote and inaccessible."*

I want to argue that such occasions, often associated with a shift towards K in Simon, are moments when the therapist gains, at some level, an awareness of the therapy as a co-constructed space featuring an analytic third (the *"something happening in the room today"* in the first example, or *"psychic field"* in the second). The term *analytic third*, coined by Ogden, may be understood to refer to the psychic field operating between patient and therapist, which does not belong exclusively to either but is inhabited by both. In my research, systematic study of micro-episodes of interaction, taken in

²⁷ Reporting the feelings and thoughts of the therapist is a well-established practice in clinical literature, but less easy to find in case studies based on a systematic examination of clinical material.

sequence, demonstrates how the identity of the “third” emerges in the relationship between patient and therapist. In the first of the selected sessions, chosen as representative of the first eighteen months of intensive therapy, the material shows that a paranoid-schizoid third is very alive in the mind of both patient and therapist. Both have to struggle with the fears and defences aroused in relation to a suspicious, hostile object. Each, in their identifications, appears in relation to a third which resists change, and cannot tolerate uncertainty. By the time of the second session, the situation has changed and a more depressive third seems to be active: patient and therapist seem in touch with a flexible, responsive object in their interactions.

Ogden argues:

“It is the transference-countertransference, not simply the transference, that constitutes the matrix in which psychological meanings are generated in the analytic situation.”

Ogden (1994: 47)

The mapping tool, showing feelings, identifications and defences/responses in each member, details how I am a partner with Simon in determining what the unconscious phantasy becomes. It is possible to discuss the many layers of possibilities embedded in each episode (discussed further below), the influences of the analytic third in determining what patient and therapist are able to detect and respond to in one another, and what of the communication remains out of reach to each or both. There are several moments when the meaning of an action is unclear and several hypotheses compete. It is often necessary to wait and see what follows from an exchange before being able to tell which of the possible meanings has prevailed.²⁸ The eventual direction in which the relationship moves, is the product of the interactions of the pair.

The part played by the therapist in constructing – rather than simply discerning – meaning, emerges as a significant factor. So in Simon’s therapy, I can be seen to play an active part in fostering or suppressing conflicting voices within Simon at different moments, nudging us out of, or further into, a familiar, often destructive, pattern of identifications and defences. In the process, potential contact and processes of growth in Simon are brought into being or die in the moment. It becomes clear that change in the therapist’s internal situation (relationship to the analytic third) is part and parcel of the

²⁸ Emde’s view, stressed by Philips, makes a similar point that interactions have to be studied retrospectively – from the perspective of what follows – for meaning to emerge.

therapy making progress – ie Simon coming to know and access different parts of himself and others.

Britton's papers on triangular space attribute similar importance to a shift in the analyst being required for a state of impasse in the therapy to yield and for the patient to progress (Britton 1989, 1998). Britton's internal dialogue with himself introduced, he argues, a vital third into the patient-analyst relationship, allowing him a space to think where he had felt paralysed by his patient's powerfully projective and dyadic mode of relating. In Simon's therapy, this may be expressed in terms of the moments when I was able to step outside a dyadic position and see our relationship as triangulated with a third force - the shared unconscious phantasy which is Ogden's analytic third or, perhaps, the "*unconscious pathological object relationship*" mentioned by Britton and Steiner (1994). The shift in perspective from dyadic to triadic allows for therapist and patient to find a position alongside one another, in relation to what is happening between them.²⁹ For the therapist-researcher³⁰, this brings the crucial space to gain some distance from very persecuted and persecutory feelings: she is able to tolerate them as aspects of a situation to some extent external to both herself and her patient. In consequence the identity of the analytic third begins to change and acquire some depressive features. The containment that her shift provides allows Simon too to find a new position – in the example from session 1, his activity acquires more play-like features; and in session 2, there is a shift from two-dimensional to three-dimensional thinking, allowing him to own a vulnerable part of himself in a rare moment of self-reflection. As noted in the analysis of session 2, contact between Simon and therapist is revitalised and there is a corresponding flowering of language: "*symbolic communication is enhanced, words acquire new layers of meaning, and some unconscious aspects of the therapy relationship are made available for reflection in a powerful and immediate way.*"

²⁹ In child development research, a similar shift from exclusively self-other interactions to mother and child being able to jointly reference a third object is regarded as a major development in a child's capacity for mentalisation. Music summarises: "*there is a clear developmental line from the very early interpersonal understandings of the first weeks of life, to skills developed towards the end of the first year such as proto-declarative pointing, joint attention and social referencing, to the communicative capacities that develop via speech and gesture in the next few years, and eventually to the abilities to understand other minds.*" (Music 2011: 55)

³⁰ Within the research process, it was very helpful to move from a first-person to third-person position in relation to the clinical record: a process involving translating "Simon" and "I" into "patient" and "therapist". This links to Britton's description of the move between a "subjective" and "objective" perspective which occurs in a triangular relationship when the existence of different object relationships comes to awareness, along with "the capacity for seeing ourselves in interaction with others and for entertaining another point of view while retaining our own." (Britton 1998: 42)

How the concept of the analytic third might be related to oedipal themes in Simon's therapy is not touched on here, but strikes me as an area for "*more seeking, more curiosity*." (Fisher, 2011). Could it also be helpful for understanding the network difficulties and breakdowns which frequently arise around children like Simon?

Implications for child psychotherapy practice

The analysis of micro episodes tests out the conditions under which children with complex, hard-wired disorders, arising out of early deprivation, can be helped. It shows the difficulties arising from internalising a damaged sense of self and other at an early age: the limited capacity for new experience, both developmentally and emotionally; the restricted modes of mental functioning available, making working at complex levels of language / insight pointless if not counter-productive, for long periods at the start of therapy.

The research may helpfully add to the finding reported by Fonagy and Target, that "*intensive treatment was remarkably effective for some children with relatively severe, long-standing, and complex psychosocial problems, including conduct disorder, given the presence of at least one emotional disorder diagnosis*." (Fonagy and Target, 1998). The authors hypothesise that therapeutic success with this subset of children is attributable to the role of the therapist in supporting the development of the child's mentalising capacity through opening a window on the world of self and other, by way of the therapist's own openness to, and verbalisation of, the emotional experience of the therapy relationship.

My work with Simon as analysed through the two sessions, demonstrates in a systematic way the hypothesis linking work at a primitive emotional level, with the evolution of language, a wider emotional register, and more complex interactions. As suggested by the experimental studies of child development which informed Fonagy and Target's hypothesis, effective therapy – like parenting - is shown here to be a dyadic process requiring considerable time, emotional engagement, and attentiveness, proceeding in an oscillatory fashion rather than in a straight line, with mistakes, set-backs and interactive repairs, playing a central part.

The role of detailed, frequent clinical supervision in the process cannot be overstated. As this research shows, a therapist, particularly one in training, is also frequently in need of another, attentive mind to help her navigate the powerful feelings and defences aroused in her when working at such a primitive emotional level. Where supervision is not available, there are serious risks of the therapist and child becoming locked into playing out a pathological unconscious phantasy. Supervision in Simon's case brought a new perspective and space for thought, at one remove from the emotional dynamics at work between patient and therapist, which I have argued occupy the centre ground of psychotherapy with very deprived children. Through such company, the study shows that the therapist's tolerance and receptivity, like the child's, can be gradually helped to extend, so it becomes possible to meet in an emotionally authentic way, the very disturbing unconscious phantasies seeking containment in the therapy.

The relevance to child psychotherapy research and pointers forward

Having begun the research process with some misgivings, I have found that a rigorous and detailed analysis, drawing on theorised thematic analysis methods, has the potential to extend clinical and theoretical understanding, and contribute to an evidence base for psychoanalytic work with deprived children. While my research findings are limited by the restricted number of sessions examined and must necessarily be regarded as provisional, I have been struck by the wealth of insight which research of this kind can generate. It seems to me that adding to the volume of sessions studied in this sort of depth has much to offer the profession, both in developing its own conceptual framework, and in bringing evidence to the table for debate with other disciplines.

Research supervision has played a central part in the process, through triangulating my reading of the clinical material, bringing new layers of meaning into focus, and finding links with other areas of research and psychoanalytic writing.

At a meta-theoretical level, I have been particularly interested by the connections to quantum, chaos and complexity theory which have been drawn to my attention by my supervisors in the course of the research. Britton (2011) writes about the influence on Bion of Heisenberg's uncertainty principle, which marked the paradigm shift from Newtonian to quantum physics. Rustin points out that Bion's writing makes frequent reference to the work of Poincaré, the French mathematician and physicist who laid the

foundations of modern chaos theory. Rustin's 2001b paper and Britton's and Shulman's more recent articles (2011) usefully track resonances across the disciplines.

It has been fascinating in my study, to find that the picture to emerge from a detailed session analysis, applied to both patient and therapist, using a method devised for the purpose, finds many conceptual allies in the paradigms arising from quantum and chaos theory. I have made retrospective, and very brief, use of some such allies, for instance: Mandelbrot's concept of fractals to argue the value of detailed research of selective therapy records (see footnotes in Methodology Chapter); and ideas from chaos discourse for expanding on my choice of an open matrix, as opposed to a closed system of classification, for looking for patterns in the complex interactions of patient and therapist (see Methodology Chapter).

I would like to conclude by touching on some further areas of convergence which strike me as potentially rich for the psychotherapy researcher. The discussion of the layers of possibility embedded in each interaction, which are nudged one way or another by the moment-to-moment activity of the therapist, seems to coincide closely with the quantum physicist's re-conception of reality in terms of "a world of potentialities or possibilities rather than things or facts." (Britton 2011: 76) In the world of quantum physics, observation (for which we may substitute K) is not neutral but an active factor which shapes the properties of what is being observed. So, in this study of Simon's therapy, the therapist's attention is found to be best understood not as a simple investigation of a determinate, "fixed" state of affairs – Simon's internal situation; but rather, as an event in a probabilistic universe which is constantly unfolding and not along pre-determined lines. Simon's internal situation, analysed from moment to moment, is shown to hold multiple coexisting futures, like the particles of quantum physics whose position remains indeterminate until the moment of measurement. Micro-analysis shows that it is often the therapist's K and –K that collapses the potential of any given moment to give it a determinate shape: what Britton explains in quantum terms as the moment of measurement which brings "the collapse of the wave packet – that is, the transformation of the probability wave into a point." (op cit: 70) This argument, that Simon's therapy progressed in a series of interactions, acquiring cumulative direction over time out of multiple possible pathways present at each point of interaction, is taken further by

complexity theory's concept of development occurring along a route of bifurcations arising from positive feedback in the system.

In a similar way, I find that the chaos scientists' ideas of emergence, and of natural processes which are interactive and self-organising, patterned but not repetitive, are highly relevant to the construction of therapy I have begun to form. From its study of natural phenomena, chaos discourse introduces concepts of complex, adaptive systems whose evolution cannot be described by simple, linear explanations of cause and affect. Aram describes such a system as: *"a self-organising process .. (where) agents operate together, interact together locally, capable of producing emergent novelty, go through iterations or repetitive interactions which are non-linear by their definition, are heterogeneous, take a life of their own, are characterised by transformative rather than formative causality."* (Aram 2011). I anticipate that my formulation of therapy as a co-constructed space, featuring an analytic third, with the capacity to evolve and develop new forms through an oscillatory process of interactions over time, finds scientific articulation in the concept of such a system.

In chaos theory, there is purpose to "the edge of chaos" found in the constant interplay of stability and instability, regarded as producing essential conditions for life and development.³¹ Stability on its own is equated with sterile and lifeless regularity. Instability in isolation produces equally fatal disintegration. The parallel is striking with Britton's account of psychic development as requiring perpetual movement between the uncertainty of a Ps position and the certainty of a D state of mind, which I have referenced frequently in this research, and which is also discussed in Rustin's paper (Rustin 2001b). Britton develops similar links between his account and the uncertainty principle of quantum physics in his 2011 paper.

Other areas of overlap, mentioned by Rustin and Shulman, appear highly relevant while lying beyond the scope of this study. I have in mind the area where chaos theory's concept of strange attractors meets Bion's idea of the selected fact, and how the idea of a strange attractor might be related to the shared unconscious phantasies which I have argued were at the heart of Simon's therapy. Likewise, regarding Simon's disturbed

³¹ *"The 'edge of chaos' is where life has enough stability to sustain itself and enough creativity to deserve the name of life. It is the constantly shifting battle zone between stagnation and anarchy, the one place where a complex system can be spontaneous, adaptive, and alive."* (Waldrop 1992: 12, cited in Aram 2011)

internal situation at the start, and the long shadow it cast over the therapeutic relationship, I would have liked to have followed Shulman in exploring the point where the chaos concept of sensitive dependence on initial conditions intersects with psychoanalytic theorising about the impact of primary, infantile experience on psychic development. Rustin points to a third area of productive overlap, in the link between scientific thinking around phase-transitions, and Bion's concept of catastrophic change, which I would like to have explored in relation to the emotional dynamics of Simon's shift to a different position.

My hunch is that these science-based accounts of change and development in natural and social systems, could provide significant underpinning to my conclusion, arrived at from a very different starting point and set out above, that therapy works as a dyadic process requiring considerable time, which proceeds in an oscillatory fashion rather than in a straight line, and features mistakes, set-backs and interactive repairs, as core factors. As Aram puts it:

"Evolution .. in complexity discourse is not an incremental, progressive affair, it is a rather stumbling sort of journey in which the system moves both forwards and backwards, and that is arguably the most effective way to be."

Aram (2011)

When ideas converge in this way from a number of different directions, exciting areas of interdisciplinary dialogue emerge. There is also the cumulative strengthening and growth in confidence which occurs when emergent thoughts in one area finding recognition in another. Perhaps this is particularly so for psychoanalytic research, so often regarded as a poor relation at the league table of scientific research (see Methodology chapter). Rustin sums up:

"The value of complexity theory for psychoanalysis is that it provides a much more adequate meta-framework for its ways of thinking than the mechanistic models that have earlier dominated the sciences ... It turns out that complexity, emergent properties, susceptibility to phase-transitions...individual difference, and ubiquitous contingency, may be normal facts of mental life, not merely the imprecise reflections of the inadequate scientific method of psychoanalysis."

Rustin (2001b:138-139)

Chapter Seven

Relevance

My opening description of Simon referred to the strong feelings of exasperation mixed with concern which he stirred up in the adults responsible for him. Such feelings are very common among carers and professionals who live and work with deprived children like Simon who are hyperactive, attention-seeking, challenging, controlling, and often cruel and destructive towards others. As I found in Simon's therapy, the pressure to control such children and limit their demanding, destructive behaviour can drive out curiosity about why they re-create damaging relationships around themselves, and appear unable to self-regulate or learn from experience. Sometimes it can seem as if all the available resources are going towards putting in place external limits, and there is no longer any real hope among carers and professionals, of the child's internal situation improving.

NICE guidelines and current clinical practice for older school-age children with ADHD and conduct disorders focus on strategies for managing the condition. They recommend first line parent education/group work, and CBT/social skills work with the child. In the case of severe ADHD, medication is regarded as the superior treatment. While NICE guidelines are clear that medication should not be offered in isolation from psychological, behavioural interventions and educational advice, in practice such interventions are often minimal and linked to medication reviews. Large numbers of children with an ADHD diagnosis are medicated through to adulthood.

The current research investigates a different treatment option, not excluding medication but relating change to processes occurring in parallel with medication, within an intensive psychological, relationship-based therapy. Despite the severity of his presenting symptoms, Simon was managing without medication ten months before the end of treatment. Change was apparent in his more open, receptive relationship with his therapist; a new curiosity and playfulness with language and ideas; less extreme, emotional outbursts; a reduction in hyperactivity; more extended periods of play and attention; and greater awareness of himself and others. These changes extended beyond the consulting room to Simon's home and school life, where improvements were noted by both carers and teachers (see Chapter 1). Such outcomes raise speculation about what

helps a deprived child to find a different position for himself, even in cases of serious deprivation, and after a lapse of several years.

Exploring the dynamics behind Simon's starting position and subsequent change has been the focus of the present study. The sessions analysed in Chapters 4 and 5 demonstrate the reach of feelings and expectations dating back to early childhood, and their power to shape current relationships and experiences with others. It is seen to be a struggle for patient and therapist to free themselves from the shadow of Simon's experience with his birth family. From systematic examination of the patient-therapist interaction, I bring evidence to support the hypothesis that psychic movement happens in the context of a slowly evolving, emotionally live, relationship with a regular therapist, who is helped through supervision to

- stick with the child even when the only relationship possible seems a damaged and damaging one;
- stay curious;
- put up with doubts, confusion and repeated disappointment;
- hold safe boundaries round the child, while remaining flexible and attentive to the unexpected as well as the expected;
- acknowledge destructive feelings and repair mistakes and misunderstanding;
- tune in to the child's level of emotional development and ways of communicating;
- make space for feelings and thoughts to develop.

On this analysis, the disturbance, sense of failure, and damage which carers and professionals can feel around children like Simon, are seen to be linked to the child's sense of self and others. Being receptive to such feelings, without losing the capacity to reflect on them or hold safe boundaries, is found to be an indispensable aspect of a therapeutic relationship with the potential to help deprived children grow and change. The model of psychic development occurring within a relationship, which develops over time through a process of attentiveness, emotional exchange, attunement-seeking interactions, and reflection, is hypothesised to hold good in a clinical context, and have therapeutic value for addressing emotional and cognitive damage caused by early deprivation.

The qualities of effective therapeutic intervention thrown up by the research and listed above, are all to do with relationship and process. In contrast to the treatments referred to in the NICE guidelines, the hypothesis presented through my analysis is that *therapy* with deprived children (as distinct from the day-to-day management of their behaviour) is concerned less with having a package of social and behavioural strategies to hand, and more with being emotionally alive to, and curious about, the interactions that form in therapy. This links to the view that the deficit being addressed concerns an area of mental functioning (the capacity to mentalise, process experience) rather than a skills base (area of know-how). I bring forward a systematic, empirically-based account to support the hypothesis that, with children like Simon, starting from a position of certainty about interpretations, solutions and strategies, interferes with the therapist's emotional availability, attention to the unexpected, and thoughtfulness about what is happening in the here and now. I found through detailed analysis that such a stance was often associated with disengagement, stagnation, or a battle for control between me and Simon.

Systematic analysis of clinical material thus usefully consolidates the case for generalising theories of mind arising from the study of parent-infant dyads to a clinical context, and providing intensive, long-term treatment options for a subset of very deprived children. Limiting treatment options to medication / brief behaviour management interventions may be argued on resource grounds but as the evidence accumulates, it is increasingly hard to deny that what works for this group of children, and what they need, is long-term, relationship-based therapy.

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Appendix 1

PRP

score 1(low) - 5 (high)

category

relatedness patterns are

			session 1							
			R1		R2		R3		R4	
1	Mutuality allowing freedom for (and potentially loving links between) participants	<i>d</i>	1	1	4	4	1	1	2	2
2	vengefulness, retaliation, operating by the 'law of talion'	<i>ps</i>	4	2	1	5	4	2	4	2
3	participants able to benefit from the capacities and contributions of others	<i>d</i>	1	1	3	3	2	2	2	2
4	lack of concern, use of people as things	<i>ps</i>	4	2	1	5	4	2	4	2
5	intense, univalent, black-or-white exchanges, perhaps wonderful or awful	<i>ps</i>	4	2	1	5	3	3	3	3
6	clear or subtle indications of locked-in hostility, abuse, victimisation, and/or controlled-controlling relations (eg sado masochism)	<i>ps</i>	4	2	1	5	3	3	4	2
7	genuine, appropriate concern between participants	<i>d</i>	1	1	3	3	1	1	1	1
8	capacity for ambivalence, in which the participant(s) grapple with the complexities of relationships	<i>d</i>	1	1	3	3	1	1	1	1
9	potential for forgiveness, with a tendency to seek resolution of difficulties and reparation of harm done	<i>d</i>	2	2	3	3	2	2	2	2
10	destructive envy, spoiling, devaluation and/or contempt	<i>ps</i>	5	1	1	5	4	2	4	2
	<i>self-object representations are</i>									
11	loyal, committed, 'straight'	<i>d</i>	1	1	3	3	1	1	1	1
12	narcissistic, self-preoccupied, unattuned, using others for self gratification	<i>ps</i>	3	3	1	5	3	3	3	3
13	emotionally available and caring, with recognition of the needs and wishes of others	<i>d</i>	1	1	3	3	1	1	2	2
14	able to acknowledge dependence and helplessness without overwhelming anxiety, possibly genuinely grateful	<i>d</i>	1	1	3	3	1	1	2	2
15	benign, benevolent, helpful to development	<i>d</i>	1	1	3	3	1	1	2	2
16	omnipotent, feeling no need of others	<i>ps</i>	3	3	2	4	5	1	3	3
17	persecutory, dreadful, malevolent, gratuitously nasty	<i>ps</i>	4	2	1	5	3	3	3	3
18	3-dimensional, substantial, coherent, defined and integrated people	<i>d</i>	1	1	3	3	1	1	2	2
19	betraying, untrustworthy, abandoning, deserting	<i>ps</i>	4	2	1	5	4	2	4	2
20	ill-defined, 'thin', fragmented and/or amorphous figures	<i>ps</i>	1	5	1	5	3	3	3	3
	<i>predominant affective states are</i>									
21	integrated feelings of loss and mourning	<i>d</i>	1	1	3	3	1	1	2	2
22	experiences solitude as at times rewarding and beneficial	<i>d</i>	1	1	1	1	1	1	2	2
23	intolerable frustration or sense of deprivation and/or extreme emotional 'hunger'	<i>ps</i>	5	1	4	2	4	2	4	2
24	feelings of claustrophobia and/or intrusion	<i>ps</i>	4	2			2	4	3	3
25	overwhelming depression	<i>d</i>	4	4	3	3	2	2	3	3
26	feeling gratified, enriched, satisfied or nourished	<i>d</i>	1	1	2	2	1	1	2	2
27	flooding anxiety	<i>ps</i>	4	2	2	4	1	5	4	2
28	uncontrolled rage	<i>ps</i>	3	3	2	4	2	4	3	3
29	pleasure in sustained closeness and/or intimacy	<i>d</i>	1	1	3	3	1	1	1	1
30	profound empty aloneness	<i>ps</i>	4	2	2	4	4	2	3	3
				53		106		59		65

PRP
score 1(low) - 5 (high)
category
relatedness patterns are

		session 2							
		R1		R2		R3		R4	
1	Mutuality allowing freedom for (and potentially loving links between) participants	d	3	3	3	3	3	3	3
2	vengefulness, retaliation, operating by the 'law of talion'	ps	2	4	1	5	2	4	1
3	participants able to benefit from the capacities and contributions of others	d	3	3	3	3	4	4	4
4	lack of concern, use of people as things	ps	1	5	1	5	3	3	2
5	intense, univalent, black-or-white exchanges, perhaps wonderful or awful	ps	2	4	2	4	4	2	1
6	clear or subtle indications of locked-in hostility, abuse, victimisation, and/or controlled-controlling relations (eg sado masochism)	ps	2	4	2	4	1	5	1
7	genuine, appropriate concern between participants	d	3	3	3	3	5	5	3
8	capacity for ambivalence, in which the participant(s) grapple with the complexities of relationships	d	3	3	2	2	4	4	3
9	potential for forgiveness, with a tendency to seek resolution of difficulties and reparation of harm done	d	3	3	3	3	3	3	3
10	destructive envy, spoiling, devaluation and/or contempt	ps	1	5	1	5	1	5	2
self-object representations are									
11	loyal, committed, 'straight'	d	2	2	2	2	3	3	1
12	narcissistic, self-preoccupied, unattuned, using others for self gratification	ps	2	4	1	5	1	5	2
13	emotionally available and caring, with recognition of the needs and wishes of others	d	3	3	3	3	3	3	3
14	able to acknowledge dependence and helplessness without overwhelming anxiety, possibly genuinely grateful	d	3	3	2	2	2	2	3
15	benign, benevolent, helpful to development	d	3	3	2	2	3	3	3
16	omnipotent, feeling no need of others	ps	2	4	1	5	1	5	4
17	persecutory, dreadful, malevolent, gratuitously nasty	ps	2	4	1	5	1	5	1
18	3-dimensional, substantial, coherent, defined and integrated people	d	2	2	2	2	1	1	3
19	betraying, untrustworthy, abandoning, deserting	ps	2	4	1	5	1	5	3
20	ill-defined, 'thin', fragmented and/or amorphous figures	ps	2	4	1	5	2	4	3
predominant affective states are									
21	integrated feelings of loss and mourning	d	1	1	2	2	4	4	3
22	experiences solitude as at times rewarding and beneficial	d	1	1	1	1	1	1	1
23	intolerable frustration or sense of deprivation and/or extreme emotional 'hunger'	ps	2	4	3	3	4	2	3
24	feelings of claustrophobia and/or intrusion	ps	2	4	2	4	1	5	1
25	overwhelming depression	d	1	1	2	2	1	1	1
26	feeling gratified, enriched, satisfied or nourished	d	4	4	1	1	5	5	3
27	flooding anxiety	ps	2	4	3	3	1	5	2
28	uncontrolled rage	ps	1	5	1	5	1	5	1
29	pleasure in sustained closeness and/or intimacy	d	4	4	3	3	4	4	3
30	profound empty aloneness	ps	1	5	2	4	1	5	1
			103		101		111		102

Appendix 2							
#	Session 1	memo	identifications		feelings	defences	K content
	red relates to patient, blue relates to therapist		patient	therapist		responses	
	Coming down the stairs with my earlier patient, I hear Babette's voice and find her with S in the waiting room. She is chatting to the little girl's father who holds a large baby. I say a brief goodbye and return to collect S after a further 15 or 20 mins, during which I have needed to cross the waiting room doorway a few times, going backwards and forwards.						
1	In the room, he sits and when I am sat down, says "So ... did you do anything nice over half term?" He sounds flat and uninterested. <i>I remind him that we had met on Friday and wonder if perhaps today it feels like he is back in the old routine – "back to school". I add that today feels rather different from Friday when he had come full of the meeting with his brothers and sisters the day before.</i> He gives a token nod and tells me that Fred's shed is nearly finished, just needs painting and the tools moving in. <i>I say this sounds like the process of reshuffling people round the house is now underway, in preparation for the new baby.</i> He nods with a distracted look, then says he was going to say something and now has forgotten it. <i>"Perhaps there is a feeling that I am</i>	<i>P feels displaced from T's mind and resents intrusion of w/e break - other child/baby. Awareness of something (the present disturbance) moving out of reach. Something has been lost.</i>	<i>unwanted, uninteresting child who can't keep mother's interest</i>	<i>indifferent mother, who does not hold onto him, replaces him</i>	<i>distant, pushed out, disappointment</i>	<i>minimum contact allowed. P blanks what is stirring him up - pushes it out of awareness</i>	<i>weak K. P makes uncs link to another space being prepared for a baby. Begins uncs preoccupation with framework - the shed - prelude to shift of focus to framework of therapy</i>
	<i>talking too much today?"</i> I hazard. For a few moments, I am silent while he continues to look at pains to remember something, then shakes his head, saying he can't remember it. I respond that I can see something has got lost and perhaps it feels worrying, not being able to hold onto his thought. (He feels I take something away from him?)	<i>T registers P's feeling of loss - feeling her way</i>	<i>indifferent, perhaps hostile, rejecting child</i>	<i>disappointing, inadequate mother</i>	<i>uncertain, then intrusive, depriving, disappointment</i>	<i>trying to join, explore; also defending against immediacy of P's disappointment - the current sibling rivalry with other P and baby</i>	<i>defended K- restricted by p-s identifications</i>
2	"So ... am I coming here in the summer holidays then?" he asks, in slightly aggrieved tones. As he speaks, he stands and moves to his box. <i>I reply that I have noticed this has been on his mind as he has asked me this a few times, and as I have said before, there will be a break coinciding with the school holidays.</i> "So is that it, do I never come back?" <i>I say that it isn't the end and that he will come back again in September.</i> "But you said something about it changing?" <i>I am perplexed and ask him what he thought I'd said.</i> He says it was something about meeting up until then and then having to see. <i>I respond that it is agreed that he will be coming up until the end of the year, until Christmas that is.</i> "And then what?" <i>I reply that then we will have to think about what happens next.</i>	<i>P continues expressing suspicion of T's ability to hold a space for him.</i>	<i>abandoned disappointed child</i>	<i>unavailable, unreliable mother</i>	<i>pushed out, raw. Disappointment, grievance</i>	<i>attack. Deafness to T's previous talk of holidays, evidence of thoughtfulness</i>	<i>weak K. Turning away now, out of disappointment, grievance</i>
		<i>T registers P's struggle with breaks and clarifies practical arrangements, acknowledging medium-term uncertainty.</i>	<i>hostile, threatening child</i>	<i>disappointing, inadequate mother</i>	<i>depriving, disappointed</i>	<i>focus on structure, setting. Deafness to P's vulnerability</i>	<i>Defensive K tending to concrete literal thinking</i>

Appendix 2							
#	Session 1	memo	identifications		feelings	defences	K content
			patient	therapist		responses	
3	There is a pause while he stands at the table and skids paper balls down it and into the bin. He adds a few planes, giving me a look and asking me if they are going in the bin.	P retreats to play, testing / checking T's readiness to follow him. Can T provide containment?	rubbished child or rubbish child?	container or rubbish bin mother?	abandoned, pushed out, unheld - wanting more	turning to messy play. Trying to engage T	early K - uncs exploring if T's K can receive, hold his experience? Or is T's K a rubbish bin to evacuate into?
	<i>I say that some are and some aren't. I add that I think it is very hard for him, not knowing how long he is going to be able to come here, and perhaps he thinks I'll be making these decisions without thinking about it with him, as if he'll have no say and could be just chucked out from one day to the next.</i>	<i>T registers the play but makes bid to return focus to uncertainty of therapy, and P's doubts about her commitment to holding a space for him.</i>	vulnerable, rubbish child	container mother	pushed out, deflected, rubbished	linking back to unwanted feelings, keeping minimal contact with play	K carrying traces of sado-masochistic identifications
4	His response is to round on me with a familiar question about who's the boss here, is it Mary or me or Jane? I say it's important to him to know who's in charge – he chips in to say Babette has told him Jane's in charge of one side of things, and Mary and I work on the other, so is that right?	P rejects T's redirection and signals issues of trustworthiness need to be addressed. Who's side is T on?	deceived child and anxious child	unreliable, lying parent	raw, exposed, unsafe. Punitive	testing framework, shifting to attack on T's competence, contesting control	between weak K and - K. exploration mixed with wish to expose, punish T
	<i>I say I suppose it is about people doing different things and it all working together, but I think for him, he does feel someone has to be in charge.</i>	<i>T acknowledges importance to P of someone being in charge but misses link to here and now uncertainty.</i>	hostile, abandoned child	beleaguered mother, bad mother	inadequate, under pressure	retreat to generalities	K weakens - becomes concrete, literal - then more reflective
5	He has started to add small strips of sellotape to his sellotape ball, and now I point this out and wonder if perhaps he wants me to overlook what he's doing. "Whaaat?" he says with a half laugh. I say he doesn't want to remember the agreement we had made about the sellotape. "What agreement?" I describe it again. "Well so what? I don't care anyway."	P signals feelings of alienation and hostility - no contact endures. Projects confusion: both attack but also a wish to patch up something?	tough, unfeeling, self-regarding	worthless, rubbish figure	unsafe, out of control, alienated, in pieces	controlling, contesting limits, rubbishing connection	-K. using K to attack link. Provocative "forgetting". Body thinking.
	<i>I say that again I'm thinking about all the times when people have let him down by saying they will do something and then not doing it, and that I think by breaking our agreement about the sellotape he is letting me know what that feels like. (only this time, he's not going to be the one to care).</i>	<i>T misses link to here and now, taking up P's complaint in connection with external failures, to try and repair connection with P.</i>	hostile manipulative child, and needy child	parental authority	under attack; confused. What do I take up? Attack on K? or wish to patch up?	Limit setting, then deflection	K - trying to get to know -

Appendix 2							
#	Session 1	memo	identifications		feelings	defences	K content
		red relates to patient, blue relates to therapist	patient	therapist		responses	
	He protests that in any case he's had this roll for a long time and look, it's still not finished.	P dismisses T's interpretation, justifies himself, reiterating deprivation, alienation from T/therapy.	tough, unfeeling, self-regarding	unreliable, indifferent mother	unsafe, exposed	evasive, contesting limits, rubbishing connection	-K. evading and attacking link
	<i>I say he thinks perhaps he's using it up so slowly that I shouldn't notice what he's doing with it, and there's a feeling that I'm being very unreasonable to go on about our agreement, when he is being so careful.</i>	<i>T notes P's attack and underlying sense of grievance</i>	<i>hostile manipulative child, and needy child</i>	<i>parental authority</i>	<i>under pressure to give way, stubborn</i>	<i>limit setting, holding position</i>	<i>K becoming defensive / defended</i>
	"Whatever – I don't care anyway," says S and tosses the roll of sellotape away.	Does anyone care? Caring drives you mad. P backs off from confrontation	tough, unfeeling	critical, depriving parent	cornered, hostile	backs off, breaks connection	flight from K to -K
	He gets his felt tips out of his box and stands them upright on the table like skittles. Then he uses the sellotape, rolling and spinning it into them to send them down.	P cuts off in demolishing play	tough, unfeeling	weak, critical, depriving parent	alone, rejected, useless	retreat to messy play	no K - body thinking expressing H
6	<i>I am silent, thinking. After a few moments, I say that I've been thinking that another thing different about Mondays is that it's the day when he sees me saying goodbye to another child.</i>	<i>T links P's alienation to encounter with other child at start of session</i>			<i>pushed out, rejected, useless</i>	<i>reverie, looking for connection</i>	reverie and stronger K
			<i>hurt child</i>	<i>concerned mother</i>			
7	"What???" he expostulates in tones of disbelief. "I don't even notice, why would I mind?" <i>I reply that I think it does make it very in his face, the fact that I see other children here as well as him (this feels very cruel to say), and that this can hurt.</i> "What are you talking about? Anyway, I could have left home at 5 and still been here on time..."	P denies interpretation but returns to take up comment, mentioning early arrival at start of session	tough, unfeeling but hints of vulnerable child	cruel mother or concerned mother?	exposed, raw,	renewal of contact, but move to split off, deny feelings, vulnerability	T's link accepted, then attacked. Between K and -K, touching "anyway"
	<i>I respond that added to everything else, he's had a long wait and it can be very hard to feel like you're being kept waiting.</i>	<i>T acknowledges P has had a long wait</i>	<i>hurt child</i>	<i>concerned mother, bad mother</i>	<i>more in touch, gentler</i>	<i>validating unwanted feelings</i>	K in empathic acknowledgement of uncsc link
	"No!" <i>I wonder if perhaps he was thinking, why didn't we start early, seeing he was here at 5 – and instead I'd kept him waiting.</i> "I didn't care .. I was playing on my phone.. anyway, you can't do that can you?"	P spurns T's acknowledgement, then challenges T's authenticity /availability	tough, unfeeling	cruel, depriving mother	exposed, raw,	feelings, vulnerability denied. Suspicious testing to expose T	-K. P lies to deny link, attacks T's authenticity
	<i>I agree that I can't start the session early, but I still think he may have feelings about it and it might make him angry and upset.</i>	<i>T confirms session boundaries and difficulty these pose for P</i>	<i>hostile, upset child</i>	<i>between concerned and depriving mother</i>	<i>pushed away</i>	<i>Confirm limits. re-focus on unwanted feelings</i>	<i>K edged with H, veering to punishment -K</i>

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#	Session 1	memo	identifications		feelings	defences	K content
	red relates to patient, blue relates to therapist		patient	therapist		responses	
	S gives me a pitying look.	P's suspicions confirmed. T not on his side, just pretending - really sadistic	tough, unfeeling, contemptuous	untrustworthy mother	hostile	breaking contact	H. rejection of K.
8	He carries on playing with the pens, then throws me a look: "You carry on thinking then, are you still thinking ... thinking about nothing?"	P attacks limitations of "thinking" therapist. No thing or absence is unbearable, making thought impossible	bad, rejected child, and contemptuous, rubbishing	useless, absenting parent	abandoned, rejected, hostile	attack, rubbishing, to make connection	H. attack on thinking. Envy of K. K split - projected into T.
	<i>I feel sad and say, I think that to him, it can feel that me thinking about him is like me thinking about nothing – that it can't have any value or purpose.</i>	<i>T accepts painfulness of therapy, P's hurt/disappointment with "thinking therapist"</i>	<i>hurt child</i>	<i>concerned receptive mother</i>	<i>sad, hopeless</i>	<i>interpretation</i>	<i>K</i>
	He is taking all the lids of his pens, and now throws them lidless into his box as if they too are good for nothing. He gathers the lids into the sellotape roll and jiggles them, shooting me a look and saying "Don't laugh!" <i>I say that he thinks I'm laughing at him.</i> "You are!" he says, "Like this..." putting on a cheesey grin and saying "hee hee hee". <i>I say it sounds like I can't get anything right today.</i> "Except thinking..." he says disparagingly.	P expresses hurt, feelings of rejection, being laughed at. Challenges T's sincerity	between hurt child and contemptuous	contemptuous, cruel mother	hurt, humiliated	shows hurt feeling, moving to attack, rubbish connection	Limited K - awareness of hurt, shifting to -K
9	The pen tops are thrown carelessly into the box and S goes to the little table, near where I am sitting. He grabs hold of the toy basket and then turns to ask me if the wooden cars are in it.	P looks to T for something more	helpless, needy, deprived child	withholding mother	aggrieved, deprived,	Assumed helplessness. Pushing for more	K projected into T. P splits K, disowning K in himself, looks for K in T.
	<i>I say I think he is in a better place to see than I am. "No, but are they..?" he wants to know, then turns back to rummage in the basket, complaining that they aren't there. After a few moments, he unearths the red one, then fishes out the blue and the green. I comment on him wanting me to know and find them for him.</i>	<i>T sidesteps challenge, reminds P he has resources of his own</i>	<i>demanding, greedy child</i>	<i>beleaguered mother, withholding mother</i>	<i>under pressure, pushed out of role</i>	<i>challenges P's helplessness</i>	<i>K lost - literal thinking</i>
	He pulls some fat felt tips out of the basket and tells me he can send them flying across the room, demonstrating.	P shows resentment, frustration with T's refusal to respond to his demands. Unsafe when left on his own.	rubbish, rubbished child	rubbish, unresponsive mother	angry, abandoned, deprived, unsafe	evacuates feelings in messy play. Attack on rubbish resources.	Body thinking. No K

Appendix 2								
#	Session 1	memo	identifications		feelings	defences	K content	
	red relates to patient, blue relates to therapist		patient	therapist		responses		
10	I talk about so many things getting thrown around today. He sets the cars up on the little table and starts a game, which begins with the sellotape roll crashing into them. When it goes off the table and flies across the room, he asks me to fetch it for him.	P responds to T's acknowledgement with shift to "game"		rubish, unresponsive mother, alongside more receptive mother figure	abandoned, deprived, unsafe; partly understood	destructive play. Assumed helplessness. Pushing for more	T's observation - negative capability - momentary K. P's body thinking/no K turns to projective K and simultaneous experience of loss.	
	When I don't obey,	T becomes passive - withholds help	destructive, needy child	over-demanding child	tormented, tormenting mum	withholding	back off from contact	Early K disappears, fractures
	he abandons the roll and starts smashing the cars into each other, again and again, until one or other of them is pushed off the table. Occasionally he adds a few plastic or wooden bricks. It is repetitive and empty.	P retreats to increasingly destructive play		mindless, fragmented child	mindless, unreceptive mother	angry, abandoned, deprived, unsafe	Cutting off in destructive empty play. Evacuating feelings.	Body thinking. No K (K evacuated). H.
11	I watch silently for a while. After some minutes I comment that in this game the cars are having to push each other out, and I am thinking about S talking about his brothers and sisters, how he'd been worried that they would just end up pushing and fighting and instead he'd found that they wanted to be with him and had been thinking about him. But I think today it feels so hard to hold onto that, or to feel – like on Friday – that he has a place in his own family and in Fred's family. Instead he feels he's back having to fight for it.	T tries to renew contact with P, linking play to P's conflicted feelings towards external family-loss of friendly relations		concerned, struggling mother	pushed out, attacked, helpless	reverie followed by search for connection	K	
	S continues to play, as if I haven't spoken.	P remains cut off	tormented child	mindless, fragmented child	mindless, unreceptive mother	angry, abandoned, deprived, unsafe	Cutting off in destructive empty play. Evacuating feelings.	Body thinking. No K (K evacuated). H.
	There is another pause while I register just how much I am feeling pushed out by him. I venture another comment, saying that I think he wants me to know what it's like to be dropped out of mind.	T registers feeling of rejection and interprets P's wish to make her experience what he feels, seeing another child, losing a session		tormented, tormenting child	concerned, struggling mother	pushed out, attacked, helpless	Looking for connection, linking play / feelings to P's experience in session	K
12	"What do you mean?" he wants to know. I talk about him playing on his own today, perhaps telling me that he's fine on his own, I'm to feel that he doesn't care if I'm sitting in this chair or not, I'm no use to him. "Yeah why don't you go and sit in that chair over there," he responds.	P renews contact to express his ambivalence	needy child alongside contemptuous child	stupid, rubbish mother alongside more receptive mother	still angry, conflicted	renewed contact is attacking denigratory	weak K, confused by - K under burden of H and E.	

Appendix 2							
#	Session 1	memo	identifications		feelings	defences	K content
	red relates to patient, blue relates to therapist		patient	therapist		responses	
	I say I wonder if this has something to do with him seeing me with someone else, feeling dropped out of my mind and kept waiting. And I'm also thinking that perhaps I didn't pay enough attention to the fact that he had to miss his Thursday session last week. (This all feels unhelpfully muddled in my own mind – as if I'm thinking out loud - and I wonder if it's better not to have said anything).	<i>T recalls several reasons for P feeling dropped</i>	tormented, tormenting child	Beleagured, defensive mother	pushed out, retaliatory, guilty	Looking for links turns defensive, producing muddle.	struggling fragmented K mixed with -K
13	S 's cars and bricks are now being shoved and thrown into the window sill. I say they are close to the window, then watch until one bangs into the glass and say "Simon ..." in warning tones.	P's play gets more destructive, risky	destructive, mindless, fragmented	rubbish mother	angry, out of control, at risk	evacuates feeling in violent, risky activity. Looking for boundary	Body thinking. No K (K evacuated). H.
	He says "sorry" and	<i>T sets boundary</i>	tormented, tormenting child	Beleagured, defensive - turning strict parent	rattled	sets boundary, closes down, accusatory	concrete thinking, verging on no K
	when I don't hear this and repeat that he may not throw things at the window,	P's acknowledgement of boundary is ambivalent	misjudged child	rubbish mother	picked on, angry	closes down, accusatory	the lie again? -K
	tells me "I said I'm sorry", reproachfully. He tosses the bricks carelessly into the basket on the window sill behind him, without looking where they go. Then he returns to the car-bashing game, tearing up one of his paper planes to make a score sheet, dropping the remaining pieces carelessly on the floor.	<i>T misses acknowledgement and repeats boundary</i>	tormented, tormenting child	Beleagured, defensive - turning strict parent	rattled	stresses boundary, controlling, unrecitative	concrete thinking, verging on no K
	There is a brief turning towards me, when he pushes the score sheet across to me, with the pen, but when I don't immediately respond he takes them back again.	P shows grievance with unreceptive T; continues aggressive play, but modified to reduce risk	misjudged, destructive child	rubbish mother	picked on, angry	returns to evacuate feelings in messy play. Rubbishing	-K, turning to no K, body thinking
		P again bids to connect with T through play but when T resists, retreats again to solitary play	deprived, abandoned child	rubbish, unresponsive mother	angry, needy	controlling test for contact, then cutting off in solitary play	looking for K in T? collapses into no K
14	As the cars spill off the table, I occasionally retrieve the ones which land near me. I think to myself about S feeling like one of these fighting jostling cars and needing me to pick him up. Out loud I say that there are times when I think he wants me there to pick up the pieces, but this can sometimes turn into making me into a rubbish collector.	<i>T registers feeling trashed, controlled and links to P's demands for a mummy T to tolerate his aggression and repair damage</i>	tormented, tormenting child	concerned, struggling mother	attacked, pushed out, controlled, sad	partial scaffolding of play, looking to repair contact; interpretation of angry needy feelings in play	K
	The cars swing from fairly controlled nudging and jostling, to violent and dramatic clashes which clear the table.	P's play grows more violent	destructive, mindless, fragmented	rubbish mother	picked on, angry	evacuates feelings in violent play	between looking for K and attacking K in T. Body thinking
	I talk about noticing the violence in his play today and	<i>T observes the violence in P</i>	tormented, tormenting child	concerned, struggling mother	kept out, impotent	keeping contact with observation	K

Appendix 2							
#	Session 1	memo	identifications		feelings	defences	K content
	red relates to patient, blue relates to therapist		patient	therapist		responses	
	this stirs him to ask me what I mean.	P challenges T's observation, keeps contact going	needy child alongside destructive child	critical parent	prickly, suspicious	keeps contact going	renewal of K
15	<i>I describe how things are being thrown around the room with so much force. After another pause, I add that perhaps he is feeling very angry with me and this feels like it cannot be said in words (or thought about).</i>	<i>T links to P's anger with T and difficulty thinking about this</i>	tormented, tormenting child	concerned, struggling mother	barely tolerated, sad	add to observation with interpretation, linking activity to P's anger	K
	S reels off a string of numbers, saying sarcastically: "There you are, I've said it in numbers." He glances at the clock, saying "ten minutes." I agree that we have ten minutes left and I notice he is keeping his eye on the time today. He parodies this, with ostentatious glances at the clock every few seconds, then shoots me a look saying "you've still got to tell me when to stop, you know."	P shows conflicting urge to demolish T, keep T available, and links to approaching end of session.	destructive, fragmented, needy	contemptible, absenting parent along with needed parent	angry, raw, precarious feelings about ending	sarcasm, attack on T, controlling	-K swinging to K, then projection of K into T
	<i>I agree that I do need to tell him when it's time and he knows this, but I think he still feels very thrown out when I tell him</i>	<i>T interprets P's feelings of rejection, abandonment around session boundaries</i>	tormented, tormenting child	concerned, struggling mother	attacked, pushed out, controlled, sad	confirming limits, her autonomy, linking to P's difficult feelings	Restricted K
16	He continues playing with the cars up until the last couple of minutes, when I tell him it is time to clear up now. He says he just needs to finish this match and find out who the winner is, anyway there isn't any clearing up to do.	P retreats again to play, in bid to control ending	deprived, abandoned child	unfair, depriving, abandoning mother	pushed out, deprived	cutting off, controlling	-K, attack on T's K, E of container?
	<i>I remind him there are things to sort out in his box. When he doesn't respond, I repeat that it is time to stop, and when this is ignored, get up and move to the table, putting the felt tips in his box back together.</i> Behind me, he tries to get me back, saying "Emily, here's the final score." <i>I feel cross with him and continue sorting his box.</i>	<i>T asserts session boundary. Registers anger with P but unable to interpret</i>	hostile, tormenting child	strict retaliatory parent	pushed out, irritable	asserting boundary, taking charge	collapse of K into controlling, concrete thinking
	He comes over, saying "so it's time to go, is it." <i>I repeat that it is time to go.</i> "OK then, goodbye," he pulls a piece of paper out of his pocket, dropping it on the table – it is his scrunpled score sheet. I go with him to the door, where he turns and says goodbye again and that he will see me next week. <i>I return the goodbye, saying that our next session will be on Thursday.</i> "Same thing," he says, repeating his goodbye as if trying to mend something between us.	P displays conflicting wish to keep T available, together with urge to trash therapy.	between needy, deprived child and destructive, heartless figure	rejecting, depriving parent	pushed out, anxious, angry, rubbished	evacuating feelings in messiness, fragmenting confusion of approaches and rebuffs.	looking for K in T, but turning to -K and no K under pressure of ending

Appendix 3

#	Session 2	memo	identifications		feelings	defences	K content
	red relates to patient, blue relates to therapist		patient	therapist		responses	
1	S arrives on time with Derek. He is a moment following me into the room, where he greets me. He says he missed his breakfast today as there wasn't any time. I ask about this and he tells me he didn't wake up until 7.40 – ten minutes before Derek arrived to collect him. He had been watching I'm A Celebrity the night before and had slept through his alarm ... nobody else had woken him. He has gone behind my chair to look out of the window, sort through things in the toy basket. Now he comes back with a load of pens in his hands. He sits at the big table and looks over at me. "So how are you this morning ... are you tired?" I comment on the hurry for him and wanting me to know he is feeling tired, along with also checking up on me .. am I in the same state, tired like him?	P is not sure he is ready for change / T/ live relationship. Uncsc link to hunger (missed breakfast) and abandonment (no-one to wake him). Wish to hold on to the familiar (Celebrity, pens). Problem with being a celebrity - only bad celebrity familiar - could he be a different celebrity - eg celebrated?	deprived child mixed with curious, concerned child	depriving figure mixed with interested, tolerant figure	friendly, curious, with traces of habitual grievance - ready if needed	registering change, exploring own and T's state of mind. Keeping old defences available	K
		T signals openness to P and P's wish to find out where they both are today	tormented, tormenting child	interested, receptive parent mixed with beleaguered parent	friendly, curious, some wariness	exploring, reflecting	problem of how to stay open to the new..? T as new therapist, mother - rushing to identify P's states of mind - memory and desire foreclosing on space for uncertainty, not knowing, newness, development
2	S says he made a mistake yesterday – it's the Friday session he wants to drop, not the Thursday one. "What do you think about that then? Do you think we should do that?" I ask what the thinking is behind this change of mind. S says it's so he doesn't have to miss school. I say it sounds like deciding which session to drop is being difficult for him, today there's the thought of Friday's missed school, missed breakfast, missed sleep – yesterday he was talking about missing out on Thursday on time with friends. It's like he really feels in two minds and wants to turn the decision over to me at some level. It also seems to be hard for us to think about what might be lost by dropping to two sessions a week....	Uncsc link - change brings vulnerability to loss - the dropped session. P continues to investigate T's availability - can the T think about his needs - does she want him or not?	tough boy who doesn't need anyone	rejecting therapist, becoming rubbish therapist	vulnerable, wary, curious	exploring; dilemma posed by change, attraction of habitual defences - omnipotent control of loss, vs denial of responsibility/ evasion of loss	K and interest in T's K. Exploration vying with tendency to splitting, projection of K. P acknowledging he has made a mistake - has more than 1-dimensional mind - can be in and out of touch with self/reality
		T acknowledges difficulty of dropping session - seeks to clarify the underlying preoccupation - is a loss involved? Missed (?) opp to explore what is experience of missing something?	volatile, avoidant child	reject therapist	friendly, curious, some wariness	exploring, reflecting	

Appendix 3

#	Session 2	memo	identifications		feelings	defences	K content
			patient	therapist		responses	
3	S mentions he's got loads of paper today. He is speaking in a rapid slurry way which I find hard to make sense of. After I've checked one or two word with him, he responds jokingly: "What's wrong with you today, have you gone deaf or something?" I agree that it does seem that I'm having trouble hearing him. S responds with a yawn and a stretch, "it's probably me that's the trouble really." I say perhaps it is something we both share in, then, he's finding it hard to speak and I'm finding it hard to hear ...?	P backs away to focus on what is concretely available. Avoiding bringing loss into focus. Signals awareness of resource - thinking? - which is usually in short supply	lost, vigilant boy, becoming boy with a mind, vulnerable boy	important figure but hard to reach, ambiguous between good and bad.	vulnerable	backing off	turning away - suspending K link with T
		T flounders to stay in contact			lost, uncertain,	reflecting, open to what could be happening	
		P complains about T's failure to stay with him	confused, vulnerable boy	confused parent who can't understand	lost by T	relecting	K
		T agrees it is a shared problem			lost	owning uncertainty, responsibility	
		P acknowledges his role in obstructing communication			accepted	owning uncertainty, responsibility	K
4	S nods and laughs. I think about him switching from talk about the session we are going to lose, to the thought of having more paper than usual. Perhaps it is hard to stay thinking about what is going to be lost and what this might mean to him. He says he's going to write down .. I can't catch what comes next .. and he's going to take it away with him at the end of the session. This, said with a challenging look at me. As I begin to respond, he says OK then, he'll write it down on a piece of paper he's brought in his pocket. I grasp that he is talking about writing down the pros and cons of dropping the Thursday or Friday session. I say it sounds like he really feels the only way he can hold onto his thoughts is to put them onto a piece of paper which he can carry away with him. He doesn't trust himself to be able to carry them away in his head. He has drawn his school timetable out of his pocket and is now studying it. I make a link to him needing to carry the timetable around with him, to know where he's meant to be.	T invites P to return to theme of lost session - misses signal of fresh resources	deprived boy who can't hold onto good things	tormenting figure - possessing / stressing what he lacks	friendly, curious	exploring	
		P signals his mixed feelings about thinking - part going along with T; part resisting / showing himself as someone unable to hold onto thoughts. Wish to keep thoughts and take away thinking part of self, mixed with old envy, jealousy, wish to challenge T.			curious, wary, vulnerable	between exploration and evasion, diversion	K vying with wish to suspend K
	He starts reading through it, linking initials to the names of teachers and trying to get me to guess which names go with which initials. I suggest he wants to get me into a game .. and also perhaps he wants to get me into school, or school into here ..	He makes counter-proposal of game - wish to play with T - stay in friendly contact, protect contact from threat of his envy.	provoking child mixed with needy, dependent child	exasperated parent mixed with concerned parent			

Appendix 3							
#	Session 2	memo	identifications		feelings	defences	K content
	red relates to patient, blue relates to therapist		patient	therapist		responses	
	S agrees, he wants to play a game, will I play with him ... a lovely pen game? I comment that he wants to turn away from this conversation, it feels much easier to focus on concrete things like breakfasts and paper and pens, than less tangible things like the relationship between us, and how this might be affected by the change ... S stands up and tells me to guess how much money he's got with him today – he'll give me a clue, look – and he places a heap of coins on the arm of my chair. If I guess right, I can keep the money. I say this is his way of trying to get me into a guessing game with him so we don't have to go on talking about something getting lost – there seems to be an old idea that he can bribe me to play along with him?	T mirrors P's ambivalence - misses ambivalence in P's proposal of game - tries to bring P back to K and theme of loss with series of interpretations	aggressive, needy child vying with friendly playful child	depriving therapist vying with friendly, accommodating therapist	kept at arm's length	checking, challenging. Foreclosing. Retreat to familiar	restricted K - T's wariness of P interferes with capacity to explore P's idea of game. T reverts to familiar interpretation at cost of holding space for something new
5		P shows he is not interested in T's offer - repeats his counter-proposal, "buying off" K, or signalling need for more primitive K. Money also an indication of resources P has brought with him. T misses this potential, picks up on negative. Thinking / negotiation collapses into struggle for control.	controlling boy in fear of hurt	restraining therapist / parent	vulnerable	back off, play used to divert, corrupt K; signal infantile condition; retreat to omnipotent control	Only infantile K possible. Place of repetition in infant-mother play - framework for surprise, new experience - Stern. T out of step with P's infantile condition? Premature insistence on more advanced thinking?
6	"Yes, and you've taken the money so now we can play!" He wants to play I Spy. I say I'm not going to join in the game. He rushes on to the thought of a story game – he will write down lots of words and give them to me to make a story with. I say something about him not wanting to think about our story but he is already scribbling down words. He hands me the sheet and I say again, gently, that I am not going to join him in turning away with a game. S begins to write as if taking dictation, copying down what I say. I suggest there's an idea around that anything he or I says is going to be exposed to ridicule. S switches to playing the teacher who is setting me a test. It's a maths quiz. He calls out the questions, saying he will only repeat them once,	P gets more manic in efforts to take charge, and impose terms, dictate interaction. wish to take over T's mind - merge?	controlling boy fearing loss of object	elusive, separate, independent object	vulnerable	omnipotence - blanking loss / difference? merging?	what do you call -K when more directed to merging than to breaking link with other? Primitive K operating through projective identification?
		T opposes P with repeated interpretations and refusals to follow P's lead in substituting action for thinking.			courted	checking, challenging, exploring	Premature insistence on more advanced thinking. Baby's need for holding - can't manage premature separation
	moving on to the next question regardless of my lack of response. I comment on him becoming the teacher and me the pupil. "Yeesss!" he says. I wonder about teachers and the role they occupy – they are the ones who take charge and tell people what to do – perhaps this is what's going on here, he is taking charge, I'm to do what I'm told.	P overrides T, forcing on with game regardless. Perhaps also signal of his need for T to pay attention, stop being the one who knows!			vulnerable	omnipotence - blanking loss / difference? merging?	-K? wish to push K into -K? Or projective identification K? brief projecting his own K into T (she has to think of the answer), collapsing into further projective identification / attack on K (play derailing thinking). Experimentation also - can T's K survive P's attacks? Are there opportunities where it could go the other way? T could have taken up infantile need to tell the story for P...

Appendix 3

#	Session 2	memo	identifications		feelings	defences	K content
			patient	therapist		responses	
	red relates to patient, blue relates to therapist						
	S agrees with emphasis. He starts checking the answers to the quiz, challenging me for the answers. "What's 7 x 7?" I say I think this is something he can work out. "But I don't know..." I talk about his fear of making a mistake which gets in the way of him having a go. S continues through the quiz, now wanting me to confirm his calculations. "7 x 7 is 49, isn't it?" I agree that sounds right, and say something about how he distrusts his own capacity to sort out problems and get to the answer.	T partially concedes, responding to P's pressure for answers, but adding interpretation of P's avoidance of thinking. Fear of making mistakes gets in the way of P's thinking - uncsc mirrored by T. Limits of P's hope of a K object played out by both P and T.	avoidant, controlling child becoming needy child	restraining therapist / parent becoming concerned, tolerating need	controlled	hold back, checking, exploring	getting more together with P's state of K; T's fear of making mistakes (as new therapist) has also been getting in way of her remaining open to P, exploring P's conflicts with open mind. T's "getting to know" state of mind getting cramped by anxiety to get it right
7	He is marking the table and accidentally-on-purpose jiggling the desk drawer open. I say his name, warningly. "Whaaa?" he laughs at me. I say playing with the drawer means we'll have to stop .. it's like now he is making me into the teacher .. he feels we have to keep swapping this role backwards and forwards.	P pushes T to step out of role, abandon thinking; also shows T that he can't manage on his own.	controlling needy boy	elusive, separate, independent object	kept at arm's length, vulnerable	invading	K link gives way to physical enactment; no K; body thinking. All K evacuated
		T takes charge, sets limits, and then interprets P's wish to replace thinking with battle for control	controlling needy boy	containing therapist - mix of understanding and restraint	manipulated	takes charge; physical checking; exploring	frees P up for ordinary curiosity in next episode
8	S starts talking about the cars outside, sounding like a detective. He reckons I must own the Subaru because that's the only car there which was there at this time the week before. He is surprised – this is a "bad boy racer" car. I ask what kind of car he thinks I should have? He suggests a small Peugeot – something not very fast. Something slow and reliable, I query? S agrees with a grin. He wants to interpret my response to mean that the Subaru is my car – "see, you just confirmed it when you said..." I comment that he's got these little pieces of information and he is trying to get them to join together to get a much bigger answer. He laughs and mentions that he saw someone on a bike the other day – it was Babette going up the hill – he'd never seen her on her bike before, she looked tired. I talk about him seeing her on other business – a part of her he doesn't usually see.	P switches to alternate, less oppositional theme. He is surprised and made curious by T's unexpected speed, potency.	curious boy mixed with deprived boy	containing therapist mixed with withholding, evasive therapist	kept at arm's length;	exploring as means for gaining access - edged with invasive purpose	return of k, features element of surprise
		T follows P's lead to explore further				exploring	
		P shows awareness of T and Dom as real and separate people. Can acknowledge his curiosity about what is off limits.	curious boy mixed with deprived boy	curious therapist	accepted	exploring	K
		T interprets P's wish to understand, see, have, what is beyond his reach			in touch	exploring	

9	S says he's hungry, can't he go and get something to eat or fetch a drink. I say that he needs to wait until the end of the session. He comes over to the cushions beside my chair, grabbing a blanket and saying that he's going to sleep now – bye. He curls up on the chair across the room, as I comment on his wish to sleep through the last bit of the session. He talks about wishing he could go to the kitchen and put something in the microwave – the microwave would say "hello".	Contact brings uncsc link to loss, hunger. Wants to blank out K contact, go back to safer place. Turning from human contact to robot voice.	needy boy mixed with avoidant boy and fed boy	elusive, separate, independent object mixed with nourishing object	vulnerable	back off, like baby turning away from mother when contact risks getting too intense?	Active K suspended - digestive K - pause to digest
10	I wonder if this has something to do with his wish for a world of talking machines. S starts talking in a robotic, dalek voice. I am not to confuse him for a human being, he says – robots aren't human and don't like being muddled up. I ask what robots do, what makes them different from humans? He replies that he cooks, cleans, drives .. as I begin to say these all sound quite human, he adds that he can write a dictionary in a few minutes, and that robots don't have feelings, they aren't curious. He follows this with a robotic question and I point out that it sounds like this robot is curious after all. S says robots aren't alive, they are just a jumble of metal parts. He reels off a robot identity number, then adds "aka Simon". I ask what they are, if they aren't alive? He hesitates and then says robots are dead. I talk about them being neither alive nor dead, perhaps? S says he is going to sleep until Monday. I think about him wanting to sleep his way over the weekend break, until his next session.	T interprets his wish to replace human with robot world, inviting P to stay in touch.	lively engaging child, very young child	receptive, responsive parent	in touch	alert, explore	
		P begins play with robot identity. Word play. Exploring conflicting feelings - wish to kill off curiosity, feelings, but impossibility of this.			in touch, accepted	play, explore	lots of K! play and talk is exploring himself and his link to T. Ending with another break / rest from K.
		T accompanies P's exploration, moving between play and interpretation, putting words to conflict: his wish to be alive, potent, without feeling; to deny separation and feelings that go with it.	lively engaging child, very young child	playful, responsive maternal figure	in touch	play, explore	ref Strachey - mutative interpretation - and relationship to P's insight
11	I call him "aka Simon" and S switches to being another robot, feigning ignorance of its predecessor – "Who said that? Who is aka S?" I suggest this robot has wiped its memory as S does too, sometimes, denying he's ever had a certain thought or an experience we've shared gets obliterated. "No" says the new robot S, repeating this to each of my comments. I tease him about becoming a "No" robot, a one-word machine. We play with "no" and "know". I wonder if there's also a wish to be someone who doesn't – can't – make mistakes...?	T takes up and plays with P's words	lively engaging child, very young child	playful, responsive maternal figure	in touch	reverie, alert, explore	
		P develops play to symbolise robotic drive to expel thinking, memory, shared experience.			in touch, accepted	play, explore	ready for more K
		T interprets play as symbolising P's way of splitting up his mind			in touch	play, explore	
		P plays at blanking T	lively engaging child, very young child	playful, responsive maternal figure	in touch, accepted	play, explore	K
		T joins play on words - meaning expanded back and forth between P and T.			in touch	play, explore	the link between K and mind able to detect its own mistakes

Appendix 3							
#	Session 2	memo	identifications		feelings	defences	K content
			patient	therapist		responses	
		red relates to patient, blue relates to therapist					
12	I have a sudden thought that S has placed the baby doll on the back of my chair – the baby doll has only recently arrived in the toy basket and he did this in a previous session. I think back to when he was looking out of the window at the beginning of the session and going through the toy basket. I stand up to look behind me and sure enough, the doll is lying along the top of the chair cushion. S asks me what I'm doing. I collect the doll, saying I had suddenly wondered if it was lying behind me, and sit back down with it on my lap. S laughs and abandons his robot persona. He comes across to take the baby from me, alternately shaking / thumping it and showing it precociously walking and dancing.	T becomes aware of forgotten baby doll - split off baby P - and signals this to P: she is ready and waiting to play with baby P.	lively engaging child, very young child	attuned maternal figure	in touch	play, explore. Owning uncsc contact with P	enhanced K in T
		P drops robot persona and joins T in play with baby doll, showing his mixed aggression and tenderness towards it	lively engaging child, very young child	attuned maternal figure	in touch, understood	further joining, development of play	K
13	He glances at the clock and asks me when I realised it was stopped? This was a reference to the Thursday session when he had taken it down and fiddled with it. Now S acknowledges he had removed the battery. I talk about his wish to sabotage the clock. S denies this – it's not sabotage, sabotage is when you throw something across the room and destroy it! I question this, saying sabotage can also be quite subtle – like when games and sleep and can be used to sabotage his session time. . .	P becomes aware of time - the coming end of session - and talks about what he does to stop it / his awareness of it. Baby P's wish for timelessness	lively engaging child, very young child	attuned maternal figure	in touch, understood	explore	K; exploration of T's mind - separate from his own but linked
		T links to his different ways of attacking his resources	controlling, devious child, hostile	beleaguered therapist	in touch	explore	
14	We begin a bantering exchange around the "aka" label. I say "aka Simon" a few times, playing with the sound of it, hearing it take on the sound of a pet name for a loved child. S laughs and plays along, first testing that I know what aka means, then picking it up to talk to "aka baby" doll. I notice his mix of tenderness and aggression with aka baby. I apply it to some of the things he does and says – "lets play a game – aka I don't want to think about that." Somewhere in the middle, S says "It's funny, you know, but I don't feel hungry any more." I suggest perhaps he has filled up on something in here today – a different sort of meal has been enjoyed.	Further play with baby P - T and P share tenderness towards baby. T interprets baby's need for relief when thinking gets painful. Hunger was in mind not in tummy.	lively engaging child, very young child lively engaging child, very young child, needy child	attuned maternal figure attuned maternal figure	in touch	explore	K
15	S starts to ask the time – how much longer have we got. I interpret this as "aka, I don't want to be surprised by the ending ... I want to be the one who says it's time." It is time and S says goodbye, telling me to "look after aka baby."	P signals awareness of time running out and questions how much longer?	very young child, needy child very young child, needy child	attuned maternal figure attuned maternal figure	in touch, aware	explore	K
		T interprets P's wish to avoid pain by preparing himself and taking charge.			in touch	explore	
		P able to stay in touch and leave baby self provided for.			in touch, understood	accept	K

Appendix 3							
#	Session 2	memo	identifications		feelings	defences	K content
	red relates to patient, blue relates to therapist		patient	therapist		responses	
16	I hear him and Derek going downstairs. A minute later, as I am putting things away, there's the sound of feet running back up the stairs and then a knock on the door. S doesn't wait but pushes his way back in, saying he's left his money behind – where is it. I remind him he put it away in his pocket. "But it's not there!" I add it was his shirt pocket. S feels and finds it. "Thanks" and is gone.	After leaving, P's deprivation, suspicion resurfaces - thinking goes - and T's reassurance is needed. P experiences something valuable to him being lost - the separation from T - and because of projective processes, this is also loss of thinking P	deprived child	lost mother mixed with bad mother	lost	panic push for physical reassurance	K giving way under pressure of separation. But P's anxiety can be allayed, reassured..

Appendix 4

Q-Set sort on Sessions 1 and 2 – ratings by ER and CS Aug/Sep 2010

Session 1

Negatively salient

Good or partial agreement as follows:

T	therapist directly rewards desirable behaviour
C	Child is compliant
C	Child is curious
C	the quality of child's play is fluid absorbed
C	child communicates without affect
C	child struggles to control feelings or impulses
T	therapist offers help or guidance (P)
T	therapist's remarks are aimed at encouraging child's speech (P)
C	child ignores or rejects therapist's comments and observations (P)
T	therapist's interaction with child is sensitive to child's level of development (P)
C	child achieves a new understanding or insight (P)

Variance:

therapist self-discloses (ER 1; CS 4)
child is clear and organised in verbal expression (ER 1 ; CS 7)
there is focus on helping the child plan behaviour outside the session (ER 2; CS 5)
real rather than fantasized meanings of experience are actively differentiated (ER 2; CS 5)
child engages in make-believe play (ER 2; CS 5)
humour is used (ER 2; CS 6)
there is discussion of why child is in therapy (CS 1; ER 5)
therapist's remarks are aimed at encouraging child's speech (CS 1; ER 4)
child feels shy, embarrassed (CS 2, ER 5)

Positively salient

Good or partial agreement as follows:

T	therapist comments on child's non-verbal behaviour
C	child does not feel understood by therapist
I	therapist interprets meaning of child's play
C	child appears unwilling to examine thoughts, reactions, motivations re problems
C	child is active
C	child expresses negative feelings towards therapist
C	child is provocative: challenges the therapist or rules / boundaries
C	child is competitive, rivalrous with therapist
C	child has difficulty leaving session (P)
C	child expresses anger or aggressive feelings (P)
T	therapist sets limits (P)
I	interruptions, breaks, or end of therapy are discussed (P)
T	therapist makes explicit statements about end of hour, weekend, holiday (P)
C	child attributes own characteristics or feelings to therapist (P)

Variance:

child feels wary or suspicious (ER 8; CS 3)
child is demanding (ER 9; CS 4)

Session 2

Negatively salient

Good or partial agreement as follows:

T	therapist self-discloses
T	therapist is directly reassuring
T	therapist is non-responsive
I	real rather than fantasized meanings of experience are actively differentiated
I	There is focus on helping the child plan behaviour outside the session P
C	child's play lacks spontaneity P
C	child is clear and organised in verbal expression P
T	therapist acts to strengthen existing defences P
C	child does not feel understood by therapist P
T	therapist actively exerts control over the interaction P
T	When the interaction with the child is difficult, therapist accommodates child P
I	child's recurrent or recent life situation is emphasized P
T	therapist is judgemental and conveys lack of acceptance P
T	therapist attempts to modify distortions in child's beliefs P

Variance:

child explores relationships with significant others(ER 2; CS 5)
the quality of child's play is fluid, absorbed (CT 2; ER 7)
child feels wary or suspicious (CT2; ER6)
child feels inadequate and inferior (CT2; ER6)

Positively salient

Good or partial agreement as follows:

T	therapist is sensitive to child's feelings
C	child is curious
T	therapist accurately perceives the therapeutic process
T	therapist interprets warded-off or uncsc wishes, feelings or ideas
C	child is animated or excited
C	child is demanding P
T	therapist points out child's use of defences P
C	child draws therapist into play P
C	child is active P
I	material of the hour is meaningful and relevant to child's conflicts P
C	child has difficulty leaving session P
C	child is competitive, rivalrous with therapist P
T	therapist makes explicit statements about end of hour, weekend, holiday P
I	therapist and child demonstrate shared vocab or understanding re events/feelings P
T	therapist sets limits P
C	child engages in make-believe play P
T	therapist tolerates child's strong affect or impulses P

Variance:

therapist clarifies, restates, or rephrases child's communication (ER 8; CT 3)
therapy relationship is discussed (ER 8; CS 5)
therapist tolerates child's strong affect or impulses (CT 8; ER 5)
child attributes own characteristics or feelings to therapist (CT 8; ER 3)

session 1	Session 2
Features of the child's emotional states , behaviour, experience	
<p>The child does not seem to exhibit deferential or compliant responses or behaviours. Lacks interest in his surroundings, or in understanding something or someone better. Shifts from one activity to the next without a sustained focus in such a manner that no activity develops into something that can be understood or followed. Expresses different affects through voice-range, make-believe characters or postures.. Does not appear to make an effort to restrain or regulate feelings he is experiencing. <i>Responds to his therapist's remarks with play, comments or associations. Resists looking at issues from a new perspective, or vantage point.</i></p> <p>He conveys the feeling of being misunderstood by his therapist. He resists examining his role in perpetuating his problems, avoids, blocks and repeatedly changes the subject whenever a particular topic is introduced. He is quite talkative and mobile. He expresses feelings of scorn, anger and antagonism towards his therapist. Behaves and speaks in a manner aimed at provoking the therapist or challenging the apparent rules and boundaries of the therapy hour. Seems competitive with the therapist. <i>Resists the end of the session, prolongs discussion and play when end of the hour is announced. Expresses resentment, anger, bitterness and aggression. Attributes desirable or undesirable characteristics of feelings to the therapist that appear to be reflective of the child's sense of self or state.</i></p>	<p><i>Child's play is imaginative, lively and child generates new ideas. He rambles and frequently digresses. Child conveys sense that the therapist understands his experience or feelings. He exhibits curiosity and interest in surroundings and the thoughts, feelings or behaviours of the therapist. He appears excited and animated. He makes numerous demands/requests of the therapist and pressurises her to meet his requests .Child actively includes therapist in his play. He is talkative and mobile. He shows difficulty leaving the session, prolonging the play/discussion when the ending is announced. He is competitive with the therapist. Child plays imaginatively and symbolically.</i></p>

session 1	Session 2
Features of the therapist attitudes and actions	
<p>The therapist does not attempt to shape or reward behavioural changes. <i>She does not offer help or instruction when asked for help by the child. She does not actively encourage the child's verbalisations. Her comments are above or below the child's apparent level of development.</i></p> <p>She draws attention to the child's non-verbal behaviour. <i>She defines parameters regarding the behaviour or actions of the child. She alerts and prepares the child for the approaching separation.</i></p>	<p>Therapist refrains from self-disclosure even when child presses her to do so. She tends to hold back from providing direct reassurance when the child evidently anxious or upset. Therapist is responsive and affectively involved during interactions with the child. <i>She does not shore up defences or suppress troublesome thoughts or feelings. She intervenes relatively infrequently, follows the lead of the child by allowing him to introduce main topics, or to structure his own play. She does not exert an effort to improve matters, or to soothe the child when the interaction becomes difficult. Therapist refrains from overt or subtle negative judgements of the child. She accepts child's distortions without comment or challenges to child's stated view, when thoughts or ideas are incomplete or implausible.</i> She is sensitive to the child's feelings and can communicate this understanding in a way that seems attuned to the child. Therapist conveys an accurate assessment of the child's experience of the therapy relationship. She draws the child's attention to feelings, thoughts, or impulses that may not have been clearly in the child's awareness. <i>Therapist identifies the way the child wards off awareness of threatening information or feelings. She alerts and prepares the child for approaching separation. She defines parameters regarding the behaviour or actions of the child. She allows expression of strong affect without modification either verbally or through action.</i></p>

session 1	Session 2
Nature of the interaction	
The therapist clarifies , explains the meaning, or conveys the significance of the child's play. <i>There is talk about the interruptions and breaks in treatment.</i>	Neither therapist or child focus attention distinguishing between fantasy and reality when such distinction is unclear. <i>The therapist refrains from guiding child in the planning of his behaviour despite requests or pull from the child to do so. Discussion of current life is actively avoided in discussion or play. The material of the hour is importantly related to the child's psychological conflicts. Child and therapist use idiosyncratic or unique words in a similar manner.</i>

Appendix 5

Diagnostic features of ADHD

ADHD is defined by DSM-IV and ICD10 as combining three central features – Attention Deficit, Hyperactivity, and Impulsivity. Each of these categories has corresponding diagnostic criteria, a number of which must be present in the child, as Orford summarises:

“ The criteria (of attention deficit) include such characteristics as carelessness, difficulty in carrying out instructions, difficulty in organising tasks, avoidant behaviour, distractibility, forgetfulness and losing belongings. The characteristics of hyperactivity include: fidgetiness, inability to remain seated, excessive activity, difficult in sustaining leisure activities and play, being ‘on the go’ and talking excessively. Impulsivity includes answering questions before they are asked and difficulties in waiting and interrupting. Six of these criteria must be met for six months and in all aspects of the child’s life for an ADD/ADHD diagnosis to be reached.” (Orford 1998: 255).

Four core deficits of the condition were identified by researchers at McGill University during the 1970s, comprising:

“(1) deficits in the investment, organization, and maintenance of attention and effort; (2) inability to inhibit impulsive responding; (3) inability to modulate arousal levels to meet situational demands; and (4) an unusually strong inclination to seek immediate reinforcement” (Barkley 1990: 14). Gilmore (2000) observes that early predictors of the condition can be found in two regulatory disorders in younger children, identified by “difficulties in regulating behaviour and physiological, sensory, attentional, motor or affective processes, and in organising a calm, alert, or affectively positive state” (DC: 0-3). The regulatory and organisational character of the difficulties led Gilmore to identify them as belonging in the province of ego development, since these functions are widely regarded as ego tasks. Jones (2002) further summarises a range of associated difficulties, noted in the research literature: “Children with ADHD exhibit a wide range of problematic academic and interpersonal deficits, including poorer social skills (Merrell & Wolfe, 1998) and difficulty with empathy (Braaten & Rosen, 2000), than do children without this problem. It has also been reported that noncompliance, interpersonal friction with adults, peer rejection, aggression, and school problems are associated impairments related to ADHD (Melnick & Hinshaw, 2000).”

Appendix 6

1. Letter to patient explaining research (similar letters to carers)

Emily Ryan
Child Psychotherapist

Tel

Dear,

I have been doing a Clinical Doctorate at the Tavistock & Portman NHS Foundation Trust in London, which is a national centre for the training of child and adolescent mental health professionals and also a major provider of mental health services. As part of that course, linked to the University of East London (UEL), I am now writing a research thesis on clinical work featuring ADHD and deprivation.

As part of this I would like to research what can be learned from my work with you and share this thinking with other professionals so that they can use what has been learned to help other young people in the future. Doing research like this is an important way of developing and improving our understanding about the help we can offer young people with the difficulties they encounter.

I would like to ask for your permission to refer to the case record for this purpose.

Before making a decision, you should read the following information. You do not have to decide straightaway: please talk to others about it if you wish.

You do not have to agree if you do not want to. Whether or not you do will make no difference to any further treatment that you may receive in the future, nor will you benefit in any way if you do agree.

I will change your name and other details so that no-one will be able to recognise you or your family.

If you wish, I will provide you with the factual statements I make about you and with information about the way I have changed your details. If you were to disagree with these, we would arrange a meeting together with the Organising Tutor of the Doctoral programme in order to discuss how best to accommodate your views.

The completed dissertation will be lodged in the Tavistock library, 120 Belsize Lane, London NW3 5BA, as would any subsequent publication based on it.

If you want to see what has been written you will need to contact the Organising Tutor of the Clinical Doctorate in Child and Adolescent Psychotherapy at the Tavistock clinic who will put you in touch with me. This is also the person you should contact should you wish to make a complaint about this process. The Tutor's telephone number is

I will ring during the next week so you can tell me what you think.

With good wishes,

2. Follow-up letter enclosing consent form

Emily Ryan
Child Psychotherapist

Tel:

Dear

Thank you all very much for consenting to my using the clinical record of my work with X, for my doctoral research. I enclose consent forms – one for X to sign, and the other for Y or Z to sign. You can fax them back to me, or if you prefer, you can return them in the stamped addressed envelope enclosed.

X, I also wanted to add that if there are questions you want to ask about the research, I would be happy to arrange a time to talk to you on the phone or in person. I leave this to you to decide. You can reach me on the mobile number listed above – if I can't answer the phone, you can leave me a message and I will call you back.

I was very glad to hear that things are going well for you all.

With good wishes,

3. Consent Form sent to patient (similar forms sent to carers)

Consent Form

Title of Project: *Tracking Change: a thematic analysis of change in a case of intensive psychoanalytic psychotherapy, with a deprived ADHD patient.*

Name of clinician: *Emily Ryan*

1. I confirm that I have read and understand that you intend to use the case record on your work with me in your thesis as explained in your letter dated 2nd October 2009. I have had the opportunity to consider your request for my consent, discuss it with others, and ask for further information.
2. I understand that my agreement is voluntary and that I am free to withdraw it at any time without giving a reason, and without my medical care or legal rights being affected.
3. I understand you will change my name and other details in the research report so that no-one will be able to recognise me or my family. I can ask to see any factual statements you make about me, and for information about the way you have changed my details. If I were to disagree with these, I can request a meeting with you, together with the Organising Tutor of the Doctoral programme, in order to discuss how best to accommodate my views.
4. I agree to your using the case record on your work with me for your thesis.

Name of patient

Signature _____ Date ____/____/____

Name of clinician *Emily Ryan*

Signature _____ Date ____/____/____