THE DEVELOPMENT AND VALIDATION OF A MANUAL
OF CHILD PSYCHOANALYSIS

JILL MARIE MILLER

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ABSTRACT

Although manualisation of psychotherapies is considered a precondition for systematic psychotherapy research, there has thus far been no attempt to manualise psychoanalytic treatment. The present study concerns the development of a manual of child psychoanalysis. It involves the investigation of the explicit and implicit principles which guide the work of child psychoanalysts at the Anna Freud Centre.

In the first part of the thesis a historical review of the development of child psychoanalytic technique is reported. The comparison of major contributions reveals that many ambiguities exist in the recommendations made for child psychoanalytic techniques and that actual practice can only be considered to be implicitly guided by some undetermined amalgam of these recommendations. The relationship between theory and practice is explored, and the types of research usually found within child psychoanalysis are reviewed. These reviews highlight the need for manualisation which has the potential to clarify the necessary and sufficient components of child analytic treatment techniques.

An initial attempt to manualise the key therapeutic ingredients, guidelines, and strategies of child psychoanalysis is presented. This attempt at systemisation is described and the results of a validation study are given. A further study is reported which attempted to validate a novel approach to the content analysis of psychoanalytic material.

The validation of a second attempt at manualisation, informed by the results and difficulties encountered in the previous studies, is reported. This study explores the face validity of definitions used in the new manual and results in a comparison with analyst's explicit working models. A further, large scale empirical study is reported which attempts to determine child psychoanalyst's implicit working definitions of psychoanalytic concepts, as well as their technical means and aims. Findings indicate that systemisation of treatment techniques may be possible on the basis of this instrument.

The discussion of the thesis recommends the composition of a manual for child psychoanalysis. The implications of this research for the theory and practice of child psychoanalysis are considered, as well as future directions.
ACKNOWLEDGEMENTS

An empirical investigation of child psychoanalysis would not be possible without those analysts who agreed to participate in all of the studies which constitute this thesis. I would like to thank the staff of the Anna Freud Centre for their expressed interest and generosity in giving so much of their valuable time and energy, and for their in-depth and honest discussions of their clinical work and beliefs.

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The authors of both manuals require special acknowledgement as it was their drafts which were examined in two of the studies. They include Rose Edgcumbe, Peter Fonagy, Hansi Kennedy, George Moran and Mary Target. Whilst the construction of these manuals is the responsibility of the authors, this research played an influential role. The problems with Manual I were delineated in the first study, which lead to recommendations for a second attempt at manualisation. The concepts and classifications found in Manual II were informed by the second study.

My greatest thanks goes to my advisor, Professor Joseph Sandler. The theoretical and methodological discussions under his direction at the Psychoanalysis Unit at University College provided me with an understanding of and orientation to psychoanalysis and research which has been invaluable. His knowledge of contemporary psychoanalysis and its history have greatly influenced the development of my own model of psychoanalysis.
PART I.
THE THEORY AND TECHNIQUE OF CHILD PSYCHOANALYSIS

Chapter 1.

The historical roots of child psychoanalysis

INTRODUCTION

The first four chapters of this thesis discuss the development of the theory and technique of child psychoanalysis. The path of this historical exposure begins in the early 1900s when children were not considered to be candidates for analysis, and when they eventually were, it was concluded that they were unanalysable. The journey continues into the 1920s when the method of child analysis was first conceived. The theories of both Anna Freud and Melanie Klein are examined, as well as the controversies between these two schools of thought. The numerous contributions made to the theory by other authorities, through to contemporary child analysts seventy years later are also considered. The importance of this historical journey is to highlight how analysts have thought about their approach and methods, to describe what they have conceptualised child analysis to be, and to delineate the points of discord and debate. In this way the remainder of the thesis can be placed within an historical context which serves to emphasise the need for manualisation.

THE HISTORICAL ROOTS OF CHILD PSYCHOANALYSIS

The first psychoanalytic therapy of a child has been credited to Sigmund Freud (1909) with the young boy called Little Hans. Freud's purpose in undertaking this project was not to see whether analysis was possible with a child, but rather to check the correctness of his theories which had their origins in the reconstruction of adult patients. In 1905 he laid out his hypotheses of infantile sexuality in " Three essays on the theory of sexuality" , whilst wishing for more direct proof of his theories.

In search for further evidence Freud gathered observations of children's sexual life, collected by friends and students. Among these were reports he received at regular intervals from the Grafs about their young son Hans. Max Graf, a music critic and musicologist, had been a follower of Freud's since 1900. He was a member of Freud's

Wednesday Evening Psychological Society and later a member of the Vienna Psychoanalytic Society. When Hans was born both parents were immersed in psychoanalysis. In consultation with Freud they agreed to try and raise their child with enough coercion to maintain good behaviour, but not within the overly strict guidelines common in Vienna at the time. In Freud's evaluation of the results of this decision, "the child developed into a cheerful, good-natured and lively little boy, the experiment of letting him grow up and express himself without being intimidated went on satisfactorily". The Graf’s observations of Hans provided information for Freud's papers on children's sexual theories (1907) and the sexual enlightenment of children (1908).

When Hans was nearly five he developed a phobia of horses at which time his parents consulted Freud for advice. Freud suggested that Hans' father treat him under Freud's supervision, sending reports as the treatment progressed. Thus, the case of Little Hans was the analysis, once removed, of a reconstructed child, as opposed to the direct analysis of a child. Freud himself thought this work was a unique experience arising from scientific interest, not thinking children in their own right were possible candidates for analysis. However, the impact of his work was enormous, yet difficult to understand eighty years later as what he discovered in 1909 is often now taken as a given. The work with Little Hans demonstrated what had previously only been theorised about and reconstructed from adult patients. As Anna Freud said:

What had been merely guessed and inferred became a living, visible and demonstratable reality...the oedipus complex was seen toward living parents in the external world as well as in ongoing fantasies and in the transference.

Sandor Ferenczi (1913) was the first to attempt to treat a child directly with psychoanalysis. He concluded that he was unsuccessful in adapting the technique of adult analysis to children because the child refused to cooperate, only wanting to play. Freud and his contemporaries were used to dealing with adult patients and were not equipped to understand a child's language. Now analysts would see a child's play as part of analysis and as a mode of communication.

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In the years that followed there were few developments regarding the field of direct child psychoanalysis. There were some attempts to apply psychoanalytic principles to other areas connected with children. Siegfried Bernfeld (1925)$^8$ used his psychoanalytic understanding and applied it to children in residential settings. August Aichhorn (1925)$^9$ took psychoanalytic principles and used them in his attempts to understand and re-educate delinquents. Anna Freud (1931)$^{10}$ is well known for her attempts to apply psychoanalysis to the education of children by parents and teachers.

Hermine von Hug-Hellmuth was the first to undertake systematic analyses of children. Following her PhD studies in physics she became a teacher. Influenced by her friend, mentor, and analyst Isidor Sadger, Hug-Hellmuth began to write papers on analytically informed child observations. At some point, when exactly is unknown, she began to analyse children and was to eventually become a respected member of the Vienna Psychoanalytic Society. She published a total of thirty-five articles mostly on children and child analysis, but also on women and the family. Hug-Hellmuth’s papers on children contain an explanation of the unconscious; a discussion of sexual urges, including pre-oedipal and oedipal desires, and masturbation; a discussion of curiosity and sexual education; descriptions of anxiety, guilt, fantasies, narcissism, masochism, and primal scene experiences; as well as the technique of child analysis. Young children, Hug-Hellmuth concluded, were not suitable for analysis without a concomitant educational influence. She said: “The curative and educative work of the analyst does not consist only in freeing the young creature from his sufferings, it must also furnish him with moral and aesthetic values.”$^{11}$ Furthermore, as she thought the analysis of a child should not penetrate too deeply, the analyst needed to be content with only partial success. Although skeptical about the feasibility of such an endeavor, Hug-Hellmuth thought a child’s spontaneous play could be used to supplement or replace free association, the means of analysing an adult. This idea paved the way for understanding a child’s communication through actions.

In the twenties two young women who were exploring the treatment of children entered the psychoanalytic scene, Anna Freud and Melanie Klein. Three schools of thought about child analysis began to develop headed by these two analysts and Hug-Hellmuth. Because of their interest in children, they were able to understand the child’s language and form of communication. Therefore, they were better able to adapt a psychoanalytic method to working with children than the adult analysts of their time. Hug-Hellmuth thought that analysis had to be limited in accordance with the develop-

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mental and cognitive capacities of the child. With her death in 1924, the field became dominated by Melanie Klein and Anna Freud. Anna Freud had a strong developmental approach that took into account the child's areas of competence, whereas Melanie Klein was convinced that analysis similar to that of adults was possible with children.\textsuperscript{12}

\textsuperscript{12} As the first child analysts were women, and the field has traditionally been dominated by this gender, the analyst will be referred to as "she" or "her" throughout this thesis, except in direct quotations when "he" is often used. The child patient will be referred to as "him".
PART I.
THE THEORY AND TECHNIQUE OF CHILD PSYCHOANALYSIS

Chapter 2. Anna Freud

BACKGROUND

Anna Freud's background is one of devotion to the field of children, their development, and psychoanalysis. She began as a teacher, where her interest in child development grew, applying psychoanalytic principles to education. She created a network of people devoted to work with children and also trained as an adult psychoanalyst. In 1937 she opened the Jackson Nursery in Vienna, a preschool setting providing day care for children one and a half through three years of age. It was here that Anna Freud began her studies on separations and substitute caregivers, libidinal development, the impact of the internal and external world on a child, child development, and the systematic use of observations of children. A year later the Jackson Nursery was closed as Hitler had marched into Austria requiring Anna Freud and her family to flee to London. Two years later she unpacked the materials from the Jackson Nursery and, along with Dorothy Burlingham, opened the Hampstead War Nurseries where they were able to continue their work.

The War Nurseries began as a Children's Rest Centre with the aim of relieving the needs of London children made homeless by air raids, and who were either still unevacuated or unevacuable. In 1941 the funding for this project was taken over by the American Foster Parents' Plan which provided Anna Freud and Burlingham the opportunity to improve and stabilise the original centre, and to open two new houses. There was the Babies' Rest Centre in London for small children who were too young to be sent to the country without their mothers, and a country house in Essex for purposes of evacuation. These residential nurseries provided war time homes for children whose family life had been broken up temporarily or permanently. What was unique was that they were not run along traditional institutional lines. Instead, the War Nurseries tried to re-establish for these children what they had lost, the security of a stable home with its opportunities for individual development. However, the absence of the family itself was the one characteristic of institutional life it was impossible to avoid.
Volume III of Anna Freud's writings details fifty-six monthly reports on the activities of the Hampstead War Nurseries and lays down the major scientific conclusions drawn from their work. These reports were the first studies of children who had to go through their early years deprived of family care. The interest of others in the effects of early loss and separation on families followed, in particular John Bowlby and Donald Winnicott in London and later René Spitz in the United States. The war was the precipitating and aggravating agent for these studies, but the importance of them is not the war itself. It is the effects of the dissolution of families and the impact of residential care on children. Reviewing her work three decades later Anna Freud was "glad to note that during the last 30 years many of the findings presented here as new have become familiar tenets on which a much more critical view of residential upbringing and its consequences for personality development are based".

In 1945 the War Nurseries closed. Anna Freud's concerns about and interest in child development, and the impact of loss and separation, continued as her attention turned to children who were concentration camp survivors. This work provided the unrivaled opportunity to observe the development of these young victims after their liberation, especially in terms of children's social relationships to each other. As Anna Freud said:

These children, who grew up oblivious of the existence of parents and without permanent ties to adult figures, demonstrated in pure culture what our separated war children had displayed to us in approximation, mainly, the deviations in personality formation that arise if family ties are replaced by ties to a group of peers, and the greater or lesser extent to which these latter can be utilized for satisfying an infant's need for emotional closeness to other human beings.

Anna Freud's activities also focused on the training of child psychoanalysts. The aftermath of the war saw an increased interest in children and the need for child training and Child Guidance Centres throughout Britain. The end of the war also brought renewed interest world wide in psychoanalysis. The Hampstead Child Therapy Training officially began in 1947, training candidates who had previously been workers in the War Nurseries. Three intakes were initiated prior to Anna Freud opening The Hampstead Clinic in 1952. In 1958 the Hampstead Nursery took its first preschool aged children. The name of the clinic changed to the Anna Freud Centre after her death in 1982.

It is difficult to assess Anna Freud’s work without also seeing the teacher in her. Her interest was first in normality and only subsequently in the deviations from it which constitute pathology. Anna Freud maintained a strong tie between clinical material and theory throughout her life, integrating findings of clinical psychoanalysis and observational studies. These studies included infants and toddlers in residential care, her experiments in group upbringing with child survivors, and later, children from deprived homes who were in daytime care at the Hampstead Nursery. Her theories were constantly developing to which the eight volumes of her writings attest. In the last decade of her life she said:

We should gradually evolve a technique which fits the child perfectly, whether it is similar to the adult technique or not...We haven’t done so yet. We are nearer than we were twenty years ago, or even ten years ago, but we are still quite a long way off.4

THE EARLY YEARS

In 1926 Anna Freud wrote her Introductory Lectures on Child Analysis which outlined her early thinking. As no model existed for child psychoanalysis, other than the applied work of Bernfeld and Aichhorn, Anna Freud formed a group of interested analysts composed of Marianne Kris, Hedwig and Willi Hoffer, Editha and Richard Sterba, and Jenny Waelder-Hall. The 1926 Introductory Lectures arose out of the seminars Anna Freud gave to this small group of pioneers, and were a response to Melanie Klein’s first paper which had been published a year earlier.

Basing her findings on the analysis of ten latency age children, Anna Freud introduced what child analysis was and contrasted this to adult analysis. The child, she said, was different from the adult in many respects. This necessitated modifications in the technique which had been used for neurotic adults, the subjects upon which Freud based his technique. Unlike adults, children were immature and dependent creatures, and specific criteria for treatment found in adult cases were missing with children. Children came into treatment not of their own choosing, lacked insight into their illness, and often lacked a wish to be cured.

The origins of Anna Freud’s thinking about development, technique and the task of child analysis can be found in these early papers. Although she found many similarities in comparing the analytic process with children and adults, she also found differences

which were to be the basis for the development of a technique designed specifically for children. She had no qualms about modifying a technique developed for adults saying:

> In my opinion, it is no reflection on the analytic method, designed as it is for a single particular object, the adult neurotic, if one seeks to apply it with modifications to other types of objects. There is no harm in contriving to use it for other purposes. Only one should be at pains to know what one is doing.\(^5\)

Her interest in what became known as the widening scope of psychoanalysis, the application of psychoanalysis to other than neurotic disorders, was to be seen in many years to come. This interest began with the development of a technique particular to children.

However, Anna Freud also thought that her approach to working with children was not different from what was done in adult analysis in all respects. She said:

> But I maintain that in order to suit a new situation I merely extended certain elements of an attitude that you all show to your patients, though without especially stressing it.\(^6\)

These elements which she thought everyone used, irrespective of the age of the patient, included: arousing the patient’s interest in and decision for analytic work; indicating that the analyst was there to help and support the patient; accepting the patient’s version of his conflicts with his family and the external world; and making oneself interesting and useful to the patient.

Anna Freud suggested a preparatory period prior to the onset of analysis, an idea which she later abandoned, but which contained the roots of many commonly known techniques today.\(^7\) The task of the preparatory period was to make the patient analysable, in other words, to induce in the child insight into his disturbance, impart confidence in the analyst, and to turn the decision for analysis into the child’s own. This phase, she thought, did not involve “real analytic work” in the sense of making unconscious process conscious or analysing transference and resistance, rather the aim was “...to create a tie strong enough to sustain the later analysis”.\(^8\) She discussed that the aim was not to establish a positive transference, rather implied was the aim of establishing a treatment alliance which could be maintained in the face of resistance, a concept introduced much later.

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\(^7\) Anna Freud always maintained that her ideas about a preparatory phase were misunderstood. What she had in mind was the making of a relationship with a child prior to doing analysis. (Hansi Kennedy, 1990, personal communication)

The establishment of the sort of relationship Anna Freud was describing required following the child and his material, as the child was a particularly difficult subject who "...requires that his own childish peculiarities be appropriately matched." Implied was the need to be able to step into the child's shoes and understand the world from his viewpoint, one which differs sharply from that of an adult. In order to do this the child analyst needs to understand development and know how to talk in the language of a child.

As it was thought children were often not as bothered by their symptoms as their parents or others, another aim initially allotted to the preparatory phase was making symptoms which are ego-syntonic dystonic. Here the roots of what might now be called creating conflict can be seen.

The crux of transference work with adults in 1926 involved the development of a transference neurosis. Freud first introduced this concept, along with the compulsion to repeat, in 1914. The compulsion to repeat referred to the patient's enactment of his past within the transference relationship. A transference neurosis occurred once the patient's whole illness was concentrated upon a single point, his relation to the analyst. The analyst was now situated at the very centre of the illness. Thus, in "place of his patient's true illness there appears the artificially constructed transference illness, in place of the various unreal objects of the libido there appears a single, one more imaginary, object in the person of the doctor." As transference neurosis was the aim of analysis with adults, and the primary vehicle for change, the question arose as to whether children developed a transference neurosis. At this time Anna Freud strongly believed they didn't. She defined the concept as follows:

He (the patient) gives up the old objects on which his fantasies where hitherto fixed, and centers his neurosis anew upon the person of the analyst...he replaces his previous symptoms with transference symptoms, transposing his existing neurosis, or whatever kind, into a transference neurosis, and displays all his abnormal reactions in relation to the new transference person, the analyst.

However, in the case of a child, thought Anna Freud, the original objects remained real and important figures in the child's life. Unlike the adult, the child was dependent on them in the present. Consequently, the original objects were never fully replaced by the analyst in the transference. Transference was still a feature in child analysis, although at this point she believed it involved only single episodes of friendly and hostile impulses. The negative

impulses directed toward the analyst should be dealt with immediately as, thought Anna Freud, they disturbed the child greatly, could foster dangerous feelings, and could become feared tempters to the child to act upon them. It was in the positive transference that the fruitful work of the analysis happened in that an affectionate attachment was a prerequisite for all later analytic work. At this point in the development of her theory Anna Freud believed that the transference to the child analyst did not readily lend itself to interpretation, a view she was later to change.

In 1926 most analysts thought their task was to raise conflicts between the instinctual unconscious, ego, and superego to a higher level, making what was unconscious conscious. Once this was accomplished, instinctual impulses were removed from repression and made accessible to the influence of the superego which would determine their fate. This applied to both children and adults, however with children there was one important difference. The outer world affected the mechanisms of the infantile neurosis more deeply with the child as his investment and dependence on parental objects was greater, and necessary. This factor created two differences in the analysis of children. Firstly, the child's superego was still in the process of developing and needed the help of people in the environment. Secondly, as the child's superego and ego were not yet sufficiently mature to reject some impulses, sublimate others, and allow gratification to still others, the responsibility for the fate of these instinctual impulses remained with the parents. However, this created problems, as "the parents who are now called upon to help in the child's recovery are still the same people who let the child get ill in the first place". Consequently, it was up to the analyst to intervene in the child's development. Anna Freud said:

It seems to me that there remains but one solution to this difficult situation. The analyst must claim for himself the liberty to guide the child at this important point, in order to secure, to some extent, the achievements of analysis. Under his influence the child must learn how to deal with his instinctual life...

Anna Freud called this process educational, using the term in its widest sense. As will be elaborated further, it is here that the roots of what was later to be seen as the task of child

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analysis - restoring the child to the path of normal development - are found. It made the analyst's task a difficult one as she had to both analyse and educate in this sense.

The analyst accordingly combines in his own person two difficult and diametrically opposed functions: he has to analyze and educate, that is to say, in the same breath he must allow and forbid, loosen and bind again.15

In order to accomplish this difficult task the analyst needed to assess not only the internal state of the child, but also the external forces which contributed to the child's disturbance. Parents had to be able to support treatment and aid in the child's further development once analysis was completed. Here Anna Freud was alluding to the the idea that parents should be worked with as well. Due to the child's continuing development and the ongoing influence of his environment, analysis was no guarantee that the child would not have difficulties in the future. Anna Freud always believed that what analysis could do was restore the child to a path of normal development, thus improving his chances in the future, but not necessarily protecting him from later problems.

The roots of Anna Freud's theory of child analysis are found in these early papers. Over the years she expanded, altered and added to her original propositions.

ANNA FREUD'S DEVELOPMENTAL POINT OF VIEW

In her early papers Anna Freud said that the task of child psychoanalysis was to both analyse and to educate. Implicitly she seemed to suggest that what was meant by "educate" was intervening in a child's development. This meaning became explicit in later writings as she formulated what was to become the central focus of her theory of child analysis - a child's development.

The Search for Criteria for Child Analysis

Anna Freud struggled to identify what the criteria for analysis with children should be. Obviously, the criteria used for adults did not suffice. To begin with, the degree of suffering was not adequate as an indicator. For example, it could be the environment which suffered rather than the child, or in severe cases a child's defences could be strong enough to prevent suffering although at a cost, and in less severe cases a child could be suffering far

more. Secondly, with a child a disturbance in the capacity to love and to work was hard to
gage. The equivalent to a capacity to work was the capacity to play. A disturbance could
manifest itself in an inability to play or in excessive imaginative play at the cost of
constructive play, however this was also not a sufficient criteria. Anna Freud concluded then
that the criteria for child analysis were disturbances in a child’s development. The indications
for treatment were not the neurotic manifestations themselves, but what bearing these had on
the developmental process. She said:

...there is only one factor of such central importance that its impair­
ment through a neurosis calls for immediate action; namely, the
child’s ability to develop, not to remain fixated at some stage of
development before the maturation process has been concluded.\textsuperscript{16}

Anna Freud’s developmental viewpoint was incorporated into her theory and
technique, as well as in her thinking about assessment. This viewpoint ushered in the
formation of her Diagnostic Profile and the idea of developmental lines. It was “...the essence
of this approach”, she said, “that developmental considerations take precedence over
consideration of symptomatology and manifest behavior” \textsuperscript{17}.

Symptoms

Overt symptomatology, said Anna Freud, could be deceiving. In children symptoms
could be transitory and appear at a time in development when high demands were made on
the child’s personality. When that time passed, the symptoms could disappear. This was not
a sign of pathology, rather a reaction to a stressor. However, symptoms could be lasting and
regarded as the first sign of permanent pathology. Symptoms could also shift, as when an
anxiety moved from one important object to another or one compulsion was substituted for
another. The analytic stance has always been that symptoms themselves are no more than
symbols. They are surface manifestations which indicate that some mental turmoil is taking
place beneath the surface within the child’s psychic world. Furthermore, the same symptom
or behaviour exhibited by two children could have different roots and internal meaning.
Thus, symptoms were not the key to understanding. Instead, Anna Freud believed the analyst
needed to look to the nature of the child’s internal world, to the level of development reached,
and to the organisation of the child’s intrapsychic structures. The focus was the whole child,
all elements of his functioning and internal organisation, both healthy and disturbed. The


\textsuperscript{17} Freud, A. (1962). Assessment of pathology in childhood: Part I. In \textit{The Writings of Anna Freud Vol. V},
emphasis was on the deviation from, and interferences with, normal personality develop­ment.

The Diagnostic Profile

Anna Freud thought it was through a diagnostic assessment that the analyst could make a thorough investigation of the child’s personality, making it possible to pinpoint the relevance of a symptom to a particular child at a particular time. This involved assessment of the developmental level, psychic structure, and dynamic significance. Her Diagnostic Profile was an attempt at such an assessment. It was a way to hypothesise the underlying metapsychological pathogens in order to ascertain the appropriate therapeutic intervention. It’s basis was a developmental viewpoint, and dynamic considerations instead of descriptive ones. During an assessment, a multitude of facts are gathered, but it was basic to Anna Freud’s analytic thinking that “the value of no single item should be judged independently, i.e., not without the item seen within its setting”. The Profile involved an external picture of the child and proceeded to an internal picture containing “information about the structure of his personality; the dynamic interplay within the structure; some economic factors concerning drive activity and the relative strength of id and ego forces; his adaptation to reality; and some genetic assumptions”. The primary questions the Profile attempted to answer from a metapsychological perspective were: what level of development has the child attained, is he where he needs to be, and what is holding him up? The diagnostician would then recommend the best way to help the child move forward.

The Concept of Developmental Lines

By means of the Diagnostic Profile, the state of a child’s inner agencies, various functions, conflicts, attitudes, and achievements are fitted into a background of a developmental norm. But what is this developmental norm? Development had long been thought of as passing through phases. Psychosexual phases (oral, anal, phallic, etc.) had their origins in the reconstruction of adults rather than work with children, either therapeutically or through observations. In addition, all theories about phases were tied to particular areas of interest; for example Freud and neurosis, Margaret Mahler and psychosis, or Erik Erikson

and social psychological development. Anna Freud supplemented the notion of phases with imbalances in development when she introduced the concept of developmental lines in 1963.\(^2\) Lines were a method of looking at where the child was in his development and assessing where imbalances were. Lines were tied to the observable. From the surface what was going on in the depths was inferred, as markers along a line were indicators of the interaction between drive development, ego development, and the environment. From these surface indicators conclusions could be drawn about the state of a child’s mental organisation and capacities. Lines of development, thought Anna Freud, were valid for almost every area of the child’s personality. Some examples are: from dependency to emotional self reliance and adult object relationships; from suckling to rational eating; from wetting and soiling to bladder and bowel control; from irresponsibility to responsibility in body management; from the body to the toy and from play to work. All lines of development interact and mutually influence one another. When one, or several lines lag behind the others, an imbalance in development results. By understanding the steps along lines of development the analyst could elucidate normality and pathology, as well as the balance and harmony, or consequent disturbances between various lines, thus refining theory and technique accordingly.

The Widdening Parameters of Child Analysis

Anna Freud came to the conclusion that the area that belonged to child analysis was development and that a child’s development was its aim. With expanding research into this field, child analysts were learning more and more about the developmental process which in turn had an impact on theory and technique. As with adult analysis, neurosis had been the focal point for child analysis. An infantile neurosis was originally thought to develop during the oedipal phase. Its formation was due to the child’s inability to resolve the oedipus complex and/or the castration complex, and his subsequent regression to earlier fixation points. A conflict resulted as the child’s ego was then confronted with primitive modes of satisfaction which were now intolerable. Arising from this conflict was a compromise solution whose surface manifestation was a symptom. Now, Anna Freud’s thinking led her to adhere to the idea of applying psychoanalysis to disturbances other than the neurosis. She thought the more knowledge analysts gained the greater the parameters

of analysis would become. However, she warned some years earlier that any extension of
the parameters always needed to have the aim of "...bringing about the ultimate purposes
and processes of the analytic end requirements".21

Anna Freud and her colleagues at the Hampstead Clinic began to assess and treat
analytically a variety of pathologies which arose from other than the infantile neurosis.22
These were excessive delays in acquiring vital ego functions; primary disturbances of
narcissism or object relatedness; or disorders due to a lack of ego control, faulty superego
development, or both. In 1966 Anna Freud introduced the concept of developmental
disturbances. She defined these as:

disorders which arise owing to the particular external and internal
strains and stresses, dangers and anxieties connected with particular
developmental phases, and which are transitory in the sense that they
faire away with the passing of the developmental level on which
they have emerged.23

However, between the infantile neurosis and the developmental disturbance were a whole
range of disturbances that needed to be considered both in terms of form and treatment by
analytic means.

In 195824 Michael Balint introduced the concept "basic fault" to describe certain
disorders which did not originate in the three person relationship of the oedipal phase. A
fault was not a situation, complex, or a conflict. Instead it arose from the early mother-child
relationship.

Balint's theories were grounded in the idea of a mutual interdependence in the early
mother-child dyad. This concept, of a child needing his mother and a mother needing her
child, is allied with Bowlby's attachment theory. Balint was opposed to Freud's concepts of
primary narcissism and oral dependence. "It is not the relationship to the oral component
instinct that is relevant for the understanding of this syndrome (the basic fault)". he said, "
but the fact that it originates in a primitive two-person relationship which may or may not be
'oral'."25 Thus, these disturbances are called "basic" because the events which give rise to
them belong to this early relationship and lack the structure of a conflict. The term "fault"

22 Some of this work was carried out by a research group on the study and treatment of children diagnosed
as borderline. See Sara Kut Rosenfeld 1972a and 1972b, and with Marjorie Sprince 1963 and 1965. As
part of this research Ruth Thomas in collaboration with Rose Edgcumbe, Hansi Kennedy, Maria Kawenoka
and Lilian Weitzner adapted the Diagnostic Profile to borderline and psychotic children (1966).
23 Freud, A. (1966). Links between Hartmann's ego psychology and the child analyst's thinking. In The
328-340.
comes from geology and crystallography. It means an irregularity in an overall structure, as in a fault line that is ever present and may lie hidden until stresses occur which may lead it to disrupt, or even break, the structure. Basic faults are like certain kinds of traumas, akin to what Masud Khan called "cumulative trauma". In describing a basic fault Balint said:

Although highly dynamic, the force originating from the basic fault has the form neither of an instinct nor of a conflict. It is a fault, something wrong in the mind, a kind of deficiency which must be put right. It is not something dammed up for which a better outlet must be found, but something missing either now, or perhaps for almost the whole of the patient's life. An instinctual need can be satisfied, a conflict can be solved, a basic fault can perhaps be merely healed provided the deficient ingredients can be found; and even then it may amount only to a healing with defect, like a simple, painless scar.

Anna Freud struggled with the question of early deficits referring to Balint's concept of a "basic fault". She wondered if it was possible to treat these and were they reversible? Was analysis the method with which this could be done? She cautioned analysts not to delve into the first years of life and disregard the conflicts which were overlaid during development since in the attempt to reverse early processes, one could in the end find them irreversible. In 1957 she said:

While the effects of such early deprivation can be mitigated by later favorable influences, they cannot be undone or reversed or solved in a more age-adequate way, as conflicts can: this means that they are not in the true sense of the word a legitimate object of analytic effort.

However, in 1968 she further examined interferences with development where the damage to a child was not self inflicted as the result of internal strife, but was caused and maintained by ongoing influences from the environment. These sorts of difficulties could underlie later infantile neurosis. Anna Freud thought analysts knew little about treating disorders of this type and she continued to find it questionable whether and how far the neglect of developmental needs could be undone in treatment. Yet, she did think the child's response to the after effects of these could be alleviated. The neurotic superstructure which overlaid, rather than caused, the basic damage could be dealt with analytically. In regards to the underlying deficit, the analyst could work within a framework of an improved version of the child's initial environment aiming at a belated fulfillment of neglected developmental needs, an approach Anna Freud did not think was analytic. This "corrective emotional (i.e.,

developmental) experience" could be successful when the original frustration of needs and later fulfillment weren't too far apart in time. In addition, the analyst could work with the parents with the idea that the ones who did the harm are the best ones to undo it. Success was dependent on the health and receptivity of the parents and the extent to which environmental influences had not been internalised.30

Thus, Anna Freud concluded that treating patients with developmental disturbances did fall under the auspices of child analysts. Developmental disturbances now included not only those transitory disturbances defined in 1966, but the concept referred to a broad category which included non-neurotic disorders commonly known as borderline, narcissistic personality disorders, atypical disorders, and psychosis. What was important to consider in treating these children was the technique employed, and to recognise that this technique differed from that used in the treatment of neurotic children. The original psychoanalytic technique had been devised for the neurosis proper where the resolution of internal conflict was helped by interpretation of unconscious elements. However, in 1970, the analytic approach:

now embraces the basic faults, failures, defects, and deprivations, i.e., the whole range of adverse external and internal factors, and it aims at the correction of their consequences...there are significant differences between the two therapeutic tasks and that every discussion of technique will need to take account of these.31

Nevertheless, Anna Freud thought there was no undoing of the past, rather analysts helped the patient's ego come to terms with the residues, to face and cope with the consequences. She added that "to the extent to which developmental harm can be undone belatedly, child analysis may accept it as its next duty to devise methods for the task".32 This distinguished her approach to developmental defects from that of analysts taking a more "corrective" approach.

Franz Alexander (1948) first introduced the term "corrective emotional experience". He meant that the analyst should actively be different than what the patient expected. For example, if the expectation was of a critical father, the analyst should be a benign father. In this way, he thought, faulty development was corrected. Anna Freud's meaning was different. She thought when a disturbance was created by the environment the child had a chance in the analysis of having a different experience which could, perhaps, be correcting. This did not mean starting development over, rather returning to the path of normal development.


Finally, in 1978 Anna Freud introduced the concept of developmental disharmonies which encompassed early disturbances belonging to the basic fault. Disharmonies were tied to developmental lines and could be intra or intersystemic. It was thought that these disharmonies were what underlie infantile neuroses and that the two were inextricably bound up together. "Developmental disharmonies", she said, "are a fertile breeding ground for almost every type of infantile neurosis."33 Insight into developmental disharmonies and a variety of developmental disturbances influenced the view of infantile neurosis. An infantile neurosis was no longer seen only as the outcome of the child's inability to resolve the oedipus complex, but involved the whole of the child's personality and the convergence of difficulties throughout preoedipal and oedipal development. Anna Freud wrote:

...the true infantile neurosis which the child has acquired now is no longer the ego's answer to the frustration of single instinctual trends. Rather, it is an elaborate attempt to deal with a massive and complex upheaval caused by the clashes between opposing drive derivatives; between conflicting, exciting, pleasurable, and painful affects and mutually exclusive attitudes toward objects. Although the precipitating events belong to the area of the oedipus and castration complexes, the whole neurotic involvement is contributed to by the residues of past stages from infancy onward, and quite especially by the libidinal fixations which have left their mark on the individual during his development.34

Found in Anna Freud's 1927 papers are the roots of her developmental viewpoint which continued to be refined and expanded throughout her life. A child's development was the focus of child analytic work and the basis of her Diagnostic Profile. As she struggled to understand the origins and metapsychology of other than neurotic disturbances and the appropriate treatment methods, she introduced the concepts of developmental lines, developmental disturbances and developmental disharmonies, and re-evaluated the notion of infantile neurosis. Whilst Anna Freud concluded that developmental disturbances were best treated by analytic means, and that these were an area analysts needed to study further, she remained pessimistic about the results.35 She believed the effects of deprivation could not be undone, or corrected as Alexander and others thought, but perhaps new adaptations could be found.

THE CHILD PSYCHOANALYTIC PROCESS AND TECHNIQUE

In 1923 Freud wrote "The ego and the id" which was followed by "Inhibitions, symptoms and anxiety" in 1926. These papers marked the beginning of a shift in psychoanalysis from content analysis to the analysis of structures, mechanisms and ways of functioning. They became the basis of Freudian and Anna Freudian work.

The Analytic Process

Following on these papers Anna Freud wrote The Ego and the Mechanisms of Defence in 1936, which she presented to her father on the occasion of his eightieth birthday. In this important contribution to the field she developed Freud's 1923 and 1926 ideas of the centrality of the ego and its defences against anxiety and other affects. She emphasised the ego's mediating position between the impulses of the id and the demands of the outside world, and expanded Freud's revised 1923 concept of the superego. Although the aim of psychoanalysis, and of deep interpretations, was the discovery of repressed instinctual impulses, affects and fantasies, Anna Freud thought psychoanalysis was not only the analysis of the id or the unconscious, but needed to be concerned with the ego as well.

From the beginning analysis, as a therapeutic method, was concerned with the ego and its aberrations: the investigation of the id and of its mode of operation was always only a means to an end. And the end was invariably the same: the correction of these abnormalities and the restoration of the ego to its integrity.

Thus, as a process, psychoanalysis involved all aspects of the personality; the id, ego, and superego, and the interaction between them. She thought that if analytic investigation occurred in relation to only one, the picture was incomplete and distorted. Only when the examination was extended to all aspects of the personality "can we speak of psychoanalysis".

In 1954 Anna Freud outlined the "classical definition of psychoanalysis" as understood at that time. A therapeutic procedure was psychoanalytic if it recognised and worked with transference and resistance. The task of analysis was to undo the interlocking of the id and ego forces, the analyst directing her efforts from one side to the other following the patient's material. Transference and resistance were the focal points in the process. The patient suffers from internal conflicts which are between personality structures. Conflicts arise from the past and are not accessible to consciousness. Instinctual strivings in the id, which are unconscious, attempt to rise upward and manifest themselves in the present, using objects in the external world for this purpose. The analyst offers herself as the object on whom these past unconscious experience can be made conscious and relived. This is the transference. However, there are resisting counterforces from the ego with the aim of keeping id strivings down and preventing them from becoming manifest. To deal with this resistance, the analyst helps the patient become aware of his defensive devices, making them inefficient. By dealing with both the transference and the resistance, the analyst and patient bring about a revival of earlier times when the id and the ego clashed. Conflicts are then reactivated and new solutions found. This, Anna Freud said, is the analytic process. How the analyst goes about doing this is the technique, and it is the technique which changes according to the disturbance.

In order to understand how and why the technique changed Anna Freud said the analyst must examine the intrapsychic structure of the patient, not the symptom. For example, questions about resistance linked to the degree of health of the ego and superego, whereas questions about transference linked to the drives, and to what would now be thought of as object relationships apart from drives. Variations in technique were based on the nature of these structures, as Anna Freud said, "...we have to be guided not by a descriptive diagnosis of the case but by insight into its structure."40

In 1965 Anna Freud wrote Normality and Pathology in Childhood41 which was the watershed of her work to date. Here, in refining her definition and outlining analytic techniques with children, she again looked at the question of child analysis versus adult analysis. Initially she thought child analysis proceeded along the same therapeutic principles as adult analysis, though translated into child terms. These principles implied not making use of authority and eliminating suggestion as far as possible, discarding abreaction as a therapeutic tool, and keeping manipulation and management of the patient to

a minimum. The legitimate tools of this method were the analysis of resistance and transference, and the interpretation of unconscious material. The definition of what child analysts do was therefore similar to that of adults:

...to analyze ego resistance before id content and to allow the work of interpretation to move freely between id and ego, following the emergence of material; to proceed from the surface to the depth; to offer the person of the analyst as a transference object for the revival and interpretation of unconscious fantasies and attitudes; to analyze impulses so far as possible in the state of frustration and to avoid their being acted out and gratified; to expect relief of tension not from catharsis, but from the material being lifted from the level of primary process functioning to secondary thought processes; in short: to turn id into ego content.  

However, those indispensable aspects of the technique with adults were often absent in children, an earlier view Anna Freud continued to hold. In this book she summarised this view again. Children, she thought, lacked insight into their abnormalities, didn't develop the same wish to get well or the same type of treatment alliance, habitually their ego sided with the resistance, the child didn't decide on his own for treatment, and the relationship with the analyst wasn't exclusive as the parents and family retained their importance.

In addition, Anna Freud considered the question of whether children could free associate. By this time Melanie Klein had developed a play technique with children which she believed was the equivalent to free association. Anna Freud disagreed. In the first place, she thought, a child's play was not being used by the child with the aim of being cured, as free association was with adults. Secondly, by interpreting a child's play symbolically it avoided the process of going from the surface to the depth and systematically working through conscious and preconscious resistances, defences and distortions. Rather, "...it aimed at laying bare the deeper layers of the child's unconscious" only. Further differences arose in the technique with children as they tend to act under the pressure of the unconscious rather than to talk. By nature children act out instead of verbalising, therefore the distinctions between remembering, repeating, reliving, and acting out are blurred. Rather than attempting to contain expressions within the psychic sphere, the child had free motility within the session allowing him to use his natural mode of expression through action. The analyst was required to attempt to reduce reality actions to play actions in the transference with fantasy elaboration, and move toward verbalisation and secondary process thinking.

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By the seventies child psychoanalysis had grown to the status of a treatment modality in its own right. No longer was it continually compared and contrasted to adult analysis. Anna Freud outlined the process of child analysis in treating the infantile neuroses and the many disturbances of behaviour and social adaptation based on them.

The uncovering of unconscious motivation, reconstruction of past events (traumatic and otherwise), interpretation of transference feelings and behavior serve well for combating wrong conflict solutions and inadequately primitive defense, and above all for undoing the regressions which have initiated the whole neurotic process.44

Although how the child analyst worked, her techniques, may vary from adult analysis, the expected aims of child psychoanalysis were in line with the established ones. The results the child and adult analyst hoped to achieve included undoing repressions, regressions and inadequate conflict solutions; and increasing the sphere of ego control. An aim exclusive to child analysis was to free developmental forces from inhibitions and restrictions and enable them once more to play their part in the child's further growth.

Defence

Any discussion of Anna Freud's theories must include defence as it was always at the core of her thinking. Defence mechanisms are now considered basic to analytic thinking and are often taken for granted. Her classic book The Ego and the Mechanisms of Defence was the first extensive study of this concept. It was in these writings that she began to investigate the specific defences, their modes of operation, their role in normal and pathological development, their relation to specific forms of illness, their hierarchical organisation, and their relation to developmental phases along with their influence on development. Ten defence mechanisms were outlined: regression, repression, reaction formation, isolation, undoing, projection, introjection, turning against the self, reversal, and sublimation. Furthermore, she discussed denial (in fantasy, work, play, and action), identification with the aggressor, and altruistic surrender. Among the defence mechanisms repression was assigned a unique function as it was seen to be the central defence mechanism with other defences allied, subordinate, or supplementary.

Defences, thought Anna Freud, could be pathological as well as adaptive. They are a special group of ego functions which operate automatically outside of awareness, in other words unconsciously, and are mobilised by anxiety. As they serve a protective function against an inner or outer danger situation, the analysis of defence is inextricably linked to the analysis of conflict, thus holding a central place in psychoanalytic technique.

In 1939 Heinz Hartmann followed on Anna Freud's book with *Ego Psychology and the Problem of Adaptation*. In this book he introduced the concepts of the undifferentiated phase; conflict-free ego development and conflict-free sphere; and primary and secondary autonomy. He discussed the role of endowment, as well as inborn ego apparatuses. Defences, he said, may simultaneously serve the control of drives as well as adaptation to the external world. Greatly influenced by Anna Freud, as she was by him, Hartmann also elaborated the concepts of ego strength and weakness, as well as normality.

**Resistance**

Following the introduction of the structural theory in 1923, Freud began to elaborate the idea of resistance. In "Inhibitions, symptoms and anxiety" he discussed five types of resistance, three of which originated in the ego, one in the id, and one in the superego. A decade later in *The Ego and the Mechanisms of Defence* Anna Freud expanded the concept. Resistances, she said, were an object of analytic study and provided useful information as to the patient's mental functioning. "Analysis of resistance could be seen as essentially the analysis of those aspects of the patient's defences which entered into and contributed to the pathological outcome of conflicts."  

Resistance develops during the course of every analysis and is related to transference and defences against anxiety evoking material. The inability to carry out the conscious intent of working in analysis showed the resistance due to defences. Where there was no intent, the resistance couldn't be seen. Anna Freud distinguished resistance from conscious withholding which was opting out of the therapeutic contract. In addition, resistance was different from a basic unwillingness to participate in the analytic process. This was an indication that the child had no real wish for treatment.

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Anna Freud thought children experienced similar resistances to adults. The ego resists analysis so as to safeguard the defences, the superego resists analysis because of forbidden thoughts and fantasies which are perceived to threaten existence, drive derivatives released by analysis act as a resistance against analysis if they press for fulfillment in action, and the id resists change because of its tie to the principle of repetition.

At the same time there were differences. Arising from the immaturity of a child's personality and the developmental process itself, forces opposing analysis are stronger. There are thus further complications, intensifications, and variations. Children do not take a long term view of situations. Consequently, the discomfort and anxiety which analysis can create in the present often outweighs the idea that, in the future, one will feel better. The child's first choice may be to end treatment and get away from this difficult situation. The child's ego is immature and insecurely balanced between internal and external pressures, so the child feels more threatened by analysis, holding on to defences more rigidly than the adult. Immature and primitive defences tend to operate alongside more sophisticated ones, thus doubling the resistance. In addition, children tend to externalise their conflicts which results in battles with the environment, rather than experiencing them internally. They also look for external solutions, and act in preference to talking. The treatment alliance with the child, as well as with the parents, is a crucial element to counteract these difficulties. The analytic process of dissecting the personality and bringing conflicts into consciousness is, by its nature, opposed to the developmental process of resolving conflicts and establishing character attitudes. Therefore, the developmental process itself can contribute to resistance. These factors make for an especially difficult situation when trying to treat children in analysis. The child analyst can face longer stretches of resistance without the full benefit of a treatment alliance. As Anna Freud said, "...the forces opposing analysis are, if anything, stronger with children than with adult patients".47

Conflict

Conflict and the adaptation to conflict were central to Anna Freud's thinking about analysis. The main therapeutic efforts of analysis were:

...a change in the balance of strength between id, ego, and superego, an increase in their tolerance for each other's aims and, with this, of the harmony between them.48

This presupposed the presence of intrapsychic conflict. Conflict could be seen in a variety of disturbances, and in development normally. These developmentally determined inner

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disharmonies were normal byproducts of structural development and usually were dealt with by the child's ego in conjunction with parental support.

Anna Freud thought the type of conflict experienced by the child was important in determining the appropriate intervention. External conflicts, between the child and the outside world, were best handled by guidance or other educational means. Internal conflicts, conflicting forces within the id, Anna Freud thought were difficult to treat by any means. She was referring to constitutional factors and what would now be thought of as maturation. Internalised conflict by definition was intersystemic, between the agencies of the mind. Analysis was best suited for those children suffering from internalised conflicts and the focus of treatment was the resolution of these. The task, then, was to intervene in development, understanding where the hold-ups or difficulties were taking place.

Infantile neurosis, where internalised conflict was the source of the disturbance, was thought to be most effectively treated by analysis.

Only a therapy devised to reach into the extreme depth of the psychic apparatus and to revive experiences of the remote past can be expected to alter the quality of the defenses, to undo regressions, and, generally, to alter the balance of forces within the structure of the personality.

But what about the role of conflict in other disturbances? In regards to developmental problems and disturbances Anna Freud thought they could also be treated by analysis because, as with the neurosis, the conflicts were internalised. The difference was that the conflicts did not belong to the past, but were ongoing and acute caused by the strains of the developmental phase the child was presently going through. If it appeared too difficult for the child's ego to handle the crisis, come to a resolution and move on, analysis was indicated in order to further the chance for normal development. There was another category of disturbance Anna Freud called "a subspecies of the infantile neurosis", the equivalent to adult perversions or delinquency, where conflicts were not resolved by means of an infantile neurosis, but rather were removed altogether through lowering of ego standards. Intervention was seen as a threat to the peaceful inner state the child had created. In these cases the analyst was faced with the task of creating conflict. Anna Freud said:

...intrapsychic conflict has to be reintroduced within the structure and experienced by the child before its analytic interpretation can be accepted and become effective.

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49 Anna Freud considered constitutional and organic factors important in a child's development, an outlook which was far sighted.


In cases where environmental influences met head on with internal complexes, impulses, anxieties and fantasies, and were ongoing, analysis wasn't necessarily the answer. Clarifying this, and her thoughts about what analysis could do do, Anna Freud said:

...child analysis is most clearly indicated where the patient's fears, fights, crises, and conflicts are the product of his inner world and can be solved or dissolved into nothing by tracing their roots into the unconscious, by enlightenment, insight, and interpretation. Where the threat, the attacker or the seducer are real people, the therapeutic situation changes all together.52

In 1974, looking at the issue of preoedipal conflict, Anna Freud said that conflicts belonging to the prephallic phase were conflicts with the environment, rather than between internal agencies. However, compromise formations in the prephallic phase were the prestages of the infantile neurosis as they represented the first attempts of the maturing ego to come to terms with instinctual frustration. Thus, childhood psychopathology had a twofold causation: one rooted in the conflicts, defence, and compromise formation; and the other rooted in the developmental process. Conflict is a natural byproduct of development as every step along the developmental line is a compromise between conflicting forces. Anna Freud added:

Whatever clashes occur at the time proceed externally between the infant and his environment, not internally within a not yet existing structure...It is only in the later course of differentiation and structuralization that the resultant deviations from normal growth become involved in the phase-adequate internal conflicts as they are known to us.53

Interpretation aims to bring repressed or defended material into consciousness and to help the child's ego to find solutions for his internal struggles which are no longer based on anxiety, panic, and infantile misapprehensions of reality, but on internalised conflict. Analytic work will undo regressions and lift crippling conflicts off the developmental lines.

The Transference, the Treatment Alliance and the Real Relationship

In the thirties and forties, the infancy years of child psychoanalysis, there were two contrasting views about the role of transference in the analysis of children. Melanie Klein believed that transference was evident from the beginning of an analysis and that all of the child's feelings directed toward the analyst arose out of the transference. Anna Freud disagreed. In 1945 she said that even if part of a child's neurosis was governed by a transference neurosis, which she was skeptical of, another part remained with the child's original and ongoing objects. However, over the years, Anna Freud's views about transference in child analysis changed. In 1954, responding to a symposium on the Widening Scope of Psychoanalysis, she spoke of modifications forced on the analyst by the individual features of the patient's personality and the nature of his transference. Focusing on patients of all ages, she discussed variations of the classical transference of neurotics as outlined by Freud. She included narcissistic transferences based on need satisfaction or early deprivation and loss; ego distortions; idealised transferences; and the patient's need for a real object. The different types of transferences raised a number of technical issues. Implied was the idea that as analysts broaden their parameters, variations resulted which changed the technique and improved the theory.

By 1957 Anna Freud had gone beyond her early ideas that a negative transference was detrimental to the therapy and threatened its continuation. Instead, she thought the analyst could work through these phases of negative transference and that they added valuable material. However, she maintained that negative transferences should be interpreted more promptly "...to prevent their increasing to quantities which might defy interpretation and carry the patient away from the possibility of any alliance with the analyst".

Anna Freud reconsidered the idea of an introductory phase to the analysis. By 1965 she no longer thought that transference in children was restricted to a single transference reaction, or that it did not develop into a complete transference neurosis. She remained unconvinced, however, that what was called transference neurosis in children was the same as with adults, and held true to the classical view of transference. Initially there was a real relationship which gradually and increasingly was dominated by the transference until a full transference was formed. The real relationship established itself once more around termination. She now considered the idea that there were various forms of transference which did not fit the classical mode, and that transference formations could be seen from the

beginning of treatment. However, initially the analyst was not only an object for transference, but also a new object as the child's hunger for new experiences and new objects was greater than that of the adult. Consequently, the analyst had a double relationship and needed to learn to move between the two and sort out the mixture, a complicated task.

If he accepts the status of new object, different from the parents, he undoubtedly interferes with the transference reactions. If he ignores or rejects this side of the relationship, he disappoints the child patient in expectations which the latter feels to be legitimate. He is then also apt to interpret items of behavior as transferred which, in fact, are nothing of the kind. Transference should be taken up at the beginning of treatment, but Anna Freud cautioned: "don't interpret transference before it is transference". She thought not all responses to the analyst were transference, rather some were linked to the child's anxieties about strangers and new situations.

Anna Freud now thought that children did form a transference proper during analysis where they repeated by means of regression and used the object of the analyst to transfer their object relations from all levels of development. In regards to interpretation of the various levels of transference, she remained strong in her belief that the analyst moved from the surface to the depth. This aided in the development of a treatment alliance which was needed in order to interpret the deeper levels. Going to the deepest layer first would contribute to the negative transference and resistance. Equally, it would require symbolic interpretations of behaviour and activities which, she added, ignores the ego defense which are built up against the unconscious content, and this means increasing the patient's anxieties, heightening his resistances, in short, committing the technical error of bypassing analytic interpretation proper.

A subspecies of transference proper was externalisation. Anna Freud was the first to talk about externalisation as an important aspect of transference, a notion she introduced in 1936 and expanded on in 1965. In present day psychoanalysis, externalisation would be seen as a part of the transference. Anna Freud explained how the child has a tendency to externalise whereby the analyst is used to represent an aspect of the patient's personality structure, rather than an object representation. Thus, externalisation is not only a repetition of the past due to the child's distortions, if one thinks of externalisation of internal object representations as many do today, but reflects the child's intrapsychic structure. These externalisations of internal and intersystemic conflicts, making the battle with the analyst

rather than being contained within the child, were important as "they reveal what happens in the child's inner world, in relations between his internal agencies, as contrasted with the emotional relationships to objects in the external world".59

As externalisation was a subspecies of transference, so too did Anna Freud think there were other aspects of the transference which did not involve only instinctual impulses. Ego defences could be transferred and equally needed to be interpreted. Transference of defence was first outlined in 1936. In this type of transference she included "the repetition of the measures which the patient had taken, early in his life, to protect himself against the painful consequence of childhood and sexual wishes".60 Alluded to in this concept is a related type of transference delineated by Sandler et al61 in 1969 and elaborated still further by Anna Freud in 1980, the transference of habitual modes of relating. These are modes of relating often seen in the first few sessions which involve feelings of great intensity. They are not specific to the analyst per se, rather are in the nature of character traits. They link to transference of defence if the origin of character traits is understood as defences which are incorporated into a character style and attain a degree of autonomy. A habitual mode of relating is a form of transference in the broadest sense of the word, but not on the same level as a full fledged transference manifestation or transference neurosis.

Anna Freud also distinguished transference of current relationships and transference of past relationships as children bring their current life concerns, as well as transference of internalised relationships based on past experiences, into the relationship with the analyst. In the former the analyst needed to differentiate the transference from the spill over of the child's ongoing pathological relationships. In regards to the formation of a true transference neurosis in children Anna Freud said:

The question then is: How far does the child transfer past relationships and fantasies from the present-day objects to the analyst? This is the distinction.62

As the child's primary objects remain important to him, and more convenient, he rarely transfers everything in the analysis. Anna Freud went on to say:

...it is largely a matter of quantity, that is, of how much is transferred... The appearance of transference material in a young child's analysis does not diminish... the living out of the neurosis at home, quantitatively speaking. The qualitative differences are the differences between real objects and fantasy objects in the child and the adult.63

Always incorporating her developmental viewpoint, Anna Freud said that in order to work within the transference and various types and formations of it with children, the analyst needed to understand what stage of development the child's object relationships were in, and the ways the child normally used his objects to support his development.

Affect

Anna Freud thought the role of affects was crucial to child analysis. Defences were against drives, but also against anxiety and affect. Because a child's play was not the equivalent to free association, the analyst turned to the analysis of the way a child's affects were transformed within the session. This gave clues to the patient's attitudes toward his drives, to the nature of his symptom formation, and to the nature of the ego's activities. By bringing ego resistances and defences against affects into consciousness, the analyst also brought an understanding of the id.

Other Techniques

Interpretation of resistance, conflict, and transference were central to the technique and aim of child analysis. Whilst the interpretation of unconscious material was the same with children as with adults, with the aim of analysis being "...the widening of consciousness without which ego control cannot be increased"64, there were amendments which pertained to the child's immature ego.

The ego of the young child has the developmental task to master on the one hand orientation in the external world and on the other hand the chaotic emotional states which exist within himself. It gains its victories and advances whenever such impressions are grasped, put in to words, and submitted to the secondary process.65

Verbalisation was thus a crucial aspect to interpretation and the two went hand in hand. As verbalisation was a prerequisite for secondary process thinking, the analyst needed to verbalise those strivings which had not yet succeeded in achieving ego status, consciousness, and secondary elaboration.

Internalised conflict was not the only factor which indicated child psychoanalysis as an intervention, as Anna Freud outlined when discussing disorders not arising from conflict, but could also be indicated when there were arrests, defects, and deficiencies in development. In these cases the therapeutic process changed in nature. In addition to the elements of interpretation of transference and resistance; the widening of consciousness at the expense of the unconscious parts of the id, ego and superego; and the increase of ego dominance; there were others. There was the verbalisation and clarification of preconscious material which lessened anxiety and prepared the way for interpretation proper. In regards to borderline pathologies she said:

...therapy is served for him by verbalization and clarification of internal and external dangers and frightening affects which are perceived preconsciously but which his weak and helpless ego, left to itself, cannot integrate and bring under secondary process dominance.66

In regards to early deprivations and defects in object relationships, interpretation could not restart development, rather it was the intimacy of the patient analyst relationship that was important.

On the basis of this new and different emotional experience, the child may move forward to more appropriate levels of libido development, a therapeutic change set in motion within the outward setting of child analysis but on the basis of 'corrective emotional experience'.67

Anna Freud clarified that a "corrective emotional experience" of this sort could only work if it occurred approximately within the same developmental phase in which the damage had taken place. In other instances where the child had a weak ego and suffered from archaic fears, it was possible to interrupt the process so the child could proceed developmentally. Here the therapeutic element responsible for the improvement "...is the analyst's reassuring role, not his analytic one."68 Reassurance meant the explanation of reality aimed at dispelling anxieties. In another example she discussed patients where the ego exerted too much pressure on an impoverished drive constellation. This sort of child needed help with

stimulation of fantasy and the opening of outlets for id derivatives. Here the analyst acted as an auxiliary ego when drive activity was insufficiently controlled by an undeveloped ego. In addition, other techniques paved the way for or supplemented interpretation, such as clarification and confrontation.

THE CHILD PSYCHOANALYTIC PROCESS AND TECHNIQUE
ANNA FREUD'S FINAL YEARS

Anna Freud considered numerous aspects of what would be included in a definition of what analysts do. Not only does she talk about interpretation, defence, resistance, conflict, affect, and transference, but also about creating conflict; the role of the real relationship between analyst and patient; the role of verbalisation, clarification and confrontation; intervening in the developmental process; a modified version of Alexander's corrective emotional experience; reassurance; and acting as an auxiliary ego. She concluded that in the area of permanent regressions and fixed neurotic symptomatology nothing but analysis could change the child. However, few patients present with one pure form or another, rather most disturbances consist of mixtures and combinations of many elements. To this Anna Freud concluded in 1965:

It is this mixed psychopathology of childhood for which the comprehensive method of child analysis is needed. Only in child analysis proper is the whole range of therapeutic possibilities kept available for the patient, and all parts of him are given the chance on the one hand to reveal and on the other to cure themselves.69

In 1980 Joseph Sandler, Hansi Kennedy and Robert Tyson published a comprehensive book on technique in child psychoanalysis based on discussions with Anna Freud. Here they elucidated the question of what is child psychoanalysis. They described how a technique was fashioned which complied with the main demands of classical psychoanalysis: to interpret resistance and transference phenomena; to undo repressions and regressions, and to substitute sophisticated, adaptive measures for primitive, pathogenic mechanisms of defence; and to strengthen ego functions and widen the area in the mind over which the ego could exert control. With children there were adaptations to the analysis of resistance as this was originally defined as the resistance to free association.

The authors went on to say that there was no absolute psychoanalytic technique for use with children, rather there was an adaptation of a set of analytic principles. What was important was that the aims of treatment were conceived of psychoanalytically. They took Anna Freud's contention, spelled out in 1965, that analysis is a mixture of techniques based on psychoanalytic understanding of the child and the child's development, and that analysis proper is the whole range of therapeutic possibilities kept available for the patient. They said:

The therapist departs from child analysis and enters the realm of psychoanalytic psychotherapy when he intentionally limits himself to specific procedures and avoids following the material into certain areas or avoids making use of any of the wide range of child psychoanalytic techniques available when such techniques are indicated. Child psychotherapy is a modification imposed by analysts or therapists on the basis of an a priori selection of techniques. The child therapist who gives only transference interpretations is practicing psychotherapy rather than psychoanalysis. Formulating relatively specific aims in regards to the particular child patient does not mean localizing the interventions or departing from the analytic procedure. 

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BACKGROUND

Melanie Klein's interest in the treatment of children began in Budapest when she was in analysis with Ferenczi. Interestingly, her analysis coincided with Ferenczi's attempt to analyse a child, an endeavor he abandoned believing children were unanalysable. However, he encouraged Klein's interest in child analysis and was instrumental in her decision to enter the field. In Berlin, where she moved in 1920, Klein began to undertake analyses of children with the support of Karl Abraham. At the first conference of German Psycho-Analysts in Würzburg in 1924 Klein read a paper on an obsessional neurosis in a six-year-old girl. Abraham's interest in and understanding of the practical and theoretical potentials of child analysis were clear when he commented "the future of psycho-analysis lies in play technique". In 1926 Klein published "The psychological principles of early analysis". Anna Freud's Introductory Lectures were, in part, a response to these two papers.

Ernest Jones expressed great interest in Klein's work and the idea of analysing children. In 1925 he invited her to London as a guest lecturer for the British Psycho-Analytic Society. In 1926 she immigrated there where she continued to develop her theories until her death in 1960.

Through the thirties the understanding of children and child analysis were the focus of Klein's research and theoretical advances. Her attention, and that of her followers, turned to psychotic and borderline adults in the forties. The advances in Kleinian theory over the next fifty years grew out of work with these adults, rather than with children, although it has been maintained by Kleinian analysts that the difference between work with children and with adults is minimal.

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Whilst the task of discussing the development of all of Klein's theories is too great for the purposes here, certain fundamental areas will be emphasised.

Sigmund Freud's theories took a dramatic shift in the twenties. Strains had been placed on his topographical model by clinical psychoanalytic findings and the subsequent theoretical adjustments. The structural theory was introduced in 1923 with its division of the mind into id, ego and superego, and in 1926 Freud proposed his second theory of anxiety where anxiety was now conceived of as located in the ego and as acting as a motive or signal for defence. Both of these papers followed on Freud's reconsideration of drive theory in 1920 when he divided the drives into the life and death instincts. This 1920 paper, along with Abraham's 1924 paper "A short study on the development of the libido, viewed in light of mental disorders" where he explored sadism in the young child, gave aggression and unpleasurable feelings in mental life and development a central place in psychoanalytic theory. Furthermore, it altered the previous view of conflict. Whereas earlier the basic psychic conflict was thought of as a conflict between sexual, pleasure-seeking drives and reality-oriented, self preservative drives, it was now conceptualised as the opposition between pleasure and self-preservation, and the need for unpleasure and the urge to repeat painful, destructive and self-defeating experiences.

This was the starting point of Klein's work. She interpreted and expanded Freud's view of conflict as the conflict between life and death instincts, and in 1927, as the conflict between love and hate. The conflict between love and hate was thought to be the central conflict which ran throughout development. This central conflict and the death instinct have remained fundamental components of Kleinian theory.

Initially, Klein followed Freud's model of psychosexual phases. However, she was soon to elaborate the concept of object and moved from libidinal and economic considerations to thinking in terms of internal object relations. She formulated this notion within Freud's structural theory as Klein thought the ego and superego were comprised of good internal objects. Bad objects, on the other hand, which arose from the child's externalised anxieties, became persecutors and necessitated the activation of defence. Unlike Freud, who thought the ego's first mode of defence was repression, Klein thought it was expulsion. The infant, thought Klein, attempts to expel impulses in the service of self

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Unlike Freud, who thought the ego's first mode of defence was repression, Klein thought it was expulsion. The infant, thought Klein, attempts to expel impulses in the service of self protection and as a way to destroy the object. Here can be found the roots of her later ideas about projective-identification. Even at this early phase, anxiety and sadism were central to Klein's thinking. Sadism could cause anxiety and anxiety could increase sadistic impulses.

MELANIE KLEIN'S EARLY THEORIES OF CHILD ANALYSIS

Melanie Klein spelled out her views about child psychoanalysis in her book *The Psycho-Analysis of Children*, first published in 1932. The two originators of child analysis initially asked similar questions. However, they reached different conclusions and established different ideas. Many of these were directly opposed. Like Anna Freud, Klein also thought there were conditions which seemed to be missing in work with children which were the basis for analysis with adults, namely, the inability to free associate, and the lack of a wish for treatment, and insight into their disturbance. In addition, was the question of the child's immature ego and what impact this had on how to treat a child analytically. Klein agreed with Anna Freud that children did not give free associations verbally in the style of adults, however she thought play was the child's equivalent to free association where "the child expresses its phantasies, its wishes, and its actual experiences in a symbolic way". She thought a child's play used the same language as dreams. In order to understand the child's communications the analyst needed to understand the symbolism of the play and take it in relation to the whole of the child's behaviour within a session. By interpreting early in the course of treatment, Klein thought, the child experienced relief which in turn helped him understand the value of being analysed, increased his willingness in the process, and gave him insight. In relation to the child's weak ego, Klein added that the ego gained strength as the analytic work proceeded. Children protect themselves from reality by denying it due to the difficulty in tolerating frustrations, which was characteristic of neurotic children. One result of analysis was the strengthening of the ego and an ability to adapt to reality.

Whilst the analytic approach and situation differed between children and adults, the basic principles remained the same. What the analyst attempted to do, regardless of age, was to analyse the transference situation, analyse resistance, remove early infantile amnesia and the effects of repression, and uncover the primal scene. Klein was adamant that the

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analyst should refrain from any so called non-analytic interventions or educational influences. With children, there were two additional aims. First, to make conscious the child's unconscious criticisms of his parents and their sexual life, then test these grievances against the reality so they could lose their potency. Second, to "uncover and clear-up psychotic traits in the early life of the individual".12

In 1932 Klein outlined important differences in the analytic approach to children and adults. In the analysis of adults the analyst began at the surface and moved to the depth, going first for what was "nearest to the ego and to reality"13. In child analysis the analyst attempted to bypass the ego "taking the shortest cut across the ego" and going "in the first instance to the child's unconscious and from there gradually get in touch with its ego"14. In this way the analyst went from the depth to the surface in order to reach "the place where the strongest latent resistance is and endeavor in the first place to reduce anxiety where it is most violent and most evident"15. The result of going from the surface to the depth, thought Klein, was a strengthening of the resistance rather than an alleviation of it. Klein later changed her views about adult analysis so it too was in agreement with her stance of moving from the depth to the surface.

Transference, interpretation, anxiety, guilt and unconscious phantasy were the keys to Kleinian child analysis in these early years. The greatest psychological task of the child is the mastering of anxiety, and early anxiety situations were seen to be the basis for all psychoneurotic illness. It was the task of analysis to reduce the child's anxiety. As Klein said:

The more analysis can do in the way of reducing the force of the child's early anxiety-situations and of strengthening the ego and the methods employed by its ego in mastering anxiety, the more successful will it be as a prophylactic measure.16

The analyst helped the child accomplish this task through transference interpretations. A transference neurosis, said Klein, did develop in the analysis of children as long as a method was employed which was "the equivalent of adult analysis, i.e., which avoids all educational measures and which fully analyzes the negative impulses directed towards the analyst"17. Transference was taken to mean all aspects of the child's relationship with and reactions toward the analyst, and in this sense, a transference developed from the very first contact with the child. Shyness, anxiety, timidity, unfriendliness, or a lack of trust were taken "as

a sign of a negative transference"¹⁸ and interpreted as such. The treatment situation, through the use of play, became a total transference situation and, said Klein:

...gives the child the possibility of completely living out and working through that original situation in phantasy. In doing this, and in uncovering their infantile experiences and the original cause of their sexual development, the analysis resolves fixations and corrects errors of development.¹⁹

She emphasised the need to take the transference back to the original object.

As interpretations were aimed initially at the depth, rather than the surface, Klein said that analysts should not be wary of making deep interpretations from the beginning of analysis. The function of deep interpretations was threefold: (1) to gain access to the unconscious, (2) to diminish anxiety, and (3) to prepare the way for analytic work. The aim of an interpretation was to trace the representational content, anxiety, and sense of guilt to the deepest layer of the mind.

In Klein's view the task of dealing with the child's ego and superego, relationship with reality, and the process of working-through were secondary to the task of going to the depth first, linking unconscious content to the transference, and alleviating anxiety and guilt. Klein thought that newly gained knowledge was first unconsciously worked over and it was this which brought relief. Resulting from this analytic work was a strengthening of the child's ego and a better adaptation to reality. She said:

The establishment of the child's relations to reality as well as the stronger emergence of its ego take place in the analysis of children only step by step in connection with progress in ego development. They are a result, not a precondition, of the analytic work.²⁰

The "working over" of interpretations was accomplished later in the analysis in step with ego development. Full sexual enlightenment and a full adaptation to reality resulted from a complete analysis. In addition, analysis resolved sadistic fixations, decreased anxiety and the pressure of the drives, thus decreasing the severity of the superego. As the superego and sexual life reached a higher level of development, the ego expanded and was able to reconcile superego demands with reality. The child was then better able to regulate sexual activities since the severity of the superego was mitigated, and an adequately strong ego was developed as a consequence of the analysis of unconscious content and phantasies.

Klein thought analysis affected the factors which underlie the child's faulty development and laid "the foundations for the unimpeded level of the child's future sexual life and personality."\(^{21}\) It lessened the strength of pre-genital fixation points and sadism, however it never removed them all together. As anxiety situations never cease to operate, analysis could not "completely cure" or "exclude the possibility of a future breakdown with absolute certainty."\(^{22}\) Yet, with the power of pre-genital impulses weakened by decreasing anxiety and guilt, the superego could then be assisted in moving forward to the genital stage and sublimations which were more solidly founded could be instigated.

Klein believed that analysis should be applied to all children as "every child passes through a neurosis differing only in degree from one individual to another."\(^{23}\) Child analysis was a prophylaxis against neurosis in adulthood and "later characterological defects and difficulties are best prevented by being eliminated in childhood."\(^{24}\) Difficulties in development were thus seen as neurotic in character, rather than some being transitory or a byproduct of development, and were the basis of future pathology. Klein said:

> As, however, a certain amount of difficulty is inevitable in the child's development, we are, I think, inclined to appreciate too little how far these every-day difficulties are to be regarded as a basis for, and indicative of, serious developmental disturbances.\(^{25}\)

Indications for analysis were based on symptoms, such as difficulties in eating, sleeping, inhibitions, etc., and the focus was on the guilt or anxiety which underlie the symptom.

Whilst Klein's theories were based on the analysis of young children, she believed they were applicable to children in the phases of latency and puberty as well. In latency the developmental considerations "stand in the way of the commencement and the course of the analysis."\(^{26}\) The child's ego works to strengthen its position by placing its energies in the service of repression which in turn is supported by reality. Thus, Klein went on, the analyst can't expect assistance from the child's ego, further proof of why the analyst should "come as soon as possible to terms with the unconscious agencies in order to assure the cooperation of the ego"\(^{27}\) and go for deep interpretations. By interpreting the child's doubts and fears in terms of unconscious content and sexual theories, the latency child's ongoing desire for knowledge will continue to dominate, guilt and anxiety will subside, and the analytic situation will be established. In puberty, the situation more closely approximated

the young child where instinctual impulses, unconscious and phantasy life dominate; however at this age the ego is more successful at warding off and modifying anxiety. In order to assure that treatment is not broken off, it is the analyst's task to quickly gain access to affects as these manifest in the transference. This then lessens the negative transference typical of adolescence, and lessens the anxiety, thus establishing the analytic situation.

The Depressive Position

In 193528 Klein formulated her concept of the depressive position. This was a move away from the idea of psychosexual phases, to that of positions which incorporated her views of internal objects and the interaction of the life and death instincts expressed in love and hate. In distinction to chronological concepts as thought of by phases, Klein's positions were structural concepts. They coexist autonomously and refer to a grouping together of characteristic phenomena. As conceived of today, the depressive position is composed of characteristic anxieties, defences, and object relationships which are thought to develop in the second trimester of infancy. As they are never fully worked through, these continue throughout life. The distinctive features of the depressive position include the painful recognition by the infant that his own feelings of love and hate are directed toward the same object rather than splitting between good and bad objects; the integration of these part objects into whole objects; and the development of a capacity for concern for the object which is an outcome of this integration.

The beginning of the Oedipus complex is placed within the depressive position in Klein's theories, much earlier than Anna Freud believed. As objects are integrated into wholes, the combined parent figures come into play as the father now becomes a significant figure. "In the earliest stages of the Oedipus complex the infant has phantasies of the mother containing father's penis or the whole father, and of father combining with the mother's breasts and vagina, all in a state of perpetual gratification".29 Through the use of the defence of projective-identification the child aims to separate and attack the sexual parents.

Advances in Kleinian thinking have occurred in present day about the depressive position based on work with psychotic, borderline, and extremely envious patients. These include the recognition by the infant of the object's separateness and independence; and the relationship between the depressive position, symbolic thinking, and creativity.

The Paranoid-Schizoid Position

Klein introduced the concept of the paranoid-schizoid position seven years later and elaborated on it in 1946. This development coincided with a move away from child psychoanalysis to the analysis of psychotic adults. The conceptualisation of this position included the anxieties, defences, and object relationships which were postulated to be characteristic of earliest infancy. Whereas the depressive position entails the integration of part objects into whole objects, the paranoid-schizoid position involves only part objects as the infant splits its objects into good and bad as a defence against the death instinct. "The struggle between the instincts is manifested in the war between the loving, good part of the ego, identified and identifying with a single, whole, ideal object on the one hand, and the persecutors, which are the projected fragments of destructive impulses, themselves fragments of a 'bad' ego, on the other hand." The anxieties and defences of this position include splitting, projective-identification, fragmentation, introjection, and idealisation.

Klein's ideas about the paranoid-schizoid position led to other theories of her colleagues in later years, for example Herbert Rosenfeld's work on confusional states and narcissism; Hanna Segal's views on symbolism; and Wilfred Bion's theories of thinking.

Envy and Gratitude

During the fifties, Klein concentrated on the important roles of envy and gratitude. Envy was seen to be the oral sadistic and anal sadistic expressions of the destructive impulses and came to hold the place of "a primary constitutional feeling". From envy there is no relief, only defence. Envy is not only harmful, but can be a "lethal emotion", which only lessens or becomes tolerable "when mitigated by love". Gratitude relates to trust and love in good objects and "implies the ability to accept and assimilate the loved primal object..."
without greed and envy interfering too much”. Envy and gratitude "may be seen as another variation on the theme of the strife between love and hate", the core conflict in Klein's theory.33

WILFRED BION AND THE CONCEPTS OF PROJECTIVE-IDENTIFICATION, CONTAINMENT AND THE CAPACITY TO KNOW

The concept of projective-identification was to become the focus of much further thought and writing. The impact of Bion's work on projective-identification and the interplay of transference and counter-transference was significant on Kleinian psychoanalysis. Klein defined projective-identification as an early mechanism of defence where "the young infant defends his ego from intolerable anxiety by splitting off and projecting unwanted impulses, feelings, etc., into his object".34 Bion extended and changed this concept. He thought projective-identification was not only a defence, but the first mode of communication between mother and infant, and the origin of thinking. According to Bion:

the infant discharges unpleasure by splitting off and projecting anxiety-arousing perceptions, sensations, feelings, etc...into the mother for her to contain them...This is her capacity with love to think about her infant - to pay attention, to try to understand...Her thinking transforms the infant's feelings into a known and tolerated experience. If the infant is not too persecuted or too envious, he will introject and identify with a mother who is able to think and he will introject also his own now modified feelings.35

As projective-identification was the primary mode of communication between infant and child, so too was it taken to be an important mode of communication between analyst and patient. This lead Bion to the concept of container where the mother and/or analyst acts as the container for the feelings, impulses, etc. which the child or patient projects into his objects.

Bion thought the capacity to know, developed from Klein's "epistemophilic instinct", which he symbolised with K, was at the centre of mental life. Also at the centre of mental life were the pleasure principle and reality principle, and life and death instincts, in other words, love and hate which he symbolised with L and H respectively. This led to technical considerations as he thought the key to each session with a patient was related to either K, L,

or H. The analyst needed to decide which of these was key to a particular session and gage her interventions to that. Qualifying that Bion did not wish to make rigid the use of this idea, Edna O'Shaughnessy has suggested that the analyst:

...ask of the clinical material the question: Is the material in this session emerging as an expression of, or anxiety about, or a defence against...L or H or K...If K is most urgent in the material there is a next question: What form of K?36

Thus, thinking and knowing, projective-identification and containment came to hold a central place in Kleinian technique.

The insight the patient gains in analysis rests on primitive introjections which are emotional experiences of psychic reality linked to his analysis. Equally, the analyst's understanding rests on emotional experiences of knowing his patient in the original and deepest mode, i.e. through reception, containment and thought about his patient's projective identifications.37

COUNTER-TRANSFERENCE

In the fifties and sixties work with psychotic patients who produced more primitive types of transferences brought advancements in the theory of counter-transference. In his 1947 paper "Hate in the countertransference" Winnicott was one of the first to write about the analyst's emotional response to her patients. Specifically he focused on the analyst's own feelings of hate and fear as these arose in the counter-transference. "The truly objective countertransference", Winnicott said, is "the analyst's love and hate in reaction to the actual personality and behavior of the patient, based on objective observation."38 When the analyst experiences hate toward a patient, Winnicott thought, she must tolerate it and not deny the existence of the feeling. Instead, "hate that is justified...has to be sorted out and kept in storage and available for eventual interpretation"39.

Winnicott's forthright account of the analyst's justified counter-transference hate opened up the field to a legitimised study of the analyst's affective responses. His approach was taken up two years later by Paula Heimann (1950)41 in her key paper "On counter-transference". In this paper, Heimann argues that "the analyst's emotional response to his

patient...represents one of the most important tools for his work. The analyst's countertransference is an instrument of research into the patient's unconscious". Like Winnicott, she distinguished between the analyst's emotional response to her patient and her use of the feelings experienced. "What distinguishes this relationship from others, is not the presence of feelings in one partner, the patient, and their absence in the other, the analyst, but above all the degree of the feelings experienced and the use made of them, these factors being interdependent." The aim for the analyst is to "sustain the feelings which are stirred in him, as opposed to discharging them (as does the patient), in order to subordinate them to the analytic task in which he functions as the patient's mirror reflection".42

When Heimann first presented this paper in 1949 at the sixteenth International Psycho-Analytic Congress in Zurich, it was taken as heresy. It became, however, an inspiration to younger analysts and the views she proposed are now widely accepted. Other British object relations theorists have expanded on Heimann's idea of the analyst's affective response and have described the transference-countertransference relationship in terms of roles, most recently Sandler (1976)43 and Pearl King (1978)44.

Klein strongly disagreed with Heimann's point of view. She believed countertransference was a hindrance to the analysis and something the analyst needed to sort out. The analyst's emotional response to her patient was not, thought Klein, an analytic tool nor an instrument for research. Pearl King, in her introduction to Heimann's collected papers45, speaks of Klein's disagreements also arising from her anger with Heimann for not consulting her about this work. Heimann formulated her views on counter-transference independently which was the beginning of her estrangement from Klein. In 1955 Heimann formally split from the Kleinians and joined the British Independent Group.

Although Klein disagreed with Heimann, counter-transference has become one of the fundamental concepts in Kleinian theory. However, there are differences in the formulation of the concept. Unlike Heimann and others who believe that countertransference is the analyst's response to the two person patient-analyst relationship and something to monitor as a way to figure out what the patient is trying to tell her, Kleinians use counter-transference to mean the analyst's response to the patient's projective-identification. The patient projects aspects of his internal world into the analyst. What the

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analyst feels is thus the patient's feelings, rather than the analyst's own emotional response to them.

Klein never wrote about counter-transference and few of her colleagues have either (see Roger Money-Kyrle 195646 and Irma Brenman Pick 198547). Instead the focus is more on projective-identification. However, Esther Bick did write about counter-transference in child analysis in 196148. In this paper, presented at the first Child Symposium held at an Internal Congress of Psycho-Analysis, she said that interpretations were based on the "analyst's intuitive response to the situation growing out of the pre-verbal projective process from the child's unconscious into the analyst"49. She further commented that the counter-transference stresses with a child were greater than those experienced with adults due to the nature of the child's material and the unconscious conflicts which arise in relation to the child's parents.

The counter-transference difficulties which related to the nature of the child's material included the intensity of the child's dependence, the positive and negative transference, and the primitive nature of the child's phantasies, all of which could arouse the analyst's unconscious anxieties. Bick thought the child's material was more difficult to understand than adults due to its primitive sources and modes of expression. Consequently, child analysts required a deeper knowledge of the primitive levels of the unconscious. Bick continued that the nature of the child's material "imposes on the child analyst a greater dependence on his unconscious to provide him with clues to the meaning of the child's play and non verbal communication"50 thus emphasising the importance of the analyst's counter-transference as a response to what the child has projected into her.

Bick also spoke of the importance of the analyst's examination of her attitudes toward the child's parents. She explained that the child has a two fold relationship with his parents. One is his normal and healthy dependence on them relative to his age, and the other is the infantile elements due to the child's internal difficulties. The aim of analysis is to bring these infantile elements into the transference with the development of a transference neurosis. Thus, a diminishment of the expression of these elements at home is expected. However, Bick added, as they could intensify in relation to parents once again during analytic holidays, the analyst needed to be prepared for this. Furthermore, the child analyst

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needed to be aware of the potential problem of her own unconscious identifications. These could manifest themselves in three ways: as an identification with the child against parents, with the parents against the child, or with a protective parental attitude towards the child. These difficulties in relation to parents are "an integral part" of the child analyst's work, "intricate and delicate to handle, needing flexibility and considerable confidence in child analysis in general and one's own work in particular."51.

In this paper Bick discusses the analyst's response to the child's projective-identifications as counter-transference, but she also alludes to the analyst's own unconscious identifications and anxieties which the child's material can arouse. Implied, however, is not counter-transference in Heimann's sense where feelings reside in both analyst and patient and are interdependent, but feelings in either the patient or the analyst with their absence in the other.

CONTEMPORARY KLEINIAN CHILD ANALYSIS

The theory of Kleinian child psychoanalysis is based on Melanie Klein's early papers, written in 1932. Whereas certain adaptations and changes to her theory were made by Klein and others since that time, specifically the areas of internal object relationships, projective-identification, and analyst as container, most agree that the technique she devised and the principles she established remain relatively unaltered in more recent times (Segal 197252, Pick and Segal 197853, Susan Isaacs Elmhirst 198854). The transference, as a total situation, remains as the fundamental scope for interpretation. Transference is seen to occur and develop on the basis of the child's projections of internal parental figures into the analyst. Through the transference the patient repeats earlier emotions and conflicts. The patient is helped:

...by taking back his fantasies and anxieties back in our transference interpretations to where they originated - in infancy and in relation to his first objects. By re-experiencing early emotions and fantasies, and understanding them in relation to primal objects, the patient can revise these relations at their root, and thus, effectively diminish his anxieties.55

Through the child's play and other communications, the analyst aims to discover and interpret the unconscious content which is expressed, be it fear, wishes or phantasy, and thus relieve the anxiety and guilt. Pick and Segal outlined the aims of Kleinian child analysis as seen in a more contemporary theoretical framework.

Treatment aims at aiding the patient to be less rooted in the paranoid-schizoid position, less dominated by splitting processes, and more firmly on the road to integration and an increased capacity for love and concern. During the process of the patient's transference onto the analyst of early parental imagos, the analyst's capacity to contain the patient's projections, and to talk to him about them gradually, enables the patient to have more insight into the nature of these impulses. As the patient can take in the analyst's understanding as good, his good internal object is strengthened, and helps him to deal with his destructive impulses. As he can do this and make more constructive efforts to preserve his good internal objects, persecutory anxiety and guilt lessens and his trust in his good internal object and his own goodness will be strengthened.56

Although new developments have been made over the years leading to new conceptions, the basic orientation and formulations of Kleinian analysis, both child and adult, have been retained with little alteration. These include unconscious phantasy; internal objects and the inner world; the orientation of drive theory and object relationships; the death instinct and envy; and the defences of projection, identification and introjection.

The Concept of the Death Instinct

The concept of the death instinct is a central component of Kleinian theory. Envy is the most destructive and intractable form of the death instinct. Individuals are not only driven by the death instinct, but by the life instinct, both of which are attached to objects. It is thought that from birth children have a rudimentary capacity to relate to objects both in the external world and in phantasy, although the capacity to distinguish internal from external is limited. In addition, the child has a rudimentary ego at birth with the capacity to feel anxiety, which the infant works to fend off psychically.

Unconscious Phantasy

Klein's concept of unconscious phantasy resulted from the analysis of children. Klein found that children had violently aggressive and loving phantasies, both vivid and bodily concrete, which were a source of intense anxiety. Unconscious phantasy, Klein thought, was the means of psychically representing drives and was the primary content of all unconscious mental processes. Susan Issac's 1948 paper, "The nature and function of phantasy", contains the original Kleinian ideas about phantasy and remains basic to Kleinian theory. It is through the constant operation in phantasy of projection, introjection, and identification that the inner world of objects and self is built up. This inner world is used throughout life to give meaning to events in the external world. Whilst the elucidation of unconscious phantasy has been the main focus in Kleinian child psychoanalysis, Elizabeth Bott Spillius, in her comprehensive two volumes entitled Melanie Klein Today, admits:

...in skilled hands this approach has an imaginative grasp that compels admiration (but) concentration on unconscious phantasy has sometimes led to routinized 'symbolic' interpretations that can be true to anyone's unconscious and miss out the particular child's nuances or expression.

The Concept of Part Objects and Interpretation

Spillius discussed another change in Kleinian theory and technique. Previously the concentration had been on anatomical part objects, specifically the breast and penis, as the earliest objects of infantile and unconscious preoccupation. Now, Kleinian analysts are more cautious when formulating interpretations using this language as there has been a shift from structure to function. Interpretations are framed, at least initially, in terms of the function of the part object since Kleinian analysts now think that individuals relate to psychological part objects rather than anatomical part objects. Functions are understood to be aspects of the self projected into the part object.

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Additional Considerations of Technique

The focus of present day advancements in Kleinian analysis is an interest in technique, specifically in the transference and counter-transference and their interrelation. Betty Joseph's work on acting in the transference as a means of fostering emotional contact and change is one example. Contributions of Kleinian child psychotherapists trained at the Tavistock clinic have also highlighted changes in the understanding and work with children. Anne Alvarez (1988) looked at the ways in which play contains the hopes and aspirations of children and their capacity to have fun, rather than only looking at play as an evasion of reality. In another paper Alvarez (1989) examined the Kleinian idea of defence. Defences, she said, could be healthy, protective and at times necessary, rather than always pathological and in need of being analysed away. Meira Likierman (1988) looked at a little emphasised aspect of maternal psychic nourishment, "the mother's primitive, narcissistic, positive projective identification" which could give the baby an experience of love and goodness. Susan Kegerreis (1991) took on the challenge that Kleinians only interpret and see the pathological and negative. In re-examining Klein's early clinical writings she found that:

...one can see repeatedly her demonstration that it is the conflict over the realisation of one's destructiveness that matters, the meeting within of love and hate, not just the existence of hate.

However, Kegerreis went on to say

...what so often seems to get emphasised in accounts of Kleinian technique is the analysing of the destructiveness itself, rather than the anxiety for the fate of our internal objects in the face of it.

Kegerreis proposed, and illustrated with a case example, that the focus with certain patients needs to be the interpretation of the positive, rather than the negative. It may be love and hope which is hidden rather than the opposite. This means, she said, that "a technique that emphasises showing him (the patient) how the destructive forces are maintaining their supremacy can, in fact, reinforce their power".

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In Klein's views on analysis, work with children and adults is seen to be the same, with little alteration of technique or theory. However, contemporary Kleinian analysts who work with both children and adults, for example O'Shaughnessy, Joseph and Robin Anderson, are interested in seeing if recent developments in techniques with adults are also appropriate with children. The results of their work remains to be seen.

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The early era of child psychoanalysis was plagued by controversies and criticisms between the two schools of the time, Anna Freud and Melanie Klein, which culminated in the now famous Controversial Discussions which took place at the British Psycho-Analytic Institute from January 1943 to May 1944. Whilst these debates involved psychoanalytic theories on all levels, the origins began years earlier in relation to analytic work with children.

Klein criticised Anna Freud for educational methods, for her early ideas about a preparatory phase and the negative transference, for not recognising the transference neurosis in children, and for overly involving the child's parents. She thought all of these things precluded setting up a genuine analytic situation and, since she viewed child analysis as running parallel to adult analysis, there was no need to impose any restrictions on the analysis of children. In turn, Anna Freud was critical of Melanie Klein. She thought Klein used symbolic interpretations excessively, a method which, in her opinion, failed to respect the child's ego and bypassed defences instead of analysing them. Klein overlooked the developmental status of the child and treated him adultomorphically, carrying out id analysis.

Nevertheless, over the years there was some synthesis of these two founders of child analysis. Anna Freud reconsidered the idea of a preparatory phase, extended her ideas about transference in children, involved parents less although she still placed great importance on including them to some degree. With the analysis of younger and more disturbed children her technical procedures widened. In 1948 Klein said about Anna Freud that "our views coincide on the possibility of conducting an analysis from the beginning by analytic means" and pointed to "a lessening of divergences between her and myself as regards to the psychoanalysis of children".1

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Thus, there are some similarities between the theories and techniques of Anna Freud and Melanie Klein, and many differences. Whilst both had a developmental orientation in their work, the differences in this viewpoint were vast. Anna Freud began as a teacher and the first children she analysed were of latency age. Her theories were rooted in normality and the deviations from a hypothetical norm, ideas which were incorporated into her assessment and psychoanalytic techniques. The aim of analysis was to restore the child to a path of normal development. For Klein the aim of child psychoanalysis was to clear up psychotic traits. This points to the origins of her theories of development, based on the analysis first of the very young child, then on the analysis of psychotic and borderline adults. Furthermore, the two held divergent conceptualisations of early childhood. Klein thought that in the first months, perhaps weeks, of life there existed in the child a range of differentiated object relationships, partly libidinal and partly aggressive. By this time the child's psychic apparatus had already differentiated into ego and superego and was capable of an elaborate system of unconscious fantasy. Anna Freud, on the other hand, thought that in the first months the child's psychic apparatus was governed by narcissism and the urge for satisfaction. The psychic structures of ego and superego developed gradually and over time. The development of object relationships went through a series of phases, the basis of which was the interaction with the primary caregiver, the mother.

Klein and Anna Freud agreed that a child's mode of communication was through action and play, and they followed the child's material using these vehicles as well as verbal communication. Klein thought the child's play was equivalent to free association and composed of symbols which should be treated as primary process. Anna Freud strongly disagreed and thought interpretation based on play alone was symbolic and subject to speculation, doubt, and arbitrariness. The analyst observed the child's play in order to understand the ways in which the child's ego coped with impulses, the superego and reality, in other words, the interaction of mental forces. It was the child's affect and changes in affect and levels of anxiety which provided more reliable clues as to the meaning of the child's communication. Klein too placed an importance on affect and anxiety and both agreed that defences were against these, as well as the drives. Whilst both included defences in their theoretical framework, Anna Freud elucidated many types of defence mechanisms, whereas Klein focused exclusively on introjection and projection. Anna Freud agreed with Klein that projection and introjection were primitive defensive processes, but disagreed that they existed from the beginning of life.
The framework in which an analysis of a child was conducted was the relationship
with the analyst and in both theories this relationship holds a central position. However,
here too are differences. Klein argued for the totality of the transference. All aspects of the
relationship of the child to the analyst fell under the rubric of transference. Whereas Anna
Freud concurred that transference was a crucial element in child analysis, she was cautious
as to what was transference and what was not, arguing for a more narrow definition of the
concept. She looked to the intricacies and nuances of the relationship and included other
elements such as the treatment alliance, and the analyst as a new or real object.

Conflict too was central to both theoretical orientations. Anna Freud conceived of
conflict as a normal byproduct of development. She viewed conflict within a structural
model as by her definition internalised conflict was intersystemic, i.e. between the agencies
of the mind. Klein, on the other hand, viewed conflict from a drive theory orientation.
Conflict was between the life and death instincts, which later was conceptualised as between
love and hate.

Resistance too was an aspect of both theoretical frameworks. Anna Freud saw
resistance as an expected analytic phenomenon and spelled out various types of resistances
found within a child analysis. The analysis of resistance was a central component to this
treatment modality and a fundamental concept in Anna Freudian theory. Klein spoke less
of resistance and implied in her writings, and those of her contemporaries, is the notion that
resistance is a lack of cooperation and a stubbornness on the part of the patient.

The fundamental concepts of psychoanalysis which were first outlined by Freud,
and then by others, were transference, defence, resistance, and conflict. All of these
concepts play a role in Anna Freudian and Kleinian theories, however the meanings of the
concepts are incongruent. It is not only the meaning of the concepts which point to the
differences between these two theoretical frameworks, but the accompanying ideas about
technique. Klein worked from the depth to the surface, whereas Anna Freud proposed
working from the surface to the depth. Both thought the other's way of analysing promoted
and strengthened resistance.

Anna Freudian technique involves working first with what is most close to
conscious awareness beginning with defence interpretation and the development of a
treatment alliance, and proceeding to the interpretation of resistance and transference, all the
while focusing on anxiety and affect. In this way the analyst moved down to the depths, to
what was unconscious. The unconscious world was composed of conflicts, fantasies,
impulses and wishes which were the subject of the analytic work.
Kleinian technique proposed bypassing the surface and interpreting the unconscious through symbolic representations in the child's play and the transference which occurred from the very first session. Unconscious fantasy was the focus of the analysis. Counter-transference was an important tool, conceived of in terms of the analyst's response to projective-identification.

Anna Freud and Melanie Klein influenced the thinking about child analysis throughout the world. Anna Freud dominated the thinking of North Americans, whereas Klein influenced child analysts in South America. Other child analysts who had fled to various parts of the world during the war began to develop their own trainings and theories, initially along the lines of the two founders.

THE CONTRIBUTIONS OF BOWLBY, SPITZ AND WINNICOTT

No discussion of child psychoanalysis would be complete without including the contributions of John Bowlby, René Spitz and Donald W. Winnicott, all of whom influenced the way analysts thought about children and development. They made a profound impact on the thinking of early child development and the relationship between the child and his primary caregiver. As with Anna Freud, these analyst's theories were based on the observation of children, as well as studies of separations between mother and child.

Donald W. Winnicott

Winnicott began as a pediatrician in the twenties, attaining some eminence in this capacity in Britain prior to World War II. His interest in and concern about the emotional problems of his patients led him into psychoanalysis in the thirties, being the first pediatrician to train as a psychoanalyst. During the war he was the psychiatric consultant to the Hostels Scheme for evacuated children, where he observed first hand the impact of the child's separation from his family. Winnicott was a leading figure in the British Independent group and the British Object Relations school, twice serving as president of the British Psycho-Analytic Institute.
During his forty years at Paddington Green Children's Hospital in London, Winnicott had the occasion to observe thousands of mother-infant dyads from which he developed his ideas on transitional phenomena. He linked his observations with insights gained from psychoanalysis through his work with mothers and their infants, children, and disturbed adults. Development, thought Winnicott, was a natural progression which involved the processes of individuation and adaptation. Development begins with the mother-infant relationship as Winnicott said there was no such thing as an infant, only an infant as part of a couple with the mother. "If you show me a baby you certainly show me also someone caring for a baby, or at least a pram with someone's eyes and ears glued to it. One sees a 'nursing couple'."\(^2\) This first relationship is one of reciprocity, each partner in the couple influencing the other. Object relationships begin with a relational matrix between mother and infant. Rather than conceptualising that the infant simply seeks instinctual gratification from an object, Winnicott thought that the infant began life as a sociable being seeking contact with a person. It was the maternal care which helped the baby begin to be and to feel real. His studies were devoted to the recognition and description of what was "a good enough mother" who could sustain the infant's "going on being"\(^3\). Part of the mother's function was to provide a holding environment, holding the infant both physically and figuratively. This environment led to the older child and adult's development of a self, as Winnicott believed a person could only find himself in relation to others, gaining independence through the acknowledgement of dependence. Psychopathology, according to Winnicott, originated from the breaks in the continuity of care by the primary caregiver, gaps which were caused by intrusions and deprivations and the natural catastrophes of childhood. These intrusions could contribute to the development of a "false self" at the expense of the growth of a "true self"\(^4\).

Winnicott's model for psychoanalytic treatment was the mother-infant relationship. He thought what mother's did naturally, if they were a good enough mother, could provide the model for the skill of a psychoanalyst. Thus, it was the role of the analyst not only to interpret, but to provide a holding environment for her patients where trust was established and the work could take place. Winnicott also contributed greatly to the concept of playing and playing in psychoanalysis. He thought that it was through play and enjoyment that anxiety was mastered and contained. Winnicott's wife Clare said of him, in her preface to The Piggle which was published after his death and outlines the account of psychoanalytic interventions with a young girl over a two and a half year period:

Readers will sense Winnicott's own enjoyment in his play with the child. He perceives and accepts the transference, but he does much more; he brings it to life by enacting the various roles allotted to him. The dramatization of the child's inner world enables her to experience and play with those fantasies which most disturb her. This occurs in small doses and in a setting which has become safe enough through the skill of the therapist. The creative tension in the transference is maintained, and the level of anxiety and suspense is kept within the child's capacity, so that playing can continue.\(^5\)

**John Bowlby**

John Bowlby's clinical involvement with children began in 1929 when he worked for six months at a school for maladjusted children. By 1939 he had completed his psychiatric and psychoanalytic trainings and began working in London at a child guidance clinic. Similar to Anna Freud's history, Bowlby too was interested in the impact on children of separations from their families and the development of child training programs.

Bowlby initially chose as his field of study the removal of young children from their homes who were then placed in residential nurseries or hospitals. In 1944 he wrote "Forty-four juvenile thieves"\(^6\). Through this research he discovered that a high percentage of children who fell into this category lacked a consistent mothering person. This work led him to the formulation of attachment theory.

In 1948 Bowlby instigated a child psychoanalytic psychotherapy training program at the Tavistock Clinic which coincided with the beginning of Britain's National Health Service after the war. His hope was to integrate training and research. He brought Esther Bick in to head up the training whose orientation was Kleinian. Today the Tavistock Clinic maintains this orientation, as well as a connection with the National Health Service. Bowlby remained at the Tavistock until his death in 1990 concentrating on his attachment theory and research.

Bowlby found that there was a causal relationship between the loss of maternal care early in life and disturbances in personality development. Like Winnicott, Bowlby focused on the mother-child relationship which he too conceived of as a reciprocal one. Both mother and child contribute to the form of the attachment through two main sets of influences. The first, he said:

concerns the presence or absence, partial or total, of a trustworthy figure willing and able to provide the kind of secure base required at each phase of the life-cycle. These constitute the external, or environmental, influences. The second set concerns the relative ability or inability of an individual, first, to recognize when another person is both trustworthy and willing to provide a base and, second, when recognized, to collaborate with that person in such a way that a mutually rewarding relationship is initiated and maintained. These constitute the internal, or organismic, influences.\(^7\)

These two sets of influences interact throughout life and are based on the early mother-child attachment. It is the mother's task, thought Bowlby, to provide a secure base for the infant and to allow and encourage the infant's explorations from that base. Patterns of attachment are then established which tend to persist throughout life. Thus, the patterns of family relationships experienced in childhood are crucial as they influence the development of the personality and the future relationships of the child.

Bowlby's theories of attachment were not initially well received by the psychoanalytic community as he rejected the notion of drive theory. He thought instead that the mother-child relationship was determined by evolutionary programmed attachment behaviour which served the purpose of protection. Strongly influenced by Darwin, Bowlby thought that attachment was a human instinct also present in lower animals. His theory was a causal theory as the effects of real life events on the person contributed to the creation of a disturbance. Nor were his theories based on the traditional psychoanalytic notions of dependence and independence. An individual could be dependent, but not attached, as the two concepts were different in their formulation.

Although ostracised by the analytic community in Britain for many years, Bowlby continued his work based in clinical observations and a research approach to attachment, separation, loss, and mourning. His theories fit well with operational research on patterns of behaviour and have now found a place within developmental psychology and psychoanalysis. Mary Ainsworth, who worked with Bowlby for many years, continued research in the field and has been followed by Mary Main among others. Through observational research, four types of attachment in young children were delineated: anxious-avoidant; secure; ambivalent-anxious; and disorganised which is not strictly a

type of attachment but the absence of a distinguishable pattern. Recently a fifth category has been proposed, that of reverse attachment where the child clings to the acts of parenting the parent.

René Spitz

René Spitz began his work in Vienna, then the United States where he immigrated in the forties. A pioneer in the field of infant observation, Spitz's 1947 films of infants in institutions are now famous. In the forties his interest was in the effects of deprivation. Although physically cared for, these children did not experience the stimulation and affection of a constant caregiver. Due to this type of deprivation, Spitz found disturbances in object relationships, and deficits in drive, ego, cognition and motor development. In extreme cases of maternal deprivation death could result. In the fifties Spitz and his colleagues at the University of Colorado Medical School began laboratory experiments to research the role of affects and the affective dialogue between mother and child. Reciprocity was central to Spitz's findings, as it was with Winnicott and Bowlby. The affective reciprocity between mother and infant, he found, stimulated and promoted the exploration of the environment, and facilitated expanding motor activity, cognitive processes and thought, intellect and mastery.

Spitz was also interested in the study of the development of ego functions along lines of development, akin to Anna Freud's idea of developmental lines. The observation of new behaviours and affective experiences, thought Spitz, indicated that a new level of psychic structural organisation had been reached. These surface manifestations he called "psychic organisers" which reflected underlying advances and new integrations into new organisations. One of these internal organisations was a sense of self. Spitz theorised that the development of self was a differentiating process, beginning early in infancy.

In observational studies of the first two years of life Spitz and his colleagues proposed three psychic organisers. The infant's social smiling response indicated the beginning establishment of the reality principle as the infant rediscovered in reality the object he held in his imagination. This three month smiling response also marked the differentiating of "I" from "non-I". Stranger distress was the second organiser as the infant compared the face of an unfamiliar adult with the face in memory of the mother. Distress resulted with the infant's realisation that the mother was gone. Thus, this eight month stranger anxiety indicated the infant's ability to discriminate between his love objects and strangers. The final psychic organiser was the "no" and negative head shaking so familiar...
with toddlers as "no" is now invested with aggression. The child's use of "no" in gesture and word, beginning around fifteen months, was indicative of his increased autonomy and wish for independence, along with a growing sense of separateness. These nodal points in the organisation of self, thought Spitz, culminated in the child's sense of self-awareness.

The work of Winnicott, Bowlby and Spitz, along with Klein and Anna Freud raised the consciousness of the analytic community to the importance for the child of both continuous mothering and problems of separation. Whilst Freud conceptualised a pre-oedipal scheme of development based on the reconstruction of adults, he focused on the three person relationship of the Oedipus Complex. These analysts, through observational studies of children, emphasised the child's first relationship with the mother where the origins of some pathologies could be found arising from the loss of intimacy. Although Klein tended to ignore the influence of the environment, the other four stressed the importance of these relationships for the child.

OTHER CONTRIBUTIONS: 1930 - 1959

In 1939 H. Lippman, in America, wrote about the trends in child psychoanalysis at the time. He took a limited view of child analysis saying it was only for those children suffering from "a severe neurosis", and only as a last resort after all other measures, such as attempting to relieve tensions in the home environment, had been tried and failed. The primary objective of analysis was to lessen the child's suffering by getting at the underlying cause of the suffering, whilst the goal was to help the child accept reality and prevent him reacting to it in a "neurotic manner". Lippman concurred with Anna Freud that child analysis was the analysis of the child's ego with the aim of helping the child give up maladaptive defences.

The means of accomplishing these goals, said Lippman, was interpretation. Unlike Melanie Klein, Lippman thought interpretations should not be made until "the child has so worked through the material that the meaning is quite clear to him", thus eliminating any speculation and guess work as to what meaning lay behind the child's material. The end product of analysis was a "lessening of the demands of the superego, and a strengthening of the ego, with the result that the child is much less inhibited".

Sylvia Payne, a British analyst who was one of the founders of the Independent Group, wrote about child psychoanalytic training in 1943. In her view child analysis was not defence analysis, but a process by which unconscious fantasy was made conscious. She said child analysis was "a method of observing and influencing the development of the psyche by dealing with primitive forms of mental activity, which include the earliest forms of phantasy." The source of difficulty for the child arose from the interplay between unconscious fantasy, the environment, and the child's behavioural reactions.

In agreement with Lippman, the means of achieving the aims of analysis was interpretation. The differences are found in what she thought was interpreted and how the analyst understood the child. Interpretation, thought Payne, relieved anxiety, be it interpretation of the content of the fantasy, of the transference, or of resistance. In accordance with the aim of making unconscious fantasy conscious was the understanding that access to the child's unconscious world was found in the child's play. Through the play the analyst could ascertain what the content of the unconscious fantasy was, what the child's unconscious thoughts about the analyst were (the transference), and what defences the child used to deny or repress wishes and feelings (the resistance). Resistance and defence, in Payne's writings, seem to be interchangeable concepts.

The ongoing controversies about child analysis, and analysis in general, seemed to be one of emphasis. What was the focus of analysis? The Kleinian school argued for analysis of the id which meant the unconscious, and interpretation of the content of unconscious fantasy. The Anna Freudian school argued for analysis of the ego and its interaction with the psychic structures of id and superego. In North America were other pioneers, most of whom followed Anna Freud's thinking and expanded it yet further. In the forties and fifties four of the most influential contributors were Berta Bornstein, Edith Buxbaum, Marianne Kris, and Margaret Mahler.

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10 The Independent group of the British Psycho-Analytic Institute was strongly influenced by child analysis, specifically Melanie Klein and Anna Freud, although its members were not particularly allied to either of those schools of thought. In addition, Winnicott had a strong impact as one of the founding British Independents. Interestingly, no training in child analysis has been established under the auspices of the British Independent group, however the British Association for Psychotherapy offers a child psychoanalytic psychotherapy training in this tradition.

Berta Bornstein

Berta Bornstein worked with Anna Freud in Vienna until she immigrated to America in 1938. Her early works in Vienna (1930-1936) focused on the child's need to be understood according to his level of ego development which, Bornstein thought, was the key to treating children. In the forties her work concentrated on defences, and the ways to handle a child's defences and defensive maneuvers. Helping to take child psychoanalysis beyond the realm of educational techniques, it was defence analysis, thought Bornstein, which helped to establish a working relationship with the child. Although the concepts of treatment alliance and working alliance came later, they apply retrospectively to Bornstein's procedures. Interpretation of defence and attention to the child's affects enabled the child to seek help through the analytic process, thus avoiding the need for a preparatory period. The transference could then be observed more clearly and analysed.

Interpretations, thought Bornstein in agreement with Anna Freud, moved from the surface to the depth first dealing with ego changes so the ego could then deal effectively with the demands of the drives. Interpretation of affect preceded interpretation of defence, which included not only analysis of the ego, but of the superego. It was interpretation of affect which helped the child experience the original emotion which in turn provided the background for the interpretation of unconscious material. Once the patterns of defence were known to the child, interpretation of unconscious content could follow. Aiming for interpretation of unconscious material first, thought Bornstein, lead to heightened anxiety and increased resistance. Within the realm of the technique of interpretations, Bornstein stressed the need to spare the child's self esteem, to respect the child's ideals, and to treat the child's bad conscience as a nuisance to him.

Behind every symptom neurosis, said Bornstein, was a character neurosis, and it was character analysis which the analyst did with a child rather than symptom analysis. The aim of child analysis was to make the child conflict-free as far as possible within the constraints of the environment. The components of child analysis were the analysis of the reactions to the analyst which, at this time, were called transference reactions, resistance, defence and conflict, taking into account the strength and weakness of the child's maturing psychic structures.
Margaret Mahler

In 1945 Margaret Mahler wrote a comprehensive paper entitled "Child-Analysis" which was the culmination of her views arising from her work at the Children's Service of the New York State Psychiatric Institute and Hospital. In contrast to the Kleinian school, she thought the id was not amenable to change, thus the emphasis had to be on the ego. She said:

According to psychoanalytic theory, the constitutionally inherent part of the personality, the amorphous id (instinctual reservoir), is for all practical purposes unchangeable. Hence the analyst's therapeutic efforts set in at the differentiated, changeable, and adjustable part of the personality, the ego.12

Child psychoanalysis, said Mahler, was not for "minor disturbances", but for "severe, fully developed infantile neurosis with low reversibility potential". In the case of infantile neurosis, analysis was the "therapia magna" which worked not only toward the relief of symptoms and changes in pathological patterns of behaving, "but tries to eliminate the agents of the pathogenic process as well"13.

Mahler placed child analysis within the framework of a child's development. All children, during the process of growing up, confront conflicts and the need to find solutions for them. Psychoanalysis was indicated when the conflicts were such that they were unsolvable without direct help, and resulted in neurotic symptoms and increased anxiety which impaired the child's functioning and happiness. Making the determination for psychoanalysis was thus a process of deciding the degree of deviation of the child's behaviour from the average expectable norm. Part of this process required assessing the internal structural development of the child, taking into account the age adequate integration of the child's personality in terms of the differentiation into the three mental institutions; id, ego and superego. In addition, was the question of internalisation of the conflict. In other words, how far the conflict remained between the child and his environment, and how far the struggle was between the psychic institutions within the child. Conflict, in Mahler's sense, was instinctual conflict.

Whether with adults or children, the aim of the psychoanalytic technique, said Mahler, was rendering unconscious psychic material conscious. This was effected through interpretations. Interpretations are directed at those pathological formations of the ego which ward off instinctual impulses or their derivatives. The ego is then enabled to dispose

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of pathological defences, thus bringing unconscious conflict into the child's awareness. By working-through all of the ramifications of a conflict, the mature aspects of the ego can then correct pathological attitudes and symptoms, and solve conflicts successfully.

In principle, the theory of analytic technique was the same for the adult and the child: "analysis of resistance to get to the unconscious conflict with its ramifications"14. However, thought Mahler, the procedure in its manner and details differed when dealing with children. Mahler included resistance, defence, and conflict analysis, as well as the importance of working-through. When dealing with children the analyst had to be ever mindful of the process of ongoing development and the so called educational measures. In regards to the former, Mahler said that with children analysis included within its scope:

...strengthening and consolidating personality-integrating forces so far as to warrant not only the restoration of the child's ability to solve successfully his inner conflict as it is, but to effect such structural change in the child's personality as to forestall danger of relapse in future conflict situations with which the strain of the growing-up process and perhaps difficult reality situation might confront the child.15

In regards to the latter, Mahler emphasised that child analysts exercise deliberate restraint from strictly educational measures as the analytic process becomes blurred and contaminated if suggestion, irrational reassurance, or other educational measures are applied. However, to refrain from any educational measure in an exaggerated form "is contrary to the very nature of childhood which leans and depends on the adult world". What Mahler was referring to are the areas of instinctual drive liberation and superego alteration. With a developing child, instinctual drives are in a natural process of repression and sublimation, and the superego is in the midst of a formative process. Thus, she said, certain interpretations which are educational and "favor in a gentle way the forces of the ego, which bring about renunciation of certain aggressive and infantile erotic wishes, are not only unavoidable but are an indispensable agent"16. The analyst's role involves taking a middle course between drive liberation tolerance and gentle prohibition.

Mahler's work led her into the areas of childhood schizophrenia and psychosis. Her 1955 hypotheses17 of the symbiotic origin of the human condition and of the separation-individuation process in normal development prompted years of research in the field of child development, along with Fred Pine, Anni Bergman and later John McDevitt. Four subphases of the normal separation-individuation process were formulated and validated in

repeated studies with average mothers and their normal babies. The results of this research and the phases of this developmental period, detailed in The Psychological Birth of the Human Infant (1975)\(^\text{18}\), have come to hold a central place in child developmental theory.

Marianne Kris

The analytic method of the time entailed interpretation of defence, resistance, and conflict, and working-through. Marianne Kris, along with the other pioneers of her time, stressed the need to be ever mindful of the child patient's level of ego development, not only in terms of cognitive development and the level of communication, but the need to respect the vulnerabilities of the child's immature ego. Kris thought this required:

...extra caution and patience...in dealing with the child's defenses and in assessing the degree of frustration he might tolerate; the importance of uncovering the ego aspect when addressing areas of conflict as an aid in conveying the analyst's role as an ally in combating id forces, in facilitating the reinternalization of externalized conflicts, and in avoiding the promotion of externalization: the necessity for attunement to, and verbalization of, the child's feeling states...\(^\text{19}\)

One of Kris's important contributions to the field was to introduce the idea of "adaptation of technique" to child analysis. Adaptations of technique were designed to attain compatibility with the analytic method, whereas "modifications of technique" impinged upon, and at times disrupted, the analytic process. For example, a modification of technique might be an intervention which aimed at changing the patient's environment, an educational measure which was intended to correct sexual confusion, or gratifications such as gift giving or answering patient's questions. The importance of the distinction may be difficult to see presently, however in 1947 it was not an uncommon practice to modify technique in these ways.

Kris's greatest contribution was to the field of transference, a concept she began to elaborate in the forties. Prior to that time it was accepted among non Kleinians that, owing to the continuing presence of original objects, the child did not form a transference in analysis. When transference reactions were talked about they were taken to mean displacements of current attitudes directed towards the parents, rather than transference as a repetition of past relationships. With the changes in thinking about transference which arose from Anna Freud and her colleagues in London, Kris was one of the first, if not the


first senior analyst in America, to embrace these findings. Kris added that the contamination of the transference was one of those factors inherent in technical modifications which endangered the analytic process. By the fifties, and certainly by 1960, the child's potential for transference and the capacity to form a therapeutic alliance were widespread views, aided by Kris's contribution.

Edith Buxbaum

Edith Buxbaum made two further contributions to the field of child analysis. One was including transference as Kris had initiated, and the other was looking at other than neurotic cases. Child analysis was originally designed for the treatment of the infantile neurosis. Buxbaum (1954)²⁰ outlined what the analyst did when working with a neurotic child. She included clarification, specifically of reality; interpretation, meaning the explanation of irrational behaviour in terms of fantasy and past experience; transference interpretation (now included as it hadn't been before); and "educational measures" where the child's aggressive attacks needed containment. In addition to these analytic methods, Buxbaum thought work with parents was important, the form of which varied dependent on the age and pathology of the child and on the character structure and emotional difficulties of the parents.

However, analysts were finding there were cases which deviated from the so called classical infantile neurosis. It became clear to Buxbaum that modifications of technique, adaptations in Kris's terms, were necessary for those cases, whilst earlier analysts had argued that other than neurotic cases were not suited for analytic treatment. Although she made it clear that the point at which modifications were no longer considered psychoanalysis was beyond the scope of her writing, she discussed necessary modifications in relation to specific forms of pathology. With certain symptomatic disturbances in children under five years of age, she thought it necessary to promote regressions and evoke previous prohibitions with the aim of finding the way back to the origins of the disturbance. The aim then was to "re-educate the child to self control...rather than to have to inhibit drives to such an extent that development is blocked"²¹. To treat children with behaviour disorders, Buxbaum thought the child needed to form a positive relationship with the analyst, to learn to exchange love and praise for restrictions and frustrations, and to give up old satisfactions for new ones in order to progress developmentally. This first required "ego building" devices, and later, if a neurotic structure was found to underlie the delinquent

behaviour, this could be treated "analytically". Aichhorn's work in the twenties with delinquents was along similar lines. In regards to children who suffered from more severe disturbances in the realm of an inability to form stable object relationships, for example autistic, psychotic, or atypical disturbances, the analyst first needed to form a relationship with the child scanning for signs of what he would respond to, then "re-educate". In this sense Buxbaum meant to intervene in and correct developmental deviations and distortions by setting controls on uncontrollable behaviour, undoing inhibitions, clarifying in order to correct false impressions, and interpreting symbolic material.

The dividing line, thought Buxbaum, between those children who suffered from an infantile neurosis and those who suffered from the other disturbances she outlined, was the oedipal phase. Children who had reached this phase more closely matched an infantile neurosis. She added:

The more independent of the environment the child functions, acts and behaves, the more his treatment resembles that of adults, in which the therapist is chiefly concerned with conflicts from within.

If the child's disturbance had origins in earlier phases of development, and he had not yet reached the oedipal phase, modifications of technique were indicated which more closely resembled those used with younger children. However, whatever the pathology or developmental phase of the child, the aim of analysis was always "restoration of function and initiation of the capacity for growth and maturation"22.

The Aim and Technique of Child Analysis

In the late fifties the trend of discussions by contributors to the field was modifications of technique. Taking this a step further in order to differentiate when child analysis was no longer analysis, the American Psychoanalytic Association held a panel in 1957 entitled "Indications and goals of child analysis as compared with child psychotherapy"23. Several points were illuminated pertinent to the question of what constitutes child psychoanalysis. The panel concluded that the goal of child analysis, as with adults, was to uncover and resolve unconscious conflicts and free the energy which was bound up with them. However, with the child unlike the adult, the goal and technique were coordinated with the stage of the child's development. In terms of technique, the investigation of past experience and the interpretation of fantasy went hand in hand with the analysis of ego defences and the transference. The aim of child analysis was to deal with

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internalised conflict and identifications, and to help the child work-through and come to a resolution of not only unconscious internalised conflicts, but conflicts between id, ego and the external world. The panel continued that this involved not only analysing the transference, but "depth interpretations" which were thought not to be possible in psychotherapy.

OTHER CONTRIBUTIONS: 1960 - 1969

The original prototype of all analyses was derived from Freud and the so called neurotic patient. Child analysis arose out of this model. Throughout its early years and well into the sixties it sought to define itself in relation to adult analysis. Consequently, child analysts struggled with the questions of how did child and adult analysis compare and contrast, as the profession attempted to rationalise itself based on the adult model and to prove to its audience that analysis with children was indeed analysis as Freud had defined it. Out of this struggle other questions began to surface, not only related to treating children in general, but to children of different ages and developmental levels. Linked to this was the ongoing question from the previous decade of what the parameters of analytic treatment were as knowledge and theories were expanded and refined, not only about personality structures which fell under the heading of neurotic, but about other forms of disturbances and the developmental process as well. What techniques were analytic ones and when did the method of treatment fall over the imaginary line into other than analysis?

Considerations of Technique

Many agreed (Geleerd 1962, Kramer and Settlage 1962) that the analytic procedures were the same with children as they were with adults and that the same basic concepts were fundamental to any age group. Analysis began at the surface with interpretation of defence and proceeded to the depths with the analysis of the transference, which in turn prepared the way for interpretations of unconscious repressed memories and fantasies. But always, be it child or adult, analysis was defence analysis. As Selma Kramer and Calvin Settlage stated:

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The unconscious conflicts are brought to consciousness by interpretation of those defenses which the child uses in warding off the instinctual impulse or its derivatives. By gaining insight into these defenses, the child's ego slowly and syntonically is enabled to understand and to develop adequate means of handling the unconscious material against which it has been defending.26

The differences between the adult and child models were thought to be in the means used to reach the common aims which were reflected in the areas of technique.

Elisabeth Geleerd, in a Symposium on Child Analysis, stated that the techniques used with children needed modification due to the child's level of ego development. Verbalisation was a necessary component as it helped the child to gain an understanding of his feelings and emotional relationships and, in turn, his reactions. Verbalisation and clarification prepared the ego for the interpretation of defence, the transference and id fantasies.

Kramer and Settlage agreed there were additional theoretical concepts and specialised techniques which were required with children necessitated by the immaturity of the child's ego and the child's continuing need to be dependent upon his parents. The child analyst continually and actively used her own ego to supplement the ego capacities not yet fully developed in the child. If the child was uncontrollable the analyst needed to provide the ego control lacking in the child. Sexual content should not be avoided, but handled carefully so as not to appear either too seductive or permissive in the child's eyes. Concurring with Anna Freud, the authors stated that the observation of the child's affect was extremely important in understanding the defensive nature of the material. Timing and caution in regards to interpretations of conflict were of the upmost importance due to the vulnerabilities of the child's ego, and the need to be able to gradually master conflicts and give up pathological defences in favour of healthy ones. If defences yielded too quickly, large quantities of anxiety were liberated which were felt to be intolerable. In addition, rather than relying on direct verbal communication from the child, the analyst had to learn to understand all medias of communication offered by the child, be it play, drawings, games, fantasies, etc.


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These technical alterations always linked to and remained within the framework of analysis and its aim: structural change within the personality so that the ego is able to cope with impulses and external reality. It was thought that it was the expansion of the healthy ego which resolved conflicts and enabled the child to withstand both the revival of old conflicts and impulses, and the appearance of new pressures which were ordained by the nature of development.

In 1964 the American Psychoanalytic Association held a panel discussion on "Child analysis at different developmental stages". The panel explored the areas of what constituted child analysis, its aims and technical components, as well as the variations required at different developmental stages. Psychoanalysis was seen to be a developmental theory, and as Seymour Lustman said, it deals with "an internalized hierarchy of development within each person which makes him capable of functioning with varying degrees of maturity or primitiveness, reflective of internal states of such organization".

Panel members expressed their views about child analysis and its components. Eleanor Galenson said that because of the child's psychological maturity the analyst had to act as an auxiliary ego and superego at times. Verbalisation was a crucial tool not only for the development of a sense of reality and secondary process thinking, but as a way to help the child put words on forgotten experiences which were once verbal or preverbal. Interpretation of defence and the exploration of other ego functions were crucial aspects of the analytic process. E. James Anthony and Marjorie Harley spelled out how a child could tolerate more "pure analysis" than was originally thought, and that the analyst analysed from the beginning, rather than initiated a preparatory phase. Geleerd discussed how the analyst needed to avoid educational and other nonanalytic practices so as not to obscure or interfere with the transference, and Selma Fraiberg outlined the methods of analysis being the analytic work and education of the child towards self observations and understanding. One of the major technical differences between adult and child analysis was the visibility and accessibility of the analyst, and the panel elaborated on the complications of staying within an analytic role with children. Anthony expounded on how, due to the absence of the physical separation from the patient which the use of the couch provided, the analyst was more exposed to aggressive and seductive acts from the patient which were designed to test her. In addition, he thought, the young child's motor activity disturbed the analyst's free floating attention as did the child's demand for cooperation in the production of material. Anthony concluded that the analyst needed not only technical adaptations, but to monitor the

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analysis more closely in terms of the setting and the avoidance of gratification, as well as her own counter-transference. Others disagreed with Anthony. Geleerd thought that most child analysts could be both a participant and an object in the child's life, and remain neutral at the same time. Galenson added that the analytic situation was not defined by the physical setting, but by the analytic point of view of the analyst. Harley, implicitly in agreement with the complications imposed on the monitoring of the analyst's own counter-transference, emphasised the need to stay within the analytic role and avoid the temptation to move out of it, a temptation which was greater with children.

Transference and the Therapeutic Alliance

The role of transference in child analysis, one of the controversial areas from its inception, was discussed by the 1964 Panel, as well as a relatively new concept, the therapeutic alliance first introduced by Elizabeth Zetzel in 1956. All participants agreed there had been many changes over the years in regards to transference, however there still remained many disagreements regarding the concept. Galenson saw the child analyst as partly a transference object and partly a real object for the child. Fraiberg concurred saying that the analyst maintained neutrality and analysed the transference, but not the whole of the analysis was under the influence of transference. Some participants had previously expounded on transference in child analysis involving an extension of the child's current reactions and relationships, to which Harley agreed, but she added that this was not the whole story. Transference also involved a repetition of the past. Earlier libidinal and aggressive strivings were animated by the analytic process and directed toward the analyst. With the lifting of repressions, which was the outcome of interpreting the relationship with the primary objects, manifestations of past experiences were revived in the transference and thus became material for the analytic work. The long debate as to whether children developed a transference neurosis, as distinct from a transference, continued. Harley and Geleerd agreed that a transference neurosis was observable with some children, even young children, during certain stages in the treatment.

Throughout the sixties and into the seventies debates about the nature and degree of the child's potential for transference development continued. Developmental considerations played a role. Unlike the adult, the original objects with whom the child's infantile relationships were formed, and around whom the child's infantile fantasies were woven, were still present and played a crucial role in the child's day to day living. In addition, the child's ego structure lacked the cohesiveness of the adults so the process of internalisation was not

a stable one. Therefore, could transference in child analysis be equivalent to that of the adult? In a 1966 Panel\(^\text{30}\) dealing with the specific issues of transference in child analysis, participants noted a paucity of reported transference neurosis in children. They concluded that the understanding of the concepts of transference and transference neurosis, and how they should or should not be applied to children, were still confusing and lacked uniformity.

Related to the issues of transference was the therapeutic alliance. Here there was more consensus. Liselotte Frankl and Ilse Hellman (1962)\(^\text{31}\) demonstrated clearly in a clinical paper arising from their work at the Hampstead Clinic that a child had the capacity to form a therapeutic alliance. This constituted a radical change. Previously some analyst's had been convinced that a child had to be wooed into treatment as the decision was not his to enter analysis, nor did he, by nature, wish to cooperate. Now, analysts believed that children formed a therapeutic alliance and were capable of entering a therapeutic contract. The 1964 Panel agreed that the therapeutic alliance was distinct from the transference. Because of the alliance, a child was able to withstand longer periods of negative transference than was once thought. Although the alliance was aided by the real attributes of the analyst, it lead to the development of a transference.

Considerations of Technique - The Young Child

The third area tackled by the 1964 Panel was the variation of techniques based on the developmental level of the child being treated. Fraiberg spoke at length about the treatment of children under five years of age where she thought the greatest technical differences were found. Whilst a child of this age will make the content of his fantasies known through play with fictional characters, in her experience she found that the affect was usually split off. Questions and interpretations needed to be woven into the play and directed initially toward the fictional character. The aim of this approach was to help the child acknowledge that the impulses arise from within him and that the punishments are derived from his own conscience. For the child to meet this aim he needs to experience with the analyst his wishes, anxieties, and guilt feelings which are initially excluded from consciousness by externalisation. Thus, the analytic work with a child of this age moves back and forth between the fictional characters and the patient himself as the child is better


able to locate the conflicts within himself. On the other hand, with older children, language takes over for action and although they may also play, the main analytic work happens in the realm of verbalisations.

Judith Kestenberg (1969)\(^{32}\) agreed with Fraiberg and Anna Freud that the younger the child the more the technique had to be adjusted due to ego attitudes, frustration tolerance, the state of needs and drives, the sense of reality, and the nature of the child's object relationships and family life. Technical devices, not the psychoanalytic methods, goals and principles, were adjusted to the child's level of development. For example, interpretations were structured in line with the organisation of the patient's development. Work with a preoedipal child may involve help with integrative work involved in ego building. A phallic child may require help in coping with global excitements and in relating them to fantasies and wishes. A phallic-oedipal child may need help maintaining or recuperating the ability to differentiate which leads him away from the global excitement to internalisation and delineation of the superego.

The Question of Parameters of Technique

The questions of the differences and similarities between child and adult analysis were raised once more in 1965 at an American Psychoanalytic Association Panel entitled "The relationship between child analysis and the theory and practice of adult psychoanalysis"\(^{33}\). There was consensus that the analytic principles remained the same no matter what age the patient, and that the technique was adapted according to the level of maturity and the task in hand. Thus:

as long as the analyst continued to interpret defenses, transference, and content, it is less important whether this is applied to play activity, behavior, or verbal communication. And to the analyst this should not involve a change in any essential fundamental of the psychoanalytic method.\(^{34}\)

But, the question still remained whether the analysis of children required the use of parameters. Parameters in this sense refers to Kurt Eissler's 1953 term meaning "the deviation, both quantitative and qualitative, from the basic model technique, that is to say, from a technique which requires interpretation as the exclusive tool"\(^{35}\). Parameters, Eissler

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thought, should only be introduced when it had been proven that the basic model of
technique did not suffice. However, they must never transgress the unavoidable minimum
and are only used when they eventually lead to self elimination. The effect of a parameter
on the transference must never be such that it can not be abolished by interpretation. The
danger of parameters, Eissler said, is the increased possibility of falsifying the therapeutic
process as they offer the patient's ego the option of substituting obedience for structural
change, the aim of analysis.

The 1965 panel agreed with Harley's proposed use of adaptations of technique
rather than parameters or modifications. Adaptations of technique were called for when
working with children. As development is a continuum which goes throughout life, said
Kris, adaptations were required due to the developmental phase the patient was in. In
contrast, parameters are definite modifications brought about not by development, but by
extraneous circumstances, and threaten to interfere with the analytic work. Samuel Weiss
(1964) cautioned others regarding the use of parameters in child analysis. He said:

If parameters of technique become in turn the basic model them­selves, then we run the risk of succumbing to tradition of expedient
therapeutic intervention, which then casts doubt on the validity of
child analysis as a science.36

Weiss went on to ask the important questions which analysts were to continue to grapple
with in the years to come. Do analysts have a basic model of technique for child analysis or
does each group have its own operational definition? How many modifications can be made
and still call the therapy child analysis?

OTHER CONTRIBUTIONS: 1970 - 1979

The seventies saw an important shift in thinking about child psychoanalysis. There
was a move away from comparing adult and child analysis as the latter began to be viewed
as a treatment modality in its own right. It was now generally agreed that the analytic
attitude with interpretation as the main vehicle applied to both adults and children. Where
the differences lay were in the techniques employed. Structural change, the aim of analysis,
was different with children because of the process of development. Structural change is
defined in accordance with the process of development and with children this process is
ongoing and in flux. Consequently, it was thought that techniques used with children were
not modifications of the techniques used with adults, but treatment methods with their own

rational (Anna Maenchen 1970\textsuperscript{37}, Panel 1974\textsuperscript{38}, Isidor Bernstein and Albert Sax 1978\textsuperscript{39}, Jules Glenn 1978b\textsuperscript{40}). Maenchen put it aptly when she wondered why analysts attempted to get a model of child analysis as close as they could to that of adults. The child isn't a miniature adult, nor "is the model of adult analysis that sharply defined"\textsuperscript{41}.

**Child Analysis as a Process**

Child analysts now began to concentrate on attempting to define what child analysis was and how one did it. Maenchen, in agreement with Anna Freud, thought that child analysis served as an organiser for the personality and as an accelerator of development. Harley (Panel 1971\textsuperscript{42}) defined child psychoanalysis as a method composed of the clinical concepts and principles governing psychoanalysis in general, for instance the emphasis on the patient's inner psychic life and the ways perceptions and patterning of past experience influence current perceptions and behaviours. It is a method which attempts to avoid offering gratification, advice, or guidance.

Others defined child psychoanalysis as a "process" and attempted to discern what exactly this process was. It was a process which began with defence analysis and character analysis (Charles Feigelson 1977\textsuperscript{43}, Bernstein and Sax 1978, Glenn 1978b, Samuel Ritvo 1978\textsuperscript{44}), and lead to the analysis of repressed wishes, impulses, memories and fantasies, in other words making unconscious conscious (Feigelson 1977, Glenn 1978b, Rudolf Ekstein 1979\textsuperscript{45}). The process was dependent not only on the analysis of defence, but on the analysis of transference (Bernstein and Sax 1978, Glenn 1978b, Ritvo 1978), resistance (Glenn 1978b, Ritvo 1978, Ekstein 1979), and internalised unconscious conflict (Bernstein and Sax 1978, Glenn 1978a, Ekstein 1979). It culminated in the process of working-through (Feigelson 1977, Bernstein and Sax 1978, Glenn 1978b). However, this process is

\textsuperscript{40} Glenn, J. (1978b). General principles of child analysis. In Ibid., 29-63.
illusive, as according to Glenn "the psychoanalytic process is difficult to define because it refers not to a single configuration, but to an endless variety". He thought insight was an important component as one insight lead to the patient revealing further material which in turn lead to other insights. In addition, insight strengthened the therapeutic alliance. The alliance was important for the further uncovering, interpretation, insight, and realignment of internal psychic structures. Analysis and understanding of defences lead to the discovery and interpretation of drive derivatives. Analysis was thus accomplished through the gradual emergence and working-through of all of this material which linked to the reality of the patient's life, the transference, and the patient's fantasies, dreams, and behaviours.

As Anna Freud and others had said before, and analysts continued to believe, the important difference between the analytic process with adults and children was the developmental process itself. Consequently, many thought the analytic process had to be adapted to the developmental process, and, in some instances, could be limited by this process as well. Development had to be taken into account and consideration given to the levels of the child's language, maturation, and emotional expression. The impact of the analytic process on the development and growth of psychic structures "is a prime issue for the child analyst" as "child analysis takes place during a period of genesis and growth of psychic structure". The analyst, thus impacts the developmental process, as Ritvo stated:

...the analyst, via his responses to wishes and fantasies and his verbalization and interpretation of them, offers the ego of the child alternative ways of finding detoured discharge, gratification, or control, which influence the formation of psychic structure or organization. Thereby, the child analyst may be instrumental in facilitating the child's fulfilling a developmental need.

In attempting to refine what was meant by "analytic process", some sought to distinguish psychoanalysis from other forms of therapy. Feigelson (1977) thought, in order for analysis to be analysis rather than something else, the analyst needed to be simultaneously active, interested and involved, whilst at the same time reflecting on her own mental processes and associations. Although free association was not a requirement, this "evenly hovering attention" on the part of the analyst was. The analytic process required the regularised interaction of the mental agencies of two people, the patient and the analyst. This, in conjunction with the aspects of the process discussed earlier, in addition to working-through which, thought Feigelson, effected the greatest changes, is what distinguished psychoanalysis from other forms of therapy. When all of this is not

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happening, he said, "I have doubts about the treatment being a psychoanalysis". Glenn (1978b), on the other hand, thought that analysis was dependent on "correct interpretations" for its therapeutic effect, but other factors could also contribute to the patient's improvement. However, the difference between analysis and other forms of treatment was the foundation upon which therapeutic results rest. According to Glenn: "Those therapeutic factors that we have found to be incidental in analysis become the primary cause of improvement in other forms of treatment".

The Aims of Child Analysis

There seemed to be general agreement in the seventies that child psychoanalysis was a process. What the process was remained illusive as it was often defined by its techniques, for example interpretation of transference, resistance, defence. However, when it came to the aims of analysis, what the analyst tried to achieve through the process, contributors to the field tended to be clearer and in agreement. The aims were two fold. Psychic or structural change was the aim of the psychoanalytic method, structure meaning the psychic agencies of ego, superego, and id (Maenchen 1970, Panel 1974, Feigelson 1977, Bernstein and Sax 1978, Glenn 1978b). In addition, was the goal of the resumption of normal development. Goals and techniques needed to be coordinated with the developmental needs of the child enabling him to resolve those internalised conflicts which impeded further development (Hansi Kennedy 1971, Panel 1971, Peter Neubauer 1972). In short, to remove "obstacles in the path of normal development".

Technique

The tools used to meet the aims are the techniques, and the tools were thought to be determined by the level of maturity of the child's ego. Technique is dictated not only by the symptomatology or the developmental phase the child should chronologically be in, but by the actual and particular state of the child's ego functioning which is connected to the psychopathology. As Maenchen said:

...we analyze the child on whatever level we find him: on whatever level the fixation left him or the regression pulled him back to. The requirements of that, I would think, should determine the technique. 54

Thus, the technical procedures were keyed to the child's development and changed as development and growth proceeded (Panel 1971, Neubauer 1972, Panel 1974).

Interpretation

Interpretation was thought, without a doubt, to be the main vehicle of the analytic work and the core technique. It applied to all of the other components of what was thought to be analysis, e.g. transference, defence, resistance, conflict, etc. (Maenchen 1970, Feigelson 1977, Glenn 1978a, Ritvo 1978, Ekstein 1979). Ritvo placed the tool of interpretation within a developmental framework, as what was crucial to the effectiveness of the interpretation was not only what was being interpreted, but the timing of interpretations and the child's ability to hear them. Resistance played a role, but in addition was the child's ability to comprehend and carry out the steps of abstraction, conceptualisation, and generalisation.

But, how does an analyst go about interpreting? Maenchen (1970) said that one proceeded from clarification to interpretation within the framework of a therapeutic alliance. Glenn (1978b) attempted to provide general rules. First, he said, defences were interpreted before drives. Following Anna Freud's basic premise that interpretations moved from the surface to the depth, anxiety, affect and defences were interpreted first. Glenn continued that with these interpretations of surface manifestations, defences altered which allowed entrance of unconscious content into consciousness and made them available for

exploration and interpretation. At the same time, the patient's conflicts were more clearly elucidated and interpreted as well. Glenn also thought it important that external influences be taken into account whenever an interpretation was made.

The components of transference, a controversial and confusing topic from the beginning of child analysis, gained some clarity in the sixties; treatment alliance was first discussed in the sixties; and counter-transference, which was first thought to be a hindrance to analysis, were further elaborated on and clarified in the seventies.

The Treatment Alliance

As mentioned, Maenchen thought the framework for the analytic work was the therapeutic alliance. Neubauer (1972) said that the initial task within the analytic process was the establishment of a therapeutic alliance which in turn permitted the analytic process to occur. He defined this alliance as "a complex dynamic interplay between patient and analyst" which permits the analysis to continue whether the transference is negative or positive. Two components were necessary to achieve a treatment alliance; forming a relationship and making it work for the therapeutic aim. Glenn (1978a) concurred that a treatment alliance needed to be established first, and that it continued to achieve stability in what he termed the middle phase of treatment. The need for a treatment alliance now seemed to be a crucial aspect to the development of the analytic process and one of the keys to its success.

Transference

By the seventies there was not an analyst around who did not talk about the importance of transference in child analysis. Neubauer thought that transference phenomena were an essential requirement for analysis. He defined transference as an experience from the past being transferred to the analyst while proving to be irrational in this new relationship. Interpretation of transference proceeded with children as it did with adults. Ritvo (1978) agreed that transference was a crucial element in the process. The transference phenomenon aided the understanding, interpretation and reconstruction of the patient's material, but as importantly, "it also restores the feeling of immediacy, reality, and

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conviction to psychological phenomenon arising out of the past\textsuperscript{57}. Harley and Maenchen were more cautious. Maenchen agreed that transference developments were crucial, but interpretations of the transference were not the exclusive tool of the analysis. Harley (1971), in a paper entitled "The current status of transference neurosis in children\textsuperscript{58}", argued for a narrow definition of transference which included only specific forms of reactions to the analyst. Habitual modes of relating or character traits were, in her opinion, not transference, unless repressed components which resulted in the formation of these modes of relating were revived and experienced in relation to the analyst. The key to transference was thus the revival of unconscious elements whose origins were in the past, re-enacted in relation to the analyst.

**Counter-transference**

It was now not only transference that analysts were concerned with, but increasingly the issue of counter-transference. Robert Kohrman, Henry Fineberg, Renee Gelman and Samuel Weiss (1971)\textsuperscript{59} used the term counter-reactions to mean a universal phenomenon covering the total response of the child analyst to the patient, the patient's parents, and the therapeutic situation. Counter-transference proper was defined as the analyst's unconscious reactions to the patient's transference originating in those unresolved conflicts of the analyst which parallel the patient's. Counter-transference proper was Freud's original definition of the concept. It was thought to hinder the analytic process and necessitated further analysis on the part of the analyst. However, counter-reactions were an important element to the analytic process. They could be used by the analyst as an aid to understanding the patient's processes and material, and furthered the course of the analysis. Counter-reactions, the authors thought, were often more present in child analysis than adult analysis due to the nature of children, their activity, and the pressure on the analyst to act.

**Reconstruction**

The notion of reconstruction began with Freud and was an important element in analysis. It is a process which involves the recovery of past memories and experiences which are then reconstructed in the analysis and eventually worked through. In the


seventies debate around the topic of reconstruction in child analysis was in evidence. Maenchen (1970) said that the development of a sense of history for the child was due to the analytic process, a process which included the recovery of memories and reconstruction, and that it was these elements which produced structural change. Neubauer (1972) thought that the analytic technique of reconstruction, as well as affective reliving and the attainment of insight, were the methods of achieving the aims of psychoanalysis.

In 1977 the American Psychoanalytic Association attempted to tackle the issue of reconstruction in a panel discussion entitled "Reconstruction in child and adult psychoanalysis". Neubauer reiterated his views saying that complete reconstructions of preverbal stages of development lead to the understanding of defences, wishes, reality events, and psychic organisation. Sharfman agreed with the importance of reconstruction especially in relation to trauma. The analyst first reconstructed the trauma so the patient could master it. Reworking and reconstruction on other levels of development then followed. However, Rosner spoke of the difficulty of reconstructions with children as children do not want to remember the past.

The idea that children do not want to remember was first introduced by Hansi Kennedy in 1971 in her paper "Problems in reconstruction in child analysis". In this controversial paper Kennedy challenged the tradition-bound importance attached to the recall of memories and the meaning of the concept of reconstruction. Reconstruction was a concept which grew out of the analysis of adults and led to the understanding of the role of screen or cover memories. However, through direct work with children, clinical and observational, Kennedy concluded that childhood experience could not be recovered in its exact original form, rather superimposed on the original situations were the child's distortions, projections and conflicts, and aspects of later phases of development. Consequently, "later events may add special significance to earlier experiences, which may then be recalled as if they themselves had been traumatic or of particular psychopathological significance". In addition, it was Ernst Kris and Anna Freud's views, which Kennedy reiterated and concurred with, that experiences are molded into patterns and it is these patterns which child analysts deal with rather than specific events. Kennedy concluded that what child analysts do is construct patterns of experience and attempt "to catch and verbalize the affective significance and atmosphere" of a period in life, rather than reconstruct a

specific event or trauma. The point is that what are called reconstructions are inexact and are not about specific events as they happened in reality. Inexact as they are, Kennedy did think they could have a therapeutic effect and further the analytic work, however the fit and timing of the interpretation were crucial. Reconstructions, she said, must have an "intrapsychic fit" which is achieved by picking up on the affective and anxiety producing elements in the child's material, thus providing the child with a new perspective on something which once had psychic reality to him. The analyst draws the child's attention to what previously were unconscious affects and ideas, and links these to present day feelings and concerns which were isolated from the unconscious elements. She thereby provides insight and enlarges the child's self awareness. Thus, Kennedy said:

reconstruction in child analysis functions primarily as a means of providing a conceptual framework to the child whereby he can understand his present experiences and dilemmas.64

In other words, the aim of any interpretation is to show the child the way he functions in a particular manner at the moment, rather than the reconstruction of the past.

Working-Through

As noted by many authors in the seventies the process of working-through was crucial to an analysis, and was one aspect that set analysis apart from other forms of therapy. Maenchen thought that:

the lasting effect of analysis is produced by working through of inaccessible material, by the shift from primary to secondary process thinking, and by changes in the psychic structure (id, ego, superego).65

Others (Neubauer 1972, Feigelson 1977, Glenn 1978a, Ekstein 1979) concurred that working-through was crucial. Neubauer agreed that working-through was important with older children as new alternatives that were now open to the child needed reinforcement so that regression to old patterns was avoided. However, with prelatency children the working-through period was absent due to the developmental needs of the younger child. "The analysis now permits the development to proceed, and thus new psychic functions emerge at higher levels of organization."66

Conflict

The areas of conflict and development are thought to go hand in hand in child analysis. Conflicts are not only based on development and certain developmental tasks which prove difficult for the child to work out, but also impede the developmental process itself. It is therefore a task of child analysis to interpret conflicts, and enable the child to resolve them in a way which promotes the developmental process. (Maenchen 1970, Kennedy 1971, Feigelson 1977, Bernstein and Sax 1978, Ekstein 1979.)

Additional Techniques

Other techniques of the analytic process were called by many as the "analysis of" for instance, the developing ego and superego (Panel 1971); defence (Panel 1971, Panel 1974); wishes (Panel 1971); affect (Maenchen 1970); and resistance (Panel 1974). This begs the question of what "analysis of" something means. To some "analysis of" is parallel with "interpretation of", as in interpretation of defence or resistance (Feigelson 1977), whereas with others the meaning remains unclear. However, what is evident is addressing the areas of the child's developing ego and superego, defences, wishes, affects, and resistance that are pertinent to the analytic process. In terms of defence, Maenchen (1970) added that the interpretation of defence, coupled with the naming by the analyst of the child's instinctual urges, establishes an intercommunication within the child. This serves the process of integration. In relation to affect, the interpretation of mood, anxiety and real happenings promotes introspections which accelerate the development of ego functions.

It was Anna Freud who said that the child takes from an analysis what it is that he needs from the variety of interventions and techniques which are offered to him. Most authors concur and admit that other than the techniques previously described, there are many things analysts do based on the developmental process and the nature of childhood. Neubauer (1972) spoke of the analyst providing ego building experiences in addition to the analytic work. At the 1971 Panel on "Technical problems in the analysis of preoedipal and preschool children" Maenchen outlined one adaptation of technique. As child analysis provides a controlled situation for play and fantasy, some form of gratification is thus permitted "making it easier for the child to give up a wish and accept frustrations which are unavoidable".67 Glenn (1978b) agreed with this formulation. Neubauer also thought that the child's ability to accept frustrations and the repetition compulsion were components of

analysis. He went on to say that enabling a child to achieve a developmental step, if his pathology was based on a developmental lag, was also an important aim. Feigelson (1977) spoke of the need for empathic attention to the patient’s autonomy, which included attention to and respect for the phase-specific developmental phase. Glenn (1978a, 1978b) discussed the many uses made of the analyst by the patient other than as a transference object or as an object of a therapeutic alliance. He included the analyst as a new object, as a real object, as a displacement object, and as a new object representation which involves a change in self-representation as well. In addition, was the identification with the analyst in order to achieve a sense of wholeness, to build inner structures, or to achieve object constancy.

**Indications and Contraindications for Child Analysis and Subsequent Adaptations of Technique**

The seventies also brought further discussions on the types of patients for which analysis was best suited, and whether adaptations of techniques were indicated with children in different developmental phases. In a 1973 panel entitled "Indications and contraindications for child analysis: Current views" Harley stated that "child analysts are not yet in full accord in respect to the theory and technique of child analysis". She added that the "issues of indications and contra-indications for child analysis become blurred if our conception of the analytic treatment method lacks uniformity". Harley divided the attitudes of analysts into three groups. On one end are those who take children into analysis with severe pathologies (psychotic, borderline), and on the other end, those who reserve analysis for the "strictly neurotic". There is a third group which lies between these two extremes, those who assess whether the disturbance reflects a developmental deviation or lag, what the degree of severity is, and in what way intrapsychic conflict is involved. Harley asked: "How far can we extend variations of the analytic method and still regard what we are doing as analysis proper?".

Maenchen (1970) posed similar questions wondering why some seemed eager to apply analysis to cases which might not be suited, rather than perfecting the techniques for cases in which analysis is known to work and is indicated, a question Anna Freud had asked many years earlier. However, Maenchen conceded that there had been some reported successes with borderline patients who lacked object constancy by helping the child incorporate the analyst as an object and thus modifying the original part object. Analytic

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work in these cases involved careful analysis of the transference neurosis and controlled regression during treatment. Mahler's tripartite therapeutic design aimed, with psychotic patients, to give a corrective symbiotic experience based on the assumption that individuation and independent functioning cannot be achieved without a previously successful symbiotic experience. Others would disagree that a corrective emotional experience in this sense was possible as analysis could not change the problems only "change the solutions of the problem". Maenchen concluded that the central issue was one of a differential diagnosis based on the structure of the ego, the type of anxiety, the type of object cathexis, and the type of conflict.

Agreeing with Maenchen, the 1973 Panel conceded that some who had previously been considered unanalysable have been helped by preliminary work making analysis at a later date possible. However, there was a range of disagreements among the Panel concerning what disturbances could be properly analysed in analysis. The arguments of analysability and unanalysability were used. The very young child (under five years of age) and children with ego disturbances or fixations were thought to be analysable by some, whereas others felt it was only those children with neurotic problems arising from an infantile neurosis who could benefit from analysis. Glenn (1978a) thought those children who had achieved stable object relationships and whose drives were embroiled in unconscious conflicts which produced serious symptoms or inhibitions were candidates for analysis. Reality testing needed to be intact and ego deficiencies at a minimal. Psychotic patients, he thought, were best treated by other forms of therapy, whereas the treatment of borderline patients depended on what ego functions were intact, impaired, and to what degree. Consequently, the question Harley asked in 1973 remained unanswered in a uniform way.

What was answered in the seventies was the question of analysing the preoedipal or prelatency child. Maenchen (Panel 1971) outlined how in the past this had been a question, whereas in 1971 it had been shown that this age group could frequently be analysed and the themes evident with older children were found, although often only the beginning of the oedipal phase was seen. Neubauer (1972) was the one who showed the success of analysis with the very young. He stated that in the analysis of all children, but especially with the young child, the analyst is continually confronted by a changing psychic system which affects every aspect of the child's functioning. Although development is interfered with, in other areas development continues to proceed uninterrupted. Glenn (1978a) thought that analysis was essentially an identical process at any age. Maenchen (1970) disagreed saying that in the analysis of the preschool child modifications of technique were more often

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required which could cloud the issue of proper analytic technique. With latency children the analyst was on firmer ground, however once again could be lost with adolescence. She added, "...psychopathology plays havoc with our wish to formulate neatly a technique of child analysis in precise relation to developmental phases."\(^1\)

OTHER CONTRIBUTIONS: 1980 - 1990

The seventies saw child psychoanalysis coming into its own, moving away from the position of the step-child of adult psychoanalysis. It was a decade of further delineation of the techniques of this treatment modality. The eighties brought questions about the aims and process of analysis conceptualised within models of psychic structure and encompassing a developmental viewpoint.

Models of Psychic Structures

Historically Freud conceived of psychic structure as a tripartite model of id, ego and superego. Conflict played an important role as it contributed to the structuralisation of the ego and superego. The central and most complicated developmental conflict was the Oedipus Complex, and once resolved the tripartite model was thought to be in place. However, there was some degree of internal structure prior to the resolution of the Oedipus Complex which made it possible to deal with conflicts by internal modification, the basis of an infantile neurosis, rather than conflicts remaining with the environment. Conflicts by definition were between internal psychic structures, for example between id and ego, ego and superego, id and superego.

Marian Tolpin (1978)\(^2\) and G. Stechler and S. Kaplan (1980)\(^3\), basing their views on Heniz Kohut’s self psychology model, proposed a different view of psychic structure as comprised of a cohesive sense of self. Tolpin distinguished structural deficits from the conflict model with which psychoanalysis was so familiar. Faulty structure formation was based on “structural deficits, faults and failures” rather than “faulty conflict solutions, compromise formations, and disguised derivatives of the repressed infantile

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neurosis"\(^74\). The origin of these structural deficits was the psychological failings of parents who couldn't fulfill the developmental needs of the child in an average, expectable environment. Tolpin said:

...structural deficits occur when the child's self-objects fail to meet normal endowment half-way and do not provide the indispensable transitional precursors of psychic structures which gradually undergo internalization and effectively maintain the vitality, initiative, and self-esteem of a cohesive self.\(^75\)

Tolpin agreed with Anna Freud's idea that neurotic structures could superimpose themselves on earlier developmental disturbances, thus the analyst needed to be able to differentiate one from the other.

Phyllis Tyson (1988)\(^76\) argued against this idea of self as structure. Furthermore, she disagreed with the distinction between self and ego saying the "sense of self emerges and endures because of the synergistic functioning of the ego", and retained the structural model as psychic structure. However, she re-evaluated these structures considering the role of affect, conflict, libidinal object constancy, and the infantile neurosis in their formation and the integration of the three agencies. "A complete view of psychic structure formation", said Tyson, "must consider not only the origin and development of each of the psychic systems, but also their integration with the overall personality".\(^77\) It is the ego which organises and regulates the personality, as well as being an organisation of interrelated functions.

Hansi Kennedy and George Moran (1991)\(^78\), in a paper presented at an International Scientific Colloquium at the Anna Freud Centre in 1989, took yet a different view. Rather than conceiving of structures as id, ego and superego agencies, or as a cohesive sense of self, they thought in similar terms to Merton Gill (1963)\(^79\) who spoke of microstructures. In Kennedy and Moran's framework psychic structures refer to the manner in which the individual organises or constructs experience into mental organisations. Structural change implies enduring modification of mental organisations. They said:

...a child's capacity to regulate his inner world, and to understand the world outside, depends upon increasingly elaborate internal organizations...the use of earlier, more primitive, structural


organizations is abandoned when they are at odds with more highly developed levels of functioning.  

The Aim of Child Analysis

The concept of psychic structure has implications for the aim of child psychoanalysis. A panel of the American Psychoanalytic Association in 1980 entitled "Conceptualizing the nature of the therapeutic action of child analysis" concluded that the aim of child analysis was the alleviation of underlying structural deficiencies, thus increasing the child's capacity to cope with internal and external stresses. Whilst the result was an enrichment of the whole personality, the basic personality structure remained the same. Weiss disagreed that structural change was the aim of child analysis. Analysis, he thought, was the re-working of existing structural conflicts, whereas psychotherapy was the acquisition of new structures. "The acquisition of new structure is ubiquitous in any kind of relationship, whether it is intended to be therapeutic or not. The acquisition of new structure should not be a main goal in analysis."  

These authors are speaking of psychic structures as id, ego and superego. Kennedy and Moran also conceptualise the aim of analysis as structural change, but from the viewpoint of their framework where structures are defined as mental organisations. The aim of child analysis is reached "when previous pathogenic organizations and solutions cease to be applied automatically to deal with conflict". However, they went on to say, "earlier psychic organizations always remain and can potentially be reactivated under the impact of regressive shifts." 

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It was Anna Freud who said that the aim of child psychoanalysis was to restore the child to the path of normal development. Therapeutic interventions were aimed at removing the obstacles on this developmental pathway. This notion persisted and was reiterated by the panel in 1980: "An important goal in child analysis is to help the child resume his development so that he can be functioning at the phase-appropriate level." Kennedy and Moran, in attempting to examine the aims of child psychoanalysis, found themselves in the position of rethinking this basic assumption as they asked themselves what exactly did "restoring the child to the path of normal development" mean? They found it was not always easy to distinguish between aim and method. Anna Freud had formulated the distinction as follows:

It is very much like driving somewhere. Your aim is to arrive, and if instead of looking at the road, you think how nice it will be when you arrive, you will probably have an accident. Concentrating on the driving process implies steering the car.

The end point of the car's journey is the aim, whilst steering the car is the means of reaching the aim, in other words the method or technique.

Kennedy and Moran formulated the concepts of intermediary aims and outcome aims. Outcome aims refer to structural change, whereas intermediary aims refer to the steps along the way towards the outcome aim. Intermediary aims change as the analysis progresses and affect technique. They are based on the analyst's assessment, within a psychoanalytic frame of reference, of why the child acts and talks as he does. The analyst's assessment may entail intermediary aims which lead to interventions that address conflict and defence, or developmental needs, as with children who suffer from developmental delays or deficits, or borderline or severe narcissistic disorders. In regards to interventions based on developmental needs the authors added that "closer scrutiny of our technique may show that such interventions enter, to varying degrees, into our therapeutic work with many child patients." Furthermore, intermediary aims are influenced by the child's phase-specific developmental status. These developmental issues need to be taken into account as they are different for children under five, latency children,
preadolescents or adolescents. Whereas developmental issues play a role in intermediary aims, so too do they influence outcome aims. Kennedy and Moran conclude that:

> From a developmental point of view the outcome aimed at is the building up of suitable structural organizations which optimize the potential for development, within the limitations set by the child's constitutional, maturational, and environmental givens.\(^{87}\)

Others agreed that development affects aims and technique when working with children. Samuel Abrams (1988)\(^{88}\) said the goal of psychoanalysis for all ages "is achieved when pathogens are uprooted from an earlier psychological organization and freshly placed into a more mature one where they can be transformed", however "the impetus for therapeutic action and the steps in the sequence are somewhat more complex with children"\(^{89}\). This is due to the two fold aspect of analysis with children and the dual role of the analyst. The analytic process, with its emphasis on regression and the revival of the past, pulls the patient backward as the analyst tries to understand how the child got into trouble. At the same time, the developmental process pulls the patient forward. It is the analyst's task not only to reach backwards, but to facilitate progression so that the child's "ways of knowing the past are expanded" and "the foundation for his future might be more securely laid"\(^{90}\). Harley (1986)\(^{91}\) cautioned that although it was useful, and necessary, to keep in mind the child's ongoing and evolving developmental process, there was also an inherent danger in a developmental viewpoint. The analyst could shift too much to the side of assisting development in ways not central to the analytic method, thus doing psychotherapy rather than psychoanalysis. However, if "the analyst maintains an analytic atmosphere, and concentrates on the analytic process and on his transference role rather than on that of real or new object", the child may nonetheless use the analyst as a new or real object. But, continued Harley, "the gains thus derived I would judge to be by-products"\(^{92}\).

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What Harley calls by-products are the goals and outcome of analytic work with children who suffer disturbances of the self, according to Tolpin. Recognition of the analyst as a new object and a corrective emotional experience can produce intrapsychic achievements which depend on the acquisition of new psychic structure - and these are precisely the acquisitions and improvements which are 'expectable' when self-object transferences (versus neurotic transferences) are explicitly recognized, interpreted, and worked through.93

Kennedy and Moran, citing the views of the Anna Freud Centre, say that it is difficult to correct or restore something that is missing. "At best, the therapist can help (the patient) to make adaptations to such deficits and the consequent distortion of development." However, an interpretative approach may not achieve the desired aim. Rather, "this work is based on psychoanalytic knowledge of developmental needs and involves an admixture of interpretation and ego-supportive elements within the context of a one-to-one relationship"94.

The context of a relationship between patient and analyst is now central to the thinking about child psychoanalysis and the foundation upon which all else rests. The analyst serves as a transference object, but also as a new object, a real object, and as an object for identification. Transference is a given in child analysis, but what all the dimensions of transference are and how to define the concept clinically in a precise way remains open to interpretation, in adult and child psychoanalytic theory.

Consistently over the years, from Anna Freud and Melanie Klein through to contemporary child analysts, it has been thought that the basic components of child psychoanalysis were interpretation, transference, defence, conflict and resistance. Other concepts have been discussed as well, such as treatment alliance, working-through, reconstruction, counter-transference, and insight. But, what exactly do these analytic concepts mean? As has been demonstrated (see chapter 4), the meaning of these basic concepts differed between Anna Freud and Klein. Victoria Hamilton (1990), in an extensive empirical study of the concept of transference and the technique of transference interpretation, interviewed sixty-five psychoanalysts of differing theoretical orientations in Britain and North America. She found that the concept of transference and the technique of transference interpretations varied from analyst to analyst. In other words, there was no one consistent and agreed upon definition of the concept. It would be safe to hypothesise that if studies like Hamilton's were done on other concepts, similar results would be found.

The literature shows that there are other elements, what some call the byproducts of analysis and what others see as the central components, which have been included in discussions about child analysis over the years. These include verbalisation, clarification and confrontation; reassurance; gratification; the multiple roles of the analyst including new object, real object, an object of identification, as auxiliary ego or superego; and the list goes on. The same question has been proposed over and over: Are these truly analytic interventions, or the things child analysts should avoid because they might muddle the analytic stance or are "educational"? Until the last two decades child psychoanalysts have been preoccupied with doing exactly what adult analysts do. Furthermore, analysts of either adults or children have been concerned with following the basic analytic principles first outlined by Freud. Anything else could be conceived of as breaking the rules. However, adult analysts also include some of these other elements in their techniques and approaches to patients. So, are they analytic or not? If so, when do they become unanalytic? There needs to be some basic rules and guidelines in order to define a treatment as analysis rather than something else.

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Is child psychoanalysis defined by its techniques, or is it defined by its aims or its processes? Within the literature, if one looks at derivatives of Anna Freudian theory, there is, by 1990, some agreement as to the aims of child psychoanalysis. Two are primary, and as Kennedy and Moran (1991) elucidated, these are the outcome aims, not the intermediary aims which are those steps along the way to the achievement of the outcome aims. Returning the child to the path of normal development is one aim. Whilst this may be a somewhat broad and elusive idea, it is clear that a child's development and aiding a child's continued progression in a somewhat normal manner is a desirable outcome of analysis. Psychic structural change is the second agreed upon aim. Here too are found differences as to the meaning of psychic structures, but the common ground is that internal change results so that the child is no longer acting or feeling in ways he did before which derailed him from the hypothetical path of normal development. Analysts also agree there is this thing called an analytic process which operates within the context of the relationship between the patient and the analyst, and that in child analysis development is an aspect of this process. However, what is included in this process is not completely agreed upon, which again raises questions about technique and the definition of concepts.

Over the years there have been continued questions and examinations about who child analysis is best suited for, or put another way, which children are analysable and which ones aren't? From its inception psychoanalysis was derived as a method of treatment for neurotic disturbances. Throughout the years it has always been agreed upon by analysts that psychoanalysis is the treatment of choice for patients suffering from these. However, as Anna Freud said, there are actually few child patients who could be classified as purely neurotic. "In most cases, the disturbances consist rather of mixtures and combinations of elements which contribute in varying degrees to the final pathological result." Furthermore, child psychoanalysts have treated in analysis, or at least intensive therapy, patients suffering from a wide variety of disturbances including developmental disturbances, borderline, psychotic and atypical disturbances. There is a consistency in the literature that treatment of patients with disturbances such as these requires some adaptation or modification of technique, or that the balance of the types of techniques used is more heavily weighted in certain areas than in others. Once again the question of technique has arisen in full circle.

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In relation to technique in child analysis, perhaps the question isn't what do these concepts mean, but more importantly, how do they manifest clinically? Then, what does the analyst do, how does she do it and why? As aptly said by Anna Freud in 1927, "one should be at pains to know what one is doing".4

Theory and Practice

Theory has indeed been at the forefront of psychoanalytic debate from the beginning. The first psychoanalytic model arose out of collaborative efforts between Josef Breuer and Freud. Eventually Freud found Breuer's theories, based as they were in hypnosis and the seduction theory, wanting. Freud went on to discover infantile sexuality, the Oedipus Complex and transference, and to study dreamwork, out of which he proposed the topographical model. Further clinical experience and research brought other advances and new models, specifically the structural model and Freud's revised theory of anxiety. Theoretical discourse occurred even at this time, with Carl Jung and Alfred Adler questioning some of Freud's hypotheses. The disagreements were such that they broke away from Freud and went on to formulate their own models. Theoretical debate has continued. Some models have dropped out of the picture and some have grown in their acceptance. Arnold Rothstein's book Models of the Mind (1985)5 is an attempt to look at six different theoretical models within present day psychoanalysis: Structural theory, the Klein-Bion model, Sullivanian or the Interpersonal model, Kohutian or the Self Psychology model, Object Relations theory, and Lacanian theory. Whilst theories may differ, what is more difficult to ascertain is what the techniques are which accompany these models. As Hamilton said, "specific technical procedures are rarely spelled out - it is as if we believe that once a theory is thoroughly explicated, its application will follow naturally".6

George Klein (1976)7 distinguished two theoretical traditions in psychoanalysis: the clinical and the metapsychological. It is his contention that within the clinical tradition analysts have looked for reasons for behaviour, whereas in the metapsychological realm they have looked for mechanisms. It is the clinical, thought Klein, which analysts should

restrict themselves to studying, as the clinical and metapsychological are on different logical planes. Attempts to study both orientations has "been confounded, creating empirical and theoretical havoc".

Merton Gill (1976) would agree with Klein, however others (Joseph Sandler and Walter Joffe 1966, Robert Wallerstein 1976, B. Rubenstein 1980) have stressed the importance of studying both the clinical and metapsychological. Sandler and Joffe illustrated the interdependence of the experiential and non-experiential levels of psychological processes when they examined fantasy. Fantasy is experiential, whereas the process of fantasising is non-experiential. One cannot be understood without the other as the process explains how fantasy happens. If analysts don't study the process, as Klein suggested, "the possibility of a comprehensive psychoanalytic description and explanation of the function and structure of the human mind" is abandoned.

Not only are there difficulties in psychoanalytic theorisation, but within psychoanalytic concepts themselves. Any one concept may be defined in diverse ways dependent upon who is doing the defining. Through an examination of the psychoanalytic literature an abundance of theoretical reviews of psychoanalytic concepts can be found carried out in an effort to clarify their meaning and to rectify contradictions, logical inconsistencies, and ambiguous qualities of and between numerous concepts.

Thus, psychoanalytic theory, concepts and practice are often divergent. From theoretical expositions the ways in which the theory is applied and what techniques the analyst employs in her application are often difficult to distinguish. Whether analysts mean the same thing when they speak of theoretical or technical concepts is also often hard to discern. Emanuel Peterfreund (1975) has commented, taking a rather pessimistic view, that analysts do not seem "to know how they attain the results claimed". He believes that psychoanalysis has suffered from "its tendency, notable since Freud, to theorising virtually

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divorced from clinical data". If clinical data is evident, it is "without regard to the nature of the analytic process from which the clinical material emerged”. Peterfreund goes on to point out the lack of clarity found in concepts and in the common usage of psychoanalytic language. He thinks there is a tendency "to use loose, vague, poorly defined, catchall jargon and clichés instead of specific and exact clinical observations and hypotheses".15

Child Psychoanalysis and Research

Along with the questions as to theory and its relationship to the clinical, there have been others regarding how to study psychoanalysis. Psychoanalysis as a science has typically not involved an empirical model for validation. For the most part it has relied upon the method of observation in the psychoanalytic situation to inform theory. Single case reports are examined in depth and hypotheses made, a method first devised by Freud. Clinical experience with patients of certain types has led to new theories, for example Heinz Kohut and work with narcissistic personality disorders or Otto Kernberg and his theories about borderline disorders. In the literature it is possible to find case reports where vignettes from patient's material are given, however these vignettes are often used to illustrate the theory proposed rather than to clarify the concepts or technique.

Traditionally, research in child psychoanalysis has not followed an empirical model either. However, there has been an attempt to look at the child and extrapolate theory from there, rather than propounding the theory first as a way to explain the child. Naturalistic observations have been a part of this research pioneered by such analysts as Anna Freud, Spitz, Bowlby, Kris and Mahler. Observation has, in many realms, successfully verified, extended, or re-examined aspects of developmental and psychoanalytic theory. However, as Peter Fonagy (1982)16 pointed out, there are inherent limitations. These are the difficulties in identifying necessary and sufficient conditions and cause and effect relationships. Replication is a problem, as is the inability to distinguish between equally acceptable interpretations of data. Observational researchers have attempted to overcome these limitations within the last two decades. The result has been the development of new

psychoanalytic theories, rather than validations of previous constructs (see Louis Sander 1980\textsuperscript{17}, Bowlby 1980\textsuperscript{18}, J. D. Lichtenberg 1981\textsuperscript{19}, Daniel Stern 1985\textsuperscript{20}, Robert Emde 1988\textsuperscript{21}).

The Study Group approach has also been used extensively in child psychoanalysis and has advanced child and adult psychoanalytic thinking in a number of areas. This approach involves a group of psychoanalysts in systematic research discussion of clinical observations with a particular focus. The study groups at the Yale Child Study Center, whose most recent work focuses on the meanings of play in child analysis (Cohen, et al 1987\textsuperscript{22}), is one example. The comprehensive book entitled The Technique of Child Psychoanalysis (Sandler, et al 1980\textsuperscript{23}) was the outcome of a study group at the Anna Freud Centre, as was Kennedy and Moran's work (1991\textsuperscript{24}) on the aims of child analysis, Clifford Yorke et al's paper (1990\textsuperscript{25}) on the development of a sense of shame, and Rose Edgcumbe's work (1981\textsuperscript{26}) on the acquisition of language, to name just a few in the last decade.

The systematic study of process records is a research approach that has been used by the Centre for Research into Adolescent Breakdown in London. This method involves the collection of data through the review of process notes from a series of analyses which took place with a research purpose in mind. Analysts at the Brent Consultation Centre and the Centre for Research into Adolescent Breakdown tested out hypotheses derived from a theory of adolescent development and breakdown which grew out of their clinical

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experience as well as earlier research studies into attempted suicide, promiscuity and sudden academic failures in adolescence (Moses Laufer and M. Eglé Laufer 1984, 1989).

The work of the Anna Freud Centre in London has been responsible for the advancement in thinking about psychoanalytic concepts in a number of areas. This work arose not only out of Study Groups, but out of the Hampstead Psychoanalytic Index (Sandler 1962), developed in the early fifties at the instigation of Dorothy Burlingham. An Index of the recorded case material of fifty children in psychoanalysis at the Centre was initially constructed. Child analysts were asked to classify the material from their cases, drawing upon psychoanalytic theory. From the pilot study a preliminary set of common categories providing a framework for the Index was devised integrating theory and clinical observations. Large amounts of material were broken down into smaller units of observation and then understood within the framework of units of psychoanalytic theory. Inconsistencies, inaccuracies, and gaps in understanding were revealed. As attempts were made to resolve the problems encountered in various psychoanalytic concepts, revised theoretical formulations arose and brought further refinements to psychoanalytic thinking. More cases were Indexed and the interaction of clinical and theoretical notions continued with greater and greater refinement of concepts occurring. A number of papers on psychoanalytic concepts resulted on such areas as the superego, the ego ideal, the nature of unconscious fantasy, sublimation, obsessional manifestations, and depression (see Sandler 1987). The procedure of construction of the Index itself became a model for the use of scientific methods in psychoanalysis, and the resulting product of an Index of clinical material classified along the lines of increasingly well-defined theoretical concepts was then available for use in future research tasks (see Humberto Nagera 1966, 1969, 1970a, 1970b).

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The Hampstead Index is a method whereby psychoanalytic concepts and clinical material, i.e. the metapsychological and the clinical, join together in a way to refine meaning. As Sandler said:

What was striking was that if the Index group had not tried constantly to achieve some sort of fit between their theoretical formulations and the clinical material recorded in the Index, it would have been easy to create convincing theories without becoming aware of the many conceptual problems involved. But when it came to trying to apply such theories to the material in the Index, it was clear that aspects of the theories had to be modified and definitions reformulated.35

The Research of Psychoanalytic Concepts

Following his work with the Index Sandler went on to think more about the idea of concept research, and specifically the area of psychoanalytic technique. In 1983 he wrote "Reflections on some relations between psychoanalytic concepts and psychoanalytic practice"36 where he proposed that theory encompasses a body of ideas, rather than a consistent whole, and psychoanalytic theory should be related to the work analyst's do. In other words, a theory is a "clinically, psychopathologically and technically oriented one, which also includes a central preoccupation, not only with the abnormal, but with the normal as well"37. Thus, theory and concepts need to be based in the clinical and technical, incorporating a view of development.

Sandler thought that the ongoing development of psychoanalysis involved the expansion of meaning of various concepts. These psychoanalytic concepts have multiple meanings which vary according to the context in which they are used. Many commonly agreed upon and central concepts in psychoanalysis have "a set of dimensions of meaning, as existing in a meaning-space, in which it moves as its context and sense changes"38, which accounts for the "elasticity" of concepts. Sandler pointed to the important difference between the "private" and "public" contexts in which psychoanalytic concepts and techniques are practised and discussed. The public presentation of an analyst's clinical and theoretical views are based on what is standard within one's school of thought, or what is

thought to constitute "proper analysis". The private views link to what actually goes on in the consulting room and the development of the analyst's "part-theories". Sandler outlined the process of the evolution of these part-theories. He said:

The analyst will continue to underestimate the discrepancies and incongruities in the public theories and will learn to move from one part of his theory to another without being aware that he has stepped over a number of spots in this theory that are conceptually weak. With increasing clinical experience the analyst, as he grows more competent, will preconsciously (descriptively speaking, unconsciously) construct a whole variety of theoretical segments which relate directly to his clinical work. They are the products of unconscious thinking, are very much partial theories, models or schemata, which have the quality of being available in reserve, so to speak, to be called upon whenever necessary. That they may contradict one another is no problem. They coexist happily as long as they are unconscious.39

The way technical concepts are applied allows for variations in the analyst's clinical work. As Hamilton pointed out, Freud "changed his concept of interpretation in response to both technical issues encountered in his handling of the transference and shifts in his conceptual model of the mind"40. Freud's views of analyst as interpreter shifted from excavator, to translator, to putting forward constructions or hypotheses about the patient's descriptively unconscious communications with the added importance of timing and skill. Variations in theory and technique arise not only from a change in the analyst's outlook and expansions of the theory, but also from new insights into development, the variety of disturbances which analysts are faced with, and special conditions in certain cases. Anna Freud proposed that, as no two analysts are alike and thus would not treat a given patient in the same way, variations are also based on the individual nuances of the analyst's personalities. These nuances, she thought, should be treated as important finding rather than chance occurrences, as they could lead to new theoretical understanding. She said:

In the variations of the analyst's 'acting out' in technical behavior we may, therefore, find new clues for the systematic study of character structures and personalities. Efforts of this type serve to deepen and intensify our work rather than to extend its scope.41

Sandler expanded this idea saying that not only are no two analysts alike, but an individual analyst won't follow the same technical procedures with each patient as she has different models to organise her understanding (also see Bowlby 197942). The analyst adjusts what

she says or does to what she feels is necessary with each patient. The interaction with the patient then affirms or disaffirms the procedure implemented. By making explicit these implicit part-theories of psychoanalysts, advances in theoretical understanding and technique occur.

Sandler's idea of making analyst's implicit theories explicit has been applied empirically to the study of various psychoanalytic concepts which, by definition, are elastic. The concepts under study had been stretched in their usage so that their meaning had become obscure. Carla Elliott (1985)\(^{43}\) was the first to attempt empirical research in this area, looking at the concept of sublimation. In a review of the literature she found ambiguities and logical inconsistencies and contradictions as the concept related to allied concepts. Her study was an attempt to elicit the dimensions of the concept and the different ways the concept was applied in practice. Thus, Elliott looked at the internal structure of the concept of sublimation as used by analysts (their private theories), rather than looking at analyst's theoretical definitions (their public theories). Out of the collected data, obtained through interviews and ratings of clinical examples, Elliott proposed alterations in the definition of sublimation which fit more with analyst's implicit theories, rejecting some previous aspects of the concept, retaining others, and adding yet other components.

Elliott's sample of analyst's were ones trained within a similar theoretical orientation. Hamilton (1990)\(^{44}\) was the first study of comparative psychoanalysis, using a sample of analysts from different theoretical orientations in Britain and North America. It was a systematic attempt to investigate psychoanalyst's conscious and preconscious beliefs and the ways these beliefs related to specific clinical practices. Through an unstructured interview method she elicited and clarified the constructs upon which the concept of transference and techniques of transference interpretation were based. She found that analysts had clusters of beliefs which informed their clinical practice, and that these clusters were based on the analyst's theoretical understanding and clinical use of transference and related concepts arising out of their implicit part-theories, rather than on their theoretical training or orientation. Sandler, Anna Ursula Dreher and Sibylle Drews (1991)\(^{45}\) also used the method of unstructured interviews to look at the concept of trauma, the ways the concept has been used implicitly by analysts, and the multiple dimensions of meaning.

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Conclusion

Analysts possess their own individual culture, as well as the culture from whence they were trained. The culture consists of historical, developmental, and personal factors which enter into their theories and styles. Clinical models must relate to what the analyst does, and the more this correlation exists the better the theory becomes. The approach of the Anna Freud Centre has always been one based in child development, observation, and the clinical material the child brings. The *Technique of Child Psychoanalysis* book is an attempt to look at what it is that analyst's do, organised around the Treatment Situation and Technique manual of the Hampstead Index. However, much is missing. It looks at aspects of technique, but not the whole of technique and the intricacies and nuances of work with children. By reading this book, or others, an individual does not become an analyst. Then, how does one learn to do analysis? How are these intricacies and nuances incorporated into one's technique, and the refinements which are required based on what the child is presenting to the analyst at any given moment in the consulting room? What is analytic and what isn't, and does it depend on the child, the timing, the material, what came before and what will follow, and what the analyst will do next? The learning required to become a child psychoanalyst is not only through the study of theory, concepts and literature, but mostly through the treatment modality itself. It is a method learned by doing and passed on by word of mouth. It comes from supervisions, clinical seminars and presentations, consultations and informal discussions with colleagues, experience, and the analyst's own training analysis. In order to formulate a comprehensive view of the technique of child analysis, the ways the analyst works and what her private implicit theories are must be tapped into, incorporated as they are from these informal learning experiences.

This thesis is an attempt to study empirically the technique of child psychoanalysis as done within one school of thought, Anna Freudian, and specifically, analysis which is done at the Anna Freud Centre. As Roy Schafer said, this is not an easy task.

The problem of analyzing one structure of thought within one school is so formidable that even analysts who belong to that school cannot agree altogether on which basic assumptions have to be made, on the mutual interrelations of the various key propositions of that school, or what constitutes evidence, and on what the relation of evidence is to the particular analytic methods that are practiced.46

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Taking the studies of Elliott, Hamilton, and Sandler, Dreher and Drews as a basis, the present studies will attempt to investigate the conscious and pre-conscious beliefs of child psychoanalysts trained at the Anna Freud Centre in order to ascertain what it is these analysts do, how they do it, and why. The common ground of these analysts is the culture within which they were trained. The outcome of this thesis would then supply the basis for a Manual on the technique of child psychoanalysis which is current within this culture.
According to one count, there are now over 400 different approaches to psychotherapy (Karasu 1986). Over the last forty years there have been numerous studies designed to assess the effectiveness of some of these. Evident in these studies (see Luborsky, Singer and Luborsky 1975 and Smith, Glass and Miller 1980 for reviews) is the lack of a precise definition of the specific treatment modality regardless of theoretical orientation. Not only are definitions vague, but the applicable techniques and processes are not clearly spelled out. In comparative studies of two or more different types of therapies, with the aim of examining which is most effective, "distinctions among treatments can be observed" which are "generally consistent with what would be expected, given the theories which underlie the therapies under comparison". However, available research, reviews and meta-analyses (Bergin and Lambert 1978; Lambert, Shapiro and Bergin 1986; Robinson, Berman and Neimeyer 1990) have failed to provide any strong or consistent evidence for differential effectiveness.

The problems encountered in these types of research parallels the difficulties in psychoanalytic writings, the metapsychological versus the clinical. The therapies and research are based on theoretical formulations void of a specificity as to the techniques employed to meet the aims. As has been discussed (see chapter 5), psychoanalytic literature traditionally focuses on theory rather than techniques and their clinical application.

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Those who have attempted to delineate techniques in their work (Fenichel 1945, Glover 1955, Greenson 1967, Menninger 1958, and regarding child analysis Glenn 1978, Sandler, Kennedy and Tyson 1980) tend to describe them in general terms. There has often been an assumption that analysts who are identified with a certain orientation are practicing the same form of analysis. However, as early as 1940 Edward Glover found this was not necessarily the case. Based on questionnaires on technique given to members of the British Psycho-Analytic Society in 1932 and 1933 Glover discovered that "a number of orientated and practicing analysts holding to the fundamental principles of psychoanalysis, varied in their methods in every imaginable way". Robert Wallerstein noted that Glover did not think these varied methods were based on different theoretical frameworks of psychoanalysis, rather he "ascribed this whole range of discerned differences in clinical technique to individual differences in personal character and abilities". Not only does a loose connection between theory and technique exist, but the delineation and clarification of technical applications is further complicated by the fact that the meaning of theoretical labels and concepts has become elusive.

In order to overcome these difficulties, a detailed description of a treatment modality which identifies its key therapeutic ingredients is necessary. Formal psychotherapy manuals as a systematic way to guide the conduct of psychotherapies were introduced in the seventies as a means to this end. Manuals arose out of the needs of researchers, teachers, and practitioners for a method which provided more explicit guidelines for therapists to follow outlining specific techniques and strategies applicable to a particular form of therapy. The theory behind a manual is that it defines a treatment modality in detail, including its basic principles and techniques, which brings the connection between theory and practice closer together. In addition, it aids research investigations within that treatment modality and between different models of psychotherapy. According to Lester Luborsky, one of the pioneers in the development of the concept of manualisation, a manual serves three purposes. First is to aid in the objective comparison of psychotherapies in research studies. Second, a manual aids in the measurement of the

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degree to which a given therapist provided what is intended in a given approach. Third, a manual aids in the training of therapists as it specifies the main techniques within a form of therapy.

The first manuals written applied to behaviour therapies (Wolpe 1969\textsuperscript{16}). Behavioural therapy lends itself to formalised treatment manuals as the set of procedures in this treatment approach are, usually, applied in a systematic way. Therefore, behaviour therapy fits with the function of a manual which is to outline the procedure, techniques and strategies of an approach, delineating what is an acceptable implementation. However, when entering the realm of other forms of therapy, such as ones based in psychoanalytic principles, certain inherent problems become major obstacles to overcome. Psychoanalysis and psychoanalytic psychotherapy, by their very nature, entail a process whose direction depends at any given moment on what has transpired previously within the process. In addition, the therapist's interventions and the patient's thoughts and behaviours are determined by a multitude of factors. Thus, the data upon which the therapist bases her decisions about what to do, or not do, come from a variety of directions, including the patient's speech and content, the subjective perceptions of the patient, and the therapist's introspections. Another problem relates to the therapist's intent. Without knowing the intent behind an analyst's intervention, it is difficult to determine whether the intervention was an analytic one or non-analytic one, as what may look like a non-analytic intervention can actually be part of the overall process. Furthermore, there are many equally valid pathways to what constitutes therapeutic progress. As Luborsky and Robert DeRubeis stated, "the less prescriptive is a treatment approach, the less it lends itself to specification in the form of a manual, and the more the manual writer must allow for flexibility of approach by the therapist"\textsuperscript{17}.

Alan Kazdin\textsuperscript{18} would concur. He has said that it is not the task of manualisation to detail in a cook book fashion all it is that a therapist does in a specific form of treatment. Rather, the issue is one of general characteristics. The metaphor of a cook book works in relation to the setting and supplies needed, as well as the generalities, but when it comes to the recipe; i.e. the what, why and how tos, the metaphor breaks down. The result of the cook book approach, as Otto Kernberg et al (1989\textsuperscript{19}) discussed, leads to reductionism, does injustice to the human diversity of patients, and suggests there is one and only one approach. There are further pitfalls to manualisation. By implication manuals posit a

\textsuperscript{18} Kazdin, A. (1990). Personal communication.
standard sequence of maneuvers to be carried out, which is not necessarily the case in psychoanalysis, and they can emphasise technique thereby down playing the role of an interpersonal relationship between patient and analyst. Codification of a therapy can also create the illusion that what is not incorporated is not relevant.

Psychotherapists, psychoanalysts and researchers have begun to make attempts toward the manualisation of their treatment modalities, ones which are more complicated than the original behavioural therapies applied to manuals, and ones which take into account the problems mentioned. Four different manuals will be discussed here.

A Manual for Supportive-Expressive Psychoanalytic Psychotherapy: The CCRT Model

Luborsky made the first attempt with a manual for supportive-expressive psychoanalytically oriented psychotherapy. He began as a clinician and researcher first at the Menninger Foundation, where the basic premise of supportive-expressive constructs originated, then at the University of Pennsylvania Department of Psychiatry. From his work Luborsky began to develop a manual for psychotherapy in 1973. Adding further refinements gained from research, Luborsky published Principles of Psychoanalytic Psychotherapy: A Manual for Supportive-Expressive Treatment in 1984. In writing this manual Luborsky's expressed aim was to "assemble in a manual format the most representative and commonly used techniques in the practice of psychoanalytically oriented psychotherapy", which would provide the necessary tools for studies of the effectiveness of this treatment model. His book differs from other references to psychoanalytic psychotherapy due to its manual format which elucidates principles backed by research, and because it provides the prescribed methods of handling a therapy of this sort.

Luborsky's manual is divided into three parts. Part one, "The background and use of the manual", outlines the purposes of the book, theories of psychotherapeutic change, the history of psychotherapy manuals, and an explanation of how to use the manual. Curative factors central to this theory are self understanding, achieved through expressive techniques; the helping alliance, achieved through supportive techniques in collaboration with the patient's readiness to experience the alliance; and the incorporation and consolidation of the therapeutic gains facilitated by attention to the meanings of termination. Part two is the manual itself, the how tos and whys of this therapeutic approach. Luborsky deals with

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beginning treatment, supportive relationships, expressive techniques, ending treatment, variations and adjuncts, and analogic summaries. Within this section he presents guidelines for conducting supportive-expressive therapy. Principles the therapist is to follow are delineated with the aim of understanding the patient's motives. The framework of Luborsky's model is what he calls the core conflictual relationship theme (CCRT) which presents itself in the relationships the patient has. These include relationships to important people in the patient's present life, relationships based in the past, and the transference. Luborsky's research contributions inform his ideas in three main areas: (1) the predictive value of the helping alliance; (2) the guidance to the understanding of the transference patterns provided by the CCRT method; and (3) the implications for matching patients and therapists by different methods of assignment. Part three, "Appendices", contains a sample report of a diagnostic evaluation which is used to assess the appropriateness of a patient for this treatment model, and a portion of a session demonstrating the CCRT method. Also included is the rating scale for supportive-expressive psychoanalytically oriented psychotherapy. A manual is a research tool with the purpose of training therapists in a specific approach and then rating them on manual-based categories, thus measuring what is actually delivered. In this way the conduct and efficacy of a therapy can be assessed. Luborsky's rating scales is the instrument relevant to such evaluations.

It is Luborsky's contention that a consistent therapeutic technique be designed which can be studied for research purposes. His manual is an attempt to create a group of clinicians who are trained appropriately within this approach in order to evaluate the model. Luborsky is clear that this manual is not intended for independent use, but under supervision by someone trained in this method. He supplies a guide for supervisors to follow in conjunction with their trainees. Psychotherapy, says Luborsky, is best learned under an apprenticeship model.

Luborsky states that he is not trying to present a "how-to-do-it" manual, and by definition a manual is a guide rather than a cook book, but his manual does have a recipe quality. The therapist is asked to read and reread the manual and to do the same with the supervisor, going over the operational techniques point by point. It is a difficult line to demarcate because, on the one hand, a manual is a guide which defines a certain modality of treatment and cannot be all inclusive of that modality, but on the other hand, it is an instrument of learning a method which will, in the end, be measured by a certain set of manual based principles. Luborsky's manual is single minded in its pursuit of the CCRT. If one looks at the whole of psychoanalytically informed psychotherapy, conflict is but one element. However, by design this method evolves around the central conflict proposition, and not other aspects of psychoanalytically oriented therapy.
Luborsky's continued research examines the factors influencing the outcome and efficacy of psychoanalytic psychotherapy from the CCRT model. To date he and his colleagues in the University of Pennsylvania Psychotherapy Project (The Penn Studies) have designed operational measures for three psychoanalytic concepts. The first is the therapeutic alliance. Three methods for measuring the therapeutic alliance have been developed based on ratings, counting signs and questionnaires (Luborsky et al 1983\textsuperscript{22}, Luborsky et al 1985\textsuperscript{23}). The reliability and validity of each of these measures has been examined and found to be satisfactory, and, according to Luborsky, "all three showed significant predictions of the treatment outcomes"\textsuperscript{24}.

The development of the therapeutic alliance measures led to an objective measure of transference patterns. These patterns are drawn from independent judges who rate patient's spontaneous narratives conveyed during treatment about their various relationships, including the one with the therapist. The CCRT method is the basis for these ratings as it "represents a formalization of the usual inference processes of clinicians in formulating transference patterns"\textsuperscript{25}. These measures have also been found to be reliable and valid. Comparison studies indicate a correspondence between the CCRT pattern and Freud's (1912\textsuperscript{26}) observations which led him to his concept of the transference pattern. Whilst these findings represent "progress toward objectification of the transference concept"\textsuperscript{27}, whether Freud's 1912 observations portray the multiple dimensions of transference as conceived of in the minds of analysts in 1990 remains to be seen. In addition, Luborsky and others are in the process of comparing the CCRT method with other quantitative relationship pattern methods in order to investigate their consistency. Some of these other methods are: the Patient's Experience of the Relationship with the Therapist (PERT)

measure (Gill and Hoffman 1982\textsuperscript{28}, Kächele et al 1985\textsuperscript{29}); the Plan Diagnosis Method (Weiss and Sampson 1986\textsuperscript{30}); the Dynamic Focus Method (Schacht and Binder 1982\textsuperscript{31}); and the Configurational Analysis (Horowitz 1979\textsuperscript{32}).

Finally, the Penn Studies aim to measure the accuracy of interpretations as these "have been considered to be the prime means of facilitating insight"\textsuperscript{33}. It is Luborsky's contention that "the greater the convergence" with the CCRT, "the more the patient benefits"\textsuperscript{34}.

Luborsky and the others involved in the Penn Studies believe that "the value of clinical data as a basis for research rests on the guided use of clinical data"\textsuperscript{35}, guided by such operational measures as they have outlined. This coincides with the purpose of manualisation. Through the clear delineation of a treatment modality it should be possible to develop operational measures for the concepts and procedures outlined in a manual. Luborsky has gone one step further in an attempt to locate curative factors, thus researching the efficacy of the CCRT method. The Penn Study's research evidence indicates two curative factors: (1) the positive therapeutic alliance is related to the benefits that patients achieve, and (2) the accuracy of interpretation is associated with the patient's benefits at the end of treatment. The Penn Studies hypothesise a third curative factor which is currently under investigation: the degree of self awareness obtained by the patient is associated with the therapist's accuracy of interpretation.

\textsuperscript{34} Luborsky, L. and Crits-Christoph, P. (1988). \textit{Ibid.}, 84.
A Manual for the Cognitive Therapy of Depression

In 1979 Aaron Beck, along with A. John Rush, Brian Shaw and Gary Emery, published their manual entitled Cognitive Therapy of Depression36. Unlike Luborsky's manual which is meant to apply to multiple types of disturbances, Beck and his colleagues are looking at one type of disturbance, depression. The manual is based on two decades of work resulting in the evolution of a theory of depression that stresses the primacy of cognitive elements. Beck's investigations on depression began in 195637. His early model was based on psychoanalytic theory as conceived of in the fifties. Initially, Beck thought the basic dynamic factor in depression was aggression turned against the self expressed as the need to suffer, an idea originating from drive theory. Research led him to critically reexamine this point of view and to evolve a new model and therapeutic approach focused on specific attitudes. Two volumes on depression precede this one, written in 196738 and 197639, which illustrate the evolution of Beck's theories now based in a cognitive point of view. According to Beck,

...entry into depressive states occurs because of relatively fixed cognitive schemes that lead a person to regard himself, his experience, and his future in a negative way. The individual systematically misconstrues events to fit these patterns. The treatment goal is cognitive modification by techniques targeted toward relief of specific symptoms or problem areas.40

Based on Beck's previous research, this manual is the outcome of a Study Group approach. Weekly conferences at the Department of Psychiatry at the University of Pennsylvania were held where therapists presented specific problems they encountered with their patients, using the cognitive approaches described. Out of the suggestions made from these meetings, based on the participation and collaboration of its members, a series of treatment manuals were devised which represent the basis of the present manual.

The resulting manual expands on the treatment of depression from a cognitive orientation. It begins with a theoretical overview, followed by a proposed structure for therapeutic interviews. The authors describe the systematic application of cognitive and behavioural techniques employed in a process of specifying discrete goals and setting up step-by-step procedures for achieving these goals, whilst providing feedback to the patient. This therapy is based on the premise that patients who are depressed hold irrational and

dysfunctional assumptions from which their thoughts derive. The first goal is to identify which of the patient's thoughts cause the depressive disorder, systematically moving through conceptual layers to the deeper dysfunctional assumptions. From these groups of dysfunctional assumptions the patient's "central rules or equations by which he structures his life are identified. The task of therapy...is to discover, together with the patients, these basic rules, to demonstrate their inappropriateness, and thus to have the patient give them up."41 Target symptoms and a structured, task-oriented approach are the focus resulting in a short-term model. The authors assert that the cure of depression, utilising this form of therapy, can be accomplished in fifteen to twenty sessions, spanning a period of eleven to fifteen weeks, depending on the severity of the symptomatology.

In this manual the authors discuss outcome studies of cognitive therapy. They report that cognitive therapy is more effective in treating depression than pharmacotherapy, behaviour therapy using interpersonal skills training, or no treatment at all. In another study of depressed patients in outpatient therapy, cognitive therapy was thought to be more effective than the use of an antidepressant drug. Those patients undertaking cognitive therapy and those given antidepressants both showed significant decreases in depressive symptoms, according to an evaluation based on self-reports, observer evaluations, and therapist ratings. However, almost 80% of the patients in cognitive therapy demonstrated marked improvement or complete remission of symptoms by the end of therapy, compared to only 20% of those who participated in pharmacotherapy.

To date, no longitudinal research which evaluates the outcome of cognitive therapy for depressed individuals has been done which would indicate that the changes observed at the end of therapy are lasting, or whether symptoms re-occur. In addition, no comparative studies of this model to ones based in a psychoanalytic model have been conducted. This lack has led to criticism of Beck's approach. As Jules Bemporad stated, it is unclear whether the dysfunctional assumptions or automatic thoughts found in depressed patients are the "cause or result of the depressive state". Furthermore, "it would appear that if recurrences are to be prevented and real change to transpire, the premorbid irrational beliefs that gave rise to the depressive episode (rather than followed it) must be altered"42. Although the initial improvement reported may be accurate, the permanence of this improvement needs to be questioned. Mardi Horowitz has concurred. Whilst Beck's group looked at the surface phenomena in the form of symptoms and explored the belief systems which support them, "they do not explain why these beliefs have achieved such

extraordinary power in guiding a person's thoughts and feelings, despite their irrational inconsistency with the real possibilities of life. What is missing in this approach is the use of the patient-therapist relationship.

However, cognitive therapy is concerned neither with the unconscious meaning of symptoms, nor with the intrapsychic structure of the personality which motivates them. It looks, instead, toward symptom relief within a short-term model which promises effectiveness in diminishing or shortening the clinical episode under question. The importance of this work is evidenced by the fact that cognitive therapy, as described by Beck and his colleagues, has been included in a National Institute of Mental Health guided multicentre study of the effectiveness of psychotherapy for depressive disorders. This is a massive research effort presently underway which is contrasting two forms of psychotherapy, cognitive therapy being one, each with and without the use of an antidepressant drug.

A Manual for Time-Limited Dynamic Psychotherapy

Another research project resulting in manualisation came out of the Vanderbilt University Psychotherapy Research Group where Hans Strupp and Jeffrey Binder studied time-limited dynamic psychotherapy (TLDP). They developed a treatment manual which was published in book form in 1984 under the title Psychotherapy in a New Key: A Guide to Time-Limited Dynamic Psychotherapy. This model developed out of research and continues to form the basis for a systematic study of TLDP in progress at Vanderbilt. The researchers are interested in three areas: the extent to which specialised training has a measurable effect on the process and outcome of treatment; what kinds of patients could benefit from this sort of treatment; and, the limitations of their treatment modality.

The model Strupp and Binder propose has a strong Sullivanian influence. It is an approach to individual psychotherapy which integrates clinical concepts from a variety of psychodynamic perspectives. The basic assumption underlying the theoretical model is that disturbances are rooted in the past. Current symptoms result from the misapplication of early-formed interpersonal patterns to current relationships. Thus, the relationship between the patient and therapist is of prime importance and it is within this context that the techniques of TLDP are embedded. The therapeutic aim is to help people whose difficulties

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manifest themselves through "anxiety, depression and interpersonal difficulties which are viewed as the product of chronic maladaptations". Unlike cognitive therapy where the focus is on symptom reduction, TLDP is aimed at "more lasting modification of the patient's character structure".45

This manual begins with a review of the history and field of short-term psychotherapy, followed by a description of the method developed and used at Vanderbilt University. The author's theories about disturbance, the therapist's stance, assessment, techniques, and termination are outlined. Included are clinical illustrations demonstrating the method employed. The selection of patients suitable for short-term work is discussed, a selection based on patient characteristics and a capacity to relate, rather than diagnosis. Similar to Luborsky's method, a central conflict is formulated which is pursued throughout the treatment.

The authors conclude with research considerations. Their model has close ties with research, born out of research studies and clinical practice. A training program has been developed based on the principles and techniques arising from this research. Frank's work (197346, 198247) is applicable here (also see Goldfried 198048, 199149). Whilst research to date has indicated that it is not possible to show the superiority of one technique or approach over another, Frank has proposed that psychotherapeutic change is a function of factors common to all therapeutic approaches. According to Frank, the fact that all psychotherapies operate under a conceptual schemata with associated procedures, is one common factor. The implication is that the therapist's training in and enthusiasm for a certain model may increase the effectiveness of that therapy. Another commonality is what Frank calls the "nonspecific factors", as opposed to "specific factors" which are therapeutic techniques. Nonspecific factors are based on the relationship between patient and therapist, and include such characteristics as understanding, respect, interest, encouragement, acceptance, and forgiveness. Frank emphasises that relational and theoretical factors contribute to efficacy (nonspecific factors), not necessarily the type of techniques employed (specific factors).

Strupp and his colleagues instigated research studies in the seventies in order to look at this specific-nonspecific hypothesis. Strupp (1973^50) thought it was possible that some techniques were superior to others when it came to particular patients, particular problems, or under particular circumstances. Several factors evolved from this research which were of central significance to outcome. These became the basis for the TLDP manual. First was the type of patient. The assessment of patients was not based on diagnosis or the level or severity of pathology, but on those individuals who had the resources and ability for collaborative work which allowed them to take advantage of the kind of relationship and techniques offered. Second was the quality of the therapeutic relationship, central to this work and an important predictor of outcome in time-limited treatment. This relationship originated in the establishment of a working alliance and was based, for the most part, on patient variables. Interestingly, the type of relationship offered by the therapist and the techniques employed were found to be invariant. In other words, therapists did not tend to adapt or modify their approach based on the patient's characteristics or material. The third factor was the therapist's reactions to the patient's aggressive hostility. These reactions indicated that the therapist's counter-transference interfered with the therapy.

In further studies the authors found that the outcome of treatment was determined by the balance of these factors. Thus, they placed an emphasis on patient criteria, "the patient's character makeup, the nature and depth of their disturbance, and their ability to become productively involved in psychotherapy"^51, rather than on specific or nonspecific factors. This raises several questions. Is the proposed model suitable only for certain patients who have specific characteristics? If so, what about other patients? Are manuals designed based on one patient population, as well as a theoretical and technical model, or is there room in the conceptualisation of a manual for the adaptation of a set of principles and prescribed techniques when clinically indicated? The literature on child psychoanalysis proposes that adaptations and modifications are appropriate with certain patients and in certain circumstances. But at the same time is the question of the point at which modifications alter the model to such a degree that its original form is lost.

Like other manuals, Strupp and Binder's also has a tool to measure whether the treatment proposed in the manual, and by which therapists have been trained, is indeed the treatment employed. Through the use of the TLDP Adherence Scale compliance with the prescribed treatment methods can be measured. The scale "is designed to make appropriate determinations concerning a therapist's practices as they are being applied in therapy with particular patients"\textsuperscript{52}.

The Vanderbilt work and the TDLP training program is research still in progress. It represents a technique that is being tested, but as yet is not "proven". The ongoing goals of this project include the comparison of treatment outcomes; in-depth investigation of the process by which change occurs through the study of individual therapy hours; and, a study of the range of patients in order to achieve clarity as to this treatment modality's limitations.

A Manual for the Psychodynamic Psychotherapy of Borderline Patients

Psychodynamic Psychotherapy of Borderline Patients\textsuperscript{53}, published in 1989, was written by Otto Kernberg and his colleagues in the Borderline Psychopathology Research Project at the Cornell Medical Center - Westchester Division. It is a manual describing a standardised method of treatment, operationalising an approach to borderline patients developed and advocated by Kernberg over the years. Through the manualisation of this modality, it is hoped that scientific investigation as to the efficacy of the model can be facilitated.

The authors state that the manual is not intended by itself to teach psychodynamic psychotherapy with borderline patients, rather it is an adjunct to beginning therapists and a handbook for those who are more experienced. It presumes a familiarity with a psychodynamic model and experience in conducting therapy of this sort, following generally accepted principles of psychoanalytic treatment. The authors are clear that the book is not an attempt to be all inclusive, rather it acts as an outline of what they believe to be the necessary and sufficient constituents of treatment. Included is an explanation of the theory which underlies the techniques, descriptions of the phases of treatment, guidelines for working with difficult issues, and clinical examples integrating theory and practice.


This manual is both concrete and technically prescriptive. "The authors state how they think the mind of the borderline patient works, and then explain and describe how a therapist should act to elucidate or ameliorate the patient's difficulty." There is a controversy which runs throughout the theory of treatment of borderline patients. On the one hand, is a limit-setting, confrontational approach, whereas on the other hand, is an empathic, regression-fostering approach. Kernberg's model falls under the former. Kolb and Gunderson, in a review of this manual, thought Kernberg's model minimised the need to also be supportive and that if readers followed the directions in the book too literally, treatment dropouts would be common. They continued by saying:

we believe that the successes of Kernberg and the co-authors with their borderline patients are more closely related to what they actually do, rather than what they say. Their effectiveness may be enhanced by the interventions featured in this book, but it may depend upon the intense, intelligent, caring attention those patients receive - which is unappreciated in this book.

The model remains to be systematically studied as to its efficacy, however the manual demonstrates the beginnings of an attempt to look at the questions of a supportive versus confrontational approach.

Kernberg and his colleagues do not elucidate research indications or methodology in this manual, however elsewhere (Koenigsberg et al 1988) the development of a research instrument is discussed at length. The importance of an instrument lies in the need to measure whether the techniques employed are what the manual specifies, thus monitoring its application. Empirical data as to the relative timing and mixture of techniques in the actual treatment situation are then provided. For this model an instrument needed to be designed which would address the full range of interventions used by psychodynamically oriented therapists in treating borderline patients, in addition to distinguishing supportive and expressive approaches. The Therapist Verbal Intervention Inventory (TVII) was developed which includes items "derived from review of related instruments, a survey of interventions described in the psychodynamic literature, and the clinical experience of the authors." Although it is in the process of being tested and revised, preliminary findings suggest that "the TVII appears to be a potentially useful tool for monitoring psychotherapeutic techniques in ongoing studies of the treatment of patients with severe personality

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disorders. The definitions of the items and illustrative clinical examples used by Harold Koenigsberg and his co-authors comes from the manual.

Conclusion

Each of these manuals is a beginning. To date their validity has not been tested completely, but they do meet, in principle, Luborsky's criteria of a manual. They attempt to define and elucidate the theories and techniques behind a certain treatment modality, and in some cases, with a certain patient population. Three are based on psychoanalytically informed ideas, whereas Beck's model originates in cognitive theories. A contrast between a short-term model and a more conventional model is evident. A manual which examines psychoanalysis as a treatment modality, or addresses the treatment of children, does not yet exist. The closest proximity is the Hampstead Psychoanalytic Index which classifies clinical material.

The Hampstead Psychoanalytic Index

All child psychoanalysts at the Anna Freud Centre are responsible for the documentation of their analytic case material. This documentation includes detailed weekly reports, often composed from daily process recordings of sessions. Weekly reports outline the main themes and processes of the analysis that week, changes and/or progressions, and a metapsychological understanding, citing examples from the child's material. Weekly reports of some of these cases are then documented further in the Hampstead Psychoanalytic Index. Candidates are required to Index at least one analytic case during their training, and staff are asked to Index cases of particular interest. The Index is a comprehensive system of classification of analytic material based on a series of manuals. The outcome of Indexing a case is a set of typed cards, cross referenced when appropriate to other headings. Each typed card contains a piece of material - a unit of observation - and a reference to the appropriate pages in the patient's case notes from which it was extracted or that it summarises.

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The Index is comprised of seven manuals. Each manual contains pertinent definitions and requirements. Within each manual are sub-headings. Analysts are asked to use the headings given, but are free to add further sub-headings if they wish to point out specific aspects of the case which are not included in the manual. The classified data fall under two general areas: General Case Material and Psychoanalytic Material. General Case Material details physical and psychological aspects of the child's environment which could potentially affect his psychic functioning. Also recorded are data concerning the child's personal development. Psychoanalytic Material is the bulk of the Index and is composed of six manuals. There are three Ego Manuals. Ego General deals with the functions of the ego, for example control of drive activity, identifications, learning, memory, reality testing, thinking, etc. Reactions to Ego Anxiety details contents which arouse anxiety and the type of ego responses or reactions to this anxiety. Ego Defences is the third Ego manual and has three sections: general characteristics, defence mechanisms, and other defensive measures. The Instinctual Manual provides a basis for the organisation and breakdown of clinical material which is understood as an expression of drive derivatives. The Superego Manual is concerned with the structural, dynamic, economic, and genetic aspects of the superego, as well as certain responses of the ego. Object Relationships provides for the indexing of the child's capacity for object relationships, as well as their characteristics. There is a Symptoms Manual which classifies the child's symptoms, etiological factors, and changes seen over the course of the analysis. Finally, is the Treatment Situation and Technique Manual (TS&T) which is divided into five sections: attendance and interruptions; attitudes and relationship to the therapist and treatment; child's modes of expression; interpretations and interventions; and, aims and results of treatment. In addition, each Manual contains a summary card.

The result of Indexing a case is a detailed and all encompassing metapsychological understanding of the child at the time he entered analysis, and the changes which resulted from the analysis. Other than TS&T, the material is organised around theories of development and intrapsychic structures, rather than technical constructs. However, technical applications are implied. On the series of cards applicable to each manual, the analyst's metapsychological understanding is outlined supported by clinical examples which illustrate the techniques the analyst employed. Each card contains at least one relevant clinical example, the analyst's understanding of it, the intervention, and the child's reactions and subsequent material.
Conclusion

The Index is rooted in clinical observations from which theory and concepts are developed and clarified. In this respect it is a unique and comprehensive research and learning tool, as well as a method of classification of psychoanalytic material. Techniques and their application, for the most part, are implicit within the metapsychological formulations. In order to operationally define what it is that an analyst does in a way which includes rational, objectives and techniques, the method of analysis needs to be made explicit, rather than remaining implicit as found in the Index. Before the phenomena and processes of child analysis, as well as its efficacy, can be studied, the dimensions of an analysis must be identified, and the concepts defined and applied in a systematic way to the aims, methods and limitations of the treatment modality. The present research is an attempt to begin this process.
INTRODUCTION

The climate of psychotherapy research in the United States and Britain embraces an interest in the outcome and efficacy of therapeutic approaches. The National Institute of Mental Health guided multicentre study on the effectiveness of psychotherapy for depressive disorders is one example of this. To date this type of research has involved work with adults. However, an interest in the treatment of childhood disorders has begun to surface in the research community. In 1988 the Anna Freud Centre, which has specialised in the research and development of child psychoanalysis for almost 40 years, was invited by the National Institute of Mental Health to prepare an application for a controlled outcome study on the effectiveness of child psychoanalysis. This led to the formation of a working group with the brief to plan such a study and carry out the background research necessary for such an application. The group established the scope of the study and began work on what would be the most substantive part of the application: a manual for child psychoanalysis.

Before the outcome and efficacy of a psychotherapeutic approach can be studied, the key therapeutic ingredients of this approach must be determined in order to provide a thorough and clear account of what the therapist actually does. The method by which guidelines, strategies, and techniques of a treatment approach are made explicit is a manual. A manual delineates what the appropriate implementation of a treatment approach is. Once this is determined it becomes possible to study if the approach used by a therapist is indeed the one intended. Only then can outcome and efficacy be measured.

A working group of four senior psychoanalysts devised a plan for a manual of child psychoanalysis with the intent of defining the areas of uniformity and consensus arising from theory, training, and practice at the Anna Freud Centre. The work produced in the Hampstead Psychoanalytic Index, including the book on technique by Sandler, Kennedy and Tyson (1980), a review of techniques as described in the literature on child psychoanalysis, and years of extensive case reports of child psychoanalytic patients provided a basis in terms of the structure of this manual and the definitions required. The aim of the manual is to make explicit the consensus in the area of technique which has evolved at the Centre over the past decades. Despite the differences which undoubtedly exist, the similarities in technique far outweigh the differences, even if such differences tend
to provide the focus for discussions on technique. The manual would then formalise within a single theoretical framework the therapeutic traditions of the Anna Freud Centre. This chapter details a preliminary attempt at such a manual.

**METHOD**

The group working on this manual was comprised of four psychoanalysts. Three of the members were child psychoanalysts trained at the Anna Freud Centre, all qualified over ten years, who held the most senior positions at the Centre. Two of the authors were also senior adult psychoanalysts, and one was a psychoanalytic research consultant.

The group began by reviewing the literature on the theory and technique of child psychoanalysis. They then proceeded to review reports of child analytic work at the Centre looking specifically at techniques and their application. The reports reviewed included weekly reports, samples of Indexed cases, and formal clinical papers which are prepared and presented by staff and trainees for presentation at the Centre, many of which go on to be published in psychoanalytic journals.

From the findings of these inquiries, and through the use of the Index, the group identified a number of topic headings which were essential to a manual. These topic headings followed along similar lines as Sandler, Kennedy and Tyson's book on the technique of child psychoanalysis which is based on the Index manual entitled "Treatment, Situation and Technique". Included in their book is: the framework of treatment; the therapeutic relationship; the child's modes of expression; interpretation and intervention; and, the outcome of treatment. The topic headings chosen by the group constituted the plan which they would follow.

The group carried out general discussions on each topic which included illustrations provided by the members. Further discussion and elaboration ensued. These discussions were audio taped and transcribed providing a basis for future work.

Working groups were set up which included members of the total group. These separate working groups began to draft sections on each of the topics. The strategy adopted for the structure of the manual was a series of technical points within each overall topic. Each technical point was followed by an example from analytic case material which
The topics the group discussed resulted in a provisional table of contents. This table of contents included:

- Chapter 1: The Scope of the Manual
- Chapter 2: The Rationale for Psychoanalytic Treatment and Treatment Aims
- Chapter 3: Arrangements for the Treatment and its Initial Stages
- Chapter 4: The Nature of Psychoanalytic Material
- Chapter 5: Therapeutic Alliance
- Chapter 6: Clarification and Elaboration of the Material
- Chapter 7: Interpretation of Conflict
- Chapter 8: Interpretation of Resistance
- Chapter 9: Interpretation of Transference and the Use of Counter-response and Transference
- Chapter 10: The Termination and Follow-up of Analysis

These chapters were the topics which each working group drafted and brought back for further revisions to the entire group. The topics which were completed resulted in four chapters of the manual: Chapter 3 - Arrangements for the treatment and its initial stages; Chapter 4 - The nature of psychoanalytic material; Chapter 5 - Therapeutic alliance; and, Chapter 6 - Clarification and elaboration of the material. Appendix 1 contains the complete chapters.
Chapter 3 discusses in detail the initial arrangements required prior to beginning an analysis. These include discussions with parents about analysis and the process, parents' involvement, school contacts, and practical arrangements such as times, fees, missed sessions, etc.

This chapter also covers the initial session with the child. It details the context and aims of the first session where the analyst presents herself as a supportive ally, listening and responding to the child's anxieties without reassuring, and noting the child's expectations and fantasies about treatment. The primary aim of this initial contact is to assure that the child will return to analysis. Common initial analytic issues are also addressed. For example, the impact on the child of a change from the diagnostician to the analyst, and the child's initial responses to the analyst and the treatment process, be they anxiety, hostility, unconvincing enthusiasm, or indifference. Table 7.1 outlines chapter 3.
Initial therapeutic meeting with the parents

1. Context and purpose
2. Generic guidelines
   a. The explanation of child analysis
   b. Parental involvement
   c. Repetition of information
   d. The depth of explanation
   e. Child-specific style
3. Specific Issues
   a. The real and internal concerns of the child
   b. Additional explanations, where necessary
   c. Making practical arrangements
   d. Attendance
   e. The child has been misled by the parent(s)
   f. Times of sessions
   g. Transport
   h. Holidays
   i. Money
   j. Arrangements for contact with parents during the treatment
   k. Some warnings about the nature of the therapeutic process
   l. Contact with the school

Initial meeting with the child

1. Context and aim
2. Fantasy and expectations
3. Necessary explanations
4. Some typical problems
5. Common initial analytic issues
   a. The analyst versus the diagnostician
   b. Anxiety about beginning treatment
   c. Hostile reaction from the child
   d. Over positive reaction on the part of the child
   e. An apparently indifferent reaction on the part of the child
Chapter 4 is an extensive chapter entitled "The nature of psychoanalytic material". Analytic material refers to the ways a child brings his material, verbally or non-verbally or through a variety of activities and behaviours, and how the analyst understands the meaning and unconscious conflicts of these communications. The analyst looks to the child's expressions for themes or consistent meaning underlying a number of independent sets of material. The aim of this chapter is to classify and illustrate the verbal and non-verbal modes of analytic material. It begins by detailing what is meant by the nature of analytic material and its formal characteristics. The remaining part of the chapter is broken into two subsections: Modes of Expression and Modes of Disguise.

By manual definition, analytic material consists of the child's behaviour during a session. This material represents the child's current concerns, thoughts and feelings as consciously and unconsciously experienced. The child's modes of expression are outside of his awareness, at least at the time they occur. The manual considers these descriptively unconscious modes of expression. The analyst aims to understand a child's internal world on the basis of her observations of the child's actions. The section entitled Modes of Expression addresses the many ways the child's actions inform the analyst's understanding. Included are the form and content of actions and the ways in which unconscious meaning of actions are conveyed. How words convey unconscious meaning are detailed as the analyst breaks down the child's language, looking at its component parts either within or excluding the patient's conscious intended meaning. Special modes of expression, such as verbal and action slips, as well as symbolic expressions, are included.

Aids to the analyst's understanding of analytic material comprises another section of Modes of Expression. This includes known information about the child's development, current life, and past analytic material. In addition is the continuity of the child's material as the analyst attempts to identify themes in what appears, on the surface, to be unconnected statements. Children present thoughts or actions which contain multiple meanings, in addition to the consciously intended one. This is also addressed, as are the child's drawings.

Modes of Disguise is the other major subsection of chapter 4. The child's preconscious and unconscious concerns do not normally gain direct expression. Rather maneuvers and mechanisms with the aim of distorting or disguising the material interpose themselves, thus preventing awareness of unconscious mental content. These modes of disguise, or mechanisms of distortion, are listed and described. They include forms of substitutions, reversals, and exclusions. Table 7.2 outlines the contents of chapter 4.
TABLE 7.2
MANUAL I

CHAPTER 4: THE NATURE OF PSYCHOANALYTIC MATERIAL

The nature of analytic material
1. General characteristics of analytic material
2. The evolution of meaningful analytic material
3. Unconscious schemata

Formal characteristics of analytic material
1. Hallmarks of analytic material
2. Play with toys and games
3. Verbal and non-verbal modes of bringing material
4. The involvement of the analyst

Modes of expression
1. The analyst's understanding of the unconscious meaning of actions
   a. The unconscious meaning of the form of actions
   b. The unconscious meaning of the content of actions
   c. The ways in which unconscious meaning of actions is conveyed
   d. The literal meaning of actions
   e. Context specific meaning of actions
   f. The interpretation of repeated action sequences
2. The analyst's understanding of how words convey unconscious meaning
   a. Level of sound
   b. Separating words into meaningful components
   c. The literal meaning of a word
   d. The unconscious use of homonyms
   e. The breakdown of the meaning of compound words
   f. The breakup of syntagmas
   g. The interpretation of idiomatic expressions
   h. The literal meaning of phrases and sentences
3. Special modes of expression
   a. Verbal slips
   b. Action slips
   c. Symbolic expression of material
4. Aids to understanding
   a. Context provided by known event
   b. Contiguity of content
   c. The combination of contents in a single element
   d. Pictorial language
TABLE 7.2 continued

Modes of disguise

1. Disguise by substitution
   a. Substitution involving perception and/or action
      1. Substitution of a perception
      2. Substitution of an action
   b. The relationship between the self and the object
      1. Self to object substitution
      2. Significant other to object substitution
      3. Significant other to self substitution
      4. Substitution of one aspect of the self for another
      5. Self to object to self substitution

2. Disguise by reversal
   a. Affect reversal
      1. Reversal of affect about another person
      2. Reversal of affect of other towards the self
      3. Reversal of affect that the child feels about himself
      4. Reversal of affect about events and activities
   b. Reversal of roles
      1. The child takes on a role so as to embody desired aspects
         of a person
      2. The child takes on a role which reverses an unacceptable
         attribute
      3. The child's role relationship to the therapist
   c. Reversal of actions
   d. Initiation of a preventative act

3. Disguise by exclusion
   a. The forgetting of information
      1. The content of the forgotten event
      2. Forgetting may occur repeatedly within a particular
         dynamic context
      3. The act of forgetting may communicate awareness of
         traumatic aspects of an event or the entire event
   b. The active denial of information
      1. The blanket specific disclaiming of content
      2. The long term exclusion of a pertinent category of ideas
         or affects
      3. The counteraction of reality by creating an alternative
         reality
      4. The disowning of disguised expression
      5. The exclusion of repudiated content by its incorporation
         into a rational account
   c. Disguise by exclusion of affect
   d. Disguise by exclusion of the source of an affect
   e. Disguise by infantile expression

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Therapeutic Alliance is discussed in chapter 5. The stated aim of analysis is to understand and overcome internal difficulties and resistances. A therapeutic alliance is a product of a child's conscious and unconscious wish to cooperate with this aim. The therapeutic alliance is distinguished from the child's wish to attend sessions because they are pleasurable. It contains aspects of transference, however if reliably established, it has a degree of autonomy from variations in the transference relationship. Furthermore, a therapeutic alliance may exist at many levels and the child's conscience may contribute to its formation.

The analyst actively promotes the therapeutic alliance from the beginning and continues to foster its development throughout treatment when necessary. Various ways in which the analyst does this are detailed in the manual, as are problems which hinder its formation and development. Table 7.3 outlines the contents of this chapter.
TABLE 7.3

MANUAL I

CHAPTER 5: THERAPEUTIC ALLIANCE

Definition

Promoting the treatment alliance

1. Increasing the child's awareness of a painful internal situation
2. Promoting the child's curiosity
3. Promoting the idea of therapeutic efficacy
4. The analyst's attention and understanding
5. The parents' promotion of treatment alliance

Problems with the treatment alliance

1. Mistrust
2. Basic unwillingness to enter treatment
3. Basic mistrust
4. The child using the analysis as a form of gratification
5. The child is not enjoying the treatment
6. The child has major environmental problems
Chapter 6, "Clarification and elaboration of the material", begins with a definition of clarification. Clarification is conceived of as a verbal intervention which explains internal or external events or processes in a comprehensible language to the child. It usually precedes and paves the way for an interpretation. The technical problems of reassurance and interrupting the free flow of material when the child seeks clarification are addressed.

Various types of clarifications are outlined and include reassurance and explanations. At times the analyst requests clarifications from the patient as further information is needed in order to understand what the child is presenting. The appropriateness and inappropriateness of this is also discussed.

Aids to interpretation is the final subsection of chapter 6. These aids are used to prepare the way for direct interpretations as a means of diminishing excessive anxiety within the child. They share the features of displacement and externalisation of mental content and affect. When to use aids to interpretation and their functions are described. The authors then discuss various forms these aids take and some of the potential problems confronted with their use. Table 7.4 outlines this chapter.
TABLE 7.4

MANUAL I

CHAPTER 6: CLARIFICATION AND ELABORATION OF THE MATERIAL

Definition

Forms of clarification

1. Reassurance

2. Explanations
   a. Clarification of part events
   b. Clarification of current events
   c. Clarification of bodily experiences
   d. Clarification of psychological processes
   e. The treatment situation

Analyst's requests for clarification

Aids to interpretation

1. Definition

2. When to use aids to interpretation

3. Functions of aids to interpretation

4. Forms of aids to interpretation
   a. Displacement onto toy figures
   b. Referring to 'parts' of the child
   c. Referring to other children of the therapist's acquaintance
   d. Using drawings
   e. Using role play
   f. Using humour
   g. Interpretive stories

5. Problems in using aids to interpretation
   a. Provoking resistance
   b. Undermining reality testing
   c. Outgrown aids
   d. Collusion with the child's defenses
DISCUSSION

It is apparent, if one looks at previous literature, then at the work of Sandler, Kennedy and Tyson which is based on the Index, how the manual writers came to the topics which they included. Chapter 1 serves as a general introduction to the manual and chapter 2 looks at the aims of treatment. Chapter 3 - Arrangements for the treatment and its initial stages - is similar in principle to the Index section looking at the framework of treatment, however it is more detailed. This is the setting within which analysis occurs and the necessary arrangements, as well as issues related to working with parents. Chapter 4 - The nature of psychoanalytic material - covers several areas. The idea is similar to the Index section on the child's modes of expression. The difference is that the manual authors attempt to dissect in detail how a child expresses his material in terms of actions and verbalisations, rather than looking more generally at verbal and nonverbal means as the Index does. It is a way of examining how a child communicates and how this method may express unconscious content, rather than what the analyst does with these communications. Chapter 4 also covers what the authors call "modes of disguise". This is discussed further below.

The concepts in the Index section on the therapeutic relationship are addressed in the manual in two chapters: chapter 5 on therapeutic alliance and chapter 9 on transference, counter-response, and their use and interpretation. Although chapter 9 is not completed, what appears to be missing in the manual is the other uses made of the analyst by the patient which has certainly been a consistent topic in discussions found in the literature over the years.

Interpretation and interventions, as outlined by the Index, would parallel in principle with chapter 6 on clarification and elaboration of the material, and chapters 7 through 9 which deal with interpretation. Interpretation is one of the main components of analysis according to the literature, and the topic of the "other things analysts do" has been a subject of debate. A question to consider, based on this manual, is whether the essential elements analyst's interpret are transference, conflict and resistance, or whether there are other types of material which also need to be included.

The last section of the Index relates to the outcome of treatment which the manual addresses in its final chapter on termination.
The main concepts found in the literature when a child analysis is described and defined are interpretation, transference, defence, conflict, and resistance. The manual includes, as topic headings, all of these except defence. It could be argued that when the authors talk about modes of disguise in chapter 4 they are referring to defensive maneuvers by another name. They describe in detail what it is a child does to disguise, but do not address interpretation or other interventions explicitly.

On the surface it looks as if the manual authors cover those essential topics or concepts linked with child psychoanalysis, on the basis of the literature and the Index. This was the authors intent. However, the multiple dimensions of the analyst's activities does not seem to be included. Whether they should be or not is open to debate as, according to the literature, it is unclear whether these are main components of psychoanalysis or byproducts of the process.

The most prominent questions pertaining to this manual relate to its content. The completed chapters are very detailed showing the minutia and finite elements of an analysis, in an attempt to describe what it is a child analysis looks like. This fits with the aim of this manual which is to give an ultimate level of detailed description of what should happen in a child psychoanalysis, as if one were describing a video tape. However, does the manual specify the main techniques of child psychoanalysis in a way which could be used to determine if the approach employed by an analyst is the one intended by the manual? This is the main purpose of manualisation. Prior to proceeding with the completion of the rest of the manual, testing out what has been written was indicated in order to determine if it was understandable, if the manual writers were on the right track in terms of their aims and procedures of a manual, and if indeed the manual was usable by other child psychoanalysts as a guide to and explanation of their work. This is the aim of study 1.
PART III.  
EMPIRICAL INVESTIGATIONS  

Chapter 8.  
Validation of Manual I: Study 1  

INTRODUCTION  

Manual I is a proposed manual of child psychoanalysis written by four senior psychoanalysts at the Anna Freud Centre. To begin the process of writing such a manual, the authors initially outlined ten topics pertinent to child psychoanalysis as practiced at this institution which they thought should be included. The topics chosen were based on the literature on child psychoanalysis and technique, the Hampstead Psychoanalytic Index manual entitled "Treatment Situation and Technique", and a review of written case reports of child psychoanalytic patients at the Centre. Through a process of full group discussions and separate working groups who drafted definitions, technical points and clinical illustrations of the topics, the authors arrived at a consensus of what to include in the proposed chapters. This resulted in four completed chapters out of the ten proposed chapters. These were then submitted for validation. Chapter 7 outlines the method of writing this manual and Appendix 1 contains the completed chapters. 

As discussed in chapter 6 there are three purposes which the manualisation of a specific psychotherapeutic approach aims to fulfill. First is to aid in the objective comparison of psychotherapies in research studies. This purpose does not apply as the proposed manual is not intended to be used, at least initially, to compare child psychoanalysis with other treatment modalities. A second purpose of a manual is to aid in the training of therapists as it specifies the main techniques within a form of therapy. Prior to being used as a training aid, it must be determined that this manual does indeed specify the techniques of child psychoanalysis. Finally, there is the purpose of aiding in the measurement of the degree to which a given therapist provided what is intended in a given approach. Again, this does not apply until it is decided that the manual spells out the approach of child psychoanalysis. However, whether the approach described in clinical material of child psychoanalytic cases is the same approach described in the manual could be determined. 

Whereas the overall chapters headings included in Manual I represent the essential techniques of child psychoanalysis as found in the literature and illustrated in clinical material, whether the contents of these chapters actually defined and delineated these techniques had to be tested. Several questions needed to be answered in order to proceed with the manual.
The first question is whether the manual is understandable by other child psychoanalysts trained at the same institution. It is assumed that there are certain fundamental concepts and techniques within a specific theoretical orientation and institution which are agreed upon by analysts who are trained at and continue to practice within that orientation and institution. Although this assumption has been called into question (Glover 1955, Schafer 1983, Hamilton 1990), in general analysts who have a shared culture should be able to understand the same language.

The second question relates to the manual writer's aims. The authors propose to give a detailed description of what a child psychoanalysis should look like and what should happen within an analytic process. The manual is based, in part, on clinical material from Anna Freud Centre case reports. If the manual has met this aim, it should be possible to match descriptions detailed in the manual to examples from analytic case material which would then validate its contents.

The final question is whether the manual is usable by other child psychoanalysts as a guide to and explanation of their work. For a manual to be useful, a child psychoanalyst needs to be able to turn to it to guide her in the implementation of techniques appropriate to this modality. Not only is a manual such a guide, but it should explain the methods, rational and objectives of child psychoanalytic techniques. This question links to the overall intention of manualisation.

This study is an attempt to validate the proposed manual and test out these questions.

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METHOD

Design of the Study

Manual I is intended to provide a thorough and clear account of what child analysts actually do, by outlining the technical procedures within the tradition of the Anna Freud Centre. Each chapter of the manual is broken down into sub-headings. These sub-headings are technical points, often illustrated by a clinical example, which pertain to the overall chapter topic. These sub-headings are the classifications used within this study. If these classifications are applicable to child psychoanalytic technique, analysts should be able to assign them to clinical material in a reliable way.

The purpose of this study is to see whether the manual classifications can be applied easily to examples taken from child analytic cases. Judges, who are experienced child psychoanalysts, were given a series of clinical examples along with classifications and definitions from manual chapters. They were then asked to rate the classifications in terms of their applicability to the examples before them. This study proposes to determine inter-rater reliability between these judges ratings. In this way it would be possible to ascertain if the manual, as it is written, is indeed indicative of analysis as practiced at the Anna Freud Centre, thus validating it as a useful guide and answering the proposed questions.

Sample

Ten judges participated in this study. The total was comprised of eight judges qualified as child psychoanalysts at the Anna Freud Centre and two judges who were child psychoanalytic psychotherapists trained elsewhere. Out of the total judges, three had been qualified over ten years and seven had been qualified under five years. Two were also trained as adult psychoanalysts. All of the judges had extensive experience in the detailed observation of analytic material required in order to be able to write process recordings and weekly reports. Most had also indexed at least one psychoanalytic case. In summary, the judges were trained and experienced in the sophisticated understanding of psychoanalytic principles and material for which the Anna Freud Centre is well known.

Seven sections of Manual I were used in this study. The total sample included three judges for each section of Manual I, two of whom were qualified child psychoanalysts from the Anna Freud Centre and one of whom was a child psychoanalytic psychotherapist. One judge rated all seven sections, one judge rated five sections, one judge rated two sections, and seven judges rated one section a piece.
Materials

Everyone at the Anna Freud Centre, staff and trainees alike, writes weekly reports on all of their analytic patients. These reports illustrate the material for that week and include process recordings of all or part of the sessions, changes seen, movement in the material or lack there of, and the clinician's conceptualisation and understanding of the material. In addition, all trainees and some staff write daily reports which are detailed process recordings of each session and constitute the basis for the weekly report.

Clinical examples for this study were taken from sections of Anna Freud Centre weekly reports which illustrated the process and interaction between patient and analyst, rather than the analyst's conceptualisation. The clinical examples were taken from nine different case files. These cases were chosen through extensive discussions with senior child analysts who were asked to recall examples of cases which would illustrate, in their opinion, good psychoanalytic technique. The suggested case files were read and nine were selected to be part of this study. The nine cases were chosen on the basis of two criteria: (1) The patient was in five times weekly analysis, and (2) The weekly reports were comprehensive and clear, and illustrated material taken directly from sessions, in other words, what the patient said or did, what the analyst said or did, and the patient's response.

The cases covered a range of pathologies. Overt symptomatology included anxiety; phobias and obsessions; angry, demanding, defiant and clingy behaviour; enuresis and encopresis; fighting; suicide threats; and sleep disturbances. Diagnostic classifications, as used at the Anna Freud Centre, included both neurotic disturbances and developmental or personality disorders, one patient exhibiting autistic features as well. The range of ages of the patients at the onset of treatment was 3.5 years to 11.8 years, and included six boys and three girls. Adolescents were omitted from the sample as the issues and techniques which the patient and analyst face constitute adolescent psychoanalysis, rather than child psychoanalysis, which is the focus of this research. The children included in the sample were in five times weekly analysis from 1.5 years to 6 years. In the nine cases chosen, eleven analysts had treated these children accounting for two patients who were transferred from one analyst to another due to the external factor of the analyst relocating.

The 400 clinical examples initially chosen from these case reports were screened a second time for clarity and narrowed down to 180. For this study a total of 140 clinical examples were selected randomly from the 180. The page of the clinical report which contained the example to be used was photocopied then the example was cut out. Names were blackened to assure confidentiality. Each example was pasted to an index card. At the
top of the card the patient's gender and age at the time the example occurred were noted. Also included was the length of time the child had been in analysis. The cards then were divided into seven sets of twenty examples so that the examples illustrated some semblance of what the manual section was asking for. Each set of twenty examples was photocopied so that a page contained one or two examples. The examples were then numbered one through twenty. Judges rating the same manual section had the same set of clinical examples. Each of the seven different sections had a different set of examples.

Three of the four completed chapters in Manual I were used in this study. Portions of these chapters were taken and broken down into seven different sections for purposes of manageability. Chapter 5 - Therapeutic Alliance - was one section. Judges were asked to look at five different classifications within this section. Chapter 6 - Clarification and elaboration of the material - also made up one section which included seven different classifications. Chapter 4 - The nature of psychoanalytic material - was broken into five sections. Modes of expression comprised two of these sections with fourteen classifications each. Aids to understanding was one section with thirteen classifications. Modes of disguise was broken into two section with sixteen and nine classifications respectively. Table 8.1 lists all of the sections and their classifications.
### Table 8.1

#### Validation of Manual I: Study 1

**Sections and Classifications**

**Section #1 - Therapeutic Alliance**

- **TA1**: Increasing the child's awareness of a painful internal situation
- **TA2**: Promoting the child's curiosity
- **TA3**: Promoting the idea of therapeutic efficacy
- **TA4**: The analyst's attention and understanding
- **TA5**: The parent's promotion of treatment alliance

**Section #2 - Clarifications**

- **C1**: Reassurance
- **C2a**: Explanations - Clarification of past events
- **C2b**: Explanations - Clarification of current events
- **C2c**: Explanations - Clarification of bodily experiences
- **C2d**: Explanations - Clarification of psychological processes
- **C2e**: Explanations - The treatment situation
- **C3**: Analyst's requests for clarification

**Section #3.1 - The Nature of Analytic Material: Modes of Expression**

The unconscious meaning of the content of actions

- **2.1**: Prototypical
- **2.2**: Symptomatic
- **2.3**: Compulsion to repeat
- **2.4**: Attempts to ward off anxiety
- **2.5**: Expression of wishes and feelings towards the analyst and/or to elicit a specific response from the analyst
- **2.6**: Motivated by pleasure in using physical capacities

Ways unconscious meaning of actions is conveyed to the analyst

- **3.1**: Meaningful distortions - Distortions of single actions
- **3.2**: Meaningful distortions - The style of actions or sequences of actions
- **3.3**: Literal interpretation of acts - Literal meaning of acts
- **3.4**: Literal interpretation of acts - Literal meaning of action sequences
- **3.5**: Literal interpretation of acts - Special meaning of particular acts
- **3.6**: Context specific meaning of acts - Meaningful units of action within a sequence
- **3.7**: Context specific meaning of acts - Linking of two distinct actions
- **3.8**: Interpretation of repeated action sequences

**Section #3.2 - The Nature of Analytic Material: Modes of Expression**

The analyst's understanding of how words convey unconscious meaning

- **1.1**: Level of sound
- **1.2**: Separating words into meaningful components
- **1.3**: Literal meaning of a word
- **1.4**: Unconscious use of homonyms
- **1.5**: Breakdown of the meaning of compound words
- **1.6**: Breakup of syntagmas
- **1.7**: Interpretation of idiomatic expressions
- **1.8**: Literal meaning of phrases and sentences

Special modes of expression

- **2.1**: Verbal slips
- **2.2**: Action slips
- **3.1**: Symbolic expression of material - Association by contiguity
- **3.2**: Symbolic expression of material - Commonality of function
- **3.3**: Symbolic expression of material - Commonality of attitude
- **3.4**: Symbolic expression of material - Commonality of sensory experience
TABLE 8.1 (continued)

Section #4 - The Nature of Analytic Material: Aids to Understanding

Context provided by known event
1.1: Current events in the child's life
1.2: Significant events in the child's past
1.3: Past analytic material

Contiguity of content
2.1: Elaboration of a narrative sequence
2.2: Adjacent content provides affective background
2.3: Representing both sides of a conflict
2.4: New meaning derived from linking two distinct themes

Combination of contents in a single element
3.1: Disguise function
3.2: Multiple expression of wishes
3.3: Expression of conflict

Pictorial language
4.1: Direct representation
4.2: Transposition of the context of the image
4.3: Concrete representation

Section #5.1 - The Nature of Analytic Material: Modes of Disguise

Disguise by substitution - involving perception and/or action
S1: Substitution of a perception
S2: Substitution of an action

Disguise by substitution - self and object
S01: Self to object substitution
S02: Significant other to object substitution
S03: Significant other to self substitution
S04: Substitution of one aspect of the self for another
S05: Self to object to self substitution

Disguise by reversal - affect
RA1: Reversal of affect about another person
RA2: Reversal of affect of other towards the self
RA3: Reversal of affect that the child feels about himself
RA4: Reversal of affect about events and activities

Disguise by reversal - roles
RR1: The child takes on a role so as to embody desired aspects of a person
RR2: The child takes on a role which reverses an unacceptable attribute
RR3: The child's role relationship to the therapist

Other disguises
R: Reversal of actions
P: Initiation of a preventative act

Section #5.2 - The Nature of Analytic Material: Modes of Disguise

Disguise by exclusion - forgetting
EF: Forgetting of information

Disguise by exclusion - active denial of information
ED1: Blanket specific disclaiming of content
ED2: Long term exclusion of a pertinent category of ideas or affects
ED3: Counteraction of reality by creating an alternative reality
ED4: Disowning of disguised expression
ED5: Exclusion of repudiated content by its incorporation into a rational account

Disguise by exclusion - affect
EA1: Disguise by exclusion of affect
EA2: Disguise by exclusion of the source of an affect

Disguise - other
DIE: Disguise by infantile expression

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Procedures

Potential judges, taken from the pool of qualified child psychoanalysts at the Anna Freud Centre, were initially approached by letter followed by a personal contact. It was explained that the present investigator was working on a study about the techniques of child psychoanalysis. A proposed manual had been written on this topic. This research was an attempt to validate this manual to determine if it was a useful guide to child analysts and if it delineated the techniques of child psychoanalysis. Their participation in this study was requested. Included in the letter was a general time frame for completion of the study and the amount of time this task would take.

Of those who agreed to participate, three were randomly assigned to each section of the manual, seven sections in all. Judges were assigned a number, rather than using their name, in order to assure confidentiality of their responses. Each judge was given a packet of information which included a cover letter; a set of instructions, classifications and rating scales (Appendix 2); the section of the manual they were being asked to validate (see Appendix 1 for the complete manual); a set of clinical examples; and a comments sheet.

The cover letter described the contents of the packet of information and went on to thank the judges for their time and consideration given to the study. Procedures for returning all of the information and a time line for completion were included, as were ways to contact the investigator with questions or comments.

Judges were asked to read through their enclosed copy of the section of the proposed manual to familiarise themselves with its content. The manual began with a definition of the topic, for example therapeutic alliance, modes of expression, etc. The classifications then followed. Under each classification heading was a description of what was meant by that classification and, in some instances, a clinical illustration.

Corresponding to the manual was a rating sheet. The horizontal axis listed each classification by its corresponding number. A complete list of classifications and numbers for that section were outlined above the rating sheet for easy reference. The vertical axis of the rating sheet listed the numbers of the clinical examples (#1-20).

Judges were asked to read each clinical example then to look at each classification. They were instructed to rate each classification to each clinical example using a three point scale: ++ meant the classification was very applicable to the example; + meant it was applicable; and 0 meant the classification was not applicable to the example. The rating the
judge chose was then placed in the appropriate box on the rating sheet. It was stressed to judges that they were attempting to classify the examples based on their understanding of the manual and their ability to use it as a guide, not on their own conceptualisation of the concepts.

Once all of the classifications had been rated to each clinical example, judges were asked to turn to the comments sheet. Here it was requested that they write their impressions of this section of the manual, for example what they found useful, interesting, impossible, etc., and any suggestions. The completed packets were returned for the analysis of the data.

RESULTS

The statistical analysis applied to the data was a coefficient of agreement (KAPPA) which measures reliability of the data. Each judge was compared with the other two in a two-way frequency measure in order to determine whether there was agreement as to the applicability of manual classifications to clinical examples. An average of the three comparisons was then computed. KAPPA coefficient of .6 or .7 indicates reliability.

Section 1: Therapeutic Alliance

The results of the statistical analysis of Section 1 - Therapeutic Alliance - are shown in Table 8.2. All coefficients between judges and within the average fell below .6. The highest coefficient between judges was .414 (judges 1 and 2) on TA1: Increasing the child's awareness of a painful internal situation. The highest average coefficient was .179 within the same category. The results indicate that judges were unable to apply the classifications of therapeutic alliance to the same clinical examples in a uniform way.
TABLE 8.2
VALIDATION OF MANUAL I
RESULTS OF SECTION 1: THERAPEUTIC ALLIANCE

<table>
<thead>
<tr>
<th>CLASSIFICATION</th>
<th>J1/J2</th>
<th>J1/J3</th>
<th>J2/J3</th>
<th>AVERAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>TA1:</td>
<td>.414</td>
<td>.021</td>
<td>.103</td>
<td>.179</td>
</tr>
<tr>
<td>Increasing the child's awareness of a painful internal situation</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TA2:</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Promoting the child's curiosity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TA3:</td>
<td>.036</td>
<td>.217</td>
<td>.163</td>
<td>.139</td>
</tr>
<tr>
<td>Promoting the idea of therapeutic efficacy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TA4:</td>
<td>0</td>
<td>.138</td>
<td>0</td>
<td>.046</td>
</tr>
<tr>
<td>The analyst's attention and understanding</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TA5:</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>.333</td>
</tr>
<tr>
<td>The parent's promotion of treatment alliance</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Comments from judges indicated that many of the classifications were confusing and that it was difficult to distinguish one from the other based on the manual. TA1: Increasing the child's awareness of a painful internal situation and TA2: Promoting the child's curiosity, were hard to distinguish. In addition, it was difficult to differentiate TA3: Promoting the idea of therapeutic efficacy and TA4: The analyst's attention and understanding from TA1. For example, one of the descriptions in TA3 talks about interventions which are aimed at clarifying the child's affective state. Judges thought this was very similar to increasing the child's awareness of an internal painful situation found in TA1. Another similarity judges found hard to differentiate was identifying the child's feelings of comfort or relief associated with interpretations found in TA3, from the provision of attention and special understanding found in TA4.

Judges also commented that there were aspects of a therapeutic alliance which were not included in the manual, but which they found in the clinical examples. One related to interventions by the analyst which aid the child in knowing that he is responsible for himself and can do something about his own difficulties, interventions which can strengthen the treatment alliance. Another area not included, but commented on, was the idea that analysis is a cooperative effort requiring the patient's help, which can also promote the therapeutic alliance.

Finally, judges commented that some of the clinical examples illustrated increasing the child's awareness of a painful internal situation (TA1), however it was unclear whether clinically this related to the therapeutic alliance or not. In other words, increasing the child's awareness in this regard may have to do with things other than the therapeutic alliance.
Section 2: Clarification

In Section 2 - Clarification - the average coefficients again indicated a lack of reliability, the highest coefficient being .268 on C1: Reassurance. Between judges, two coefficients indicated there was agreement as to the application of the manual to clinical examples on two different categories. On category C2c: Explanations - Clarification of bodily experience, the coefficient for judges 1 and 3 was .643. Judges 1 and 2 scored .630 on C2e: Explanations - The treatment situation. However, the other comparisons between judges resulted in coefficients of 0 making the averages .211 and .210 respectively. Table 8.3 illustrates these results.

<table>
<thead>
<tr>
<th>CLASSIFICATION</th>
<th>RESULTS OF SECTION 2: CLARIFICATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>C1: Reassurance</td>
<td>.259  .346  .200  .268</td>
</tr>
<tr>
<td>C2a: Explanations - Clarification of past events</td>
<td>0      0     -111  .037</td>
</tr>
<tr>
<td>C2b: Explanations - Clarification of current events</td>
<td>-.111  -.154 -.154  -.139</td>
</tr>
<tr>
<td>C2c: Explanations - Clarification of bodily experiences</td>
<td>0     .643  0     .211</td>
</tr>
<tr>
<td>C2d: Explanations - Clarification of psychological processes</td>
<td>.421  .074  .242  .246</td>
</tr>
<tr>
<td>C2e: Explanations - The treatment situation</td>
<td>.630  0     0     .210</td>
</tr>
<tr>
<td>C3: Analyst's requests for clarification</td>
<td>0      .360  0     .120</td>
</tr>
</tbody>
</table>

All of the judges commented that they found it difficult to differentiate, based on the manual, one type of clarification from another in the clinical material. Furthermore, they could not separate out the difference between a clarification and an interpretation, or a clarification and a comment made by the analyst. It was also noted that some of the clinical examples illustrated a clarification by the analyst of a developmental process. There is no classification within the manual in which a clarification of this type would fall. Judges wondered if C2a: Clarification of past events, C2b: Clarification of current events, or C2d: Clarification of psychological processes, would apply. However none of these actually describes developmental processes.
Section 3.1: The Nature of Analytic Material - Modes of Expression

Table 8.4 outlines the results of the statistical analysis of Section 3.1: Modes of expression. Again the analysis shows no reliability. The highest average coefficient was .188 on 2.4: Attempts to ward off anxiety, and almost half of the categories resulted in a coefficient of 0 or below. The highest coefficient between judges was .483 on 3.1: Meaningful distortions - Distortions of single actions, between judges 1 and 3, however the other comparisons fell at 0.

<table>
<thead>
<tr>
<th>CLASSIFICATION</th>
<th>J1/J2</th>
<th>J1/J3</th>
<th>J2/J3</th>
<th>AVERAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>The unconscious meaning of the content of actions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.1: Prototypical</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2.2: Symptomatic</td>
<td>.158</td>
<td>0</td>
<td>0</td>
<td>.053</td>
</tr>
<tr>
<td>2.3: Compulsion to repeat</td>
<td>.138</td>
<td>-.154</td>
<td>-.136</td>
<td>-.051</td>
</tr>
<tr>
<td>2.4: Attempts to ward off anxiety</td>
<td>.119</td>
<td>.124</td>
<td>.320</td>
<td>.188</td>
</tr>
<tr>
<td>2.5: Expression of wishes and feelings towards the analyst and/or to elicit a specific response from the analyst</td>
<td>0</td>
<td>.444</td>
<td>0</td>
<td>.148</td>
</tr>
<tr>
<td>2.6: Motivated by pleasure in using physical capacities</td>
<td>0</td>
<td>.444</td>
<td>0</td>
<td>.148</td>
</tr>
<tr>
<td>Ways unconscious meaning of actions is conveyed to the analyst</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.1: Meaningful distortions - Distortions of single actions</td>
<td>0</td>
<td>.483</td>
<td>0</td>
<td>.161</td>
</tr>
<tr>
<td>3.2: Meaningful distortions - The style of actions or sequences of actions</td>
<td>-.143</td>
<td>-.159</td>
<td>-.132</td>
<td>-.145</td>
</tr>
<tr>
<td>3.3: Literal interpretation of acts - Literal meaning of acts</td>
<td>0</td>
<td>.205</td>
<td>0</td>
<td>.068</td>
</tr>
<tr>
<td>3.4: Literal interpretation of acts - Literal meaning of action sequences</td>
<td>.038</td>
<td>0</td>
<td>0</td>
<td>.013</td>
</tr>
<tr>
<td>3.5: Literal interpretation of acts - Special meaning of particular acts</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>3.6: Context specific meaning of acts - Meaningful units of action within a sequence</td>
<td>0</td>
<td>-.081</td>
<td>0</td>
<td>-.027</td>
</tr>
<tr>
<td>3.7: Context specific meaning of acts - Linking of two distinct actions</td>
<td>0</td>
<td>0</td>
<td>.006</td>
<td>.002</td>
</tr>
<tr>
<td>3.8: Interpretation of repeated action sequences</td>
<td>-.011</td>
<td>0</td>
<td>0</td>
<td>-.004</td>
</tr>
</tbody>
</table>
All judges commented on difficulties with the classifications: The ways unconscious meaning of actions is conveyed to the analyst (3.1-3.8) as they thought it was unclear exactly what the manual meant. Some judges further delineated specific problems. Meaningful distortions: Distortions of single actions (3.1) and Literal interpretation of acts: Literal meaning of action sequences (3.4) were difficult to differentiation except in very literal and concrete ways. The judge wondered if this was the point of the manual, i.e. to be literal and concrete. It was thought that all of the classifications which related to action sequences - Literal interpretation of acts: Literal meaning of action sequences (3.4); Context specific meaning of acts: Meaningful units of action within a sequence (3.6); and Interpretation of repeated action sequences (3.8) - were impossible to distinguish clinically. One judge commented on 2.3: Compulsion to repeat, saying that a compulsion to repeat relates to other than trauma which is the only area the manual addressed.

Section 3.2: The Nature of Analytic Material - Modes of Expression

The second section of classifications of Modes of Expression was Section 3.2. The only signification statistic (.608) was between judges 2 and 3 on 2.2: Action slips, however the comparisons between other judges was .459 resulting in an average of .509, the highest average within all the classifications. Table 8.5 details these results.
TABLE 8.5

VALIDATION OF MANUAL I
RESULTS OF SECTION 3.2: THE NATURE OF ANALYTIC MATERIAL
MODES OF EXPRESSION

<table>
<thead>
<tr>
<th>CLASSIFICATION</th>
<th>J1/J2</th>
<th>J1/J3</th>
<th>J2/J3</th>
<th>AVERAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>The analyst's understanding of how words convey unconscious meaning</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1: Level of sound</td>
<td>0</td>
<td>0</td>
<td>.527</td>
<td>.176</td>
</tr>
<tr>
<td>1.2: Separating words into meaningful components</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>1.3: Literal meaning of a word</td>
<td>0</td>
<td>0</td>
<td>.095</td>
<td>.032</td>
</tr>
<tr>
<td>1.4: Unconscious use of homonyms</td>
<td>.338</td>
<td>.072</td>
<td>.153</td>
<td>.188</td>
</tr>
<tr>
<td>1.5: Breakdown of the meaning of compound words</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>1.6: Breakup of syntagmas</td>
<td>0</td>
<td>0</td>
<td>-.111</td>
<td>-.037</td>
</tr>
<tr>
<td>1.7: Interpretation of idiomatic expressions</td>
<td>0</td>
<td>0</td>
<td>.275</td>
<td>.092</td>
</tr>
<tr>
<td>1.8: Literal meaning of phrases and sentences</td>
<td>.368</td>
<td>.180</td>
<td>.254</td>
<td>.267</td>
</tr>
<tr>
<td>Special modes of expression</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.1: Verbal slips</td>
<td>.459</td>
<td>.459</td>
<td>.608</td>
<td>.509</td>
</tr>
<tr>
<td>2.2: Action slips</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>3.1: Symbolic expression of material-Association by contiguity</td>
<td>0</td>
<td>0</td>
<td>.381</td>
<td>.127</td>
</tr>
<tr>
<td>3.2: Symbolic expression of material-Commonality of function</td>
<td>.318</td>
<td>.178</td>
<td>.017</td>
<td>.171</td>
</tr>
<tr>
<td>3.3: Symbolic expression of material-Commonality of attitude</td>
<td>0</td>
<td>0</td>
<td>.016</td>
<td>.005</td>
</tr>
<tr>
<td>3.4: Symbolic expression of material-Commonality of sensory experience</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Judges found they could not understand some of the classifications within this section, especially 3.1: Symbolic expression of material: Association of contiguity, and could not differentiate the four classifications of symbolic expression (3.1-3.4). They wondered why it was necessary to break down into finite entities how words are used and what the point of this was. One judge commented that an example related to syntax in terms of grammatical word order, which the manual did not include.

Section 4: The Nature of Analytic Material - Aids to Understanding

Again in Section 4: Aids to understanding, none of the average coefficients showed reliability in terms of matching the manual classifications to clinical examples. Between judges 1 and 2 on 1.1: Context provided by known event: Current events in the child's life, there was a substantial coefficient of .695, however the other comparisons between judges was .385 and .394 resulting in an average coefficient of .491. This was the highest
average within this section. On 2.2: Contiguity of content: Adjacent content provides affective background, judges 2 and 3 showed inter-rater reliability with a coefficient of .643, but the other comparisons were 0. Refer to Table 8.6 for these results.

**TABLE 8.6**

**VALIDATION OF MANUAL I**

**RESULTS OF SECTION 4: THE NATURE OF ANALYTIC MATERIAL AIDS TO UNDERSTANDING**

<table>
<thead>
<tr>
<th>CLASSIFICATION</th>
<th>11/12</th>
<th>11/13</th>
<th>12/13</th>
<th>AVERAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Context provided by known event</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1: Current events in the child's life</td>
<td>.695</td>
<td>.385</td>
<td>.394</td>
<td>.491</td>
</tr>
<tr>
<td>1.2: Significant events in the child's past</td>
<td>.174</td>
<td>0</td>
<td>0</td>
<td>.058</td>
</tr>
<tr>
<td>1.3: Past analytic material</td>
<td>.086</td>
<td>.592</td>
<td>.306</td>
<td>.328</td>
</tr>
<tr>
<td><strong>Contiguity of content</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.1: Elaboration of a narrative sequence</td>
<td>0</td>
<td>.044</td>
<td>0</td>
<td>.015</td>
</tr>
<tr>
<td>2.2: Adjacent content provides affective background</td>
<td>0</td>
<td>0</td>
<td>.643</td>
<td>.214</td>
</tr>
<tr>
<td>2.3: Representing both sides of a conflict</td>
<td>0</td>
<td>0</td>
<td>.216</td>
<td>.072</td>
</tr>
<tr>
<td>2.4: New meaning derived from linking two distinct themes</td>
<td>-.184</td>
<td>-.098</td>
<td>.231</td>
<td>-.017</td>
</tr>
<tr>
<td><strong>Combination of contents in a single element</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.1: Disguise function</td>
<td>0</td>
<td>.154</td>
<td>0</td>
<td>.051</td>
</tr>
<tr>
<td>3.2: Multiple expression of wishes</td>
<td>0</td>
<td>0</td>
<td>.113</td>
<td>.038</td>
</tr>
<tr>
<td>3.3: Expression of conflict</td>
<td>0</td>
<td>-.092</td>
<td>0</td>
<td>-.031</td>
</tr>
<tr>
<td><strong>Pictorial language</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.1: Direct expression</td>
<td>.444</td>
<td>0</td>
<td>0</td>
<td>.148</td>
</tr>
<tr>
<td>4.2: Transposition of the context of the image</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>4.3: Concrete representation</td>
<td>0</td>
<td>0</td>
<td>-.094</td>
<td>-.031</td>
</tr>
</tbody>
</table>

Regarding Context provided by known event (1.1-1.3) one judge commented that this was the easiest section to rate and that each subsection was clearly distinguishable. It was 1.1 which showed inter-rater reliability between two judges, but none of the other coefficients were substantial. Another judge pointed to an area not covered by the manual, that the relationship with the analyst and current events in the analysis not only fuel current concerns, but revive long standing ones.

The rest of this section of the manual was found to be confusing by all of the judges. In Contiguity of content (2.1-2.4) the classifications were thought to overlap too much for clarity as they were not sufficiently discrete. Specifically 2.1 (Elaboration of a
narrative sequence) overlapped with 2.2 (Adjacent content provides affective background) and 2.3 (Representing both sides of a conflict). Furthermore, 2.1 and 2.3 overlapped with 2.4 (New meaning derived from linking two distinct themes).

The comments regarding Combination of contents in a single element (3.1-3.3) were similar, i.e. they weren’t sufficiently discrete and overlapped too much for clarity resulting in grave difficulties in rating. Multiple expression of wishes (3.2) was thought to overlap with Expression of conflict (3.3). One judge elaborated that they overlapped because, by definition, there must be a repudiated wish in order for there to be a conflict. There were multiple comments about 3.1 (Disguise function). It was thought that this classification might be made clearer if the child’s unawareness was stressed and that it would be better to classify 3.1 in terms of defence. Related to the issue of disguise and defence is one comment regarding the entire section of Combination of contents in a single element. One judge said that this certainly could be a disguise, but that there are more than wishes (3.2) and conflict (3.3) which are disguised. The section said nothing about affects. Lastly, in the manual 3.2 speaks of a repudiated wish. Some of the examples fit this, however the wish wasn’t necessarily "repudiated". In addition, there could be a combination of more than one wish, some of which may or may not be repudiated, which the manual does not address.

With Pictorial language (4.1-4.3) judges again found that the classifications overlapped and that it was impossible to differentiate one from another. The description in the text of the manual wasn’t clear enough to understand how this subsection was different from the others. Direct representation (4.1) and Concrete representation (4.3), which were found to be especially confusing, were mentioned the most as impossible to distinguish. Judges asked: "What is direct versus concrete?". Transposition of the context of the image (4.2) was further confused with 4.1 and 4.3. Lastly, one judge commented on 4.1. According to the manual a drawing can represent a wish or a memory. This judge thought that anything could be directly represented in a drawing, not only a wish or memory.

One other general comment was made. The manual talks about content and words being aids to the analyst’s understanding of the patient's communications. Many other things are also aids which were not addressed, for example actions and affect.
Section 5.1: The Nature of Analytic Material - Modes of Disguise

Table 8.7 shows the results of the statistical analysis of Section 5.1: Modes of disguise. As with the other sections there was no reliability as to the rating of the manual with the clinical examples. The coefficient of judges 1 and 2 was .623 on SO2: Significant other to object substitution, however the other comparisons scored at .012 resulting in an average of .216, the highest average. Of the 16 classifications, 75% of the averages fell below .1.

<table>
<thead>
<tr>
<th>CLASSIFICATION</th>
<th>J1/J2</th>
<th>J1/J3</th>
<th>J2/J3</th>
<th>AVERAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disguise by substitution - involving</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>perception and/or action</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>S1: Substitution of a perception</td>
<td>0</td>
<td>.071</td>
<td>.044</td>
<td>.038</td>
</tr>
<tr>
<td>S2: Substitution of an action</td>
<td>0</td>
<td>-.061</td>
<td>0</td>
<td>-.020</td>
</tr>
<tr>
<td>Disguise by substitution - self and object</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SO1: Self to object substitution</td>
<td>0</td>
<td>0</td>
<td>.041</td>
<td>.014</td>
</tr>
<tr>
<td>SO2: Significant other to object substitution</td>
<td>.623</td>
<td>.012</td>
<td>.012</td>
<td>.216</td>
</tr>
<tr>
<td>SO3: Significant other to self substitution</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>SO4: Substitution of one aspect of the self for another</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>SO5: Self to object to self substitution</td>
<td>0</td>
<td>0</td>
<td>.048</td>
<td>.016</td>
</tr>
<tr>
<td>Disguise by reversal - affect</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RA1: Reversal of affect about another person</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>-.073</td>
<td>-.070</td>
<td>-.143</td>
<td>-.095</td>
</tr>
<tr>
<td>RA2: Reversal of affect of other towards the self</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>RA3: Reversal of affect that the child feels about himself</td>
<td>0</td>
<td>0</td>
<td>.437</td>
<td>.146</td>
</tr>
<tr>
<td>RA4: Reversal of affect about events and activities</td>
<td>0</td>
<td>.103</td>
<td>0</td>
<td>.034</td>
</tr>
<tr>
<td>Disguise by reversal - roles</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RR1: The child takes on a role so as to embody desired aspects of a person</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>RR2: The child takes on a role which reverses an unacceptable attribute</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>RR3: The child's role relationship to the therapist</td>
<td>.262</td>
<td>-.048</td>
<td>.397</td>
<td>.204</td>
</tr>
<tr>
<td>Other disguises</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>R: Reversal of actions</td>
<td>0</td>
<td>.174</td>
<td>0</td>
<td>.058</td>
</tr>
<tr>
<td>P: Initiation of a preventative act</td>
<td>.286</td>
<td>.091</td>
<td>.231</td>
<td>.203</td>
</tr>
</tbody>
</table>
Comments by judges again indicated that the classifications were confusing and almost impossible to distinguish, and that the manual was difficult to understand. In regards to Disguise by substitution - self and object (SO1-SO5) there was much confusion. Self to object to self substitution (SO5) was especially difficult to distinguish. Judges wondered whether, by the manual definitions, the analyst was an object or a significant other. The use of "significant other" was open to interpretation. Did the manual mean immediate family, extended family, peers, the analyst, or what?

Disguise by reversal of affect (RA1-RA4) and roles (RR1-RR3) were areas judges pointed to which were especially confusing and where it was difficult to determine which classification might apply. Whereas one judge thought RR3 (Child’s role relationship to the therapist) and RA4 (Reversal of affect about events and activities) could be differentiated, RR1 (Child takes on a role so as to embody desired aspects of a person) and RR2 (Child takes on a role which reverses an unacceptable attribute) were impossible to do. Furthermore, Reversal of actions (R) seemed to have already been covered in all of the other sections on reversals, and Initiation of a preventative act (P) was difficult to distinguish from reversal.

Another judge pointed to a clinical example where the patient did to the analyst what he felt the analyst had done to him. There was nowhere in the manual where this common defence mechanism of reversal was discussed. In relation to the child taking on the role of another (RR1 and RR2), the manual outlines the reasons a child might do this as arising from a wish to embody desired aspects of another or to reverse something unacceptable. There are other reasons a child does this, for example the defence of passive into active.

Section 5.2: The Nature of Analytic Material - Modes of Disguise

The last section of Manual I to be studied was 5.2, the second half of Modes of Disguise. Table 8.8 shows that the results again did not demonstrate inter-rater reliability. The highest average coefficient was .244 on EDI: Blanket specific disclaiming of content. Judges 1 and 3 showed reliability on EF: Forgetting of information, with a coefficient of .643, however the other comparisons resulted in 0 making the average .214.
### Table 8.8

**Validation of Manual I**

**Results of Section 5.2: The Nature of Analytic Material**

**Modes of Disguise**

<table>
<thead>
<tr>
<th>Classification</th>
<th>J1/J2</th>
<th>J1/J3</th>
<th>J2/J3</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disguise by exclusion - forgetting</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EF: Forgetting of information</td>
<td>0</td>
<td>.643</td>
<td>0</td>
<td>.214</td>
</tr>
<tr>
<td>Disguise by exclusion - active denial of information</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ED1: Blanket specific disclaiming of content</td>
<td>.212</td>
<td>.368</td>
<td>.152</td>
<td>.244</td>
</tr>
<tr>
<td>ED2: Long term exclusion of a pertinent category of ideas or affects</td>
<td>0</td>
<td>.457</td>
<td>0</td>
<td>.152</td>
</tr>
<tr>
<td>ED3: Counteraction of reality by creating an alternative reality</td>
<td>.137</td>
<td>.048</td>
<td>.124</td>
<td>.103</td>
</tr>
<tr>
<td>ED4: Disowning of disguised expression</td>
<td>0</td>
<td>-.099</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>ED5: Exclusion of repudiated content by its incorporation into a rational account</td>
<td>.238</td>
<td>0</td>
<td>0</td>
<td>.079</td>
</tr>
<tr>
<td>Disguise by exclusion - affect</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EA1: Disguise by exclusion of affect</td>
<td>.273</td>
<td>0</td>
<td>0</td>
<td>.091</td>
</tr>
<tr>
<td>EA2: Disguise by exclusion of the source of an affect</td>
<td>0</td>
<td>-.075</td>
<td>0</td>
<td>-.025</td>
</tr>
<tr>
<td>Disguise - other</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DIE: Disguise by infantile expression</td>
<td>.121</td>
<td>0</td>
<td>0</td>
<td>.040</td>
</tr>
</tbody>
</table>

Comments related, for the most part, to Disguise by exclusion - active denial of information (ED1-ED5). Judges found these categories difficult to distinguish. In addition, blanket specific disclaiming of content (ED1) is an element in all denial which made the rating of this classification difficult. One judge wondered about symbolic disguise and that there was nowhere in the manual this seemed to fit. Would it be Counteraction of reality by creating an alternative reality (ED3), but this doesn't mean the same thing.

One judge was explicit that she did not find this method of dissecting a child's defensive material as helpful as identifying specific defences and wondered why the manual writers chose to talk about defences in such a confusing way. The judge would not want to use this method, as understood from the manual, to further understand clinical material.
Introspective Reports

Judges' general comments about the manual section before them indicated that overall they found the manual to be turgid and difficult to comprehend. Applying the classifications spelled out in the manual did not work with real clinical examples and it was thought the detail and finite method employed in the manual missed the point of analytic material. One judge thought differently, finding it interesting and quite challenging to try to define what it was that was happening in a treatment in the way spelled out in the manual. This judge added it might be useful to use a manual of this sort when the analyst felt stuck and in need of an evaluation of the analysis.

Throughout the manual judges wondered where the transference and the analytic relationship was. It was thought to be an error that this was not included in these sections.

DISCUSSION

In this study three judges were given one section of the proposed manual which included classifications of the chapter topic and definitions. Seven different sections were used from three of the manual chapters. The chapters included therapeutic alliance, clarification, and the nature of psychoanalytic material. Judges were asked to rate the classifications as to their applicability to clinical examples taken from nine different five times weekly child psychoanalytic cases.

The statistical analysis (KAPPA) demonstrates, in looking at the two-way frequency measuring inter-rater reliability, that two judges agreed as to the matching of classifications with clinical examples in only 6 of the 78 classifications (.08%). In terms of the average coefficients of all three judges there was no inter-rater reliability. The highest average coefficient from all seven sections was .509 found in the Modes of Expression classification 2.2: Action slips (Table 8.5). Over half (62%) of the average coefficients were .1 or below.

The evidence is overwhelming that judges, all of whom are experienced and sophisticated clinicians, found it impossible to apply any of the manual classifications to examples from analytic cases of children in any uniform or reliable way. Several reasons for these difficulties can be concluded.
From the data it is evident that judges found difficulties in understanding what it was the manual meant. They thought the classifications overlapped too much and did not address discrete entities. Many found the manual turgid and overly complicated. Therefore, one reason judges did not agree was that the manual, as it is written, is not clear enough for others to follow.

It was the author's aim to give a detailed description of what a child psychoanalysis looks like. The data show that this aim was not met. Judges were unable to match classifications from the manual to clinical material. Thus, what the analysis looked like clinically was different than what the manual described. Judges' comments further indicated that it was difficult to apply the manual to the clinical reality. They also thought, as a description of an analysis, there were things the manual omitted.

This aim of the authors is at cross purposes with the aim of manualisation, which is to specify the main techniques used within a treatment approach. This accounts for another reason the proposed manual does not work. Rather than focusing on technique, which entails the rules and guidelines by which an analyst works, the authors attempted to give a full description of an analysis by finding out what an analyst does at the behavioural level. The manual tries to act as a videotaped description of what happens in an analysis. This does not relate to the constructs analysts use, the things they hold in their minds, in order to understand the material before them.

The proposed manual is also fundamentally inconsistent with the topics the authors tried to use. The basis for these topics came from the literature on child psychoanalysis and its techniques. The two used in this study were therapeutic alliance and clarification. These are concepts which are theoretically driven. Therapeutic alliance, for example, applies to many different things within an analytic process. The analyst may aim to promote or develop an alliance at the beginning of treatment, however it is an aspect which waxes and wains throughout an overall process. Many things may promote or strengthen an alliance, some of which the manual outlines and some of which the judges pointed to which were not included in the manual. At the same time, as the comments suggested, some of the things analysts do that the manual outlined may have a different intent behind them that does not relate to the therapeutic alliance. For example, TA1: Increasing the child's awareness of a painful internal situation, or TA2: Promoting the child's curiosity, could also be aims of the analyst related to making unconscious processes conscious, defence or conflict analysis, or a step in a process of helping the child examine why he acts in certain ways linked to a self representation. The optimal word here is intent. A detailed description of the analyst's behaviour misses her intent. Without knowing the analyst's intent it is impossible to
comprehend what an analyst is trying to do. Intent motivates technique and includes aims and means. Its origin is at the level of the analyst's mind rather than her behaviour.

Similar problems were found with the section on Clarifications. Judges could not ascertain what the difference was between an interpretation or a comment and a clarification. The manual does discuss the different types of things an analyst may clarify, for example current events or past events, however when the analyst does this, why, and its relationship to the overall process is lost within the minuitia of the manual descriptions.

Theoretical concepts such as therapeutic alliance and clarification, which are overarching concepts, do not lend themselves to the level of description the authors were attempting to obtain, that of a videotape. Instead, they are concepts which have general principles and guidelines backed up by specific aims. They do not fit with the author's aim of describing what an analysis looks like, other than saying these two concepts are a part of an overall analytic process. They do fit in terms of what should be included in a manual, in other words the main techniques, but the guidelines and strategies which are part of these techniques are not an aspect of this manual.

The chapter entitled "The nature of psychoanalytic material", which the sections Modes of Expression and Modes of Disguise arise from, does fit with the author's aims. They try to dissect into finite elements what one sees when they look at an analysis. From this viewpoint it is a useful contribution. The authors detail the child's use of actions and words into their most minute components. However, as a guide to the techniques employed in analysis it is not useful as it does not correspond to any strategies or sets of rules the analyst might adopt.

One of the questions this study attempted to answer was whether the approach used by an analyst as demonstrated in clinical examples was the same approach as outlined in the manual. The question is incongruous because this manual does not describe an approach. It fails to identify and distinguish the processes which are at work in an analysis; those processes include analyst's ideas which govern the way they work. Through the discovery of these processes one could identify and delineate the strategies, rules, and psychoanalytic theory driven conventions which analyst's use. In this way what happens in an analysis and what it looks like would be specified, however it would be via what the analyst thinks, both consciously and preconsciously, rather than through a description of her behaviours.
As Sandler suggested, a psychoanalytic approach is specified at the level of the analyst's preconscious and unconscious mind, her "private" views, which link to what actually goes on in the consulting room and the development of the analyst's "part-theories".

In order to successfully manualise child psychoanalysis a different method needs to be undertaken. The starting point is the internal working model of the analyst. It is through the investigation of analyst's conscious and descriptively unconscious beliefs that the what, how, and why of child psychoanalysis within a specific culture can be found. The what is the first question and includes the concepts and techniques analyst's hold in their minds which fuel their understanding of any given patient before them. Once this is established, the next step is defining these concepts and determining how and why they are used.
PART III.
EMPIRICAL INVESTIGATIONS

Chapter 9. Classification of Child Psychoanalytic Material: Study 2

INTRODUCTION

The manualisation of a treatment modality is organised around the components which constitute its specific approach. The starting point of the manualisation of child analysis is to ascertain what these components are.

Attempts to make this determination have been tried by thoroughly examining the literature. Throughout the history of child analysis there has been general agreement that interpretation, transference, defence, conflict and resistance are basic components. Only interpretation is a technical concept. The others are concepts describe the patient’s unconscious processes which are subject to the analyst’s interventions. Does this mean that what the analyst does is interpret these? Whilst interpretation is a primary technique, analysts would agree that it is not the only technique. Here is where agreement ceases. Concepts like treatment alliance, working-through and insight have been included, but these do not accurately describe what the analyst does. Does she interpret these things? Traditionally, some have thought the child analyst reconstructs history based on the recovery of past memories and experiences. Others (Kennedy 19711) have called this premise into question. Instead, the analyst constructs the affective significance of patterns of experience which impact the way the child functions in the here and now. Other elements and dimensions of analysis have been the subject of analytic discourse. Are they byproducts of the analytic process (Harley 19862) or its main technical components (Tolpin 19783)? Thus, the comparison of major contributions to child psychoanalysis by authorities in the field reveals that many ambiguities exist in the recommendations as to its components. The literature does not provide the answer to what the primary components of child psychoanalysis are.

The tradition of the Anna Freud Centre is based in child development and observation. From the beginning of her work Anna Freud looked first to the child through systematic observations, an approach beginning with the Jackson Nursery in Vienna, continuing with the Hampstead War Nurseries in London, and carried over into the development of training


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and research in child psychoanalysis. The strong tie between the clinical and theoretical has been maintained by her colleagues and successors at the Anna Freud Centre. The Hampstead Psychoanalytic Index and the extensive re-thinking of psychoanalytic concepts for which the Centre has become so well known, originate in clinical material. Theory and technique are revised and re-worked by looking at what the child brings and what is observed by the analyst, rooted within a developmental viewpoint. In this way theory and technique are based in the clinical and observable.

If an approach laid out in a manual is going to match the reality of what child psychoanalysts actually do, the process of defining this approach must begin by looking at two areas. First is the clinical material which demonstrates what the child brings to the analytic process. Second is the mind of the analyst. As analysts learn their treatment modality through an apprenticeship model and continue to refine their approach through experience and discussion with colleagues, as well as from what they read, they hold in their minds implicit theories of how they work. The task of manualisation is to make these theories explicit.

The aim of this study is to determine the technical and theoretic concepts which are part of analyst's internal working models. Using clinical material from a variety of child psychoanalytic cases, and a group of child psychoanalysts from the same culture, it is possible to determine the repertoire of concepts and techniques analyst's have in their minds when they think about child analysis. This includes a range of possible components. Any given analyst will impose her own theoretical framework to her understanding of any patient or clinical material before her. Many different frameworks of child analytic methods and processes are then gathered, even from analyst's who are trained within the same theoretical model. Found within these frameworks would be a range of commonalties. It is a given within a study of this sort that, when looking at clinical material, one analyst may label an interaction an interpretation, whereas another may call it a verbalisation, due to the analyst's differing implicit theories about one technique or another. However, both would be components of the analytic process. Identifying these components is the first step in clarifying theory. It is this repertoire of commonalties which comprise the basis for the manualisation of child analysis.
METHOD

Design of the Study

This study is designed to ascertain the repertoire of concepts and techniques analysts have in their minds when they observe clinical material. The result is a range of commonalities which would comprise the main components of the child psychoanalytic approach as practiced at the Anna Freud Centre.

In order to see how analyst's think about clinical material sixteen judges, all grounded in the training of the Anna Freud Centre, were given a set of clinical examples from a wide variety of child patients. They were asked to list what concepts came to mind which would illustrate the material before them. A content analysis was applied to the data resulting in specific categories based on the concepts or labels judges listed. These were rated by frequency of occurrence. These categories represent the dimensions of an analysis. What concepts should be included in a definition of child analysis can be delineated from these.

Sample

Sixteen judges participated in this study. The total was composed of twelve qualified child psychoanalysts from the Anna Freud Centre, three senior candidates in child psychoanalysis at the Anna Freud Centre, and one qualified child psychoanalytic psychotherapist trained elsewhere. Of the thirteen qualified judges, five were qualified for ten years or more, one was qualified between five and ten years, and seven were qualified for under five years. Three of the judges were also qualified as adult analysts.

Materials

Clinical examples for this study were taken from weekly reports of nine different case files of children treated in five times weekly psychoanalysis at the Anna Freud Centre. These were the same cases used in Study 1. Chapter 8 details the process of selection of these cases and their demographics.

The 400 clinical examples were initially chosen because they illustrated the analytic process instead of the analyst's conceptualisation of the material. In other words, the example spelled out what the child presented, how the analyst responded to this material, and the child's reaction to the analyst's response. These examples were screened a second
time for clarity and narrowed down to 180. For this study a total of 40 clinical examples were selected randomly from the 180. These were divided into four sets of 20 examples each. The sixteen judges were each given one set of 20 examples so that four judges were labeling the same 20 examples and eight judges were labeling the same 10 examples.

Procedure

Qualified child psychoanalysts and some senior candidates were initially approached by letter requesting their participation in this study. It was explained that the investigator was doing research on the technique of child psychoanalysis as practiced at the Anna Freud Centre. The interest was in how analysts thought about and classified clinical material. The general time frame for completion of this study and an approximate amount of time this task would take were outlined.

The sixteen judges who agreed to participate were randomly assigned to one of the four sets of clinical examples. Each judge was assigned a number to assure confidentiality of their responses. They were given a packet of information which included a cover letter, a set of instructions, and a set of clinical examples.

The cover letter described the contents of the packet of information. Procedures for returning the information, a time line for completion and ways to contact the investigator with questions and comments were detailed.

The judges were told that the aim of this study was to elicit the repertoire of concepts or labels that child analysts use to think about psychoanalytic methods and processes. They were asked to label each clinical example, which had been selected randomly from a diverse group of cases, according to what they thought might be going on. This could entail a wide range of possibilities. For example, one could use a label that was very general, e.g. affect, conflict, verbalisation, working-through, etc.; or something more specific, e.g. an interpretation of defence; or something more elaborate still, e.g. an interpretation in the transference of the child behaving towards the analyst in the here and now as he does with his mother and linking it with a past event. Judges were cautioned that there was no right label. What was taking place within the process was difficult to tell as the examples were taken out of context. They were instructed to list the possibilities which occurred to them from different angles. The examples could be looked at in terms of what the patient was doing, what the analyst was doing, and/or the interaction. Although some examples would elicit more labels than others, judges were asked to try and write at least five possible labels under each example.
Judges were given the following example to illustrate what was being asked of them.

Male patient R, age 12.5:
R explained to me the ways in which W was nasty to him and we could see that they were involved in a mutual interaction of humiliation and revenge. R said that he was glad if W got hurt but added that he would like to stop the chain. I noted the contribution of R's childhood feelings and frustrations, and that he was in particular revenging himself on J via W. R agreed. He wondered when it would stop, be "satisfied". He could see the role of fully tracing and understanding the feelings involved.

Some possible labels could include:
(1) Conflict
(2) Interpretation
(3) Defence
(4) Wish
(5) Interpretation of an enactment of a past relationship/internal object relationship in an extra-transference relationship
(6) Engaging the patient's observing ego in the analytic process
(7) Reinforcing the treatment alliance

The completed packets were returned for the analysis of the data.

RESULTS

A content analysis was applied to the data. Arising from judges responses came 160 initial categories. Of these, 44 were excluded from the final list due to a minimal number of responses, or were absorbed under other headings, for example hopelessness under affect. This left a total of 116 categories.

Judges responses to each example were broken down in detail, placed in the appropriate categories, and numbered according to frequency of use. Categories included all aspects of the heading spelled out by the judge. This included not only a description of the heading, but the patient as well as the analyst's response. For example, under the category of aggression was included the type of aggression (anger), what the aggression was about (toward parent), the patient's response to the aggression (fear of), and what the analyst did with it (verbalise). Aspects of a response such as this would also be included under the categories of object relationships (aggression toward parent), fears (fear of
aggression), and verbalisation (verbalisation by analyst of aggression). Table 9.1 lists the 116 categories by frequency. These range from Defence with a frequency of 332 responses, to Solutions with a frequency of two.

Figure 9.1 illustrates the breakdown of the 116 categories by frequency. Eleven categories had a frequency of 100 or more, three had a frequency of 50-99, 13 categories fell within a frequency of 25-49, 36 had a frequency of 10-24, and almost half (53) fell below 10.

Figure 9.1: Number of categories within a range of frequency

Appendix 3 contains the complete list of categories, responses which fell into each category. It is descriptive of an analysis as a whole. As it is impossible to report the results of all 116 categories here, certain ones have been chosen for discussion. These demonstrate the method of content analysis employed and the dimensions of the concepts arising from the mind of the analyst based on her observations of clinical material. Three specific concepts will be discussed. Defence and transference are included. Both of these fell under the ten most frequency labeled concepts and are always included in the literature when the primary child psychoanalytic techniques are listed. Affect is discussed which also fell within the top ten concepts. Affect is included as it plays a key role in Anna Freudian technique. According to theory it is through the observation of a child's affect and subsequent changes in affect that clues are obtained as to the meaning of a child's communication. Lastly is a composite of certain sub-categories within the overall categories which pertain to what the analyst does. This is entitled "Activities of the Analyst" and specifically addresses the broad range of techniques analyst's use.
# TABLE 9.1

**STUDY 2: CLASSIFICATION OF CHILD PSYCHOANALYTIC MATERIAL CONCEPTS AND FREQUENCY OF RESPONSE**

<table>
<thead>
<tr>
<th>Rank</th>
<th>Frequency</th>
<th>Concepts</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>332</td>
<td>Defence</td>
</tr>
<tr>
<td>2</td>
<td>273</td>
<td>Interpretation</td>
</tr>
<tr>
<td>3</td>
<td>188</td>
<td>Conflict</td>
</tr>
<tr>
<td>4</td>
<td>163</td>
<td>Self</td>
</tr>
<tr>
<td>5</td>
<td>149</td>
<td>Affect</td>
</tr>
<tr>
<td>6</td>
<td>137</td>
<td>Wish</td>
</tr>
<tr>
<td>7</td>
<td>132</td>
<td>Transference</td>
</tr>
<tr>
<td>8</td>
<td>124</td>
<td>Object Relationships</td>
</tr>
<tr>
<td>9</td>
<td>116</td>
<td>Fears</td>
</tr>
<tr>
<td>10</td>
<td>109</td>
<td>Analyst, other</td>
</tr>
<tr>
<td>11</td>
<td>107</td>
<td>Aggression</td>
</tr>
<tr>
<td>12</td>
<td>94</td>
<td>Anxiety</td>
</tr>
<tr>
<td>13</td>
<td>59</td>
<td>Ego</td>
</tr>
<tr>
<td>14</td>
<td>53</td>
<td>Verbalisation</td>
</tr>
<tr>
<td>15-16</td>
<td>46</td>
<td>Identification</td>
</tr>
<tr>
<td>15-16</td>
<td>46</td>
<td>Treatment Alliance</td>
</tr>
<tr>
<td>17</td>
<td>45</td>
<td>Fantasy</td>
</tr>
<tr>
<td>18</td>
<td>44</td>
<td>Sexual</td>
</tr>
<tr>
<td>19</td>
<td>41</td>
<td>Superego</td>
</tr>
<tr>
<td>20</td>
<td>38</td>
<td>Anal</td>
</tr>
<tr>
<td>21</td>
<td>34</td>
<td>Oedipal</td>
</tr>
<tr>
<td>22-23</td>
<td>32</td>
<td>Enactment</td>
</tr>
<tr>
<td>22-23</td>
<td>32</td>
<td>Regression</td>
</tr>
<tr>
<td>24</td>
<td>31</td>
<td>Ambivalence</td>
</tr>
<tr>
<td>25</td>
<td>30</td>
<td>Guilt</td>
</tr>
<tr>
<td>26</td>
<td>28</td>
<td>Clarification</td>
</tr>
<tr>
<td>27</td>
<td>27</td>
<td>Self Observation</td>
</tr>
<tr>
<td>28-29</td>
<td>24</td>
<td>Narcissism</td>
</tr>
<tr>
<td>28-29</td>
<td>24</td>
<td>Resistance</td>
</tr>
<tr>
<td>30-31</td>
<td>23</td>
<td>Castration</td>
</tr>
<tr>
<td>30-31</td>
<td>23</td>
<td>Support</td>
</tr>
<tr>
<td>32-34</td>
<td>22</td>
<td>Loss/Abandonment</td>
</tr>
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<td>32-34</td>
<td>22</td>
<td>Reality</td>
</tr>
<tr>
<td>32-34</td>
<td>22</td>
<td>Separation</td>
</tr>
<tr>
<td>35-36</td>
<td>21</td>
<td>Masturbation</td>
</tr>
<tr>
<td>35-36</td>
<td>21</td>
<td>Ways of Bringing Material</td>
</tr>
<tr>
<td>37-38</td>
<td>20</td>
<td>Change</td>
</tr>
<tr>
<td>37-38</td>
<td>20</td>
<td>Rivalry</td>
</tr>
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<td>39-40</td>
<td>17</td>
<td>Containment</td>
</tr>
<tr>
<td>39-40</td>
<td>17</td>
<td>Linking</td>
</tr>
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<td>41-43</td>
<td>16</td>
<td>Envy</td>
</tr>
<tr>
<td>41-43</td>
<td>16</td>
<td>Reinforcement</td>
</tr>
<tr>
<td>41-43</td>
<td>16</td>
<td>Sadomasochism</td>
</tr>
<tr>
<td>44-46</td>
<td>14</td>
<td>Engagement</td>
</tr>
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<td>44-46</td>
<td>14</td>
<td>Oral</td>
</tr>
<tr>
<td>44-46</td>
<td>14</td>
<td>Understanding</td>
</tr>
<tr>
<td>47-48</td>
<td>13</td>
<td>Control</td>
</tr>
<tr>
<td>47-48</td>
<td>13</td>
<td>Curiosity</td>
</tr>
<tr>
<td>Rank</td>
<td>Frequency</td>
<td>Concept</td>
</tr>
<tr>
<td>------</td>
<td>-----------</td>
<td>------------------------------</td>
</tr>
<tr>
<td>49-51</td>
<td>12</td>
<td>Insight</td>
</tr>
<tr>
<td>52-56</td>
<td>11</td>
<td>Acceptance</td>
</tr>
<tr>
<td>57-63</td>
<td>10</td>
<td>Internalisation</td>
</tr>
<tr>
<td>64-70</td>
<td>9</td>
<td>Acting Out</td>
</tr>
<tr>
<td>71-73</td>
<td>8</td>
<td>Gratification</td>
</tr>
<tr>
<td>74-80</td>
<td>7</td>
<td>Damage</td>
</tr>
<tr>
<td>81-87</td>
<td>6</td>
<td>Communication</td>
</tr>
<tr>
<td>88-95</td>
<td>5</td>
<td>Acknowledgement</td>
</tr>
<tr>
<td>96-102</td>
<td>4</td>
<td>Acting In</td>
</tr>
<tr>
<td>103-108</td>
<td>3</td>
<td>Concerns</td>
</tr>
<tr>
<td>109-116</td>
<td>2</td>
<td>Dependence</td>
</tr>
</tbody>
</table>

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DEFENCE

The most frequently identified concept was Defence with a frequency of response of 332. Figure 9.2 illustrates five areas which were delineated from the data based on judges responses. They include: type of defence (232 responses); what the defence was against (44); quality of defence (8); the relationship between the patient and the defence (9); and, what the analyst did as it pertains to the defence (39).

Figure 9.2: Defence - Categories

![Bar chart showing frequency of Defence categories]

Type of Defence

By far and wide the type of defence was identified the most with a frequency of 232. Excluding the singular label of "defence" which was noted 42 times, 37 other types of defence were listed. Denial, displacement and externalisation were all listed over 25 times (36, 25, and 27 respectively). Passive into active was identified 17 times, and projection 10 times. That leaves 32 types of defences identified under 10 times, 17 of which were listed only once. This result speaks to the multitude of ways a child excludes from awareness uncomfortable or unacceptable content. Some examples of what was included are avoidance (9), aggression turned against the self (5), identification with the aggressor (4), projective identification (4), reversal of affect (6), and splitting (6). See Figure 9.3.
What Defences Are Against

Judges also identified what these things children defend against are, as far as they could tell from the material presented to them. Affect was most frequently mentioned, with a frequency of 28 out of 44 responses. Affect included such things as aggression, disappointment, pain, helplessness, and feelings related to the self. Anxiety was identified five times and loss four times which included one response described as "a defence against a break in treatment". Seven other responses were mentioned once, three of which related to an aspect of the self or self esteem. See figure 9.4.

Activities of the Analyst

The third area identified by the sample was the function of the analyst. In other words, what it was the analyst did with the defence. This category had a frequency of 39. Primarily, the analyst interpreted, be it an interpretation of the defence, of the need to defend, or the motive of the defence. Other functions were identified only two or three times, but
have similarities. Some of the areas described could be conceived of as an aspect of interpretation, but were either more specific or more general. For example, the "analysis of defence" is more general as it speaks to the entire process which the example is only a part of, rather than to a singular function at a specific moment. "Linking defence" (with affect or fantasy) is one step in an overall interpretation where the defence and what is defended against are described. Equally, "describing a defence" is telling the child what it is they are doing. These types of responses are grouped together as part interpretations. Another response, which is a somewhat different function, was "disentangling the child's defence from the mother's". Whilst interpretation may be the way one does this, the aim is specific to issues other than what the defence is against. "Collusion with", "misunderstands", and "undermines" have different connotations and constitute the "other" category of functions of the analyst. On the one hand, the meaning ascribed to these by the judge could be of a mistake made by the analyst. On the other hand, there could be times within an analytic process when the aim is to collude with a defence because it is necessary for the child's functioning at a specific time, or to undermine certain defences which are interfering with functioning. Figure 9.5 illustrates the responses to this section.

Figure 9.5: Defence - Functions of the analyst

The Patient and Defence

The fourth area delineated under Defence has to do with the patient. The result of defence interpretation and/or the analytic process were identified three times: the child begins to give up a defence, gains insight into a defence, and gains understanding of the defence. Three responses related to how the child used a defence, e.g. as a conscious attempt to get rid of thoughts, to enhance self esteem, or the need to defend. Additionally, two responses described the defence itself. The defence illustrated a fixation or was a progressive defence. One response was a description of the patient and his defences, as the patient "showed a lack of appropriate reaction formation". See figure 9.6.
The Quality of the Defence

Finally, in their responses judges described the quality of the defence which they noted in the examples. Of the eight descriptions included were: inadequate, ineffective, interferes, maladaptive, progressive, and uneconomic. Other than "progressive defences", this category describes the difficulties that defences can cause and when they would need to be analysed. See figure 9.7.

AFFECT

Affect was the fifth most identified concept in this study, with a frequency of response of 149. However, this is not the only category which pertains to affect. In addition, is the category of Aggression which was the eleventh most identified concept with a frequency of response of 107. By combining these two categories, the frequency of response increases to 256, making affect the third most identified concept, only surpassed by defence (332) and interpretation (273).

Four areas are distinguishable within the combined categories of affect and aggression: the type of affect (132 responses); the person the affect involves (9); the relationship between the affect and the patient (74); and what the analyst does as it pertains to patient's affect (41). Figure 9.8 illustrates these four sub-categories by frequency of response. For a separate breakdown of affect and aggression see Appendix 3.
Type of Affect

The range of types of affect is vast. Aggression was the most frequently mentioned with a response of 47 out of 132. This included aggression, anger, hostility, rage, sadism, and aggressive or murderous feelings. The all-encompassing term "affect" was identified 18 times, followed by feelings and shame each identified 10 times, humiliation 8 times, and pain with a frequency of five. Twenty different types of affects were identified with a frequency of under five, 12 of which were identified once. Such affects as disappointment (4), helplessness (4), hurt (3), despair (2), exclusion (2), and loneliness (2) were included. This points to the wide range of affects experienced and worked with in child psychoanalysis. See figure 9.9 for a breakdown of the 26 types of affect identified.

Object of Affect

At whom the affect was directed, the second sub-category of the combined categories of affect and aggression, was not discussed by many of the judges. Only nine responses elucidate this. Of these, three responses indicated affect directed towards the self,
two spoke of affect directed towards the analyst, and four identified affect directed at another person. Interestingly, 7 of these 9 responses related to aggression. See figure 9.10.

Figure 9.10: Affect directed toward

The Patient and the Affect

Figure 9.11 speaks to the third area, the relationship between the affect and the patient. This is further broken down into two sections. First is what the patient does with the affect in relation to himself. Some sort of defence against the affect was most frequently labeled with a response of 45. This includes the many ways in which patients attempt not to experience an affect which is perceived as threatening. Some examples of the defence include: reversal, splitting, identification with the aggressor, projection, turning aggression against the self. Other areas of the patient's intrapsychic processes were seen to relate to affect as well. These include: anxiety about or fear of the affect (8); wishes, specifically aggressive wishes (9); conflict over aggression (4); or affect linked to a fantasy (2).

The second section relating to affect and the patient is affect seen specifically as part of the treatment process and, in many cases, arising because of the analysis itself. Of the 16 total responses, 10 of these had to do with the expression of an affect; e.g. expression (3), as a response to the analyst (3), expression in the transference (2), communication of an affect (1), and enactment (1). The other 6 responses in this section include: recognition by the patient of an affect (3), available affect (1), an increased range and flexibility of affect (1), and mastery (1).
Activities of the Analyst - Affect

Finally is what the analyst does with a patient's affect. The most common activity, according to judges' responses, is that analysts make an interpretation or verbalise the affect. These two concepts received a frequency of 14 and 13 respectively. The analyst may also make a clarification (4) or links the affect with something else (4), such as a defence or an anxiety. However, analysts may do other things as well. Six areas were delineated by judges with a response of one. These include: acceptance of affect, containment of, empathise with, recognise, support the benefits of mastering an affect, or, as one judge suggested, avoid the patient's affect all together. The latter response could point to an interference in the analytic process by the analyst, or the analyst could have a conscious intent in doing this. Figure 9.12 illustrates the fourth area of affect.

Figure 9.12: Analyst's response to affect
Anxiety and Fear

If affect is broadly defined as a feeling state, then the affects which have been discussed do not tell the whole story. Anxiety and fear would need to be included so as to encompass the whole range of feeling states. These two categories received a frequency of response of 94 and 116 respectively, and would make the total frequency of response to the all-encompassing category of affect 466, elevating it to the most frequently discussed concept in this study. Further research is needed in order to decide whether anxiety and fear appropriately fall under affect or require a separate subheading, or even if fear and anxiety should be linked together even though the physiological response may be similar. For the purpose of this study they will be included under affect, but discussed separately.

As with other concepts, judge's responses related to anxiety and fear can be broken down into four areas. Different types of anxieties or fears (72 responses) were indicated which were further delineated 14 times into descriptions of what the anxiety or fear was of. In addition, anxiety and fear as it relates to the patient, and what the analyst did with the anxiety or fear were indicated with a frequency of response of 13 and 14 respectively. See figure 9.13.

Figure 9.13: Anxiety and Fear - Categories

<table>
<thead>
<tr>
<th>Types of Anxiety and Fear</th>
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<tbody>
<tr>
<td>Type</td>
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<td>80</td>
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</tbody>
</table>

Figure 9.14 shows the types of anxieties or fears labeled which had a frequency of response of 72. The general term "anxiety" was noted 32 times, and the term "fear" was noted 11 times. More specific types of anxieties included: castration anxiety (10), separation anxiety (6), masturbation anxiety (3), and primitive anxieties (2). Whilst these response could equally fall under the sub-heading of what the anxiety is of, e.g. of castration or separation, these are types of anxieties described by psychoanalytic theory.
which have a broader meaning linked to developmental phases. That leaves 8 other types of anxieties which were listed only once. Included were anxious ambivalent, core conflict, oedipal, persecution, primal scene, superego and unbearable.

Figure 9.14: Type of anxiety or fear

![Bar chart showing the distribution of anxiety or fear types.]

What the Anxiety or Fear Is Of

Anxiety or fear as it relates to loss was labeled most frequently by those judges who went a step further in their description to include what the anxiety or fear was of. This could be the loss of another (12 responses) or loss of the self (6 responses). The anxiety or fear could also be linked to aggression (8); revealing or discovering aspects of oneself, either in relation to another person or to the patient himself (7); retaliation (6); castration (5); rejection (5); sexuality which includes masturbation (5); a wish (5); damage (4); or humiliation (4). Other areas labeled once or twice totaled 33. Some examples are fear of being small, stupid, cheated, replaced; of change or competition; of the dark, failure, envy, growing up, or winning. This speaks to the fact that a child can be anxious about or fearful of any number of things. See figure 9.15.
The Patient and Anxiety/Fear

The third area under anxiety and fear is what the patient tried to do with the anxiety or fear. Included were ways of defending against it, with a frequency of response of 6. Enactment, control, mastery of, or gaining relief from the experience were all labeled once. Three other areas were also mentioned once and included conflict, thoughts which provoke the anxiety, and anxiety as a description of an attachment. Figure 9.16 illustrates anxiety and fear as it relates to the patient.

Activities of the Analyst - Anxiety and Fear

As was found with affect in general, when it comes to anxiety and fear the judges thought what the analyst did most often was to make an interpretation. Out of the 19 responses which related to the analyst's actions, 11 of these were interpretation. In addition, the analyst may try to contain the anxiety (two responses) or make a verbalisation (two
responses). Linked to the area of containment, but requiring different strategies, is when the analyst needs to physically hold a patient as the anxiety or fear is beyond the realm of containment with words. This was noted once. Three other strategies were listed once: linking the fear with something else; communicates the patient's ability to bring the fear into treatment; or, as with the affects discussed above, the analyst's avoidance of the patient's anxiety. See figure 9.17.

Figure 9.17: Analyst's response to anxiety or fear

![Bar Chart](chart.png)

**TRANSFERENCE**

Transference was clearly thought by judges to be an important concept in child psychoanalysis. It rated seventh out of 116 concepts with a frequency of response of 132. This is not surprising as the literature suggests that transference is one of the most important vehicles for therapeutic action and change in psychoanalysis. The four areas delineated within the category of transference (see figure 9.18) included: type of transference (30), what the transference is of (27), the relationship between the patient and the transference (17), and the analyst's actions as they pertain to the transference (58).
In terms of the type of transference, excluding the singular label of "transference" which was noted 17 times, six other types of transference were listed. These include extra-transference and sadomasochistic transference with frequencies of five and four respectively. The four other types of transference had a frequency of response of one. These were erotic, homosexual, negative, and reversed. Figure 9.19 illustrates the different types of transference.

Figure 9.19: Type of transference

What is Transferred

Figure 9.20 refers to the second area of transference, what judges thought the transference might be of. The 27 responses in this category are broken down into four different sub-categories. Broadly speaking, transference implies the transfer of a relationship from a significant other onto the person of the analyst in the present. Some
judges spoke of transference in this way. This could be the transference of an object relationship (6), or more specifically, in relation to the original object (1), other objects (1), or the mother (1). The second sub-category is the quality of the relationship being transferred. The affective state was labeled five times and included ideas like denigration, abandonment, and aggressive. Ambivalent was labeled three times. Other qualities of the relationship were mentioned once each and included infantile, provocative/intrusive, and conflictual. The third sub-category is the time in life the relationship occurred which is being transferred. Although this sub-category applies to all of transference, it was delineated explicitly four times. Included were the transference of a past relationship (2), of current problems (1), and a habitual mode of relating (1). The fourth, and final sub-category is Other. This too entails relationships, but what judges were thinking may not be a specific relationship per se. Included were the superego (1), which is an agency of the mind from a structural point of view, a wish (1), and an oedipal conflict (1).

The Patient and the Transference

The third area of discussion under transference is the relationship between the patient and the transference. There are two different ideas which are relevant. First, is what the patient does with or in relation to the transference. Most frequently noted was enactment, listed 9 times. In addition was acting out of the transference (1), bringing material into the transference (1), and withholding in the transference (1). Secondly, is how the patient experiences the transference. This was labeled five times and included: critical, longing for and fear of closeness, dependence, wishes, and more generally, a reaction to the transference. See figure 9.21.

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4 Habitual mode of relating means a way of relating based on earlier experiences which becomes ingrained in the character structure. It is seen in all, or most, of the child's ongoing relationships. Rather than being a transference which develops during the course of analysis, it is evident from the beginning of treatment. It is qualitatively different than the transference of past or current relationships.
Activities of the Analyst

Finally, is the sub-category related to technique, i.e. what the analyst does in relation to the transference. Figure 9.22 illustrates the 58 responses. First and foremost, the analyst makes an interpretation (48). This could be an interpretation of the transference (33), or an interpretation in the transference (10), or an extra-transference interpretation (5). The analyst may also link the transference to something else, which was noted five times, for example to past or other relationships, or to the treatment situation. Verbalisation as a technique was labeled twice where a wish or an affect in the transference was verbalised by the analyst. Three other activities were listed by judges, each one time: dilution or encouragement of the transference, and distinguishing the analyst from the original object.
ACTIVITIES OF THE ANALYST

Certain categories, or parts of categories, from the overall classification of child psychoanalytic material specifically detail activities of the analyst. These encompass the techniques employed by analysts when working with children. Interpretation and verbalisation are two, but there are also the multitude of "other things" analysts do when confronted with a child patient.

In order to compile all of the activities analysts are engaged in, all classifications titled with a technical concept were gathered together. Each sub-section of the category which related to the technique was included. Sub-sections pertaining to the patient were excluded. For example, in Activities of the Analyst interpretation would include the type of interpretation, what was interpreted, the analyst's method of interpretation, and her aim. Excluded would be the patient's response to the interpretation. Affect would not be included under Activities of the Analyst as it is something which originates from the patient. However, the sub-section under affect entitled "analyst" would be included under other technical concepts. In other words, a label like clarification of affect would be found under clarification, and so forth.

The number of categories of Activities of the Analyst totals 29, which includes one entitled "Analyst, other". This category is made up of all of those activities which were not labeled frequently enough to merit a category in their own right. Table 9.2 lists all of the categories of Activities of the Analyst by frequency of response. They range from Interpretation with 262 responses to Recognition with two responses.
<table>
<thead>
<tr>
<th>Rank</th>
<th>Frequency</th>
<th>Concepts</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>262</td>
<td>Interpretation</td>
</tr>
<tr>
<td>2</td>
<td>78</td>
<td>Analyst, Other</td>
</tr>
<tr>
<td>3</td>
<td>52</td>
<td>Verbalisation</td>
</tr>
<tr>
<td>4</td>
<td>27</td>
<td>Clarification</td>
</tr>
<tr>
<td>5</td>
<td>23</td>
<td>Support</td>
</tr>
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<td>6-7</td>
<td>16</td>
<td>Containment</td>
</tr>
<tr>
<td>6-7</td>
<td>16</td>
<td>Reinforcement</td>
</tr>
<tr>
<td>8</td>
<td>15</td>
<td>Linking</td>
</tr>
<tr>
<td>9</td>
<td>14</td>
<td>Engagement</td>
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<tr>
<td>10-11</td>
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<td>Reassurance</td>
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<tr>
<td>10-11</td>
<td>11</td>
<td>Reconstruction</td>
</tr>
<tr>
<td>12-13</td>
<td>9</td>
<td>Encouragement</td>
</tr>
<tr>
<td>12-13</td>
<td>9</td>
<td>Intervention</td>
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<tr>
<td>14</td>
<td>8</td>
<td>Confrontation</td>
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<tr>
<td>15-16</td>
<td>7</td>
<td>Acceptance</td>
</tr>
<tr>
<td>15-16</td>
<td>7</td>
<td>Explanation</td>
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<tr>
<td>17-19</td>
<td>6</td>
<td>Developmental Help</td>
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<tr>
<td>17-19</td>
<td>6</td>
<td>Empathy</td>
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<tr>
<td>17-19</td>
<td>6</td>
<td>Fostering</td>
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<tr>
<td>20-22</td>
<td>5</td>
<td>Education</td>
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<tr>
<td>20-22</td>
<td>5</td>
<td>Promoting</td>
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<tr>
<td>20-22</td>
<td>5</td>
<td>Suggestion</td>
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<tr>
<td>23-24</td>
<td>4</td>
<td>Extra Analytic Material, use of</td>
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<td>23-24</td>
<td>4</td>
<td>Responsibility, aided by analyst</td>
</tr>
<tr>
<td>25-26</td>
<td>3</td>
<td>Acknowledgement</td>
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<tr>
<td>25-26</td>
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<td>Counter-transference</td>
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<td>27-29</td>
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<tr>
<td>27-29</td>
<td>2</td>
<td>Recognition</td>
</tr>
</tbody>
</table>
Figure 9.23 illustrates the breakdown of categories by frequency of response. Of the 29 total categories one had a frequency of 100 or more, two categories fell within a frequency of 50-99 (which includes Analyst, other), one had a frequency between 25-49, 7 had frequencies between 10-24, and over half (18) fell below 10.

Appendix 4 outlines all of the Activities of the Analyst categories and their frequency of response. They are organised by the activity name, each of which is a technical concept. In practice, analyst's activities are initiated by what comes from the patient. It is an assessment by the analyst of what the required intervention is, based on what the patient presents and the analyst's theoretical model which provides a framework for understanding the child's internal world. Therefore, in looking at what it is that analysts do with children, one looks first to what the child presents, then the analyst's activities which are a response to this. The data for this study was gathered in this way.

Rather than presenting the results of this section of the study under the heading of each technical concept as Appendix 4 illustrates, the data will be organised around what children present. In this way it will more closely resemble what happens in practice. Seven areas which describe the child's material were delineated from the data. Figure 9.24 outlines these areas and the number of responses pertaining to activities of the analyst. They include: surface manifestations (17); feeling states (67); the child's unconscious creations (111); intrapsychic structure (59); relationship with the analyst (97); other (12); and activities not specified by the child's material (192). These areas will be defined and presented in detail.
Surface Manifestations

First are the surface manifestations. These include: the external (rather than psychic) reality in the child's life; the events in a child's life; what the child does and the behaviours he presents; what the child says; and finally, the symptomatology which, according to psychoanalytic theory, is a surface manifestation with underlying psychic origins. These surface manifestations and behaviours were not noted to any great degree by judges which suggests that analysts are more concerned with what lies below the surface.

Reality and symptoms were identified most frequently, each with a response of five. In terms of reality, the analyst may acknowledge the reality, clarify or verbalise it for the patient, confront the patient with reality, or make an interpretation. As far as symptoms are concerned, interpretation was most frequently mentioned, but the analyst may also link the symptom to something else, or verbalise the problem. Events and behaviours were the next most frequently labeled surface manifestations each with a response of three. Analyst's interpret events, but may also link an event with something else. When it comes to the child's behaviour, the analyst may draw the patient's awareness to it, accept a certain behaviour, or interpret the child's actions. Analyst's may also physically hold a child, but

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5 Psychoanalysis views overt symptomatology as a symbol which indicates that some sort of conflict or stress is taking place in the preconscious or unconscious areas of the mind or within the psychic structures. As it is a causal therapy, interventions are usually directed toward what underlies the symptom, i.e. that which is descriptively unconscious, rather than at the symptom itself. According to theory, if the root of the symptom is not reached in this way and the symptom itself is only treated, other pathological formations may develop which express the same latent content as the original symptom.
when judges spoke of this they related it to the internal processes of the child. For example, an intervention of this type could be necessary due to the child's overwhelming anxiety or an inability to control himself. Therefore, physically holding is included elsewhere. Only one judge spoke specifically about what the child said, and the need to clarify this. Figure 9.25 shows the techniques which are directed toward these surface manifestations.

Feeling States

According to judges the patient's feeling states are closely watched and interventions are often based on these. Feeling states in this context are taken to include affects of all kinds, anxieties and fears, and the child's needs. The frequency of response indicated that feeling states are interpreted (29); verbalised (16); linked to something else (5); or clarified (4). In addition, they may be accepted by the analyst (2), for example accepting the patient's longings or negative feelings; understood (1); or recognized (1). The analyst may also provide the child with an alternative to his present feeling state (1) or observe the child's affective response to an interpretation (1). Furthermore, analysts contain feeling states (5), most often anxiety. Whilst contain could mean physically holding, it could also mean containing through the use of words. See figure 9.26.
Containment

A significant number of responses were labeled as an activity of the analyst without being linked to what was coming from the patient. These will be discussed further below, however one could apply to surface manifestations and feeling states. The overall heading is "Containment". This includes the singular wording of containment (2); as well as physically holding the patient in order to contain (6); containing by offering limits and restrictions (1), or through a verbalisation (1); or offering the patient greater control through analytic understanding (1). See figure 9.27. Equally, the need for containment, which the child's behaviour would indicate, could arise not only from anxiety or affects, but also from an enactment which is a sub-heading of the next category of Activities of the Analyst.
The Child’s Unconscious Creations

Like feeling states, an enactment can be prompted by something else originating within the child’s internal world and can manifest itself behaviourally. It may link to any number of theoretical models of the mind; be it drives, ego and superego; object relationships; or a response to memories or experiences. Furthermore, an enactment may link to the child’s affects, anxieties and needs. There are a number of constructs such as this. They are the child’s unconscious creations or processes arising from the psychic world, demonstrated and observable in the clinical material, to which analysts direct their activities. Some of these are an outcome of the developmental process itself and can further development or hinder its progress. The third heading under Activities of the Analyst relates to these and is described by the title "The Child’s Unconscious Creations". Included are: defence (40), conflict (32), wishes (16), fantasy (9), regression (5), enactment or acting out (5), resistance (3), and magical thinking (1). See figure 9.28 for a breakdown of these categories.

Figure 9.28: Activities of the Analyst - Categories of the child’s unconscious creations

As has been previously discussed, defences are a focus of the child psychoanalyst’s attention and interventions. Defence received a frequency of response of 40, the highest in this category. Most frequently mentioned by judges in thinking about activities of the analyst was the interpretation of defence (31). However, analyst’s also do other things. They may "analyse" a defence (2), which speaks more to the overall process which would lead to an interpretation. They may link a defence with an affect or a fantasy (2). Furthermore, analyst’s describe defences to their patients (1), collude with (1), disentangle (1), undermine (1), or even misunderstand defences (1). (Refer to figure 9.5.) In relation to the child’s resistance to the psychoanalytic process, which received a frequency of response of three, judges labeled both clarification and interpretation as activities of the analyst.
Analyst's interpret conflict (21), but conflict is also the focus of other interventions. Analyst's verbalise conflict (4), clarify (2), help the patient to recognize (1) or conceptualize conflict (1), and, in some circumstances, create a conflict (3). The child's wishes too are interpreted (13), as well as encouraged (1), verbalised (1), and "taken up" (1). Regressive wishes may be supported (1). Regressions themselves are encouraged (1) or facilitated by the analyst (1), as well as accepted (1) and interpreted (1).

According to judges, based on the clinical material they were given, analyst's interpret enactments or acting out (5). No other interventions were noted in this area. However, with fantasies they may not only interpret (1), but also verbalise (3), clarify (2), link the fantasy with something else (1), contradict a fantasy with reality (1), or even seek the child's fantasies (1).

Thinking is included in this section, as what was illustrated in the clinical material according to one judge was "magical thinking", which was interpreted.

Figures 9.29 and 9.30 illustrate the activities analysts engage in as they pertain to the child's unconscious creations. Certain techniques are grouped together. Support includes acceptance. The heading "bring out" means things analysts do to help children recognise these unconscious processes. Included are: help the patient conceptualise or recognise, describe, encourage, facilitate, and seek. Take-up is included under analyse.

Figure 9.29: Activities of the Analyst - 1. Child's unconscious creations
Intrapsychic Structures

The "something else" which the child's unconscious creations are linked to is classified as intrapsychic structures. There are many ways to think about this concept, but the responses of judges fell under two broad headings. One is the structural model as originated and defined by Sigmund Freud, which 26 responses spoke to. The other is object relationships which had a frequency of response of 32. See figure 9.31.

Figure 9.31: Activities of the Analyst - Categories of intrapsychic structures
Freud's structural model is composed of the id, ego and superego. Id, in this context, is often used simultaneously for drives. Only two judges labeled the clinical material specifically in drive terms. One was the interpretation of a drive fixation, the other was an "instinctual" interpretation.

Activities of the analyst which are directed toward the ego, or involve the ego in some way, were frequently mentioned by judges. They spoke to the ego in general, as in supporting the ego, promoting ego strength, using reality testing to reinforce the ego, or engaging the ego in the analytic process or in self observation. Responses also indicated certain aspects of the ego. For example, the analyst may clarify the ego ideal, or, the analyst may engage the observing ego in the analytic process or support the observing ego. Related to the observing ego is self observation. Self observation is included here under the discussion of the ego as the processes judges are referring to are similar. Analysts engage self observation, along with fostering, facilitating, promoting, and supporting it.

As with drives, the superego did not play as great a role in judges thinking as the ego did. One judge spoke of interpreting the superego. Figure 9.32 charts the analyst's activities as they pertain to intrapsychic structures as defined by the structural model.

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Figure 9.32: Activities of the Analyst - Intrapsychic structures

Structural Model

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As Sandler, Dare and Holder (1982) stated: "The id is regarded as the reservoir of the instinctual drives and wishes (particularly childhood, sexual and aggressive wishes) as well as of repressed contents held back by the ego by the application of counter-forces". (Emphasis added by this author.) In Frames of reference in psychoanalytic psychology: XII. The characteristics of the structural frame of reference. Brit J. Medical Psychology, 55, 204.

It has been suggested (see Jacobson 1954, Hartmann 1956, Spiegel 1959, Sandler et al 1963) that in his early writings Freud used the term "ego" interchangeably with "one's own person" or the "self". Sandler, Holder and Meers (1963) followed this thinking in their understanding of Freud's use of "ego ideal" and introduced the concept "ideal self". The practice of interchanging ego and self when referring to "observation" and "ideal" seems to be common.
The second heading under intrapsychic structures is self and object relations. Object relations can be a confusing concept as it is often unclear whether relationships with objects in the child's environment or relationships with internal objects is the focus. Only one response to the clinical material spoke specifically about the child's external relationships. This was "enables the patient to distance himself from his family". Other responses were not as obvious as the judge could have been thinking about external or internal objects or both, as internal objects are based in part on the internalisation of objects in the child's environment. Due to the lack of clarity, the global term of object relationships will be taken to mean both internal and external object relations and/or their interaction. Interpretations involving object relationships received a frequency of response of five.

Self and object representations interact with one another in the context of a relationship. Judges indicated this interaction when they took the label interpretation a step further and included such topics as loss and separation, identifications, oedipal relationships, etc. Analysts may also verbalise or clarify, the subjects speaking specifically about the boundaries between self and other, or the areas of separation and separateness.

Those activities of the analyst which fall under the heading of self representation only included: interpretations aimed at the self representation, e.g. the infantile parts of the self or self image; the analyst supporting an aspect of the self, e.g. the grown up or big child part of the self; clarification of a child's view of himself; promoting narcissism; or reinforcing the positive aspects of a child's self image. All of these relate to the child's view of himself and self esteem. Another area to include under this heading is the child's sense of responsibility for himself and his actions. This was labeled by judges as instilling responsibility or interpreting the child's contributions to his own difficulties.

Figure 9.33 breaks down the analyst's activities into those related specifically to object relationships (5); the interaction between self and object relationships (15); self representation (7); and the child's sense of responsibility for himself (5). As was discussed earlier, self observation could be put into this category as well as under ego, as could certain affective states such as humiliation.
Relationship with the Analyst

Analysis is aimed at the relationships a child has, whether to people in his environment, to internal objects, or to himself. The analytic work takes place within the framework of a relationship to the analyst. This is the fifth heading under Activities of the Analyst, the relationship with the analyst. It includes the treatment alliance (response of 24), transference (49) and other types of relationships the analyst may employ (18), in addition to counter-transference (7). One judge spoke broadly of the analyst "attempting to establish a relationship" with the child, which could speak to any or all of these categories. See figure 9.34.
Judges labeled many activities of the analyst in terms of the treatment alliance. The analyst prepares or sets the stage for, and works toward a treatment alliance. The analyst may also work on, promote, build, and foster the treatment alliance. Lastly, and most frequently mentioned, was the analyst reinforcing a treatment alliance which speaks to the idea that a treatment alliance needs nurturing and work throughout the analysis, rather than it being securely formed at the beginning. See figure 9.35.

Figure 9.35: Activities of the Analyst - Relationship with the analyst

Treatement Alliance

Transference has been discussed under its own heading, therefore it will not elaborated again here (see figure 9.22). However, it is interesting to note that under the category of Interpretation (see Appendix 4) of the 177 different types of things judges thought analysts interpreted, 46 or 26% were of transference. This is by far and wide the highest percentage, only followed by defence at 17%. In addition, when subjects labeled the method of interpretation, 43% were interpretations made "in the transference".

Other than transference and treatment alliance, judges noted other kinds of relationships the analyst has with a child. These included the analyst acting as an auxiliary ego, as a superego, as a new object, or as a real object. See figure 9.36.

Figure 9.36: Activities of the Analyst - Relationship with the analyst

Analyst as
An aspect of the child's relationship to the analyst is the analyst's responses to the child. This falls under the broad category of counter-transference. Counter-transference was labeled singularly three times, but might also include labels like the analyst's avoidance of affect or anxiety, or mimicking or provoking the patient. Of all the categories counter-transference would be the most difficult to find by reading clinical material as it is rare that the analyst will mention her own counter-transference responses. Therefore it was inferred by the judge.

Other

The sixth subheading under Activities of the Analyst is entitled "Other". This broad category includes activities linked in their labeling to the analytic work, changes in the child, and development. When it comes to the analytic work, the analyst may support it (1), offer analytic understanding (1), or stress the analytic function of the therapist (1). In relation to change, the analyst verbalises change (3), motivates the patient to change (1), reviews changes that have been made (1), or interprets progressive moves (1). In terms of the child's development, the analyst promotes progressive development (1), introduces developmentally appropriate expectations (1), and intervenes in the developmental process (1). Figure 9.37 illustrates the number of interventions pertaining to each of these categories.

Figure 9.37: Activities of the Analyst - Categories of other

Activities Not Specified

The seventh and final subheading includes all of those activities of the analyst which were labeled by judges, but not connected to something specific coming from the child. For example, when interpretation was labeled with additional comments as to what was interpreted, as in the interpretation of defence, it was included under the appropriate subheading. In this example that would be the child's unconscious creations. However, interpretation was labeled an additional 54 times and could be the interpretation of a whole
host of things not described by the judge. Containment (11), which has been discussed, falls here (see figure 9.27). Play is another heading. It is in the nature of child psychoanalysis that analysts play. They involve themselves in the child's activities by playing a specific role, altering a role ascribed to them by the child, responding through action, using displacement, etc. Play received a frequency of respond of 10. Other activities and the frequency of response included: verbalisation (18), clarification (12), reassurance (11), reconstruction (11), confrontation (7), explanation (7), developmental help (6), empathy (6), education (5), encouragement (5), suggestion (5), intervention (4), makes use of extra-analytic material (4), asks questions (2), gratifications (2), modifications or changes in technique (2), and supports mastery (2). In addition, there were numerous activities of the analyst which received a frequency of response of only one. Although each received a minimum response, it is important to mention them as they speak to the breadth and width of what analysts do with children. These included:

- Breaks neutrality
- Conveys expectations
- Encourages curiosity
- Explores issues
- Has expectations of the patient
- Makes unconscious conscious
- Makes value statements
- Reinforcement
- Shares understanding
- Uses metaphor

It is interesting to note that "making unconscious conscious" was only mentioned once as this is, according to much of the literature, an aim of psychoanalysis. However, it is feasible that many of the activities of the analyst have this as there aim, as the processes and intrapsychic structures which have been discussed are, by their nature, unconscious. Figure 9.38 illustrates these sub-headings.
SUMMARY AND DISCUSSION

This study aimed to ascertain the components of child analysis as viewed within the culture of the Anna Freud Centre. Previous attempts to delineate this approach have looked first to the theory trying to fit clinical material to it, a method which was found to be lacking. This study took a novel approach starting with clinical material children presented in analytic sessions. Analysts grounded in the same theoretical foundation were asked to list psychoanalytic concepts which illustrated the clinical material before them either from the point of view of the child, the analyst, or the interaction between the two. The result is a list of concepts which describes child psychoanalysis from the point of view of what the child presents as understood through the internal working model of the analyst.

Those concepts thought to be primary according to the literature on child psychoanalysis, were also found to be important concepts in this study. Results indicate that they were often in the minds of analysts thinking about clinical material as they received some of the highest scores. Defence was the most frequently mentioned concept with a score of 332. Conflict, transference, and interpretation were also in the top ten concepts. Interpretation was the second most frequently listed concept with a score of 273, conflict was third with a score of 188, and transference was seventh with a score of 132. Resistance is the other concept always included in definitions in the literature. In this study, resistance did not even fall within the top 50% of concepts listed. It was ranked 29 with a frequency of response of 24. There are different ways to interpret this result. On the one hand,
resistance could be over-rated in the literature as in practice analysts do not take it into consideration. On the other hand, resistance is a phenomenon of the analytic process closely allied theoretically with defence. Thus, it may be difficult to tell whether what is being presented by the child is a defence or a resistance without material from a series of sessions, which this study did not provide. Furthermore, analysts may consider defence and resistance in the same way, interchanging the concept within their internal working models.

This study confirms what has been written by authorities in the field as to the importance of defence, conflict, transference, and interpretation. It further confirms that analysts do other things as well, which the literature discusses with some controversy as to what these things are. As this study attempted to find the range of commonalities in the preconscious minds of Anna Freudian child analysts, what other concepts would be included within this range? Over one hundred other concepts were listed by analysts. How is the inclusion of these to be understand? Are they all important or only some? How is the determination to be made as to what is and isn’t important or primary?

One approach to answering these questions is to choose those concepts which are the most common in the minds of child analysts. This requires an arbitrary cut off as to what is common and what is not. It could include the top ten concepts, or only those receiving a frequency of response of 100 or more, or those concepts which fell in the top 10%. For purposes of discussion, the latter approach will be used.

First, looking at concepts which describe the child’s material, defence, conflict and transference would apply. Affect is included which, as discussed under results, would encompass fears, anxiety, and aggression. The remaining concepts within this range are self, wish, object relations, ego, identification, treatment alliance, and fantasy. Secondly, looking at technical concepts, the top 10% from Activities of the Analyst would include interpretation, verbalisation, and clarification. Analyst, Other is excluded as it does not involve a specific concept.

Another approach is to look at all 116 concepts. These can be divided into groupings which have similar properties. Two major areas can be delineated. First is what comes from the child and is subject to interventions by the analyst. This first grouping can be further broken down into six sub-groupings. These include psychological processes, feeling states, developmental considerations, intrapsychic structures, the relationship with the analyst, and the analytic process. What comes from the child influences the second grouping as based on the child’s material analysts determine what technical interventions are required. This is the second major grouping, the techniques analyst’s employ.
Psychological Processes is a broad grouping. Included are what has been called "the child's unconscious creations", for example concepts like defence, conflict, fantasy, enactment, and resistance. In addition, are internal processes or what it is the child does. Such concepts as identification, internalisation, and inhibition are examples. The two are grouped together because they are related concepts. The relationship is akin to what Sandler and Joffe (1966*) called experiential and non-experiential levels of psychological processes. Twenty-three concepts fall into this category. All totaled, these concepts were mentioned 1020 times by judges. Table 9.3 lists these concepts by ranking and frequency of response.

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### TABLE 9.3

**STUDY 2: CLASSIFICATION OF CHILD PSYCHOANALYTIC MATERIAL**

**PSYCHOLOGICAL PROCESSES**

<table>
<thead>
<tr>
<th>Rank</th>
<th>Frequency of Response</th>
<th>Concept</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>332</td>
<td>Defence</td>
</tr>
<tr>
<td>3</td>
<td>118</td>
<td>Conflict</td>
</tr>
<tr>
<td>6</td>
<td>167</td>
<td>Wish</td>
</tr>
<tr>
<td>15</td>
<td>46</td>
<td>Identification</td>
</tr>
<tr>
<td>17</td>
<td>45</td>
<td>Fantasy</td>
</tr>
<tr>
<td>22</td>
<td>32</td>
<td>Enactment</td>
</tr>
<tr>
<td>23</td>
<td>32</td>
<td>Regression</td>
</tr>
<tr>
<td>29</td>
<td>24</td>
<td>Resistance</td>
</tr>
<tr>
<td>33</td>
<td>22</td>
<td>Reality</td>
</tr>
<tr>
<td>47</td>
<td>13</td>
<td>Control</td>
</tr>
<tr>
<td>56</td>
<td>11</td>
<td>Thinking</td>
</tr>
<tr>
<td>57</td>
<td>10</td>
<td>Internalisation</td>
</tr>
<tr>
<td>62</td>
<td>10</td>
<td>Symptom</td>
</tr>
<tr>
<td>64</td>
<td>9</td>
<td>Acting Out</td>
</tr>
<tr>
<td>79</td>
<td>7</td>
<td>Withdrawal</td>
</tr>
<tr>
<td>80</td>
<td>7</td>
<td>Withhold</td>
</tr>
<tr>
<td>86</td>
<td>6</td>
<td>Obsessionality</td>
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<tr>
<td>93</td>
<td>5</td>
<td>Repression</td>
</tr>
<tr>
<td>96</td>
<td>4</td>
<td>Acting In</td>
</tr>
<tr>
<td>99</td>
<td>4</td>
<td>Inhibition</td>
</tr>
<tr>
<td>105</td>
<td>3</td>
<td>Exhibitionism</td>
</tr>
<tr>
<td>113</td>
<td>2</td>
<td>Idealisation</td>
</tr>
<tr>
<td>115</td>
<td>2</td>
<td>Provocation</td>
</tr>
</tbody>
</table>
The second sub-grouping is entitled Feeling States. Included are all affects and types of anxiety that judges mentioned, as well as needs. Twenty-one concepts are included under feeling states with a total frequency of response of 639. Some of these concepts could be included in other groupings as well. Whilst ambivalence is a feeling state, in certain instances it can also be a conflict. Trust or mistrust, or safety could also be linked to object relationships, whereas passivity is related, by some, to drives. See Table 9.4.
<table>
<thead>
<tr>
<th>Rank</th>
<th>Frequency of Response</th>
<th>Concept</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>149</td>
<td>Affect</td>
</tr>
<tr>
<td>9</td>
<td>116</td>
<td>Fears</td>
</tr>
<tr>
<td>11</td>
<td>107</td>
<td>Aggression</td>
</tr>
<tr>
<td>12</td>
<td>94</td>
<td>Anxiety</td>
</tr>
<tr>
<td>24</td>
<td>31</td>
<td>Ambivalence</td>
</tr>
<tr>
<td>25</td>
<td>30</td>
<td>Guilt</td>
</tr>
<tr>
<td>41</td>
<td>16</td>
<td>Envy</td>
</tr>
<tr>
<td>48</td>
<td>13</td>
<td>Curiosity</td>
</tr>
<tr>
<td>54</td>
<td>11</td>
<td>Needs</td>
</tr>
<tr>
<td>59</td>
<td>10</td>
<td>Omnipotence</td>
</tr>
<tr>
<td>61</td>
<td>10</td>
<td>Shame</td>
</tr>
<tr>
<td>68</td>
<td>9</td>
<td>Longings</td>
</tr>
<tr>
<td>72</td>
<td>8</td>
<td>Helplessness</td>
</tr>
<tr>
<td>73</td>
<td>8</td>
<td>Passivity</td>
</tr>
<tr>
<td>74</td>
<td>7</td>
<td>Damage</td>
</tr>
<tr>
<td>95</td>
<td>5</td>
<td>Trust/Mistrust</td>
</tr>
<tr>
<td>98</td>
<td>4</td>
<td>Frustration</td>
</tr>
<tr>
<td>101</td>
<td>4</td>
<td>Safety</td>
</tr>
<tr>
<td>103</td>
<td>3</td>
<td>Concerns</td>
</tr>
<tr>
<td>111</td>
<td>2</td>
<td>Grandiosity</td>
</tr>
<tr>
<td>112</td>
<td>2</td>
<td>Greed</td>
</tr>
</tbody>
</table>
Developmental Considerations is the third sub-grouping under the child's material. At the Anna Freud Centre a developmental viewpoint is incorporated into the psychoanalytic understanding of children and the techniques which analyst's employ. Built into each concept are developmental considerations. For example, when thinking about conflict the analyst would consider what conflicts are part of a developmentally appropriate phase and what conflicts are not. Conflicts can be carried over into a later developmental phase and hinder normal progression, or the child can regress to earlier conflicts which also skews development. From this standpoint, developmental considerations would be part of the definition of most concepts. Although further exploration of analyst's definitions would be needed in order to understand these developmental considerations, certain concepts which link specifically to development were included by judges. The psychosexual developmental phases of oral, anal, phallic, and oedipal would fall under this category. These are complicated phases which involve multiple lines of development, e.g. object relationships, drives, ego, etc. As with other groupings, some of the concepts are multi-determined. Masturbation and castration could equally fall under anxiety, however they are linked to certain developmental phases. Ten concepts fell into this sub-heading with a total frequency of response of 117. See Table 9.5.
## TABLE 9.5

STUDY 2: CLASSIFICATION OF CHILD PSYCHOANALYTIC MATERIAL

DEVELOPMENTAL CONSIDERATIONS

<table>
<thead>
<tr>
<th>Rank</th>
<th>Frequency of Response</th>
<th>Concept</th>
</tr>
</thead>
<tbody>
<tr>
<td>18</td>
<td>44</td>
<td>Sexual</td>
</tr>
<tr>
<td>20</td>
<td>38</td>
<td>Anal</td>
</tr>
<tr>
<td>21</td>
<td>34</td>
<td>Oedipal</td>
</tr>
<tr>
<td>30</td>
<td>23</td>
<td>Castration</td>
</tr>
<tr>
<td>35</td>
<td>21</td>
<td>Masturbation</td>
</tr>
<tr>
<td>45</td>
<td>14</td>
<td>Oral</td>
</tr>
<tr>
<td>60</td>
<td>10</td>
<td>Phallic</td>
</tr>
<tr>
<td>78</td>
<td>7</td>
<td>Progression</td>
</tr>
<tr>
<td>100</td>
<td>4</td>
<td>Primal Scene</td>
</tr>
<tr>
<td>114</td>
<td>2</td>
<td>Maturation</td>
</tr>
</tbody>
</table>
As has been discussed (see chapter 4) intrapsychic structures can be understood in various ways ranging from Freud's tripartite model of id, ego and superego; to internal representations of self and objects; to a conceptualisation of mental organisations. No matter how this term is viewed, what goes into the establishment of intrapsychic structures are the three previous sub-groupings: psychological processes, feeling states, and developmental considerations. Eighteen concepts fall under the sub-grouping of Intrapsychic Structures with a total frequency of response of 566. Those concepts which relate to self and object relationships, such as separation, differentiation, dependence, etc. are also included. See Table 9.6.
### TABLE 9.6
STUDY 2: CLASSIFICATION OF CHILD PSYCHOANALYTIC MATERIAL

INTRAPSYCHIC STRUCTURES

<table>
<thead>
<tr>
<th>Rank</th>
<th>Frequency of Response</th>
<th>Concept</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>163</td>
<td>Self</td>
</tr>
<tr>
<td>8</td>
<td>124</td>
<td>Object Relation</td>
</tr>
<tr>
<td>13</td>
<td>59</td>
<td>Ego</td>
</tr>
<tr>
<td>19</td>
<td>41</td>
<td>Superego</td>
</tr>
<tr>
<td>27</td>
<td>27</td>
<td>Self Observation</td>
</tr>
<tr>
<td>28</td>
<td>24</td>
<td>Narcissism</td>
</tr>
<tr>
<td>32</td>
<td>22</td>
<td>Loss/Abandonment</td>
</tr>
<tr>
<td>34</td>
<td>22</td>
<td>Separation</td>
</tr>
<tr>
<td>38</td>
<td>20</td>
<td>Rivalry</td>
</tr>
<tr>
<td>43</td>
<td>16</td>
<td>Sadomasochism</td>
</tr>
<tr>
<td>65</td>
<td>9</td>
<td>Competition</td>
</tr>
<tr>
<td>70</td>
<td>9</td>
<td>Responsibility</td>
</tr>
<tr>
<td>76</td>
<td>7</td>
<td>Homosexuality</td>
</tr>
<tr>
<td>77</td>
<td>7</td>
<td>Instinctual</td>
</tr>
<tr>
<td>84</td>
<td>6</td>
<td>Fixation</td>
</tr>
<tr>
<td>89</td>
<td>5</td>
<td>Differentiation</td>
</tr>
<tr>
<td>105</td>
<td>3</td>
<td>Identity</td>
</tr>
<tr>
<td>109</td>
<td>2</td>
<td>Dependence</td>
</tr>
</tbody>
</table>
According to theory the relationship with the analyst is the framework of the analytic process. This is the fifth sub-grouping of the child's material. Three concepts fall under this heading with a frequency of response of 181. However, this is a more complex category than this statistic represents. The analyst also acts as an auxiliary ego or superego, or as a new or real object, which the results of Activities of the Analyst indicate. Consequently, Table 9.7 is an underestimate of this sub-heading.

**TABLE 9.7**

**STUDY 2: CLASSIFICATION OF CHILD PSYCHOANALYTIC MATERIAL**

**RELATIONSHIP WITH THE ANALYST**

<table>
<thead>
<tr>
<th>Rank</th>
<th>Frequency of Response</th>
<th>Concept</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>132</td>
<td>Transference</td>
</tr>
<tr>
<td>16</td>
<td>46</td>
<td>Treatment Alliance</td>
</tr>
<tr>
<td>104</td>
<td>3</td>
<td>Counter-transference</td>
</tr>
</tbody>
</table>
The sixth and final sub-heading under the child's material are those concepts which link to the analytic process itself. Insight, working-through, and termination would be examples. Thirteen concepts fall under this heading with a frequency of response of 117. See Table 9.8.

TABLE 9.8
STUDY 2: CLASSIFICATION OF CHILD PSYCHOANALYTIC MATERIAL
THE ANALYTIC PROCESS

<table>
<thead>
<tr>
<th>Rank</th>
<th>Frequency of Response</th>
<th>Concept</th>
</tr>
</thead>
<tbody>
<tr>
<td>36</td>
<td>21</td>
<td>Ways of bringing material</td>
</tr>
<tr>
<td>37</td>
<td>20</td>
<td>Change</td>
</tr>
<tr>
<td>49</td>
<td>12</td>
<td>Insight</td>
</tr>
<tr>
<td>50</td>
<td>12</td>
<td>Mastery</td>
</tr>
<tr>
<td>53</td>
<td>11</td>
<td>Analytic Process</td>
</tr>
<tr>
<td>63</td>
<td>10</td>
<td>Working-through</td>
</tr>
<tr>
<td>69</td>
<td>9</td>
<td>Nonverbal</td>
</tr>
<tr>
<td>81</td>
<td>6</td>
<td>Communication</td>
</tr>
<tr>
<td>102</td>
<td>4</td>
<td>Termination</td>
</tr>
<tr>
<td>107</td>
<td>3</td>
<td>Symbolic</td>
</tr>
<tr>
<td>108</td>
<td>3</td>
<td>Unconscious</td>
</tr>
<tr>
<td>110</td>
<td>2</td>
<td>Free Association</td>
</tr>
<tr>
<td>116</td>
<td>2</td>
<td>Solutions</td>
</tr>
</tbody>
</table>
The second major grouping of the concepts which judges listed are technical constructs. These are outlined under Activities of the Analyst (see Table 9.2). Twenty-eight concepts were included, in addition to "Analyst, Other", with a total frequency of response of 618.

Not all of the concepts found in this study would be considered primary techniques which should be included in a manual. However, only taking those most frequently mentioned, for example the top 10%, misses the complete picture. It does not include the intricacies and nuances of the psychoanalytic process with children. By including all 116 concepts perhaps this picture is more closely approximated. Thus, what a manual needs to address are the sub-headings which are helpful in illustrating the whole of an analysis.

The framework of the analysis is the relationship between child and therapist which, according to the analysts in this study, is multi-dimensional. The transference is key, as is the treatment alliance. However, there are also times the analyst avails herself as an auxiliary ego, or as a new or real object. This relationship, as well as the child's psychological processes, feeling states, and intrapsychic structures are subject to interventions by the analyst. This means the analyst looks to the child's affects and anxieties; ego, self and object relationships; defences, conflicts, fantasies and wishes, to name just a few. This work occurs within an analytic process, taking developmental considerations into account. Certain outcomes are expected, for example mastery, change, insight, and working-through. Lastly, are the ways the analyst intervenes. These interventions range from interpretations, verbalisations, and clarifications; to empathy, fostering, and acknowledgement; and even suggestion and gratification at times.

Whist this study has provided a list of analytic concepts, it has not defined these concepts. This is the next step in elucidating a model of child psychoanalysis as there needs to be some level of clarity and agreement as to what analysts mean by these terms. Furthermore, neither the analyst's intermediary or outcome aims have been considered. Aims are based on a specific child, his age and developmental level, as well as the type of disturbance. Aims address psychological processes, feeling states, intrapsychic structures, and the relationship with the analyst. The ways the analyst plans to meet these aims are her techniques.

This study provides a framework for the organisation of a manual of child psychoanalysis made up of definitions, aims, and means. There are two approaches to filling in the content of this framework. One is to have senior child psychoanalysts construct chapters on each topic, a similar process as was instigated with Manual I, and to
have other analysts validate their conclusions. Another approach is through unstructured interviews with analysts who use their own clinical material to describe and define psychoanalytic concepts, aims, and means. Both of these approaches will be used, and the results compared.
PART III.
EMPIRICAL INVESTIGATIONS

Chapter 10. A second attempt at manualisation: Manual II

INTRODUCTION

The results of Study 1 (see chapter 8) provide overwhelming evidence that Manual I did not meet the criteria for manualisation, nor was it a viable instrument for child psychoanalysts. What an analysis looked like according to that manual in no way matched the clinical reality. The essential difficulty was that Manual I did not focus on technique. Instead it described a treatment at the level of the analyst's behaviour.

Manual II takes a very different approach. It attempts to specify child psychoanalysis beginning at the level of the analyst's internal working model through the identification of the processes which govern the way in which she works. These processes and concepts are based on observable clinical material.

There are three main questions a manual needs to address. First, each concept needs to be defined in a generally agreed upon way. Next is the therapeutic aim. Aim addresses the analyst's intent and outlines what she is trying to accomplish. What is the aim and why does the analyst have this aim in mind at this time? The third area is how the analyst reaches her aim. These are the means. Means describe the methods the analyst uses, her techniques. The means explicate what makes an intervention analytic versus some other sort of intervention. Means are not intended to be all inclusive as there may be other ways of meeting an aim, but a manual outlines the primary ones. In summary, the format for a manual includes three areas: definition, aim and means. Limitations is a fourth area to consider. These are the limits of doing the work as outlined with certain children or in certain instances.

Manualisation is about the integrity of a treatment modality. The point is not to define a complete analysis, but to describe a way of working. There may be other elements not included which are also part of analysis, however a manual contains the key components.

The aim of Manual II is to describe the current practice of child psychoanalysis within the culture of the Anna Freud Centre. The concepts and processes which are included came from Study 2 (see chapter 9), as well as the thinking of the manual group members. Unlike Manual I, the clinical material children present is the starting point from which these main therapeutic ingredients arose.

METHOD

The group of psychoanalysts who wrote Manual I (see chapter 7) are the same ones who worked on this manual. Four analysts made up this group all of whom held senior positions at the Anna Freud Centre. Three of the members were child psychoanalysts trained at the Centre, all qualified over ten years. Two of the authors were also senior adult psychoanalysts, and one was a psychoanalytic research consultant.

These four psychoanalysts went through a long process of thinking through concepts, delineating which ones should be included in Manual II. Their plan was continuously revised. The authors followed the two broad categories discussed in chapter 9 which are a composite of the 116 concepts delineated in Study 2. The first category outlines those elements which come from the child and are the subject of the analyst's interventions. The second category incorporates the analyst's techniques, what she does and how she intervenes.

The original outline of the manual included all six of the sub-categories of "what comes from the child". The authors included the top five concepts under the heading "Psychological Processes". Defence, the number one concept, and resistance, which ranked eighth in this sub-category, whilst different concepts, have similar properties so constituted one chapter. Conflict and identification, the second and fourth ranked concepts were other chapters. The authors suggested that fantasy, ranked fifth, be included with wish, the third concept, and fear. Acting out was also considered, which was the fourteenth concept in the sub-grouping Psychological Processes.

"Feeling States" was the next sub-classification of child psychoanalytic material found in Study 2. Affect, the number one concept, was included by the authors. Fear, the number two concept, was joined with fantasy. The remainder of concepts found under Feeling States were subsumed under the major heading of affect. The authors considered another chapter to incorporate anxiety (the fourth ranked concept), guilt (the sixth concept), and shame (the eleventh concept) separate from affect.
"Developmental Considerations" was the third classification. The authors proposed a chapter entitled "Developmental Concepts" which would encompass infantile sexuality and the other concepts found under Developmental Considerations.

The fourth sub-classification was entitled "Intrapsychic Structures". The authors suggested a chapter on self representation and self-evaluation. This included self, the most frequently mentioned concept under this heading, and self observation, which ranked fifth. Object relations was another proposed chapter which was the second most frequently mentioned concept in this classification. Conscience, which the authors considered including under object relations, involves the grouping superego which was the fourth ranked concept. Ego was not included by the authors as it is a broad concept which in some form would be addressed in all of the other chapters.

The fifth classification under what comes from the child is "Relationship with the Analyst". The three main concepts from Study 2; transference, counter-transference, and treatment alliance, would all constitute chapters, treatment alliance independently and transference and counter-transference grouped together.

The last sub-classification from Study 2 is "The Analytic Process". The concepts which were included under this heading are part and parcel of an overall process. The authors suggested a chapter entitled "The Analytic Process", but also thought two concepts merited chapters in and of themselves. These were working-through and insight.

The second broad classification delineated from Study 2 was the analyst's techniques. Whilst many of these would be subsumed under the means section of each chapter, some technical constructs needed specific chapters in order to define these important aspects of an analysis. The authors proposed one chapter entitled "Interpretation and Other Interventions". This would presumably include not only interpretation, the number one ranked concept in this classification, but also verbalisation and clarification. which ranked in the top five. Another chapter entitled "Modification of Technique" was also proposed which would address most, if not all of the other activities analyst's engage in determined by Study 2.

The authors suggested three additional chapters pertinent to a description of child psychoanalysis. These were external circumstances and information, diagnosis and assessment, and developmental distortions. Table 10.1 lists the original chapters as proposed by the manual working group.
TABLE 10.1

MANUAL II
ORIGINAL OUTLINE OF CHAPTERS

1. Defence and Resistance
2. Conflict
3. Fantasy, including Wish and Fear
4. Identification
5. Acting out
6. Affect
7. Anxiety, Guilt and Shame
8. Developmental Concepts
9. Self Representation and Self Evaluation
10. Object Relations, including conscience
11. Transference and Counter-Transference
12. Treatment Alliance
13. The Analytic Process
14. Working-through
15. Insight
16. Interpretation and Other Interventions
17. Modification of Technique
18. External Circumstances and Information
19. Diagnosis and Assessment
20. Developmental Distortion

The manual writer's process of working was similar to Manual I, however their approach and intent was different. They began by carrying out general group discussions on each concept. It is a given that the unit used to define child psychoanalysis is the entire treatment. In this vein, the authors studied examples of cases in depth, their own as well as other analyses conducted by staff and trainees at the Centre. Specific cases were followed throughout the process of constructing the manual. These clinical examples informed the manual contents and provided illustrations for theoretical and technical points.

The overall group broke down into working groups and drafted sections on each topic using the framework of definition, aims, and means. These working groups reported back to the entire group and the concept was discussed in further detail. Each chapter was redrafted to include the consensus of the group's discussions. Defence and Resistance was the first chapter to be written. Conflict, Affect, and Transference followed.

Ongoing in this process was the continuous revision of the contents of each chapter, as well as the suggested list of chapters. Modification of Technique and Developmental Distortions were eventually dropped as chapters in and of themselves. As an alternative, Developmental Help was proposed. This is a technical construct familiar to Anna Freudian analysts which traditionally has been thought to constitute a modification of technique directed at developmental distortions. Anxiety, guilt, and shame were omitted as a separate
chapter and included under Affect. Developmental Concepts was also omitted because they play a part in the definition of each concept and analytic technique, thus are addressed throughout the manual. Psychic Change and Regression were two added chapters.

Eventually, the authors concluded with twelve chapters for their proposed manual on child psychoanalysis. These are outlined in Table 10.2. An added chapter was The Psychoanalytic Understanding of Childhood Psychological Disturbance which includes two viewpoints of disturbance. Those disturbances which necessitate developmental help and the entire notion of psychic change area both addressed. This chapter, along with the ones outlining the development of object relations and the analytic process, serve as a basis for the manual.

**TABLE 10.2**

**MANUAL II**

**REVISED CHAPTERS**

1. The Psychoanalytic Understanding of Childhood Psychological Disturbance
2. The Development of Object Relations
3. The Psychoanalytic Process
4. Conflict
5. Affects
6. Defence and Resistance
7. Object Relations in the Clinical Context
8. Self Representation and Self Evaluation
9. The Treatment Alliance
10. Interpretation
11. Transference
12. Counter-transference
Once the first chapter was written, the authors returned to Defence and Resistance, Conflict, Affect, and Transference. These chapters were revised to take into consideration the two models of disturbance proposed in chapter one.

Whilst these twelve chapters coincide with the main findings from Study 2, they do not constitute a finished product. Two chapters entitled Assessment, and Termination and Follow-up are presently being written. As the work on this manual is ongoing, other concepts are under consideration. These include ones previously mentioned such as identification, fantasy, acting out, regression, working-through, insight, other interventions including developmental help, and external circumstances and information.

RESULTS

Table 10.2 outlines the completed chapters of Manual II. Appendix 5 contains Manual II in its entirety. The three chapters which provide the basis of the manual, as well as the framework for the subsequent chapters, are summarised below.

Chapter 1, The Psychoanalytic Understanding of Childhood Psychological Disturbance, proposes that disturbance in childhood is initiated by conflict. The authors use conflict in its broadest sense. Rather than a narrow definition of conflict proposed by some, as conflict between the intrapsychic structures of ego and superego for example, conflict is conceptualised as conflictual wishes.

Two potentially pathological means are available to the child to deal with psychological conflict. These "means" constitute two different types of disturbance. Dependent on what means the child uses, the analyst's aim and technique will vary. Underlying this conceptualisation is a view of psychic change. As the analyst's outcome aim is psychic change, this chapter considers this concept and what internal changes the analyst attempts to initiate.

The division of psychological disturbance into the two proposed models is somewhat artificial. It is not taken to mean that a child falls in one or the other category. Any one child may have difficulties in both areas, or the weighting of one or the other may be greater.
The first model is called the Representational Model and entails what is more commonly conceived of as the subject of psychoanalysis. When faced with conflicting wishes the child excludes from consciousness, through defensive maneuvers, threatening ideas and feelings. A brief list of common conflicts child's analyst's encounter in their work with children is included.

This model follows the classical line of the formation of a neurosis. Conflict which is intolerable or unacceptable generates anxiety which signals the initiation of defence. Regression and symptom formation can result. Mental representation is an all encompassing term understood as the way in which content, affects, wishes, objects, etc. are represented internally. The outcome of conflict, according to this model, is the distortion of mental representations.

The Mental Process Model is of a different nature. Mental representations are products of the mental processes which create and organise them. This distinction is difficult to make and observe clinically, but it is an important one. These processes are what analysts have previously thought of as ego functions. The Anna Freudian technique aimed at mental processes has commonly been known within that culture as developmental help. This chapter attempts to clarify what exactly this type of disturbance is and what the analyst's technical aims are.

In the Mental Process Model the child deals with conflict by inhibiting the process itself. As a result, his capacity for and development of mental representations is limited. Technically, the analyst aims to reactivate the inhibited mental process. This in turn impacts the development and restructuring of mental representations. A partial list of mental processes is given categorised into eight areas: the organisation and control of impulses and wishes; the organisation and control of affective mental states; reality oriented mental/ego functions; object relations - external; object relations - internal; self-organisation; self-monitoring; and self-evaluation.

In general, this chapter proposes two tasks confronting the child analyst. She works with both distorted mental representations and inhibited mental processes. This view of child analysis, conceptualised in a way which attempts to explain the underlying processes and mechanisms involved, is unique to the Anna Freud Centre. It includes both what has traditionally been called "psychoanalysis" and "developmental help". Developmental help is elevated to the position of "proper analysis", as the aims and techniques of both models encompass child psychoanalysis.
Chapter 2, The Development of Object Relations, defines object relations. It describes the ways in which the child's modes of relating, developing out of relationships with parents and caregivers, provide models for subsequent relationships and play a crucial role in the development of psychic processes. External and internal influences interact and contribute to the development of object relations.

A simplified synthesis of the Anna Freud Centre viewpoint of the development of object relations is given. Six different levels of object relations, from birth to latency, are described both in terms of object relations and psychosexual phases of development. The ways these levels of object relations manifest themselves in the analytic situation are elaborated.

Chapter 3 is entitled The Psychoanalytic Process. According to the authors the psychoanalytic process consists of:

changes occurring within the analysand's mind which arise from changes in mental representations and/or the freeing of developmental processes; ideally this is due to increasing insight into the determinants of past and present experiences and behaviour, which opens up possibilities for changes in adaptation. It can, however, also occur without obvious or explicit insight, arising from the patient's experience in interaction with the analyst.

The analytic process with so called "neurotic" children, as well as children suffering from borderline, narcissistic, and developmental disturbances, is outlined within the models of representational and mental process disturbances. Specific characteristics and complications due to the nature of children and the developmental process itself are included.

These three chapters constitute the basis of Manual II. The remaining chapters speak to specific analytic concepts. Chapter 3 is the first in the manual to use the framework of definition, aim, means, and limitations. Chapters 4-12 also follow this framework. They each examine certain concepts providing a definition of the concept based on a consensus of the authors. What the analyst's therapeutic aim is, and then how she goes about meeting these aims, the means, are outlined. Limitations to this way of working are also delineated. Illustrations of specific cases are provided throughout.
DISCUSSION

The purpose of manualisation is to give a detailed description of a treatment modality identifying its key therapeutic ingredients. In this way the most representative and commonly used techniques are assembled. The aim of manualisation of child psychoanalysis as practiced at the Anna Freud Centre is to make explicit the dimensions of an analysis, to define the concepts, and to apply them in a systematic way to the aim, methods and limitations of this treatment modality.

Rather than fitting the theoretical to the clinical, a method which has been tried and failed, the aim of this manual was to begin with the clinical and elucidate the theoretical from there. Manual II seems to meet this aim, as well as the overall aims of manualisation. What these authors ascribe the components of child psychoanalysis to be coincides with the range of concepts other analysts at the Centre elucidated. Whether the definition of these concepts, as well as the analyst's aim and techniques, is in agreement remains to be seen. The next step is to validate the contents of Manual II. This is the aim of Study 3.
Chapter 11. Validation of Manual II: Study 3

INTRODUCTION

Manual II is an attempt to describe the current practice of child psychoanalysis within one culture, the Anna Freud Centre. Its conceptualisation is the result of the collaborative effort of four senior analysts. It consists of twelve chapters whose headings originate in the results of the second study in this thesis, The Classification of Child Psychoanalytic Material (see chapter 9).

Having specified which concepts should be included, the next step in the process of manualisation is to determine the definition, aim, and means of each concept. Such a formulation is suggested in Manual II. It begins with two chapters which provide the manual's overarching theoretical basis. The remaining chapters are on ten analytic concepts. Each is defined followed by a description of the analyst's aims and way of working. Limitations are elaborated.

This study focuses on the contents of Manual II. The aim of the study is to validate the definition of concepts and their application as proposed by the authors. It will ascertain if the manual as written is understandable and usable by other analyst's, and can be used as a guide to and explanation of their work. If it is in conformity with the manualisation standards discussed in depth elsewhere (see chapters 6 and 8), it should explain the methods, rational and objectives of child psychoanalysis at the Anna Freud Centre.

METHOD

Design of the Study

To test the validity of Manual II subjects, who were all analysts whose clinical foundation and ongoing experience were with the Anna Freud Centre, were asked their opinions about what had been written. The questions of agreements and disagreements with the proposed model were addressed through unstructured interviews. A content analysis was then applied to the data. The results demonstrate the degree to which analytic practice as described in the manual parallels actual practice as determined by the subjects.
Sample

The sample used for this study was thirteen staff members from the Anna Freud Centre. All had done their training at this institution and were qualified as child and adolescent psychoanalysts. Six of the subjects qualified over ten years ago and were also designated Supervising Analysts. Three had been qualified between five and ten years, and four had been qualified under five years. In addition, one was a qualified adult psychoanalyst from the British Institute for Psycho-Analysis and one was in the process of doing her adult training there.

Each of the seven chapters used in this study were validated by five subjects. At least one of these five subjects, but sometimes two or three, was a Supervising Analyst. A total of 35 interviews were conducted. Four subjects validated one chapter, one subject validated two chapters, three subjects validated three chapters, and five subjects validated four chapters. Table 11.1 illustrates the chapters each subject validated. Subjects are noted by letter (A-M).
### TABLE 11.1

**STUDY 3**  
MANUAL II CHAPTERS SUBJECTS VALIDATED

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<tr>
<th>Subject</th>
<th>D/R</th>
<th>Conflict</th>
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<th>Transference</th>
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Materials

Seven chapters from Manual II were used in this study. Table 11.2 lists these. Defence and Resistance, Conflict, Affect, and Transference were the first chapters the manual authors completed so constituted the first four validation studies. Object Relations in the Clinical Context, Interpretation, and The Psychoanalytic Understanding of Childhood Psychological Disturbance were the next three studies.

TABLE 11.2

STUDY 3
MANUAL II CHAPTERS VALIDATED

1. Defence and Resistance
2. Conflict
3. Affect
4. Transference
5. Object Relations in the Clinical Context
6. Interpretation
7. The Psychoanalytic Understanding of Childhood Psychological Disturbance
The first four chapters were completed prior to the writing of The Psychoanalytic Understanding of Childhood Psychological Disturbance. They were then revised once this chapter was done. Since the validation studies were taking place simultaneously to the writing of Manual II, the original versions of these four chapters were used instead of the revised ones. Because of the length of The Psychoanalytic Understanding of Childhood Psychological Disturbance, the rendition given to subjects was in summary form highlighting the main points. Participants in that study were familiar with the proposed conceptualisation of childhood psychological disturbance as it had been presented to them previously in an extended version (see Fonagy et al 1993 in press1), and was the topic of an International Scientific Colloquium on Therapeutic Process in Child and Adult Psychoanalysis in 1991 at the Anna Freud Centre. Appendix 6 contains the versions of the seven chapters used in Study 3. The clinical illustrations provided in each chapter did not constitute a part of this study.

Procedure

Individual interviews on six of the chapters were conducted with five subjects each. These interviews were audio taped. Subjects were told a document had been written which outlined the use of a concept in child psychoanalysis. This study was designed to see if there was agreement by other analysts with the content of this document. Subjects read each section of the chapter one at a time. Following each section they were asked a series of questions. Subjects began with definition, then proceeded to aim, means, and limitations. After each section subjects were asked for feedback on what they had read. Was it clear and understandable? If not, they were asked to elaborate on the difficulties as they perceived them. Subjects were questioned about what they agreed with and didn't agree with, and what, if anything, they thought was missing. Other thoughts and comments the subject's had were elicited. Once each of the four sections were reviewed in this manner, subjects were asked for any comments about the entire chapter. The interviews were then transcribed for the analysis of the data.

The face validity study on The Psychoanalytic Understanding of Childhood Psychological Disturbance was handled somewhat differently due to its extended length. Five subjects were given written copies of a summary of this chapter and a comments sheet which outlined the same types of questions proposed with the other concepts. Instead of the four sections found in the other six chapters (definition, aim, means, and limitations),

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this chapter contained six sections: introduction, the representational model, its aim and means, the mental process model, and its aim and means. General comments relating to the entire chapter were also requested. Of note is that all five subjects who validated this chapter, had already validated three other chapters, so were very familiar with the study, its format and intent.

RESULTS

A content analysis of the interviews was done on each chapter. The results of the analysis of each chapter are presented below in the order in which they were validated.

DEFENCE AND RESISTANCE

For the most part subjects thought the chapter on defence and resistance was clear and understandable, except for the definition of defence which 40% of subjects found extremely confusing. Although sections may have been clear, this did not mean there was complete agreement with what was written. There were disagreements or additions by some subjects with each section. Figure 11.1 illustrates the percentages of participants who thought each section was understandable or confusing, were in total agreement with what was written, and had comments. Figure 11.2 demonstrates the number of disagreements and additions. These results are discussed under the appropriate sections below.

Figure 11.1: Defence and resistance - Level of clarity and agreement
Definition of Defence

In general 40% of subjects found this section confusing and unclear. They also thought the definition of defence was too narrow.

The author's definition of defence begins:

Defence is an aspect of normal psychological functioning (ego-functioning) usually unconscious, the aim of which is to protect the individual from the danger of being overwhelmed by anxiety and/or catastrophic loss of self-esteem. These affective states are expected to result from the adverse effects of recognizing attitudes. The most important "adverse effects" are: guilt, shame, helplessness, loss or destruction of an important person or of that person's love, loss of self-cohesion or well-being.

Subjects thought this left out all sorts of other unpleasant affects. Although other affective states are discussed, subjects were confused as to what exactly was meant. They wondered "Adverse effects of what?". One other disagreement was noted. "Catastrophic loss of self-esteem" was thought to be too strong as the loss of self esteem did not have to be catastrophic.

There were no comments about the next sentence which says:

Defence is thus mainly directed against aspects of the internal world, but may also be directed against aspects of the external world, if these threaten to arouse overwhelming anxiety or loss of self-esteem.
The definition of defence concludes:

Normal defence results in the individual having sufficient self-control and adaptability. In normal development there is a range of defence appropriate for each stage (age). In pathological defence the range is restricted or is inappropriate for the child's age. This results in major interferences with normal functioning, e.g. excessive inhibition, phobic anxiety, etc.

Some subjects had difficulty with "a range of defence appropriate for each stage". Although certain defences are characteristically seen at certain phases, this is a theory which has never been refined or clearly worked out. It was questionable, thought some, whether one could say which defences were appropriate and which weren't at specific times of life.

Forty percent disagreed with the use and definition of "pathological defence". Twenty percent suggested "defence organisation" rather than defence, and did not understand what was meant by "the range is restricted". The other 20% also found this unclear and thought what was probably meant was an overuse of one defence. This same 20% saw it more useful to couch it in terms of an interference in one's capacity to look at reality, which is a different meaning than intended by the authors.

One other comment was that a defence against fear or humiliation is usually tied up with the self representation.
Definition of Resistance

All subjects understood the definition of resistance, however only 20% were in complete agreement.

The definition of resistance reads:

In the analytic situation a defence becomes manifest as resistance: the refusal to pursue a line of thought felt to be dangerous, and/or to take in or think about ideas offered by the analyst. The most serious resistances are unconscious; in addition, children often consciously withhold thoughts and feelings.

Sixty percent of subjects found this definition too narrow. They thought the definition implied that defence and resistance were synonymous. There were other differences between the two which were not spelled out and the definition needed to be expanded. One added a further definition. This is a resistance which protects the child from a felt threat to the integrity of the self. With this resistance, the child isn't yet ready and needs time for something to settle.

Aim

All subjects found this section clear. Forty percent were in agreement. The author's description of aim says:

The analyst's long-term aim is to modify pathological defence by broadening the range of defences available to the child and reducing the use of excessively restricting defence so as to allow the patient greater freedom, through more efficient self-control and adaptability. The short-term aim is to demonstrate to the patient the operation of each defence as it occurs, on the assumption that awareness is the first step towards modification.

Comments about aims varied. The aim of defence analysis may be to allow the patient greater freedom through adaptability. However, this isn't necessarily through more efficient self-control, but can be through the loosening of self-control. One subject thought it wasn't really "demonstrating to the patient the operation of each defence as it occurs" as this would be persecutory. Also, aims did not take into account certain defences which were needed and appropriate at any given time or within a certain developmental phase, which should be added.
Other comments related to different aims not included in this chapter. Often the analyst aims to make defences redundant. Once what is defended against is analysed, the child discovers that the defence is no longer needed. In turn, what was defended against is then allowed to become part of reality. Furthermore, the aim may be different dependent on whether the defence is against an anxiety or an unbearable reality, which is not discussed.

Means

As with aims, all subjects understood means and 40% were in complete agreement. There were a number of additions.

Means says:

This is done by drawing the patient's attention to examples in his play, in his descriptions of experiences, and in his attitudes and behaviour towards the analyst, especially his resistances. In this way the therapist spells out for the patient the nature of the defence, what he is defending against, and the effects the defence has on his functioning. This usually allows the patient to see alternative ways of handling the situation, but the analyst may also draw the patient's attention to such alternative ways. Thus, over time, the analyst repeatedly and in different ways demonstrates how specific defences interfere with particular aspects of functioning.

Five additions were suggested to this section. The timing of the analyst's interventions was thought to be crucial. Going straight for the interpretation of defence without laying the groundwork, or when the timing isn't right, can strengthen the defence instead of getting at what lay behind the defence. Related to this are times an interpretation of defence is felt as an attack because it threatens the integrity of the self. This is when defences are against fear and humiliation and tied up with the child's self representation. The patient's sense of safety was also thought to be important and an aspect of the treatment alliance.

Two other comments linked to resistance. One thought it important to discuss resistance further as resistance is not only defence. Another added that the analyst needed to empathise with the child's resistance. In certain kinds of resistance the child will come around when he is ready. It is important for the analyst to let the child know she understands he can't talk about something in particular now because it is too much for him, but will later.
Limits

Only 20% of subjects agreed completely, whereas 80% had things to add to this section.

Limits begins:

The analysis of defence is especially appropriate for conflict-based neurotic) and some narcissistic disturbances in patients in whose defences are overly strong and rigid.

In relation to narcissistic disturbances it was thought the aims may be the same, but the means were different. With these children defences protect them against fear and/or humiliation which is tied up with self representations. Defence interpretation is felt as an attack.

Limits continues:

In psychotic or borderline patients with weak defences it has to be used sparingly and with caution.

Subjects thought defence interpretation with these children was not necessarily used sparingly, but often not at all, at least initially. In these instances the aim is to build defences.

Limits goes on to say:

In older children, with rigid and excessive defences already being built into their character, the modification of defences will require lengthy working through in intensive treatment.

This section does not comment on why a certain defence might be present. It is not only that defences have already been built into the child's character, but that they have been built in because of a particular anxiety which needs to be worked on. This does require lengthy working-through, as the manual suggests, but it is a matter of what the defence is against rather than the defence itself.

There were no specific comments about the conclusion of Limits which says:

In children with more moderate defence, especially younger ones who are still changing developmentally, defences can often be modified more quickly, even in brief, non-intensive therapy.
Finally, it was suggested that latency be included as there are certain limits inherent in this developmental phase.

Overall Comments

One overall comment about this chapter is worth noting. This subject thought quite strongly that the manual emphasised changing the mechanism of defence. However, what the analyst attempts to accomplish in order to help a child is to analyse what is being defended against.

CONFLICT

The majority of subjects found all of the sections of the manual chapter on conflict clear and understandable. Whilst subjects did not always completely agree or had comments and additions, these were usually minor. In general, this chapter ran parallel with how subjects thought about conflict in their own analytic work.

Figure 11.3 illustrates the percentage of subjects who found each section understandable, confusing, were in total agreement, and had comments to add. Figure 11.4 outlines the number of disagreements and additions in each section on conflict. The data is discussed below.
Sixty percent of the subjects found the definition of conflict clear and understandable and 80% had comments. There were only two disagreements and no additions were suggested.

The definition begins:

Conflict is a normal part of mental life and occurs whenever contradictory wishes, aims or ideals are simultaneously present. Such conflicts only become problematic for the individual and material for the analytic work when they become linked with basic unconscious anxieties and no adaptive solution can be found in reality.

The term "basic unconscious anxieties" was the focus of 40% of the comments. One subject was unclear what this term meant and asked for clarification. Another wondered if this statement was accurate. She was not sure if problematic conflicts were always linked to unconscious anxiety or whether there could be other things involved.

The definition goes on to discuss the fact that there are conflicts specific to developmental phases, as well as individual ones. It describes normal development, then turns its attention to pathological development. The rest of subject's comments related to the two forms of pathological development outlined.

The first begins:

(1) The conflict may remain unresolved; if it also remains unconscious the individual then feels inexplicably uneasy, anxious or depressed; if it reaches consciousness in some form (derivatives), the individual finds himself experiencing contradictory feelings or wishes.
One subject asked "why uneasy, anxious or depressed?". She understood that the individual would feel anxious, but was not sure about the others, especially "depressed". This subject thought there might be other responses as well.

The second form of pathological development reads:

(2) An unconscious solution may occur which is, however, unacceptable to the individual and/or people in his environment (symptoms, character traits, behavioural or affective disturbances).

One subject thought this was a blanket comment which needed to be unpacked. She added that one could have "character traits which are not necessarily related to unconscious conflict".

All subjects agreed that: "Unresolved or pathologically resolved unconscious conflict is the basis of all neurotic disorder and plays an important role in most other forms of emotional disturbance."

Lastly, one subject was unclear what the authors meant when they go on to say:

(There are also types of pathological development in which insufficient conflict occurs, but these will not be dealt with in the present manual.)

With clarification by the interviewer as to the meaning of this statement she agreed.

Aim

Eighty percent of subjects had no difficulty understanding this section. It states:

The analyst's aim is to recognise and revive, preferably in the transference, past and present conflicts which are causing problems for the individual, and to interpret their unconscious elements in sufficient detail to allow the individual to find a better adapted solution.

One subject did find this section confusing. At first she disagreed thinking the authors were referring to digging up past conflicts. She re-read the section which was then understood to mean difficulties which are inherited from past conflicts and are causing problems in the present. To this she agreed completely, however her confusion may point to a need to clarify this statement further.
Another subject did not like the terminology "causing problems for the individual" thinking it was too vague. She suggested "impinge on the child's feeling of well being or ability to move forward" instead. In addition, "interpret their unconscious elements in sufficient detail" was thought to be unclear language.

Means

The majority of subjects (60%) found this section understandable. There were two disagreements and two additions, as well as comments.

Means begins:

The analyst scan's the patient's material (play, talk, expressions of feelings, attitudes and behaviour towards the analyst) for signs of contradictory wishes, feelings, aims or ideals, for evidence of defence, and for inappropriate reactions.

One subject disagreed that the analyst "scans the patient's material". Instead of looking for signs, she thought, the analyst tries to be aware. Her objection was that she thought it wasn't as conscious of an activity as the statement implied. This may point to processes and methods which are preconscious activities of the analyst.

The section continues:

He (the analyst) also pays attention to what is missing in the child's behaviour; this would include both lack of control due to insufficient conflict, and over-control producing inhibition.

One subject did not understand this statement. Lack of control, she commented, might not be due to insufficient conflict, but to other things.

The remaining comments had to do with the next statement which reads:

The analyst gradually builds up in his own mind a picture of the way the child has resolved conflicts or failed to resolve them;

One subject added that it was not only a picture of conflict resolution the analyst put together, but of the conflict itself. Another subject was confused. She thought it was a question of who defines what the conflict is and whether or not it is resolved. Her objection was the analyst imposing something on the child, rather than understanding the statement as the analyst building a picture based on what comes from the child. In addition, she thought it important to distinguish between conflict and a habitual mode of relating.

No comments were made about the last statement:
as he (the analyst) judges the time is right he gradually communicates this understanding to the patient. The analyst traces the themes for the patient, spelling out the ramifications - (working through).

Limits

Subjects had few comments about limits. The majority (80%) were in complete agreement. All found it clear and understandable, although one subject thought it was somewhat "narrow".

This section states:

The analysis of conflicts is most efficacious in neurotic disturbances, where it constitutes the main areas of analytic work. It also plays a part in some forms of developmental, borderline and psychotic disturbances but in these disturbances it is not, by itself, sufficient to effect amelioration.

One subject suggested, in order to be clearer and more precise, that this section could read: "The analysis of conflicts is more of a focus in neurotic disturbances whereas in other disturbances the work is supplemented with ego strengthening and building defences to effect amelioration."

AFFECTS

Sixty percent of subjects were confused with the author's definition of affects. All found limitations understandable and clear, whereas 60% understood aim and means. Subjects were not in compete agreement with what was written. Only 40% agreed completely with the definition, and 20% with aims. No one agreed completely with either means or limitations. Numerous disagreements and additions were spelled out by subjects. Figure 11.5 illustrates the percentage of subjects who found each section understandable, confusing, were in total agreement, and had comments to add. Figure 11.6 outlines the number of disagreements and additions in each section. This data is delineated under the appropriate heading below.
Definition

This section was confusing to 60% of subjects. Some stated this generally as "difficult to understand", "not clear", or "very condensed". One subject thought the language needed to be simplified. Some were more specific pointing to certain sentences. Additions, disagreements and/or comments were added.
This section begins:

Affects are regarded as complex states which are rooted in biology and have important psychological functions.

One subject agreed that affects are complex states, however suggested the terminology "complex feeling states". Nowhere is feeling or emotion mentioned. Another agreed completely that affects are rooted in biology. However, one subject did not understand this aspect and wondered what the evidence was. She said: "Are the authors assuming that psychological functions aren't parallel to biology, that you don't get psychological functioning from the moment of conception along with biology?"

The definition continues:

Affects are primary organisers of the child's mental functioning, insofar that they provide the basis for attributing meaning to experiences. They are thus used to monitor, evaluate and direct action, thought, defences and symptoms.

One subject agreed that affects are primary organisers, but thought the statement "they provide the basis for attributing meaning to experience" was unclear in its meaning.

The definition concludes:

The conscious or unconscious experience of affect acts as a signal to the child's adaptive capacities. Thus they serve to prevent the individual from becoming overwhelmed by a state of helplessness associated with earlier experiences of massive discharge.

One subject thought this was very unclear and was not at all sure what the authors meant. Another subject had theoretical disagreements with the concept "unconscious experience of affect". She did add that technically it probably doesn't make much difference as "we work as if affects are unconscious or out of awareness". Here the theory and technique are divergent.

In general, 20% of subjects thought the proposed definition of affects laid particular emphasis on defence. Affect has to do with far more.

Affects functioning as a motive was discussed by 40% of subjects. It was suggested that the role of motivational affects, as well as promoting affects, be stressed in the definition. In addition, some affects function in a powerful way leading to mechanisms which keep certain thoughts, actions, other affects, etc. away from consciousness. This is true especially with anxiety and guilt. Twenty percent of subjects thought anxiety merited a separate section.
Aim

Most subjects (60%) found the aims section understandable and clear, but interestingly one subject did not understand the entire section. She thought it didn't answer the question of aims. Only 20% agreed completely with its content.

Aim begins with:

Affects are essential in the routine search for unconscious meaning in the child's verbal and nonverbal behaviour in psychoanalysis. They are central to clinical work with children because they guide the analyst to the child's conflicts and fantasies, and they are experientially accessible to the child.

One subject agreed to a point. The comment that affects "are experientially accessible to the child" was thought to be inaccurate. Affects are not experientially accessible if they are unconscious or defended against.

The section continues:

Therefore understanding of the child's affect serves to encourage the child to bring analytic material.

One subject asked: "Whose understanding? The child's or the analyst's?" Another subject took the sentence to mean the analyst's understanding and added that this can carry "a pleasurable gain" for the child. However, 40% of subjects disagreed that it was always the case that the analyst's understanding encouraged the child to bring material. Rather, there are times it may inhibit analytic material.

Aim is concluded with:

Identifying and accepting the child's affect helps the child to listen to and elaborate the analyst's interpretations and therefore has a further role in facilitating communication and understanding between the child and the analyst.

Again, one subject was confused. "The child or the analyst identifying and accepting?" The assumption was it is the child who does this.

It was suggested that the aim of making unconscious affect conscious, thereby facilitating the child's conscious awareness of an affect, be added.
Another commented that nothing about the relationship between child and analyst was included. Affect serves an important role in this regard. Aims "only talks about making affect accessible to the child and helping the child to listen to interpretations". The subject went on: "It doesn't stress the underside of affects, the basis of the relationship. One of the reasons for identifying affects is to build a relationship. That is missing."

Means

As with aims, 60% of subjects found this section understandable and 40% found it confusing. The latter commented that what was written was "difficult to take in", was "not clear or understandable", or even that the section was "judgmental and smug". None of the subjects were in total agreement. Many comments, disagreements and additions were noted.

The section on means begins:

The most basic interventions consist of labeling, describing and elaborating what it is that the child feels.

An objection was raised with "labeling". One subject didn't like the term and thought it had negative connotations. What the analyst actually does by using words, and helping the child use words, is to give the patient some way of internally representing an affect. Differentiating affect is also a part of this. The subject went on: "It's about learning to represent something and helping the child recognise the experience of an affect within himself. It's also about the differentiation of affect so a child can sense that this is a feeling I have, I can recognise what it is and have a mental representation of it."

The first paragraph continues:

The analyst will draw attention to the child's efforts to avoid unpleasurable emotions and the ways in which he seeks to protect himself from anxiety and other distressing affects, e.g. by altering or reversing certain feelings in favour of less distressing substitutes.

One subject criticised this statement. The analyst drawing the child's attention to something is "not an interpretation or even a clarification". The subject thought this sentence had more to do with defences against affect.
This paragraph concludes:

Such interventions may foster a feeling within the child of being understood by an adult who takes what he feels seriously or at least views it as important. It is hoped that this will increase the child's own interest in making sense of his emotional experience.

Subjects (40%) did not think these interventions necessarily meant that the child was going to feel more understood. One subject suggested "understanding affects hopes to help the child make sense of his emotional experience" instead of "It is hoped that this will increase the child's own interest in making sense of his emotional experience". Understanding of affect actually may increase the child's wish for the analyst to go on understanding without having to do so himself.

In general, one subject commented that this first paragraph was too "specious". Another thought the means section "covered things in a muddled way". The second paragraph in particular seemed to skip around, not make much sense, and there were things "thrown in" which did not seem to fit.

The second paragraph starts off with:

Affects which accompany unconscious conflict and thus form an integral part of unconscious fantasy have a priority for the analyst and are often addressed in terms of the way in which they function to arouse or reduce anxiety. Certain negative affects such as guilt, shame, feelings of humiliation are often discernible in derivatives of unconscious fantasy, whether in dreams, the transference or other aspects of the child's material.

None of the subjects had comments about the first sentence. However, there were multiple objections to the second sentence. All subjects disagreed with the terminology "negative affects", did not understand what it meant, or did not find it useful. Some (40%) found it judgmental. The use of painful or unpleasant affect was suggested as an alternative by 40%.

Most subjects (60%) wondered why or how guilt, shame and humiliation fit in this sentence. It isn't that these specific affects are the ones which are often discernable. Certainly these can be manifestations, but any affect is discernable in unconscious fantasy. Furthermore, the feelings mentioned can also be brought directly, not only in derivatives.

Other comments were added. The key or main question, one subject thought, is not about the affect itself, but about the sources of difficulties which give rise to it. Affect is discernable because of conflict which this section discusses, but in a muddled way.
Interpretations which refer to these affects (negative affects, i.e. guilt, shame, humiliation) and their important motivational role in the formation of defences are crucial in that such interpretations reduce anxiety. However, such interpretations of negative affects also engender resistance.

Subjects agreed that all affects, not just the ones mentioned, have a motivational role in the formation of defence, although one thought "guilt is not a motivator". However, affects also have other motivational roles, as with the development of self and object representations and relationships, which are not discussed by the authors. Other comments related to the interpretation of these affects. Interpretation can not only reduce anxiety, but heighten it which has to do with more than "engendering resistance". One subject thought the interpretation of affect was not crucial to reducing anxiety. In addition, another subject added: "Interpretations which engender further resistance are mistimed."

Accurate identification and appropriate repetition in various contexts are essential in the process of working through conflict.

Whilst subjects agreed completely with this statement, one thought it didn't fit in this paragraph. This is the same subject who found this section muddled and that it skipped around.

Affects generated by the child's experiences in the external world and outside of the analytic situation are also addressed particularly with children who live in environments which fail to meet legitimate developmental needs.

Subjects said that addressing experiences from the external world is something they do with all children, not just those discussed (40%). It was added that the fact the child has brought these things into treatment means they become part of treatment. Whilst addressing the outside world the analyst is also looking at what it may mean in the transference.
The last paragraph under means states:

Clarifying or interpretive interventions will arouse specific affects within the child and the analyst will attend to these. This process can facilitate the child's emotional investment in the person of the analyst and is thus an important prerequisite of the development of the transference.

One subject wondered what "the analyst will attend to these" means. Another added that it is not only a process of interpreting and clarifying affects.

The relationship between patient and analyst was discussed by several subjects. One thought this section, more than aims, laid emphasis on the important role recognising affect has in the development of the relationship. This is one of the crucial areas of work with affects. Another said that it is the relating of an affective experience which is important. It is this affective experience which binds the child to the analyst and in the transference. The analyst may have little to do with the affective experience, but it is the relating of it and the feeling of it that the child has in the presence of the analyst that makes the transference work.

Limitations

All subjects found this section understandable and clear. No one completely agreed with what was written, and all had comments.

Limitations begins with:

Whilst the long-term aim is to identify and label affects with a view to enhancing the understanding of experiences and facilitating adaptation, this is a lengthy aspect of the analytic process. At any particular moment it may not be appropriate to verbalise affect if, for example, it could disrupt defences which are, at the moment irreplaceable, such as reaction-formation; or at a point when the child is certain to take the intervention as criticism which would lower self-esteem catastrophically.

First of all, one subject pointed out that an aim of work with affects is referred to which is not discussed under the aims section. Perhaps it should be added there. Two other comments related to the verbalisation of affect and reaction-formation.
It was agreed that it may not be appropriate to verbalise affect if it will disrupt needed defences. One subject thought it should be added that with some children it isn't a matter of disrupting defences. Rather, the defences aren't sufficiently strong enough. This links to the next paragraph so will be discussed further below.

Another subject agreed completely with the point about reaction-formation. The analyst doesn't want to undo that defence by verbalising the anxiety too much. But at the same time, defences which a child is trying to approach which are developmentally appropriate may have to be examined. In those instances it is important that the defence isn't undermined, but the anxiety or affect is addressed. As the analyst wants to support adaptive processes, she needs to take up the difficulty in a way which also fosters the wish to be grown up.

The second paragraph reads:

The child's wish to control his affect should be reflected by the interpretation which should avoid the implication of an invitation to express affect.

Forty percent of subjects thought this needed a clearer meaning. On the one hand, with some children the wish to control affect can be defensive. On the other hand, with other children the analyst doesn't want to invite the acting-out of affect. At the same time, the analyst needs to allow the child to feel certain ways. Whether or not the child controls affect with words depends on how the analyst deals with it in treatment. For example, with children who do not have defences which are strong enough, even the mention of an affect, which includes the wish to control that affect, may lead to acting-out. In these cases the analyst is trying to build defences and interventions are about containment as she works to help the child contain and control his affects.

The final paragraph states:

Of course in various circumstances the analyst may use the affect as a guide without necessarily interpreting it. Affects may be stunted in certain children with particular environmental deviations and interpretations of affects in such cases will not lead to relief.

There was complete agreement that affect is used as a guide. As with anything else in analytic therapy the analyst does not necessarily interpret then and there. It is a question of timing. This is with all children. One subject disagreed that affects are "stunted". It may be that affects are more unconscious or that there is less freedom for the child to allow himself to feel things which are dangerous.
Forty percent of subjects did not think that the interpretation of affect is always a relief, not only in those cases mentioned. Several examples were cited. With children who have overly repressed their affects, the way the analyst handles these difficulties is a timing problem and an object related problem. She is going to help the child be more free flowing with his affects. The affects are there, rather than lacking as "stunted" implies. With borderline children who do not have sufficient defences, interpretation is also not experienced as a relief. With narcissistic disturbances affects are not stunted, rather affect prompts narcissistic injury. Interpretation of affect can accentuate this injury rather than being felt as a relief. With these children the technique is different.

One subject had an addition to the limitations section. She thought with any patient there were some affective states which were extremely difficult to find and communicate. "Sometimes there are affective states that people experience that are peculiar to themselves and it takes a long time for the analyst and patient to really get hold of what the patient is experiencing."

One general comment about the entire limitations section was that it addresses when the analyst doesn't interpret something which she feels wouldn't be helpful at the time. This is not specific to affect, but to everything.

Overall Comments

All subjects commented that affect is difficult to separate out from other areas that are a part of their work with children. Affect leads to other things and is part of everything. In addition, 40% of subjects thought this chapter mainly related to defence, whilst work with affect is important to all of the analysis.

TRANSFERENCE

Eighty percent of subjects found all sections of the transference chapter understandable. A majority were in total agreement with definition, means and limitations, and 40% were in agreement with aims. Most subjects had comments. These percentages are illustrated in Figure 11.7. There were a few disagreements and additions on each section, but primarily subjects had comments and additions in regards to the complete chapter. These numbers are outlined in Figure 11.8. A discussion of the data follows.
Definition

Eighty percent of subjects found the definition of transference understandable and agreed with its contents. Sixty percent had comments.
There are two paragraphs in the manual author's definition of transference. The first describes and explains transference within the analytic situation. It says:

Transference refers to special aspects of the relationship the patient develops with the analyst in the course of psychoanalytic treatment. Transference is characterised by a process where feelings and attitudes emanating from the patient's childhood relationships are revived and directed specifically towards the therapist. Thus the child's current feelings, fantasies, thoughts and behaviour towards the analyst become increasingly dominated by real or fantasied early experiences and interactions between the child and his primary objects.

The second paragraph talks about universal transference and distinguishing it from transference in the clinical setting. It begins:

Transference elements enter to a varying degree into all relationships and these are often determined by some characteristic of the other person who represents some attribute of an important figure in the past.

One subject thought more should be added to this statement. Transference elements are not only involved in relationships to people, she said, but also in situations an individual finds himself in, perhaps anxiety situations. Another subject assumed the authors meant there was something in the child's internal relationships whereby he holds a certain position which prompts him to interact with people in a certain way.

This paragraph concludes:

It is important to distinguish between the general tendency to repeat past relationships in the present and the clinical situation and procedures of psychoanalysis which facilitate the development and exploration of this phenomena and where it reaches an intensity and focus that does not usually occur in relationships.

One subject thought this sentence was muddled. It was too lengthy and included too many things. She did agreed with the content. Another subject was not sure she agreed "it is important to distinguish". She wondered why it was important and what use was it clinically?

Subjects addressed both paragraphs. One agreed "with the first paragraph more than the second". Another subject thought the two paragraphs should be reversed "otherwise it is too contradictory". She explained that the way it was written confused transference as a factor in all relationships and transference as a tool in analysis. Yet
another subject agreed with the definition. However, she added, it didn't actually clarify what transference was, how the analyst handled it, and how she used transference as a tool in treatment.

Aim

Again 80% thought this section was clear, however only 40% were in total agreement.

This section begins:

The elucidation of transference is of crucial importance in clinical work. Transference provides a source for unconscious material to reveal itself powerfully through changes in the patient's relationship and attitudes to the analyst in the course of treatment.

One subject thought what the authors meant was confusing. She understood this section, but thought it needed to be clearer.

There were no comments on the next sentence:

The psychoanalytic process facilitates regressive shifts and with it the re-emergence of childhood wishes and modes of relating which facilitates and intensifies the development of transference.

The second paragraph reads:

Transference can also become a source of resistance to the analytic work when it is not recognised, understood and appropriately interpreted.

Subjects agreed with this statement, however one added that transference also becomes a source of resistance when it is recognised. She referred to children who experience enormous narcissistic humiliation and shame when they recognise the transference. This affect arises when they see themselves again and again doing or behaving in certain ways.

The next paragraph states:

The patient is not aware when transference elements enter into his relationship to the analyst and experiences his feelings as appropriate to the present and to the person involved. The analyst permits this illusory apperception to develop and find expression and tries to respond to it only as analytic material. This is facilitated by the analytic setting for adults where the analyst is out of sight and action is restricted.
The final paragraph says:

In child analysis this is more difficult to deal with because children often enact transference manifestations via unconscious attempts to manipulate or provoke the analyst to interactions which represent repetitions of earlier experiences. The analyst has to develop special techniques in dealing with such role assignments.

Subjects commented on the comparison between adult and child analysis. One thought there was an assumption being made that acting out and trying to push the analyst into repetitions of earlier experiences did not occur in adult analysis. She disagreed. Another subject commented that adults do this as well, but it is more subtle. With children the analyst does need special techniques in handling these manipulations, as the manual goes on to discuss. For example, in the play the analyst may go into a role and gratify some, then step out of the role once again. Some children can't stand the frustration otherwise. She went on to say that with children or adults it is the setting and the way the analyst offers herself which influences the development of the transference. It isn't what the analyst does.

General comments to aims included the thought that what was written actually said more than it initially looked. Another requested more of an emphasis on the "here and now transference" as "not all transference is of the past".

Means

The majority of subjects (60%) were in agreement with the contents of means and thought it was understandable (80%).

Means begins:

Transference will be better understood by the analyst if he distinguishes the various elements that enter into the child's relationship e.g. the child's habitual mode of relating; the use he makes of the analyst as a real object etc. But the analyst's technique will be focused to facilitate the development and understanding of transference.

Forty percent of subjects did not think this clarified how the analyst was suppose to distinguish these elements. It was added that in reality it was not so easy to do. One also commented that the use the child makes of the analyst as a real object is one of the universal aspects of transference. What the child picks out of the real object relationship often has
transference aspects to it. She went on to say: "All of it has to be taken as transference elements. Until you find out that they aren't you act and work on the basis of how the child is relating to you has got links to the past."

The second paragraph begins:

Opportunity for transference distortion is enhanced by the therapist not feeding back information about his own life in order to correct the child's misperceptions and by reflecting on the child's wishes, intentions, conflicts and concerns without adding value judgements.

One subject agreed, but sometimes the analyst has to make a trade with the child. In other words, answer the question but also discern the fantasy which lays behind it. She added: "There is no such thing as an uncontaminated transference."

This section concludes:

Most importantly instead of accepting the role the child unconsciously assigns the analyst, he will interpret what the child is trying to enact. For example "You are trying to get me to throw you out like your mother threatened to do" etc.

One subject did not like the example. She thought it implied that each time the analyst followed up with what the child was trying to do to her, she did so by reflecting it back to the mother or significant object. She disagreed with this technically.

One subject expressed her complete agreement with this section by saying "That is exactly what I think analysis is all about."

Limitations

Eighty percent of subjects understood limitations and 60% were in complete agreement.

This section reads:

In the course of time the child's capacity to test reality against the illusory quality of his transferences will increase, but especially with young children, or children whose reality testing is not well developed, the analyst will have to provide auxiliary support for this to occur.
Forty percent of subjects wondered what "auxiliary support" meant. One subject commented that the ability to test reality against the illusory quality depended on the child. Some have more of a capacity for this than others. Another thought analysts tend to underestimate a child's reality testing. It is more adequate than given credit for. She added: "Kids have reality testing if they want it. If they don't it means resistance or defence, rather than an inadequacy."

One subject expanded on the technique with severely disturbed children. She thought the aims and technique were different. With these children the analyst attempts to build up a part of the psychic structure which is lacking because of a fragmented or unintegrated ego. However, a transference of an object relationship is involved and worked with, but slowly.

**General Comments**

All subjects had general comments and something to add, each different from the others. One thought the chapter lacked discussion of that phase in analysis when the child experiences the transference as appropriate to the analyst. As this illusory quality increases, analyst and child enter a delicate phase of the analysis when the transference can become frightening to the child or shaming, but also supportive as "scary things contained". During this phase the analyst hopes the child's self observing capacity strengthens.

The fact that defence, as in the transference of defence, was not included was mentioned by another subject. She thought this should be added.

Another subject pointed to the lack of any mention of affects and how emotional the transference can become. The authors do talk about transference as a special aspect of the relationship, which may imply the affective relationship, but this needed to be spelled out more clearly.

Taking the transference back to the original objects was commented on. One subject thought there were times this was inappropriate as it took the intensity out of the relationship. In her opinion it wasn't necessary to make these links when the transference was of an internal object. As long as the shift took place it didn't really matter. On the other hand, if it was helpful in terms of the child's relationship with a real parent, then it would be important to do. She thought the dos and don'ts of this needed to be clarified.
Finally, another subject thought it important to allow for the fact that the reality is not quite as clear as the manual implied. She also wanted more emphasis on the here and now transference and what was useful to the resolution of transference.

OBJECT RELATIONS IN THE CLINICAL CONTEXT

A large majority of subjects found all of the sections on object relations understandable and were in total agreement. A minority had comments or additions and there was only one disagreement. The category "questions" was added to the analysis of the object relations data as there were a number of subjects who wondered "do the authors mean...?", or were not sure about something. This, and other comments, are discussed in detail below. See figures 11.9 and 11.10.

Figure 11.9: Object relations in the clinical context - Level of clarity and agreement

Figure 11.10: Object Relations in the Clinical Context - Number of disagreements, additions and questions
Definition

Eighty percent of subjects understood the definition and were in agreement. The authors outline three areas the term object relations refers to. The first two are:

1) the child's actual relationships with real people in the external world; (2) the processes of creation of mental, i.e., internal representations of himself and other people. These representations can be used for further processes of conscious and unconscious fantasying, thinking and feeling about the interactions between himself and others; they develop as a mixture of perceptions of reality and projections of the child's own wishes, impulses, feelings and anxieties;

Both comments on the definition of object relations were in regards to the third area which is:

(3) the modification of these internal representations to produce versions of himself and objects which are idealised, denigrated, good, bad, etc., and the part they play in the development of conscience.

One subject was not clear why there was an emphasis on conscience. Another did not understand this component, nor was she sure if conscience was really a part of object relations.

Aim

Most comments had to do with aims. At the same time, all subjects understood this section and 80% were in total agreement.

Aim begins by outlining the overall aim of the analyst's work with a child's object relations. The manual says:

The overall aim is to make the patient aware of pathological features in his relationships to self and others, by demonstrating to him maladaptive identifications, distorted perceptions, inappropriate expectations and fears, thus helping him to modify not only his current modes of relating, but other aspects of his behaviour derived from pathological aspects of relationships. As in any other relationship, the patient's relationship with the analyst reproduces aspects of the child's earlier as well as current relationships with important people, real and fantasied, as well as the interactions between the child's own self and conscience.

All subjects agreed with this.
The manual adds a subsidiary aim which is:

to encourage this repetition, since it serves to reveal most vividly
how the individual perceives important people in the past and present,
what he expects and fears from them, and in what ways he is
identified with them.

One subject thought the word "encourage" sounded as if the analyst was promoting
this repetition in a false way. She suggested the use of "facilitate" instead.

The manual continues:

These factors may also be explored in the child's accounts of
relationships with other people, and in his play and other activities in
treatment. But the relationship to the therapist is usually the most
emotionally alive and immediate situation both for the patient to
convey his feelings and ideas, and for the therapist to interpret them.

One subject agreed the relationship to the analyst was the most alive and immediate
for adult patients, but wondered about children as "the child still has parents".

Aims concludes by discussing general transference and transference proper. The
general transference:

reveals the influences from important past and present relationships
which are likely to be found in all the child's external relationships;

whilst the transference proper:

conveys especially the pathological and regressive elements which
are responsible for the child's problems and therefore most require
interpretation.

One subject thought pathological and regressive elements could also be a part of a general
transference.

One aim was thought to be missing. That was the integration by the child of all of
the various aspects, both positive and negative, of his internal self and object relationships.

Means

Eighty percent of subjects understood means and were in agreement. Forty percent
made comments and two questions were raised.

The authors say that "almost everything that happens during an analysis may be
viewed in the context of the patient's self and object relationships". They go on to describe
two closely linked analytic tasks. One subject was not clear about these. The first task is:
to pick out those features which are particularly useful at any given moment for helping the child to understand the problem areas in his functioning. (What is "useful" will vary at different points in the analysis according to how much the child already understands, how strongly he feels about it, how reluctant or willing he is to understand more, etc.).

She wondered whether the authors meant that the analyst observes or takes note of something, but doesn't say anything. If so, the terminology "pick out" would better be replaced with "observe".

The second analytic task is:

to select the most effective way of interpreting these features to the child; directly in relation to the real external objects; in whatever displacement or projections onto other people, toys, or imaginary characters the child may be using; or in relation to the analyst, i.e. a partial or full transference interpretation.

This subject wondered if this task meant to find ways of saying what was observed in the first task. If both assumptions were correct, she agreed.

There were no comments on the remainder of the means section which concludes:

The possibility for pathology in object relationships are almost limitless, but for each patient there will be areas of particular importance.

Limits

There was 100% agreement with limits and all found it clear and concise. This section reads:

The exploration of pathological aspects of internal and external object relations is appropriate in any form of disturbance. However, the approach to be used, e.g. via interpretations of unconscious internal interactions as reproduced in the transference, via clarifications of the dynamics of real, external relationships, etc., depends on the capacity of the patient to make use of the various approaches.

One subject added a limitation she thought was missing relating to borderline children and those who have a propensity for splitting. In those cases the use of splitting as a defence, in addition to the child's cognitive difficulties, pose limitations on the ability to integrate all aspects of self and object internal relationships.
INTERPRETATION

At least 60% of the subjects found all sections of interpretation except aim understandable. Most had comments, there were a few disagreements, and a number of additions were suggested. Definition and aim were the most problematic sections, whereas 60% were in total agreement with means and limitations. See Figures 11.11 and 11.12 for this breakdown. Discussion of all sections follows.

Figure 11.11: Interpretation - Level of clarity and agreement

Figure 11.12: Interpretation - Number of disagreements and additions
Definition

Sixty percent of the subjects understood definition. All had comments which included two disagreements and five additions.

The definition of interpretations begins:

Interpretations are a form of commentary offered by the analyst on the child's verbalisations and behaviours.

Sixty percent did not like the terminology "form of commentary". They either didn't know what it meant, or thought it was too "minimalistic" or "simplistic" not capturing the complexities of interpretation. Another subject suggested adding play to verbalisations and behaviours.

The next sentence reads:

Typically they (analysts) draw the child's conscious attention to an aspect of his experience which he has a motive to avoid or repudiate.

One subject said "an interpretation should include something about what the child has done with the repudiated content or feeling". This links to comments by another 60%. They thought the unconscious aspect was missing as it is unconscious content or aspects of experience which the analyst's interpretations are aimed at. As one subject said: "The definition doesn't get to the link between conscious and unconscious and the need to make the child aware of unconscious aspects of verbalisations and the like."

There were no comments on the remainder of definition which says:

The content of an interpretation is formulated on the basis of the analyst's understanding of the child's behaviour based upon his theoretical knowledge or psychoanalytic psychology as tempered by his clinical experience and is informed by knowledge of the background of the particular patient.

Subjects had overall comments about the definition of an interpretation. One subject thought the definition was "facile and superficial, which interpretations aren't". She added "It's about listening like mad and trying to add one and one together". Another thought the definition was too vague. "It is a global statement which doesn't actually clarify what most people would understand by an interpretation."
Aim

Less than half (40%) of subjects understood this section. Aim had the most additions and two disagreements, as well as a number of comments.

The first paragraph reads:

Psychoanalytic interpretation aims to bring the patient's conscious understanding to bear upon conflictual aspects of his behaviour, including thoughts and feelings, and in this way to show him how perceptions of himself as well as of others in the environment may be distorted by internal conflicts and their attendant affects. Thus the primary aim of interpretation is to bring the child's awareness to parts of his mental world which he previously construed as unacceptable, threatening or painful, and thereby to enhance his mental representation of himself as worthwhile, effectual and having a greater degree of choice in relation to others and his environment.

Forty percent thought this sounded "too conscious". One elaborated that the assumption is made that unconscious aspects are included, but it never says so. The aim, she added, is about "bringing memories and other unconscious content into various levels of conscious understanding". That needs to be clarified.

A further comment was about "conflictual aspects of his behaviour, including thoughts and feelings". Conflicts as they relate to objects should be included.

The next paragraph states:

Psychoanalytic interpretation also aims to strengthen mental processes which, as a result of inhibition, create distorted and dysfunctional mental representations. Interpretations address stunted mental processes only indirectly. When the analyst makes an interpretation he engages the child with an implicit invitation to identify connections and integrate the interpretation with his desires and his preconscious beliefs, i.e. with his view of himself. In order to link the analyst's interpretation of the content of the child's current psychological state, the child will be motivated to employ his inhibited mental capacity.

Several comments were made about this paragraph. One subject said mental processes can be disrupted or disturbed by other defences, not just inhibition. Forty percent wanted to add wishes to desires and preconscious beliefs.

In these two paragraphs the authors are describing the aim of interpretation as it applies to two different types of disturbances, those based in conflict and those related to mental processes. Forty percent of subjects spoke to this. As they found it difficult to differentiate clinically between these two, they thought this was a major stumbling block to
the way in which analysis was presented in this chapter. Another subject did not understand this as a presentation of two models. She understood the conflict model, but in the second paragraph she misunderstood who was identifying with whom. She thought it important that the analyst identify with the child adding "if you haven't done that with the child they will refute the interpretation". She wondered if the second paragraph was referring to affects. When the interviewer clarified the two models, she still wondered where affects fit in. "Do mental processes include affective ones? If not it is merely intellectualisation."

The third paragraph under aim begins:

Ideally, the child's response to interpretation recapitulates aspects of the analyst's mental activity which fall within the developmental capabilities of the child. The child's passive observation of the analyst's use of the process may further encourage the patient to reactivate inhibited modes of mental function.

Forty percent weren't at all sure what "recapitulates aspects of the analyst's mental activity" meant. Another forty percent disagreed with the statement "the child's passive observation". The child is not, they thought, passive in this process.

This paragraph goes on to outline five different functions interpretation can serve. The first two are:

1) to increase the child's experience of control over overwhelming affects and hence a reduction in the feelings of helplessness through the labeling of emotional states; 2) to reduce the inhibiting consequence of psychic conflict through an understanding of the incompatibility of ideas or wishes;

Subjects had comments about the third function of interpretation.

3) to improve the child's ability to appraise reality by helping him to differentiate his fantasies from actual occurrences in the outside world;

Forty percent asked "what reality"? Did the authors mean external reality or psychic reality? One elaborated saying: "If the authors are referring to external reality, what is their definition of this? External reality is always seen through one's experiences. Therefore the reality the analyst is registering and talking about may not be the child's reality. This needs clarification."

One subject pointed to the fact that (4) is grammatically unclear. It reads:

4) to provide the child with a sophisticated implicit theory of how he and others' functions including ways which he and others use to cope with unpleasurable or threatening aspects of experience;

The fifth function of interpretation says:
5) to strengthen the child's ability to adapt to noxious environmental influence through highlighting his capacities and the alternatives open to him.

One subject was confused as to the meaning of the entire third paragraph and the five functions of interpretation.

In commenting on aim in general, 40% thought the role of the analyst's counter-transference should be added.

Means

Eighty percent of subjects found this section clear and understandable and 60% were in total agreement. There were four additions and no disagreements.

One comment was to merely point out that in the third paragraph when the theoretical assumptions to the rules of interpretation were laid out, number six was missing.

In the fifth paragraph when working-through is discussed one subject commented that it was not clear how much time working-through takes and what is involved.

The additions related to types of interpretation and the ways in which they are given. The way an interpretation is "couched" is important. This refers to the analyst's words and the tone of voice, both of which make an interpretation "hearable" to the patient. In addition, the way in which a patient experiences an interpretation is an important factor. When an interpretation feels intrusive or attacking, the patient will defend against it. Thus, the interpretation is not heard and opposition to the analytic process is strengthened.

Another subject added the method of "non-verbal" interpretations. These are interpretations via the written word, songs, in displacement, or the play. It was also suggested that the authors define the contents of a full interpretation versus a partial one.
Limitations

As with means, 80% of subjects understood this section and 60% were in total agreement. There was only one addition.

As found under aim, one subject commented that the differentiation between mental process and representational type problems, which the manual refers to, is difficult to make clinically.

One subject thought the need to have an interpretation validated is extremely important and should be added. Another thought the entire section didn't sound as if the analyst "was with the child".

Overall Comments

Forty percent of subject's comments related to the wording of the interpretation chapter. A minor point was that the analyst is referred to as him and her. Either one or the other should be used to provide consistency. In addition, some parts of this chapter were thought to be written in an inaccessible style. Simpler and more direct language was suggested. For example, "words or language" could be substituted for "verbal productions".

A differentiation between interpretation, verbalisation, and clarification was suggested by 40% of subjects. Twenty percent requested the inclusion of "mutative interpretations".

THE PSYCHOANALYTIC UNDERSTANDING OF CHILDHOOD
PSYCHOLOGICAL DISTURBANCE

As discussed and explained elsewhere (see procedure) this validation study was conducted in a different manner than the others. Instead of a face-to-face interview, subjects were given copies of The Psychoanalytic Understanding of Childhood Psychological Disturbances which summarised the theory and its main points. They were asked to write out their responses to a series of questions.
For the most part, subjects said they found this chapter clear and thought they understood what the authors were getting at. Whether these numbers are accurate is in question and discussed below. There were a few disagreements and additions, but primarily subjects had numerous comments. No one was in complete agreement with any of the sections. Figures 11.13 and 11.14 show these numbers.

**Figure 11.13: The Psychoanalytic Understanding of Childhood Psychological Disturbance - Level of clarity and agreement**

<table>
<thead>
<tr>
<th></th>
<th>Understandable</th>
<th>Confusing</th>
<th>Total Agreement</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Intro.</strong></td>
<td>100%</td>
<td>0%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td><strong>Representation</strong></td>
<td>80%</td>
<td>20%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td><strong>Aim Model</strong></td>
<td>60%</td>
<td>40%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td><strong>Mental Process</strong></td>
<td>40%</td>
<td>60%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td><strong>Overall</strong></td>
<td>50%</td>
<td>50%</td>
<td>100%</td>
<td></td>
</tr>
</tbody>
</table>

**Figure 11.14: The Psychoanalytic Understanding of Childhood Psychological Disturbance Number of disagreements, additions and comments**

<table>
<thead>
<tr>
<th></th>
<th>Disagreements</th>
<th>Additions</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Intro.</strong></td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td><strong>Representation</strong></td>
<td>4</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td><strong>Aim Model</strong></td>
<td>6</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td><strong>Mental Process</strong></td>
<td>8</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td><strong>Overall</strong></td>
<td>16</td>
<td>4</td>
<td>20</td>
</tr>
</tbody>
</table>

There is a question whether subjects actually understood what the authors were proposing, or whether they only thought they did. Some of the data, which is described in detail below, seems to imply that 40% of subjects took the representational model to mean internal self and object representations. What the authors actually say is: "The representational model of psychological disorder focuses on the distortion or repression of
the mental representations of one or the other of the conflicting wishes." Here the authors are talking about representations of wishes. The investigator's understanding of this model is that it refers to the way in which any number of things are psychically represented. That includes wishes, self and objects, but also representations of affects, conflicts, etc., etc. So, whose understanding is correct? If the subjects are correct in their understanding, then it is indeed 100% who found the representational model understandable. If not, this number is reduced to 60%. Whether what the remainder of subjects understood the authors to mean and what was actually meant by the representational model, or the mental process model for that matter, cannot be ascertained further from the data. Regardless, this discrepancy points to the fact that the models are presented in a confusing way.

Introduction

Subjects had the least to say about the introduction. There was one partial disagreement.

The introduction begins by saying:

Within a psychoanalytic model, childhood psychological disturbance is seen as initiated by conflicts. The manner in which children adapt to such conflicts provides the basis for our understanding of childhood disturbance.

It then goes on to introduce the two models of disturbance which are delineated more in detail later on.

One subject asked: "Are all disturbances based in conflict?". It was her understanding they weren't. Instead, some disturbances are "an unusual line of development" where the child may be in conflict with the environment, but it isn't necessarily a conflict within himself (internalised conflict). Whilst this comment addresses the subject's understanding of the proposed model, it does not clarify whether or not she agrees all disturbances are based in conflict which this chapter implies.

Another subject was in "partial disagreement" with, what to her, seemed to be a suggestion that there were two distinct models. In her experience both exist in the same patient. Which model interpretation addresses at any one particular time is a matter of the analyst's technique.
Another comment was along similar lines. It was this subject's contention that inhibition, which is the bases of the mental process model, was used by children who fit the representational model. For example, a child with a learning inhibition "may have resorted to such a possibly damaging defence to reduce anxiety and guilt" related to what underlies the learning problems. Furthermore, one subject thought other defences, not just inhibition, could account for a mental process disturbance.

One comment asked for clarification. The authors say:

The models identify two distinct, potentially pathological, means available to the child to deal with psychological conflict.

This subject thought what those "means" were should be briefly outlined.

The Representational Model

Eighty percent of subjects had comments about this section and there were four suggested additions.

This section begins:

The representational model of psychological disorder focuses on the distortion or repression of the mental representations of one or the other of the conflicting wishes.

One subject found this formulation difficult. "It means", she said, "having to recast all conflict as conflicting wishes". In other words, conflict, according to the authors, involves only wishes whereas this subject thought there were conflicts which involved other things. For example, conflicts involving internalised prohibitions, fears and guilt.

The first paragraph goes on to say:

These distortions represent an attempt at a compromise which serves to reduce anxiety and other forms of psychic pain. Psychological disturbance arises, not because these manipulations take place, but because they are only partially successful and anxiety and guilt continue to interfere with the child's functioning.

One subject added: "Also because defensive maneuvers interfere with reality appraisal, be it internal or external reality."
The second paragraph begins:

The imagined gratification of a wish is invariably linked to the mental representation of a sought after affective state. In this way affects and wishes are intrinsically linked in the construction of mental representations.

Referring to the second sentence one subject asked "in what way?". "The link", she went on to say, "is assumed by not spelled out". She thought the idea proposed was an interesting one. Whether she agreed or not was unclear.

This paragraph continues:

In many instances the individual's anticipated emotional experience associated with the gratification of a wish is also beset by negative affect (e.g. sadness, anxiety, guilt, etc.). Such negative affects are at the behest of mental representations of situations particularly those associated with the absence or the displeasure of the caretaker.

This, thought one subject, was unclear. She wondered if it was saying that "the anticipated pleasure of the fulfillment of the wish may also carry associated sadness, anxiety or guilt, especially linked to mental representations of the caregiver's absence or displeasure with the wished for state".

The third paragraph reads:

The multiple emotional implications of a wish are what we refer to as conflict. The range of wishes that may be entailed in conflicts leading to childhood disturbance covers the full spectrum of human motives.

One subject suggested "the multiple contradictory emotional implications of a wish".

The fourth paragraph says:

In order to retain some semblance of pleasurable affect, the mechanisms used by the child to exclude mental representations from consciousness are applied in a less than comprehensive fashion. In this way, mental representations or wishes may be distorted so as to hide from consciousness aspects of anticipated negative affect.

The comment about this paragraph suggested it should specify that it is the relation to conflictual wishes as not all pleasurable wishes are conflictual.
Anxiety and other unpleasant affects initiate defence which leads to the division between conscious and unconscious mental experience.

One subject thought this was only true if the authors were talking about what was dynamically unconscious. "Even then", she wondered, "what about the role of primary repression?"

Representations deliberately excluded from consciousness are not integrated with the child's increasing knowledge of his world, and permit the child to maintain a large number of contradictory beliefs and expectations. With development, unconscious mental representations will be more and more incompatible with representations maintained in consciousness. Consequently the threat of the return into consciousness of these representations will be experienced as more dangerous because it implies a general return to an earlier childlike mode of thinking.

One subject wasn't sure she agreed. She thought what was presented might be true at a higher level of ego functioning, but what she thought the authors seemed to be talking about in this paragraph was the censorship. Therefore, she added, "this seems an unduly sophisticated mechanism or motive at that level".

The child with the representation disorder responds to his failure to adapt to the demands of progressive development by attempting to resolve his conflicts in a regressive manner. Neurotic compromise formations engender anxiety because they are only partially successful in keeping repudiated aspects of mental representations of experience out of conscious awareness. These unwelcomed representations may include distressing perceptions of the self, of the object, or of the self and object in interaction.

One subject expressed her confusion about the proposed model here. "What exactly does representational disorder mean?" she asked. "Is it an object representation disorder?" She was very unclear whether the authors were talking about a failure in object relationships or some allied failure in other processes having to do with the ego. Another subject thought that resolving conflicts in a regressive manner was far too simple of a formulation.

In addition to specific comments, there were more general ones about the representational model. One subject did not see how one model could be used without the other. She found it a "contradiction to think of growth, which presumably is intrinsic in the
developmental process of the mental process model, not going along side, often merging with, the psychic process and object relationship developments which are intrinsic in the representational model".

Another subject found the idea of "representations bridging affect and some other side which may show an ego capacity" interesting. Also, she found the idea of "linking wish to mental representations" useful as a way of thinking. However, she didn't think the processes which were involved or exactly what a representation was were clear. "Is a representation an object representation or something else?"

One further comment was whether it would be worth including the "acts of repression which are part of normal functioning".

The Representational Model - Aims and Means

There were two specific comments about this section. One involved confusion in the first paragraph when the authors say:

The ambiguity of the situation which the analyst presents to the child serves to activate, i.e. to make current, unacceptable mental representations. When the child behaves in a distinctively individual way, the analyst reacts to this distinctiveness with the assumption that communication about the adaptation the child has made underlies it.

One subject wondered "adaptation to what? To conflicts?" This is unclear.

The other comment related to the second paragraph. It begins:

As children develop more sophisticated ways of representing experiences of external reality, they tend to exclude more primitive mental representations. These primitive forms remain active but only unconsciously. The problem with the child's functioning arises when the more primitive, unconscious, representations are activated by internal or environmental demands. The child analyst, in making interpretations of unconscious forms of earlier experience, opposes the child's natural tendency to favour more complex forms of mental representations.

This subject objected to "more complex forms of mental representations". She did not think that primitive implied less complex. Rather, early forms of organisation can be just as complex as later ones.
One of the general comments to this section actually applies to both models. It is "the analyst's task", this subject thought, "through listening, waiting, exploring, verbalising, clarifying, interpreting, and verifying to know which type and strength of defences are preventing development of all systems including object relations". The analyst must choose, based on the material before her, where to gear her interpretations, which could involve either model. By having both models in her mind she is able to do this.

There is something else seemingly implied in this comment which relates to an overall understanding of the representational model. When this subject says "development of all systems including object relations" it seems she is taking the representational model to mean the representation of objects. It is not clear that this is what the authors mean.

Finally, one subject wondered if aims and means should include something about "the analytic experience offering a new object for a new representation".

The Mental Process Model

The majority of subject's comments were directed to this section. They found the mental process model more confusing than the representational one.

The first paragraph states:

Mental representations cannot be separated from the processes which create and organise them. They are best conceived as the products of mental processes. Mental processes refer to all the diverse ways available to the human mind to create and act upon its mental representations. Such processes are not only relevant to but are pre-requisites for all developmental attainments.

When the authors say that "mental processes refer to all the diverse ways available to the human mind", one subject suggested that examples be given of these "diverse ways" which would add clarity.

The next paragraph subjects discussed was the third one. One subject thought the first sentence was not at all clear. It says:

In the early stages of the evolution of a mental process, its further development may be influenced by the balance between pleasure and unpleasure contained within the mental representations upon which the process acts.
The next sentence says:

In later development, mental processes occur automatically and outside awareness, and with the development of defence mechanisms the child will have the capacity to bar from access to consciousness those specific mental representations associated with the experience of unpleasure.

One subject thought this statement was too global. In reality, "children do experience unpleasure and this implies they don't". She suggested instead, "the capacity to bar from access to consciousness some of those specific mental representations".

The third paragraph continues:

Earlier in development, the child is able to prevent unpleasurable mental experiences arising by inhibiting the mental process itself.

This seemed to imply, thought one subject, "conscious control in some form rather than an automatic mechanism". She also thought the statement was too global. She went on to explain: "One has to take into account the fact that this doesn't happen all the time, at least in major ways, even given much distress. In other words, I think that the way in which ego functions/mental processes persist despite the fact of the painful recognitions they may bring is also worth noting."

One subject noted how very important the next sentence in this paragraph was. It states:

The curtailment of a mental process has more drastic consequences for development, than does the repudiation of specific mental representations.

There were no further comments on the remainder of this paragraph or the next one. The fifth paragraph begins:

Individuals differ in the extent to which specific mental processes have fully matured. Psychological disturbance is associated with relative immaturity of selected mental processes. Under-developed mental processes give rise to distorted object and self representations.

The comment by one subject referred to the last sentence. "What was cause and effect" she wondered. "Could it also not work the other way around?" This subject seemed to be asking whether object and self representations could have an impact on the mental process and its operation or development. No one had comments about the rest of this paragraph.
In the sixth paragraph the authors list six different "hallmarks" of psychological disturbance. They begin by saying:

To distinguish these two models of disturbance within the clinical context we consider the following as 'hallmarks' of psychological disturbance related to the inhibition of psychic processes:

Subjects had comments on the fourth, fifth and sixth "hallmarks". The fourth one states:

4) the patient is unaware of the absence of a capacity and may regard his mental functioning as adequate.

One subject didn't think this was necessarily true. The fifth hallmark reads:

5) the analyst may preconsciously 'compensate' for the patient's lack of mental capacity and may even find himself emotionally invested in the patient's adequate mental functioning.

The addition of "compensate for the patient's lack of mental capacity much like an auxiliary ego" was suggested. The sixth hallmark states:

6) the patient does not apparently benefit initially from the analyst's implicit use of those processes which are inhibited within the patient.

One subject did not understand what the authors meant.

There were no comments on the final paragraph. Subjects did make overall comments about the mental process model. One thought the problem was the processes the authors were talking about "remain unspecified". Without more specifics it seems "it is merely a matter of substituting one term (ego function) for another (mental process)"

Another subject agreed with the idea presented that the failure of mental processes could be defensive. But, "the question is whether there are some failures which are not defensive and if so which ones".

Yet another subject found the mental process model "ambiguous" and one which the authors applied to a vast range of disturbances. She wasn't sure she agreed with this application. Her understanding of a "developmental disturbance" was "delays in development in one or more lines of growth". Analytic or psychotherapeutic intervention may or may not be needed dependent on the number of lines involved. Furthermore, developmental disturbance does not mean there was "interference with the integration of the ego" which the mental process model implied. With narcissistic and borderline disturbances, she thought, the "representational model aspects" had to be worked with as well as "participating in the patient's mental processes". Building up a sense of self is crucial with these children as there is fragmentation or a lack of integration. The technique is "very different from developmental disturbances".
The Mental Process Model - Aims and Means

There were a number of comments about the aim and means of the mental process model.

A specific commented related to the first sentence where one subject thought it was not clear what the authors meant. It reads:

In addressing therapeutically disturbances deriving from the inhibition of mental processes, the patient's active mental involvement is elicited by the analyst's attention to the elaboration of the preconscious mental content of the patient.

Other comments were about the entire section. The analyst's interventions are described by the authors as "interpretations". One subject disagreed that interpretation was always the intervention, rather there were many other things analysts do with these patients. She asked: "Is that not one of the main differences between the two models?"

Another subject thought the emphasis of aims and means was too focused "on the representational side". "In doing so", she said, "it leaves out affects". It is unclear, but perhaps the subject was referring to object representations, rather than all representations.

One subject questioned: "Is this really what we do?"

Overall Comments

On the whole, one subject thought this chapter was written clearly, but was very dense. She had to re-read it a number of times to take it in. Clarifications would be helpful in order to know exactly what was meant. This criticism may relate to the summarised form of this chapter.

Another spoke of how difficult she found it to differentiate clinically between the representational and mental process models of disturbance. She thought this was a grave problem in the way in which analysis was presented in the manual.
Finally, whilst she understood what the authors were saying, one subject found "the language style convoluted". Whilst the model itself was clear, it could have been expressed in less wordy and simple language. Another said she "needed convincing about the entire presentation". "What exactly is new", she asked, "other than an original way of expressing familiar concepts?"

DISCUSSION

The aim of this study was to determine if the contents of Manual II were in agreement with child analyst's working models of psychoanalytic concepts, and the degree to which analytic practice as described matched actual practice. In this way it is possible to ascertain if this manual meets the criteria of manualisation and describes the methods, rational and objectives of child psychoanalysis as practiced at the Anna Freud Centre.

Seven chapters from Manual II were used in this study. Each chapter was validated by five subjects who are experienced analysts at the Centre. The results indicate that some chapters were in closer proximity than others to these analyst's working models. Object Relations in the Clinical Context and Conflict were the two chapters which most closely matched subject's working models. Affects and The Psychoanalytic Understanding of Childhood Psychological Disturbance were the most problematic chapters. Table 11.3 outlines the percentage of subjects who were in complete agreement with each chapter and understood what the authors were saying. These numbers were calculated by taking the average of percentages from each of the chapter sections. It also details the percentage of additions, disagreements, and questions allotted to each chapter based on the total number delineated from the data.
Each of the seven chapters will be discussed separately in the order in which the studies were conducted. The focus will be aspects which need further clarification or revision.

DEFENCE AND RESISTANCE

Defence and Resistance had the highest percentage of subjects who understood what was written and thought it was clear, 92%. All subjects understood the definition of resistance, aim, means and limits, whereas 60% understood the definition of defence. Whilst most subjects understood this chapter, only 32% were in agreement with its content (40% on definition of defence, aim and means, and 20% on definition of resistance and limits). There were 24 disagreements or additions, 12% of the total.

These results indicate there are four main areas to reconsider in the present chapter. First of all, subjects found the definition of defence confusing. Second is the concept of resistance. Whilst subjects understood what the authors were saying they thought it was implied that resistance and defence were, in essence, the same thing. Subjects disagreed. The definition of resistance needs further clarification and subject's requested additional
information about this concept under means. Aim is the third area which needs further consideration. Some subjects disagreed with the basic premise that the aim of defence analysis is the modification of defence. They thought the aim was making certain defences redundant. This is a different orientation than the manual suggests. Rather than the defence itself being the focus of this kind of work, the analyst's primary aim is the analysis of what is being defended against.

The last area relates to the section on limits, but also to the revisions to this chapter which were not part of this study. These revisions address disturbances of mental processes, rather than the representational model. To outline these briefly, the authors talk about children who are in danger of being overwhelmed by anxiety or catastrophic loss of self-esteem. In these instances, the authors propose that defence is directed against the processes of thinking and feeling. This results in a stunting of development and deficits in all subsequent functioning. The aim in working with these disturbances is to "re-start development". The authors suggest that the analysis of specific defences against specific representations will not in itself be sufficient to re-start development. Instead, techniques are geared toward making the patient aware of the gaps in his functioning. Means involves verbalisations of any signs of affects and wishes, and actively helping the child in the expression of affects and the gratification of wishes. Only then can the analyst help the child find ways of handling these and begin to find their origins in conflicts.

Eighty percent of subjects had disagreements with the limits section as written in the original version. These disagreements relate to the mental process model. The technique as described by the authors could link to one subject's comment about defences which have been built into the child's character. Whilst she did not go through the process, she did say that lengthy working-through in intensive treatment was required. Her comments addressed the need to find the anxiety which contributed to these defences. This is what takes so long. She didn't, however, outline the steps involved which is what the authors refer to in their revisions.

Other subjects commented on defence analysis with psychotic or borderline children, ones who meet the author's definition of mental process disturbances. These are children who are overwhelmed by anxiety. Rather than defence analysis as outlined, the process with these children involves building defences. Implied is the inhibition of those mental processes which contribute to the existence of defence. Subject's technique did not focus on the expression of affects and wishes, but their containment and regulation.
With children who suffer from narcissistic disturbances, it is the loss of self-esteem which is overwhelming. Whether the technique is one applicable to the representational model or the mental process model is unclear from subject's responses, however they did address the fact that the technique was different. These children experience defence interpretations as an attack which threatens their self-esteem. Subjects may also be implying that the technique, as originally outlined, also threatens the integrity of the child's self representation.

CONFLICT

Seventy-five percent of subjects understood Conflict and thought it was clear. All subjects understood limits, 80% understood aim, and 60% understood definition and means. Half, or 50%, were in total agreement; 80% with limits, 60% with aim, 40% with means and 20% with the definition. There were only nine comments, or 4.5%.

Subject's comments and disagreements were relatively minor requesting further clarification or alternate terminology. For the most part this chapter seems to match the subject's working models of conflict analysis.

In the revised edition of this chapter which addresses mental process disturbances, the authors mention those children whose anxiety is so overwhelming that the only way to survive is to abandon functioning. In these instances the analyst aims to re-start or correct stunted or deviant processes. The analysis of conflict is not enough to engage these processes and thus effect change.

Subjects comments about the limits section relate to these revisions. One subject thought limits, as written in the original version, were too narrow. Another suggested changes which addressed "ego strengthening and building defences" as conflict analysis is not enough to ameliorate changes with certain children. These additions speak to disturbances in the mental processes which contain and regulate anxiety.
Only 15% of subjects were in complete agreement with Affects (40% in agreement with the definition and 20% in agreement with aim). The percentage of those who understood what the authors were saying and thought the presentation was clear is higher, 65%. This includes 100% on limitations, 60% on aim and means, and 40% on definition. There were a total of 55 disagreements or additions, or 27.5%.

These results indicate that Affects is a problematic chapter. Subjects expressed their difficulty in separating out affects from the rest of analytic work. Affect is used by these analysts as a guide to most everything. There was a sense that this chapter, rather than talking about all of these areas, focused primarily on defence and its relationship with affect. Subjects also thought the role of motivational affects was important. The chapter does talk about affects motivating defence, but subject's thought there was much more. For example, the role of affects in the development of self and object representations. Furthermore, subjects said the role of affects in the development of the relationship between child and analyst was not emphasised enough. All subjects disagreed with the author's terminology "negative affects". They found it unclear and not useful. The suggestion of "painful or unpleasant" was made as an alternative.

In terms of the specific sections outlined under affects, the author’s definition was confusing to most subjects. Subjects had the most to say about means. Some thought these were muddled, and various revisions and clarifications were suggested. Limitations was another section all subjects commented on.

As some of the comments about the chapter in general, and specifically about limitations, link directly to the revisions the author’s made, these will be summarised briefly. Most of the revisions were added to the means section. There the authors discuss times the analyst is confronted with children who are overwhelmed by their affects or where the absence of affect is striking. They propose that both of these situations suggest the presence of inhibited mental processes, particularly those governing affect regulation. Because of this inhibition, the child fails to create mental representations. The most useful aspect of interpretations with these children, the authors suggest, are ones which emphasise the overwhelming quality of the affect and the helplessness this engenders. Under limitations the authors say that interpretations of affects will not lead to relief in children whose affects are stunted.
Subjects gave examples of what the authors would call mental process disturbances where the mental process itself is inhibited. Throughout the interview they spoke of examples where the interpretation of affect did not help the child feel understood, engender relief or decrease anxiety. In fact, the interpretation could do the exact opposite. Three different types of patients were presented. Whilst the technique with these patients was not spelled out by subjects, their comments are worth noting as they point to differences in aims and technique.

First were those who fall under the diagnostic category of borderline. These children lack defences which help them contain their anxiety and affects, thus often feel overwhelmed. Rather than interpreting these states, the analyst works to build defences and focuses on containment and control. Second were children who suffer from narcissistic disturbances. With these children subjects said the technique was different. The interpretation of affect, and sometimes even the presence of affects, prompts injury and humiliation. Third were children who have severely repressed their affects. This is similar to what the authors refer to when they say that affects appear to be absent. Subjects said that the way they handle difficulties of this sort is a "timing problem and an object relations problem", thus implying that the focus of the work is somewhat different.

In general, there were two other comments which apply to mental process disturbances. First of all, there was disagreement with the word "stunted". Stunted, some thought, implied that affects were not present or lacking whereas, with these children, affects are unconscious or their expression is inhibited ("lack of freedom in expression"). There was also clarity given to the process of labeling and differentiating affect which is discussed under means. This subject thought labeling was not only about giving the child words for his feelings. The process of labeling and differentiating affects involves giving the child a way of internally representing an affect. This may point to a mental process difficulty. If the child does not have a mental representation of an affect, he is unable to recognise the experience of that affect within himself. It also suggests that the use of words and language is somehow connected to the mental processes which create mental representations, at least of feelings.
TRANSFERENCE

Transference was thought to be clear and understandable by 80% of subjects. All sections were understood by 80%. The percentage of those who were in complete agreement was 60%; 80% on definition, 60% on means and limitations, and 40% on aim. Whilst subjects agreed and understood, there were 23 comments, or 11.5%, many of which were suggested additions.

Most of the subjects who validated this chapter made comments which pointed to areas which needed to be clarified. For example, although they agreed with and understood the definition of transference, subject's thought it was somewhat confusing in its presentation and requested expansion. Clarifications were requested throughout the manual. Specifically, subjects did not think the means section spelled out how to distinguish the various elements of the child-analyst relationship, which the manual suggests is important, and didn't know what "auxiliary support" meant which is mentioned under limitations.

The majority of the comments were suggested additions to this chapter. This speaks to the need for expansion in order to clarify what transference is, how the analyst handles it, and how she uses transference as a tool in treatment. Subjects requested more on the phase in treatment when the illusory quality of the transference intensifies and the child begins to experience the transference as appropriate to the analyst. The affective aspects of transference seemed to be missing, an important aspect because of how intense and emotionally laden the transference can become. It was requested that the process of "taking the transference back to the original objects" be expanded. Subjects thought there were times this was indicated and times it wasn't, only serving to decrease the intensity of the relationship. Further information on transference of defence, the resolution of the transference, and distinguishing the "here and now" transference from "transference of the past" were all asked for.

This study validated the original version of the transference chapter. The revised edition is re-written in a way which is clearer, but still does not address subject's concerns. In regards to the integration of the mental process model, the authors add that both earlier mental representations and mental processes can emerge in the transference. Subjects said very little which would address this addition. One subject did comment on the treatment of "very disturbed" children, meaning primarily those with a diagnosis of borderline. She said in these cases the technique and aim were different. What the analyst does is build up parts
of the psychic structure which are lacking "because of a fragmented or unintegrated ego". In some ways this implies mental processes according to the author's definition. Transference of object relations does, she said, come into the treatment, but the analyst has to work very slowly with this.

OBJECT RELATIONS IN THE CLINICAL CONTEXT

Object Relations in the Clinical Context was the first chapter validated which was a revised edition following the author's conceptualisation of psychological disturbance. It was the chapter subjects agreed with the most and had the least to say about. There were only four additions or disagreements (4%), and 90% understood and thought the chapter was clear (definition and means 80%, aim and limits 100%). There was complete agreement by 85% (limits 100%, and 80% on the other three sections). These results suggest that the model of working with object relations proposed in the manual closely matches that of analysts in practice.

Subject's comments primarily addressed clarifications of certain terminology or phrasing, and for the most part were minor. There were two additions which should be noted. One was a further aim of working with object relations. This was the integration by the child, of all aspects, both positive and negative, of his internal self and object representations. The other addition was related to this aim and limits. This subject discussed borderline children and those who have a propensity for splitting. The defence of splitting, as well as deficits in cognitive capacities, posed limitations, she thought, on the child's ability to integrate all aspects of his self and object representations.

INTERPRETATION

The chapter on Interpretation was thought to be clear and understandable by 65% of subjects (means and limitations 80%, definition 60%, aim 40%). However, only 35% were in total agreement (means and limitations 60%, aim 20%). Subjects had 25 disagreements or additions, or 12.5%.
The author's definition of interpretation and the aims they spelled out were the most problematic sections of this chapter. There were also general comments about the wording and writing style. Some subjects thought it was inaccessible and that simpler, more direct language could be used.

In general, subjects thought the author's definition of interpretation was too vague and global, and that it didn't capture the complexities of what interpretation meant. Eighty percent of subjects commented on the absence of the unconscious aspect of what interpretations are aimed at, something they again pointed to under aim. Whilst the authors talk about drawing the child's "conscious attention" to things he has a "motive to avoid or repudiate", they do not address what the child has done with repudiated content or feelings. The fact that they are unconscious is implied under the definition, but subjects thought it important to make it explicit. This applied to aim as well. Subjects concurred that the aim of interpretation is to bring into conscious awareness that which is unconscious.

The aim of interpretation was the most confusing section of this chapter and the one subjects had the most difficulty with. The authors address aims as they relate to the two models of psychological disturbance, the representational model and the mental process model. Some subjects thought the presentation and conceptualisation of these two models was a major stumbling block to the way interpretation and analysis are presented in the manual. They found it difficult to differentiate the two clinically. In addition, some subjects did not seem to understand the mental process model. This applied to the section on limitations as well as aim. The question is: if the authors were clearer in their presentation of the two models, would it be easier to differentiate them clinically? Furthermore, analysts do make different kinds of interpretations with different aims dependent on the child's pathology and internal organisation, but the manual does not seem to address these subject's models. At the same time, this study did not ascertain what the nature of their models were.

Subjects also expressed confusion about, or disagreement with, the five functions interpretations serve. These are outlined under aim. In addition, the absence of the role of the analyst's counter-transference was noted.

Means and limitations was clearer. Subjects did suggest the process of working-through be expanded to include the time it takes and what is involved.
Subjects also commented on aspects they thought were missing from the manual. The ways in which an analyst gives an interpretation which contributes to the patient's ability to hear and accept them was one. Various methods of making interpretations were also suggested as well as the differentiation between a "complete" and "partial" interpretation. The importance of having validation and confirmation of an interpretation was also thought to be absent. Subjects wondered about the need to add something about verbalisation and clarification as they relate to interpretations, and "mutative" interpretations.

THE PSYCHOANALYTIC UNDERSTANDING OF CHILDHOOD PSYCHOLOGICAL DISTURBANCE

The Psychoanalytic Understanding of Childhood Psychological Disturbance was the most problematic chapter and the one subjects had the most difficulty with. No one in this study was in complete agreement with any of the sections. The numbers show that 84% thought they understood what was written (introduction, representational model, its aim and means 100%; mental process model and its aim and means 60%), however this percentage is probably lower (76% or less). Subjects had the most to say about this chapter, 56 comments or 28%.

The basic difficulty with this chapter is whether or not the contents were clear and understandable to the subjects in this study. Although subjects said they understood the two models of psychological disturbance proposed by the authors, the results indicate their understanding is in question. What this discrepancy points to is the fact that the two models are presented in a somewhat confusing way. Several factors account for this.

Some of the subject's comments may relate to the fact that this chapter was presented to them in a summary form covering the main points of the theory. There were numerous comments requesting further clarification, and one subject thought the chapter was too "dense". However, subject's who made these comments seemed to understand the models but were requesting further expansion. Furthermore, the ideas presented in this chapter were not new to subjects. They had read an extended version of this chapter previously, a version which was the topic of an International Scientific Colloquium some months prior to this study.
One of the things which does seem to account for subject's confusion is the terminology. Terms which usually relate to common psychoanalytic concepts are used, but applied in a somewhat different way. For example, the concept of representations. The authors of Manual II have taken this concept and attempted to expand and clarify it. However, what they refer to as representations is somewhat confusing. In the manual chapter they speak of representations of conflicting wishes. In an expanded paper (1993 in press) they speak of mental representation as a theoretical construct used to "understand and explain the inner world of patients". The specific model of mental representations they use is based on work in cognitive science and "includes the notion that representations are stored as networks or nodes spread across the brain". A representation is "a pattern of activation within such a hypothetical neural net". This, in essence, is an attempt to integrate psychoanalysis with other sciences, specifically neurology and cognition. However, it does not clarify what is represented in the child's representational world. Implied in this paper is a multidimensional view of representations, but what is explicit is self and object representations. The authors say:

Objects may be represented in numerous ways as person schemas, as representations of frequently encountered patterns of relationship, as assumptions of functions frequently associated with the object, as representations of typical interpersonal interactions and so on.

Self and object representations are the most familiar components of the representational world to analysts at the Anna Freud Centre. These concepts fit with their theory of object relations and are understandable to them. They also know the most about these components from their clinical work. What some analysts automatically assume representations mean are self and object representations. This, it seems, is what happened in Study 3. Whilst subjects thought they understood the representational model, in fact some of them were using this concept in a more limited sense than the author's intended. This speaks to the need for further clarification within a framework which is understandable to analysts.

The mental process model presents similar difficulties. Process is a concept which has certain meanings in psychoanalysis. There is the concept of primary and secondary processes which refer to two types of mental functioning, usually thinking. Primary process is characteristic of unconscious mental activity, whereas secondary process is characteristic of conscious thinking. Process also refers to the analytic process. Analytic process is sometimes taken to mean a process within an analysis which contains certain

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analytic principles, for example treatment alliance, transference, interpretation, resistance and working-through. Analytic process can also mean the way in which the analyst follows the material presented to her by the patient. In other words, what follows on what and how are they connected. Mental, unconscious, or psychological processes are other contexts in which the word is used. These often imply concepts like defence, conflict, resistance, fantasy, identification, etc. For example, this investigator included a category entitled "psychological processes" in Study 2 (see chapter 9) which included twenty-three of these "processes".

The manual author’s meaning of mental processes is quite specific, at the same time vague. Mental processes, they say, create and organise mental representations. This is what is commonly known in psychoanalytic theory as ego functions. The authors are trying to be more specific and define in detail what all the ego actually does. They are clear these hypotheses are tentative. The authors state that they are beginning to "enumerate mental processes pertinent to psychoanalytic models of psychological disturbance" and as yet "lack sufficient information" to allow the specification of "those mental processes which account for particular psychological capacities". To date, through an examination of 150 Indexed cases at the Anna Freud Centre, 39 mental processes have been identified which are grouped under eight headings: (1) the organisation and control of impulses and wishes; (2) the organisation and control of affective mental states; (3) reality orientation; (4) external object relations; (5) internal object relations; (6) self-organisation; (7) self-monitoring; and (8) self-evaluation. However, as the authors contend, it is only through "the psychoanalytic study of psychological disturbance that the precise nature of the malfunctioning of mental processes will eventually be ascertained".

The nature of these tentative hypotheses contributes to some of the difficulty with this chapter. It does seem, from the data, that subjects did understand the meaning of mental processes, or at least of ego functions. They were unclear about the difference, if any, between the mental processes and ego functions, and the subsequent technique and aims.

The authors also suggest that mental process disturbances are what is commonly known as developmental, borderline and narcissistic disturbances. Whilst the last two are clearer to subjects, developmental disorder has a variety of meanings dependent on who is defining the term. This may relate to the change over the years in the concept. Anna Freud (1966) initially defined these disorders as ones arising from strains, stresses, dangers and

anxieties associated with certain developmental phases. Once the developmental phase passed, the disorder faded. In other words, they were transitory. However, she later reconsidered this concept. Developmental disorders, she concluded, underpinned infantile neurosis and a neurotic superstructure overlaid them. By 1970\(^6\) developmental disorders was extended to include non-neurotic disorders such as borderline, narcissistic, atypical and psychosis.

The final concept which is somewhat unclear is conflict. According to the authors all childhood psychological disturbance is initiated by conflict. Here they are using conflict in a broad sense, whereas traditional psychoanalytic theory defines conflict as neurotic conflict. In other words, conflict involves conflict between psychic structures. This is not to say either way is correct, only that they are different and perhaps contribute to some confusion. In the chapter on psychological disturbances the authors speak only of conflicting wishes. This leaves out a whole host of other conflicts, or requires the analyst to recast all conflicts as conflicting wishes. In the chapter on conflict the authors define this concept as wishes, aims and ideals which are simultaneously present.

Another unclear area from the results of this study is whether the author's formulations coincide with how the analysts who validated this chapter actually think and work. Subject's comments related to whether they understood the model and what was unclear, but they did not address whether or not they agreed, or if the model was compatible with their own thinking. Subjects were asked this question, as they had been in the three validity studies they participated in previously, however in this study they never really answered. Two possibilities for this lack of response come to mind. First of all is whether subjects were inhibited in their responses. These formulations of childhood psychological disturbance were presented to an international audience as ones which represented the Anna Freud Centre, and had been written by senior analysts from that institution. Perhaps subjects were hesitant to disagree. Whilst this is a possibility, subjects were not inhibited in agreeing or disagreeing with the formulations of other chapters. These were face-to-face interviews where it might have been somewhat easier for subjects to present their own views, especially when prompted to do so by the investigator.

A second possibility is that subject's own models of psychological disturbance are unformulated and constitute their part-theories. Part-theories are made up of the analyst's private theories and her preconscious beliefs and models which organise her understanding and techniques. As they are descriptively unconscious, their conscious formulation remains somewhat elusive. Subject's are familiar with the concept of developmental help, which is, in part, what the authors refer to as the technique appropriate for mental process disturbances. However, these interventions have been thought of as something other than analysis, and what exactly they aim to do or what aspect of a child's disturbance they address may be a component of these part-theories.

CONCLUSION

The seven studies presented indicate that the instrument used is a viable tool in determining the validity of Manual II. The degree of agreement between the author's models of analytic concepts and analyst's working models has been demonstrated. What this study has not done is ascertain how analysts actually work with patients. This relates to the idea of analyst's preconscious beliefs and theories which organise and motivate the way in which they work. This is the topic of Study 4.
INTRODUCTION

Child analysis encompasses a wide range of concepts and mixtures of techniques. These are based on analytic principles and theories, and the psychoanalytic understanding of children, psychological disturbance, and development. As Anna Freud and others have said, child analysis proper is the whole range of therapeutic possibilities the analyst makes available to a patient. How then does one go about defining the components of child analysis and what it is analysts do if what is possible is an ever ending range? The key lies in the common ground.

Study 2 delineated the repertoire of theoretical and technical concepts analysts have in their minds when they think about child analytic material. The results were organised around classifications of concepts with similar properties, based on the commonalities found in the data. Further work on this repertoire by the authors of Manual II resulted in chapter headings which represent the main therapeutic components of Anna Freudian child analysis. Through a collaborative and consensus approach, this group of analysts formulated the contents of these chapters. Study 3 demonstrated the degree of agreement between the author's models of these concepts and analyst's working models.

What that validity study examined was analyst's conscious working models. However, as others have speculated (A. Freud 1954\(^1\), Sandler 1983\(^2\)), and researched empirically (Elliott 1985\(^3\); Hamilton 1990\(^4\); Sandler, Dreher and Drews 1991\(^5\)), analysts hold preconscious beliefs, theories and models in their minds which influence and motivate the way in which they work. These researchers developed methodology using

unstructured interviews which enabled them to elicit these descriptively unconscious part-theories and the dimensions of meaning of specific analytic concepts. By making these implicit theories explicit, clinical models and theory were clarified.

This study takes the premise of analyst's preconscious working models and applies it to a treatment modality, child psychoanalysis, rather than a single psychoanalytic concept. Through a method of unstructured interviews it is possible to discover not only the meanings of concepts which analyst's hold in their minds, but also the aims and techniques which are implicit in their part-theories. Unlike Hamilton's research where clusters of beliefs were found among psychoanalysts from many different theoretical orientations and trainings, this study focuses on a specific group of analysts who share a theoretical and clinical foundation. Because of this shared foundation, the commonalities found in analyst's internal working models would constitute one theoretical orientation and approach to child psychoanalysis.

The aim of this study is to examine child psychoanalysis as practiced at the Anna Freud Centre. How analysts think about their patients and what they actually do with them in the privacy of their consulting rooms (their private theories rather than their public ones) are elicited through interviews based on analyst's own clinical work. In this way the gap between stated clinical models and actual models lessens which in turn refines the theory. With the establishment of a model of child psychoanalysis which is current within this culture, and matches the reality of what analysts actually do, the manualisation of this approach is enhanced.

METHOD

Design of the Study

This study is designed to elicit analyst's implicit theories and beliefs about child psychoanalysis. Seven analytic concepts and techniques are investigated which were delineated from Study 2. The result is a model of child psychoanalysis based in actual clinical practice which defines concepts and applies them in a systematic way to the aims and methods of this approach.
The method of semi-structured interviews is utilised with a focus on how these concepts manifest clinically, what the analyst and patient do, how they do it, and why. Five interviews with experienced analysts from the Anna Freud Centre were conducted on each concept. A content analysis was then applied to the data.

**Sample**

The same subjects who participated in Study 3 were used in this study. The sample consists of thirteen staff members from the Anna Freud Centre, all of whom had done their training at this institution and were qualified as child and adolescent psychoanalysts.

A total of 35 interviews were conducted. The concepts subjects were interviewed on were the same concepts they discussed in Study 3. Subjects also participated in the same number of interviews. A more detailed description of the sample can be found in chapter 11.

**Materials**

Six of the seven concepts used in Study 3 were also used in this study. These included: defence and resistance, conflict, affects, transference, object relations in the clinical context, and interpretation. Interviews were not done on analyst's understanding of childhood psychological disturbance, which was the seventh area examined in Study 3. The theory of psychological disturbance is a vast and rather complicated area which does not lend itself to the methodology used here. The diagnostic category of developmental disturbances was looked at in this study with a focus on those techniques which constitute what has been called, within the culture of the Anna Freud Centre, developmental help.

Semi-structured interviews were constructed on each concept to be studied. The interviews were clinically focused. The general outline was designed to elicit the subject's working definition of the concept, her aims, or what it was she was trying to accomplish, and how she went about working with the child as it pertained to the concept at hand. Clinical constructs which related to the concept being studied were included in the interview as well. For example, when subjects spoke of their work with a child in terms of object relations, they were also asked about the transference as observed in the material and its link, if any, with object relations. Questions were designed to ascertain the influence of the analyst's developmental viewpoint as it pertained to the specific concept. This was important as it is this viewpoint which is the foundation of Anna Freudian theory. Subjects were also asked if they worked in the way they had described with all patients regardless of age or
pathology. If there were differences, they were asked to demonstrate these clinically. They were also asked if they worked with psychotherapy patients in the same way. All interviews were focused on how the concept being studied manifested clinically, what the subject did, how and why.

These were the general areas covered during each interview. A summary of the interview format for each concept is provided below. What was important was that the investigator followed the subject's clinical examples and her explanations of what she did in her approach and how the child responded. Whilst each interview had a specific format, this did not mean that other areas were not also covered. What these were depended on each subject and how she presented the material. Subjects were repeatedly asked for clarification and further explanation.

Defence and resistance were the first concepts to be studied. Once subjects had given their working definition of these concepts they were asked what they thought was the result of a "normal" and "pathological defence". Through clinical examples subjects illustrated how they took the concepts into account in their analytic work, what it was in the child's material that they paid particular attention to when thinking about defence and resistance, and what clues they looked for (or found) which indicated the defence or resistance was in operation. The subject's technical approach to the concepts and her aims were then examined. Did she begin by acknowledging the defence/resistance or drawing the child's awareness to it? What did she do next? Each step in the process of the analysis of the defence or resistance was illustrated. When the subject spoke of the interpretation of these particular concepts, did she always include what was being defended against? When would she or wouldn't she? Whether or not the subject discussed with the child the effects of the defence or resistance on his functioning was also explored. During the process of describing her approach, the subject was asked about her short-term and long-term aims, as well as the influence of her developmental viewpoint on her definition, aim and technique. In addition, whether or not the subject pointed out alternative ways of handling a situation to the child, whether there were times she purposefully did not analyse a defence, and the relationship between transference and defence were examined. Subjects were asked to give other examples, specifically of a child of a different age or with a different type of disturbance, and these were discussed in a similar way. Finally, subjects addressed whether there were instances with children of certain ages or disturbances where the analysis of defence or resistance varied or did not play as much of a role in their work, and the difference, if any, between psychotherapy and analysis in regards to these concepts.
The conflict interview began in a similar way requesting subject's working definition, however they were also asked to explore the notions of "normal" and "pathological" conflict, conscious and unconscious conflict, and what it was that made a conflict problematic in a child's life. Not only the conflict itself was discussed, but solutions to conflict. Subject's illustrated how an unacceptable or maladaptive solution manifested itself clinically, in addition to unresolved conflicts. Throughout the interview the question of whether conflict was a component in all disturbances was explored. As the subject described examples from her patients the investigator paid special attention to the clues which came from the child's material which led the subject in one direction or another. How she went about identifying conflict and solutions, or the lack thereof, the ways in which the subject perceived the conflict interfered with the child's functioning, and her method of communicating her understanding to the child were elicited. Each step in the process was examined by assisting the subject in discussing how she began, what did she do next, how the child responded, and so forth. As her aims and technique were explored, the interview also focused on the relationship between transference and conflict; whether in her interpretations the subject always talked about both sides of the conflict, when she would or wouldn't and why; whether all interpretations were conflict based; and if the subject provided the child with alternative ways of resolving conflict. Furthermore, the subject was asked whether there were circumstances when she would not approach a conflict even if the child had attempted to resolve it in a manner which was problematic. The impact of the subject's developmental viewpoint was explored throughout the interview, as well as differences, if any, based on the child's age or type of disturbance. The subject was then asked about her approach with psychotherapy patients.

In the affects interview subject's working definition of the concept were explored in depth. Would they include anxiety and guilt in their definition, or did they make special distinctions? What were their thoughts about the notion of unconscious affects and did they see this manifest clinically? Whether or not the subject agreed with the idea that some analyst's have that affects have a signal capacity, what function this served for the child, and what use the child made of his affects were all elicited. Subjects were also asked about the distinction between "positive" and "negative" affects. As subjects described their work and gave clinical examples of the ways in which they gained an understanding of what the child was feeling or the nature of his affects, the use the subject made of the child's affects was explored, as well as her approach based on her aim. Did the subject begin by labeling the affect? What did she do next? Using the subjects words as she described the process (e.g. labeling, verbalising, interpreting) the investigator assisted the subject in being as clear as possible about what words she actually used with the child. Did the subject only make interventions which addressed the affect itself, or was her work with affects always in
relation to other things? How did the child respond or make use of the subject's understanding and interpretation of affects? Did the child experience relief when the subject made her interventions? Addressing affects in relation to the external world as well as the analytic world were explored, as well as the emphasis the analyst placed on the expression or control of affects, and whether or not there were times the subject did not make an intervention and her reasoning behind this. Subjects were also asked to examine whether or not they had found a relationship between their work with affects and the development of the transference, or more generally the child-analyst relationship, and the influence of this relationship on the way in which they worked with affects. Once again, the investigator paid close attention to the influence of the subject's developmental viewpoint and explored this in more depth when appropriate. In this interview subjects were not only asked about the differences in their aim and approach with child of certain ages and pathologies, and with psychotherapy patients, but if there were also variations when it came to anxiety, shame or guilt.

When asked about their working definition of transference, subjects were also asked whether they agreed with the idea that transference was a universal phenomena. What was the difference, if any, between this and transference in the analytic situation? The investigator attempted to help the subject be explicit about what they thought transference was, and whether or not they would classify all aspects of the child's relationship with the analyst as transference. If the subject made a distinction, how did she go about differentiating these other aspects clinically? What in the child's material gave evidence of transference, or that the transference had developed; whether or not, how and why the subject might facilitate the development of the transference; the methods she used to meet her aims; and the influence of her developmental viewpoint were all explored as the subject discussed her patients. If it did not come up in the clinical examples subjects gave, they were asked specific questions and the investigator requested further illustrations. These questions included whether or not the subject ever answered a child's questions about her, why or why not and when; if there were times the subject corrected the child's perceptions of her; what the child's perception of the transference might be; the relationship between transference and enactment; and the resolution of the transference. The investigator paid close attention to the subject's sense that the child was attempting to get her to act in certain way, how the subject handled these situations, and the words she used in her interventions. Finally, whether or not transference work was applicable with all ages, pathologies and with psychotherapy patients, and the differences in the subject's aims and methods, if any, were examined.
In the object relations interview when subjects described their working definition, they were asked, if they had not already addressed it, whether or not they made a distinction between internal and external object relations, and if so what was the relationship, difference and/or similarities between the two. The area of the development of internal object relations was also explored, for example what contributed to this development, if and how internal object relations changed or were modifiable on a day to day or moment to moment basis throughout the life cycle, or whether they were set or static. What use the child makes of his internal representations of objects, and the relationship, if any, between internal representations and conscience were explored. As subjects discussed their patients, the ways in which they formulated their view of the child's object relations and the evidence they gathered which led to this formulation were elicited. The investigator attempted to assist the subject in going through the process of her interventions with a view toward her aim, with explanations about why she intervened in the way she did rather than taking some other approach. For example, if the subject made an interpretation in displacement, why this rather than directly? Or, if she made an interpretation in the transference, why this rather than keeping her intervention in relation to people in the child's life? In this way the investigator could ascertain when and why the subject might have intervened differently. The investigator paid special attention to the ways in which the subject presented the idea of internal representations to the child and explored this in depth. The relationship, if any, between the transference and/or the child-analyst relationship and object relations was also examined. If it had not already come up in the interview, the investigator asked about the relationship between object relations and fantasy, thinking and affects, requesting illustrations. The impact of the subject's developmental viewpoint on her understanding and formulation of the child's object relations, as well as the ways in which it influenced her aims and technique, were discussed throughout the interview. As with other interviews, the differences, if any with children of certain ages and disturbances, and the subject's work with psychotherapy patients were examined.

Many of the subjects came prepared to the interpretation interview with examples from their daily process recordings which they had picked at random. This provided the opportunity of obtaining the exact wording the subject had used and whether or not her developmental viewpoint had an influence. Through an examination of the examples subjects provided, the investigator elicited the subject's working definition of interpretation, what from the material informed her interpretations, the ways in which the child communicated his concerns to the analyst (both conscious and unconscious concerns), and what the subject's aims were. The ways in which the subject decided to make certain interpretations were explored in depth. For example, what led the subject to make the interpretation she presented when she did, what led her to interpret one thing rather than
another especially when there was evidence in the material that she could go in more than one direction or when two levels of operation were apparent (e.g. preoedipal and oedipal). Examples of the child's response to the subject's interpretations, either immediate or delayed, were also requested as the investigator kept an eye on whether or not the child confirmed what the analyst had said and how he did this, and whether the interpretation enhanced the flow of the material. Subjects were asked if they thought there were times interpretations were not helpful to the child and to elaborate with examples. The construction of interpretations was also examined. This included what, according to the subject, an interpretation needed to include; the notions of a partial or complete interpretation; the distinction between verbalisation, clarification and interpretation; "here and now" interpretations and interpretation which make links to the past; and whether the subject's interpretations always involved conflict. Subjects were also asked to describe and illustrate the relationship between interpretation and working-through. The influence on subject's technique and aims of children of different ages and disturbances, as well as psychotherapy patients, was also discussed.

The developmental disturbance interview began by requesting the subject to describe the patient(s) they were presenting in terms of the nature of his disturbance. The investigator explored with the subject what they thought the etiology of the child's disturbance might be (both environmental factors and the subject's model of the child's internal world), and what psychic processes or mechanisms maintained and/or accounted for the disturbance. As close as possible, the step by step process the subject went through in addressing the child's disturbance was elicited. This format followed that of the other interviews as the subject's interventions, aims, the words she used, how she approached the child, etc. were examined in depth. If it had not come up already, subjects were asked explicitly about their definitions of ego functions, ego deficit, and developmental help. Once the process between subject and child was illustrated, sometimes with more than one patient, the investigator asked for subject's comments and degree of agreement with three quotations from Anna Freud. These are described under the results section. Subjects were also asked to think about what they had presented, and whether or not the type of disturbance and techniques they had described could fit with one patient, or was there a distinction between their so called neurotic patients and those who exhibited a developmental disturbance. In addition, subject's thoughts about treating the patient(s) they presented in psychotherapy, as opposed to analysis, were elicited.
The semi-structured interviews are contained in the Appendices. The defence and resistance interview is found in Appendix 7, the conflict interview in Appendix 8, the interview on affects is in Appendix 9, the transference interview is contained in Appendix 10, object relations in the clinical context is in Appendix 11, the interview on interpretations is found in Appendix 12, and the developmental disturbance interview is contained in Appendix 13.

Procedure

A pilot study was first conducted to ascertain if the method and design employed with the interviews would work. The concepts of defence and resistance were used in the pilot study. Three subjects were interviewed. The analysis of this data established the instrument as a viable tool which elicited the way analysts thought about and worked with concepts clinically. The sample for each concept was then expanded to five subjects.

Potential subjects were initially approached by letter, followed by a personal contact. They were informed that the aim of this study was to determine what analyst's definitions of concepts were, and how they went about working with these concepts from a clinical perspective. Thirteen staff members agreed to participate.

Individual interviews were conducted with each of the five subjects. One concept was discussed in each interview, except defence and resistance which were studied together because of their theoretical relationship. Once five subjects were interviewed on one concept, another series of five interviews were conducted on another concept, until all seven concepts were completed. There was a total of 35 interviews.

Each interview lasted approximately one to one and a half hours. The subject was informed beforehand what concept would be the topic of the interview. They were instructed that the interviews would be clinically focused and they would be asked to discuss one or two of their patients. No further preparation was requested.

Adolescents were not included in this study because the technique with these patients is somewhat different than child analysis. This is due to the differences in developmental levels and tasks. Consequently, subjects were asked to present preschool and latency aged children who were in psychoanalysis.
Subjects who participated in the study on developmental disturbances were provided with additional information. They were given, in written form prior to the interview, a global definition of psychological disturbance. The definition said that disturbances, in the widest sense, can be broken down into the two broad categories of "neurotic disturbance" and "developmental disturbance". Developmental disturbances were said to include a wide range of pathologies commonly known as the diagnostic categories of borderline, narcissistic, atypical, psychosis, and developmental disturbance as an entity in and of itself. Subjects were told that analysts sometimes think, with developmental disturbances, in terms of developmental help and/or techniques and concepts which may vary from those used when the diagnosis of neurotic was given. Subjects were then asked to present in the interview two child patients they were treating in analysis whom they thought fit under these two broad categories. Alternately, the could present one patient whom they thought constituted a mixture of these two types of disturbances. Subject's understanding of their patients and their technical interventions would be the focus of the interview.

The interview began by informing subjects that the purpose of the interview was to think about the role of the concept under study in their analytic work with children, and specifically in relation to their technique. They were asked to think about and discuss the concept in relation to examples from their analytic cases. The investigator attempted to keep the subject's comments focused on patients and patient's material instead of on theory. Examples were repeatedly asked for, especially in terms of what the child presented, what the analyst did, how she did it and why, based on the material which came from the child, and in what way the child responded. The subject's thought processes were made explicit in terms of how she understood the child's material, what prompted her to do what she did, what was she trying to get at, and how was she thinking about this particular patient.

Interviews were recorded on audio tapes. The confidentiality of subjects and their patients was assured.

RESULTS

Each audio taped interview was transcribed. Once all five interviews on one concept were transcribed, a content analysis was applied to each interview. The data from the five interviews were then compiled and the numbers calculated. The results of this analysis follow. Concepts are presented in the order in which they were studied.
12.1 DEFENCE AND RESISTANCE

Defence and resistance were the first concepts to be studied. Subjects were asked to discuss both together due to the similarities between them as defined by the literature. Therefore, the aim of this section was to not only elicit the meanings of each concept, but to establish whether or not there was a relationship between the two.

DEFINITION OF DEFENCE

The majority of subjects (80%) spoke of defence as a “mechanism” and that it was an aspect of normal functioning. In other words, defences are mechanisms which all people use all the time. They help the child and without them he could not function. Defences are a necessary aspect of psychic functioning. Other subjects defined defence as a “force”, as an “ego function”, or merely as a description of something that happens. See figure 12.1.1.

Figure 12.1.1: Definition of defence

Purpose of Defence

There was strong agreement about the purpose of a defence. All subjects thought the purpose was to provide protection in some way, be it in providing safety, keeping anxiety provoking material at bay, or preventing the child from being overwhelmed. Similarly, 40% responded that defences provide internal stability or equilibrium. Although this may imply protection from disequilibrium, it is a more specific response and a different function. Avoidance was a purpose ascribed to defence by 40% of the subjects. Avoidance means that a defence keeps the child from thinking about or feeling something. Along this line was the
idea that the purpose of defence is to keep something which is unconscious from becoming conscious, which 20% of the subjects commented on. This, in turn, could mean avoidance, as it is an avoidance of that which is unconscious, however there could be a multitude of reasons to keep unconscious processes out of awareness. Further responses (20%) related to development. The purpose of defence was to foster development. See figure 12.1.2.

Figure 12.1.2: Purpose of defence

“Pathological” Defences

Subjects were asked about “pathological” defences. Interestingly, 80% disagreed with the terminology “pathological”, the same 80% who commented that defences were a normal aspect of functioning. Other terminology was suggested which is more descriptive of the problems to psychic functioning which defences can cause. The most frequent alternate terminology (60%) was the “overuse of defence” when a certain defence is relied upon too heavily. Other problems were defined as (20% respectively) “maladaptive defences”, “untimely defences”, or that the problem lies in the “range of defences” available to the child. See figure 12.1.3.

Figure 12.1.3: Alternative terminology to pathological defence

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Following on this, ideas about the result of defences which are interfering in some way or not working, what in the interview had been defined as "pathological", were elicited. The majority of responses (80%) spoke of a "restriction". This could be a general restriction to the personality, or more specifically, a restriction in "internal freedom" or a "constriction in maneuverability of the psyche". Related to this, yet more specific, were 20% of responses. These stated that the result of problematic defences was a cost to the child's personality, for example in learning or making friends. Additionally, the result could impact reality appraisal (40%), as when defences interfere with the child's capacity to look at reality or when they distort his perception of reality in some way; or development (40%), as when a defence hinders development or is still being used when, by the nature of the developmental phase the child is in, it should have been given up. Only 20% commented on the result being a symptom. See figure 12.1.4.

Figure 12.1.4: Result of problematic defence

Two other points are worth noting here. One subject spoke at length about anxiety. She was the underlying anxiety which made the defence important, not the defence itself. This has ramifications in terms of aims and means. Second, there were discussions about personality functioning as a whole, which can be built on defences or a defence organisation.

What is Defended Against

There were multiple responses about what is defended against, both stated explicitly and illustrated in examples. All subjects stated affect, be it painful or unpleasant. Other areas included conflict (60%), some sort of felt danger or something which is threatening to the child (60%), reality (60%), fantasy (40%), an aspect of the child's self representation (40%), something which hurts or is painful to the child (40%), wishes (20%), and drives (20%).
Anxiety, which was talked about by 40%, took a different angle. Anxiety either initiated the defence, or was the result of whatever was being defended against. In other words, it is all these other things which are defended against, but it is anxiety which prompts the defence into action. In this way the process of defence was thought to include three steps: something threatens to come into consciousness, this causes anxiety, and anxiety initiates the defence. See figure 12.1.5.

Figure 12.1.5: Defence directed toward

<table>
<thead>
<tr>
<th>Level of Defence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affect</td>
</tr>
<tr>
<td>100%</td>
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Although implied in the discussions and examples of all subjects, only one was explicit that what was defended against was unconscious. Subject were clearer about the level of defence. In other words, whether defence was an unconscious, preconscious or conscious process. One subject was adamant that defence is always unconscious, whereas a conscious adaptation is not a defence. Of all subjects, 80% thought defence was an unconscious maneuver, 20% thought it could also be a preconscious maneuver, and 40% thought defence was, at times, a conscious maneuver. In terms of conscious types of defence, 20% thought this notion related to times a child said "I don't want to talk about that", or attempted to avoid a subject. See figure 12.1.6.
Pertinent to a definition of defence is the idea proposed by some of a so called "developmental line of defences". According to this proposition, certain defences employed early in childhood are later given up or altered as more sophisticated defences come into place. Certain defences are expectable and appropriate at certain phases of development, but not at others. In this study no one disagreed with this notion. However, the amount of agreement varied from 40% who definitely agreed, to 40% who agreed with reservations, to 20% who were uncertain (see figure 12.1.7). Reservations included the fact that no one has worked this out, although there might be some credence to the idea. Even though certain defences are traditionally seen at certain phases, like intellectualisation in adolescence, subjects thought it would be very difficult to say what defences were appropriate at any one developmental phase. The 20% who showed great uncertainty exhibited a discrepancy in their thinking. When asked directly, they responded that all defences were seen at all levels of development and certain defences were not appropriate to certain developmental phases. However, in other areas of the interview, comments were made related to defences which were thought to be appropriate at one phase and not another.
DEFINITION OF RESISTANCE

The majority of subjects (80%) thought resistance was a clinical concept which pertains specifically to the analytic situation, rather than a psychological concept like defence. Twenty percent were explicit that resistance was an aspect of every analysis. See figure 12.1.8.

The Relationship Between Defence and Resistance

One of the aims of these interviews was to ascertain if there was a relationship between defence and resistance, or if they were entities in and of themselves. All subjects thought there was a relationship, or at least a relationship between defence and one type of resistance. There was more than one kind of resistance. All thought this relationship was the fact that resistance used defence in some way. Forty percent thought a child used his typical defences in the service of resistance; 20% said resistance was the building up of defence; 20% thought resistance mobilised defence; and another 20% saw resistance and defence as the same kind of maneuver. See figure 12.1.9.
Although all subjects thought there was a relationship between these concepts, 60% thought there were also differences between them. Some said the differences related to specific responses as opposed to general responses. In other words, defence was mechanism specific whereas resistance wasn't (20%), or resistance was a general mode of response to psychic pain whereas resistance was a specific response (20%). Another 40% gave a descriptive definition of the differences. Defence was like pushing against something, whereas resistance was against movement. For example, when the analyst tried to pull a child along and he didn't want to go. Whether resistance and defence were the same thing, 20% thought it didn't really matter clinically if you called something a defence or resistance. Technically the analyst does the same thing. Another 20% wondered if they were the same thing. what was the point of having two different concepts. See figure 12.1.10.

Figure 12.1.10: Relationship between defence and resistance - Same, similar, different
Types of Resistance

Subjects discussed other types of resistance found within the analytic situation. All thought there were other kinds, however 20% were not able to be specific. Forty percent spoke of conscious withholding or a conscious resistance, which differed from a basic unwillingness for therapy. Recalling the definition of defence, it is questionable whether the conscious type of defence, as a child saying "I don't want to talk about that", is a conscious defence or a conscious resistance.

Twenty percent discussed character resistance where resistance becomes an aspect of a character formation and a habitual mode of relating. Another 20% defined one type of resistance as the way a child paces himself. This was different from a defence against letting something in or out. It refers to times a child resists as a way to allow time for something to settle. The child needs time to take something in and absorb it. He resists as a way to say he isn't yet ready. Eventually the resistance comes down and the material flows again. See figure 12.1.11.

Data pertaining to resistance not only fell in the realm of what resistance was, but the reason behind the resistance. Three categories were delineated: the analytic process, self or object representations, and other. See figure 12.1.12.
First, resistance relates to something which is going on in the analysis and links to the process. For example: 40% said resistance occurred when a child did not want to take the next step toward understanding what lay behind the resistance; 20% commented that resistance was not wanting to take something in, whereas 20% said it was keeping something out of treatment; 20% thought resistance was specific to certain interpretations or aspects of the process. See figure 12.1.13.

Resistance can also relate to aspects of self or object representations. In terms of representations, 80% thought that resistance arose because the child did not want another to know about something or to share with another, often for fear of what the other's response would be. Sixty percent thought resistance could be a response to a self representation, for example when the child doesn't want to know something about himself because it is unacceptable or painful. Thus, resistance works counter to self knowledge. See figure 12.1.14.
Resistance also arises for other reasons. Twenty percent said the reasons were similar which initiate defence. Another 20% thought resistance was against anything which was slightly unnerving to the psyche. Yet another 20% spoke of resistance occurring because of a fear of the revival of an early experience. These responses relate to the analytic process, as well as self and object representations and transference. Due to the overlap and the specificity, they warrant their own category. See figure 12.1.15

The aim of defence analysis as illustrated by subjects in this study constitute five categories. All subjects spoke of aims as they applied to the defence itself, and what was being defended against. Eighty percent discussed aims which link to solutions and/or adaptations. There were variations within these three categories which are discussed below. Another 40% defined the aim as making defences redundant. Making defences redundant included all three areas; aims linked to the defence itself, what lay behind the defence, and solutions. The thinking was that when the therapist analysed what was being defended against, the child finds that this was no longer as anxiety provoking as it once was when the
ego was weaker. As a result, the child discovers that the defence is no longer needed and what was defended against becomes part of reality. Another 40% elaborated aims which help the child open up, or allow for more open expression. See figure 12.1.16.

Figure 12.1.16: Aim - Categories

Aims Related to What is Being Defended Against

All subjects spoke of the aim of getting at what was being defended against. Sixty percent explained that what they tried to do was bring what was being defended against from an unconscious to a conscious level. There was further elaboration by 20%. They said the point of doing this was to work on what was defended against in the transference. Another 20% were yet more explicit. It was not what was being defended against which the analyst aimed to bring into awareness, but the anxiety which led to the defence. It is the anxiety which makes the defence important. This approach is somewhat different. The theory is that what is being defended against causes anxiety when it threatens to come into awareness. Anxiety signals the defence to come into action, and it is anxiety which is the focus of the aim. See figure 12.1.17.

Figure 12.1.17: Aim - What is defended against
Aims Related to the Defence Mechanism

According to all the subjects the aim of defence analysis is also related to the defence mechanism itself. Finding more adaptive defences was the aim of 40%. Another 60% defined the aim as it pertained to defences which interfere with functioning. Twenty percent elaborated that the aim was to undermine defences which were in the way of future development; 20% commented that the aim was to help the child gain insight into defences so they no longer interfered; and another 20% said the aim was to help the child catch himself from doing the same thing over and over again. The child does this by using the knowledge gained in analysis about the purpose a specific defence serves, at the same time reminding himself of the reality. See figure 12.1.18.

Figure 12.1.18: Aim - Defence mechanism
Aims Related to Solutions and/or Adaptations

Eighty percent of subjects spoke of aims with relate to solutions/and or adaptations. Responses within this category varied. Subjects spoke of new adaptations, adaptive defences, and adaptive solutions.

Twenty percent were clear that finding different ways to defend against something was not an aim, as the analyst didn't change one defence for another rather. Instead, she worked toward new adaptations. However, 40% did speak about changing defences. They thought an aim was to find more adaptive defences. Another 20% commented on aims, not as they relate to more adaptive defences, but to finding more adaptive or different solutions to the conflicts which were being defended against. Yet another 20% were somewhat unclear. The stated aim was to find more flexible solutions, however what was vague was whether this meant solutions to what was being defended against, or that a defence was a solution and one aimed to alter that. The differences within these categories are discrete, but important. The emphasis either lays with changing the defence mechanism itself, or analysing what initiates the mechanism and keeps it active. The conclusion could be that both aims are pertinent dependent on the circumstances. See figure 12.1.19.

![Figure 12.1.19: Aim - Solutions or adaptations](image)

Figure 12.1.19: Aim - Solutions or adaptations

MEANS - DEFENCE ANALYSIS

Whereas the aim of analysis is why analysts do what they do, the means is what and how they do it. In looking at the data from the Defence and Resistance interviews, the means fall into three general areas. First are the clues from the child's material which inform and guide the techniques the analyst uses, in other words, what and where is the
information. Second are the interventions the analyst makes and the various components of her technique. Third is the way the analyst's developmental viewpoint influences her technique.

**Clues to Defence**

Seven different areas of the child's material were pointed to by subjects as pertinent to helping them determine what it was that was going on, and thus aided them in deciding what to do and when. Each will be discussed individually below. They included: the child's play or activities (100%); repetitions found in the child's material (100%); the child's behaviour (80%); the defences the child uses (80%); transference (40%); confirmation of interpretations (20%); and other (80%). See figure 12.1.20.

![Figure 12.1.20: Clues to defence](image)

The child's play, or the activities in which he engages, was one of the two most frequently discussed aspects of analytic material which provide information to the analyst. Generally, looking at the child's play, or what it is he is involved in, was discussed by 40%. Displacement of aspects of self and object representations onto play materials and activities was illustrated by 20%. This is when characters in the play have a certain role which represents an aspect of the child. It is safer for the child to displace these representations onto characters, rather than acknowledging them as an aspect of himself. Further clues are evident when, after an interpretation of the defence which is acknowledged by the child, these displacements repeat themselves. When an activity takes on a new meaning was elaborated by 20%. This is when an activity which was known by both analyst and child to mean one thing, took on a new meaning.

All subjects thought repetitions were also relevant. In general, this was when something repeated itself over and over, or a pattern became apparent in something the child was doing or in his manner of relating (60%). It could also mean the reoccurrence of a past
behaviour or displacement onto a character in the play which had previously been understood to mean something specific.

The behaviour of the child was discussed by 80% of subjects. The manner in which the child presents himself, either at the beginning of a session or at some point during the session, indicated to the analyst that something was going on related to defence. This was illustrated in 40% of the examples. The other 40% discussed a change in the child's behaviour. This could be a sudden change in how the child presented himself, a behaviour which had not been seen before, or regressed behaviour. It could also be the reoccurrence of a past behaviour which the analyst, and perhaps the child, now knew from past experience indicated anxiety.

The defence itself provided clues according to 80%. The analyst looks for the frequency of defence, the defence expressed in the transference, or for an overdone rigidity of defence which indicates to the analyst there is an anxiety underneath. Subjects thought the analyst usually couldn't observe the anxiety leading to the defence, especially if the defence was unconscious. It was the defence which was observable.

The transference also supplied clues to the child's defences and what was being defended against according to 20%. The defence could express itself in the transference. Equally, it was important to keep an eye on the transference in order to understand who the analyst was representing to the child at any given moment. This assisted the analyst in understanding what the defence was protecting the child against.

Confirmation of interpretations provided information in 20% of the examples. Specifically, this was when two modes of communication were operating simultaneously. The verbal mode indicated the defence was in operation, however non-verbally, in the play or behaviour of the child, the break down of the defence was observable.

Finally, there were other aspects of the child's material which provided clues in 80% of the examples. Subjects thought it extremely important to watch the child's material in order to gain an understanding of what preoccupied the child, instead of relying on what the analyst thought might be preoccupying the child. Clues are found in the incongruities of material, in something which happens that the analyst does not understand. Knowledge from parents could also be important, for example information received in parent guidance which the analyst holds in her mind. Over time this information could explain the material. Lastly, one example indicated how something the child does, be it play, an activity, or a behaviour, which previously served a defensive function turned around and became analytic currency. It was something which had been interpreted and understood by the analyst and
the child, but now took on a signal function. The child knew the analyst would take up whatever it was about, and displayed this type of communication as a way to assure she would.

**Technique - Steps in the Process**

The steps involved in making interventions seems to be fourfold. First, is laying the groundwork, followed by verbalisation and other interventions, then interpretation and working-through. See figure 12.1.21.

Eighty percent of subjects addressed the importance of laying groundwork. This entail: the setting safe for the child so interpretations can later be accepted. It includes the establishment of a treatment alliance. Finding a shared mode of communication with the child is equally important as it aids in the acceptance of the analyst's communications.

The second step, according to all subjects, seemed to involve primarily verbalisation. For example, verbalising the presence of defence, or the reason for the defence. This included pointing out to the child the way he acts or behaves through various examples. Part and parcel of this process is the analyst sorting out what the defence is (20%). In addition, the analyst acknowledges that a defence is present (20%), which is different from verbalising, and empathises with the patient's pain by saying that she understands how hard it is (20%).

The next step is interpretation, also addressed by all the subjects. The analyst builds up to an interpretation within the analytic process. This enables her to get at the anxiety which led to the defence, then to what was being defended against (20%). The analyst may also help the child recognise that the defence isn't working (20%).
Finally, is the process of working-through, which all subject emphasised as crucial. Working-through involves repeated explanations and/or interpretations over time which are presented in various ways and within different contexts. The analyst tries to help the child catch himself from doing the same things over and over again as he gains increasing knowledge about the purpose served by the defence. Thus, he is able to remind himself of what the reality is likely to be. Repeating interpretations and working-through aid the child in bringing further material (20%). The technique and manner of repeated interpretations is important as well, as 20% pointed out. The analyst needed to be careful not to overtalk interpretations, as this hinders the process and flow of material.

**Technique - Characteristics of Interventions**

Another category which presented itself in the data was the characteristics of interventions made by the analyst. These fell into several areas which are illustrated in figure 12.1.22.

First is what an interpretation included which was relayed by 60% of subjects. To be complete, an interpretation needed to include what the defence was, the reason for the defence, and what was being defended against. At the same time, according to 20%, the defensive function could be taken up without knowing what it was that was being defended against. This was a means to getting at what was underneath the defence as it aided the child in bringing further material.

Timing of interpretations was seen to be crucial and discussed by 60%. The analyst determines when the child is ready to hear an interpretation. Otherwise the intervention intensifies the defence. Furthermore, when to interpret the defence alone, and when to go for what was being defended against, was a constant assessment. Related to timing is the idea that because the analyst knows what the defence is, it does not necessarily mean that the timing is right to relay this to the child.

Eighty percent of subjects raised the need to be careful whenever making interventions with patients. This relates to timing. Interventions should be gentle and tentative at first, then in a more solid way when the child has a greater capacity to hear.

Other characteristics of interventions included: being non-punitive (20%); the analyst's tone of voice (20%); the type and method of interventions vary dependant on the meaning of the defence (20%); and the method of making interventions in displacement (20%). In regards to the latter, when a child works in displacement, keeping interpretations
within that mode of expression can help him to slowly begin to take on as his own and acknowledge that which was previously displaced onto characters in the play.

![Figure 12.1.22: Technique - Characteristics of interventions](image)

**Technique - Other**

Other areas to the technique of defence analysis were raised. Most importantly was the transference and/or the patient's relationship with the analyst which was emphasised by 60% of subjects. It was the relationship with the analyst and the trust in this person that helped the child to try something new. This relationship is also the context in which all of analysis takes place. Subjects thought it was impossible to divorce the technique from this framework.

Other techniques were illustrated in the examples. One was getting the child interested or intrigued about his behaviour and/or defences, and that there was something underneath these (20%). The idea of the analyst bringing something into the play material which would help the child elaborate further was another (20%). For example, developing a story line within the context of the child's play which incorporated his anxieties and fears. Often the child will then elaborate the story further. He provides additional information as to what is being defended against as unconscious material begins to surface. See figure 12.1.23.

![Figure 12.1.23: Other techniques](image)
Technique - Decisions Concerning Which Defences to Analyse

Finally is the area of whether an analyst makes a decision to analyse certain defences or to leave them alone. Sixty percent thought they made these decisions, whereas 20% thought theoretically they should be able to, but clinically it was difficult and often impossible. Forty percent agreed they left certain defences alone, either because they were working effectively or because they were part of a developmental process. Another 20% thought they concentrated on those defences which were getting in the way of the child managing. See figure 12.1.24.

Figure 12.1.24: Technique - Decisions concerning which defences to analyse

The Influence of a Developmental Viewpoint on Technique

All subjects thought their developmental viewpoint had an impact on their technique, however the way it did varied. Thinking within the framework of a child's development, and the phase he was in, affected subject's approach to a child in some way, according to 60%. For example, it influenced the way the subject interpreted or the words she used, but the aim remained the same; or the way a child thinks and reacts, or his conflicts and defences vary dependent on the phase the child is in. This affects the analyst's approach and the way an analyst thinks about a child. What is appropriate at one phase may not be at another and indicate a sign of disturbance. Forty percent spoke of defences which are part of a developmental process, or appropriate and expectable at certain phases. Responses varied between leaving these defences alone, to the proposal that they may still need to be analysed. See figure 12.1.25.
MEANS - ANALYSING RESISTANCE

As subjects discussed their patients only two gave stated examples of resistance. However, in the opinion of the investigator, some of the other examples could have been of resistance, or defences used in the service of resistance. Although in the definition of resistance subjects varied in their opinions as to the meaning of the concept, technically the means do not vary that much from analysing defence. Many of the same strategies seem to apply. A few points made specifically about resistance, which vary from defence analysis, are worth noting.

Empathising with a child's need to resist was illustrated by 40% of subjects, a higher percentage than found with defence. This involves the analyst letting the child know she understands, not only that resistance is taking place, but that there is something the child can't talk about or is fearful of.

The one technique which came up with resistance, but not with defence, was, in a sense, coaxing the child. Eighty percent of subjects raised this in one form or another. It involves putting the right carrot out, or face saver, so movement toward understanding is not as frightening for the child, or helping the child clear the path. The closest parallel in regards to defence analysis was engaging the child's interest and curiosity in what lay behind the defence discussed, by only 20%. Figure 12.1.26 shows these points graphically.
LIMITATIONS

Two areas are covered within this section. One is whether there are limitations to defence analysis when it comes to certain ages, pathologies, or areas of disturbance. The second involves differences, if any, between working with defence and resistance in psychotherapy versus psychoanalysis.

Age, Pathology and Environmental Circumstances

Subjects thought certain pathologies or external circumstances posed limitations. Figure 12.1.27 outlines these categories as delineated from the data.

Twenty percent commented that the more neurotic the child the more defence analysis was done. Sixty percent thought defence analysis was not appropriate with borderline or psychotic disturbances. With these children the problem was not ineffective defences, but the lack of defences. The technique involves building up defences. Auxiliary ego support is indicated. Because these children experience high levels of unmanageable anxiety, interpretation is ineffective. Instead, the analyst tries to help the child contain anxiety. Defence analysis may be appropriate, but not until other work has been done. At the same time, 20% thought when anxiety was acted out, no matter what the disturbance, the analyst needed to contain the anxiety long enough for the patient to hear.

With narcissistic disturbances, according to 40%, the technique varies. Defences are closely tied up with self representations and interpretations of defence are felt by the child as an attack. They threaten the integrity of the self and often strengthen the defence and
consequent resistance. The analyst still thinks in terms of defence analysis, and the aim remains the same, but the means is different.

Reality factors influenced the technique of defence analysis, according to 40%. These are cases where certain defences are needed against an absolute reality. The difference is between defences against a horrendous reality, and defences against something from the past which might not be needed any longer. Some thought children with traumatic past experiences who defended strongly against them, may not be amenable to treatment.

Development influenced technique and limitations according to 40% of subjects. This was specific to the developmental phase of latency. Limitations were thought to be inherent as resistance and defences are, by nature of the developmental phase, stronger at this age than others.

![Figure 12.1.27: Limitations - Factors or disturbances contributing](image)

**Psychotherapy**

There was 100% agreement that there is little, if any, difference between psychoanalysis and psychotherapy when it comes to analysing defence and resistance. Any technical difference there might be related to individual patients, rather than treatment modalities. For example, differences were based on the rigidity or fluidity of defences, or technically not wanting to break defences down so the patient had little to cope with in between sessions. This could be a factor when the analyst sees the patient five times a week, or once a week.
CONFLICT

DEFINITION

Conflict was defined in general terms by subjects in this study as two things which contradict or oppose each other. It may involve opposing or contradicting wishes (40%), self ideals (40%) or any number of things which the child wants at the same time (40%). Conflict can be experienced by the child as being pulled in two directions, either of which entails gains and/or losses (40%). The child is left feeling stuck or immobilised. A good example of this was a conflict about growing up. The child wanted to be both little and mother’s baby, and the big boy.

All of the clinical examples illustrated conflict in these ways. Furthermore, they demonstrated that conflict, which can be conscious or unconscious, is wrapped up with some kind of unconscious anxiety. It was through the course of analysis that child and therapist discovered what this anxiety was. See figures 12.2.1 and 12.2.2.

Figure 12.2.1: Definition of conflict

- Two things that oppose or contradict
- Pulled in two directions
- Conscious or unconscious
- Involves unconscious anxiety
Some subjects (60%) viewed conflict within the tripartite structural model as, for example, a conflict between ego and superego or superego and id. Whilst conflict implies structuralisation (80%), one subject (20%) conceptualised this differently. She described conflict within an internal object world model. For example, as a pull between internal object representations, or between self and object. See figure 12.2.3.

Normal Conflict

All subjects agreed that conflict is a normal part of life and development. With each developmental phase comes age appropriate conflicts and solutions (80%). However, not all conflicts are linked to developmental phases as there are many things a child can be in conflict about which are unusual and unique to that particular child (20%). Conflicts have a useful function, are part of life, and can be dynamic (100%). One subject added that whilst conflict is one of many things that go into the makeup of a person's personality, there are also conflict free areas to the psyche. Conflict is a motivator for defence (20%). See figure 12.2.4.
Problematic Conflict

These conflicts which are part of everyone's life sometimes cause problems for a child. Four types of problematic conflicts were cited. Problems occur when conflict is unresolved (80%), or when the solution to the conflict is maladaptive or dysfunctional in some way (80%). This includes conflicts which aren't dealt with by adequate defence (20%), thus causing an inhibition or restriction to the personality. The third way conflicts become problematic is when the conflict and the adaptation or solution to the conflict are both disturbing to the personality in some way (20%). Finally, again related to the conflict and the solution, are instances when the child's character and style of relating become ingrained with conflict and attempts towards resolution (40%). This occurs when a conflict has been adequately solved, but with maladaptive behaviour. The result is a character distortion which re- evoke s the conflict as it is re-enacted through the child's personality and the way he behaves towards others. Thus, the conflict is revived. Habitual modes of relating is an example. See figure 12.2.5.
Conflicts which are unresolved, or where there has been a resolution which is problematic, stimulate anxiety (20%), impinge on the child's well being (20%), prevent forward movement or impede development (40%), and/or interfere with the child's functioning (60%). See figure 12.2.6.

**Figure 12.2.6: Problematic conflict - Characteristics**

![Bar chart showing the distribution of problematic conflict characteristics](image)

**Conflict and Type of Disturbance**

All subjects agreed that neurotic disturbance involves conflict. Examples were given where unresolved conflicts from earlier times in life were carried forward developmentally into later phases (20%), and what was once an adequate resolution to conflict did not work anymore (20%). Whilst conflict analysis is central to the analytic work in these cases (20%), it is not the only thing analysts do (20%). See figure 12.2.7.

**Figure 12.2.7: Conflict and neurotic disturbance**

![Bar chart showing the distribution of conflict and neurotic disturbance](image)

Subjects also agreed that not all disturbances are conflict based. However, conflict can be secondarily. Unresolved difficulties which are carried forward in development form parts of or become interwoven with conflict as early deficits gather conflicts around them (60%). With these children conflict analysis may be indicated, but not until other work has been done (40%). See figure 12.2.8.
AIM

Subjects concurred that the primary aim in doing conflict analysis relates to conflicts which are unresolved or where solutions are maladaptive or interfere with functioning and development in some way. In one form or another this was illustrated by all subjects. The aim is not only finding solutions to conflict, but to resolve conflicts in such a way that developmental progression is promoted (20%) and functioning is not interfered with (40%), leaving room for more creative possibilities and solutions (20%). The type of solution is important. Ideally it should be adaptive (80%), productive (40%), and/or economic (20%). Thus, the aim is to assist the child in not being burdened by neurotic, infantile or other negative problems inside of himself (20%). See figure 12.2.9.
In order to meet these aims the analyst looks for conflicts which are causing problems in the child's present life (20%) and helps him recognise them (60%). Making unconscious anxieties conscious (100%) is a necessary step. All subjects agreed that the critical vehicle in child analysis for the awareness of and work on conflicts is the transference. See figure 12.2.10.

![Figure 12.2.10: Intermediary aims](image)

**MEANS**

Conflict is not a single entity which child and analyst simply find and resolve. A complicated process is involved. The analyst attempts to find the main nucleus or heart of the conflict (60%). She looks for all of the strands of conflict, which have multiple dimensions and ramifications, as many things feed into conflict (80%). As part of this process the analyst builds a picture in her mind of what the conflict is (80%) and the child's attempts towards resolution (100%), forming hypotheses over time which she checks out as the material develops (20%). The analyst consciously or unconsciously scans the child's material (40%), observing the ways in which the conflict comes up again and again, as she determines patterns (40%) and connects different pieces of material together (20%). She ascertains what is holding up the child's development (20%) and distorting his personality (20%), and works with the anxieties which are wrapped up in the conflict (100%). The analyst proceeds slowly and carefully (40%) through a variety of steps (20%) as she assesses, works with and on the child's conflicts and their ramifications. Whilst focusing on conflict analysis, the analyst and patient may be doing other kinds of work at the same time (40%). See figures 12.2.11 and 12.2.12.
Clues to Conflict

The material the child presents provides clues to his conflicts and attempted resolutions and/or developmental hold-ups. Whilst how the conflict manifests may depend on the area in which the conflict impinges the most, first and foremost all subjects agreed that the analyst gathers information through the child's relationships. This may be the transference (100%), or the relationship with the analyst in general. For example, what the child says to or about the analyst, how he feels towards the analyst, or what he wants from her (40%). The nature of the child's attachments (20%) provides clues, as does what he says about others (20%) or about himself (20%). Furthermore, the way a child relates to others can be a solution to a conflict (40%). See figure 12.2.13.
Other clues in the material subjects pointed to included the child's affects, particularly his (100%); defences (80%) or inhibitions (40%); symptoms (40%); dreams and fantasies (60%); the child's behaviour (40%) and play (60%); as well as what is missing in the material which the child fails to bring into treatment (60%). See figure 12.2.14.

Conflict and Technique - General

When it comes to the analyst's techniques in working with conflict, all agreed that the analyst first identifies what the conflict is (100%), then relates it in various ways to the play, relationships, behaviour, etc. (40%). The analyst verbalises conflict (100%) and makes interpretations (100%).

As there are multiple strands to conflict, and the analyst is attempting to get at the nucleus, there are other things she does as well. She looks for patterns and identifies these to the child (40%). The analyst works with and explores the child's affects and anxieties.
(100%) which can reveal conflicts. She addresses defences against conflict (60%) and works with resistance (20%). Furthermore, the level of anxiety and the strength of the child's defences are indicators as to how confrontative the analyst can be at any one time (40%). The analyst may point out something to the child related to conflict, such as the comment "Did you notice that...", or wonder about something with the child engaging his curiosity and participation (60%). This can include wondering about things the child does not talk about. Exploring the child's thoughts and fantasies (20%), addressing competing pulls the child experiences (20%), helping the child see his contribution to conflict (20%), and working back to where the conflict originates (20%) may also be methods used by the analyst. The working-through of conflict and its ramifications was discussed by all subjects. See figures 12.2.15 and 12.2.16.
Conflict and Transference

All subjects agreed that conflicts eventually come into the transference and are enacted in the relationship between child and analyst. The transference is a critical vehicle for work with conflicts. Sometimes the analyst is able to get at conflicts in the transference first, then relates them to the outside world (60%). Other times conflicts are worked on first in relation to the outside world then are brought into the transference (60%). Either way, conflicts are analysed both inside and outside of the transference (100%). The transference can be used to help the child become aware of unconscious conflicts. Some subjects (40%) spoke of conflicts which come into the transference which are part of the child's habitual mode of relating. Others were specific that the critical piece to this work is the transference because conflict in the transference is clearer in its form and meaning (40%). See figure 12.2.17.

![Figure 12.2.17: Conflict and transference](image)

Conflict and Interpretation

Most subjects (80%) agreed that not all interpretations made in analysis involve conflict. The one subject who disagreed used conflict in its broadest sense. This is to say that everything is based in conflict, be it affects, thoughts, development, etc. For example, even drawing the child's attention to affects he isn't aware of involves conflict in some way. See figure 12.2.18.
Subjects addressed the question of whether they always interpret both sides of the conflict. Everyone seemed to say yes and no. Some subjects (40%) said, in principal, they try to aim for this but don't always get it in. Another subject said she usually does, whereas 40% said "not always". Several factors contribute to whether both sides of the conflict are interpreted or only one. The transference is one (20%), as is what the child is able to tolerate at a particular moment (40%). In addition, as one side of the conflict is usually more unconscious, it may take longer to get at what that is. In other words, the analyst takes what is most near consciousness then waits and listens for the other side (40%). All subjects did agree they will eventually include both sides of the conflict in their interpretations as it is important to demonstrate this to the child and pull it all together. However, when the timing isn't right, pointing out both sides of a conflict may merely be an intellectual exercise which has little effect (20%). See figures 12.2.19 and 12.2.20.
Figure 12.2.20: Interpret one or both sides of conflict - Contributing factors

Whilst it is important that both sides of the child’s conflict are eventually addressed, there are times the analyst may emphasise one side more than the other in her interpretations (80%). The child’s self esteem at a particular moment may be an indicator (20%), as is what the child is able to tolerate (40%). The child’s level of development and ego strength are other indicators (60%). With young children, or ones who suffer from developmental delays, the analyst may wish to emphasise the progressive more grown up side of the child in her interpretations (40%). In addition, she may be cautious not to undo reaction-formations (20%), encourage acting out (20%), or to make the conflict experienced so strongly in the child that he has to undo it (20%). See figure 12.2.21.

Figure 12.2.21: Interpretation - Emphasise one side of conflict over another Contributing factors

Subjects were clear that conflict analysis involves the interpretation of conflict and all of its ramifications. It does not include the analyst offering solutions to conflict. The child himself, subjects thought, is usually quite capable, with the conflict analysis described, of finding solutions which are adaptive and help him move forward developmentally. However,
the analyst may, at times, wonder with the patient “What if...”, but not very often (40%) and only after other work has been done (20%). This technique may be part of working-through and reminding the child, as when the analyst says “Remember when you used to do...”. (40%). See figure 12.2.22.

Figure 12.2.22: Interpretation - Offering solutions to conflict

Conflicts Which May Not Be Addressed

Not all conflicts are part of the analytic work. For example, the analyst assesses if a conflict is appropriate to the developmental phase the child is in. If it is in accord with these developmental tasks and the child’s solutions are not causing problems, the analyst may leave the conflict alone (20%). Related to this are conflicts where the adaptation has been “good enough” and doesn’t cause excessive anxiety (20%). In later phases of treatment, such as termination, the analyst may have to leave conflicts alone which are now surfacing (20%). Other factors which contribute to the analyst not addressing certain conflicts are when interpretations would undermine adaptations or solutions which are the best the child can come up with at a given time considering environmental circumstances (40%), trauma (40%), or developmental transitions such as beginning or changing schools (40%). One subject commented that it is often very helpful to take “an informed wait and see attitude” both with children and parents in order to assess if an intervention will be required. See figure 12.2.23.
LIMITATIONS

As mentioned under definition, subjects agreed that not all disturbances are conflict based. However, there is some inconsistency in this statement. Vignettes were given to illustrate conflict which did not imply structuralisation, as the definition states (40%). For example, a conflict between the primitive anxieties of annihilation and engulfment. Whilst this may be viewed by some as conflict, the technique is not one of conflict analysis as described under means. Equally, 60% of subjects said that conflicts can be involved secondarily in a disturbance as deficits gather conflicts around them. Thus, whilst it may be true that not all disturbances originate from conflict, all subjects implied that conflict in some form is involved in all disturbances. See figure 12.2.24.

The technique in these non-conflict based disturbances is different than what has been described. All agreed that the analyst is working with deficits involving ego and object relationships development, rather than conflicts. This technique may involve ego strength-
ening (20%), building defences (40%), work with primitive anxieties (20%), creating conflict (20%), or, where adaptations to circumstances are dysfunctional, showing the child another way (20%). Once work on these deficits has been done, the analyst may approach secondary conflicts (40%). See figure 12.2.25.

Figure 12.2.25: Technique - Non-conflict based disturbance

Psychotherapy

Conflict analysis is as important in psychotherapy as it is in psychoanalysis (100%). However, 80% agreed that in psychotherapy the same depth is not achieved, nor are all of the ramifications or vicissitudes of unconscious conflict as apparent. Therefore, the analyst is apt to intervene without as much information or by relying more heavily on her hypothesis (40%), to use the here and now more without links to the past (20%), or to take a more active role (20%). In addition, the transference is not as intense in psychotherapy (20%) and the ability to work-through is curtailed (20%), both of which affect technique. Whilst the aim may be the same in psychotherapy, the pace is slower as the analyst needs to be especially careful in her approach to conflict (40%). Because sessions are less frequent, she will not be able to provide the same support and input. See figure 12.2.26.
Figure 12.2.26: Conflict and psychotherapy

- Conflict analysis important
- Not the same depth
- Rely more on hypothesis
- Slower and more carefully
- Here and now without past
- More active role
- Transference not as intense
- Less able to work through
12.3 AFFECTS

DEFINITION

When asked for a working definition of affect, all subjects spoke of the concept in terms of a feeling or a complex feeling state. Most subjects (80%) characterised affect as a range or spectrum of feelings or emotions. Responses included: all shades of feeling; different kinds of feelings which are either positive and/or pleasurable or negative and/or painful; a wide range of feeling states, some of which are useless; and a spectrum from a vague mood state to something which is intense and emotional. One subject added that affects are rooted in biology. See figure 12.3.1

Unconscious Affect

The majority of responses (60%) indicated that psychoanalysts consider affect as unconscious as well as conscious. Those who disagreed had theoretical objections. It did not make sense to them that the experience of affect could be unconscious. Instead, it is what gives rise to an affect which is unconscious. Once that enters consciousness a feeling state responds. Interestingly, these subjects added that technically they work as if affects are unconscious. Practically it seems to make no difference. See figure 12.3.2.
Signal Function

The question of whether all affects have a signal function, like anxiety, was considered. Most subjects (80%) agreed they do. All spoke in terms of signalling a defensive maneuver. One subject added that it was difficult at times to distinguish what was operating as a signal. Was it anxiety, guilt, anger, or what? Another subject concurred. She wondered "is it the anxiety which arises because of the consciousness of an approaching affect which then initiates the defence, or is it the affect itself which signals a defensive operation?". One subject who disagreed that affect has a signal function was clear that only anxiety acted as a signal, not all affects. See figure 12.3.3

The Function of Affects

When thinking about the purpose of affects or the use made of affects by a child, 60% of subjects thought affects functioned as motives in the broadest sense. One subject added "in some instances there are affects which function in a powerful way leading to mechanisms which keep thoughts, etc. out of awareness". This speaks specifically to affects motivating defence, however they can also motivate behaviour, thoughts, fantasies,
conflicts, development, or practically anything. Affect can also be used in the service of development or to increase or decrease self esteem, as 20% of the subjects pointed out. All subjects spoke of the relationship between defence and affect. See figure 12.3.4.

![Figure 12.3.4: Function of affect](image)

Anxiety and Guilt

Anxiety and guilt are two affects which hold a special place in psychoanalytic theory. Subjects in this study agreed that anxiety and guilt are affects, so would include them in a general definition. However, 80% thought each had special characteristics different from other affects which made them important and unique. Guilt and anxiety have structuralisation and developmental implications not found with other affects.

Psychoanalysts concur that the level of anxiety and type of anxiety experienced are tied up with assumptions about where the individual is developmentally (see Clifford Yorke and Stanley Wiseberg 1976 for example). A subject elaborated using castration anxiety as an example. "The analyst recognises a special quality of anxiety about bodily damage because of the particular developmental stage from which it first arises. One will be aware of this special quality, thus what the difficult conflict may be about." This comment demonstrates not only the developmental level of anxiety, but the idea that certain conflicts are linked to developmental phases and types of anxiety. This, as one subject pointed out, has diagnostic implications. Of all subjects, 40% linked the special characteristics of anxiety to development. They added that anxiety can point to many things. All agreed anxiety has a signal function and mobilises defence.

As with anxiety, guilt too was thought to be a special category because of its developmental and structural implications. Of the 80% who discussed these special characteristics, all spoke of superego development, functioning, and conflicts. Guilt is

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thought of in structural terms. One subject explained further. "Guilt implies massive personality structure has gone on and a level of development has been reached. Prior to an internalised superego a child can have social anxiety, a fear of loss of love, a fear of doing something wrong, but not necessarily guilt in its true sense." Another subject disagreed. She spoke about the development of a capacity of concern, pinpointing this to 12-18 months. Guilt would be experienced at a very young age as "you can't have concern and not have guilt". This may or may not link to an internalised superego or structuralisation dependent on the theoretical point of view. See figures 12.3.5 and 12.3.6.

Figure 12.3.5: Definition of anxiety

![Figure 12.3.5: Definition of anxiety](image)

Figure 12.3.6: Definition of guilt

![Figure 12.3.6: Definition of guilt](image)

**Development of Affects**

Not only was the development of anxiety and guilt discussed, but the development of affects in general. Whilst how affects develop is unclear, all subjects agreed there is a difference between older children and younger ones. One subject thought that children have an enormous range of affects, comparable to that of an adult. However, they don't have the experience of how they work. Even so, a child may put any affect into action even if the
conflicts, development, or practically anything. Affect can also be used in the service of development or to increase or decrease self esteem, as 20% of the subjects pointed out. All subjects spoke of the relationship between defence and affect. See figure 12.3.4.

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words or internal representation of that affect are lacking. Other subjects (40%) commented that affects are increasingly differentiated as the child proceeds up the developmental line. Therefore, a young child, or developmentally delayed child, may have "bigger feelings" which aren't yet broken down into discrete entities. Once differentiated, the big feeling may actually be several different feelings rolled into one. Certain types of affects which appear at certain developmental stages were discussed by 20%. Resentment was an example. "Resentment can be experienced at many different levels, but it has particular qualities that may be attributable or attached to certain developmental phases. If you recognise it as such it helps you to place the kinds of things the person has had to deal with." Therefore, certain affects at certain points in development have special significance and link to certain conflicts or difficulties. See figure 12.3.7.

Figure 12.3.7: Affect and development

AIM

All subjects found it difficult to talk specifically about affect as they said it related to everything else in analysis. This was particularly true when analysing the data as it applied to aims and means. In general, the analyst's aim in working with affects varied. One aim is to monitor affect, which all subjects spoke to. The type of affect or lack thereof, and changes of affect are watched continuously by analysts. This is because the child's affect is the way into other things. The aim then, is determined by these other things. For example, the aim may be related to conflict or defence or object relationships, which the child's affect guides the analyst to. Subjects indicated that they monitor affect for other reasons as well. They look at affect which arises that is not appropriate to the situation
The data also revealed several specific aims. Bringing unconscious affect into conscious awareness was an aim of all subjects. As one subject put it: "The analyst may sense that there is something, a feeling, that is kept down and defended against. The aim is to try to get at what that is." Showing the child their patterns of dealing with painful affect was noted by 40%. The importance of affect as it relates to the relationship between child and analyst was commented on by 60% of subjects. It is important to be affectively in tune with a child in order to help him feel understood, which in turn facilitates the analytic process. Another stated that it was important to establish what the patient's affective experience is and for the analyst to know what it feels like to be that person. For example: "Sometimes there are affective states that people experience that are peculiar to themselves. It takes a long time for the analyst and patient to really get hold of what the experience is. These are affective states which are difficult to find and communicate with anyone." Thus, affect is the basis of the relationship. One of the reasons for identifying affects is to nurture and develop this relationship, quite apart from any analytic work. Providing a sense of safety was noted by 20% of subjects as an important aim. See figure 12.3.9.
MEANS

Just as the aim of the analyst's work with a patient's affects varies dependent on other things, so too does the way in which she works. All subjects agreed that affect is the key to or at the center of most therapeutic work and is as important as any action or verbalisation. Without affect the analytic work would not proceed. Analyst's monitor affect. The type of affect or lack of affect can be as important as the rest of the child's material in making sense of what is presented. Whilst monitoring affect may be an aim, equally it may be a means. Work with affect paves the way into other areas to be analysed, such as conflict, defence, object relationships, transference, etc. In other words, the technique has to do not just with affect, but encompasses everything. Thus, it is difficult to separate out affect from these other things. As on subject commented, "the content which a child presents is going to be important content because of the affect". Furthermore, at the heart of the child's conflicts and difficulties is painful affect. However, as one subject noted, there are times affect is central and the analyst pays particular attention to it and there are other times it isn't because something else is in the forefront.

The data showed that the way the analyst deals with affect depends on the patient and the pathology. This means that there is no one way of going about it. One subject explained. "You can talk about the experience of affect with some kids, but not others. Some will throw out your words to get rid of them, some will take them in and go with it and feel understood, whereas other kids will take your words in but can't look or do much with it until later." The question of the timing of interventions is crucial, as well as the manner in which the analyst relates an affective experience to the child. See figure 12.3.10.
Figure 12.3.10: Technique - Affect guides the work

Clues to Affect

How is it that analysts monitor affect? What clues in the material do they look for? First of all, the monitoring of affect seems to become second nature to child analysts. Subjects thought they tended to do more with affect and watch it more closely than they were consciously aware of. Therefore, what child analysts do in this regard is such a part of them that they seldom think about it. Often it is through the supervision of another therapist that what is done implicitly becomes explicit.

In general, there were certain areas subjects were able to pinpoint and illustrate which helped them monitor or determine what the child's affect was. However, one subject noted: "It is hard to know how I know, or what makes me believe that a child is feeling something." This points to the subtleties or nuances of the material which 80% of subjects talked about. What the child presents (60%), how he presents it (40%), and the affective tone of the session (40%) are areas the analyst watches. She looks for patterns in the material of when and what affects appear (60%). One example given was when an expression of affect became so called analytic currency. "When the child used the same expressions of affect through what he did to me (celotaping analyst's hands), this became a mode from which he and I now knew what was going on (feelings of loss). It was a pattern and a repetition which became analytic currency." Patterns of affect relates to another area analysts look, what has gone on in previous sessions (100%). It is not only one session the analyst observes, but the accumulation of all that has gone on before.

Uncharacteristic reactions of the child (40%), whether an affect is appropriate to the situation (20%), and the different levels of material which present themselves (40%), as when what the child says and feels are two different things, are additional areas. The
child's associations (20%) and what the analyst knows from the child's history (20%) are two others. In other words, any material (20%) can convey to the analyst what the child's affects and experiences are. See figures 12.3.11 and 12.3.12.

**Figure 12.3.11:** Monitoring of and clues to affect - I. General

![Graph showing percentages of various factors]

Subjects were able to illustrate certain specific areas as well. These included nonverbal clues, child's play, fantasies, symptoms, how the child is with the analyst, how the child is with or what he says about other people, and the analyst's counter-response.

Nonverbal clues were mentioned by 80% of subjects and included things like body language or the child's movements. To quote one subject: "It can be a way of looking or not looking, the child's eye movements."

The child's play was discussed by all subjects. This included the way a child behaves in and with play or drawings. Through drawings a child can express affect either directly or in displacement.
The child’s fantasies, sometimes unconscious fantasy, give clues to the analyst as to the child’s affects and how they use them (60%). However, since fantasy can also be used defensively, the analyst must determine whether the fantasy is a defence against affect or an expression of affect.

Symptoms were discussed by one subject. She gave an example of a symptom of biting and the process of unraveling the multiple affects which were expressed in it.

All subjects discussed the ways a child is with the analyst and how this indicates affective states and experience. It can be how the child behaves with the analyst (40%), a sudden touch by the child (20%), or an enactment (20%). How and where the child places himself in relation to the analyst (40%) is another area analyst’s watch. For example if the child puts things between himself and the analyst. Lastly are the patterns of the way a child is with the analyst which have come to mean certain things to both of them (20%).

The child’s thoughts and statements about other people were pointed to by 60% of subjects. These may be a displacement for feelings about oneself or may link to the transference.

The analyst’s counter-response provides information as to the child’s affective state according to 60% of subjects. For example, the patient may recreate a situation within the analysis where he gets the analyst to feel like other people in his life or as he himself feels. Figure 12.3.13 illustrates the specific areas analysts look to in working with a child’s affects.

Figure 12.3.13: Monitoring of and clues to affect - Specific
Techniques - General

Whilst the analyst's techniques vary dependent on other factors, there are techniques which are applied generally to all children. All subjects talked about work with affect as a series of steps in a process. Preparatory work occurs initially (20%) and is followed by a chain of things. The steps are repeated (20%), as one subject described: "It is a series of steps and each step isn't one step, two step, but a repetition of each step. It depends on how quickly the child can go." In these steps the analyst brings in material from previous sessions (100%), especially about affects, and links this to the session at hand. The process involves building on previous material with new material. See figure 12.3.14.

Numerous techniques were illustrated. The analyst may differentiate affect (20%), acknowledge child's affect (20%), empathise with painful feelings (20%), or draw the child's attention to certain affects (20%). Furthermore, the analyst verbalises affect (60%); clarifies affect (60%); links the affect to other things (60%), eventually to the past (40%); and makes interpretations (100%). Analysts also label affect. All subjects discussed this, however one disagreed with the terminology. She said: "It is not about giving the child a word for a feeling. It is about giving a child some way of representing affect, and then being able to recognise that feeling in himself. This may be through labeling, but it is about representations not words." Analysts also look for the child's patterns of dealing with or expressing affect. These may be pointed out to the child over and over and in different ways (40%).

Most subjects (80%) talked about engaging a child's curiosity. This is done by wondering about the appearance of an affect or where it comes from. Equally, it may involve helping the child see that there are different levels, things that he isn't aware of in the back of his mind, or contradictions (40%). This relates to unconscious processes. See figures 12.3.15 and 12.3.16.
The Analyst's Questions

The analyst has questions in her mind which she may or may not propose to the child. Techniques are directed towards answering these. Included are what caused the painful affect (20%), where does the affect come from (20%), what created the situation which provoked the affect (20%), did the child have a role in creating the situation (20%), and what does the event represent from the past (20%). In addition, there are times an affect appears in a session when it is not at all clear what provoked it or what it is about (60%). The analyst and child use clues from the material in order to figure this out. One subject added, "at those times the analyst doesn't know what is going on. She will talk about the affect with her patient and hopefully that gives clues as to what is producing it. Sometimes it doesn't. We assume it is an associated affect in some way and wait for the association." See figure 12.3.17.
The Role of Understanding Affect

What is the role of understanding affect? Some subjects said it was important for a patient to feel there was someone who would understand him, especially at the beginning of treatment. This feeling of being understood arises when the analyst is affectively attune with the child (40%). Creating a sense of safety (40%) contributes as the safer a patient feels the more he begins to express certain affects, in turn feeling more understood. However, not all interventions aimed at affect, be they verbalisation, clarification, or interpretation, necessarily promote this feeling (20%). In addition, there are times the understanding of affect is problematic. It can fosters a belief system in the child that there is an all knowing person who will take over and make it all right, without the child having to put frightening feelings into words or take responsibility for himself and his treatment (20%).

It is assumed by subjects (40%) that there is an intrinsic pleasurable gain to feeling understood, apart from the therapeutic work it may lead to. There are other gains. Understanding affect helps the child feel not so alone with his affects (20%), counteracts the feeling that no one else could ever possibly feel these horrible things (20%), gives the patient the sense that the analyst acknowledges and implicitly accepts his feelings (20%), and leads to the establishment of a connection between the child and the analyst (20%). See figure 12.3.18.
Figure 12.3.18: Technique - Role of analyst understanding affect

Interpretation

Interpretation is one of the primary techniques used by analysts in addressing a patient’s affects. As affect is related to so many things, subjects discussed whether they interpret affect by itself or in relation to these other things. One subject commented that she sometimes interprets affect in relation to other things and sometimes doesn’t. Another said she usually interprets affect in relation to other things, such as defence or conflict. The majority of subjects (60%) may initially interpret just the affect, but eventually make an interpretation of the affect in relation to other things. See figure 12.3.19.

Subjects illustrated times they made interpretations emphasising the containment of affect and those times the expression of affect was the focus. All agreed it depended on the child. With different patients, ages or pathologies different things are emphasised dependent on the aim. For example, the control of affect, expression of affect, identification of feeling states, the experience of affect, or defence against affect. The degree of ego development (100%) seems to be the deciding factor between expression and containment. It depends on how far the ego can cope and whether there is an adequacy of defence (40%). Children who have overwhelming feelings and/or panic anxiety need help to contain these states in order
to feel both safe and that their feelings are acceptable (40%). The analyst tries to contain or limit the anxiety and bolster defences (20%). In addition, with some children the interpretation of affect without the additional comments about containment can lead to further acting out (20%). However, containment is not the end product in a way to cope (20%). See figure 12.3.20.

Figure 12.3.20: Interpretation - Emphasise containment or expression

![Graph showing interpretation choices](image)

It has been established that analysts monitor affect and use it as a guide. But, do they always make an interpretation or comment on the affect they observe? Subjects said “not always”. The data indicates some general guidelines. Reality is a factor to consider. Since the child needs to cope with reality, the analyst thinks about the best way to help him do this. Thus, the analyst may leave an affect alone or address it in a different way so not to leave the child feeling hopeless or helpless (20%). This applies to breaks in treatment (20%) and disappointment in parents (20%). Timing is also a factor (40%). Furthermore, because an affect is painful doesn’t mean the analyst leaves it alone. The danger in not addressing affect is that the work will not progress. However, it is important not to bombard the child which can intensify the pain (40%).

Although the affect guides the analyst, it may not be the focus at that moment. At these times the analyst will not address it (20%). If the child expresses positive affect which is obvious to both child and analyst, it doesn’t need to be pointed out (20%). In addition, when the analyst feels the affect is appropriate and recognised by the child then the analyst may do nothing with it (20%). However, these instances may be different if the analyst thinks it is important to acknowledge the affect (40%), but doing more would push the child to retract the feeling (20%). Affect is a focus and addressed when the analyst assumes something is there but it isn’t observable, such as a defence or a missing affect (20%). See figure 12.3.21.
Whilst the analyst understanding the child's feeling states may have positive benefits to the relationship and the analytic process, all subjects thought that interpretations of affect were not always experienced by the child as a relief. Some children don't want to know about their feelings. With the analyst's interpretations they feel angry, criticised, or attacked because they disown their feelings (40%). Equally, children who feel intruded upon (20%) or have overly repressed their affects (40%) can react similarly. If, in the transference, the analyst is perceived as the one who knows the child's thoughts and feelings, interventions involving affect can engender further anxiety rather than relief (20%). In addition, with young children or borderline patients interventions of this sort can lead to further acting-out of affects, which in turn intensifies anxiety (40%).

Although there are exceptions, in some cases interpretations of affect can lead to relief. Timing is a crucial element (60%). If the analyst picks up on an affect at the right moment the child can feel enormous relief. At other moments the child may not want to differentiate affects, wishes and actions, for example, and interventions increase anxiety. Several factors were delineated as to when an intervention may induce relief. One is when the affect is more on the verge of being conscious and admitted by the child (40%). In addition, how safe the child feels with the analyst in opening himself up (40%), and how safe he feels within the therapeutic situation (20%) both contribute. It should be noted, as one subject illustrated, that there are times the analyst does not want to engender relief, but to increase anxiety so it can be dealt with. See figures 12.3.22 and 12.3.23.
Subjects agreed that affects in relation to the child’s external and internal world are both addressed in the analysis of all patients, regardless of age or pathology. Subjects added that the analyst goes where the patient is (20%). The fact the child brings something from the outside world into the treatment rooms means it is a part of the analysis (40%). Whilst the analyst addresses the outside world and deals with that, she may, at the same time, look for what it means in the transference (40%). See figure 12.3.24.
**Affect and the Relationship**

All subjects agreed there is a direct link between affect and the development of the child-analyst relationship. Subjects said that the understanding of the child's affects lead to a connection and the development of a relationship, binding the child to the analyst (60%). It is this affective experience which is responsible for the building up of a relationship (40%). The affects which are the basis of this relationship then lead to a treatment alliance (20%). Thus, there is also a relationship between affect and the development of a treatment alliance (60%) as the child trusts that the analyst will try to understand him (20%). See figure 12.3.25.

![Figure 12.3.25: Relationship between affect, development of a relationship, and treatment alliance](image)

All subjects agreed there is also a relationship between affect and the transference. They added that the affective experience, often alive in the room, influences the development of the transference (60%). One subject stated that "the analyst may have little to do with the affective experience, but by the child relating this experience and the feeling of it that the child has in the presence of the analyst makes the transference work". This affective experience is one which comes in and out of the transference (20%). Also, affective states related to past relationships are repeated in the transference (20%). One subject thought the relationship between affect and transference was about the identification of problematic affects which will eventually become apparent in the transference relationship. Another pointed to how affects are handled related to stages of the transference which change over time. See figure 12.3.26.
Several methods were illustrated which contribute to the development of the transference. The analyst's affective attunement with the child builds up the object tie and eventually the transference (40%). By being explicit or as clear as possible about what the child is feeling (20%), and through the techniques of mirroring and containing (20%), the transference is nurtured. Especially in the early phases of treatment it may be important to educate the patient about the mode of conducting an analysis, as the sharing of affect is what the relationship is about (40%). The analyst looks at how the child behaves and feels towards her which often involves analysing the anxiety which these feelings engender (20%), or even the difficulty the child has in experiencing affects in relation to the analyst (20%). This is especially true with those children who keep their feelings out of the relationship as much as possible. Whilst the affect may be in the room, it is often brought in displacement or through extra-transference relationships which the analyst will address (40%), at the same time looking for what it might mean in the transference (20%). At other times, it will make far more sense to the patient to talk about the affects in the room with and about the analyst, rather than addressing something outside of treatment (20%). In addition, when the transference becomes intense, the analyst may want to relieve this intensity because it increases anxiety (20%). The danger is that the patient will begin to feel that his affects are isolated and only in relation to the analyst, thus if he leaves treatment the problems will be solved. See figure 12.3.27.
Affects can also become problematic in the transference. For example, when certain feeling states become part of a transference issue, the child can avoid or repress them (40%), sometimes because they are too close to conflict (20%). Whilst the feeling of being understood can aid in the development of the transference, what often becomes noisiest in the transference is when the patient doesn't feel understood (20%). Other problems included: times the patient keeps his feelings about the analyst out of the treatment (20%) or when the analyst becomes someone in the transference who knows what another's thoughts and feelings are which increases anxiety (20%). See figure 12.3.28.

Affect and Defence Analysis

The study on defence indicated that one of the many things defences operate against is affect (see figure 12.1.5). It makes sense that the interviews on affect would also address defence in some way. All of the subjects discussed the fact that in their work with affects one of the things they do is look for, identify, and analyse the child's defences against affect.
Furthermore, as one subject pointed out, the analyst may only see the defence and not know what affect is being kept out of conscious awareness. The work does not stop with the identification and interpretation of a maladaptive defence. The point is to find out what is causing the affect and why it needs to be defended against (40%). Thus, work on defence against affect guides the material into other areas (60%). See figure 12.3.29.

![Figure 12.3.29: Affect and defence analysis](image)

**Anxiety and Guilt**

As was discussed under definition, there is a question whether anxiety and guilt should be included under affect or merit special consideration. The data indicated that some subjects thought the techniques were the same with these affects as with all affects, and some disagreed. In regards to anxiety, 40% said they dealt with it in the same way, and 20% said the techniques used were different. The majority of subjects (80%) indicated that the technique was adjusted according to how much anxiety could be tolerated by the patient. In certain cases where anxiety was overwhelming, the analyst concentrated more on providing safety (20%), containing or limiting the anxiety (40%), or bolstering defences so the anxiety was more manageable (40%). See figure 12.3.30.

![Figure 12.3.30: Anxiety - Technique](image)
It was clear from the interviews that anxiety holds a special place in analyst's minds. As one subject stated: "The analyst is tuned into anxiety because it indicates that these areas would be especially productive to explore." For example, 40% of subjects said that anxiety points to conflict. Another 40% commented on the link between anxiety and defence as "anxiety usually implies, if it is signal anxiety, the avoidance or repudiation or attempt to ward off something". Anxiety also has a signal function which another 40% of subjects indicated. In addition, the level of anxiety guides the analyst in how confrontational she can be (20%). Furthermore, the analyst is interested in seeing the ways in which anxiety is coped with, and whether this is adaptive or not (20%). Analysts are also interested in anxiety because it indicates certain developmental phases and/or difficulties (40%). See figure 12.3.31.

When it came to guilt, 80% of subjects commented that technically they would deal with it as they would any other affect, whereas 20% thought the technique would be different. See figure 12.3.32. All subjects said they tended to think of guilt in structural terms and when guilt was evident they looked toward the superego. Guilt guides the analyst to other areas as well. Childhood fantasies, relationships, sexuality, expectations the child has about himself and the degree of harshness experienced when those expectations aren't met were all mentioned by 20% of subjects. See figure 12.3.33.
The Influence of Development and Pathology on Technique

Affect is part of everything the analyst does. Her aims and techniques vary depending on a multitude of factors. Two of these are the developmental level of the child and the degree of pathology. The data revealed that where affective development is delayed or problematic, or with the very young child; when the child's ego is immature or weak; and in certain cases where the child's self representation is distorted, specific techniques may be applied. All subjects gave clinical examples of at least one of these instances.

Containing affect was discussed by 40% of subjects. The young child, or one who suffers from a developmental delay or borderline disturbance, needs the analyst to hold his affects which are unmanageable due to a weak ego. The analyst contains affect, but equally helps the child establish self control (20%).

It was also noted with borderline disturbances that it was especially important to provide a sense of safety (20%), as unmanageable affects intensify anxiety. Establishing the signal function of affect, especially anxiety (20%), was crucial. This aided the development of defences against feeling overwhelmed (20%).

Another subject (20%) discussed the importance, specifically with borderline and narcissistic patients, but also with all patients, of establishing what the child's affective experience is. She said: "The patient experiences what he experiences, even though he may be confused he still knows what he feels. The difficulty is that what he is feeling isn't what people expect him to feel or imagine he might feel. So one spends a lot of time getting to know what it feels like to be that particular person."

With the young child, or one who is developmentally delayed, the analyst may differentiate affect (40%). With these children affects are sharper, more extreme and less discrete. Therefore, the affect feels bigger and may need to be broken down. In addition,
with developmentally delayed children the analyst may aim to give the child a way of internally representing affect (20%). Helping the child recognise feelings within himself is worked on, as well as with children who have been fundamentally misrecognised by the environment or where affect has been overly repressed (40%).

With children where the environment has not been adequately attune or where repression of affect is overused, helping the child differentiate his own affects from others is also worked on (20%). With these same children, as well as with some who have narcissistic disturbances, "loosening up" affect was noted by 80% of subjects. In other words, helping the child allow entrance of affects into conscious awareness and experience. This may be through the fostering of affective response or giving the child permission to feel certain ways. See figures 12.3.34, 12.3.35 and 12.3.36.

Figure 12.3.34: I. Influence of development and pathology on technique

Figure 12.3.35: II. Influence of development and pathology on technique - Borderline
Psychotherapy Patients

Most of the subjects (80%) thought technique varied when working with patients in psychotherapy rather than psychoanalysis. This was due to the frequency of sessions. All agreed that affects are important, but the analyst needs to be more careful in the way she approaches them (40%) because there isn’t the chance to deal with them in the same way as in analysis. The analyst is also more selective in what she picks up on (40%) as there are times the work is on a different level. Those who thought the technique was different also pointed to the importance of not leaving the child with undefended affects at the end of a session. This would also apply to analytic patients prior to a weekend or holiday. One subject added that there were times it was difficult to do this, as the patient may bring something up. In those cases the analyst needs to be sure to emphasise containment in her interpretation. Some subjects (40%) also expected much fuller acknowledgement and exploration of affects, especially in the transference, with analytic patients rather than psychotherapy ones. See figure 12.3.37.
Figure 12.3.37: Affects and psychotherapy

- Affect important
- Technique different
- Careful in approach
- More selective
- Not leave affects undefended
- Emphasis containment
- Less acknowledgment and exploration
12.4 TRANSFERENCE

DEFINITION

Subjects concurred that transference is a universal phenomenon which occurs to some degree in any and all relationships. Some subjects (40%) thought transference was an element in every relationship, and others (20%) thought of universal transference as transitory. Transference as a universal phenomenon, all subjects said, is applying the concept in its widest sense. Forty percent added that this universal definition stretches the concept in a way which is not useful to the analytic understanding of the construct. See figure 12.4.1.

Figure 12.4.1: Transference - A universal phenomenon

Transference within an analytic relationship was defined by subjects in a more narrow sense. Interestingly, the five subjects interviewed applied different metapsychological frameworks to their definitions of transference. The first was an internal object relationship model used by 40% of subjects. Object relationships from a drive perspective as “drive relating to object” was another model (20%). A third model was a viewpoint coinciding with the tripartite structural model where transference was conceptualised as the way “the ego and superego function vis-a-vis an object” (20%). A fourth a defence and affect model (20%). Whilst this subject did think in terms of internal objects, she believed that transference “is really about defence”. A fifth metapsychological was proposed by 40% of subjects. These were subjects who presented one of the models described, and a second one referring specifically to the superego and the transference of superego identifications and internalisations. The other models these subjects used were an internal object relationships model, and the tripartite structural model. See figure 12.4.2.
Whilst various metapsychological models orient analysts and aid them in their understanding of the psychic structures and processes involved in transference, there were commonalities within these models which added clarity to what subjects thought this concept meant. All agreed that transference occurs when a relationship, or an aspect of a relationship such as certain affects or attitudes, with someone other than the analyst is recreated or enacted with the person of the analyst. Forty percent said explicitly that the processes responsible for transference were externalisation and projection. In considering the theory of internal object relationships and their development, this would be implicit in an additional 40% of responses. Transference has an illusory quality (100%) which, to the child, is real and immediate, as he experiences the analyst in a way which is a distorted view of who the analyst actually is. As transference is an unconscious process (100%), the child is not aware that his experience of the analyst is transference. According to 80% of the subjects, children of all ages experience transference in psychoanalysis. The other 20% agreed with this general approach, but with qualifications. This subject thought young children do not transfer in the specific sense described. See figure 12.4.3.
All subjects agreed that what is recreated in the transference are relationships with significant people from the past. However, other relationships are transferred as well. Eighty percent spoke of the transference of the child's present, current, or ongoing relationships. The other subject spoke of this as well, but specifically from an internal model. She explained that internal object relationships are reinforced by external and current experiences on a real basis and in an ongoing way. Furthermore, children elicit a certain response from people in their environment, transferring old patterns into the present onto external objects, as a way to hold onto an early experience. This is not specifically the transference of a current relationship, but the transference of an internal relationship in interaction with the external world. Internal relationships, be they object representations or interactions between self and object representations, can be transferred (40%), as can self representations (20%). In addition, superego identifications and internalisations (40%) and unconscious fantasies (60%) are subject to the process of transference. One subject also thought that situations could be transferred, not only relationships. See figure 12.4.4.

![Figure 12.4.4: What is transferred](image)

Transference is the major vehicle for the analytic work. Sixty percent conceived of it as a tool. Transference is the way in which the analyst is able to understand the relationships a patient has, be they internal or external or both. Sixty percent spoke of how these relationships are more analysable once they enter the transference. One subject commented that when a child talks about the relationships he has outside of treatment, it can be confusing what the other person is doing and what the patient is doing. In the transference the patient's contribution becomes clearer. In addition, once the emotional link is with the analyst and significant relationships are transferred to and recreated with the analyst, these relationships come alive in the room (60%), are thereby made current in the child's life (40%), and defence is less available (20%). See figure 12.4.5.
AIMS

The analyst uses the transference as a way to understand the nature of the child's relationships (100%), his difficulties (40%), and what is going on within the analytic process (20%). The analyst aims to exacerbate and cultivate the transference in order to make use of it (20%), to focus the transference on her (20%), to bring the child's major anxieties and problems into the therapeutic relationship (20%), and to facilitate the transference (20%) through the acceptance of the patient's perceptions of her (100%).

Further aims include: strengthening the child's observations of what is happening (20%) thus helping him become aware of the transference (20%), and bringing the unconscious meaning of the transference, for example the fantasies and internalised objects, to conscious awareness (20%). If the pattern which is being repeated in the transference is ego syntonic, the analyst aims to make it dystonic (20%).

It was evident in the comments and illustrations that subjects provided that not all aspects of the child's relationship with the analyst are transference. Thus, the analyst attempts to differentiate transference from these other elements (80%), although this can be difficult to do (20%). See figures 12.4.6 and 12.4.7.
The transference is used in child analysis to ameliorate changes in the child. All subjects commented on outcome aims related to shifts or alterations in the child’s relationships. This included shifts in internal relationships (80%), external relationships (80%), the child’s perceptions (20%) and projections (20%), the psychic balance so as to help relationships (40%), and the modification of overly harsh introjects (20%). Further aims included the child’s ability to accept his own feelings and the reasons they occur (20%), increased self esteem (20%), developmental progression (20%), and offering the child more of a choice and control in terms of conflicts, relationships, and the way he wants to be (20%). See figure 12.4.8.
Transference is a major vehicle for the analytic work and a tool the analyst uses in order to understand the child and ameliorate changes. The transference is a way to understand the child's relationships with both internal and external objects and the self, conflict, fantasy, defence, and any number of analytic constructs and processes.

Transference and the Beginning of Analysis

In general, subjects agreed that transference is something which gradually develops in treatment, rather than being evident from the beginning (80%). There are exceptions. For example, if the patient changed from one analyst to another (20%), or as a result of the move from diagnostian to analyst (20%). Another subject (20%) commented on the concept of "ready-made transference".

Whilst all agreed that it is crucial to develop a relationship with the child, this in and of itself is not transference. The analyst will tend to wait for the transference to begin to show itself and become clearer (80%). Whilst one subject stated emphatically that she does not assume that the child is talking about her when he begins to discuss his worries about other people, all subjects spoke of their interest in how the child relates to her from the first session. This does not necessarily mean that the analyst will comment on this, rather she observes the child's style of relating. The analyst attempts to recognise the first role the child puts her into which could be an early manifestation of transference, or a "transference
warning" (20%). She may take up the child's perceptions of her (20%), or even make an interpretation, however it will not be a "deep interpretation" as the analyst lacks evidence for such an endeavor (20%). See figures 12.4.9 and 12.4.10.

![Figure 12.4.9: Transference and the beginning of analysis](image)

![Figure 12.4.10: Transference and the beginning of analysis - Exceptions](image)

Distinguishing Transference From Other Aspects of the Relationship

Eighty percent of subjects agreed that not all aspects of the relationship to the analyst are transference. Another subject used transference in its widest and most universal sense, seeing all aspects of the relationship to the analyst as containing transference elements until "the analyst discovers they don't, which she never does". In other words, the analyst acts and works on the basis that the child's manner of relating to her has links to the past. However, all agreed it is important to distinguish transference from other aspects
of the relationship the child has with the analyst, a process which occurs as child and analyst progress in treatment (40%). In reality this can be difficult to do (20%), and with some children it is very confusing what is what (20%). See figure 12.4.11.

Three components to the relationship, other than transference, were delineated by subjects. All spoke of habitual modes of relating, 40% discussed the analyst as a real object, and 20% pointed to the analyst as a new object. No one spoke about the treatment or working alliance. These results are thought to be influenced by the interview, rather than the subject’s conceptualisation of the entire relationship between analyst and child. As this interview was about transference, most questions and illustrations pertained specifically to that. Subjects were asked whether they differentiated different components of the relationship, specifically habitual modes of relating, but were not asked to address themselves to other aspects of the relationship. See figure 12.4.12.

Eighty percent of subjects do make a distinction between habitual modes of relating and transference, 40% adding this was not transference in the sense they were describing. Other comments about habitual modes of relating included: it is quick to develop in the
relationship with the analyst (20%); it is the transference of attitudes (20%); it is the consistency with which a child puts himself in a certain position all of the time and acts in a certain way (20%); and, it is the way the child feels about and perceives himself (20%). One subject wondered whether habitual modes of relating are actually changeable or constitute the "bedrock". Whilst the interview did not address the technique of analysing habitual modes of relating, some subjects commented on this. They said: the analyst looks for patterns in how the child always feels when met with similar situations (20%); it takes a long time to analyse (20%), and the technique is different (20%). See figures 12.4.13 and 12.4.14.

The analyst as a "real object" was discussed by 40% of subjects. One commented that she didn’t see how analysis could work if there wasn’t an aspect of a real object in the relationship with the analyst. Another thought the use the child made of the analyst as a real object was one of the universal aspects of transference. In other words, what the child picks out from the real object has transference aspects to it. See figure 12.4.15.
Clues to Transference

The analyst looks for various indications in the material and the child's style of relating which assist her in the determination of whether the transference is showing itself and what it might be of. First and foremost is how the child relates to or behaves with the analyst. Of interest to the analyst is: whether the child's attachment is with the analyst (20%); how he behaves and relates with the analyst (100%); patterns or repetitions in the manner of relating to the analyst (60%); the child's curiosity about (20%) or questions of the analyst (20%); and responses to separations (20%). The analyst also pays close attention to the child's expectations of her (40%) and the roles he assigns to her (60%). These include the child anticipating the analyst will react in a certain way; expecting the analyst to be like a certain person or to act in a certain way; or when the way the child is addressing, relating to, or behaving toward the analyst is not how the analyst is thinking, feeling, or behaving toward the child. Thus, the analyst looks for those behaviours or affects coming from the child which are incongruent, inappropriate to the situation, illusory, or distorted (100%). The analyst also watches the child's affect. These clues to transference include feelings focused on the analyst (60%); when new affects are brought in about the analyst which haven't come in before (20%); and changes in affect (20%). The analyst's counter-response (60%) also provides clues to the transference. See figures 12.4.16 and 12.4.17.
Whilst the interaction between analyst and child provides the greatest clues, subjects pointed to other areas as well. How the child relates to other people or talks about these relationships is important (40%), as are the repetitions and patterns of these relationships (60%). How the child relates to himself (40%), changes in affect (20%) and in the child’s presentation from one session to the next (20%), as well as the content of the child’s play and dreams (20%) are also indicators. See figure 12.4.18.
Facilitation of Transference

Subjects were split in their responses as to whether they "facilitate" a transference or not. Sixty percent said they do. Forty percent thought it impossible to facilitate a transference as it is something which develops naturally on its own. As one subject said: "Kids do it on their own, with or without the analyst's help. Transference isn't really about what the analyst does." The word "facilitate" may be a matter of semantics, as all subjects illustrated things they do which focuses the treatment on the transference. Two aspects to this process were evident. First, 60% spoke of their own thought processes and observations. They keep the transference in mind when listening to a child. The analyst stays alert to what is happening in the here and now with the analyst, and wonders how she fits into what the child is talking about and/or enacting. In addition, all subjects demonstrated the ways they bring the child's material into the relationship by "talking to the transference", and drawing the child back to the analyst when his material is going away from her or when the transference is out of the child's awareness. Everyone was clear this did not mean merely adding "and me", rather bringing the analyst in when it was indicated and relevant.

There are other things analysts do which influence the development of the transference. The setting and how the analyst offers herself is one (60%), as the patient begins to trust the analyst. Defence analysis can also contribute (40%). On subject disagreed that transference develops, rather "it just happens. It is a question of recognising what is inappropriate." See figures 12.4.19 and 12.4.20.

Figure 12.4.19: Facilitation of transference
The transference has developed when the affect and attachment is with the analyst, and the child attempts to put the analyst into a certain role as indicated by transference clues. As the transference becomes more evident and focused, the treatment situation and analyst become more and more important as the child brings less from the outside world (60%). As the illusory quality increases, one subject commented, hopefully the child’s self observing capacity is also increasing. Whilst the transference can be threatening and shaming to some children, it can also be supportive as the child perceives that scary things can be contained with the analyst (20%). See figure 12.4.21.

Transference and Technique

Many general techniques were discussed and illustrated by subjects. First of all, the analyst creates an atmosphere conducive to transference analysis (80%). Through the setting and interpretations it becomes safe for the child to talk about the analyst and bring the transference in. It is important that the analyst not direct the material, but at the same time not block it either (20%). Timing is a factor, as one subject said: “Everything evolves
around timing, when the timing is right to pick something up and what the child is able to hear at any given moment." The analyst may initially address an aspect of what the patient brings, in order to comment or demonstrate something to the patient (20%). She follows the child's associations (20%). Using light humor (20%) in her approach can be helpful, especially with those children who are fragile or experience comments from the analyst as threatening. The analyst clarifies what the child is doing (20%), perhaps in his play or in relation to the analyst, and explores the child's perceptions of her with the aim of finding their origins (20%). Work with the child's defences (60%) is also part of transference analysis, as interpretation of defence uncovers affects about or perceptions of the analyst. Of note is when the analyst's timing is off, which results in a reinforcement of defences or anxiety.

All of these interventions assist the child in bringing further material, add clarity to the transference, and intensify it. Through her interventions the analyst brings the unconscious meaning of the child's perceptions and/or fantasies of the analyst into conscious awareness (60%).

The analyst also makes interpretations (100%). There are many types of transference interpretations. Examples given included an interpretation linking the child's material to the analyst and the transference; an interpretation which conveyed an understanding of the child's relationships to his internal and/or current objects, or his superego identifications and/or internalisations; and an interpretation of the child's enactments with the analyst. The analyst observes whether there is confirmation in the material of her interpretation (80%). Confirmation signs may include changes in affect, anxiety levels or defence, and the child bringing further material about significant relationships. However, the latter may also mean a flight away from the transference. See figures 12.4.22 and 12.4.23.

Figure 12.4.22: Technique - I. General

![Figure 12.4.22: Technique - I. General](image-url)
Resistance is also an element to consider in this process. All subjects agreed that not interpreting transference can lead to resistance. It is not only the lack of interpretation, but the recognition of transference which can lead to resistance. One subject gave an example where the child’s resistance intensified because of his shame at the realisation he was repeating infantile wishes and relationships. Equally, resistance is to be expected (40%) as somewhere in the core of the child’s pathology is an inhibition, fear or restriction of some kind to developing a relationship, or defences against closeness, all of which become part of the analysis and the transference. See figure 12.4.24.

By definition, transference is an enactment of some relationship with the analyst whereby the child perceives the analyst to be a certain way, or even actively attempts to put her in a certain role. All subjects conceptualised the process of transference in this way. When this occurs in the child’s play, the analyst may take on the role assigned to her until she understands what it is about, then step out of the role and make an interpretation (40%). In general, the aim is to interpret rather than accept the role the patient unconsciously assigns the analyst (100%). See figure 12.4.25.
As the transference shifts (100%), sometimes quite rapidly (60%), and changes at different stages of the treatment (40%), the analyst attempts to keep track of who she represents to the child at any given moment (60%). At times, said one subject, this is an extremely difficult process. In addition, 40% of subjects demonstrated that the transference may not be constant, but something that comes and goes. See figure 12.4.26.

What is crucial and central to working with the transference is the child’s affective experience with the analyst (100%). The analyst allows the child’s affects to be imposed on her and tolerates their intensity (40%). This speaks to the issue of working in the transference, rather than focusing on outside relationships and displacements. All subjects spoke to this. Analysts work with the feelings in the room, keeping the intensity with themselves as much as possible. This occurs once the child is established in treatment and the transference has begun to develop. At the same time, said one subject, there are times
the transference is too immediate and threatening and the child may need space to talk about "out there". At those times the analyst may leave the transference alone using what the child is capable of bringing. Timing, once again, is a factor (20%). See figure 12.4.27.

Figure 12.4.27: Technique - Affect

Developmental Level of the Child

Most subjects (80%) look at transference within a developmental context. This includes an assessment of many lines of development, but specifically the level of object relationships and defence. These same subjects agreed that developmental aspects assisted them in their understanding of transference and influenced their technique. The one analyst who disagreed said her understanding of transference was the same with all children, thus was not influenced by a developmental point of view, and her technique was not altered dependent on the child's age.

Whilst this developmental viewpoint was important with children of all ages, subjects spoke specifically about children under the age of five. Eighty percent agreed that these children exhibited transference manifestations in treatment, some of which were quite intense and immediate. Twenty percent stated under fives "do not form a transference in a specific sense". Eighty percent thought there was some variation. Primarily, the differences relate to the importance in a young child's current life of his primary caregivers. More than with older children, external objects remain crucial to the young child's developmental needs in an ongoing way. Thus, the immediacy of the analytic experience can be greater. Unlike an older child who is able to keep objects more separate, the younger child tends to blur his objects and roll them into one. Therefore, the analyst is more inclined to address the external objects in addition to the transference, in an ongoing way. One subject disagreed. She said: "Not working with transference in the way I have
described, even with young children, is an avoidance by the analyst. Young children also have a past. You can see how the child perceives that a parent behaved toward him when he was younger." See figures 12.4.28 and 12.4.29.

Answering Children's Questions About the Analyst

Eighty percent of the subjects will answer their patient's questions about them sometimes, depending on what they are. Forty percent added that there are some questions they will never answer, a decision that is not based on the analytic meaning of the question, but because the question is too personal. Twenty percent said they never answer questions.

All subjects agreed on the aim in approaching a child's question. What is important is the fantasy which prompts the question, not the question itself. In one way or another, the analyst will attempt to get the child's associations, thoughts and fantasies about her. The differences are in the way the analyst does this and why. One subject, who does not answer questions, "throws the question back to the child and lets the fantasy grow". Another subject might ask for three guesses from the patient. The other 60% spoke of striking a bargain with the child. They might tell the child they will answer, but first attempt to elicit
the child's related fantasies. Sometimes the child will no longer want or need an answer, but sometimes he does. These methods do not apply all of the time. All subjects agreed there are some questions they do not answer if there is evidence in the material that it is contraindicated, and/or the child's fantasies are available.

Those subjects who will answer some questions do so because not answering is often taken by the child as a tease or is hurtful. One subject commented that the child's ability to handle not hearing an answer is related to his level of frustration tolerance. Others (80%) said that when a child is hurt by the analyst's refusal to respond, he often withdraws and/or the fantasy is never revealed. See figures 12.4.30 and 12.4.31.

Correcting Children's Distortions About the Analyst

Usually, all subjects said, they do not correct a child's perceptions of them. As one subject commented: "The way the child sees his analyst is the point of the transference. That is what you work with." There are exceptions. One is when the child's level of anxiety becomes overwhelming (60%). The other has to do with instances when the patient's reality testing is either lost, or not very good to begin with (40%). In these cases, according to
subjects, they will correct the patient's distortion, but in the form of an interpretation. The aim is to use the child's perceptions of the analyst to demonstrate to the child that it is coming from inside him. For example, the analyst may say "You have lost the feeling that I am not that other person, but...", or, "I'm not angry with you, but you seem to feel that I am because...". See figure 12.4.32.

Figure 12.4.32: Correcting child's distortions of the analyst

Transference and Displacement

When is it that the child is talking about the analyst and the transference in displacement, and when is he actually talking about other people and there is no link? How does the analyst make this determination? Four areas were pinpointed in subject's clinical examples. First has to do with the relationship (100%). For example, once the child is moving out of the beginning phase of the analysis, is settled in treatment, and a relationship and alliance has begun to form. Trust and sense of safety are additional factors. Second is affect (100%), when the child's affect is with the analyst, changes in affect, and new affects making their appearance for the first time. Third is patterns and repetitions (80%). Is what the child brings something which comes up again and again? What are the patterns of his responses, behaviours, attitudes, and affects? Lastly, the analyst looks at the context in which the child brings his material (60%). Are there things in the material which would identify what the child brings as a displacement? One example given was a child who complained, after seeing his analyst with another patient, about a peer whom he thought was the teacher's favourite. One subject added that what a child brings may be both a displacement of the transference and a reality, or an interaction between the two. See figures 12.4.33.
Linking the Transference to Other Objects

Related to displacement, but of a different nature, is whether or not the analyst keeps her interventions in the transference. In other words, does she only talk about the child and her, or does she link her transference interpretations to other objects. Links to internal and external relationships were both examined.

Sixty percent of subjects spoke of eventually making links to internal objects and/or fantasies. Another subject also agreed, but qualified this saying that it had to do with the defences of externalisation and projection. Yet another subject said “yes and no”. She added: “Whether I make an interpretation related to an internal struggle or pick up on an object relationship (external) struggle, depends on what the material is presenting.” See figure 12.4.34.

All subjects addressed the topic of whether they make links to external relationships, either past or present. Eighty percent said they would eventually, whereas 20% said it varied. This subject added “kids will tend to do this on their own”. Those who concurred explained that they don’t from the beginning, aiming to keep the intensity with the analyst, but eventually it is important. As one subject said, “otherwise it isn’t a complete transference
interpretation”. Children need to come to an awareness, another subject added, of the powerful impact past relationships have on their present lives. Forty percent included a word of caution. There are times, they said, that linking the transference to the past is contraindicated because it removes the intensity from the analyst too soon, dilutes the transference, and can be taken by the patient as a rejection. Another spoke of a child where it was important to link the transference to other people in the child’s life because of problems with reality testing. In the transference the quality of “as if” was lost. Once further work was done on conflicts over aggression and projections, his reality testing strengthened and the “as if” quality was restored. See figure 12.4.35.

Figure 12.4.35: Link transference to external object - Past or present

This topic was explored further. Was it important to link the transference to the past by the end of analysis? Again 80% said yes and 20% said it varied. As one subject commented: “By the end of treatment one wants to make links to the external world, real objects, and significant relationships from the past because that is the real world and those are the real and internalised objects. That is the place in which the child lives.” However, another subject made the distinction between internal objects and external objects. She said if the transference was of an internal object, it wasn’t necessary to take it back to the original objects because the internal shift happened on its own. The one subject who thought it varied said: “When the patient reaches a level of comfort with his feelings toward the analyst, the transference will usually follow. Once difficulties are worked through in the transference, which facilitates shifts in the child’s internal relationships, shifts in his external relationships will automatically occur.” This subject did think it important to make links in certain cases, for example with young children and with traumatised children, because of the need to address the reality of their experience. See figure 12.4.36.
The Resolution of Transference and Termination

What do analysts mean by “resolution of transference”? Eighty percent described this phenomenon as a different relationship with the analyst. The analyst is no longer the transference object (20%), or the patient begins to see the analyst in a new light “for the person she is” or as a “real object” (60%). Another subject thought resolution of the transference meant that the child had a different relationship and different way of responding with himself, his internal world. Yet another 40% defined this as a different relationship and way of responding with the outside world, seeing parents or significant people as real objects or for who they are. One subject made the philosophical comment that “nothing is ever resolved”. See figure 12.4.37.

This so called resolution of the transference is a sign that the termination process is beginning. It isn’t that the transference is resolved prior to termination, rather the resolution may come about during the termination process. A different kind of relationship with the analyst, or seeing the analyst in a different way, may be indicators that termination is appropriate. As the child naturally moves away from the analyst and the analytic process
(80%), the analyst becomes less important to the child, whereas friends, outside activities and interests become more important. Not only are different kinds of relationships brought into treatment, but different levels of development (20%). Furthermore, the child internalises the functions of the analyst (20%). One subject spoke of the subtle changes in the analyst's technique. She added: “The omnipotent idea of the analyst isn’t the one you want the child to go away with. That belongs to the area of childhood disappointments”. Ideally, said all subjects, the transference should be resolved. See figure 12.4.38.

![Figure 12.4.38: Transference and termination](image)

**LIMITATIONS**

With certain patients variations in the technique are indicated. Four categories were delineated from the data. First is the importance of taking reality into account (40%). For example, if a child has been traumatised in some way, one subject illustrated, it is especially important to link the transference with the external object in order to assist the child in organising his internal and external world. Another subject spoke of the difference between real and fantasied objects. If a parent is unreliable, for example, the issue is not only about the externalisation of an internal relationship, but an external and current relationship as well. It is important to support reality, but not at the exclusion of interpreting what lays behind the reality and how it fits in with the child’s pathology.

The child’s level of pathology is another area. Forty percent of subjects talked about borderline or very disturbed children. With these patients the analyst works with different tools with the aim of building up one part of the intrapsychic structure. This could be the ego, as the analyst works on building defences and bringing anxiety to a signal level. However,
these subjects did think that transference played a role in the analysis of these children. The child’s object relationships are involved in the transference, for example in fears of merging or being taken over by the analyst. In these instances, the analyst goes very slowly and carefully.

Perhaps related to severe pathology, but not necessarily, are instances where there is a splitting of the transference (20%). For example, as the transference develops the analyst becomes the good object and the parent is the bad object. This situation is not one the analyst aims for. Whilst it may make for a strong alliance, it is temporary. Once the transference split shifts, the analyst becomes the bad object and the alliance dissipates. This work requires maintaining a delicate balance, and slow and careful work on the part of the analyst.

The other area found in the data were instances where a way of relating, or a wish for the object and self to be a certain way, was ego syntonic (20%). In these instances the analyst may need to create conflict first, followed by reducing the judgement which is attached. See figure 12.4.39.

Figure 12.4.39: Transference - Factors leading to variations in technique

Not only were there cases where variations in technique were indicated, but ones where the transference was not a part of the analysis, at least initially. Five areas were delineated. First, once again, had to do with reality (20%). When the environment is chaotic or traumatic, the aim is to contain the child within the session. When there is a lack of containment, therefore little ability to think about much, the transference is difficult to bring in and often contraindicated. This relates to the second area, a lack of safety (20%). When a child can’t feel safe, he won’t develop a transference. Related to the second was a third area, the child’s anxiety (20%). As one subject explained: “When behaviour is anxiety driven, for example the child who wants only to exhibit or masturbate, there is not enough structure to form a proper transference.” The child feels too anxious to feel safe enough to bring the transference. The technique, then, involves the safety and consistency of the setting.
The fourth area has to do with reality testing (20%). When fantasy and reality are blurred for a child, the analyst's approach is one of anchoring the child in reality. "Initially the transference may not be helpful."

Finally, a transference may not develop because of the child's pathology. In the example of an atypical disturbance (20%), one of the aims was to facilitate a relationship and increase the child's curiosity about the analyst. This was not about transference. The child did not see the analyst as a complete object, but as one who only served a function. See figure 12.4.40.

![Figure 12.4.40: Transference not a primary tool - Examples](image)

**Psychotherapy**

When asked about psychotherapy patients as opposed to patients in psychoanalysis, all subjects agreed transference remains a crucial element and a tool. Forty percent said they work the same way with the transference. Sixty percent said it varied from case to case, and 40% added it was more difficult to work with the transference non-intensively. One subject commented that in psychotherapy it is more important to keep the feelings and intensity in the room and in the transference because of the danger of the transference overflowing between sessions and interfering in the patient's life. For those who said it varied, the issues seem to be how attached the patient can become (20%), and how well the child can hold his affects within the relationship from session to session (20%). If the child can't, technically the analyst must handle the transference differently. Otherwise defences are continually reinforced and the treatment never goes anywhere. The stated reasons for the increased difficulty were keeping the affects within the transference to prevent overflow (20%), and that the transference can take longer to develop (20%). In regards to the latter, this subject thought the analyst had to be careful not to make false assumptions, had to "stir up the transference" from time to time, and be cautious not to take it up too early. See figures 12.4.41 and 12.4.42.
Figure 12.4.41: Transference in psychotherapy vs. psychoanalysis - The analyst's technique

- Same
- Varies
- More difficult
- Keep in T vs link
- Not make false assumption
- Stir up T
- Not take T up too quickly
- T takes longer to develop

Figure 12.4.42: Transference and psychotherapy - Contributing patient factors

- Ability to attach
- Ability to keep affects in transference
12.5 OBJECT RELATIONS IN THE CLINICAL CONTEXT

DEFINITION

This interview began by asking subjects for their working definition of object relations. Sixty percent defined the concept from an internal perspective, 20% spoke of relationships to people in the environment (external), and 20% included both an internal and external perspective. See figure 12.5.1.

![Figure 12.5.1: Definition - Object relations as internal, external or both](image)

When asked specifically about internal and external object relations, all spoke of external object relations as relationships with people in the environment. For example, subjects said “the emotional relationship the child establishes with significant people in his environment” or “the real object the child relates to in the real world”. In regards to internal object relations, 40% also framed their responses in terms of relationships. One defined the term as “the internal representation of relationships, both past and current”. Another was more explicit. She said: “The external object relationships which have been taken in and modified by a variety of factors.” This topic of modification will be returned to later as it became clear that all subjects agreed there was modification. Another 40% spoke, not of relationships, but of objects or people, as in “the internal or mental representation of significant objects”. The remaining 20% did not think in terms of internal objects, but of the fantasies of objects. This subject believed the internalisation of objects was the superego.

Subjects had more to add to their definitions of internal object relations. Forty percent said internal object relations were about the child’s personality and character. Most (80%) thought not only objects were part of internal object relations, but the internal representation of the self. As one subject said: “The relationship to the self is also an object relationship. You can’t exclude the self when you talk about those.” See figures 12.5.2 and 12.5.3.
All subjects concurred that the internal object relation is different from the external object relation. This is due to the way in which internal object relations, or as one subject discussed, the fantasies of objects, develop. There is, however, an interplay between the two as 80% said internal object relations affect the way in which external objects are perceived. See figure 12.5.4.
The Development of Internal Object Relations

Subjects were asked to consider the ways in which they thought these internal object relations developed. It begins, said one subject, prior to birth as the baby is “pre-programmed to be an object related social animal”. All subjects outlined the process as originating in the mother-infant dyad. The beginning internal representations, thought 40%, are the perceptions and affective states experienced vis-a-vis the rudimentary image of the mother. This is at the “core” of an internal object relation. Other subjects described the beginnings of this development as related to the mother’s ability to be intune with her baby (40%), and growing out of a basic sense of safety (20%). See figure 12.5.5.

The development of internal object relations is a gradual process. One subject explained, as she talked about the core representation, that there is not just one representation of an object. Different representations of the same object come about with different experiences. They “cluster” around the core eventually building up a multifaceted picture. All subjects described the building up of internal representations or additional ones being
added, as experience deepens (40%), as the child’s relationships expand (40%), and as his capacity to take in perceptions develops (20%). Once structuralisation occurs, thought 60%, these representations were fairly permanent. See figure 12.5.6.

There are a multitude of factors which go into the development of internal object relations. All agreed the ongoing experiences and interactions with others is one. The facilitation by people in the environment of the child’s capacity to link words with affects or reality (60%), the ways in which others meet the child’s needs (40%), the primary caregiver’s “mirroring function” (20%), and the parent’s conscious and unconscious modes of relating (20%) are others which come from the outside world. It is not only what comes from the environment which contributes, but as the child develops internal object relations there is an interplay between inner and outer. This is the interaction between the child’s internal representations and his external relationships (60%). See figure 12.5.7.
Things coming from the child and his internal world also contribute to the development of internal object relations. The list gathered from the data was extensive. Those areas which were identified by more than one subject included: fantasy (5), affects (3), drives (3), wishes (3), aggression (2), cognition (2), conflicts (2), identifications (2) and misperceptions (2). Nine other areas were identified by only one subject. They were: attitudes, the capacity to understand, changing needs, expectations, fears and anxieties, hopes, projections, a sense of safety, and values. See figure 12.5.8.

![Figure 12.5.8: Development of object relations - The child's contributions](image-url)

The Modification of Internal Object Relations

Internal object relations are modifiable through the process of psychoanalysis. Indeed, subjects agreed, this is one of the aims. But, do modifications occur during the course of life? All subjects said they do, but sometimes not easily (80%). The question seems to be how modifiable are they and when? At some point, thought 80%, internal object relations become set and are no longer modifiable. They become “the bedrock” or take on such a life of their own, “feeding on themselves”, that they are no longer amenable to change from the outside influences which are part of everyday life. As one subject said: “Internal object relations begin to define and limit other relationships, rather than being modified by them.” See figure 12.5.9.
Figure 12.5.9: Modification of internal object relations through the developmental process

Just as the daily input from the environment and relationships impacts the development of internal object relations, so too does it modify them. The developmental process itself contributes to modifications, as do moves from one developmental phase to the next as each phase carries with it object relationship tasks. All subjects commented on these. In addition, ways of interacting with objects, be they internal or external, which are more primitive, inappropriate, or no longer work, are modified and integrated according to 40%. The process of “looking at, re-evaluating and understanding the role of self in an internal dialogue” can also contribute to modifications (20%). In addition, bereavement (20%) and the development of ego functions (20%) play a role. See figure 12.5.10.

Figure 12.5.10: Modification of internal object relations through the developmental process - Contributing factors

The Relationship Between Object Relations and Fantasy

As fantasy plays such a major role in the development of object relations, subjects were asked what the relationship between these two was. All thought there was a relationship and that it was more than the contribution by fantasy to the development of internal object relations. Twenty percent thought the internal object relation was the fantasy and another
20% said they were “bound together”. Forty percent saw object relations as the background for fantasy. As one subject said: “A fantasy can’t exist without an object relation. Even if a fantasy doesn’t look like an object is involved, it is in some way.” Another 40% spoke of the interaction between the two. In this view object relations determine fantasy and fantasy contributes to object relations. See figure 12.5.11.

The Relationship Between Object Relations and Conscience

Subjects were also asked about the relationship, if any, between the development of conscience and object relations. Again all subjects agreed there was a relationship. One subject reiterated her initial definition that internalised objects were the superego, which is conscience. The remaining 80% had used a model of internal representations and relationships in their definitions. However, when it came to this question, 60% conceptualised conscience in terms of superego. Thus, subjects flipped to a different, but perhaps related, model of internal structures. One subject related these two models. In her conscious mind she unites them as she said: “I think a lot about how internal object relations affect and have affected the development of the ego and superego, and how all of these are incorporated into structure.” It was unclear whether the other 40% unite them as well within their preconscious working models, or whether they use two different models dependent on what they are talking about. Only 20% thought conscience was a part of internal object relations and did not speak of the superego. Figure 12.5.12 illustrates these analyst’s models of internal structures and their relationship with conscience.
Subjects went on to outline those things which contribute to the development of conscience and the processes involved. Internalisation is one process. What is acceptable to others (60%), parental strictures (20%), and things about the self which are perceived to be loveable (20%) are internalised. Identifications with authority figures (40%), the incorporation of others (40%), and introjects (20%) are also contributors. In addition, subjects said; the child’s narcissism is at the core of conscience (20%), socialisation is an aspect of the development (20%), and the protective aspects of the internal object relation becomes part of the protective function of the superego and conscience (20%). See figures 12.5.13 and 12.5.14.
This data begs the question of the difference between the processes of internalisation, identification, incorporation and introjection, however this distinction was not pursued. Regardless of the distinction, or the model of structures subjects employed, all agreed that something from the outside world was taken into the inner world of the child and contributed to the development of conscience. All agreed this was a gradual process. Eighty percent made a point of adding that sooner or later these aspects of others became a part of the child. For example “the other’s voice becomes the voice of the child” or “identifications with others become part of the self”. See figure 12.5.15.

The Function of Internal Object Relations

Subjects agreed that internal object relations impact many areas of development, relationships, and the formation of the child’s personality. They also serve multiple functions. The ones delineated from the data can be broken down into the categories of relationships, self, autonomy, structuralisation, and organisers.
First of all, internal object relations serve the function of helping the child use, make and understand relationships (80%). In addition, they are used in the process of building up the self (60%). Related to both of these is the use of these relations in the development of autonomy (60%). The internal representation of mother, for example, provides the child with a sense of security and assists him in managing when the mother is not present. As the representation of self begins to take over functions of the internal and external objects, the child is increasingly able to function independently and his sense of autonomy increases.

All subjects commented on the role of object relations in the development of psychic structures. Some called these internal object relations “the mental furnishings”. Others spoke of these relations affecting the development of ego and superego, all of which are incorporated into internal structures. Eighty percent also referred to internal object relations as organisers. They provide the child with a way of organising his world, or act as “mental signposts” guiding the child in the way he understands, feels, acts or reacts, or in what he expects. Furthermore, internal object relations provide the child with a way of anticipating and mastering. See figure 12.5.16.

![Figure 12.5.16: Function of internal object relations](image)

AIMS

The outcome aim of analytic work with object relations involves impacting change in some form on both internal representations of self and objects, and relationships with those in the external world. All subjects spoke to this. The aim, they said, is to modify internal object relations, and to change the interplay or relationship between self and objects (internal and/or external). One subject added: “You can’t change problems with external objects without addressing problems in the self.” The integration of various aspects of internal self and object representations, both positive and negative, is another aim outlined by 40%.
Another 40% thought, with the resolution of conflict and problems in object relations, the child was afforded a greater opportunity to make choices, to change, modify and develop. Additional outcome aims delineated from the data included: returning the child to a path of "normal" development (20%), and assisting the child in building up a solid sense of self and internal objects which are benign (20%). See figure 12.5.17.

The intermediary aims included first and foremost bringing those aspects of the child’s relationships to self and others which are causing him problems into his conscious awareness (100%). Helping the child gain control through ownership, as opposed to the idea that others are to blame (60%), and increasing the child’s recognition and acceptance of all that he is ashamed of or finds intolerable (40%) are further intermediary aims.

Subjects agreed that the best and most comprehensive vehicle for the facilitation of change in object relations is the transference (100%), within a safe environment which promotes affective growth and recognition of problematic aspects of self and object relationships (40%). See figure 12.5.18.
MEANS

From subject's comments and illustrations it seems that most patients come into analysis because of problems in their self and object relationships. Therefore, an object relations viewpoint is applicable to work with all patients.

Clues to Object Relations

Almost everything that happens during an analysis can be taken within an object relations context. Thus, the indications from the child's material which point the analyst and patient towards these difficulties, and add clarity to the picture, can come from most anywhere. From subjects' clinical examples the following clues were delineated.

It makes sense that the child's relationships to self and others would be the most informative. This data comes from a variety of sources. First is information gathered from parents and other people in the child's environment. This includes reports from parents about the child's history and the way he is with them and others (60%), as well as reports from auxiliary sources, such as schools, hospitals, etc. (60%). When the child is young enough, the analyst may meet with parents directly through the course of treatment. So, the analyst's perceptions of what the parents are actually like is another source (20%). See figure 12.5.19.

The child's own reports of facts, his history (80%), and his daily life (80%) also provide information to the analyst. Through the course of analysis the picture the child paints of his relationships with parents, peers, teachers, and others is also a clue (100%). How he understands other people (40%); the role he casts other people into (40%); his expectations of other's responses to him (40%); how he talks about and views his parents (20%); and splits
between good and bad objects (20%) all contribute to the analyst's conceptualisation of the child's self and object relations. See figure 12.5.20.

![Figure 12.5.20: Clues to object relations - Child's view of his relationships with others](image)

The child's view of himself is another area analysts look to (100%). This includes the child's expectations of himself (40%) and how he feels in relationship to others (40%), for example always cheated or tricked. The way the child presents himself (60%), for example his gait or appearance, also provides clues to self and object representations. See figure 12.5.21.

![Figure 12.5.21: Clues to object relations - Child's view of himself](image)

The relationship the child establishes with the analyst, the way he relates to the analyst, and the different components of this relationship are also important factors subjects spoke of constantly observing (100%). Clinical examples included: the role the child casts the analyst into (80%); the child's expectations of her (80%); the way in which the analyst is treated (60%) and what is said to her (40%); reactions to separations (60%); the child's mode of relating (40%); the child's response to knowing about or seeing another patient.
(20%); and his overall attitude to the analyst (20%). The analyst’s counter-response (40%) in also helpful in gaining an understanding of the child’s self and object representations. See figure 12.5.22.

All subjects said the child’s fantasies and play were things they paid close attention to. Illustrations given of the child’s play demonstrated the roles analyst and child were cast into, as well as a reversal of roles. Drawings (20%) and dreams (20%) are other areas. The analyst and child also gain information from the child’s affects (100%), conflicts (60%), and what troubles the child or what he is afraid of (40%). What subjects thought was extremely important were the repetitions, patterns and themes observed in the child’s material and relationships over the course of time (100%). See figure 12.5.23.

Analysts look to the child’s material for indications and clarifications about his object relations. They do this, according to subjects in this study, from a developmental viewpoint. Object relations is one line of development which goes through various stages and is bound up with other lines of development. This developmental context influences subjects
understanding and formulation of a child's object relations. As certain modifications of object relations are expectable at different stages, subjects keep these in mind. This framework alerts the analyst to pathology or regression (40%), specific conflicts (20%), or developmental tasks which colour the shape and nature of object relations (20%). This framework also provides the analyst with a view of the internal dialogue between the child's selves from different developmental phases (20%). See figure 12.5.24.

Figure 12.5.24: Clues to object relations - Analyst's developmental viewpoint
Object Relations and Technique

It is the patterns and repetitions (100%), as well as information from all of the areas listed (80%), which the analyst relies on as she gradually builds up a picture of the child's internal self and object relationships and his relationships with those in the environment (100%). This process takes a long time (60%) as the analyst works slowly (60%). She wants to be clear about how the child is feeling (40%) and how he perceives others (40%). The analyst works to build a trusting relationship (40%) so the child feels safe in bringing his thoughts and feelings about the analyst and others (40%).

Work with object relations, like any other aspect of analysis, involves a series of repeated steps (100%) as the patterns of difficulties in relationships begin to reveal themselves. All subjects commented that they found these steps and their interventions, which are different with each patient, difficult to break down. See figures 12.5.25 and 12.5.26.

Figure 12.5.25: Technique - I. The process

Figure 12.5.26: Technique - II. The process
Through the clinical examples given, several techniques and areas of intervention were delineated. The analyst can begin by wondering (60%), either to herself or with the patient, about how situations in the child's life happen (40%), the child's relationships (40%), or whether the transference is involved in what the child is presenting (20%). She explores with the child (100%) his affective experience (40%), for example how miserable a situation has made him feel or how unspecial he felt. Fantasies the child brings are also explored (60%) as the analyst looks for elaboration (40%), either through verbalisations or in the play. See figure 12.5.27.

The analyst begins to point out to the child his affects (100%), be they feelings towards others (40%) or about himself (60%), which are located inside the child (20%). She takes up his expectations (60%) of the analyst (40%) or others (20%). The analyst demonstrates to the patient, making him aware of things which seem to happen again and again, as repetitions and patterns become clearer (100%). See figure 12.5.28.
As object relations involve so much of the analysis, there are other areas the analyst works with which are related to the overall process. First and foremost subjects pointed to affects (100%). Clinical examples showed the ways in which the analyst helped the child take on board all of those things he was ashamed of, how she accepted and acknowledged the child’s feelings, or brought in other affects when she had the opportunity. In this way the material was expanded and elaborated as the analyst assisted the child in the acceptance of those things he found intolerable about himself. The analyst also works with the child’s defences (60%), conflicts (60%), anxieties and fears (40%), and separation issues (40%). She may bring in reality at times (40%). One example involved the reality of the mother’s pathology in order to clarify that the child’s perceptions of mother were not only fantasy based. Another example was bringing in a reality about the analyst, that she did remember things about the patient, but only after a great deal of interpretative work about fantasies and the transference. Most subjects (60%) commented that work in these areas revealed and clarified object relations issues. See figure 12.5.29.

![Figure 12.5.29: Technique - The analyst works with](image)

The analyst makes links (100%) to other areas in the child’s life or his internal world. In the clinical examples subjects linked the child’s material to significant objects in his life (100%), his self esteem (40%), actual memories (20%), or to previous sessions and material (100%). When the patient reported something which happened, for example at school, subjects linked this back to significant relationships or what happened at home (40%). Furthermore, subjects made links to the past (80%) and to the transference (80%). See figure 12.5.30.
In all of these interventions subjects attempted to bring into the child's conscious awareness how he felt (60%), his fantasies (60%), unwanted or shameful aspects of himself (40%), and various aspects of his internal object representations of self and others (100%). See figure 12.5.31.

Just as subjects' developmental viewpoint influenced their understanding of a child's object relations, so too did it influence their technique (100%). The way in which subjects intervened depended on the age and developmental phase of the child (60%). Certain developmental issues or phases can indicate modifications of technique (20%). With a younger child reality may be brought in more frequently because of weak reality testing (20%), or the analyst is more apt to talk about the real parents rather than an internal object approach used with an older child (20%). This is because the real parents are more important in the child's ongoing life, and internal objects are not as layered and complicated, a process which occurs with development. See figure 12.5.32.
Object Relations and Transference

All subjects agreed that the transference is the main vehicle of working with object relations. Transference, they said, is about object relations (100%). It is the transference that tells the analyst about the child's object relations as aspects of relationships, both within the internal and external worlds, are repeated or enacted in the relationship with the analyst (100%). The analyst assesses who she is representing in the transference at any given time (40%) in order to understand what the patient is recreating. Working in the transference removes distance as it is no longer about "what is out there" (20%), and decreases the opportunity for defences such as denial (20%). Through the transference both child and analyst are able to see more clearly what is going on and what is involved (60%). As the illusory quality of the transference increases, the child's distorted perceptions, which relate to his internal world, are revealed (40%). See figure 12.5.33.
Object Relations and Interpretation

The analyst verbalises (100%) and clarifies (100%), in order to reach the point where she is able to make an interpretation (100%) involving the child's object relations. These, according to subjects, are their primary techniques. Various areas were illustrated which were the focus of interpretations. The analyst interprets the transference (100%), the child's object relations involving both those people in his environment and his internal world (100%), fantasies (60%), and losses or separations (40%). In addition, she may make interpretations in displacement (40%), for example through or about characters in the child's play. See figures 12.5.35 and 12.5.36.
One of the areas looked at in the data was the way in which subjects presented in their interpretations the concept of an internal self and object to children. This varied and subjects did not necessarily use the same approach with all children.

Four areas were delineated. First was the notion of “parts of oneself” (100%). These included infantile parts, the child within, the big and little child, bits of the child who wanted different things, or more generally, parts of the child. Second was the idea of things inside the child (80%). This involved people inside (60%), such as the parent inside, an internal voice which was eventually connected to a person, or an internal image. One subject was adamant that she never did this, not liking the idea of people inside as it was a “concrete way of working”. She preferred to approach the child with the idea of feelings inside (20%), such as “You always seem to feel” or “Have you noticed how you always feel that your mother is against you”. Third was an approach involving the past (40%). For example: “You seem to still see things the way they use to be”, or “Let’s look at that statement and where it comes from”. The fourth approach subjects used in their presentation of an internal self and object was to frame their interpretations in terms of expectations (60%). Examples of this included: “You always seem to see things in this way”, “I think you expect me to be...”, or “I think you expect everyone...”. See figure 12.5.37.
LIMITATIONS

Object relations is a viewpoint subjects use with all patients regardless of age or disturbance. However, the technique may be modified (60%), or the child’s capacity to change his internal object relations may be influenced by a variety of factors (60%).

With borderline children, for example, their internal and external relationships may be too threatening, frightening or overwhelming. Thus a modification of technique is indicated. The analyst focuses more on ego support rather than stressing relationships and affects. In an illustration of work with an atypical child who had relationships, but a chaotic internal world, the subject’s approach was working with what the patient could understand and take in due to cognitive deficits. The approach was more “educative” rather than analytic.

The child’s capacity to change or modify his internal object relations may be limited due to environmental circumstances and disturbances in the parents. In addition, the child’s propensity for splitting and subsequent difficulties in integration, as well as cognitive deficits, may impact modification. See figure 12.5.38.

Figure 12.5.38: Object relations and limitations

Psychotherapy

Object relations is as important with psychotherapy patients as it is with those children in psychoanalysis. Forty percent of subjects said their technique was basically the same in both treatment modalities, however all spoke of differences. In psychotherapy the transference is, at times, different as there is less of an opportunity to re-experience early affects in the transference (60%). Furthermore, the chance to effect changes and
modifications in internal object relations is greater in analysis (40%). Related to both of
these is the depth analyst and child are able to reach in psychotherapy (20%). See figure
12.5.39.

Figure 12.5.39: Object relations and psychotherapy
12.6 INTERPRETATION

DEFINITION

In approaching the concept of interpretation all subjects used a topographical model to conceptualise their working definitions. Interpretation, they said, is the method the analyst uses to address unconscious content. It is the way she attempts to put the child in touch with unconscious material or states (60%), thereby making latent content manifest (40%). Interpretation are directed at what is happening internally (20%). Hopefully, said one subject, when an interpretation is made the content (the meaning of something for the child) is at a preconscious level. Others were not so specific and referred to what is descriptively unconscious, which includes preconscious. All subjects illustrated interpretations where the analyst conveyed an understanding and gave meaning to what was out of the child’s conscious awareness.

Sixty percent of subjects added that interpretation is a hypothesis. The analyst, through her observations and work with a child, develops a working hypothesis about his difficulties and what needs to be addressed. An interpretation is the way she tests out this hypothesis. See figure 12.6.1.

Figure 12.6.1: Definition of interpretation
**What Interpretation Addresses**

Whilst there is a school of thought that interpretations are always based in conflict, subjects in this study disagreed. They gave numerous clinical examples showing that just about anything could be the focus of an interpretation. Interpretation addresses anything that is unconscious which the analyst aims to bring into the child's conscious awareness.

Examples of interpretations were extensive. The focus of these interpretations included: anxiety (80%); various fears including fear of loss or fear of trying (60%); defence (60%); affect (40%); conflict (40%); fantasy (40%); impulses (40%); resistance (40%); wishes (40%); and symptoms (20%). Interpretations also addressed relationships. For example, the child's relationship with others (80%). These included a feeling that others withheld things from the child, wishes to be cared for, and issues around intimacy and getting along with others. At different times all subjects addressed interpretations at the child's feelings about himself. These included feeling rejected, fears of failure, and feeling worthless or bad. The child's relationship with the analyst was also a focus of interpretations and discussed by all subjects. These included transference interpretations (60%), as well as the child's concerns about how the analyst would feel towards him (40%), which may or may not be a transference interpretation. Interpretations could include one or more of the above. See figures 12.6.2 and 12.6.3.

**Figure 12.6.2: I. What interpretation addresses**

![Figure 12.6.2: I. What interpretation addresses](image)
Interpretation as a Process

All subjects described interpretation as an ongoing process. No interpretation stands alone or acts as a finished product in and of itself. One interpretation makes a step, each interpretation acting as another step. Throughout the process the analyst makes many interpretations along the same theme or strand (60%), dealing with the same issue from many different points of view (60%) or at different levels (40%). Interpretations link different things together (60%) and relate to the process of working through (100%). See figure 12.6.4.

Complete and Partial Interpretations

Subjects made the distinction between complete and partial interpretations. A complete interpretation conveys unconscious meaning. For some it begins with what is happening (60%), in other words what the child is doing, feeling, needing, the defence,
conflict, or whatever. It concludes with an explanation as to why or because (60%). Whilst the what can be unconscious (20%), it seems more usual that the why or because is the unconscious aspect (80%). See figure 12.6.5.

![Figure 12.6.5: I. Complete interpretation](image)

Most of all, subjects agreed, a complete interpretation needs to be “affectively alive and meaningful to the child” at the time it is given. This can mean that the interpretation is a “here and now: interpretation, based in the present. Eighty percent said this was sometimes the case. However, there are no set rules. Each patient and each moment in analysis was taken separately. Whatever made the most sense at the time seemed to be the guide. Another 20% thought, in general, it was a good idea to frame an interpretation in the here and now.

Along similar lines was whether subjects thought an interpretation, to be complete, needed to make a reference to the past. All subject said “not always”. Forty percent commented that they eventually do this. Another 40% said it depended on if and when the time was right, and whether there was enough evidence to make this link. See figure 12.6.6.

![Figure 12.6.6: II. Complete interpretation](image)
Not all interpretations are classified as complete. Partial interpretations are also made. These are defined as ones which don’t necessarily include all that a complete interpretation does. They are steps toward a complete interpretation. Partial interpretations relate to the methods of verbalisation and clarification. Whilst verbalisation and clarification may be steps towards a complete interpretation, this is not always the case. Some subjects were explicit they were steps (60%), whereas 40% said it wasn’t as rigid as that. Everyone agreed that interpretation, verbalisation and clarification overlap and are not clear cut entities. See figure 12.6.7.

![Figure 12.6.7: Partial interpretation](image)

Verbalisation was defined as putting anything which is unspoken into words without adding an explanation. Examples were of general observations by the analyst (40%) sometimes of actions (20%), feelings (80%), or conflicts (20%). See figure 12.6.8.

![Figure 12.6.8: Verbalisation](image)

Clarification is the analyst’s attempt to get clear (100%). Asking questions about something the child has said or done that the analyst hasn’t understood is one example. Clarification can also involve making links (60%), for example of things the child hasn’t put
together, or explaining something to the child (20%). One subject thought clarification had a reality focus where internal and external issues were clarified. For example, a clarification of the child’s inability to change his parents (external issue), but having the ability to change himself (internal issue). See figure 12.6.9.

Figure 12.6.9: Clarification

![Bar chart showing percentages of different aspects of clarification.](image)

**AIM**

As interpretation is the way in which the analyst addresses unconscious content, it makes sense that the aim of an interpretation is to bring that which is unconscious into the child’s conscious awareness. Thus, the analyst makes explicit various aspects of the child’s functioning and internal world. This is the overall aim, but it is not the only aim. All subjects agreed other aims changed dependent, in part, on the phase of treatment.

Forty percent of subjects illustrated interpretations aimed at the therapeutic process. They assisted the child in beginning to look inside himself and gave him an idea of what analysis was about. This was especially true during the initial stages of analysis.

Interpretations also aim to bring together what the child has talked about, during a particular session or over a series of sessions. Forty percent of subjects gave clinical examples of this. Another related aim all subjects spoke to was understanding what the child was trying to tell the analyst, then conveying this understanding through an interpretation.

All subjects said interpretations open up avenues for further exploration. Thus, the aim can be to encourage the child to bring more material. Interpretations which address shame or resistance are examples of these. Equally, the aim may not be to encourage the child’s expression, but to contain his impulses or anxiety which 40% of subjects illustrated. See figure 12.6.10.

430
Figure 12.6.10: I. Aim

Exploration is a further aim all subjects commented on. These are interpretations which clarify what is going on, or are used to track something further the child has presented, or when the child and analyst need to know more. Whilst these exploratory interpretations are not pushing towards the recognition of something in particular, the aim of other interpretations is to help the child recognise something the analyst has already seen. All subjects illustrated this. Reconstruction is another aim 40% gave clinical examples of.

Examples also illustrated the aim of coming at the same issue from different points of view, repeatedly over time. This is done gradually in order to make the issue acceptable (60%) to the child. This links to the process of working-through. See figure 12.6.11.

Figure 12.6.11: II. Aim
What Informs the Content of the Analyst's Interpretation

Data was drawn from subject's clinical examples, as well as from their comments to find what informed the content of the analyst's interpretations. It was clear analysts look to a number of areas when they observe a child's material.

The things a child talks about in general, as well as what he says about his relationship to himself, others and the analyst, are indicators all subjects pointed to. Sixty percent also discussed things the child didn't talk about. For example, if he never says anything about his father or about school.

The analyst looks to what the child says, but also to nonverbal communications which provide helpful information. Examples of these included the child's movements, gestures, the way he sat or didn't sit, his level of activity, his physical appearance, or the way he looked at the analyst.

The child's behaviour is another area all subjects spoke to. This included what the child was doing, his actions and enactments. Of special note was the child's behaviour upon going to and leaving the session, as well as how he was in the waiting room. Sixty percent of subjects discussed this.
As with all of analysis, the child's play is an important area of observation. This included what the child played, how he played, and what roles he assigned to himself and the analyst. The child's dreams are also important (40%). See figure 12.6.12.

Figure 12.6.12: I. What informs content of interpretation

![Bar chart showing percentages of information informing interpretation]

The child’s affect and defences were areas all subjects commented on. His anxiety (80%), the way he copes with anxiety (40%), the absence of anxiety (20%), and resistance (40%) were others.

The child’s relationship to the analyst is a crucial area all subjects addressed. This relationship informs the content of interpretations. This is both how the child is relating to the analyst (100%), and the state of the transference (80%). See figure 12.6.13.

Figure 12.6.13: II. What informs content of interpretation

![Bar chart showing percentages of information informing interpretation]

What the analyst knows from the child’s history informs her interpretations, according to 80% of subjects. What the analyst has gained from previous sessions tells her quite a bit (80%), as well as how present content fits with previous information (80%)
The analyst considers the child's level of development, as certain things have different meanings at different phases of development (80%). She also keeps in mind her current working hypothesis in order to discard, modify or confirm it (40%).

Patterns in the material, repeated themes or returns to a previous theme (80%), and the flow of the session or the process of what follows what (80%) are other areas. Subjects also took special notice of things that were different. For example, when something new entered the material for the first time (40%), or when the way in which the child presented his material was different than usual (20%). See figure 12.6.14.

Figure 12.6.14: III. What informs content of interpretation

![Figure 12.6.14: III. What informs content of interpretation](image)

**What Informs the Timing and Wording of Interpretations**

The analyst not only gathers data which informs the content of her interpretations, she also looks to certain areas to guide her in their timing and wording. The status of the treatment alliance is a major area 80% of subjects pointed to. They thought whether a child could use an interpretation and hear it depended, in part, on his treatment alliance. What is tolerable and hearable also depends on the child's level of anxiety. All subjects commented on this. The space of resistance the child is in (80%), and whether a break in treatment has just happened or will happen soon (60%) are other areas the analyst considers. How the child is experiencing the process at the moment of the interpretation (40%), and the way in which he usually accepts interpretations, which the analyst knows from previous experience (80%) are also indicators to the analyst's timing and wording of interpretations.

The phase of treatment (60%) is also important. For example, the analyst may come to understand something about the child in the beginning phase, but not interpret it then. There could be several reasons for this, for instance: the relationship is not firmly established; other areas need to be worked on before this particular aspect can be approached; or the child does not yet understand, nor is he engaged in the analytic process.
Thus, the analyst’s decisions about the timing of her interpretations varies dependent on whether the analysis is in an initial phase of treatment or later. During the termination phase the analyst could focus her interpretations in a certain directions as well, and leave other things alone. See figure 12.6.15.

The analyst also takes development into consideration (100%). The child’s level of development influences the way in which an interpretation is worded (100%), whether certain aspects of the interpretation are emphasised more than others (40%), and how much understanding and insight the child will gain (20%). Development also influences the analyst’s method of interpreting (80%), for example through the play or by telling a story about another child. Ego development (40%) is also a factor. See figure 12.6.16.
What Leads to an Interpretation at a Specific Time

The next area of exploration was more difficult to ascertain from the clinical examples: What led the analyst to make the interpretation she did at that specific time. Subjects had difficulty answering this question. They brought interpretations, and the process, to the interviews with them, but often found it hard to remember after the fact what their thought processes had been. Sixty percent said the timing of a specific interpretation was done intuitively. In other words, analyst's don't consciously think about it or figure it out at the time. Instead, the decision seems to be based on preconscious thought processes.

That issue aside, several areas were delineated. Three areas had the highest frequency of response of 80%: what had gone on in previous sessions; the child's affect; and, the context in which the material was presented. In other words, it was clear within the context what was going on. Other areas were noted by 60% of subjects. They included: how the patient was in that particular session which pointed to his openness to accepting the interpretation; the phase of treatment; patterns which revealed themselves; the transference; and what feelings were elicited in the analyst (her affective response). Forty percent of subjects said their decision was based on the related threads they saw throughout the session, and/or it was an obvious direction to explore. Two other indicators were noted by 20%: the child's material halted and went in another direction, and resistance. See figures 12.6.17 and 12.6.18.

Figure 12.6.17: I. What leads to an interpretation at a specific time

![Bar chart showing percentages for factors leading to interpretations.](image-url)
Making Choices About What to Interpret

Subjects were able to be somewhat clearer about why they made one interpretation versus another. Sixty percent said they interpreted what was “primary”, “uppermost”, or “the greatest burden to the child” at that moment. How do they know what this is? Three areas contribute to this determination: the material itself, the child’s affect and anxiety, and what is closest to conscious awareness.

Forty percent said they gathered their information from the child’s material itself. Included in this was material from previous sessions (40%), the theme being worked on at the time (60%), whether the material was in relation to the analyst (40%) or the outside world (20%), and where the transference was (60%). See figure 12.6.19.

All subjects spoke of the child’s affect or level of anxiety during the session. In addition, 40% said they chose “what is affectively meaningful to the child at the time”. Other areas linked to affect and anxiety were the analyst’s affective response (60%) and her counter-response (40%). Counter-response means the feelings or behaviour the child tries to provoke in the analyst. See figure 12.6.20.
What is closest to consciousness was an indicator for 60% of subjects. This included: what is least threatening to the child (40%), what he is capable of hearing at the time (40%), and what will make the most sense to him (20%). See figure 12.6.21.

Two further areas were discussed. One was the phase of treatment (60%) which was explained earlier. The other related to the child’s development. Whatever phase of development was dominate at the time of the session would influence what the analyst was interpreting (40%). See figure 12.6.22.
The Method of Interpretation

Three areas were delineated from the data about the method of interpretation. They were important characteristics, the process of interpretation, and various ways interpretations are given.

Several important characteristics were noted when subjects described the ways in which they interpret. First and foremost was timing. Factors which influence timing were discussed earlier. The presentation and wording of an interpretation was addressed by all subjects. They thought it important an interpretation be given in a way the child was able to accept and hear. Although what made one interpretation more hearable than another was not clearly spelled out, it seemed linked to anxiety and narcissism. The analyst neither wants to intensify anxiety so it is unmanageable, nor hurt the child’s self esteem so he feels attacked. The way interpretations are presented was talked about by 40%. This referred to things like modulation and tone of voice, rhythm, and volume. As one subject said: “The form is often more important than the words.” One subject pointed to the importance of the analyst’s connection and empathy with the child as this affected how an interpretation was presented. See figure 12.6.23.

![Figure 12.6.23: Method of interpretation - Characteristics](image)

Subjects were clear interpretation was a process. This process begins with the establishment of a safe environment (80%) where the child trusts enough to begin to recognise things he doesn’t necessarily want to see. All subjects said the process of interpretation moves the material along. As one subject commented: “When you make an interpretation that is right, pretty soon you will be making more in the same general direction.” Thus, the analyst comes at the same issue from different directions, points of view, and levels. Each interpretation builds on the others as none is a finished process in and of itself. This, all subjects agreed, is the process of working-through. The analyst and child
look at every different aspect, repeating interpretations in different contexts and in different ways, until the problem is worked through. All subjects described and illustrated in their examples this overview of the process.

This process is made up of a series of small steps where the child makes a step by bringing material, the analyst makes a step with an interpretation, the child makes another step and so on. This was described by 60% of subjects. One elaborated further. These small steps, she thought, were better than one large interpretation as the child retained more and the emotional resonance was greater. A related idea was the importance of leading the child toward making his own interpretation or connection (60%). The reasons for this were the same as taking small steps, but also the fact that the child was likely to be more accurate than the analyst.

Finally, interpretations vary dependent on the phase of treatment. Eighty percent spoke to this. It seems subjects were referring to early in treatment when the analyst goes slowly and doesn’t interpret too quickly, especially without the benefit of a treatment alliance. The treatment alliance is helpful in maintaining the relationship through difficult moments. Interpretations also enhance the treatment alliance, which one subject gave an example of. Later in the analysis the analyst’s interpretations are more direct and “deeper”. See figure 12.6.24.

![Figure 12.6.24: Method of interpretation - The process](image)

Analyst’s give different types of interpretations. They give interpretations directly to children through words (100%), as well as in displacement (60%). Interpretations are also given through the telling of a story about another child (40%), using humor (40%), in writing (20%), through stories (20%), and even by singing (20%). Interpretations are also given nonverbally (20%). One example was when a child yelled at the analyst to shut up
the analyst zipped her mouth closed, smiled knowingly at the child, and winked. Exploratory, complete and partial interpretations have already been discussed. See figure 12.6.25.

Figure 12.6.25: Method of interpretation

Confirmation of Interpretations

The analyst looks for evidence from the child to determine whether her interpretation was on target or missed the boat. Subjects illustrated and discussed the idea of confirmation. It is a mixed picture and there are obviously no set rules. All did agree that an interpretation which is "right" will eventually move the material forward. So, if the material doesn't move, the interpretation was inaccurate and/or the child was in a period of resistance which wasn't seen. Eighty percent said the child's associations, or what he began to play following the interpretation, acted as confirmation. Forty percent said confirmation was when the child's anxiety subsided.

The child openly and directly agreeing with an interpretation can also be confirmation (60%). But equally, agreement can merely show compliance (20%). Confirmation may not come until much later, which 80% of subjects talked about. For example, eventually the child will give the interpretation back to the analyst showing he understood and took it in. Or, eventually the next developmental step taken which confirms the interpretation had an effect.

Sixty percent of subjects said over time they learn the child's patterns of reacting to interpretations, especially ones which are focused in certain directions. Thus, by knowing this about the child, the analyst understands what acts as confirmation and what doesn't. See figure 12.6.26.
Negative reactions or denials are confirmations sometimes, but at others tell the analyst she was wrong. Denial, for example, can be either (40%). One subject thought when the child denied the analyst’s comments which were on target, it meant the analyst worded the interpretation in a way the child couldn’t hear. Another thought the interpretation might be right, but it stirred up resistance. Other examples were also of times the analyst was right, but the child’s style of responding was to shut down due to anxiety or something he found intolerable in himself. Forty percent commented on this. Another subject thought the content of the interpretation could be right, but the problem was the way the child was experiencing the treatment process. See figure 12.6.27.

Unhelpful or Unnecessary Interpretations

This leads into another area, interpretations which aren’t helpful to children. All subjects said wrong interpretations were not helpful, and openly admitted they made them. Thus, the analyst needs to listen to the child and be prepared for the fact she has gotten something wrong. All agreed there were other interpretations which were not helpful. These included those that went too deep too early (60%); mistimed interpretations (60%)
those that addressed shameful or humiliating aspects without laying ground work, or presenting it in such a way that holds the child or "strokes his narcissism" (40%); and interpretations resulting in the child losing control (20%). In addition, 60% thought interpreting aspects of the child's development which are moving along without difficulties were unnecessary. See figure 12.6.28.

Figure 12.6.28: Unhelpful or unnecessary interpretations

Special Considerations

Subjects gave examples of a variety of interpretations during the interviews. In examining the data some fell under the category of "Special Considerations". Because of the nature of the disturbance and/or the child's internal structure, the analyst worked in a somewhat different way. There are two categories of special considerations. One has to do with children who, at one end, experienced narcissistic damage and, at the other end, have somewhat shaky self esteem.

The other falls under what is commonly known at the Anna Freud Centre as "developmental help". These types of interventions are aimed at areas of developmental failure. The concept of developmental help, or what Fonagy and Moran (1991) and Fonagy et al (1993 in press) have conceptualised as a mental process model as opposed to a representational model, is addressed under the Developmental Disturbance study. For

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9 Briefly, these authors have conceptualised two different types of therapeutic action from the stand point of what mechanisms underlie psychic change. The representational model focuses on the mental mechanisms involved in the recovery of threatening ideas and feelings, which results in the reorganisation of mental structures. The mental process model addresses pathology which has traditionally been thought to reside in the ego. In these instances the aim is to engage previously inhibited mental processes.
the purpose of the interviews on interpretation, subjects were asked to give an example of interpretations they considered developmental help.

First, the area of narcissism and self esteem. Subjects agreed the way in which an interpretation was given was especially important with these children as they often felt interpretations were intrusions (20%), or experienced them as wounding attacks (60%). The analyst had to be especially careful. Interpretations 80% of subjects gave tended to distance the child from uncomfortable areas. Rather than making direct interpretations to the child, subjects were more apt to interpret in displacement, to talk generally about “other” or “most” children, interpret in the form of a story about another child. Gradually, the analyst worked her way closer to the child (40%). See figure 12.6.29.

Interpretations subjects called developmental help fell into several classifications. The first involves the child’s anxiety. The children presented did not have signal anxiety and lacked sufficient defences so were continuously overwhelmed. Interpretations aimed to develop this capacity in the child (40%). The steps included helping the child identify when he began to feel something, what that feeling linked to, how to read his own cues the feeling was developing, then stop himself to prevent an outburst. Whilst these steps were laid out very clearly, the process was extremely difficult and took quite a long time. Often the child couldn’t tolerate the verbalisation of his anxiety as it intensified the feeling and he would act out (20%). Therefore, interpretations were sometimes very concrete and in the play (20%). For example, learning to put the breaks on when the car got wild or building a dam with a valve so a little water could be let out at a time to prevent flooding. Containment of anxiety was a focus (40%). At times the analyst physically held the child until the time he could be contained by words. See figure 12.6.30.
If affect was a focus interpretations were often directed at how humiliated, vulnerable, or ashamed the child felt (20%). In some cases, unlike the ones above, verbalisation of affect was helpful. Not only did it provide the child with the words to describe what he was feeling, but the internal representation of an affect which helped him know how he felt and that the feeling was in him (40%). See figure 12.6.31.

Showing the child how to do something was another area of focus (60%). For example, one child was taught how to play. Another child was helped with his speech, at the same time his analyst made interpretations about expression of feelings. With another who had developed a severe inhibition against messes, the analyst coloured and eventually painted helping the child loosen up. Children also practice new skills, how to be with other people or to make friends (40%) in their sessions. See figure 12.6.32.
The role of analyst as a new object was another area delineated from the examples (60%). New object means an experience of a person which is different than what the child has had before. As one subject explained, "providing the time and patience to give the child the extras his parents weren’t able to do" is part of developmental help. The painting was an example of this. The analyst demonstrated concretely that messes were acceptable to her, whereas they weren’t to the child’s mother. Another example was of a child who always felt coerced, doing what he thought others expected of him. The interpretation given to him was "It seems you feel you should do what I want you to do, but here whatever you do is completely up to you". Other subjects talked about getting the child interested in doing something in a different way, and at times literally showing him a different way (40%). See figure 12.6.33.

Other examples of “auxiliary ego” interpretations were given. These included establishing a language with the child where both knew what the other one was saying and meant (40%). Providing encouragement was another (20%), as was keeping the child safe. This was sometimes meant concretely as the analyst helping the child or preventing him from doing something which was unsafe. At other times, safety was established by talking together. Explaining things to the child was another intervention (20%). See figure 12.6.34.
These are interpretations not in the framework of what and why as outlined previously under “complete interpretations”. They aren’t necessarily interpretations which aim at unconscious content, but at developing capacities which are lacking. They focus primarily on what analyst’s call the ego. As one subject said: “You have to build up the ego. You can’t do much with a child unless his ego is sound enough to hear what it is you are saying to him.”

**Interpretation and Psychotherapy**

In general, 80% of subjects adhere to the same philosophy of interpretation with their psychotherapy patients as they do with their analytic ones. However, there are some differences. Sixty percent said some things they would not interpret especially if the therapy was more focused due to time constraints. Because it is a longer period between sessions, 80% said they were more cautious in their interpretations. This was especially true if the child’s defences weren’t very good (40%), or his life situation wasn’t supportive enough to help him cope with something that was upsetting and difficult to take on board (20%). Sixty percent said they were careful not to arouse too much anxiety at the end of a session as the child would be left to cope with this on his own.

Sixty percent of subjects felt more pressure with a psychotherapy patient because they had less time. They meant time not only in terms of the frequency of sessions, but the length of the treatment. “Is there time”, one subject wondered, “to do all the nudging, to take the same steps that are involved on the way to interpretations?” One subject was clear how she worked depended completely on the individual child. With some she could get part way towards something and by the next week the child had taken it further, doing quite a bit of work on his own. With other children things got lost from session to session. See figure 12.6.35.

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![Figure 12.6.34: Special considerations - Developmental Help](image-url)
Figure 12.6.35: Interpretation and psychotherapy

- 80%
- 60%
- 40%
- 20%
- 0%

Same principle
More cautious
Analyst more pressured
Doesn't interpret some things
Anxiety a factor
Defence a factor
Life situation a factor
Depends on child
THE MIXED PSYCHOPATHOLOGY OF CHILDHOOD

Subjects were introduced to this interview with a global definition of childhood psychological disturbance. Disturbances, they were told, could be framed within two broad categories: "Neurotic Disturbances" and "Developmental Disturbances". Developmental disturbances included a wide range of pathologies commonly known as borderline, narcissistic personality disorder, atypical, psychosis, and developmental disturbance as an entity in and of itself. They were then asked whether they agreed or disagreed with the following quote from Anna Freud (1965).

...in actual experience few individual child patients present us with the pure clinical picture which, alone, would justify a therapy directed toward one specific factor. In most cases, the disturbances consist rather of mixtures and combinations of elements which contribute in varying degrees to the final pathological result.

All subjects strongly agreed with this statement. They conceptualised patient's pathology not as purely one type of disorder or another. Technique was adjusted according to what aspect of a child's disturbance was the focus at any given moment, and included a mixture of what has loosely been called "analytic" and "developmental help".

Subjects were then asked whether they agreed or disagreed with what Anna Freud went on to say.

It is the mixed psychopathology of childhood (as discussed above) for which the comprehensive method of child analysis is needed. Only in child analysis proper is the whole range of therapeutic possibilities kept available for the patient, and all parts of him are given the chance on the one hand to reveal and on the other to cure themselves.\(^0\)

Only 60% of subjects agreed with this quote. The other 40% thought it depended on the patient. With some it was possible to do quite a bit, if not the same work, in psychotherapy as opposed to psychoanalysis.

The five subjects who participated in this study presented eight different patients. Six were ones with whom subjects said their technique constituted a mixture of developmental help and analysis. Of these six, two were also said to include "education".

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What the difference in the minds of subjects was between education and developmental help is somewhat unclear, however implied in their examples was that education meant teaching the child new skills.

The term “education” applies to another case which was presented. The technique, according to this subject, was developmental help. She termed her work “special needs teaching”. Here the distinction between education and developmental help is blurred.

It is somewhat unclear what to call the technique applied to the eighth case. The diagnosis was narcissistic personality disorder and the pathology was quite severe. The subject’s interventions in the beginning phases of the analysis, which is what was presented, were not interpretative per se and technique was indeed modified. When asked specifically, the subject said this work wasn’t developmental help. As she stated: “In my way of thinking developmental help is helping people to move on. It is trying to put into the context of ordinary life the processes involved in growing up and making relationships. I didn’t do that for quite a long time with this child.” What this subject did do was to find a way to connect with this child, and to communicate with him by entering his narcissistically encapsulated and somewhat bizarre internal world. This took quite some time. For purposes of this study, this type of work will be called “Entering the child’s world”. Whilst all analysts do this with all children, this case was especially difficult.

Figure 12.7.1 shows the different cases presented according to the type of work as defined by the subject.

![Figure 12.7.1: Patients presented classified by technique](image)

The majority of subject’s clinical examples presented the admixture of psychopathology as discussed by Anna Freud, and the technique was both analytic and developmental help. Subjects were asked whether they thought they could have treated their patients in psychotherapy. Only one case was thought to be suited for this treatment modality. He was
a four year old diagnosed with an infantile neurosis whose ego was intact. The subject did qualify her statement. "It was possible", she said, "but it would have taken much longer and been more difficult." The other seven cases were not thought to be suited for psychotherapy because the pathology was "too far ranging". In other words, there were too many things to address from too many directions. Therapist and child needed the analytic setting and process to discover, understand, and treat all of those areas and parts of the child.

Only 60% of subjects agreed with Anna Freud that analysis was the treatment of choice for the mixed psychopathology of childhood. However, when they spoke specifically about their patients opinions changed. Subjects thought analysis was the only method which would address the mix and range of pathology in all but one patient (88%), and that one would have taken longer and been more difficult. See figure 12.7.2.

Figure 12.7.2: The disturbance and treatment of choice

Subjects gave clinical examples from these eight patients which described how they worked. What is "analysis" and what is "developmental help" is somewhat difficult to separate out and it appeared at times the two went hand in hand. As much of what would be called "analytic" is covered under the other sections of this study and, in the end, was not the primary focus of these interviews, this study pertains to what subjects called developmental disturbances and developmental help. Interventions were aimed specifically at disturbances which are traditionally thought to reside in the ego, and relate to ego functions and self and object relations. The data will be divided into sub-categories: a demographic overview of the patients themselves; the environmental factors which subjects thought contributed to the developmental disturbance; subject’s conceptualisation of the developmental difficulties; and their interventions.
The examples given were vignettes so there is a great deal of information which is not known. In addition to the interview itself, three subjects provided the investigator with four clinical papers which outlined their work with these children in more depth. Some information was gathered from these. Statistics are based on the number of patients themselves, rather than the percentage of subjects.

PATIENT DEMOGRAPHICS

Eight patients were presented. Two patients were under five, one girl and one boy both four years old. Six patients were latency age. Three were seven years old, two girls and one boy. Two were eight years old, both boys. The specific age of the eighth case, a latency boy, was not given, however he was in early latency. See figure 12.7.3.

Two patients, or 25%, had neurological as well as psychological difficulties. Therefore, certain areas were not amenable to analytic interventions. With both patients the psychological ramifications of the neurological difficulty were addressed in the analysis. Two patients had illness or difficulties of a physiological nature in the past which had greatly affected their lives. See figure 12.7.4.
All of the children except one (88%) were having grave difficulties learning in school when they entered treatment. All were of at least average intelligence. Three (38%) were highly intelligent according to educational psychological testing. Whether all children were tested or not is unclear, so this result may be higher. See figure 12.7.5.

Figure 12.7.5: Patient demographics - Learning and intelligence

Half of the patients came from intact families with both parents in the home. The other half came from either homes were parents were divorced (38%) or separated (13%). Over half (63%) had siblings. See figure 12.7.6.

Figure 12.7.6: Patient demographics - Family constellation

CONTRIBUTING ENVIRONMENTAL FACTORS

Subjects were asked to address what factors from the environment they thought could account for or contributed to the child’s disturbance. Three areas were delineated from this data: the parent’s relationship with each other, their handling of the child, and their own pathology.
First is parent’s relationship with each other. Interestingly, little was said about the marital relationship in the intact families. In the other 50% this relationship featured as a contributing factor. Discord and verbal fighting between parents was noted in three cases as ongoing during the analysis. In one of these the father had been physically abusive of the mother and remained a threat during treatment. In the fourth case the divorce occurred during the child’s infancy, and the father had been relatively absent since then. See figure 12.7.7.

Parent’s handling of the child was a factor raised by all subjects. Lack of consistent handling was noted in 50% of cases. It wasn’t necessarily the handling itself which was the issue, but the inconsistent way the parent went about it. Another case was described as parent’s “special child”. He was raised in a permissive environment, never frustrated and overgratified, as parents anticipated his every need. The child not fitting in with the family and their expectations was seem as a factor in 25% of cases. In another case, parent’s denial of anything being wrong was thought to be a contributor. Parents not protecting the child from a sibling’s verbally abusive attacks was pinpointed as yet another factor. See figure 12.7.8.

The way in which the child’s affects, including anxiety and excitement, were dealt with by parents was a factor in 88% of cases. Included were: not providing structured meaning to the child’s feeling states (25%); parents who had their own difficulties with
anxiety, therefore could not act as a model with whom the child could identify and internalise methods of anxiety control (25%); and families where there was overstimulation (38%). In 25% of the cases where there was overstimulation, subjects wondered about possible sexual abuse in the past by someone other than the parent, but evidence was far from conclusive. See figure 12.7.9.

Figure 12.7.9: Contributing environmental factors - Parent's handling of affect

The pathology of the parent was a factor mentioned by all subjects in all cases. The most prominent feature was the way a parent dealt with his or her own aggression (50%). This included projection of aggression onto the child, sexualised aggression, angry outbursts, and outright abuse. Parents using the child to meet their own needs was another factor (38%). Overly anxious parents (25%) and a depressed parent (13%) were other factors. Other than these areas, the level of disturbance or health in these parents is not known. See figure 12.7.10.

Figure 12.7.10: Contributing environmental factors - Parent's pathology
CONCEPTUALISATION OF INTERNAL DIFFICULTIES

Subjects were asked to conceptualise the child’s internal difficulties and what it was they thought maintained the disturbance. Ten different areas were delineated from the data. This is not to be taken as an all inclusive list, or as one which describes the whole patient. These are areas subjects pointed to as they relate to developmental disturbance. Some subjects were more specific than others by not only including the difficulty, but what it might mean to the child’s overall functioning.

Internal Organisation and Controls

The child’s internal organisation was an area emphasised. Fifty percent of the children were described as having chaotic and/or confused internal worlds. Explanations given for this included: a lack of boundaries, overwhelming anxieties and affects, and omnipotence. Twenty-five percent lacked any “internal sense of safety” and another 25% were “internally out of control”. These were general comments. There were also specific comments related to the internal organisation and controls of impulses and wishes, and affective mental states. See figure 12.7.11.

Figure 12.7.11: Internal difficulties - Organisation

In terms of impulses and wishes, 38% had inadequate impulse control, 38% had poor to no frustration tolerance, and 63% experienced an inability to delay. With 50%, this inability to delay was seen as an inability to delay gratification. One subject expanded. This inability to delay, she said, prevented the child from being able to judge situations. Twenty-five percent were overwhelmed by excitation. See figure 12.7.12.
In regards to the organisation and control of affective mental states, 88% of the children had difficulties with anxiety, 38% with affects in general, and 25% had difficulties with excitation. Excitation is also included under affective mental states because the child’s excitation was so pervasive and overwhelming. It was unclear how much this related to impulses and wishes, and how much could be an expression of anxiety as the line between these two is often difficult to demarcate. All of these children were flooded or overwhelmed by these affective states. One child had a limited range of affects. See figure 12.7.13.

Related to internal organisation and control is defence organisation which helps contain impulses, wishes and affects. The lack of appropriate defences was described in 88% of the children. Whilst it could be assumed that the signal function of affects which initiated defence was somehow deficient or missing, this was only mentioned in 25% of the children. See figure 12.7.14.
Self and Object Relationships

All of the children had problems in the area of object relations, both external and internal, and self representations. All but one child had no significant peer relationships (88%). Object relationships were not age appropriate (50%), or the ability to relate with other people was deficient (25%). Subjects pointed to a lack of firm boundaries between self and object representations (25%), and an inability to tune into other people or for others to tune into the child (25%). One example was of a child who only saw others as being there to meet his needs. See figure 12.7.15.

All of the children had poor self esteem. Other descriptions of the child’s self representation included: damaged (38%), omnipotent (38%), overwhelmed by humiliation and helplessness (13%), made up of distorted identifications (13%), and narcissistic (13%). Twenty-five percent lacked a coherent sense of self felt “in pieces” or “falling apart”. See figure 12.7.16.
Pertinent to this data is the function internal object relationships serve for the child. These were discussed in the object relations study (see figure 12.5.16). If internal representations of objects are not solid, or lacking in some way, the ability to understand or use relationships and build up a sense of self is effected. Furthermore, the child could have difficulties in the development of autonomy, and internal structuralisation and organisation.

Other

Problems in the area of thinking were described in 88% of children. A dominance of primary process thinking was seen in 25%, as was perseveration of thought and magical thinking. In other children, anxiety (13%) and excitement (13%) interfered with their ability to think. One child was described as having a "short attention span". Thirteen percent lacked the ability to reason which meant, according to one subject, he couldn't "check instinctual wishes and behaviour and their fulfillment". Other problems which related to thinking included: memory and the ability to retrieve memories (13%), sequencing (13%), and causality (13%). See figure 12.7.17.
Language was an area of difficulty for 25%. One child had severe language deficits so couldn't use words to express his affects, impulses and inner experiences, or influence others to meet his needs. Another child had difficulty with the use of words, so couldn't use them to master his anxiety and affects. Both of these children used their bodies and actions as an outlet for expression.

Other ego functions mentioned included deficient reality testing in 50%, and an inability to synthesise in 25%. A repression barrier was not firmly in place in 13%, which contributed to difficulties in the modification of actions. See figure 12.7.18.

![Figure 12.7.18: Internal difficulties - Language, reality testing, synthesis, repression barrier](image)

**THE ANALYST'S TECHNIQUE**

Subjects described some of the interventions they made in the cases they presented. As found in previous sections, some were more specific than others. For example, some said they acted as an "auxiliary ego" or the child "internalised controls". Others added what being an auxiliary ego meant, or described the process of internalisation of controls. What follows certainly does not entail a complete list, or should be taken to mean that these are the only things the analyst did. The division into the categories below are based on what the subject said her intervention was primarily aimed at, however one category could equally apply to others.

**The Role of the Analyst and the Setting**

Many subjects referred to general aspects of their role with the child, and descriptions of the analytic setting itself. In 75% of examples, subjects said the child saw her as the one who could help and understand him. The analyst providing auxiliary ego support was pinpointed in 50% of cases. One subject was explicit what she meant by this.
She said: "I was used to control him, check him, get him to talk, improve his reality testing. Eventually by my doing this for him, his verbalisations improved and his skills became autonomous. He needed me in this role less and less."

In the study on interpretations subjects also spoke of providing auxiliary ego support as part of developmental help. Under this umbrella concept they included establishing a language with the child, providing safety, encouraging, and explaining. Figure 12.6.24 outlines these. Subjects also referred to the role of the analyst as a new object. Those interventions provide the child with a different experience than he has had before. Figure 12.6.33 spells this out.

Being a consistent object was described in 50% of the cases in this study, and a benign object in 38%. Other characteristics of the analyst mentioned, which are probably also an aspect of being consistent or benign, included: tolerant (25%), patient (25%), calm as opposed to excitable (13%), the one who repaired the hurts (13%), and the one who never got angry (13%). One subject spoke of her role as a real person to the child and was explicit that transference did not play a role in this work. None of the other subjects spoke of their role as "real object", nor did they speak about the role of transference. They all did, however, comment on the importance of a treatment alliance and illustrated its establishment, although in some it was shaky at times. See figures 12.7.19 and 12.7.20.

![Figure 12.7.19: Technique - I. Role of the analyst and the setting](image)
It is interesting to compare these results with those in the transference study. That study indicated that 80% of subjects thought not all aspects of the relationship to the analyst, whatever the child's disturbance, were transference. They talked about the importance of differentiating transference from other aspects of the child-analyst relationship, such as habitual modes of relating, and the analyst as a real object and a new object. Interestingly, treatment alliance was not referred to in that study. Figures 12.4.11 and 12.4.12 delineate those results.

Also in the transference study 40% of subjects gave examples of children who would fall under the diagnostic category discussed here. All of these subjects thought the transference of the child's object relationships did play a role in their work. Splitting of the transference was mentioned as a hazard to be watched for. Whilst transference remained a tool for the analytic work, there were examples where it was not the analyst's primary tool. For example, when the child's environment was chaotic or he experienced a lack of safety, when the child's behaviour was anxiety driven or his reality testing was poor, or when the child's ability to relate was so deficient the analyst's aim was to facilitate a relationship. Figures 12.4.39 and 12.4.40 outline these areas.

The child's identification with the analyst was illustrated in 63% of the cases presented in this study. This included identification with the analyst's role (13%), and with the analyst as a real object (13%). Further elaboration on this aspect of the analysis was provided in 25% of cases. These children, because of their relationship and identification with the analyst, wanted to please her and gain her approval. See figure 12.7.21.
The object relations study also revealed the importance of a safe and trusting setting and relationship. This is illustrated in figure 12.5.26.

**Communication and Thinking**

In 38% of the cases presented the analyst addressed the difficulties in finding a language which she and the child could use to connect and communicate with one another. A form of communication was needed so the child could express his feelings and experiences. In one example of a child who had speech problems, this was done initially on a “preverbal” level through finger games and later through actions of family dolls and in games of hangman. With another child who experienced words as dangerous, the analyst found another way of communicating using drawings until words, through the analytic work, became less dangerous. With the third child the analyst could not necessarily speak directly to the child, instead she had to enter his somewhat secluded and narcissistic fantasy world. There she slowly learned to understand what the child was telling her and experiencing, and what he could and could not tolerate her saying.

Children who had various difficulties using words to express themselves communicated through their bodies and actions. This was illustrated in 50% of cases. The analyst began to decipher what these non-verbal communications meant and labeled them verbally.

In the case example of the child who had speech problems, the analyst literally taught him this skill, showing him how to move his tongue and mouth whilst making interpretations about the expression of his affects.
Whilst 88% of these children were described as having difficulties in thinking, only two examples were given which specifically addressed this area. The analyst helped the child think things through by either providing, or helping the child ascertain, the links between seemingly unassociated thoughts.

Figure 12.7.22 illustrates the analyst's interventions as they relate to communication and thinking.

Figure 12.7.22: Technique - Communication and thinking

References to establishing a language with the child are also found in the interpretations study. See figure 12.6.34.

Internal Organisation and Controls

One of the aims of analyst's interventions was to try and make sense of the child's disorganised internal state. Subjects illustrated several examples of this. One was the analyst making comments which conveyed an understanding of the internal state, for example, "How horrible it feels...". There were instances of the analyst putting names to things (25%), or trying to make sense of the child's fantasies (38%). One subject commented that unconscious fantasy was not a focus in her work with the child she presented.

Another subject, in talking about a traumatised child, also raised the issue of fantasy. She was especially careful not to confuse the child's fantasies with the external reality. In her example the external reality exacerbated the child's frightening fantasies, which in turn heightened his anxieties about the external world. She interpreted both the reality and the fantasies. In addition, she talked with the child about what he could have control over and take care of, which was his internal world. This helped him manage his external world better.
The influence of reality factors, as well as trauma, are also addressed in the studies on defence and resistance (figure 12.1.27), conflict (figure 12.2.23), and transference (figure 12.4.39).

Verbalisations of the child's sense of feeling unsafe was another intervention in 38% of the examples. One subject not only verbalised, but provided safety in the play by acting as the rescuer in the child's ongoing war games. Providing safety was also addressed in the interpretation study under developmental help (figure 12.6.34) and in the affects study (figure 12.3.9).

Figure 12.7.23 outlines the interventions found in this study which addressed the child's disorganised internal world.

Figure 12.7.23: Technique - Internal disorganisation

All subjects focused on the child's internal organisation and control of affective states. Anxiety will be discussed separately from affect.

Examples of interventions which addressed the child's overwhelming anxiety were given in 50% of the cases presented. One subject said "the mastery of anxiety", whilst another demonstrated how she took the child through small steps towards mastery. There was something the child clearly wanted to do, but anxiety overwhelmed him. Analyst and child, over time, went through small steps eventually reaching the desired goal, the child looking at the analyst's face as if a mirror. Twenty-five percent of the cases were illustrations of the development of signal anxiety. The analyst slowly helped the child recognise the anxious feeling prior to getting out of control. See figure 12.7.24.
All examples demonstrated the analyst’s technique as it pertained to affects. The interventions varied. The verbalisation or labeling of affects were seen in all of the cases. Other examples related to this, but included more. The verbalisation of the affect along with an explanation as to why the child was feeling that way was illustrated (25%). In other words, a complete interpretation of the affect. Another example was of an interpretation related to excitement and the ways in which it was used to exclude the experience of other feelings. Helping the child make sense of his affects was another example. This included what the feeling was, where it came from, and who it was directed at. The development of the signal function of affect, as described above with anxiety, was illustrated by one subject. The analyst telling the child she could protect him and others from his overflowing feelings was still another example. Lastly, one subject said she helped the child “curb his aggression”. See figure 12.7.25.

Some examples were not specifically about the development of internal controls of anxiety or affect, but internal controls in general. These could relate to affective mental states, but equally to impulses and wishes. One subject said very generally that the child “internalised controls”, however others (38%) were more explicit. They said the child gained internal control through the internalisation of the analyst’s verbalisations. Another way
subjects assisted the child with this developmental difficulty was through the provision of limits and rules. For example, what the child could or couldn’t do along with an explanation as to why (38%). Twenty-percent of subjects added that the child responded to her limits because he knew the analyst cared about him, and he wanted help to control himself. See figure 12.7.26.

Figure 12.7.26: Technique - Internal controls

This is by no means inclusive of all of the ways analyst’s approach the area of internal organisation and controls. All of the interventions described up to this point, as well as those which follow, could also play a role. This area was addressed extensively in the studies on affect (figures 12.3.20 and 12.3.34-36), interpretation (figures 12.6.30 and 12.6.31), and defence and resistance (figure 12.1.27). Not included specifically in the examples in this study, but in many ways implied, was the construction of defences. If the child is lacking internal controls and affects aren’t used as a signal, building up defences is a natural progression. This was addressed in the studies on defence and resistance (figure 12.1.27), conflict (figure 12.2.25), and affects (figure 12.3.35).

Also not addressed in this study is creating an internal representation of affects. This process involves the labeling and differentiation of affects. By providing words and breaking affects down into manageable entities, the child not only has a language for his feelings, but begins to recognise those feelings within himself. This process was referred to in the affects study (figures 12.3.15, 12.3.16, 12.3.34, and 12.3.36), and the interpretations study (figure 12.6.31). As one of the steps toward the development of signal affects involves the child’s ability to recognise feelings in himself, implied is the creation of affect representations.
Self and Object Relationships

According to the study on object relations, this viewpoint is used with all patients regardless of age or disturbance. Thus, the areas outlined in that study could equally apply here. This study concurred as the area of object relations, as well as self representations, was taken into account in all of the examples. At times, however, modifications of technique are indicated, or the child's capacity to change or modify his object relations is limited (see figure 12.5.38).

Separation was one area of focus in this study. In one example the child concretely worked on separations by leaving the analyst and returning to her during sessions. The use of displacement figures would not suffice. The patient practiced this skill repeatedly, moving towards mastery. Another example was given of interpretations of separation and loss. These entailed the child's fear if he gave up his symptom, mother and caregivers would be lost forever.

Other examples (25%) used the child's social skills to demonstrate and interpret object relations difficulties. Both involved the child's eating habits. The analyst worked with the child on his manner of eating taking it in small steps. For example, first he had to eat his biscuits on plate, then he had to eat without spitting, next he couldn't play and eat at the same time. All the while the analyst made interpretations about why this was important, and the impact these habits had on other people and the child's inability to make friends.

Thirty-eight percent of examples involved playing board games as a vehicle to approach object relations. Interpretations and comments during the game focused, for example, on rules, the child's need to win or have all the turns, and subsequent problems in relationships and making friends. In one example the analyst was completely excluded from the game. She finally insisted on having a turn, then interpreted the child's difficulty getting on with others. As one subject said about her patient: "This is the way he learned reciprocity, how to receive, to respond, mutual giving and taking and thus, the difference between self and object."

11 Whilst this intervention could be construed as the analyst imposing her values onto the child, there are basic social skills which are needed to get on in the world. Both subjects expressed concern that these skills were absent, as these children "ate like pigs". They already had enough problems being accepted by others. Eating school dinners in this way not only contributed to further isolation, but made them objects of attack by their peers.
Another example was the analyst working with the child on maintaining eye contact. As she explained to her patient: “That’s how people talk to each other.” See figure 12.7.27.

In terms of the child’s self representation, subjects made verbalisations and interpretations. All case examples demonstrated the verbalisation of the child’s feelings about himself. Seventy-five percent included interpretations. For example, how the child felt about himself and how others responded to him, fears of rejection, or feeling damaged. In one example the analyst distinguished between the “little boy” and “big boy” parts of the child’s self representation. This technique allowed the child a displacement figure as he used the concept of his little boy part as a way to talk about his feeling states and defences. Another example was of a different nature. The analyst learned about the child’s self representation by entering his omnipotent fantasy world. Slowly and gradually she began to give minute amounts of frustration by questioning or suggesting there might be more involved. See figure 12.7.28.
In addition to the examples of work on the development of internal controls previously described, 50% of the cases illustrated further work on self management. Subjects verbalised the child's ability to do something, empathised with how hard the child felt it was, but encouraged him to try. Another example was talking to the child about being the boss of himself. See figure 12.7.29.

![Figure 12.7.29: Technique - Self management](image)

**Showing the Child How to do Something**

Two other areas were delineated from the data which relate to one another. Showing the patient how to do something is referred to in other sections, but the examples here demonstrate something not included elsewhere. Fifty percent of examples illustrated this. The analyst showed the child how something worked, taught him how to play pretend games or a new skill, or, as one subject stated, “this patient had to be taught things other children learned naturally”.

The related area is the child practicing these new skills within the sessions (25%). See figure 12.7.30.

![Figure 12.7.30: Technique - Showing how](image)

The interpretation study illustrated this type of intervention as well. Sixty percent of those subjects did this in one way or another which figure 12.6.32 outlines.
Conflict

The last area to discuss is conflict. The study on conflict suggested that not all disturbances are based in conflict, but conflict in some form is involved in all disturbances. As subjects in that study said, conflict can be involved secondarily as deficits gather conflicts around them. However, the analyst’s technique may not involve conflicts, at least initially. Instead, conflict may need to be created, or conflict is analysed after other work has been done. Figures 12.2.7, 12.2.8, 12.2.24 and 12.2.25 illustrate these findings.

The findings in this study concur. Whilst conflict was addressed simultaneously with other work that was going on in 63% of the cases, in 25% conflict was there but the analyst did not pick up on it until other work had been done. Fifty percent of the cases demonstrated the ways in which the analyst introduced conflicts, helping the child developmentally, and worked toward making something which was syntonic dystonic. For example, one set of interventions were aimed at making the child’s use of excitement and anxiety as a way to maintain a relationship dystonic. Other examples included interpretations like: “I see how helpless you feel, but there is another part of you who wants to feel in control”, or, “Part of you feels better being little and looked after, but part of you wants to be big, independent and to have friends”. One vignette showed how the analyst worked with the child on the concept of rules. Eventually, the rules put the child in conflict with the environment which the analyst addressed. The next step was the verbalisation of the child’s internal conflict, in other words, how he both wanted and didn’t want to do something. See figure 12.7.31.

![Figure 12.7.31: Technique - Conflict](image)

A related area which came out of the conflict study data were instances when the analyst places more emphasis in her interpretation on one side of a conflict over the other. The child’s level of development and ego strength is one indicator which influences this technique. Of particular relevance here are times the analyst emphasises the progressive, more grown up side of the child. See figure 12.2.21.

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PART III
EMPIRICAL INVESTIGATIONS

Chapter 13. Defining analytic concepts and techniques: Study 4
A Model of Child Psychoanalysis

INTRODUCTION

When she wrote her Introductory Lectures in 1927, Anna Freud said that there were “two difficult and diametrically opposed functions” which she ascribed to the child analyst. These were to both “analyze and educate”¹. Through the years Anna Freud and others have expanded and refined exactly what she meant by these constructs. “Educate” was a broad term which, for some, meant educating in the sense of what a school teacher does. However, in taking a historical view of Anna Freud’s theories it is evident that what she meant was intervening in a child’s development. Childhood psychological disturbances evolve because the child has somehow derailed from the hypothetical path of normal development. It is the aim of the child analyst to help him find his way back again.

Development is the orienting premise for Anna Freudian child psychoanalysis and it is the foundation upon which this approach rests. When Anna Freud constructed her Diagnostic Profile it was within this framework. The aim of the Profile was to look at the whole child, not only at his symptoms or at one aspect of his psychological functioning. A complete assessment of a child needed to evaluate the nature of his internal world, the level of development he had reached, and the organisation of his intrapsychic structures. In this way the analyst could determine what interventions were needed, and what was the best way of assisting the child to progress developmentally. The model of child psychoanalysis proposed here, which came out of data from of interviews in Study 4 with those who utilise this approach, maintains this framework. Consistently analysts discussed the influence their developmental viewpoint had on their work, both on their aims and the methods which they employ.

The aim of child analysis, said Anna Freud in 1965, is “to turn id into ego content”². What exactly did she mean by this? She would have said this aim was achieved through a process of moving from the surface to the depth. In other words, resistances and defences were analysed before unconscious content (the id). Through such a progression, unconscious fantasies, attitudes and ideas revealed themselves in the child’s material, and
particularly within the transference relationship which served as the vehicle for the revival and enactment of the past. The analyst then interpreted these unconscious derivatives. In 1978 Anna Freud elaborated further. The analytic process involved, she said, "the uncovering of unconscious motivation, reconstruction of past events (traumatic and otherwise), interpretation of transference feelings and behavior" which combat "wrong conflict solutions and inadequately primitive defense", and above all, undo "the regressions which have initiated the whole neurotic process". Through this process the sphere of ego control increased. Furthermore, child analysts aimed to free developmental forces from inhibitions and restrictions which would enable them once more to play their part in the child's future growth.

From the birth of psychoanalysis this concept called an analytic process has been visited and re-visited, dissected and examined, as the components of this process constitute the definition of this treatment modality. Throughout history this process has, for the most part, been defined by its techniques. Authorities in the field (Geleerd 1962, Kramer and Settlage 1962, Maenchen 1970, Feigelson 1977, Bernstein and Sax 1978, Glenn 1978, Ritvo 1978, Ekstein 1979) have said, in one way or another, that the process begins with the analysis of defence and character which then leads to the analysis of repressed wishes, impulses, memories and fantasies as unconscious content is made conscious. The analysis of the transference is an important component, as is the analysis of resistance and internalised unconscious conflict. The analytic process culminates in yet another process, that of working-through. The analyst's primary tool, what she uses to effect change and analyse all of the components of the process, is interpretation. Abrams (1988) placed this process succinctly within the developmental process and refined "to analyse and educate" in a more sophisticated framework which expresses the advances psychoanalysis has made in the sixty years since Anna Freud first made this comment.

Abrams also spoke of the dual role of the child analyst and the two fold aspects of analysis with children. The analyst needs to pay close attention to the regressive pull which the analytic method fosters in order to revive the past and understand the basis of the child's disturbance. Through work on these origins in the transference change can be effected. However, the child analyst equally needs to facilitate progression as the developmental process pulls the child forward. In this way the foundations for the child's future can be strengthened, or even laid if certain aspects are missing. Thus, child analysis is concerned not only with the past, and its impact on the present, but the child's future.

It is clear that analysts agree on certain components of the analytic process which make analysis what it is. Defence, resistance, conflict, transference and interpretation are the ones which are most evident. The data from Study 2 provides further confirmation of analyst's beliefs in the importance of these components. What Study 4 has succeeded in doing is to refine the definitions of these concepts, as well as how the analyst goes about working with them. Some of the basic components of these analyst's internal working models can be found in Anna Freud's writings.

The concept of defence was first elaborated by Anna Freud in 1936\(^\text{13}\). She said that defences could be both pathological and adaptive, served a protective function, operated on an unconscious level, and were mobilised by anxiety. Bornstein (1949\(^\text{14}\)), long before the concept of a treatment alliance was conceptualised, said that the interpretation of defence, and the attention the analyst paid to the child's affects, enabled the child to engage in an analytic process. This engagement is what Anna Freud had referred to as necessary when she originally proposed a preparatory phase, and it was this engagement which this phase aimed to create. The concept of resistance was also elaborated by Anna Freud in 1936 when she described the ways in which resistance provided useful information about mental functioning. In later years she further explained that resistance developed in every analysis, so was to be expected and worked with. The interpretation of defence and resistance were important steps in moving from the surface to the depths as unconscious content revealed itself through these methods, thus influencing the development of the transference.


Anna Freud conceptualised conflict as developmentally determined inner disharmonies which are a byproduct of the developmental process. Normally, the child comes to adaptive solutions to these conflicts, assisted by his parents and other important people in his life. Whilst conflict was originally defined as neurotic conflict and a product of the Oedipal complex, Anna Freud expanded the concept to include pre-oedipal conflicts which were evident in developmental disturbances. What was important for child analysts were internalised conflicts, as opposed to external conflicts between the child and his environment. Internalised conflicts which remained unresolved, or were solved in ways which interfered with functioning and development, resulted in an internal crisis. These crises were one of the things child analysts addressed. Anna Freud also discussed the need at times to introduce or create conflict, especially when working with developmental disturbances. This is most easily discussed when confronted with a child's conflict, or lack thereof, about growing up. Growing up involves losses and gains. The analyst may have to help the child see the incentives of growing up, the things he can gain, for example new capacities, relationships or more adaptive ways of functioning, in order to sustain the losses. Thus, conflict analysis can be seen to be based in a developmental foundation.

The concept which most easily illustrates Anna Freud's modifications of theory based on clinical observations of children is transference. She came a long way from her original propositions that transference in child analysis was restricted to single episodes, and that the focus of the analyst's work should be the positive transference, rather than the negative transference which served as a threat to the process. Not only transference, but the multiple dimensions of the child-analyst relationship occupied her thinking throughout her lifetime. Transference was evident in child analysis, she concluded, even from the beginning of analysis, and was an important tool for the analytic work. However, not all elements of the relationship were transference and she restricted the use of the concept to mean the revival of past relationships and attitudes within the relationship to the analyst. Marianne Kris was instrumental in taking this viewpoint to the United States in the forties and expanding on it further. By the sixties other analysts concurred. For example, Marjorie Harley and Selma Fraiberg (1964) spoke of the ways in which the revival of past experiences in the transference occurred in child analysis through the lifting of repressions and the interpretation of the child's relationships with primary objects and the analyst. However, in agreement with Anna Freud, they thought not the whole of the analysis was under the influence of the transference, as the dimensions of this relationship were complex. In 1965 Anna Freud elaborated on the double relationship the analyst and child have with each other. The child enters analysis seeing the analyst "as a new object and treats him as

such, so far as he has a healthy part to his personality”. Equally, the analyst is a transference object as the child uses her "for repetition". This double relationship, she concluded, "is not easily handled by the analyst". The participants in Study 4 agree that the child-analyst relationship is at minimum a double relationship, if not even more complicated than that. It seems that the degree to which all of the components of the relationship are evident is dependent on the child, and what aspects the analyst emphasises and works with are based on the child's disturbance and what he needs to assist him with his developmental progression.

Anna Freud also outlined the process of the evolution of the transference. Initially, she thought, the real relationship between the child and analyst was what was most dominant. Slowly, over time and through the analytic work, the transference relationship took over with the development of a full fledged transference, and sometimes even a transference neurosis in its traditional sense. During the termination phase the transference diminished as its components were worked through, and the real relationship established itself once more. Whilst this sort of outline makes it sound as if these dimensions of the relationship are clear cut, in reality, said analysts in this study, this is not the case. These same analysts outlined a similar process in their work with patients.

Interpretation, all analysts would agree, is the primary method they use. Hansi Kennedy (1971), in agreement with Anna Freud and Ernst Kris (1956), said that what the child analysts does is to observe patterns and themes in the child's material. It is these patterns which she basis her interpretations on. This idea comes out of the notion that experiences are molded into patterns as the child's distortions, projections, conflicts, and aspects of later phases of development are superimposed on the original situations. It predated in a far sighted way what is now known about the development of self and object representations and memory from research conducted by developmental psychologists (Daniel Stern 1985). What the analyst does in her interpretations is to construct these patterns of experience and verbalise the affective significance for the child, and to show him the way he functions in a particular manner in the present based on these patterns. This importance of patterns and themes is evident in the results of Study 4 as a guide to the analyst in what she interprets. Furthermore, a developmental viewpoint also plays a role. Ritvo (1978) elaborated on the tool of interpretation and also placed it within a

developmental framework. The child's ability to carry out the steps of abstraction, conceptualisation and generalisation needed to be considered when the analyst presented her interpretation so that the child could both comprehend and hear what was being said to him. These considerations were in addition to the content of the interpretation, the timing of it, and the role of the child's resistance.

Finally, Anna Freud thought that affects were central and crucial to analytic work with children. It was through the observation of the child's affects and their transformation during, not only the analytic process, but in any given session, that the analyst could begin to understand what the child was trying to communicate. Subjects in this study concurred as affects act as a guide, and are instrumental in and related to all of the components of the analytic process.

The one concept which was studied in this thesis which has not been discussed is object relationships. When she spoke theoretically, Anna Freud viewed object relations within a drive model, although she did propose a developmental line of object relations which began from the position of the child's dependency on his parents and progressed to emotional self reliance and the capacity for adult relationships. Whilst some contemporary analysts at the Anna Freud Centre have retained the connection between drives and object relations, the viewpoint of object relations separate from drives and the formulation of internal representations is very apparent. This orientation is elaborated further in the model.

As the scope of child analysis continually widened over the years, Anna Freud concluded that not only neurosis, but developmental disturbances defined in a broad sense, were the subjects of this treatment approach. The techniques analysts employed included not only those which have been described, but resulting from this widening scope and a developmental perspective, others have also been considered to be valid. Sandler, Kennedy and Tyson, along with Anna Freud, concluded in 1980 that there were no absolute techniques when it came to analysing children, but adaptations of a set of analytic principles. Equally, children suffered from not one specific type of disturbance, but a

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mixture of disturbances. Thus, what child analysts do is use a whole range of therapeutic aims and means which are conceived of psychoanalytically so that all parts of the child "are given the change on the one hand to reveal and on the other to cure themselves"\textsuperscript{22}.

The theory of child psychoanalysis is constantly developing and its techniques ever evolving. What Study 4 attempted to do was to develop and evolve this model further based on what analyst's actual do. By examining their internal working models through interviews based on analyst's own clinical work, the theory is clarified and a model of child analysis within a contemporary framework can be delineated. From the data obtained in Study 4 it is possible to describe a model of child psychoanalysis as practiced at the Anna Freud Centre. There are certain basic premises common to all of the seven concepts studied which constitute a general framework for this model. Within each concept is a model of how analyst's understand and apply the construct. This model is described in detail in what follows. As Anna Freud said in 1970: "We should gradually evolve a technique which fits the child perfectly...We haven't yet done so. We are nearer than we were twenty years ago, or even ten years ago, but we are still quite a long way off"\textsuperscript{23}. This study hopefully takes child analysis one step closer.

AN OVERVIEW OF THE MODEL

Analyst's at the Anna Freud Centre are grounded in the topographical model, a model which orients and motivates all of the components of child analysis. One of the intermediary aims inherent in every concept is to bring that which is unconscious to the child's conscious awareness. The aim of interpretation, the analyst's primary tool, is the same. Analyst's believe there is something in the depths of the psyche which is causing the child some sort of problem. Manifestations of unconscious content are observable to the external world, having found their way to the surface in derivative form through the systems preconscious or conscious. The techniques of child analysis are directed at these derivatives which prompts the material to deepen. Eventually, the related strands of the problem reach the child's conscious awareness and some kind of change is effected.

This is a general description of a model applied to what analyst's call the child's internal world. Defence, conflict, affects and internal object relations are the aspects of this world which were studied here. There are others analysts referred to, for example, self representations and fantasies. The classifications of unconscious content organised around

the Study 2 data included: psychological processes, feeling states and intrapsychic structures. The manual authors conceptualise the internal world as representations and the mental processes which create them.

What the analyst tries to do in relation to this unconscious content are her intermediary aims. The means of interpretation and transference involve intermediary aims. Other concepts also include outcome aims, the end points the analyst hopes to reach.

How the analyst meets her aims are her means. Means are the methods and techniques the analyst employs. The primary tools are interpretation and transference. As it is affect which guides the analyst and points her in certain directions, affects too are means. Interpretation has many components when understood within the context of complete and partial interpretations. Other means the analyst utilises were referred to throughout the study, but were not researched specifically. These included: treatment alliance, counter-transference (often referred to as counter-response and affective response), and other dimensions of the child-analyst relationship. Developmental help is another method, discussed under developmental disturbance. Means are directed at unconscious content and all of its derivatives.

This work takes place under the umbrella of the analytic process. The process was referred to continuously throughout the interviews. The combination of all of the components of child analysis create the process. Analytic process is the environment between child and analyst which makes the work happen. It is the movement, the flow, the rhythm, not only of one particular session, but of all sessions put together. Timing, the importance of which subjects discussed again and again, is part of this. The relationship between child and analyst, in all respects, is a crucial factor which contributes to the environment and the movement. Interpretation is also part of the process. It contributes to the flow as unconscious content is uncovered and the material deepens. Working-through is a component taking place throughout and within the overall process. Resistance could be conceptualised as part of the process as well. It is unconscious content, but it is specific to the analytic process and works against movement and knowledge.

The environment's contribution to the process and the analytic work is important to note. Although it was not studied, it was referred to in relation to various concepts. Environmental factors can both help and hinder the analytic process.
COMPONENTS OF THE MODEL

DEFENCE AND RESISTANCE

Definition of Defence

Defence is an aspect of normal psychological functioning. From a theoretical perspective, it is an unconscious mechanism commonly ascribed to the ego.

The purpose of a defence is to protect the child in some way. Defences provide a sense of safety, protect the child from being overwhelmed by anxiety or loss of self esteem, and can keep the child from recognising certain aspects of his internal world which he feels are threatening. Equally, the child may protect himself from aspects of external reality. What is defended against is unconscious. The defence itself is also an unconscious or preconscious process. There can be a conscious purpose to defence as well, for example, when the child decides there are certain things he does not want to talk about or experience.

There are a multitude of factors a child defends against. These include affects, conflicts, realities, fantasies, impulses or wishes, or characteristics of his self representation. In other words, anything which is felt to be dangerous, painful or unpleasant. When the conscious experience of one of these threatens the child, anxiety signals the activation of defence, thereby guaranteeing the child is protected.

Although no one has ever systematically studied the idea of a developmental line of defence, there is general agreement that certain defences are expectable and appropriate at specific developmental phases. However, it can be difficult to determine which defences are appropriate and which ones are not at any one time. This is due to the fact that defences are carried over throughout development and, especially with children, more primitive types of defences often operate alongside more sophisticated ones.

Defences can become problematic to the child. When certain defences are overused or relied upon too heavily at the expense of other ways of functioning, the range of possible defences is restricted. Defences can be maladaptive, or used when more
progressive and developmentally appropriate ways of coping would be more prosperous. These result in a restriction or cost to the personality. Problematic defences interfere with the child's capacity to perceive reality and hinder the developmental process.

**Definition of Resistance**

Whilst defence is a psychological concept, resistance is a clinical concept. It pertains specifically to the psychoanalytic situation and is a characteristic of every analysis.

Often the child's most typical defences are used in the service of resistance. Like defence, resistance serves to protect the child, but it is a more global response. Descriptively speaking, defence keeps something in or out, as a force pushing against something else holding it back. Resistance, on the other hand, prevents movement, as in trying to pull something along and it won't go.

Resistance protects the child from something within the analytic process itself, or from an aspect of self or object representations. It acts to keep the child from understanding or gaining further knowledge. Resistance can be directed against certain components of the analytic process or interpretations. Equally, it works against self knowledge or knowledge by the object. In other words, the child does not want to recognise or accept something about himself, and/or does not want another to know.

There are specific types of resistance as well. Children consciously withhold information which serves the purpose of resistance, a process different from a basic unwillingness for therapy. Character resistances, where resistance becomes an aspect of a character formation and a habitual mode of relating, is another. This links with defences which become ingrained as character traits. There are also resistances which indicate the child is pacing himself, as he needs time to absorb an interpretation or insight, and allow it to settle. This is the least serious type of resistances, and often thought of as the way the child's material tends to flow.

**Aims**

The analyst's outcome aim is to make certain problematic defences redundant. Through the analysis of the defence and what is being defended against, the child discovers the defence is no longer needed as what was defended against is allowed to become part of reality. There are four intermediary aims related to this goal.
The first is to bring what is defended against from an unconscious to a conscious level. This involves the affect, conflict, wish, etc., or focuses first on the anxiety which initiates the defence.

A second intermediary aim is to help the child find more adaptive solutions. These are solutions or adaptations specifically to what is being defended against.

The third intermediary aim relates to the first two. These are aims linked to the defence itself. For example, the aim may be to undermine a defence, or for the child to gain insight or knowledge about the defence. As a result the defence no longer interferes and/or the child grows increasingly able to catch himself from acting in the same way. This relates to the process of working-through.

An additional aim, and perhaps a direct outcome of the others, is to assist the child in finding more adaptive defences, broadening the range of defences available to him and reducing the use of excessively restricting defences.

When defences do not fulfill their role of protecting the child from being overwhelmed by anxiety or loss of self esteem, the analyst's aim is to help the child build defences which are adaptive and functional. If the defence is against a reality, although painful and unbearable for a child, it is a reality. Different aims than ones where the defence is against an anxiety related to the past are required.

Means

It is difficult to separate the technique of defence analysis from analytic technique and process as a whole. The transference and the relationship between child and analyst is the framework within which analysis takes place. The analytic process, with a beginning, middle and end, is the context within which the analysis of defence and resistance occurs.

Establishing a safe and trusting relationship with the child, and finding a shared mode of communication which is understandable and acceptable to both patient and analyst, are aspects of this framework. This falls under the heading "Treatment Alliance", without which an analysis has a difficult time proceeding.

The analyst works to understand a child's communications and the way he brings his material. She looks for information from the child which clarifies what the defence or resistance is and the purpose it serves, trying to further understand what lays behind it. This
information presents itself in a variety of ways, but there are common areas the analyst looks to. The child's play and activities provide information, be it directly or in displacement, as well as changes in the play which take on a new meaning. Repetitions are other areas closely examined. These can be repetitions of a behaviour or an activity, or anything which repeats itself over and over, as the analyst looks for patterns. How the child presents himself, his behaviours, characteristics and mannerisms; the quality of the defence or how it manifests itself; the transference; the way in which the child confirms interpretations; incongruities in the material; and information from parents are other clues to defence and resistance.

Once the analyst has gathered enough information, she usually begins by making verbalisations. These involve acknowledging the defence, or verbalising the presence of a defence and its reason for being, using examples from the child's material.

The analyst builds up to an interpretation. She may interpret the defensive function or the anxiety without knowing what is defended against in order to gain further information. Eventually, she interprets the defence, the reason for the defence, and what is defended against. This occurs repeatedly, in different ways and in different contexts, as part and parcel of the process of working-through.

The timing of interventions is important. In addition, the analyst needs to be careful how she intervenes, the words she uses and the tone of her voice. This enables the child to hear, take in and use the analyst's interpretations.

Analysts make decisions during the course of a treatment whether to analyse all defences or just some, and if so which ones. The emphasis is on those defences which are getting in the way of the child managing. The analyst constantly assesses this. If a defence is not interfering it may not be a focus of the analysis, or if a defence is part of an ongoing developmental process the analyst may also leave it alone.

The analyst's developmental viewpoint informs her technique and assessment of a child's functioning. The way the analyst intervenes and the words she uses depend on the developmental phase the child is in and what conflicts and defences are expectable. As certain conflicts or defences seen at one phase may not be appropriate at another, this influences the analyst's decision about which defences to focus on.

The technique of analysing resistance is similar to that of defence with some variations. As resistance is against movement, the analyst helps the child clear the path,
empathising with the difficulty, or putting out the right carrot or face saver. Resistance is against the process and/or internal representations. Therefore, the analyst's interventions can focus on shame and guilt, and the child's fears of revealing himself.

**Other Considerations**

With borderline or psychotic children defence analysis is not necessarily an integral component of the analytic process. In general, these children have few defences to work with and unmanageable anxiety. Consequently, the analyst's aim is to build defences as she works on the side of the ego.

With children who exhibit more narcissistic disturbances, defence analysis is important. Although the aim remains the same, the technique varies as interpretation of defence is felt as an attack by the child.

With character pathology the analyst also works to reach what is defended against. However, this can taken a long time and a lengthy working-through process is required.

External reality is another important consideration. For children who have been traumatised or live in or with a dysfunctional environment, defences may not be against something based in the past, but against a difficult reality. Although defences against a horrendous reality may, in some ways, be problematic, in other ways they may be the best possible method the child has to manage at a given time.

**Psychotherapy**

Whether a child is in psychotherapy or psychoanalysis, the analysis of defence and resistance is an important part of the therapy. The technique does not seem to alter based on the treatment modality. However, the analyst is especially careful in her approach if the interpretation of defence or resistance will leave the child with anxiety which he will have difficulty managing on his own between sessions.
CONFLICT

Definition

Conflict is a normal part of life and the developmental process. Age adequate conflicts and solutions occur with each developmental stage, however not all conflicts are linked to development. Some are unique to a particular individual. Conflicts serve a useful function and motivate defence.

Conflict, be it conscious or unconscious, occurs whenever contradictory wishes, aims or ideals are simultaneously present. Sometimes conflict is experienced as being pulled in two directions which oppose each other, either direction involving gains and/or losses.

The existence of conflict implies some degree of internal structuralisation. Some analysts conceptualise this within Freud's tripartite structural model, for example conflict between the ego and superego. Others understand conflict within an internal representation model, for example between representations of self and object.

In normal development some form of compromise is reached for conflicts as they arise which allows the individual to feel and behave in certain ways which are acceptable to himself and the culture in which he lives. Such conflicts only become problematic and material for the analytic work when they are linked with unconscious anxiety. This anxiety either prevents the child from finding a solution to the conflict, or he finds one which is maladaptive or dysfunctional in some way. At times, the conflict and the solution are both disturbing to the personality, or conflict becomes ingrained in the child's character structure resulting in a habitual mode of relating. Unresolved conflict or dysfunctional solutions stimulate anxiety, impinge on the child's sense of well being, impede developmental progression, and/or interfere with functioning in some way.

Neurotic disturbances are based in unresolved or pathologically resolved conflict. In other disturbances, many of which originate in deficits, conflict is involved secondarily as development progresses. Therefore, whilst not all disturbances originate in conflict, conflict in some form is involved in all disturbances.
Aims

The analyst's outcome aim is to help the child come to a resolution to conflict which promotes developmental progression and does not interfere with functioning, solutions which are adaptive and productive to the individual. The intermediary aims include the recognition and revival, preferably in the transference relationship, of past and present conflicts which impinge on the child's present day life, and to interpret their unconscious elements in sufficient detail to meet the outcome aim.

Means

The analyst scans the child's material, observing the ways in which conflicts and anxieties manifest themselves. She looks for what is interfering with the child's development, distorting his personality, or preventing optimal functioning as she attempts to determine patterns. Through this process she connects various aspects of the material and different sessions together. As conflict has multiple dimensions and ramifications, and many things feed into it, the analyst looks for all of the strands to the conflict. In this way she builds a picture in her mind of what the child's conflicts are and his attempts towards resolution, forming hypotheses which are checked out as the material develops. The analyst aims to determine the origins of the conflict.

The analyst's picture of conflict is formulated through her observations of the child and his material. She pays special attention to the child's affects, especially his anxiety; defences and inhibitions; dreams and fantasies; play and behaviour; symptoms; in addition to what is missing in the material. Whilst all of these areas and modes of communication provide data about conflicts and their resolutions, the child's relationships are the most informative. This means the transference, but also his relationships in general including feelings and desires about and attitudes toward the analyst, other people and himself.

The analyst begins by identifying and verbalising to the child what the conflict is and relates it in various ways to the material. She identifies patterns to the child, makes links to other things, explores affects and anxieties, and works with defence and resistance. She may point something out related to the conflict, or wonder about something the child has said or done, in this way engaging the child's participation and curiosity. The analyst explores the child's thoughts and fantasies, addresses competing pulls within the child, and assists him in the awareness of his own contribution to conflict. As the analyst and child move toward the origins of conflict, they work through all of its strands and ramifications.
Throughout this process the analyst makes interpretations. When interpreting conflict she will eventually addresses both sides of the conflict, but this is not always possible or indicated initially. Her decision to interpret only one side of the conflict may be based on known factors. For example, the nature of the transference, what the child is able to tolerate at that moment which his level of anxiety or self esteem indicate, and other timing factors. Furthermore, as conflict is unconscious, the analyst does not always know what both sides of the conflict are. She takes what is most near consciousness, then waits and listens for the other side to surface.

At times the analyst chooses to emphasise in her interpretations one side of the conflict over the other. Again, issues of self esteem and the child's tolerance capacity are factors, but the level of development and ego strength are also guides. In certain circumstances, the side of the conflict which favours progressive development is more strongly emphasised. The analyst is also cautious not to undo reaction-formations or encourage acting out.

Eventually, conflicts come into the transference and are enacted within this relationship. This is an important piece of the work as it is in the transference that the form and meaning of conflicts become clearer. Conflicts may be observable first in the transference, then related to the outside world, or this process may be reversed. Either way, conflicts are analysed where they present themselves, both in and out of the transference.

Through the process of interpreting conflict and all of its ramifications, the child finds solutions for himself which are adaptive and promote progressive development. Therefore, the analyst is not in the position of offering solutions to the child. She may at times wonder about possibilities or remind the child of things he use to do, but this is more closely related to the process of working-through.

Not all conflicts come into the analytic work, or the analyst may decide not to address certain conflicts which she observes. As conflict is part of everyday life and ongoing development, only those which are causing some sort of problem are subject to intervention. The analyst also determines whether her interpretations would undermine adaptations or solutions which themselves are problematic, but are the best the child can come up with at a given time due to environmental circumstances, trauma, developmental transitions, or the phase of treatment.
Other Considerations

Not all disturbances are based primarily in conflict. Some have their origins in ego and object relationship deficits. With these patients, the technique is different as the analyst focuses more on strengthening the ego and building defences. Where adaptations to environmental circumstances are dysfunctional, the analyst may need to show the child another way. In other instances, creating conflict may be an aim. As conflicts are involved secondarily in these disturbances, conflict may be analysed simultaneously, or the analyst may move toward conflict analysis once work on the deficits has advanced.

Psychotherapy

The analysis of conflict is as important in psychotherapy as it is in psychoanalysis, however the same depth is often not achieved as the analyst will not have the same opportunity to observe all of the vicissitudes and strands of unconscious conflict. At times she may intervene without as much information, relying more on hypothesis, take a more active role, or use the here-and-now relationship without links to the past. Usually the transference does not provide as much information in psychotherapy as if often isn't as intense. Thus, the ability to work through all of the strands of conflict can be curtailed in psychotherapy. The aim of conflict analysis is the same in both treatment modalities, but in psychotherapy the work tends to progress at a slower rate. The analyst has to be especially careful in her approach to conflict as she will not be able to provide the same support and input due to the frequency of sessions.

AFFECTS

Definition

Affects are complex feeling states. They encompass a wide spectrum, from a vague mood state to something which can be quite intense and emotional. Affects are rooted in biology and have important psychological functions. They serve as primary organisers of mental functioning as affects provide the basis for attributing meaning to experiences.

Affects have a signal function which serves to initiate defence or other adaptive capacities. They can function in a powerful way leading to mechanisms which keep thoughts, actions, other affects, etc. out of conscious awareness. This is especially true with
anxiety and guilt and the initiation of defence. Affects also function as motives. They motivate behaviour, thought, fantasy, conflict, development, or practically anything. Affects can be used in the service of development and to increase or decrease self esteem.

There is theoretical disagreement with the idea of unconscious affect. Whilst some agree affects can be unconscious, others believe it is what gives rise to affect which is unconscious, not the affect itself. Once unconscious content enters conscious awareness, a feeling state responds and the affect is then experienced by the child. However, the theory and technique are divergent as analysts agree that technically they work "as if" affects are unconscious.

Affects become increasingly differentiated as a child progresses developmentally. A young child may have more extreme or sharper feelings which become more discrete as he grows older. Any child will express his affects through words and actions.

Anxiety and guilt are two affects which hold a special place in psychoanalytic theory. Guilt and anxiety have structuralisation and developmental implications not found with other affects. A developmental line of anxiety has been conceptualised. Thus, the type of anxiety a child experiences can be an indicator of a developmental phase, conflict or difficulty. Guilt is linked with personality structure, specifically an internalised superego. This is not to say that children do not experience something along the lines of guilt prior to this developmental milestone; for example social anxiety, fear of doing something wrong, or fear of loss of love, or that this milestone is pinpointed to a certain age or developmental phase. Rather, guilt and a superego are related.

Aims

Affect is at the centre of therapeutic work with children and is involved in all aspects of psychoanalysis. Analysts are ever watchful of affect. They continuously monitor its presence or absence, the type of affect expressed, whether the affect is appropriate to the situation, and changes in affect. In this way affect acts as a guide, leading analyst and child into areas which would be beneficial to explore. Affect also provides clues to the unconscious meaning of the child's material.

As the way into other areas to be analysed is affect, the aim varies dependent on these other things. For example, the aim may relate to defence, conflict, self and/or object relationships, unconscious fantasy, or transference. However, there are certain aims which are specific to work with affects. Making unconscious affect conscious is one. In
monitoring affect, the analyst observes the child's patterns of dealing with affect, often those which are most painful. Helping the child see and understand these patterns is a further aim, which then leads into other areas to be analysed.

Affect is the basis of the relationship between child and analyst, a relationship which is vital if the analysis is going to succeed. The identification of affects aids in the development and nurturance of this relationship. By being affectively intune with a child, he is apt to feel more understood which in turn facilitates the analytic process.

The analyst aims to understand a child's affects and experiences and help him feel there is someone who is trying to understand him. Whilst not all children wish to be understood at all times, and interventions do not always promote this experience, in general it is helpful to the child to sense that he is not alone with his feelings and that the analyst acknowledges and implicitly accepts them. Understanding affect and the child feeling understood hopefully helps the child make sense of his emotional experience.

Means

How an analyst approaches a child's affects and what she does is difficult to separate from the rest of the analytic. Just as the aims change dependent on where the affect leads, so too does the means. The techniques the analyst uses change dependent upon the child, his level of development, the phase of treatment, and the degree of pathology. However, there are certain guidelines analysts adhere to.

As affect guides the analytic work, the analyst monitors it continuously. Her ability to do this is based on her observational skills which become, in some ways, second nature to her. The analyst looks to what and how the child presents his material and the overall affective tone of the session, as well as the subtleties and nuances found in the child's verbal and non-verbal presentations. Uncharacteristic reactions, inappropriate affect, and the different levels of the material are other clues. Any analytic material can provide further clues to the child's affects. Some examples include: the child's play, drawings, fantasies, how he is with the analyst, what he says or how he acts towards others, and the analyst's counter-response.

The observation and monitoring of affect occurs within an overall process. Thus, it is not only one session which the analyst holds in her mind, but all that has gone before. This includes material from previous sessions and what the analyst knows from the child's history, as she looks for patterns of affective experience and coping strategies.
Work with affects takes place within this overall process as well. The process includes a series of steps, often repeated depending on how the child pacifies himself, as the analyst builds on previous material. The analyst may begin by acknowledging a feeling or empathizing with the child's experience of a painful affect, drawing the child's attention to certain affects, verbalising and clarifying. She may also educate the child about unconscious processes, for example, that there are things he is not aware of or contradictions which present themselves, and engage the child's curiosity about the appearance and origins of affect, both of which facilitate the analytic process and self observation. The analyst labels and differentiates affect with the intent of not only providing words for the child's feelings, but giving him a way of internally representing affect. Pointing out patterns, linking affect to other things, often to past experience, and the interpretation of affect are other techniques.

As affect is used as a guide, there are times it is observed but not interpreted. For example, the affect may not be the focus of the work at a particular time, rather what the affect has led to. When affect is appropriate and recognised by both analyst and child, or is obvious, interpretations may be a mute point unless to acknowledge a feeling state. As with all interpretations, timing and reality factors are an influence.

Interpretations may initially involve only the affect, but eventually the analyst will include other areas the affect is linked to. The child's affects as they relate to his external or internal world are included in interpretations, however when the environment is a factor the analyst will consider whether there is additional meaning in the transference. Dependent on the level of ego development and how adequate the child's defences are, the analyst's interpretations may emphasise containment of affect and defensive operations, instead of affective expression. This helps the child from being overwhelmed and assists him in building needed ego functions.

Although there are exceptions, the interpretation of affect can lead to the child feeling relieved. This is dependent on the timing of interpretations, how safe the child feels with the analyst and within the process, and his readiness to hear and take in the analyst's words.

Work with affects has a direct link with the development of the child-analyst relationship. The relating of an affective experience and the feeling of it a child has in the presence of the analyst binds the two together. This in turn aids in the development of a treatment alliance. Furthermore, it is this affective experience which makes the transference work. Affects related to significant people in the child's life, and his past relationships and
experiences, are repeated in the transference. Affects which are problematic for the child will eventually make their appearance within the transference relationship as well. The identification of these earlier in treatment aids in the development of the transference. However, once in the transference these affects may be repressed or avoided, as they are too close to conflict.

Whilst it may be indicated to keep interventions in displacement or to address the child's affects in relation to extra-transference relationships, eventually it will make more sense to the child to talk about these in direct relationship to the analyst. Some children need help to do this. For example, the analyst may address the anxiety this affective experience in relation to the analyst engenders. Especially in the early phases of treatment, it is sometimes helpful to educate the child about the mode of conducting an analysis as the sharing of affect is what the relationship is about.

Whilst all affects are a focus of and important to the work of analysis, the analyst pays special attention to anxiety and guilt. She is interested in how the child copes with his anxiety, whether this is adaptive or not, and adjusts her technique according to the child's tolerance of anxiety. Both anxiety and guilt guide the analyst to areas which are productive to explore. Anxiety can lead to conflict and defence. When guilt is evident, the analyst often thinks in terms of the child's superego. Guilt can guide the analyst to childhood fantasies, relationships and sexuality, as well as expectations a child has about himself and his experience of not meeting up to these.

The Influence of Development and Pathology on Technique

What the analyst tries to do in relation to affects, and how she goes about doing it, varies considerably dependent on a multitude of factors. The developmental level of the child and the type of pathology are two worth noting. The primary factors are the child's level of ego development, affective development and, in certain cases, distortions in self representations.

When the child's ego is immature or weak, the analyst may need to contain affects as a way to help the child establish self control, build defences, and develop affect's signal function. The child may need further help differentiating affect and creating its internal representation so he can recognise what he is feeling. The techniques of labeling and breaking affects down into manageable and understandable entities are two means to this end.
The creation of internal representations of affect may also be indicated with children whose affective development has been problematic in some way. For example, children who have been fundamentally misrecognised by their environment or have other environmental deficiencies, ones who have severely repressed their feeling states, or children who suffer from narcissistic disturbances of some kind. These children may need further help differentiating their affects from others and allowing entrance of affects and experiences into conscious awareness.

Whilst the interpretation of affects may, at times, not be felt as a relief to all children, with those who experience these particular difficulties the analyst needs to be especially aware of this outcome. Interpretations can result in the child feeling angry, criticised, attacked or intruded upon. Further anxiety, resistance and acting-out may result. If, in the transference, the analyst is perceived as someone who knows the child's thoughts and feelings, interpretations can engender further anxiety as well. Thus, the analyst needs to take these potential responses into consideration when she approaches affective states and experiences.

Psychotherapy

Monitoring and working with the child's affects are equally important in psychotherapy. However, techniques may vary due to the frequency of sessions. The analyst needs to be careful in her approach to affects as she does not have the opportunity to deal with them in the same way. Thus, she may be more selective in what she picks up on as she doesn't want to leave the child with undefended affects he will have difficulty coping with on his own, or emphasise containment in her interpretations. There can be a less comprehensive acknowledgement and exploration of affects in psychotherapy than is found in psychoanalysis.

TRANSFERENCE

Definition

Transference is a universal phenomena which occurs to some degree in any and all relationships. A general tendency to repeat past relationships in the present is transference in its widest sense. A narrow definition of transference is more helpful to the understanding of this phenomena within the analytic situation.
Various metapsychological models are used to orient the analyst and assist her in understanding the psychic structures and processes involved in transference. Whatever model is applied, certain components are common which add clarity to the clinical definition. Transference occurs within the analytic situation when a relationship, or an aspect of a relationship such as certain affects or attitudes, with someone other than the analyst is revived and recreated with the person of the analyst. Transference has its origins in the child's relationships with significant people in the past. At times, current relationships are also transferred, especially with the young child whose parents continue to be important figures in his ongoing life. Transference also includes unconscious fantasies and superego identifications and internalisations, as well as internal self and object representations, or the interaction between the two. These relationships are enacted with the analyst through the processes of externalisation and projection.

Transference is an unconscious process. As it intensifies in relation to the analyst, it takes on an illusory quality. The child's current feelings, fantasies, thoughts and behaviours toward the analyst become increasingly dominated by real or fantasised early experiences and interactions between the child and his primary objects. To the child the transference becomes real and immediate as he experiences the analyst in a way which is a distorted view of who she actually is.

Transference is the major vehicle for the analytic process. It is a clinical tool used by the analyst to both understand the relationships a child has, be they internal or external or both, and to bring about change. Once the child's relationships enter the transference they are more analysable as they become emotionally alive, are current in the here-and-now relationship with the analyst, and become intensely focused there.

Aims

The analyst uses the transference as a way to understand the nature of the child's relationships, his difficulties, and what is going on within the analytic process. Through the setting and the way in which she offers herself, and through the acceptance of the child's perceptions of her, the analyst aims to assist the child in bringing his relationships and problems into the transference. Transference provides a source for unconscious material to reveal itself through changes in the child's relationship and attitudes to the analyst. The psychoanalytic process facilitates regressive shifts and with it the re-emergence of childhood wishes and modes of relating which in turn intensifies the transference.
Not all aspects of the child's relationship with the analyst are transference. The analyst attempts to differentiate these other elements from the transference.

By working in the transference, the child's ability to observe himself increases, the unconscious meaning of the transference comes into conscious awareness, and the child is able to work through his difficulties. In this way the analyst aims to ameliorate changes in the child. Specifically, these outcome aims are related to shifts in the child's relationships to internal and external objects, and to himself.

**Means**

From the beginning of treatment the analyst is interested in how the child relates to her. Whilst the analyst attempts to recognise the first roles the child puts her into, in most instances this is not transference. Transference is something which gradually develops, thus the analyst will wait for it to begin to show itself and become clearer.

As the relationship grows the analyst will be able to better understand the transference if she distinguishes the various elements which enter into this relationship. Aspects of the relationship usually include the use the child makes of the analyst as a real object. In addition, the child may exhibit a habitual mode of relating or use the analyst as a new object which is different from his previous experiences.

The analyst looks for various indications in the child's material and his style of relating which provide her with information about the developing transference. Most importantly is the child's relationship and interactions with the analyst. The analyst observes the child's behaviours and attitudes toward her, the way he presents himself, his affects, as well as changes in all of these, looking for patterns and repetitions in his manner of relating. The child's curiosity about the analyst, questions of her, and responses to separations also provide clues. The analyst pays close attention to the child's expectations of her and the roles he assigns to her, either in the play or within the relationship. As the illusory quality of the transference intensifies, the analyst observes behaviours, affects, thoughts and fantasies coming from the child which are incongruent, inappropriate, or distorted in terms of the situation and the real relationship. The child's relationships with other people and to himself, the content of his play and dreams, as well as the analyst's counter-response, provide other valuable clues.
The analyst thinks about the transference within a developmental context. This includes an assessment of many lines of development, but specifically the child's level of object relationships. A developmental viewpoint assists the analyst in her understanding of the transference and influences her technique.

The analyst aims to help the child bring transference elements into the relationship with her and to focus the treatment in this direction. The setting and the way in which she offers herself influence the development of the transference. The analyst keeps the transference in mind as she listens to and observes the child, staying alert to what is happening and wonders how, or if, she fits in. She may draw the child back to her when the material is moving in another direction, or when the transference is out of the child's awareness, bringing herself in when it is indicated and relevant. Interpretations of defence uncover affects about or perceptions of the analyst which assist the development of the transference as well.

The transference and its illusory quality intensify as the child's affect and attachment become increasingly focused on the analyst. The analyst and the treatment situation become more and more important to the child, and he may begin to bring less from the outside world. Opportunity for transference distortion is enhanced by the analyst not feeding back information about her own life in order to correct the child's misperceptions, and by reflecting on the child's wishes, intentions, conflicts and concerns without adding value judgements. There are times it may be necessary to answer a child's questions about the analyst if the child isn't able to tolerate the frustration of not receiving a response. The analyst's refusal to answer may be taken as a tease or experienced as hurtful, and result in the child withdrawing and/or the underlying fantasy never being revealed. What is important is not the question itself, but the associations, thoughts, wishes and fantasies about the analyst which lay behind the question.

The analyst allows the illusory quality of the transference to develop and does not correct the child's perceptions or distortions of her. However, if the child's anxiety is overwhelming or his reality testing is lost or weak to begin with, the analyst may need to help the child re-establish the "as if" quality of the transference. She will do this in the form of an interpretation using the child's perceptions of her to demonstrate to the child what is coming from inside him. For example, she may say: "I am not angry with you, but you seem to feel that I am because..."

It is important the analyst not direct the child's material, but at the same time not block it either. Timing is always a factor. The analyst assesses when the timing is right to
pick up on an aspect of the child's material and what the child is able to hear at any given moment. The analyst may initially comment on or demonstrate to the child something coming from his material about the relationship or the transference. She follows the child's associations and his play, clarifies and explores further, and gives interpretations. All of these interventions assist the child in bringing further material which add clarity to the transference and intensify it. Through her interventions the analyst brings the unconscious meaning of the transference and fantasies into conscious awareness.

Most importantly, instead of accepting the role the child unconsciously assigns her, the analyst interprets what the child is trying to enact. When this occurs in the child's play, the analyst may step into a role until she understands the meaning, then step out again and make an interpretation. As the transference shifts, sometimes quite rapidly, and changes at different stages of the treatment, the analyst attempts to keep track of who she is representing to the child at any given moment.

Transference becomes a source of resistance to the analytic work when it is not recognised, understood or appropriately interpreted. Equally, resistance is to be expected due to the child's inhibitions, fears or restrictions to developing a relationship, or because of defences against closeness, all of which become a part of the analysis and the transference.

The child's affective experience with the analyst is a crucial component. The analyst works with the feelings in the consulting room, keeping the intensity with her as much as possible. There are times, however, when the transference is too immediate and threatening and the child needs the space to talk about something outside of treatment. As always, timing is a factor and the analyst uses what the child is capable of bringing.

When the child's material is focused on relationships or situations outside of treatment, the analyst determines whether this is about the transference in displacement and when there is no link. In order to make this assessment she looks to the relationship between herself and the child and the transference, the child's affects, patterns in or repetitions of this kind of material, and the context in which the material is brought.

Whilst it is important to keep the transference with the analyst and work on it there, usually the analyst wants to eventually make links to its origins. These can be to internal objects, external objects, the past or the present. Working in the transference facilitates the process of working-through and assists the analyst and child in reaching their outcome aims.
With young children it is especially important to make links with the transference and the primary objects as parents remain crucial to the child's developmental needs. Unlike an older child who is able to keep objects more separate, younger children tend to blur their objects into one. Therefore, the analyst is more inclined to address the external objects in addition to the transference in an ongoing way.

Ideally, the analyst aims for resolution of the transference by the termination of the analysis. During termination the child begins to naturally move away from the analyst and the process. Friends, outside activities and interests become increasingly important. A different kind of relationship with the analyst develops, as she becomes less of a transference object and more of a real person. This often parallels changes in the child's relationships to his internal world and significant people in his life.

Other Considerations

With certain patients variations in technique are sometimes indicated. In instances where a child has been traumatised, it is especially important to link the transference with external objects as a way to assist the child in putting order to his internal and external world. When the environment is chaotic or unreliable, the analyst needs to be especially aware of the distinction between fantasied and real objects. It is important to support reality, but not at the exclusion of interpreting what lays behind the reality and how it fits in with the child's pathology.

With very disturbed or borderline children, the transference of object relationships does play a role. However, the analyst's aim may have more to do with working with deficits, building defences and bringing anxiety to a signal level, rather than using the transference as the primary vehicle for the analytic work.

External reality and environmental factors, as well as the nature of the child's disturbance, may also contribute to an inability to form a transference. When there is a lack of containment, either due to a chaotic or traumatic environment, or because of anxiety driven behaviour, the transference may not be the primary issue. If a child does not feel safe enough, for a variety of reasons, he may not develop a transference. Furthermore, the child may not have enough internal structure to form a proper transference. In these instances, the analyst's aims and techniques are different. She may focus more on safety, the consistency of the setting, or the child's inability to form relationships.
Psychotherapy

The transference is equally important with psychotherapy patients. It may take longer to develop so the analyst needs to be cautious not to make false assumptions or take up the transference too quickly. If the child is able to make an attachment to the analyst, and keep his affects in the transference from session to session without undo overflow into the environment, the technique is similar to psychoanalysis.

OBJECT RELATIONS IN THE CLINICAL CONTEXT

Definition

The concept object relations refers to the actual relationships the child has with people in his environment and the internal representations he has of himself, others and these relationships. There is an interplay between the two as external relationships contribute to the development of internal representations, and internal representations affect the way in which external objects are perceived.

Internal representations develop gradually, originating in the infant-caregiver dyad, and build up as the child's experiences deepen and his relationships expand. Ongoing experiences and interactions with significant people in the child's life, which includes not only their conscious but unconscious modes of relating, the facilitation of a capacity to link words with affects and reality, the way in which the child's needs are met, and a whole host of factors from the environment contribute to the development of these representations. Not only do the child's perceptions of reality play a role, but those things which originate within his internal world such as fantasies, affects, impulses, wishes, anxieties, conflicts, cognition, and projections.

A mixture of external and internal factors contribute not only to the development of internal representations, but to their modification. The developmental process itself influences these modifications as with each developmental phase object related tasks challenge more primitive modes of interaction. When development is proceeding normally, representations are modified and integrated resulting in more complex representations of self and others. At some point, however, these representations can begin to define an individual's perceptions of external relationships rather than being modified by them.
Conscience is another aspect of object relations. Whether conscience is conceptualised as part of internal representations in general, or specifically as a superego function, external and internal factors contribute to its development.

Internal representations are used in the development of psychic structures and act as organisers for the child in terms of the way he views his world, guiding and assisting him through the development process. The child uses these representations for conscious and unconscious fantasising, thinking and feeling about the interactions between himself and others.

**Aims**

Through the analytic process a safe environment which promotes affective growth and increases the child's ability to bring and recognise problematic aspects of self and object relationship is established. The analyst aims to bring object relations to the child's conscious awareness. She demonstrates to him maladaptive identifications, distorted perceptions, inappropriate expectations and fears.

Whilst object relations are explored in the child's accounts of relationships with other people, and in his play and other activities in treatment, the transference is the most effective vehicle to ameliorate change. The child reproduces aspects of his earlier and current relationships with important people, real or fantasied, as well as the interactions between the child's own self and conscience, within the relationship to the analyst. Thus, the transference is usually the most emotionally alive and immediate situation which serves to vividly reveal how the child perceives important people in the past and present, what he expects and fears from them, and in what ways he is identified with them. As the child conveys his feelings and ideas in the transference, the analyst interprets them.

The analyst's outcome aim is the modification of both the child's internal representations of self and objects and relationships with people in the environment, in addition to other behaviours derived from pathological aspects of these relationships. Through the course of this work, the child's acceptance of those aspects of self and others which he previously found intolerable or shameful increases.

**Means**

As most patients come into analysis because of problems in their relationships to self and others, an object relations viewpoint is applicable to most analytic work. The
The analyst's developmental viewpoint assists her in the understanding and formulation of object relations as this is one line of development which goes through various stages where certain modifications are expectable, and is bound up with other lines of development. This framework alerts the analyst to pathology or regression, specific conflicts, and developmental tasks which colour the shape and nature of object relations. The analyst's developmental viewpoint also influences her technique and aims as she keeps these in line with the child's capabilities and the tasks which confront him.

Almost everything that happens during an analysis can be viewed in the context of the child's self and object relationships. Thus, the indications from the child's material which guide both analyst and child towards these difficulties and add clarity to the picture come from most anywhere. The child's fantasies, play, affects, conflicts, anxieties and worries, and the patterns and themes which reveal themselves over time all provide clues. However, the most informative is the child's relationships to self and others. Data about these is gathered through reports from parents and external sources, including the developmental history, as well as the analyst's perceptions of the child's family if she has contact with them. The child's own reports of facts, history, and his daily life, in addition to the picture he paints of his relationships, his view of himself, and his feeling and expectations in relation to self and others, are also important indicators. As the child's object relations are enacted in the transference with the analyst, what roles the child casts the analyst into, his expectations of her and his mode of relating to her, his reactions to separations, and any other aspect of this relationship provide further information.

The analyst gradually builds a picture in her mind of the child's object relations through the observation of his material and relationships. She carefully assesses how the child is feeling and how he perceives himself and others, building a trusting relationship so the child feels safe in bringing his thoughts and feelings about others and the analyst. Work with object relations, like any other aspect of analysis, involves a series of repeated steps as themes and patterns of difficulties in relationships reveal themselves.

As object relations are linked to all aspects of the analysis and in some way to all areas of the child's pathology, the analyst's interventions are varied and multifaceted. She explores with the child his fantasies and feelings in relation to her and others. She begins to point out to the child his affects and expectations about self and others, demonstrating to him things which seem to happen again and again as repetitions and patterns become clearer. Work with affects, defences, conflicts, anxieties, separation, and at times reality, serve to reveal object relations difficulties. The analyst begins to link various aspects of the
child's material to previous material, significant people in the child's present and past life, memories, himself, and the analyst. In this way the child slowly becomes aware of unconscious aspects of his object relations.

Most importantly, the analyst verbalises and clarifies, and gives interpretations. She determines the most effective way of interpreting object relations which varies at different times dependent on timing, what is useful to the child at a particular moment, and what he is able to hear. Thus, the analyst's interpretations are directly in relation to the real external objects; in whatever displacement or projection onto other people, toys or imaginary characters the child is using; in relation to the child's internal representations; or in the transference. The analyst aims to help the child understand that difficulties reside within his internal world through her presentation of the notion of internal representations. How she does this depends on what the child is capable of understanding and what makes the most sense to him. For example, the analyst may talk about different parts of the child, things which are inside of him, in terms of his inner expectations, or with references to the past.

The analyst's acceptance of the child's perceptions of her and the roles he assigns to her in the play, as well as her willingness to explore these perceptions, facilitates the development of the transference as its illusory quality intensifies. Her interpretations of the transference facilitate it as well.

Other Considerations

Whilst object relations is a viewpoint used by analysts with all patients regardless of age or disturbance, modifications of technique can be indicated due to the type of disturbance and internal organisation of the child. With borderline children, for example, their internal and external relationships may be too threatening, frightening and overwhelming. Instead the analyst may focus on ego support rather than stressing relationships and affects.

The child's capacity to modify his object relations may be limited by his disturbance as well, or by environmental circumstances and the caregiver's pathology.
Psychotherapy

This viewpoint is employed with patients in psychotherapy as well as psychoanalysis. Whilst the technique is similar, the opportunity to effect changes and modifications in internal representations is usually greater in analysis.

INTERPRETATION

Definition

Interpretation is the way in which the analyst conveys an understanding and gives meaning to descriptively unconscious content and states in order to bring them to the child's conscious awareness. Interpretations address most anything the analyst wants to call the child's attention to.

Through her observations and work with a child, the analyst forms working hypotheses about the child's difficulties and what would be helpful to address. Interpretation is the way she tests her hypotheses.

Interpretation is an ongoing process. No interpretation stands alone or serves as a finished product in and of itself. One interpretation makes one step, each interpretation acting as another step, as the analyst links aspects of the child's world, both internal and external. Interpretations are repeated in various ways as analyst and child look at threads of the same content, patterns and repetitions, and themes as they reveal themselves. Interpretations are given from different viewpoints, for example from the transference, external or psychic reality, and external or internal relationships to self and others. Interpretations also address different levels, both in a topographical sense as well as developmentally. The process of interpretation relates to working-through.

In order to be effective, interpretations need to be affectively alive and meaningful to the child at the moment they are given. This can mean the inclusion of what is current in the child's life, or if the timing is right and the analyst has gathered enough evidence, links to the child's past. The timing and wording of an interpretation depends on the individual child, the particular moment in analysis, and what makes the most sense to the child.
Analysts make both complete and partial interpretations. Complete interpretations convey an understanding and unconscious meaning. They include what is most evident to the child, for example, a conflict, defence, behaviour, a feeling, a relationship, in addition to an explanation of why. Partial interpretations are steps towards complete interpretations, although they overlap with complete interpretations and are not always clear cut entities. The most common ones are verbalisations and clarifications. Verbalisation is the way the analyst puts what is unspoken into words. Clarification is the analyst's attempt to get clear about something she hasn't understood, the child hasn't understood, or both: for example, asking questions or linking things the child hasn't put together. Partial interpretation is also the way the analyst brings something to the child's attention without necessarily providing an explanation or meaning. Drawing the child's attention to something, pointing out, describing, taking up, demonstrating, confronting, and linking are examples.

**Aims**

The primary aim of interpretation is to bring that which is unconscious into the child's conscious awareness. The analyst makes explicit various aspects of the child's functioning and internal world, and assists him in the process of recognition.

Interpretations open up avenues for further exploration and relate to the analytic process. Thus, certain interpretations aim to encourage the child's expression or to help him bring further material. Exploratory interpretations are used to track something the child has presented to its various related strands, and serve the function of providing child and analyst with further information. Interpretations are also aimed at the analytic process as they help the child look inside himself and understand the process. Another aim of interpretation is to bring various aspects of the treatment together, either within one session or over the course of time, or various parts of the child or pieces of his history as in reconstructions.

**Means**

The analyst gathers data from the child's material which informs her interpretations. This can be most anything the child presents. It includes what the child says and doesn't say, and his non-verbal communications. The child's behaviour during the session, and before and after sessions, are also indicators. The child's affects and anxiety, or their absence, the way he copes with these, and his defences and resistance also inform and guide the analyst.
Previous information, be it from what the analyst knows about the child's history, information gathered from previous sessions, or how present content fits with that information, are others. Patterns in the material, repeated themes, and the flow of the process also inform interpretations.

The analyst considers the child's level of development as certain things have different meanings dependent on this. She takes special note of anything which is different, for example when something enters the material for the first time or when the child presents himself in an unusual way.

The child's relationships are an important factor which informs the analyst's interpretations. This includes the child's relationship to himself and others. The analyst pays special attention to the child's relationship to her, both in the way he relates to her and the state of the transference. All of this data contribute to the analyst's current working hypothesis.

Interpretation is a process within an environment where the child trusts enough to begin to recognise that which he has repudiated. Analyst and child look at all of the aspects and strands of his content and affective states. Interpretations are repeated in different contexts and in different ways until the problem is worked through. The steps of the interpretive process are more helpful than an over-inclusive interpretation as the child retains more and his emotional resonance is greater. Leading the child toward his own interpretations and connections helps with this as well, but in addition, the child is more likely to be accurate than the analyst. Interpretation moves the material along.

When the analyst thinks of making an interpretation she is confronted with numerous decisions. She must decide what to interpret, if it is the right time to interpret and what words to use, her method, and the type of interpretation.

When the analyst makes a decision about what to interpret, she is sometimes in the position of having more than one option. These decisions are based on the analyst's conscious and preconscious thought processes and her observations of the child's material. What has gone on in previous sessions, the child's affects, the transference, and the context in which the material is presented guide her in this decision making process. What is uppermost in the child's mind, in other words what is closest to consciousness, the theme child and analyst have been following, the related threads seen in a session, or when something seems to be an obvious direction to explore are other guides. In her assessment the analyst also takes into account her counter-response and affective response.
What is interpreted is also dependent upon the phase of treatment. For example, what the analyst decides to interpret may be different in the opening phase of analysis than it is in the middle phase, or equally during termination. The analyst goes slowly, not interpreting too quickly, especially without the benefit of a treatment alliance. The treatment alliance, enhanced by the interpretive process, helps to maintain the relationship through difficult moments.

The analyst looks to certain areas which guide her in the timing and wording of her interpretations. The child's level of anxiety, the state of the treatment alliance and the phase of treatment, the space of resistance the child is in, and impending or previous separations are factors. The child's openness to an interpretation, and the way he usually accepts interpretations, also contribute to the analyst's wording and timing.

Development influences timing and wording as well. The analyst considers the child's level of development in her search for the proper wording, as well as the method she uses in her presentation. Because of these factors the analyst may emphasise certain aspects over others.

The analyst's method of interpretation varies dependent on a number of factors. Timing and the presentation and wording of an interpretation are important. Interpretations, to be effective, need to be affectively meaningful and given in such a way that the child can hear and take in the analyst's words. This links to the child's anxiety and narcissism. The analyst neither wants to intensify anxiety so the child experiences it as unmanageable, nor hurt the child's self esteem so he feels attacked. The analyst's modulation and tone of voice, her rhythm and volume help the child hear her words.

The types of interpretations the analyst gives vary. Some are exploratory or partial, others are complete. The analyst gives interpretations directly to the child using words, in displacement onto whatever vehicle the child uses to present his material, through stories, humor, in written form, or whatever method is most suited to the child and phase of treatment.

The analyst looks for evidence from the child which acts as a confirmation of her interpretations. As interpretation moves the material forward, if the material doesn't move it is a clue the interpretation was inaccurate or the child is in a period of resistance which was not seen. The child's associations or play following an interpretation also act as confirmation. Sometimes children actively disagree or agree with the analyst's interpretation. At times these can be confirmations, but equally denials or agreements can
show a need to defend or comply. Over time the analyst learns the child's patterns of reacting to interpretations, especially ones focused in certain directions. Thus, she will begin to understand what acts as confirmation and what doesn't.

As interpretations are a way to test out a hypothesis, the analyst needs to be prepared for the fact that not all of her interpretations will be accurate. There are also other interpretations which are not helpful: for example, those which go too deep too early, are mistimed, or address shameful or humiliating aspects without laying ground work which holds the child's self esteem. Interpreting aspects of the child's development which are moving along without difficulty are unnecessary.

Other Considerations

The technique and aim of interpretations with children who suffer from certain psychological disturbances are sometimes different than the ones outlined here. These will be discussed under Developmental Disturbance.

Psychotherapy

In general, the philosophy of interpretation with patients in psychotherapy is the same as it is with those in psychoanalysis. There are, however, some important differences. The analyst may choose only certain things to interpret, especially if the therapy is focused in specific directions. The analyst may be more cautious in her interpretations due to the child's defences, life situation or anxiety, as she doesn't want to arouse too much that would be difficult for the child to deal with on his own. Time constraints is another factor. The analyst may not have the time, due to the frequency of sessions or the length of treatment, to go through all of the steps in the process.

In some ways it depends on the individual child how much the analyst adheres to the aims and methods described and the degree of modification. Some children are able to take the analyst's interpretations quite far in a session, then work on them by themselves in between sessions. Others have more difficulty retaining or holding on to interpretations and the process from one session to the next.
DEVELOPMENTAL DISTURBANCE

The results of the developmental disturbance study are too preliminary to constitute a model. The data suggest some ideas about what analyst's call developmental help, interventions the manual authors conceptualise as aimed at mental processes. In some of subject's clinical examples it was easier to separate these techniques from other analytic interventions. In others, it was more difficult. Understandably, in those cases where mental process disorders were more severe, it was easier, but the two types of work clearly go hand in hand. This relates to the mixture of psychopathology children present. Subjects were explicit in their belief of this. Their patients exhibited a mixture of what the authors would call representational and mental process disturbances, and their interventions were aimed at both.

It is helpful in a discussion of this sort to trace the historical development of the concepts "mental representation" and "mental process" in order to understand what analysts are referring to. These concepts are rooted in analyst's notions of psychic change, the outcome aim of child psychoanalysis.

During the topographical era of psychoanalysis, Freud stressed the process of bringing into consciousness that which was unconscious as a means to achieving a satisfactory outcome. Anna Freudian child analysts still consider this an intermediary aim, however in and of itself it is not enough to effect psychic change. Once Freud proposed the structural frame of reference in 1923, he reformulated his original statement and said "Where id was, there ego shall be". In 1937, when discussing character disorders, he went on to say:

Our aim will not be to rub off every peculiarity of human character for the sake of a schematic 'normality', nor yet to demand that the person who has been 'thoroughly analyzed' shall feel no passions and develop no internal conflicts. The business of the analysis is to secure the best possible psychological conditions for the functions of the ego; with that it has discharged its task.

Psychic structures, in Freud's model, referred to id, ego and superego. Anna Freud also held this view, as she said the aim of child psychoanalysis was "to turn id into ego content". The historical development of the representational and process models begins with these views.

In 1962 Joseph Sandler and Bernard Rosenblatt, through the work of the Hampstead Index Research Group, introduced the concept of "the representational world" in an attempt to clarify what was meant by the child's "internal world". They conceptualised representations as the child's constructions which "enable him to perceive sensations arising from various sources, to organize and structure them in a meaningful way". The child creates images and organisations within his representational world of his internal as well as his external environment. In this way he is able to "know what is outside" because he has created "a representation of that outside". Sandler and Rosenblatt outlined what they thought the representational world consisted of. Included were symbols or schemas for things, activities, relationships, body representations resulting from sensations arising from the child's own body in its interaction with the environment, and need and affect representations. Representations have a "more or less enduring existence as an organization or schema that is constructed out of a multitude of impressions" and provide "the furniture for the ego functioning of thinking". Thus, there is a relationship between the representational world and the ego. It is the ego which is the active agent, whereas the representational world guides the ego. It is also "the function of the ego to construct a representational world".

Representations are the internal furniture, the framework on which everything else is hung. The results of the study on object relations concur. Internal representations are used in the development of psychic structures. They act as organisers for the child in terms of the way he views his world, guiding and assisting him through the developmental process. They are also used for conscious and unconscious fantasying, thinking and feeling.

In 1991 Hansi Kennedy and George Moran, through the deliberations of a study group on psychoanalytic concepts, expanded on the Centre's notion of psychic structures. They conceptualised these structures as "microstructures" which referred to the manner in which a child organises or constructs experience into mental organisations. Structural

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change implies enduring modification of mental organisations. More primitive structural organisations are abandoned when they are at odds with more highly developed levels of functioning. However, earlier psychic organisations remain and can potentially be reactivated.

The manual author's view of internal representations as enduring structures is in agreement. The representational model, they said, focuses on "the mental mechanism involved in the recovery of threatening ideas and feelings, and the consequent reorganisation of mental structures commonly invoked in explanations of psychoanalytic process". The analyst's outcome aim is the creation of new mental representations. Working within the transference enhances the potential for these changes, as does interpretation, however changes in psychic structures are initiated by the patient. According to the authors:

Interpretation does not create the new structures. Interpretation identifies the reason why particular internal or external experiences were difficult or dangerous to conceive of; once such dangers are addressed and elaborated in the context of other experiences, it then becomes possible for the patient himself to initiate the change in his mental representational system in a form which takes account of the previously unacceptable experience.

This view of interpretation coincides with the aims of interpretation as defined by subjects in that study, as well as the outcome aim of other concepts. For example, making defences redundant means addressing what is felt to be dangerous, and the integration of these aspects into the child's reality. Furthermore, modification of internal representations of self and other is the outcome aim of work with object relations.

Mental representations are the products of mental processes. These mental, or psychological processes, create and organise mental representations. This is an expanded version of what Sandler and Rosenblatt meant when they said it was "the function of the ego to construct a representational world". The origins of this model are found in The Ego and the Mechanisms of Defence written in 1936. Here Anna Freud emphasised the ego's mediating position between the impulses of the id and the demands of the outside world. Psychoanalysis, she said, was the analysis of the ego, as well as the id or the


In 1963\footnote{Freud, A. (1963). The concept of developmental lines. Psychoanal. Study Child. 18, 245-265.} Anna Freud introduced the concept of developmental lines. Many had conceived of development as a series of phases: for example, the phases of psychosexual development first introduced by Freud (1905\footnote{Freud, S. (1905). Three essays on the theory of sexuality. S.E. 7.}, 1908\footnote{Freud, S. (1908). On the sexual theories of children. S.E. 9.}, 1923\footnote{Freud, S. (1923). Infantile genital organization: An interpolation into the theory of sexuality. S.E. 19.}, 1924\footnote{Freud, S. (1924). The dissolution of the oedipus complex. S.E. 19.}, 1925\footnote{Freud, S. (1925). Some psychical consequences of the anatomical distinction between the sexes. S.E. 19.}) and expanded on by Rose Edgcumbe and Marian Burgner (1975\footnote{Edgcumbe, R. and Burgner, M. (1975). The phallic-narcissistic phase: A differentiation between preoedipal and oedipal aspects of phallic development. Psychoanal. Study Child, 30, 161-180.}), and Margaret Mahler's phases of separation-individuation (1975\footnote{Mahler, M.; Pine, F. and Bergman, A. (1975). The Psychological Birth of the Human Infant. New York: Basic Books.}). Anna Freud found the notion of phases inadequate. Instead, she suggested longitudinal lines of development which distinguished a mature individual from an immature one, irrespective of health or illness. Developmental lines are both descriptive, pointing to surface manifestations which are the observable steps, and metapsychological constructs, indicating what has gone on internally which made the observed steps possible. This is similar in nature to Spitz's idea of psychic organisers. There are many developmental lines which apply to every area of an individual's personality. Anna Freud explained:

Whatever level has been reached by any given child in any of these respects represents the results of interaction between drive and ego-superego development and their reaction to environmental influences, i.e., between maturation, adaptation, and structuralization. Far from being theoretical abstractions, developmental lines, in the sense here used, are historical realities which, when assembled, convey a convincing picture of an individual child's personal achievements or, on the other hand, of his failures in personality development.\footnote{Freud, A. (1963). The concept of developmental lines. Psychoanal. Study Child. 18, 247.}

The lines which were first delineated included: from dependency to emotional self-reliance and adult object relationships; from suckling to rational eating; from wetting and soiling to
bladder and bowel control; from irresponsibility to responsibility in body management; from egocentricity to companionship; and, from the body to the toy and from play to work. There are others outlined since 1963 including a developmental line of anxiety (Yorke and Wiseberg 1976). Developmental lines are multiply determined. In order for the personality to be harmonious, growth on one developmental line needs to correspond with growth on another. Imbalance between developmental lines can cause friction in childhood. Moderate disharmonies produce the many variations of normality. If the disharmonies are more severe, pathology results. The analytic task is to trace the interaction between lines and determine where and what components are causing the child difficulties.

Development not only consists of numerous lines, but is a result of synthesis. Psychological formations which make up the personality are the result of introjection, identification and integration. "Integration", Anna Freud said, "serves healthy growth provided the elements synthesized by it - namely, the constitutional givens, the rate of structuralization, and parental influence - remain within the limits of an expectable norm." However, this is not always the case. Constitutional handicaps can exist, structure building can be uneven with defects in the id, ego, or superego, or environmental factors can influence integration. The elements from these three directions are integrated and forced into a whole. As Anna Freud explained:

> It is the hallmark of the synthetic function that, while doing its work, it does not distinguish between what is suitable and unsuitable, helpful or harmful for the resulting picture. Thus, every step on the developmental line, besides being a compromise between conflicting forces, also represents an amalgamate of beneficial with malignant ingredients. The various mixtures which thereby are produced can be held responsible for the numerous variations, deviations, quirks, and eccentricities displayed in the final personality.

In 1979 Anna Freud proposed additional lines of development which she thought needed further research as they would contribute to the understanding of childhood disturbance and child analytic technique. These lines fell under the rubric of ego functions or mechanisms. She included secondary process functioning; distinguishing between the

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inner world and outer world; discharging mental excitation via mental, as opposed to somatic, pathways; impulse control; the development of a time sense; and, "from childish lack of insight into internal processes to the adult's acknowledgment of them". She concluded that normality or pathology of development was dependent on four factors: (1) constitutional and experiential elements within an average and expectable range, (2) the maturation of internal agencies at approximately the same rate of speed, i.e. neither delayed nor precocious, (3) external interventions being well-timed, and (4) age-adequate ego mechanisms, i.e. neither too primitive nor too sophisticated. Anna Freud added:

To investigate the happenings on individual developmental lines from the aspect of these four points is recommended as a next rewarding trend for child analytic work.50

In the eighties Hansi Kennedy headed up a study at the Centre entitled "A project to study variations of normality and pathology in relation to personality development". She expanded on the idea of developmental disturbances and the aspect of psychotherapeutic work Anna Freud referred to as ego mechanisms. This technique received the name "developmental help" (see Janet Shein Szydlo 198551 and Marie Zaphiriou-Woods 198852). Developmental help are those interventions which address developmental needs. Kennedy and Moran (1991) thought these entered to varying degrees in the therapeutic work with many patients, not just those classified as developmental disturbances.

The failure of what Anna Freud and others have called ego functions or ego mechanisms, and the synthetic function of the ego, results in deficits. The manual authors spoke to the concept of deficits when they said:

Formulations solely in terms of ego deficits do not readily lend themselves to explanations of how the slow yet significant shifts in ego functioning can nevertheless come about in the course of successful psychoanalytic treatments of patients suffering from such so-called "deficits".

Furthermore, the term developmental help does not "sufficiently clarify what the 'help' consists of"53.

Anna Freud's recommendation for the "next rewarding trend of child analytic work" was taken up by the manual authors in their formulation of the mental process model. They expanded the concept of ego functions to mean mental processes. This conceptualisation is an attempt to be more specific and define in detail what all the ego actually does by looking at the minutia of the organisation of ego functioning. In doing this they are trying to "move away from a kind of overview of ego function, and in particular the synthetic function as being one of the crucial workings of the ego". Furthermore, the authors want to examine all of the things analysts do when working with their patients, some of which analyst don't necessarily take note of or write about. Clearly these "other things" are extensive, as the results of Study 2 indicate. Traditionally these have been called the "by-products" of analysis or "developmental help", and have been reduced to something other than "proper analysis". However, what the authors are proposing is that the collection of techniques which constitute "proper analysis" be expanded to more closely match the reality of what analysts actually do.

One of the aims of the Developmental Disturbance study was to ascertain the nature of this disturbance and the analyst's techniques aimed at these difficulties. It was Anna Freud's contention (1966, 1968) that developmental disturbances arose from the neglect of pre-oedipal developmental needs. Deficiencies of development were caused and maintained by ongoing environmental influences. What these developmental needs and environmental influences are is an important area to examine when conceptualising the makeup and treatment of developmental disorders. Three areas were most striking in subject's assessments of the environmental factors which contributed to their patients' developmental disturbances. Aggression in the environment was one. There was a persistence of aggressive modes of relating and, at times, unmanageable aggression on the part of parents. Not surprisingly, capacities lacking in parents resulted in missing capacities in their children. These were primarily in the realm of the internal organisation and control of impulses and affective mental states. Inconsistencies in parental handling was the third factor.

Anna Freud (1968, 1970, 1978) also spoke of the importance of considering the technique used in the analysis of developmental disorders, a technique which was different from that employed with so called neurotic disturbances. With the admixture of disturbances found in most children, an idea subject's in this study agreed with, two therapeutic but different tasks are required. "Every discussion of technique", Anna Freud said, "will need to take account of these." The manual authors concur. In order to fully understand child psychoanalysis, both techniques need to be understood and clarified. The Developmental Disturbance study is an attempt to begin to look at those techniques aimed at mental processes. The aim of these techniques, according to the two model proposal, is to "engage previously inhibited mental processes in the here and now of the psychoanalytic encounter".

There is a strong correlation between subject's conceptualisation of their patient's difficulties, and the aspects of the child's internal world which they tried to effect with their interventions. Both sets of data outline difficulties in internal organisation and controls, and self and object representations. Communication and thinking are two other areas.

Because of the picture these children presented, they needed more from the analyst than being a transference object. Whilst it was clear from the examples in all seven studies that the relationship between child and analyst is multifaceted, the emphasis on the analyst's other roles was far greater in the developmental disturbance examples. This makes sense if the child is so disorganised or unable to manage his internal and external world.

The children subjects presented came from, at minimum, an inconsistent environment if not an aggressive one. These were not minor inconsistencies, but ones which would make it difficult for the child to understand cause and effect, to put things in order, to know what to expect, or to understand the world around him. The analyst as a consistent and benign object was important to the work all subject's described. Through the analyst's provision of these states, the child identified with her. The analyst as

auxiliary ego was also a role ascribed to the analyst. This means she supplied those capacities or processes which were missing in the child's repertoire until he was able, through identification with the analyst's functions and the rest of the analytic work, to utilise his own processes.

Subjects addressed in their interventions, over and over again, ego functions and self and object representations, demonstrating how they did this with a great deal of creativity. There are similar properties in most of these interventions. Subjects verbalised all sorts of things. By supplying the words and labels for internal states, the child was able to recognise what came from inside of him, and in this way formed an internal representation of that state. Through the differentiation and mastery of anxiety and affects, by breaking them down into manageable entities, the child was better able to manage on his own. With an internal representation of affects, the child could begin to recognise his own feelings. Subject could then help the child develop the signal function of affects, which in turn activated the process of defence.

The consistency and pervasiveness of difficulties in thinking was striking. The problems did not lie in innate intelligence, as all children fell within an average range. If a child is disorganised internally and overwhelmed by affects, impulses and wishes, this state is bound to interfere with thinking. By thinking things through with the child and linking various aspects of his thought processes, the child was able to think more clearly. Language and verbalisation helped organise the child internally and contributed to the formation of internal representations. Furthermore, through the use of thinking the child was able to pull things together, link up thoughts and ideas, and determine cause and effect. This is what Anna Freud and the subjects called "the synthetic function of the ego". If a child can't appraise reality, test out what is what, what is "real" and what isn't, what is internal and what comes from the outside world, this too contributes to a disorganised picture. The differentiation of fantasy and reality, and interpretations of what was what, furthered the development of reality appraisal. Setting limits and giving explanations provided internal and external order and controls, as well as contributed to cause and effect, secondary process thinking and reality appraisal. Through the provision and verbalisation of safety, the child increasingly felt more secure. He then began to internalise the analyst's nurturance, making it his own, thus could keep himself safe.

Subject's interventions in the area of self and object representations demonstrated the ways in which they helped the child retain internal images of objects, differentiate self from other, and learn self control and management, which in turn impacted self representations and object relationships. The development of the processes of reciprocity,
and mutual giving and taking, where also demonstrated. Frustration tolerance and the ability to delay, suspension of reality and the process of fantasizing which are needed in order to play, were also referred to. Showing the child how to do something was another intervention which contributed to an ability to link things together and understand cause and effect, as the child learned if he did one thing something else would happen.

This study is only a beginning. Whilst all subject's described their interventions, some were more clear than others. In addition, the mental processes these interventions were aimed at were explicit in some examples and implicit in others. Clearly more work needs to be done to discern what mental processes are and what techniques are required. Each patient is unique and thus requires different techniques dependent on the picture he presents.
PART IV.
CONCLUSIONS

Chapter 14. Final discussion and future directions

In the forties and fifties child analysis was conceptualised as the analysis of transference, resistance, defence, and conflict, with the aims of making unconscious elements conscious and the resolution of conflict. The analyst needed to be mindful of development, taking into account the child’s level of ego development, cognition, and communication abilities. Some so called “educational measures” were thought to be unavoidable, such as the containment of aggressive attacks, however the analyst needed to be cautious and restrain as much as possible from these sorts of interventions. Otherwise, analysis would not be the treatment method employed. The subject of child analysis was the neurotic child, however Buxbaum was one of the few who also considered the analysis of the other than neurotic child. These children were also thought to be subjects of analysis as long as there were technical adaptations. These included: promoting regression; the establishment of a positive relationship within which the child could make changes; ego building; and re-educating, meaning the correction of deviations and distortions.

The model of adult psychoanalysis, beginning with Freud and expanded on by others, was the model which child psychoanalysis followed. As long as the child analyst was doing what the adult analyst did, it was thought to be true analysis. The sixties brought a process of comparing and contrasting child and adult analysis within this basic philosophical framework. Regardless of the age of the patient, analysis proceeded along the same lines with the interpretation of defence, resistance, transference, the unconscious which included repressed memories and fantasies, and conflict. Certain concepts, specifically transference and a relatively new concept called the treatment alliance, were explored as to their meaning in child analysis and whether they were the same as their adult counterparts. These constituted the all encompassing relationship between the analyst and the patient. Were there other aspects of this relationship? Analysts thought so and spoke of the analyst as a new or real object to the child. But, did this make child analysis not analysis if one was not working only within the transference?

Certain technical deviations from adult analysis were allowed because the child was a young person who was still in the midst of developing, and had an ego which was not yet as fully formed as an adults. Consequently, some modifications of technique were indicated. For example, verbalisation and clarification were important as they paved the way for interpretation, or the analyst might need to serve as the child’s auxiliary ego or superego.
These variations of technique were based on the developmental level of the child, and some thought adjusted more with the very young child. Whilst it was agreed that the child analyst was an important object and a participant in the child's life, it was crucial to remain neutral. The analyst needed to be ever cautious to avoid any temptation to move out of the analytic role. It was the technique that was adjusted, not the psychoanalytic "methods, goals or aims".

The seventies brought child psychoanalysis into its own. No longer was it based on adult analysis, but was a treatment modality in its own right. The difference between adult and child analysis was in the techniques which were conceived of as treatment methods with their own rational. Child psychoanalysis was now defined as a process which served as an organiser for the child's personality and as an accelerator of development. The process included the establishment of a treatment alliance; the analysis of defence and character; making unconscious conscious which included the interpretation of fantasies, memories, wishes, etc.; the analysis of the transference, resistance and internalised conflict; working-through; and the acquisition of insight. The aim of child analysis was psychic or structural change and the resumption of normal development. The tools used to meet the aims were the techniques, which were dictated by the developmental phase of the child, specifically the phase of ego development. Interpretation was the main technique. Whilst the basic concepts and premises of child analysis remained consistent over the years, it was thought that the child took from the analytic process and relationship what it was that he needed in order to get better. This could include ego building; gratification; empathic attention; a new object; a real object; a displacement object; or a model for identification. However, these were thought of as side effects of the analytic process. The questions remained in the seventies as to how far the analytic method could be varied and still be called analysis, and for whom was analysis appropriate. There was no question that the diagnostic classification of neurotic was best treated by analysis, and now children of all ages were seen as analysable, but what about the other disturbances?

The eighties saw the expansion of the aims of child psychoanalysis begun years earlier. Analysts took the concept of structural or psychic change and reconsidered the meaning of this, as well as the aim of returning the child to the path of normal development. Thus, analysts attempted to refine what it was that the child analyst was aiming for, and reiterated that this occurred within an analytic process.

Evident from the literature is some agreement over the years, from Anna Freud and Melanie Klein through to contemporary child psychoanalysts, that the basic components of psychoanalysis are interpretation, transference, defence, conflict, and resistance. However, that is where agreement ceases to exist. Many authorities in the field believe that there are
other components to the analytic process, but what exactly these are and whether they are byproducts of the process or its primary components remains unclear. Furthermore, it has been demonstrated that psychoanalytic theory, concepts and practice are often divergent. From a review of the literature it is apparent that examples of psychoanalytic treatments are used to illustrate the application of theories. They do not clarify the meaning of technical or theoretical concepts, nor do they explain how, why, or when an analyst goes about doing what she does. The inevitable conclusion is that ambiguities exist in the recommendations made by these experts for child psychoanalytic techniques, and that actual practice can only be considered to be implicitly guided by some undetermined amalgam of these recommendations.

The method of manualisation of a treatment modality, as a way to identify the key therapeutic ingredients and strategies of a specific approach, was introduced in the seventies as a way to overcome these difficulties. Several different manuals have been reviewed in the context of this thesis which reveal that manualisation may indeed be a means of defining and elucidating the theories and techniques behind certain treatment modalities. However, a manual which addresses the treatment of children, or delineates the components of the extremely complicated approach of psychoanalysis, has yet to be attempted. This thesis outlines such an endeavor. It examines the method of child psychoanalysis within one culture, the Anna Freud Centre, and proposes a way of ascertaining the dimensions of an analysis, a definition of its components, and the application of them in a systematic way to the aims, means and limitations of child psychoanalysis.

Study 1 aimed to validate an initial attempt at a manual of child psychoanalysis. The evidence was overwhelming that it was impossible for experienced child analysts to apply any of the manual classifications to examples from analytic cases of children in any uniform or reliable way, nor did this manual meet the criteria of manualisation. The conclusion drawn was that a different approach needed to be taken in order to define child psychoanalysis at the Anna Freud Centre. The starting point needed to be the mind of the analyst, rather than her theories and behaviours. This method of research is consistent with other investigators who have attempted to define and delineate the dimensions of psychoanalytic concepts. Through the use of unstructured interviews it is possible to ascertain the psychoanalytic approach which is specified at the level of the analyst's conscious and preconscious mind. In this way her descriptively unconscious internal representations, or part-theories, which govern the way in which she actually works, are
made clearer. In addition, the method of research applied in this thesis looks first to the clinical material, what comes from the child, then to what the analyst determines is the best approach to this material based her objectives.

The first step in defining what child psychoanalyst actually do based in the reality of experience, rather than theoretical notions, is to provide a framework for the organisation of a manual. Study 2 provided a basis for this organisation. Subjects who were sophisticated clinicians grounded in the approach of the Anna Freud Centre, examined clinical examples from a series of analyses of different children who exhibited a wide range of disturbances. With each example they listed what concepts came to mind which illustrated the material before them. A content analysis of this data revealed specific categories which represent the dimensions of this treatment modality, and what concepts should be included in a definition of child analysis. The chapter headings of a second attempt at manualisation, written independently of this research by four senior analysts at the Anna Freud Centre, originated in the results of this study. Study 3 tested out the validity of the contents of this manual. The results demonstrated the degree to which analytic practice as described in Manual II was consistent with the conscious working models of child analysts.

What Study 3 was not able to determine was what analyst's preconscious beliefs and theories were which organise and motivate the way in which they work. This was the aim of Study 4 which constitutes the major part of this thesis. Unlike previous research of this kind which examined a single psychoanalytic concept, this study took the premise of analyst's implicit theories and beliefs which formulate their internal, descriptively unconscious, working models, and applied it to the whole of child psychoanalysis. Through a method of semi-structured interviews it was possible to discover not only the meaning of concepts which analysts hold in their minds, but the aims and techniques which were implicit in their part-theories. Eight different concepts were examined in this study. These included defence and resistance which were studied together, conflict, affects, transference, object relations in the clinical context, interpretation, and the application of child psychoanalytic technique to the diagnostic category of developmental disturbance.

From the data obtained in Study 4 it was possible to delineate a model of child psychoanalysis as practiced within the present day culture of the Anna Freud Centre. This model has been described in detail. It is proposed that this model constitute a manual of child psychoanalysis as understood and practiced from the perspective of this institution. This model provides not only a consistent and clear approach to child psychoanalysis.
within an overall framework of an analytic process, and directed toward certain aspects of the child's internal world, but for the first time actually suggests what constitutes "proper analysis".

Analysts have been clear over the years what they thought proper analysis was. The components of this framework have been further clarified through this research. Concepts have been defined based on analyst's internal models, and methods have been described as they are applied to clinical material. However, analysts have continually struggled with all of the other things they also do. They have not known how to understand them, why they do them, and in many instances have been both embarrassed by them and have refused to talk about them in detail for fear it meant they were doing something other than analysis. Consistently in Study 2 when subjects classified child psychoanalytic material and technique, in Study 3 when they validated Manual II, and in a more elaborate form within each of the studies under the heading of Study 4, these "other things" came up. When subjects discussed, what in the framework of the Study 4 interviews were termed "limitations", they illustrated again and again what previously analyst's have not publicly addressed, but do every day in the privacy of their consulting rooms. In one frame of reference these are techniques which are directed toward the child's ego and the organisation, or lack thereof, of his internal world. The techniques themselves are what has commonly been known, but not clearly defined, within the culture of the Anna Freud Centre as developmental help. This data suggests that there are, in broad terms, two aspects of the child's internal world which analyst's work with as they attempt to help the child implement psychic changes. Furthermore, these overarching distinct, yet interrelated aspects serve as a framework for the way in which analysts understand how people are put together and how they function. Thus, what has previously been thought of as limitations to a child psychoanalytic approach, are actually part and parcel of the complete process and technical applications of this treatment modality.

The authors of Manual II, independent of this study, also proposed a similar model. They expanded the notion of ego functions and the synthetic function of the ego in an attempt to be more specific about what child analysts do, and have suggested two models of psychological disturbance - the mental representation and mental process models. Analysts who were subjects in Study 4 conceptualised childhood psychological disturbance, and the makeup of the child's internal world, as encompassing both models. To some degree they address both mental representations and mental processes with all of their child analytic patients. It is not a "limitation", therefore, when mental processes are evident and play a role in the analyst's methods, but other considerations which need to be taken into account and worked with. A model of child psychoanalysis, at least one practiced from the orientation of
the Anna Freud Centre, thus constitutes working with both mental representations, which have been the subject of what was previously thought to constitute proper analysis, and mental processes. The analyst and child follow the material wherever it leads them. The analyst makes use of any of the wide range of techniques available to her based on what is necessary. What is necessary is understood from her analytic viewpoint within which her developmental orientation is incorporated.

No research has attempted to examine a treatment modality with the difficulties which an approach like psychoanalysis presents, nor has a complete treatment modality with all of its nuances and intricacies been studied in the way this thesis proposes. This research is based first and foremost on what comes from the child, the material he presents, and then on the analyst's technique. Unlike other research, this thesis follows the tradition of the Anna Freud Centre which looks first to the child and extrapolates theory from there, rather than propounding the theory first as a way to explain the child. Whilst this is a unique, there is a qualification to the suggested research approach which needs mentioning. The data gathered from the studies presented was interpreted through the mind of the investigator. The approach taken to the interviews by the investigator was a scientific and quantitative one where like components evident in the data were classified together, and numbers obtained which resulted in percentages of subjects who presented their material and thought in similar ways. However, it is difficult to imagine that the investigator's internal working model of child psychoanalysis did not in one way or another have an impact on the presentation of these results. At minimum, this perspective may have influenced the way in which the proposed model of child psychoanalysis was constructed. From the viewpoint of investigator as scientist this could constitute a limitation to the research, however from the vantage point of investigator as subject, it adds yet another dimension. The investigator, like all of the subjects who participated in these studies, has a foundation which originates in her training at the Anna Freud Centre and practices child psychoanalysis from this orientation. Thus, the investigator's internal working model could be conceived of as yet further evidence for the consistency of the model which is proposed.

The concepts included in this research do not constitute a complete model. Additional concepts, some of which the manual authors included in Manual II, and others which came up again and again in Study 4, are also worth considering. These include self representation and self evaluation as distinct from object representations; the treatment alliance; counter-transference; unconscious fantasy; and working-through if it is not sufficiently covered under the analytic process. The proposed model presents a description of the analytic process, however further study on this concept itself may prove fruitful as well. In addition, an expansion of what analysts mean when they talk about the ego or
mental processes, and their technique as applied to this aspect of childhood psychological disturbance is necessary. The study on developmental disturbances was a beginning and added clarity to what and how to examine this complicated area. Finally, working with the child's environment is an additional area. Child analysts know this is an important aspect of their work as parents need to be engaged in the process for an analysis to succeed. The aims and methods of doing this need to be specified. These concepts and technical approaches constitute future work that remains to be carried out, implementing the research methodology which has been presented in this thesis.

In order to study the efficacy and outcome of a treatment modality, in this instance child psychoanalysis, the key therapeutic ingredients of this approach must be determined in order to provide a thorough and clear account of what the analyst actually does. The method by which this is done is manualisation. The results of this research thus constitute the beginning of yet future work in this direction. With a manual it becomes possible to study if the approach used by an analyst is indeed the one intended. This manual then provides the basis for measuring the outcome and efficacy of child psychoanalysis as practiced at the Anna Freud Centre.
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APPENDIX 1

MANUAL I
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CHAPTER 3
ARRANGEMENTS FOR THE TREATMENT
AND ITS INITIAL STAGES

A. INITIAL THERAPEUTIC MEETING WITH THE PARENTS

1. CONTEXT AND PURPOSE

This meeting is arranged with one or both parents following diagnostic assessment and represents the 'initial contact with the parents in the context of the child’s treatment'. Its aims are to pave the way for the successful engagement of the child in treatment and to evoke parental support for the child’s analysis. Depending on the nature of the child’s psychopathology and the quality of the clinical rapport established with the parents, difficulties can be anticipated and adaptive reactions encouraged through preparation and explanation.

The manual distinguishes two modes of parental involvement in the analysis. The first involves parental support in ensuring the child's daily attendance in treatment; the second involves regular contact with parents to support them in their own concerns about the child and the family. The recommended format for the initial meeting outlined below is generic and adaptations necessary for specific cases will be illustrated in the final section concerning some typical problems. The procedure governing ongoing work with the parents will be described in a subsequent section.

2. GENERIC GUIDELINES

a) The explanation of child analysis

Initial therapeutic contact should, in all cases, include an explanation of the nature of child analysis and developmental psychopathology to parents in broad terms and employing language appropriate to the social and cultural background of the family. An account combining cognitive and emotional concepts is often suitable, e.g. "As children grow up they frequently misperceive the things that happen to them, they misunderstand the motives of others and consequently react with excessive fear or guilt." A 'nutshell' account of the aim of treatment may then lead logically to the presentation of a simplified psycho-analytic model of the treatment process which emphasizes the need to find out how the child thinks and feels and the importance of helping the child to identify the sources of
his 'misunderstandings'. Once pinpointed, misperceptions may be corrected within the context of the child's relationship to the therapist therapeutically induced with the aim that these corrections will generalize to the child's relationships outside of treatment.

b) Parental involvement

The analyst is required to pursue two potentially conflicting aims in involving the parents in the child's treatment. On the one hand, the parents are encouraged to recognize the value and importance of the treatment and to provide support for the treatment at times when the child may feel reluctant to attend. On the other hand, it must be conveyed to the parents that the child's treatment material is confidential and that the child's relationship to the therapist is a private one.

c) Repetition of information

The analyst should endeavour to remember that the initial meeting is the first of many, and that information given to parents may well need repeating and clarifying in diverse contexts during subsequent meetings.

d) The depth of explanation

The length and level of explanations given to parents will largely depend on the extent of parent's psychological mindedness and the degree of their anxiety about intensive psycho-analytic treatment. With parents who are anxious about the treatment, the analyst should avoid entering into detail about the complexities of the analytic process and though guarantees concerning a favorable outcome cannot be offered, the analyst should endeavor to instil confidence in her willingness to try to help the child and, where applicable, to help the parents to facilitate the child's progressive development.

e) Child-specific style

The nature of explanations to the parents concerning the nature of the treatment should match the child's level of development and should be attuned to the nature of the child's psychopathology. For example, the parent(s) of a child who is anxious and whose adaptation to demands placed upon him is tenuous would be warned about the possibility of therapeutically related regression. Overlooking adequate preparation of the parents for probable negative responses to treatment in terms of regression and/or resistance may lead to premature termination of the child's treatment.
3. SPECIFIC ISSUES

a) The real and internal concerns of the child

It may be important to convey to the parent(s) that the child's analysis is unlikely to be solely concerned with the inner world of the child, e.g. his daydreams and fantasies, and that the analytic process is likely to take into consideration many real concerns of the child, e.g. the behavior and expectations of others, the demands of school work, and obstacles and frustrations related to the child's wishes for achievement.

b) Additional explanations, where necessary

Some parents will need additional explanations concerning the nature of the treatment. In particular, problems are likely to arise with regard to the intensity of the treatment and the lack of a direct and obvious relationship between the nature of the treatment and the severity of the child's symptoms. In such cases the analyst may give one or more of the following 'elaborations' of her initial statements.

(i) The analyst may highlight, in terms of a particular child's history, how the psychological development of the child is currently deviating from the normal path and needs to be therapeutically induced back so that the spontaneous process of personality growth can resume.

(ii) The analyst may emphasize broader problems experienced by the child in functioning adequately. For example, how emotional problems may interfere with the child's achievements or his capacity for enjoyment.

(iii) With latency children emphasize what you expect.

(iv) The analyst may wish to explain the process of symptom substitution by linking the developmental history of symptoms such as nightmares, bed-wetting, fears of the dark and ghosts, and school failure of conflicts and anxieties which require understanding and interpretation. The analyst can in this way justify intensive treatment by aiming to tackle the source rather than simply the manifestations of unresolved emotional conflict.

(v) In cases where the analyst becomes cognizant of gross misconceptions concerning child analysis on the part of the parent(s), the analyst should endeavor to elicit these as much as possible and offer appropriate correction and reassurance. The following
is an example: The parents of James, a six year old boy referred for treatment of nightmares and a dread of separation from his mother to attend school, had read diverse accounts concerning psychoanalytic theory and treatment. In the course of the initial interview, they voiced their concern that their son would not cooperate with treatment by telling the therapist about his fears, let alone his spontaneous thoughts and "free associations." They added that James would not even confide in his mother about the nature of his fears on going to school. In response the therapist explained the fact that children are not able to confide in the therapist or to free associate like adult patients. Rather, James will be encouraged in treatment to express himself in a manner that comes naturally to him, such as drawing or play with toys and that the therapist will endeavor to understand his emotional concerns so that James will feel motivated to represent and express his fears and worries and increasingly to rely on the therapist for help in doing so.

The parents of Mary, aged 8, betrayed their belief that child analysis aimed to achieve therapeutic results by abreaction and catharsis and that the analyst would thus encourage Mary to act upon her impulses and fears in treatment. The therapist responded by explaining to Mary's parents that all children, especially those with the kinds of inhibitions which Mary showed do not gain relief or insight by feelings of being out of control. Rather loss of control is likely to cause the child to feel more frightened and less able to reflect on her repudiated wishes.

c) Making practical arrangements (General)

Practical arrangements are of enormous importance in child psycho-analysis. Arranging for a child to attend treatment five times per week is a real burden on family life, but this can also readily become a source of resistance. Scheduling attendance can become the manifestation of ambivalence which parents may experience about the child's treatment. Except in extraordinary circumstances, appointment times should fall outside regular school hours.

Practical arrangements must be made in such a way that opportunities for the expression of opposition to the child's treatment via the disruption of the analysis are minimized. To this end the parents' accuracy in realistically assessing the practical demands of the child's treatment needs careful monitoring: viz. - getting the child to treatment daily, collecting the child on time, being available during the treatment hour when necessary etc. The analyst should ensure that the parents are aware that the practical
arrangements for treatment represent a sacrifice, both for them and the child and therefore all concerned have to accept giving up other activities in the service of the child's future well-being.

d) Attendance

The analyst must emphasize to the parents the importance of regular and punctual attendance.

It is useful to warn parents at this stage that it is the nature of the treatment that children at times grow impatient and dissatisfied with treatment and that they may thus seek to avoid it. It is useful to tell parents that children at times may require parental encouragement to attend and to talk to their analyst about their reluctance or opposition.

e) The child has been misled by the parent(s)

Some children are misled as to what to expect from treatment by their parent(s) in a overt or covert way. A child being told that the Clinic is a club, is an example and in such an instance the therapist should explore the reasons why the parents have misled the child and endeavour to link these "reasons" with anxieties of the parents concerning the child's treatment and/or the parents views concerning the child's worries about treatment.

f) Times of sessions

The timing of sessions should be arranged with parents. In setting up appointment times, the analyst should aim to strike a careful balance between avoiding the disruption of activities which the child finds enjoyable (e.g. free-time, sports, hobbies, guides, clubs etc.) on the one hand and too much accommodation to a child's crowded schedule leading to the probability of missed sessions on the other. It is also important not to collude with the child's wish to use the analysis as a way of avoiding anxiety-provoking activities. The general principle which should govern the arrangements is respect for the value to the child, of his experience outside of the analysis without losing sight of the implications of the arrangements to the unfolding of the therapeutic relationship.

g) Transport

At this initial meeting, the analyst should endeavor to establish the way in which transport is arranged by the parents. The appropriateness of proposed arrangements should
be subjected to critical appraisal at this stage. For example, a young child should not be asked to undertake long unaccompanied journeys. Conversely, the need for an older child to be accompanied on all journeys may be questioned in case this should become a source of resistance at a later stage.

h) Holidays

Holidays should also be negotiated with parents at this stage. It should be emphasized that the analyst's holidays are planned to coincide with school holidays whenever possible. It should be put to parents that it would be helpful if they tried to take family holidays during the same periods. The need for continuity in the child's treatment may be justified and stressed in this regard.

Whilst Christmas, Easter and Summer holidays can thus be negotiated it is more difficult to provide clearly defined guidelines for half-term holidays. As the analysis progresses, some children will wish to see the analyst during half-term, albeit perhaps at changed times. Other children greatly resent seeing the analyst during the time they perceive as being their "holiday". The problem requires analytic review during the course of treatment. However, it is important to recognize that the unwillingness of children to attend treatment during holiday periods for the sake of the analysis may not be a sign of resistance. Parental indications at this stage that the child may not wish to attend during half-term should be responded to with acceptance but it is reasonable for the therapis to draw attention to the need to examine the child's own wishes at the time of the half-term holidays. The general spirit of these negotiations with the parents should be flexible in the recognition that parents and children will be reluctant to sacrifice certain features of routine daily life. This attitude is, however, consistent with the expectation that the parents cooperate with the aims and purposes of analytic treatment.

i) Money

The Centre's willingness to subsidize the child's analytic treatment at a level which the parent(s) can afford should be agreed and attention be drawn to the Centre's charitable status. Negotiations concerning money should preclude the possibility of parents using the claim of insolvency in the service of resistance. The parents' implicit claim of insolvency should, as a matter of course, be regarded as sufficient grounds for the waiving of fees. Parents who are solvent should be informed about the cost of treatment, and the analyst should discuss with the parents their contribution to the cost of treatment based on their financial situation.
j) Arrangements for contact with parents during the treatment

The conditions pertaining to the analyst's meeting with parents is spelt out in the section on "Extra-analytic contact during the analysis." At this stage, parents should simply be told that it is a necessary part of the treatment for them to be in touch with the analyst and/or the psychiatric social worker concerned. Practical arrangements are made during the course of the treatment, but it should be indicated to most parents at this stage that, at least during the initial months of treatment, this generally involves once weekly contact with the therapist or the social worker concerned.

k) Some warnings about the nature of the therapeutic process

i) Cautionary note about transference:

Whilst the analyst should endeavor to avoid arousing the parents' anxiety by explaining too much about the treatment, she should try and give appropriate explanations when parents express concern about the nature of the treatment. For example, a parent may not fully understand why their child cannot talk to a member of the family about their worries. In these cases, it may be useful to explain to the parents the rudiments of the phenomenon of transference. The analyst may say that she learns about a child's troubles by observing how the child behaves when the child is with her. A child will often show in the unfolding relationship with the analyst what interferes with the child's healthy psychological functioning. The analyst may go on to warn the parents that they might find the child becoming emotionally involved with the analyst in a way that differs from the child's relationship with other professionals such as the child's teacher or doctor, and that this involvement on the part of the child may provide a useful focus for therapeutic work.

The analyst's comments should be geared to the parents' intellectual and psychological sophistication, as well as the degree of their curiosity and anxiety about the nature of the treatment. Direct questions concerning how the treatment works, the need for five times weekly meetings or questions concerning the nature of the analyst's relationship with the child may be regarded as sufficient grounds for offering the above types of expanded account.

ii) Other cautionary notes:

Parents may find it helpful if the analyst addresses the fact that the process of change amongst children in analysis is often slow and irregular. It may also be worth
commenting on the transitory nature of some rapidly achieved apparent therapeutic gains. Parents will often wish to know how long the treatment is likely to last; it must be acknowledged that this is difficult to predict, but notwithstanding special considerations for individual cases, it is possible to estimate two years and perhaps even longer. A warning about the child's possible distress during periods of treatment is also a useful preparation for potential problems and a warning about mixed feelings which the parents might themselves experience can help to encourage the parents to talk with the therapist about their doubts about treatment in the future.

I) Contact with the School:

Some parents do not like the analyst to have direct contact with the school. Such contact is, however, sometimes necessary in view of the frequent discrepancies between a child's behavior in different settings. The source of the parents' anxieties may be multifaceted but will often focus on their fear concerning the labeling of the child as having a psychological problem in the school records. The analyst should endeavor to deal with the parents' anxieties as these arise, either by exploration, appropriate reassurance or interpretation. If the analyst feels that information from or ongoing contact with the school is important to the child's progress in analysis, this should be a goal of subsequent work with the parent(s). (This issue is discussed further in the section on Extra-analytic Contact.)

B. INITIAL MEETING WITH THE CHILD

1. CONTEXT AND AIM

This is the therapist's first contact with the child. Above all, the therapist should observe and listen in a concerned manner which conveys her interest in the child. At the same time, it is important that both direct and indirect signs of anxiety on the part of the child are responded to in such a way so as to ensure that the child returns for subsequent sessions. It should be the analyst's aim that the child acquires the impression of her as a sensitive and supportive ally - an adult who understands the child's feelings, concerns and worries. The analyst will want to convey to the child that anxieties and their causes can be understood and that such understanding can reduce anxiety. However, the analyst must be capable of giving responses which speak to the child's anxieties but do not involve a degree of reassurance which diminishes the emotional content of the child's presentation.
2. FANTASY AND EXPECTATIONS.

The child arrives in treatment with a whole host of ideas, some conscious and others preconscious, concerning the nature and purpose of the project. His beliefs and fantasies are determined by his conflicts, developmental stage and the view of his problems and of therapy taken by his parents. As the child's attitude to the treatment will be profoundly affected by these unverbalized thoughts and feelings, it is frequently necessary for the analyst to comment on these thoughts or expectations during the very first sessions. These verbalizations are rarely transference interpretations (see below). The way in which the analyst verbalizes the child's initial thoughts about the treatment, however, is important as it influences the way within which transference interpretations will come to be made later in the analysis.

The analyst may quickly understand some of the patient's preoccupations during this first session but it is not always propitious to verbalize this understanding for the child. In offering interpretations it is important to bear in mind the primary aim of this initial session which is to ensure the child's return to treatment on subsequent days. Thus, in the beginning it is best to focus on the anxieties and resistances with which the patient comes to analysis, rather than attempting to delineate a more precise picture of the child's fantasies and thoughts which should be allowed to evolve over the months to come and may, in any case, be understood quite differently later in the analysis. However, as already stated the analyst must not be over cautious in interpreting the anxieties and expectations with which the child arrives in the treatment situation, as this can effectively block the further development of the analysis.

3. NECESSARY EXPLANATIONS

On the whole, there is generally speaking little need for extensive or elaborate explanations of the nature of analysis. There is little that must be said at this stage with many children beyond acknowledging the analysts' intention to see the child regularly and the physical setting in which the analysis will take place. The analyst may wish to make some simple comments such as: "You will be coming to see me each week day and this is our room. These are our toys which, I wanted you to know, no-one else uses and this is your locker where you can keep them." Beyond such simple statements, orienting the child to treatment should be based on the analyst's observations from which she may infer the child's expectations and anxieties, and she may then wish to verbalize these when appropriate.
Descriptions of the physical setting of the analysis should communicate the privacy and safety of the relationship between the analyst and the child. This does not need to be explicitly spelt out unless there is direct evidence of the child's concern about the safety or confidentiality of the analytic situation (see below). Much in this regard is communicated implicitly through the analyst's manner and responsiveness to the child's concerns.

4. SOME TYPICAL PROBLEMS

There are a number of characteristic issues which can emerge during initial meetings. It is important for the analyst to listen carefully for reactions which may interfere with subsequent treatment unless dealt with at this stage and direct intervention should be reserved for such instances.

5. COMMON INITIAL ANALYTIC ISSUES

a) The analyst versus the diagnostician

Some children will show signs of anxiety or resentment about not seeing the diagnostician and the substitution of the new person of the therapist. The child may overtly talk about the previous person he saw or what they did together, make comparisons between the diagnostician and the therapist or the toys and other aspects of the physical environment. The reference may be more indirect, for example, talking about people moving away or new people entering their world (for example, a new teacher), or the loss of inanimate objects. Play themes can also reveal that the child experiences the change of person as a source of concern.

Unless the anxiety is marked, in most cases it is not necessary for the analyst to interpret initially the child's anger or anxiety about seeing a different person from the diagnostician. So, for example, the analyst may say: "I know that you have seen lots of different people already but from now on you will be coming to see me." In this way, by simply putting into words the fact of the changeover, the analyst signals to the child that she is aware that seeing many people is disconcerting and thus gives the child covert permission to express further feelings about the change.

Depending on the child's history, level of development or psychopathology, he may react more strongly to the changeover, and this may require more extensive intervention from the analyst. The child may manifest signs of hostility; for example, making denigrating comparisons between the analyst and the diagnostician. In such responses, the child may be
revealing important aspects of his view of himself and his objects, such as the feeling that "he was not good enough for the previous person and was passed on" or was "neglected by a woman and was sent to a man" or "was found to be so naughty that a particularly strict person needed to be found to deal with him." The analyst may be able to anticipate such reactions from the diagnostic material. It is generally preferable to tackle the child's reaction to the change of person with verbalization of his affect about the change rather than by interpretation of the unconscious fantasy underlying his reaction until the latter is more fully understood during the course of the analysis.

b) Anxiety about beginning treatment

It cannot be assumed that the child "knows" the treatment situation to be safe. The child may feel anxious about the treatment itself and this may become manifest with reference to the setting. The child's experience of the setting as dangerous may be expressed in relation to the room (for example, identifying sources of danger such as commenting on the distance from the window to the ground below or pin-pointing disconcerting defects in the room, such as the cracks in the ceiling). The child's concern may be more focused on the dangers that treatment involves. Thematic doll play concerned with corporal punishment of children for unruly or naughty behavior may, for example, express anxieties about the therapist as a punishing figure. Such play may alternatively express any number of diverse concerns, conflicts or memories, and here again, clarification and verbalization of such themes, leading to further elaboration of the theme over numerous sessions, should precede interpretation of the relevant material.

Nevertheless, the analyst should attempt to find a way of taking up the child's initial anxiety about beginning treatment. The analyst may, within limits, offer reassurance as well. The manner in which the analyst addresses the problem should take the child's level of development and knowledge into account. For a small child, it may be appropriate, with reference to the above example, to say that the Clinic is not a place where children are smacked for being naughty. Alternatively, the child's fear may be addressed in displacement, and the therapist may comment that she once met a child who was frightened that treatment involved being smacked for being naughty. For a somewhat older child, it may be appropriate to say "It is always a little frightening to get to know a new person."

If the child manifests substantial separation anxiety, it is permissible and appropriate to reassure the child by returning to the parent in the waiting room, if need be a number of times, during this first session or to allow the child to bring a parent into the consultation room.
In making an initial interpretation of the child's anxiety, the analyst should be careful to avoid a number of possible pitfalls. For purposes of illustration, consider a child whose initial play is focused on hospitals and surgery. An explicit interpretation to the child (for example, "You are afraid that I will cut off your leg because you feel as if this place is a hospital") is likely to be overwhelming and may cause the child to run out of the room. A blanket reassurance such as "This is not a hospital" may stifle the flow of the material. A sensitive interpretation at this stage might address the child's anxieties and also contain a degree of reassurance. By recognizing the anxiety and communicating the wish to help understand, the interpretation will serve the important aim of initiating the analytic process. The intervention may thus consist of a simple sentence such as: "Poor dolly every new place makes her frightened of having an operation. Should we tell her that there are no examinations of children's bodies or surgery here."

A common source of anxiety for the child arises out of the unfamiliarity of the analytic situation. This may be more complicated than a reaction to a new building or room or the problem of separation from the mother. The manner of interaction between the child and the analyst may engender anxiety through what the child construes as permissiveness and the activation of wishes to perform acts forbidden at home. For example a child from a strict background may find the opportunity to play with paints and plasticine alarming. In light of these considerations, it is important for the analyst to enhance the child's awareness of his anxiety over forbidden activities while also communicating to the child a sense of security that he will not be encouraged to lose control. The analyst should thus avoid telling the child that he can "do whatever he wishes, though the child may be told that he can say what he wishes. It is important that the analyst avoid an authoritarian or educational role, telling the child what he can or cannot do. Limit setting should be communicated analytically, via clarification and interpretations, not in terms of regulations. For example, the child who considers writing on the wall might be confronted with a comment such as: 'I expect you are wondering if I will say 'You mustn't do that' rather than simply forbidding the behavior.

c) Hostile reaction from the child

Some children may show hostility in the very first session. This may manifest in overt physical attacks on the analyst (e.g. biting or kicking) or verbal denigration, though it may take more subtle forms. At this stage, the therapist has to discern whether the child's hostility is a response to anxiety that he himself will be attacked, criticized or punished, or if it is an early manifestation of the child's problems in controlling anger and aggressive
impulses. In the former case, the child's fear of being attacked should be verbalized. In the latter case, limit setting is required which is neither punitive or condemning. If the child's aggression is causing pain or discomfort to the analyst, she might endeavor to set limits to discourage the child's overtly hostile behavior. Such limits are held to be an aid to the management of anxiety which may accrue from the child being allowed to be too denigrating or aggressive. This sort of limit setting rarely requires force. The analyst may comment that she wishes to understand what makes the child so angry but: "We are going to do it in a way that doesn't hurt you and doesn't hurt me." Alternatively, the analyst may say: "You must stop kicking me because I can't do my job whilst you are kicking."

There are, of course, many reasons which underlie an initial response of aggression from the child towards the analyst. For example, if the analyst is receiving the hostile aspect of the child's so-called 'split' ambivalence, this may become evident in his way of contrasting the analyst with other adults. Thus the child may say something like: "Dr. X (the diagnostician) was nice - you're horrible." If the hostility is thus understood as an habitual mode of responding rather than as the product of anxiety, the analyst is unlikely to want to take it up in the first session but permit it to evolve within the analytic relationship (see below).

d) Over positive reaction on the part of the child.

Sometimes children present as unconvincingly enthusiastic about the prospect of treatment. The analyst's reaction should be guided by the intensity of the child's reaction and the determinants of the attitude, e.g. the fantasy that the treatment is going to bring a magic solution to the child's problems. In any case, an initial warning can be useful to buttress the child against disappointment in the future. A simple comment such as: "I'm glad that you are pleased to be here but don't be too upset if it is at times more difficult to be here than today." A comment of this sort may allow the child to enjoy 'a kind of honeymoon' which permits the construction of a relationship of basic trust (see below) which will be essential to sustain the relationship with the emergence of frustration or hostility.

Some children may show eagerness because of false expectations about the nature of the treatment. These need to be explored rather than prematurely dismissed or corrected.
e) An apparently indifferent reaction on the part of the child

The child may respond in a very passive way, refusing to take part in the initiation of the analytic process. The child may wish to read a comic or just sit in silence, showing no sign of anxiety and without any apparent wish to do anything. The child's overt communication in these cases is usually that they do not wish to be in treatment. A child who is unaware of having worries may not understand why he has been taken into treatment. The analyst may wish to attempt to make the child more comfortable by acknowledging the child's difficulty in talking at this stage and indicate in a positive way that this may change. The technical problem presented by such children should not be minimized. The analyst, who through her interpretations is seen to assume the presence of strong affect without substantial evidence, may aggravate rather than ameliorate the situation. In such instances the analyst may take on the appearance of a persecutor and the child's position may become entrenched as a result of the analyst's ill-founded comments.
A. The Nature of Analytic Material

Analytic material refers to any aspect of the child's behavior to which meaning may be given through the analytic process. The term may cover verbal expression, non-verbal play, drawing or painting, dramatizations and more goal oriented activities. The analyst may thus use most modes of the child's behavior to help her understand the child's unconscious conflicts. As the capacity of the child to express himself exercises a decisive influence on the therapist's ability to work psychoanalytically, the manual represents an attempt to classify and illustrate the verbal and non-verbal modes of analytic material.

The search for analytic meaning has to penetrate beyond the superficial commonsensical or self-evident determinants of the child's behavior. For example, a child who repeatedly makes a theatre set out of flimsy paper when he could make it out of cardboard may be seen to be bringing material pertaining to his need for support and help - perhaps from the analyst - as the flimsy paper may require the analyst's constant physical support if the set is to remain functional. Such an unspoken interpretation of the above material is provisional and part of the process by which the analyst is looking for a meaningful theme or consistent meaning underlying a number of independent sets of material. The example of the need for support would be made more tenable if the same session contained material where the child repeatedly tried to make a chair stand on two legs and climbed across an imaginary tight-rope needing constantly to hold the analyst's hand. The analyst may use material from previous sessions to construe such themes.

General characteristics of analytic material:

It is a fundamental rule of child analysis that not all the child's activities are legitimately understood as analytic material. It cannot be assumed that every child comes to analysis wishing to communicate with the analyst his preconscious concerns deriving from unconscious conflict through various of his actions. At the beginning of treatment many children may intend to give little away. We may however assume that unconscious wishes will seek expression and will appear in various derivative forms during the session. For example, the child's preconscious fantasy that his body is vulnerable to being damaged may find expression through his anxiety about the intactness of the wheels of toy trucks and cars.
The analytic work in favorable instances leads the child to wish for help with his anxieties and problems. In such cases the therapist's clarifications and verbalizations of affect, particularly anxiety, will bring about a wish to communicate. Even in such cases this wish will not be continuous, and it cannot be assumed that the wish was there to begin with. Thus in all instances, the analyst is confronted with the problem of trying to identify what items of verbal or non-verbal behavior during a session constitute analytic material, which is communicative in its intent, either consciously or unconsciously, and that which, in a particular context, is spontaneous activity not relevant to the analytic process.

Verbal and non-verbal behaviors which are not recognized as analytic material may nevertheless be relevant because they provide a context or a background to getting to know the child being treated. Subjective estimates of baseline frequencies for a large range of behaviors are acquired in this way. It is inappropriate and counter-productive to interpret every single game that a child plays, every choice of toy, every occasion when the child does or does not ask for help. Patterns of activity are however useful in establishing the quality of the child's temperament, developmental level, preferences etc., all of which provide a background for the analytic work. Analytic material is created both through the analyst's recognition of specific repeating patterns in the child's behavior and through deviations from these patterns. An example of the former category is provided by the child's repeated response to anxiety by aggression.

The evolution of meaningful analytic material:

The interactive process through which the child's behavior turns into analytic material is highly complex, and perhaps more so than is the case in adult analysis. In adult analysis the availability of free associations from the adult patient provides a less equivocal set of parameters for what constitutes analytic material. In child analysis, the evolution of the material requires fostering by the analyst in a purposive and tactful way. The analyst is required to elaborate through inquiry the nature of behaviors that she deems pertinent to the current theme of the analysis.

To take an example, the child is playing with a train, pushing it up a steep gradient. The train halts half-way up the gradient and the child comments: 'The train can't go up the hill'. The analyst may appropriately ask for an elaboration, e.g. 'Oh, poor train! I wonder why it can't go up the hill'. It should be noted that the analyst is encouraging the evolution of material not simply through asking for elaboration but also by legitimizing the play world of the child by deliberately entering it. The child's answer to such requests for elaboration may provide further cues for an appropriate symbolic understanding of the child's material. In
the present example the child may say, 'The station has run out of coal and there is no steam', or 'The wheels have come-off and the train doesn't work' or 'It is dangerous to go any further up because the bandits are waiting there. Accepting the legitimacy of the symbolism of the train standing for the child, these explanations may hint at the child's feelings, wishes, fears, or apperceptions of self and self in relation to significant others. The above examples may be understood to signify that the child feels unsupported, damaged or wishes to do something forbidden. The analyst may ask for further elaborations, such as wondering why the engine driver has allowed the train to run out of coal; or why the train is in danger of breaking apart or what the bandits intend to steal. The analyst's active encouragement of the evolution of meanings is thus an essential component of this process.

**Unconscious schemata:**

Persuasive evidence now exists in the developmental literature that the child's internal representations of external reality are initially organized, not in terms of hierarchies of classifications, but in terms of an accumulating collection of schemata for events, called event schemata. These schemata of every day events are dynamic in that they consist of the relationships between agents and objects in the context of specific actions. These schemata are developed and revised with accumulating experience and maturation and so guide the child's understanding of events and organize his actions. Event schemata thus precede the development of a capacity to classify, organize, and other higher order cognitive processes. Event schemata, whilst constructed out of experience of reality, may distort the real world through the child's limited understanding of it as well as the child's capacity to alter aspects of an event schema to create a variety of alternatives in fantasy.

The child's cognitive development evolves towards more complex cognitive structures involving problem solving strategies and the concept of roles and the rules which govern social interaction. As children develop increasingly sophisticated ways of representing external reality they tend to exclude more primitive event schemata which do not conform to more advanced levels of reasoning. For example, the representation of the mother in the second year of life may include images of the mother deriving from event schemata in which she is understood to be threatening in her demand for compliance with toilet training. With the secure accomplishment of toilet training the child will incorporate his use of the toilet into his understanding of social rules, e.g. that all children should use the toilet. This higher order understanding no longer requires reference to the image of mother as threatening. However, earlier representations of mother as harsh and threatening remain. As event schemata are lower order representations they are inaccessible to direct
questioning. In this manual we refer to these as preconscious representations. Furthermore, the child may be motivated to exclude derivatives of the schemata from his conscious experience due to the unpleasurable quality of the experience they represent. In this manual, this level of representation is referred to as unconscious. Both preconscious and unconscious representations spontaneously emerge as affective organizers of the child's free play in an unstructured context.

Child analysis aims to exploit the child's tendency to reinvoke less sophisticated representations of affective and cognitive experience. The child's behavior in the analysis is regarded as constituting analytic material to the extent that it expresses such relatively primitive forms of internal representation of current and past events and the thoughts and feelings surrounding them. The behavioral products of higher level cognitive structures, which are inevitably more socialized and less specific to the individual child, do not constitute analytic material. This is not to say that the child's more mature forms of thought are disregarded or disparaged by the child analyst, for they often provide a context in which the more primitive forms of mental representation emerge and become the focus for child analytic work. For example, a child may enjoy playing a structured rule-bound game with the analyst during which he may unexpectedly break the rules. It is the element of deviation from the rules which is of interest to the analyst as it is likely to derive from a more primitive understanding on the part of the child of the activity in which he and his analyst are engaged.

The presentation of behaviors regulated by higher order thought processes may become an important way in which the child defends against the analytic process. For example, a child may use the analyst to help him with his homework in a way which effectively rules out the emergence of analytic material. However, it must be borne in mind that the task of differentiating higher order functioning from less socialized representations is a complex task requiring careful observation over a period of time in order to discern the presence of more primitive affective and cognitive structures and their meaning in the context of more reality-based and socially mature functioning. Once these meanings are discerned, clarifications and interpretations made in a fashion comprehensible to the child will encourage the child's engagement in the analytic process.

The forms of expression of preconscious and unconscious schemata are rarely direct. They emerge in derivative form. The relationship of the derivative to the underlying mental representation is not governed by the normal characteristics of verbal expression. The understanding of the mental representations underlying these derivatives, i.e. the analytic material, is based on specific principles which guide the child's expression of
internal representations in words and actions, as well as the disguising of these expressions in order to avoid anxiety, guilt or shame. The principles invoked by the analyst to elaborate upon the meaning of the child's behavior in the analysis are detailed in the final part of this section of the manual.

The elaboration of the child's event schemata and fantasies in analysis is an ongoing process in which the analyst aims to add further meaning to material with a view to developing an appropriate context for interpretation. Elaboration of the child's behavior by the analyst is a mental event which may lead to interventions ranging from clarification or interpretation, more subtle forms of communication, such as conveying an attitude facilitating to the child's affect, or may be limited to forms of understanding which are not communicated to the child. The analyst will make her elaboration by identifying thoughts and feelings, particularly those involved in conscious or unconscious conflict and those which present repeatedly creating recognizable themes in the analytic material. The child's motivation to bring further material is augmented by providing him with the experience of feeling understood. In this way the child may come to realize that his expressions have meaning in addition to that of which he is aware and that these latent meanings tend to link with other thoughts and feelings he has had in the past.

The uniqueness of the analytic situation depends on the analyst's ability to show the child that she is interested in aspects of his actions and words that other adults are not necessarily interested in, and that she can make sense of them. This is an implicit component of the analytic situation which provides the primary motivation for the patient to participate in analysis.

Even when the analytic work is well on the way elaboration is required to clarify the meaning of the child's words and behavior. Invariably, the child's overt behavior permits more than one form of elaboration. The particular elaboration chosen is determined by the context provided by the session and the evolution of the analytic process. However, the analyst may opt to pursue one elaboration in preference to others on the basis of her intuitions concerning the child's feelings at the time. The analyst's view of the child's behavior is governed by expectations which in turn will determine what he regards as material. Expectations can reflect theoretical bias, independent information about the child gained from the parents or school, as well as the past experience of the child in the analysis. It is unwarranted for the analyst to think that she is able to keep these expectations from influencing the child's behavior.
B. Formal Characteristics of Analytic Material

Analytic material is defined by the underlying psychological processes which give rise to those aspects of the child's behavior most suitable for analytic elaboration. It is more problematic and less useful to specify it in terms of the formal characteristics of the manifest behavior which provides the vehicle for the elaboration. Nevertheless, in this section we will cover a number of formal characteristics of analytic material which have implications for technique as specified below.

Hallmarks of analytic material:

There are no limits to the range of those behaviors which may be used by the analyst as the basis of her elaboration of the meaning of the child's behavior. There are, however, a few particularly helpful indicators which child analysts use to identify behaviors which are likely to form fruitful bases for such elaborations. The most telling aspect of a child's behavior in the analysis which marks out analytic material is the inexplicability of the child's behavior if its preconscious and unconscious determinants are not taken into account. This is not to say that an action or an utterance which appears to be perfectly 'reasonable' in a particular context cannot constitute analytic material. It is, however, more likely that instances where the child's behavior departs from what would be normally expectable, that analytic elaboration may prove to be particularly fruitful. Hallmarks of analytic material therefore refer to ways in which the child's behavior inexplicably departs from that which is anticipated.

The repetition and abnormal frequency of the child's behavior relative to developmental and social norms are possible hallmarks of analytic material. A child who enters the session with shoe laces untied is not necessarily bringing material but a child who always comes to a session with loose shoe laces and then proceeds to stumble may be expressing his feeling uncared-for and his wish to elicit the therapist's concern through substitution and symbolization (for example, his wish to remain dependent in relation to his mother). It should be noted however that most human behavior is potentially symbolic but this potential does not in itself make for analytic material.

Changes of pattern of behavior usually offer material for analytic understanding. For example if a child who has been engaging the analyst in play over a series of sessions suddenly stops doing so, this is likely to invite elaboration. There are a number of external indicators of such changes. These include: a) exaggerated behavior; b) sudden shifts in developmental level; c) inappropriate affect.
A change of pattern of behavior may come to be manifest in exaggerations of particular acts. For example, a child is winning in a game of draughts but refuses to take the analyst's last piece, and instead prefers to tease the analyst inordinately. The analyst may wonder what is happening in the child's relationship to the analyst in the session to provoke him to wish to demean her in this way. She may look to his feeling of smallness and low self esteem as a way to elaborate and clarify his behavior. She may further elaborate her understanding of the material in terms of experiences in past and/or current situations outside the analysis which engendered or triggered his behavior.

Tony aged ten overrode his analyst's attempts to ally Tony with the therapeutic purpose of not always giving him an immediate factual answer to all his questions. Tony badgered his analyst with the question: "What is your favorite radio station?". The analyst eventually was able to take up Tony's need to be analyst's favorite child and related this wish to Tony's long-standing desire to be his parent's favorite. Furthermore the analyst related his scornful demanding attitude to his frustration and anger in seeing his brother receive attention from his parents.

Sudden shifts in the developmental level of a child's functioning, particularly in the direction of the sudden appearance of earlier forms of behavior represent another possible hallmark of analytic material. A child who has ceased to lisp and suddenly starts doing so is marking out analytic material in such a way.

Changes in the appropriateness of affect, either in degree or quality, may be a further pointer to significant material. A child showing anxiety following success at school or pleasure following failure may be legitimately understood to be demonstrating inappropriate affect.

Play with toys and games:

The forms of play in child analysis are potentially infinite. A classification in terms of superficially observable forms of play activity is therefore unlikely ever to be exhaustive and, in any case, from an analytic standpoint can be of little value. Furthermore, play in analysis reflects a broad range of levels of symbolization. Correspondingly, play material can be used for diverse activities. For example, a crayon may be used to soil or scribble or for imaginative and symbolic expression. It is common, especially among young children, to express derivatives of unconscious fantasies partly in play with toys and partly in role play. Older children also engage in formal rule-bound play, e.g. games.

Facilitation of fantasy play: Not all children come to analysis with a developed capacity to express their fantasies employing toys. Many rely on re-enacting happenings in
their daily life, while others tend to rely on the analyst's person, furniture, or other objects in the room to express their thoughts and feelings. Notwithstanding the apparent absence of a specific fantasy in these latter forms of play, they do often constitute analytic material as they may express a complex range of thoughts, wishes and feelings via mechanisms considered in detail below.

The child in analysis is provided with specific toys and a locker in which to keep them. The provision of toys in a consistent setting constitutes an invitation to the child to elaborate thoughts, feelings and fantasies in play. Toys which the child can lock away until the next session facilitate the development of narratives and play themes which help to actualize the child's Internal world. Understanding the nature of the correspondence between the child's play and his conflicts and anxieties is the analyst's primary task. There is a danger in over-rating the role of the toy as an instrument in child analysis. It is a child's actions and verbal references to his toys rather than the toy itself which contain meaning. Toys are sometimes brought from home and used in treatment while at other times a child may wish to take play material home. Such behavior may represent the child's attempts to make links between themes in the analysis and events and occurrences outside, particularly in the home.

The choice of toys:

Child analysts are aware that certain toys, those which give relatively free rein to the child's imagination, serve the function of eliciting children's fantasy far better than others. These include pencils, paper, dolls and animal figures, plasticine and telephones. Undesirable toys are those which are known to elicit predictable play sequences or fantasies. For example guns or tanks are bound to elicit aggressive fantasies in little boys and are therefore less useful.

The demands-which toys or games place on the analyst need also to be considered. Those which demand too much participation or concentration on the part of the analyst are on the whole to be discouraged, particularly with older children as they may distract her from the analytic work. With these considerations in mind, the analyst will provide the child initially with a small range of play material chosen on the basis of the child's age and developmental level. She may add particular items on the basis of her knowledge of the child's developmental history or symptoms with the aim of facilitating the expression of specific forms of material. For example, a doctor's kit may be thought to be helpful with children with a chronic disease or an unreasonable fear of hospitals. These limitations on
initial provision are imposed in part in order to give the child an opportunity to make requests for further toys. In these circumstances his choice is likely to have analytic meaning.

The free availability of too many toys lessens the effectiveness and productivity of analytic work. The provision of too many toys may facilitate resistance as it gives the child the opportunity to obscure meaningful material by constantly changing the focus of his play.

**Verbal and non-verbal modes:**

Non-verbal covers a large range of different modes of expression which include drawing, dramatization, playing with toys and even silence. The extent to which non-verbal activity is organized, internally coherent and has a narrative structure will determine its potential meaningfulness to the analyst. The principles which guide the analyst's understanding of the child's non-verbal in the analysis are outlined below. Similarly, to arrive at a psychoanalytic understanding of the child's verbal responses, the analyst will also make use of these principles. Naturally, the specific principles applied will vary according to the mode of expression.

Children frequently discharge considerable affect bodily in analysis and such enactments of drive derivatives coincide with a failure to contain their feelings and impulses in words and verbal symbols. This poses technical difficulties as the expression of derivatives of unconscious wishes through thought or fantasy, as opposed to direct expression in action usually decreases the child's anxiety and increases his feelings of being in control. For example, when the child is aggressive towards the analyst she will endeavor to help the child to express his aggressive intent in words. It may therefore seem that verbal material can be regarded as more useful analytically because it already reflects a degree of control and containment.

However, verbal expressions by the child may be employed in the service of defense and resistance. For example, verbal material confirming an interpretation may be little more than a compliant echoing of the therapist's intervention. Non-verbal material may at times reveal a fantasy more clearly than a verbal communication. Thus verbal material does not inherently place the analysis on firmer ground than material which is brought non-verbally.
Notwithstanding the above considerations, the analyst's aim must be to assist the child to put words to his feelings and to make verbal links between his thoughts, and other experiences, thus making both feelings and thoughts more accessible to his understanding and control. The pursuit of this aim in analysis enables the child to understand that wishes and their expression in fantasies are not equivalent to action. It is in this sense that the progress towards verbal material represents therapeutic progress.

The involvement of the analyst:

The analyst should convey her readiness to become involved in the child's play, but not seek participation actively. Whilst she should avoid intruding upon solitary play on the one hand, she should not decline participation when requested on the other. In general she should take the child’s cue and interpret the meaning of the degree of involvement requested of her, as and when it becomes clear and appropriate to do so. To illustrate some of the issues governing the degree of the analyst's involvement with the child, considerations pertaining to the initiation of actions, physical contact with the child, role play and the avoidance of contact by the child are addressed.

Although the child analyst, like the adult analyst, must adopt an essentially passive stance in relation to her patient, the specific parameters governing child analysis call for more active participation by her. In the absence of a capacity for free association in the child, she will cooperate with the child's play and participate in dialogue at a level sufficient to maintain the child's motivation to communicate. However, this does not mean that the child analyst will, except in the service of overcoming specific resistances, initiate particular topics of conversation or forms of play. The principle which governs the level of the child analyst's activity is that she will initiate and participate in conversation and play so as to engage the child on a social level appropriate to him and thereby provide an atmosphere in which less sophisticated thoughts, feelings and fantasies can emerge.

A special dimension of the analyst's involvement concerns the child's request for physical interaction. The importance of physical contact is not simply its occurrence but the conditions governing its emergence as analytic material. The analyst does not normally initiate physical contact uninvited but will respond if children initiate physical contact. An example of this is the implicit request for support by a child who physically leans on the analyst.

Requests for physical contact are more age specific than a number of other issues in child analysis. For example, holding hands may be an appropriate behavior for young
children (3-5), but is outside expectable norms for older children. Of course children with physical handicaps such as blind children represent an exception.

In broad terms it may be assumed that the wish for physical contact is primarily regressive. The analyst should use careful judgment to avoid being manipulated or misperceived by the child as seductive through physical contact. At the same time she should avoid presenting an inappropriately harsh image by turning down age appropriate requests for bodily contact.

Similar criteria apply to requests from the child for the analyst to participate in role play or to take part in a game. We may define role play as the engagement of the therapist by the child which involves dramatic play in which there may be some physical contact with the therapist. Examples include the therapist being asked to act the part of a ticket collector on a bus or pupil in a school. Little significance should be attached to the mere performance of role play.

Where the analyst must use her discretion is in deciding the extent to which she conforms with the child's role assignments. For example, some children demand absolute adherence from the analyst to her designated role and forbid the analyst to step out of it. In such circumstances the analyst must pursue analytic material without excessively frustrating the child's wish to control the play.

The analyst's involvement may not be sought by the child in his activities. At times children may use under-involvement or under-utilization of the analyst in a defensive way. Playing at hiding or turning their back on their therapist, mumbling things that cannot be heard, refusing to come out of the waiting room or choosing games which completely exclude the analyst are examples. The analyst's initial reaction should be to clarify the situation by putting it into words. This is likely to give rise to further elaboration of the behavior by the child which may help the analyst to understand reasons for the child's withdrawal. Similar considerations apply to situations in which the child may over-involve the analyst for defensive purposes.

C. MODES OF EXPRESSION AND DISGUISE

Analytic material is made up of the child's behavior during the analytic session which may be construed by the analyst as expressing thoughts, feelings and wishes which the child consciously or unconsciously experiences. These experiences are however accompanied by a conscious or unconscious prohibition of direct expression. In the
absence of direct communication of these experiences the child manifests one of a number of modes of indirect expression. These require analytic understanding based upon: 1. the analyst's prior knowledge of various modes of expression of repudiated content and 2. the analyst's understanding of the means by which children may disguise their experience. In this manual we will attempt to formalize the basis upon which analysts understand a variety of modes of expression and discern the meaning behind common types of disguises.

**Modes of Expression**

It is assumed that material brought by the child represents the child's current emotions, thoughts and feelings indirectly. What the child is expressing indirectly (i.e. the contents) may or may not be outside of his awareness. The manner of its expression in the analysis must, however, be outside of awareness, at least at the moment of its occurrence.

For example, George, a 16 year old boy, who denied anxiety about his sexual urges, shared with his analyst his problem in concentrating on his homework. When asked what he did instead of studying, he recalled playing with the handle of a mechanical copier. He wondered what kept the handle up and investigated this by taking the machine apart. He described the gears inside the machine and the way in which oil was squirted on the gears and himself when the lever was pulled upright. The patient could be assumed to be aware of his conflicts about masturbating but his expression of the conflict in the session in terms of the highly suggestive account of the machine was not linked in his mind with this anxiety.

Later on in the analysis the child may develop the capacity to recognize the meaning of particular actions in the analysis. If the child deliberately and consciously uses modes of expression which he knows his analyst will "understand" in specific ways. This communication is not, by definition, a mode of expression to be considered here.

**The Analyst's Understanding of the Unconscious Meaning of Actions**

There are two interlocking components in actions of the patient as observed in psychoanalysis: a mental act in the form of conscious or unconscious thoughts, feelings or wishes and a physical act which carries the former into an observable enactment. The analyst's task is to arrive at an understanding of the child's mental world on the basis of her observations of the child's actions. Whilst the use of actions as direct expressions of the child's fantasies is commonly discussed, there are a number of other ways that the child's actions inform the analyst's understanding which need to be considered here. Thus we shall consider the analyst's understanding of the form and content of actions separately.
1. The unconscious meaning of the form of actions.

The analyst seeks to appraise the form as well as the meaning of particular behaviors with the aim of inferring how the child deals with anxiety and frustration, the quality of his impulse control and reality appraisal, the degree to which he is capable of relying on others and other basic features of personality and developmental attainments. In this regard it is the qualitative aspects of the child's actions rather than their possible content which may be the source of the most important insights for the analyst. Although the provision of a comprehensive taxonomy of such evaluative dimensions is beyond the scope of this manual, an illustrative list of some of the features most important to the analyst's understanding is provided below.

Solitary play versus social play: The child playing on his own without attempting to engage the analyst's participation may in certain contexts express the child's resistance to a theme which is currently prominent in the analysis. For example, a child who has continuous conflicts with the analyst about who is in control may at times avoid battles about what the analyst is willing to do within a session by excluding the analyst from his activities. In other contexts solitary play may signify disappointment leading to withdrawal from the analyst, escape into fantasy from emotional conflict or a ploy on the part of the child to test whether the analyst is interested in his activities.

The presence or absence of playfulness: A child's playfulness in the analysis is a quality associated with lightheartedness which can reflect a capacity in the child's flexibility in dealing with frustration. Therein, circumstances may be spontaneously exploited to blur the border between fantasy and reality. Playfulness may express the child's readiness to deal with issues which evoke a degree of frustration or disappointment in a manner that mitigates potential anger, loss of self-esteem or other painful affects. Such a tendency in children, depending on the context in which it is observed, may reflect a history of sensitive parental handling, a sense of identification with a playful parent, a defensive refusal to take matters current in the analysis seriously. In older children, jokes, wit, puns and other language play come to substitute for playful actions.

Stereotyped versus idiosyncratic play: Children who at particular times show a reluctance to engage in any other but the most structured forms of activity defined by preset rules, whether in fantasy play or conventional games, may be seeking to impose a distance from emotional concerns which threaten to overwhelm him. In other situations the child's
reluctance to depart from socially agreed normative forms of play and interaction may be indicative of an increase in anxiety, wherein the more structured activity is seen as warding off anticipated disapproval or punishment.

**Reality oriented interaction versus unrestricted action:** Activities such as schoolwork in the sessions or practicing skills required for advancement in the boy scouts may serve to express the child's wish to be grown up or adult-like, or to gain the admiration of the analyst or other adult figures. Alternatively, the seriousness with which children express their commitment to reality oriented activities may be indicative of precocious and unauthentic defensive identifications with adult figures. Particularly at early stages of the analysis reality oriented interactions may represent a compliance with what the child believes is expected from him and a way of avoiding more personally revealing communications about subjectively important issues. There are instances when children respond to any invitation to pretend and play as a threat; this may express fears of losing control, a vulnerable sense of reality testing or may reflect parental handling characterized by literalness which has failed to enhance the child's imaginative capacities.

**Direct enactments of impulses versus controlled expression:** Children in analysis at times hit, kick or throw things at their analysts, pass wind or openly masturbate. Such behaviors may simply indicate a loss of control over aggressive or sexual urges but may at times have additional significance. They may express unconscious motives such as the wish for punishment or a particular fantasy, for example that sexual relations are violent. In other contexts, enactments may convey a wish for control from the analyst, particularly from children who are allowed to run riot in the home.

2. **The unconscious meaning of the content of actions.**

The analyst regards the child's play or actions in the therapeutic situation as expressing content beyond that which is consciously intended by the child. The content expressed in actions, as with language, covers a potentially endless range of meanings. One can, however, consider a limited range of content categories based upon the common functions which actions and play serve in child psychoanalysis:

a) Prototypically, action expresses a fantasy which may be enacted at various levels of dramatization. For example, a four year old's play with a sword may frequently be indicative of a fantasy of having a big penis.
b) Actions may be symptomatic in the sense that they represent the child's anxiety about his emotional disturbance which leads him to reenact distressing preoccupations in play. For example, a five year old who repeatedly and inadvertently steps on the toy baby doll and nervously laughs, may be enacting her aggressive wishes to attack her baby sister.

c) The compulsion to repeat experiences with which the child was unable to cope in the past may express the child's attempt to master trauma whether induced by helplessness, loss or unbearable anxiety. For example, small children sometimes become panicked when subjected to surgical and medical procedures for which they are unprepared. Following such experiences they can be frequently observed to reenact various versions of the procedure to which they were exposed.

d) The child's actions and play can express his attempts to ward off anxiety, to protect himself from internal or external threat. For example, a seven year old may respond to interpretation of his anxiety in the dark by introducing unending variations of play with toy soldiers.

e) A child may use actions and play to express wishes and feelings towards the analyst, as well as to elicit specific responses from her. For example, a child may play in a charming or endearing way to express positive feelings towards the analyst, or to try to bring about gratifying physical contact. Similarly, children may use their play to tease and provoke the analyst in order to create a sense of frustration in her in an effort to lessen such feelings in themselves.

f) Not all play and action can be understood analytically. As children are constantly acquiring new skills and knowledge which in and of themselves are sources of pleasure and enjoyment, a considerable portion of the child's play in the analysis is rightfully considered as motivated by pleasure in utilizing endowed physical capacities as they mature.

3. The ways in which the unconscious meaning of actions is conveyed to the analyst

The ways in which the unconscious meaning of actions is conveyed to the analyst may be classified into four common categories. These are: 1) the meaning distortion of acts; 2) the literal interpretation of acts; 3) the context specific meaning of acts; 4) meaning derived from the repetition of acts. These are considered in turn:
Meaningful distortion of acts refer to idiosyncratic or unconventional alterations in the performance of acts which invite the analyst to elaborate the nuances within the context of the evolving analytic material. There are at least two forms which such distortions may take.

a) Distortions of single actions: The performance of acts uncharacteristic of the child or in ways which are obviously out of step with the culture may express the child's concerns, feelings or fantasies. In such instances the child performs an action (e.g. closing the door or removing his toys from the locker) in a manner that is markedly different from the 'normal'. It is the difference between normal performance and the observed action that enables the analyst to elaborate the child's current thoughts, feelings or fantasies.

Jane, aged five, was generally preoccupied with anxieties about bodily damage. In one session she began to limp about the room and her analyst commented how worrying it was for Jane to think about people who had things wrong with their bodies. In response Jane recalled seeing a crippled person entering a shop after her session the previous afternoon.

b) The style of actions or sequences of actions: The child's performance of an action or a sequence of actions may convey meaning through the 'style' in which the action is performed. Such individual modes (or manners) of performing an act which deviate from the customary may enable the analyst to gain insight into the child's current concerns, prevalent feelings or fantasies. Here the analyst's attention is focused on the way the child plays a game, draws, interacts with the analyst etc. Excessively messy play, drawing with a pencil held in-the fist and tearing the paper, and speaking to the analyst with back turned are some obvious examples.

Tony, aged nine, introduced a series of competitive games with his analyst for which he reserved the right to alter, from time to time the rules. Frequently, when playing draughts Tony altered the rules so that when he was winning he could prolong the game and chase the analyst's pieces about the board for as long as he wished. These alterations proved to be in the service of wishing to make the analyst feel small and helpless in the face of inevitable defeat.

The literal meaning of actions may figure in the analyst's elaboration of material when the meaning of words which may be used to label actions or action sequences offer the analyst the opportunity to describe actions in terms which address the preconscious and unconscious concerns of the child. We can distinguish three ways in which the literal meanings of actions may be used by the analyst:
a) The literal meaning of acts: The child may perform an act which may be described verbally in a way which reflects important aspects of the child's current thoughts or feelings. When the child's action is verbalized by the analyst the additional meaning of the act becomes apparent.

Tony, aged seven, entered a phase in his analysis when he resented almost everything that the analyst said. This was understood to reflect his resistance to the analysis of his conflicts over his mother's second marriage. During one session, Tony appeared to have difficulty in drawing because he was dissatisfied with what he drew and he was compelled to rub it out repeatedly with an eraser. His analyst commented on the link between his feeling dissatisfied at home and his repeated rubbing out of his drawing. Tony replied angrily: "I wish I could rub you out and all the stupid things you say".

b) The literal meaning of action sequences: Entire sequences of actions may also have literal meanings which the analyst may use to understand child's thoughts and feelings. This category differs from the previous one in that it is the verbal description applied to the total sequence which has an additional meaning in the analytic context.

Johnny, aged nine, began the last session before the holiday with the intention of constructing an elaborate battle scene. He began by sticking several large pieces of paper together to make the battle ground. He found it difficult to move beyond sticking pieces of paper together and playing with the glue to other aspects of the battle preparation. His analyst drew attention to his difficulty in giving up the glue and commented that Johnny liked to play with glue on Fridays and before holidays. She wondered if this might have something to do with his wish to stick close to his analyst over the holidays.

c) Special meaning of particular acts: There are a limited number of actions with strong culturally determined meanings which may be reflected in a colloquial phrase or expression. For example, the common meaning of the phrase "washing one's hands of" may be brought to mind by a child's inexplicable hand-washing. If the analyst has sufficient material to elaborate such behavior and link it with, for example, the child's contempt for a person, she may choose to verbalize the child's wish to rid himself of his attachment to an object.

Bill, aged ten, was in the final stages of his analysis. He had worked through his conflicts over his strong competitiveness with his father and in relation to the analyst. After winning a chess game he triumphantly sprung up from his chair and playfully mimicked sweeping the floor. When his analyst said that she could not quite understand what he was playing at, he replied "Mopping the floor with you".
The contexts in which actions occur may provide the analyst with elements or themes for elaboration. The principles governing the interpretations of actions are analogous to those which apply to the derivation of analytic meaning from verbal material. Fundamentally, there are two ways in which the context specific meaning of actions emerge. Actions which are combined into integral units may be artificially segmented by the analytic observer into meaningful components. Conversely, discrete actions may be combined by the analyst to create a new, analytic, meaning.

a) Meaningful units of action within a sequence: The performance of action sequences is observed by the analyst with a view to examining its components to derive analytic meaning. Such components would normally be viewed as necessary constituents of a complete sequence. However, in certain contexts, these may be viewed as expressing content in themselves in the analysis.

Judy, aged eleven, had strong and conflictual feelings about masturbation and sexual excitement and these in part appeared to account for her difficulty in going to sleep at night. In one of her sessions, in which she spent most of the time drawing lovely female figures, she drew the sleeping Cinderella. After she had completed the drawing, she mentioned her difficulty in "getting the place of the hands right". Her analyst commented that perhaps Judy's difficulties about going to sleep were related to worries about where she should put her hands at night when she went to bed.

b) The linking of two distinct actions: When the child goes through a number of independent action sequences in the same session, the analyst will be alert to identifying links between actions to clarify their meaning in much the same way that she listens to the child's verbal productions. In this way one action may provide an element in a developing narrative, provide the emotional background to a specific content or, when combined with another action, allow for the elaboration of a new meaning in composite form.

Mary, aged six, engaged in an elaborate procedure of wrapping up paper dolls in neat packages and dumping them in the bin while reciting a poem about the rag and bone man. She reacted with enthusiasm to her analyst's comment that she had once known a child who worried greatly about her wish to give her little sister to the garbage man.

Miriam, aged four, was thought to be the victim of child sexual abuse. In her very first analytic session she took the pencil she was offered she took the pencil, put it into the keyhole in the door and broke off the tip. She then lay on the couch with her skirt raised to reveal her knickers. The analyst understood this material to derive from her retaliatory wish to hurt the perpetrator of the abuse.

The interpretation of repeated action sequences: The child's play in the analysis may at times be viewed by the analyst as conveying relatively elaborate narratives depicting the
child's current concerns. The sequences which relate to the child's unconscious preoccupations are frequently highly charged and will be repeated in different contexts. Although the fantasy underlying such sequences is mostly disguised (see below), the structure of the action sequence has enough common components across situations to permit the analyst to comprehend the child's expression.

Jill, aged four, was referred for analysis because of a persistent sleep disturbance. During a session the analyst noted that she insisted on keeping the door open, her locker open, the window open, and even a drawing book which she was not using open. The analyst recalled to herself that Jill's mother reported Jill's insistence at home that her parents keep their bedroom door open at night. The analyst remarked that she thought Jill felt safer when things were open and nothing was kept hidden and secret.

The Analyst's Understanding of How Words Convey Unconscious Meaning

The normal listener restricts the meaning of words within discourse according to at least four principles: 1) The diactic field (or physical situation) in which the speech act occurs; 2) the semantic field (or verbal context) in which a particular word is placed (the meaning of the previous and subsequent words); 3) the syntactic field which may define the sense in which a word is used; 4) the habitual or currently accepted usage of a word where the etymological roots of the word are ignored by the speaker and listener. The analytic listener attempts to dissolve, override or ignore these restrictions. To put it more formally, language itself shows a tendency to synthesize or integrate its constituent components in a such a way that speaker and listener are only aware of the highest levels e.g. in listening to a sentence the listener is aware of the meaning of the sentence rather then its individual component words. The analyst decomposes or literally analyzes the patient's language, paying attention to the component parts either in the context of the patient's conscious meaning or at times even putting aside the patient's intended meaning.

We can conveniently identify at least eight levels of the language at which this psychoanalytic listening may occur.

a) Level of sound: The analyst frequently pays less attention to the meaning of a word then the paralinguistic qualities (or pronunciation) of how the word is said. The intonation, stress pattern, volume of words are examples of this.

Robin, aged 4, brought some string to the analytic session following the death of his grandmother. He initiated a game of tying his therapist to her chair with the string. He said repeatedly: "You cannot escape..You cannot escape". Rather then sounding triumphant as he normally would in such a game, his shortness of breath and choked expression lead his analyst to interpret his anxious wish to keep her safe.
b) Separating words into meaningful components: The analyst may assume that the child is unconsciously using a word almost by way of a 'play upon words' according to the agrammatical breakdown of the word into meaningful syllabic components or through a slight phonemic distortion linking the word to another word.

Robert, aged ten, was referred for analysis because he was inattentive and underachieving at school. Following some analytic work on his feeling that his parents nagged him to study subjects that he was not interested in, he entered a period of resistance characterized by reading in the sessions which the analyst interpreted as Robert's response to feeling nagged by her. Subsequently, Robert began to read a book on concentration camps. When his analyst interpreted his feeling that she, like his parents, tortured him to 'concentrate' in school and in the analysis on their interests rather than his, Robert replied: "Heil Hitler!".

c) The literal meaning of a word: In cases where a word has an abstract meaning, a metaphoric sense or a meaning which is changed by the current context of the word, the analyst may treat the concrete meaning of the word as the key to the important current unconscious thought of the child.

Andrew, aged eight, suffered from very poorly controlled diabetes. He arrived for a session and complained to his analyst of being dangerously low (i.e. hypoglycemic). His analyst understood the communication in terms of Andrew's sadness and disappointment ('low mood') that morning.

d) The unconscious use of homonyms: In instances where a word used by the child has more than one meaning (homonym) the analyst may find the unintended sense of the word to be relevant to the child's unconscious thoughts.

Tommy, aged four, was troubled by the fact that his mother had food poisoning and was preoccupied with the dangers associated with food. In the analysis he asked his analyst to get some food dye to color the water in his toy baby bottle which he liked to squirt over sheets of paper. Suddenly, Tommy became panicky and behaved as if the dyed water was dangerous and poisonous. Tommy's analyst understood his anxious preoccupation with food dye to reflect worry over his death wishes towards his baby brother which were particularly heightened by observations of his baby brother feeding.

e) The breakdown of the meaning of compound words: At times the child's communication may be most readily understood if a compound word used by the child is interpreted by the analyst as intending to convey the separate meaning of the individual words making up the compound rather than the word compound itself.

Lucy, aged six, came from a caring but strictly religious background. Her parents were alarmed by her direct questions, particularly those which related to sexuality. They were unable to provide her with words to refer to sexual
parts of the human anatomy. In her analysis she reacted strongly to her analyst's casual comment to her: "perhaps there was something she wanted to know about how babies were made". Lucy responded by berating her saying: "Something this, something that, don't you know the name of anything". Her analyst was then able to remark that she thought Lucy was angry with her parents because they did not provide her with proper words for the vagina or the penis, referring constantly to "this thing" or "that thing".

f) The breakup of syntagmas: Words are frequently coupled in syntactic units in which their combination has a meaning independent of the individual meanings of the component words. For example, "crystal clear" constitutes such a grammatical unit. In analysis, the child's syntagmas may be broken down by the analyst into its component words and she may regard these as indicating the content of the child's current unconscious concerns.

Louis, aged ten, showed rigid defenses against hostility and particularly strong tendency to show gratitude and consideration towards his analyst. In a particular session when Louis was reported to have been agitated by the receptionist following the late arrival to his session of his analyst, he said that he understood well that such things were bound to happen from time to time due to circumstances beyond the analyst's control, such as road accidents causing a traffic jam. In response to his analyst's query as to whether Louis was altogether sure that he had no other feelings or thoughts about what might have happened to her to cause her to be late, Louis replied laconically: "I am dead-sure".

g) The interpretation of idiomatic expressions: Idiomatic expressions also constitute a group of words whose meaning cannot be predicted from the definitions of the constituent words, as for example in the expression "It was raining cats and dogs". In psychoanalysis idiomatic expressions of children are occasionally examined for the significance of constituent words as these convey unconscious or preconscious preoccupations.

Melissa, a highly intelligent ten year old girl, showed a recurrent preoccupation in her analysis with fears of being abandoned and starved probably, deriving from her experiences during an extended visit to Africa at the age of two and a half during which she fell severely ill with dysentery. Following some analytic work during which this period of her life was reconstructed and partially remembered, Melissa was able to accept that she also had experiences in her early childhood which made her feel looked after, safe and well fed. Upon reflecting on the latter experiences, Melissa said ironically to her analyst upon leaving that session: "One swallow does not make a spring". This confirmed the analyst's view that Melissa's experience of being understood and having her need met aroused anxiety about achieving continuous feelings of safety. Furthermore, the idiom used confirmed the analyst's view that Melissa's vulnerability derived from childhood experiences linked to oral deprivation.

h) The literal meaning of phrases and sentences: Analysts frequently examine the meaning of phrases and entire sentences taken out of the context of the child's intended meaning for
their potential significance in relation to the child's unconscious concerns. When taken out of their context, the literal meaning of such sentences may be seen to signify and elaborate latent preoccupations.

Joe, aged five, was preoccupied in his analysis with how babies were made and showed anxiety about his parents' nocturnal sexual behavior. Recently, his mother read Joe an illustrated book about conception and fetal development. He arrived for a subsequent session with a book entitled "Busby and his girlfriend". He was very excited in asking his analyst to read it to him. In response to a part of the story, when Busby and his girlfriend had a ride on the big wheel, Joe said barely able to contain his excitement: "Big wheels are dangerous, they can turn you upside down and drop you out". His analyst understood this sentence to reflect Joe's excitement and anxiety about the inversion of the fetus in the womb prior to birth and his traumatic experience of observing his mother being rushed to hospital in the final stages of labor.

Special Modes of Expression

Verbal slips:

Children in analysis sometimes say things which appear to diverge from the line of their intended communication. Such slips may at times provide important indications of the child's current thoughts and feelings.

The hallmark of such slips is their inadvertent meaningfulness. They include: 1) the replacement of one word, including personal names, by another, 2) the phonemic distortion or mispronunciation of words so that they become phonemically similar to another word, 3) the introduction of unusual and ungrammatical word orders and 4) the agrammatical stressing of particular words. In each of these cases the analyst is able to identify an additional meaning in the child's overt communication referring to content pertinent from a psychoanalytic standpoint. The following are a few examples of this mode of expression.

Robert, aged six, was being treated analytically for school phobia precipitated by a fear of the headmistress of his school. In explaining his feelings towards his headmistress he would occasionally slip and refer to her as Mummy.

Jane, aged eight, took considerable pains to be good in her analytic sessions and compliant in relation to any suggestion made by the analyst. Her attitude in these regards made it difficult for her to acknowledge her anger with her analyst occasioned by the approaching summer holiday break. Although Jane dismissed her analyst's suggestion that she might be angry about the holidays, she accepted this view when, upon mentioning to her analyst that it was probably time to stop the session, she added that it was time to 'mess up' the room having meant to say it was time to 'clear up' the room.
Action slips

The child's accidental performance of acts in the treatment situation may at times express his current thoughts and feelings. The hallmark of such 'accidental' acts is their inadvertent meaningfulness. They include the accidental dropping or breaking of objects, marking the furniture in the room, inadvertent spilling of liquid, marring or destruction of the child’s or the analyst's productions, etc. Further examples required. In each of these cases the analyst is able to identify a meaningful intent in the child's overt behavior referring to content pertinent from a psychoanalytic standpoint. The following are a few examples of this mode of expression.

Graham, aged six, was superficially compliant and cooperative in playing with his analyst. He particularly enjoyed water play in the sink with boats and divers. Upon filling the sink with water he asked his analyst to fetch him something from the locker and the water overflowed from the sink to the floor. In the same session he again asked his analyst to get something from the other side of the room thus diverting both their attention from his failure to turn the tap off when the sink was full. The analyst understood these actions to express his pleasure in the unrestrained wish to wet in places other than the toilet.

Symbolic expression of material

Analysts frequently make use of the child's ability to symbolize his unconscious concerns in their attempts to understand the child's words or actions. A symbol is a substitutive perceptual replacement expression for something hidden with which it has evident characteristics in common, or is coupled by Internal associative connections. These connections are most commonly rooted in similarity based on the pars-prototo principle (i.e. overlap in terms of one feature implies identity). Psychoanalytic symbols differ from other types of symbolic representation in that unconscious affect is invested in the object symbolized and as a result this object (the referent) is denied access to awareness at the time when the child makes use of the symbol. Thus a child's pride in his father may manifest in his enthusiasm for toy cars. There are four classes of symbol in child analysis and these are based on the nature of the link between the symbol and the referent.

1) Association by contiguity: Some symbols derive their representational properties from the simultaneous presence, at the time of symbol formation, of the object or fantasy represented and the symbol used. This category of connection is normally made on the basis of the analyst's knowledge of the patient's history or her experience of the patient in treatment.
William, aged five, concocted a number of mixtures of chalk and water in various cups which he referred to as containing poison. In the following session he dramatized a family meal using the family dolls. In the scene the older boy was aggressive to the baby in response to which the mummy doll, with a witch-like voice, offered the older sibling a "special drink" from one of the cups which the previous day had been used for the poison mixtures. The analyst commented that she thought the older boy figure may be very frightened he was going to get poisoned for being nasty to the baby.

2) Commonality of function: The symbol may have functions (e.g. the capacity to pour or squirt) in common with the object represented (e.g. the body and its excretory functions).

Mary, aged four, was for some weeks in the analysis preoccupied with babies, kittens and puppies. To one of her sessions she brought in a set of Russian dolls. Her excitement mounted as she worked her way down to the tiniest doll. The analyst commented on Mary’s excitement about babies and where they came from.

3) Commonality of attitude: The symbol frequently shares affective or attitudinal attributes with the object represented.

Joyce, aged eight, defended against her anger with her mother deriving from her jealousy of her younger sibling by maintaining an exaggeratedly loving relationship to her mother. Upon entering her session she beamed with pleasure as she began to play a game with her analyst. The analyst commented on Joyce’s pleasure in being with her and Joyce replied that her analyst wore exactly the same stockings as her mother.

4) Commonality of sensory experience: Similarities between the sensory qualities of symbols and the objects they represent are the most common forms of symbolic representation in analysis. Visual similarity seems by far the most easily recognizable of these. Shared tactile sensory experience between the symbol and the object symbolized also occurs. Auditory symbols are relatively rare; this modality apparently lends itself less well to parsprotao representation.

Donna, aged ten, was highly troubled by her sexual interests and fantasies. In analysis she complained of having over-eaten on several occasions recently. She grossly exaggerated her feeling of being overweight and having a protruding abdomen. In response to her analyst’s comment on Donna’s tendency to exaggerate the size of her tummy she recalled putting a soft toy underneath her jumper when she was little and pretending she was pregnant. Her analyst wondered if as a little child she sometimes imagined that ladies became pregnant as a result of overeating.
Aids to Understanding

Context provided by known event

In the analysis of young children in particular the analyst will have available to her considerable information about the child's past given by the parent in the form of a social and developmental history. Events which help clarify the child's material also come to light during the course of the child's treatment. Furthermore, child analysts will be informed about important current events in the child's life through regular discussion with the child's parents.

The context provided by such events has a dual significance. Firstly, the representation of an event in the analysis may give the analyst clues as to the child's conscious or unconscious emotional stance towards the experience. Secondly, knowledge of the event allows the analyst to disambiguate the fantasy content of the child's material as this unfolds in the treatment. This process of clarification is achieved in a number of ways:

1. The child may remember the event but may have lost awareness of the attendant affects. With the context provided by knowledge of the event, the analyst will be more confident in identifying the relevant affect in the child's behavior. In the case of traumatic events resulting in a tendency in a child to become overwhelmed by anxiety, the analyst will be able to help the child verbalize, limit and otherwise master overwhelming feelings.

2. The child may have forgotten the event, or critical aspects of it, and the analyst will endeavor to help the child to remember the forgotten event by reconstructing the child's perception of what may have happened through the elaboration of the distortions of known events and fantasies she has observed in the child's behavior.

1) Current events in the child's life: Major events in the child's life may be assumed by the analyst to fuel current concerns or revive longstanding ones. For example, interruptions in treatment may elicit the child's anxieties about separation; maternal pregnancy may arouse jealous and aggressive thoughts. Parental illness may arouse anxiety about being neglected. Marital break-up may stimulate guilt about personal responsibility for the event. The analyst uses such information to clarify a) the nature of the child's affect in the session or b) explore the content and source of the affect.

Mundane, typical and innocuous events may also need to be considered by the analyst, as such events can take on added importance or analytic significance because of unconscious connections made by the child with other, more emotionally significant, events.
For example, a routine visit from a father, living away from home, may reawaken thoughts of having been abandoned with concomitant feelings of helplessness and anger.

James, aged seven, was an inhibited child with considerable conflicts over aggression in relation to his siblings. In her regular meeting with the analyst, James's mother described James's anxiety about the fate of the seven kittens born to the family cat. He fretted about the possibility of finding a home for all of them and made his mother repeatedly promise not to drown them. In a later analytic session, James brought a book about wild cats and his worries about endangered species. Subsequently he talked about his younger brother's first swimming lessons and his worry for his safety in the water. His analyst commented that the birth of the kittens seemed to have reminded James about his wish to get rid of his baby brother.

2) Context provided by significant events in the child's past: In the context of ongoing work with the parents or the child, the analyst comes to be aware of significant events in the child's past which are assumed to have had a potentially adverse or beneficial affect on the child's adaptive functioning. As with current events, this information provides a background against which the significance of the child's current behavior in the analysis may be better understood. Important events may offer the analyst the opportunity to develop specific referents in terms of external reality that may be seen to account for idiosyncratic thoughts and feelings of the child and specific themes which occur during the analysis. For example, the knowledge that the child had surgery at the age of four may provide a plausible partial explanation for the link between fears of abandonment and bodily damage.

Tony, aged ten, was born one year following the death of his sister. In response to feeling unloved and overlooked by his father over the weekend, Tony began to play at constructing jewelry out of paper clips. He tried his creation on in a girlish fashion, whilst examining his reflection in the window. His analyst understood this behavior to reflect his feelings that his father loved his deceased sister more than him and that he would not feel rejected were he a girl.

3) Context provided by past analytic material: The experience of the analysis is shared by the child and his analyst. Specific content in the analysis which emerges becomes a potential focus for further analytic work. By understanding the child's material on a previous occasion, the analyst is able to create a context for the understanding of other communications and behaviors which link directly or indirectly to the previous analytic event.

Phil, aged nine, randomly picked up objects (a pencil, a piece of a model aeroplane, a pencil holder) and after handling them he dropped them with some urgency. His analyst commented on his nervous touching of things. Phil responded by saying: "You are going to say what you said the other day, that I can't stop fiddling with things or get to sleep at night because I am worried about fiddling with myself". Two weeks later Phil could not
Contiguity of content

A normal listener usually segments narratives into different categories of content, by recognizing the junctures imposed by the speaker. These junctures may be imposed between an account of two events, topics or themes. For example an account of the day at school is regarded by the normal listener as separate and independent from subsequent comments referring to the mood of the family pet. The analytic observer will routinely examine the continuity of the material with the aim of identifying possible correspondence(s) between the two apparently unconnected statements. Thus the analyst deliberately ignores the juncture between two themes in his attempt to understand the child's material from a psychoanalytic standpoint.

Following the child's material, the analyst will take one or more piece(s) of communication offered by the child as providing the context for another communication which the child intended to be independent. Usually, there is a close temporal proximity between the communications linked by the analyst. In this way, 1) the child may be elaborating a narrative sequence, providing an affective background to an apparently independent communication, representing both sides of a conflict or 2) the analyst may create a completely new meaning from combining the two 'unrelated' pieces of communication. Put more formally, the analyst is applying the semantic field of one communication to the child's thoughts concerning another area of meaning.

The contiguity of material is not invariably recognized by the analyst. The apparently independent theme may in addition to being separated from the first by a juncture, be disguised for defensive purposes. Thus the relationship between the two elements of the child's communication is doubly obscured.

1) The elaboration of a narrative sequence: The analyst listening to the child's material will normally attempt to hold in mind the previous topics brought by the child in that session, whilst listening to and observing the current theme. Frequently, the emergence of later themes may be understood as adding to or completing the content of a previous theme and thus elaborating the narrative sequence.

Timothy, aged five, began a session by drinking juice like a baby from a toy baby bottle. He asked his analyst why his mother took his little brother Johnny to a special play group. Timothy said that when he was seven he wanted to have a little dog like Lassie so that it could have puppies and he
could watch her feed them. The analyst commented on Timothy's jealousy of his little brother who got loving warm feelings and milk from his mummy.

Tony, aged seven, returned to treatment from the Christmas holiday with a new watch which, though it was immediately noticed by the analyst, Tony did not comment upon. The following day, when Tony repeatedly and somewhat ostentatiously looked at his watch, the analyst enquired about it. Tony blithely replied that he had received it from his mother for Christmas. He then asked for toys and games which he knew would not be available and was dismissive and sarcastic about the analyst and the clinic when the analyst could not provide what he wanted. This led the analyst to say that he wondered if Tony had hoped for a present from the analyst. Tony supposed that the analyst was too busy to get him a present and then he abruptly changed the subject, commenting on the blueness of the sky. The analyst commented that she thought that Tony himself felt 'blue' and sad at not receiving a present but was concerned about asking for one in case he was then thought to be too greedy and demanding.

2) Adjacent content provides affective background: There are instances when the connection between adjacent themes is one of affect as opposed to semantic content. The affective tone of one distinct theme may provide the apparently missing affective quality of the other theme.

Shirley, aged nine, spoke at length about another child at school who could not tie her shoes properly even though she was eight years old, adding that she acted as if she was handicapped. Later in the session she rehearsed her ballet performance, repeatedly making the same mistake. Shirley burst into tears and said her teacher always said horrible things about the way she danced. The analyst sympathized with her difficulty in ballet and wondered if, when she could not do the steps properly that she felt as bad as if she could not tie up her shoes.

3) Representing both sides of a conflict: At times the juncture or separation between themes may not simply separate an underlying continuity of preconscious content, but may serve to make distinct two conflictual affects or thoughts concerning the same preconscious object. Adjacent themes may then be taken by the analyst as representing dissimilar and conflicting feelings towards the same object.

Lily, aged ten, arrived late for her session and eventually complained that the analysis interfered with her piano practice. Later in the session she recalled her fear of leaving home on setting out for school, and her wish that she could talk to her analyst about her worry. Her analyst was able to show her how she wanted both to be dependent upon and independent of the analyst.

Jenny, aged four, was prone to become distressed when her analysis was interrupted by the holidays. In the final session before the spring holiday, she angrily clung to her therapist's skirt to prevent her from ending the session whilst at the same time shouting that the therapist should get out of the room and never come back.
4) A new meaning derived from linking two distinct themes: The analyst, in listening to and recognizing themes in the child's material, "endeavors to combine these into larger units. At times the consideration of larger units provides a new meaning which may help to clarify the child's current thoughts and feelings.

Peter, aged five, was preoccupied in the analysis about his anxiety about separating from his mother. In a session he recalled going to look for his mummy in every room in the house but not being able to find her. Finally he went into his parents' bedroom and his daddy showed him by lifting the covers where his mummy was. He said his mummy could not sleep under the covers because she would suffocate. He suddenly added, "Wait a minute, whilst I shoot my gun", aiming his gun at the analyst. His analyst commented that besides being frightened when his mummy was not there, he was also angry, especially when she was with his brother or daddy.

The combination of contents in a single element

Children in analysis present thoughts or actions which contain more than one discrete meaning, in addition to the child's consciously intended one. The child's play in analysis, for example, may be interpreted in a number of ways as a consequence of the child's tendency to combine discrete elements of content in a single element. For example, the child's wish to stay with the therapist beyond the confines of the appointed hour and his angry wish to annoy the therapist may be represented in the single act of making a mess in the room just before the end of the session.

1) Disguise function: In some circumstances the combination of contents can ensure that the child will remain unaware of the underlying contents of his communication.

Jane, aged nine, maintained a disparaging attitude towards her analysis and her analyst. Similarly at home she was frequently contemptuous towards her mother, a rather famous stage actress. Upon arriving for a session she complained of the receptionist's absence from the waiting room and that she had not been able to purchase biscuits and drink as usual. She thought that the receptionist might be a failed actress, and that she had been crying in the toilet because she had not gotten the role she wanted and therefore had to go and continue to work at the clinic. Her analyst commented that Jane knew her mother was a famous actress and that her analyst, valued her work at the clinic which was now under outstanding directorship. But that because they had both failed her she liked to imagine that they viewed themselves as complete failures.

2) Multiple expression of wishes: The combination of more than one wish in a single element may permit the simultaneous expression of a number of repudiated wishes.

John, aged nine, was on the verge of tears in recounting a news item that he had seen broadcast on the TV. The broadcast was about the cruel and inhumane treatment of dogs brought to the Battersea Dog's Home which had been starved, beaten and abandoned. John expressed the wish to steal all the
dogs from Battersea and to bring them to his home where he would look after them properly without cages. The analyst understood John's distress about the forsaken dogs to reflect his guilt feelings about his aggressive wishes towards his younger sibling, as well as his repudiated feminine identification whereby he wished to feed and look after the baby like his mummy.

3) The expression of conflict: The combination of more then one discrete content within a single element, may enable the child to represent conflicts in a single communication.

Peter, aged ten, was regularly five minutes late for the session. He said that somehow something always distracted him between getting ready to leave home and actually departing. His analyst commented that she knew that Peter wanted to come to treatment and to arrive on time but perhaps he felt that arriving on time meant that she had too much control. Peter agreed with his analyst but added: "I suppose I like you to think about me and wonder where I am".

Pictorial language

The child may draw or describe an imaginary or dream image which portrays in pictorial form the child's thoughts, feelings or wishes. The analyst's task is to identify the ways in which the imagery conveys the child's concerns and to elaborate this pictorial expression into verbal form. Pictorial language is naturally most common in dream images, but frequently the child's drawings may convey meaning via devices observed in dreams. Furthermore, fantasy images referred to by children also frequently convey meaning via pictorial language.

The child may use pictorial language to represent a conscious or unconscious wish, an affect in relation to another, an affect perceived in another or an affect he experiences. Pictorial language may be used to express single thoughts or may represent memories of past events. In order to understand pictorial language the analyst uses a number of specific rules in addition to the ones considered above. In elaborating the verbal significance of an image the analyst will normally invoke a number of these rules.

I) Direct representation: In its simplest form the image will depict the gratification of the child's wish or make a direct reference to a memory. For example, a child may carefully draw a detailed picture of a sweet counter thereby expressing his pleasurable wish for abundant sweets. Although such direct expressions may not call for analytic elaboration, the particular form taken by direct expressions may in itself constitute analytic material and may call for further understanding.
Roger, aged eight, endangered himself and distressed his mother to the point where he had to be placed in a residential school for maladjusted children. His mother had a psychotic illness and was often inordinately hostile towards the boy. In a session Roger drew a picture of a gravestone over which there was a baby floating in the sky and the caption "why did this baby die?" His analyst knew that Roger's mother's hatred for her son was linked to her pathological mourning for the stillborn baby that she had delivered a year before Roger's birth. The analyst linked Roger's fear of his mother's rages and decided to broach the topic of the stillbirth by saying that his mother's comments about the baby made him frightened and worried about how his brother had died.

2) Transposition of the context of the image: Narratives that are expressed in images may represent both personally significant stories and conventional ones. In such instances the scenario relates directly to the child's unconscious fantasy and expresses a story in a socially acceptable context.

Ben, aged seven, was a highly talented drawer. After a visit to the Wallace Collection of medieval armour with his father he delighted in drawing medieval battle scenes of carnage picturing the King's knights turning on the King and slaying him. His analyst understood Ben's interest in scenes of medieval rebellion to reflect both his pleasure in sharing his father's interest in history and Ben's repudiated death wishes towards his father.

3) Concrete representation: Abstract ideas and feelings may gain concrete representation in images. These links are mostly based on some form of similarity between the two forms of mental contents. For example, the child may report a dream image of an unassailable face of Mount Everest to represent his feeling that it is impossible for him to achieve what he feels his parents expect of him. In other instances the link may be based on convention. Envy, for example, may be conveyed by the depiction of a dream image of a person as green. Spatial and temporal contiguity may also form the basis of a link between an abstract idea and its concrete representation. A small child's drawings may represent his father being busy and unavailable with drawings of a briefcase.

Jane, aged six, was understood to suffer low self esteem, in part because of the responsibility she assumed for her mother's tendency to depression. During a period in the analysis when her perception of her mother's depression was being clarified Jane described a frightening dream image in which she pictured her mother at the bottom of a well which the analyst understood to express, among other things, Jane's experience of her mother's depressed moods.
Modes of disguise

The child's material is regarded as determined by preconscious or unconscious concerns which do not normally gain direct expression. Whilst in younger children a less distorted presentation of preconscious material may be the rule, it may generally be assumed that maneuvers and mechanisms which prevent awareness of unconscious mental content interpose themselves between the original meaning and the verbal and non-verbal behavior manifested by the child. These mechanisms of distortion are listed below and range from simple substitution as illustrated earlier in the example in which the train stood for the child is perception of self to more complex and difficult to identify mechanisms such as reversal.

Disguise by Substitution

Children frequently bring thoughts or affects concerning themselves or an important other which are perceived to be embodied by or are expressed towards a substitute object. The disguised content is the affect, thought or action perceived or expressed in connection with the substitute object. It is generally assumed that undisguised expression would be construed as threatening by the child.

a) Substitution involving perception and/or action

1) Substitution of a perception: In this form of disguise an attribute is presented as belonging to one person or situation, but it is actually communicating the child's perception of another person or himself. In understanding the material, the analyst's task is to identify the original object in which the attribute is perceived and eventually to communicate this understanding to the patient (see Clarification).

(2) Substitution of an action: This category refers to instances where the object towards which an action is directed is substituted by another object providing a less threatening context for the action. Usually such actions express significant affect.

The distinction between this category of disguise and the previous one is one of emphasis rather than a clear-cut division. The substitution of one object for another for the purposes of action assumes a concurrent change in the perception of objects.
b) **The relationship between the self and the object**

We may differentiate between a number of different modes of substitution depending on the direction of the substitution relative to the self. These distinctions are made according to: 1) whether the original object is the self or a significant other; 2) whether the substitute object is an aspect of the self, another person or an inanimate object; 3) whether the substitution consists of a precept or the expression of an affect; and 4) or whether substitution consists of one aspect of the self for another aspect of the self.

1) **Self to object substitution:** Instances of this type refer to examples when the child says or does something pertaining to an object (person, animal or thing) which reflects thoughts or feelings he perceives about himself. The substitute object thus serves as a vehicle to communicate his perception of himself and his feelings about this perception.

From early on in his analysis Johnny, aged five, took a particular interest in a toy figure of a lion. He and his therapist built a cage within Johnny's toy cupboard to house the lion. On days when Johnny was irritable, cross or frustrated he pointedly instructed his therapist to be certain not to let the lion out of his cage. At a period during the analysis when weekend breaks from treatment became difficult for Johnny, he arrived for his Monday session, opened his locker and said: "We mustn't let the lion out today. He's been lonely and cold and he might bite".

2) **Significant other to object substitution:** The child expresses emotion towards an object in contexts where the latter can be seen to serve as a substitute for a significant person in the child's life.

Harold, aged eight, contrasted the care in the waiting room, from the receptionist who provided him with juice and biscuits, with the analyst's inadequate provision of toys. Harold went on to complain that the analyst did not initiate any games. The analyst commented that Harold seemed to feel she did not care about him and would not look after him. Harold then recalled that his Mummy had organized a birthday party for his little sister to which he had not been invited.

Lucy, aged nine, regretted having spilled a pot of paint over her big sister's home economics project. She knew she was not allowed to bring the paint into her sister's room and could not understand why she had done so. She went on to recall feeling left out when her sister had not allowed her to stay in her room when a group of her sister's friends had come to visit. Asked if she could remember feeling left out in any other situation recently, she smiled in recognition and recounted that her mother had told her to leave the kitchen whilst she was preparing a complicated dish for her dinner party guests.
3) Significant other to self substitution: The child's actions in the analysis may at times be understood as enacting characteristics perceived or misperceived in a significant other person.

Robert, aged nine, complained that he was having difficulty with his maths, normally his best subject. He also became disheartened in sessions when he could not play draughts up to his usual standard and "messed up" his attempts at constructing paper airplanes. The analyst commented that in recent sessions Robert seemed to feel useless and as if he was letting people down. Robert appeared on the verge of tears and said that his Mummy was always shouting at his Daddy as his Daddy did not have a job.

Louis, aged 11, was known by the therapist to have a distant and unrewarding relationship with his stockbroker father, in which both the child and his father felt that neither was interested in the other. In his sessions Louis treated his therapist with derision and contempt and claimed that he hated coming to useless sessions and for a period spent most of his time sitting in a chair staring at a comic book which he held in front of him covering his face. When his therapist commented that he read the paper to show her how bored he was, he said "Look who is talking!"

4) Substitution of one aspect of the self for another: Thoughts and feelings about one aspect of the self can be expressed by the child through less threatening self perceptions.

Timothy, aged 10, was repeatedly dissatisfied with a toy cannon that he was making with his analyst. He was discontented that the projectile propelled by a rubber band veered off in the wrong direction and did not go far enough. When Timothy became preoccupied with trying to center the trigger of his toy cannon and accidentally referred to it as a tube, the analyst was able to broach the subject of his repeated surgery for the correction of his hypospadias.

5) Self to object to self substitution: This is a more complex form of disguise wherein the initial substitution from the self to another is in itself further disguised in such a way that the disguised perception is revealed in an additional substitution from the other back on to the self.

Mary, aged six, arrived for her session irritable. Once in the treatment room she barricaded the door with furniture, turned off the light and made scary noises. The therapist commented that Mary's fear of intruders into the session might have something to do with why she was cross when she arrived. Mary said that she was very cross with her mother who had refused to buy her what she wanted from the shops on the way to treatment. Mary's therapist was then able to link Mary's fears of ghosts and bogey men at home at night to angry feelings towards her parents.
Disguise by Reversal

The child's behavior may at times best understood to reflect the child's wish to act in a manner opposite to his manifest behavior. In this case the disguised content is the affect, action or thought which is the polar opposite to that which is reflected in the child's observed behavior. It may also be assumed that as with substitution, the direct, undisguised expression of the affect, thought or action is construed by the child as a threat. The child may reverse either an inner feeling state or his relation to another person or groups of people. These manifestations of reversal are most easily categorized in terms of a) reversals of affect, b) reversals of role relationships, c) reversal of action and d) reversal of thought.

a) Affect reversal

The reversal of affect may emerge as a way of bringing material in a number of different contexts.

1) Reversal of affect about another person: The child may manifest an affect which serves to disguise its polar opposite about a significant other.

Mary aged seven was overtly anxious in a series of sessions preceding her mother's admission to hospital for minor surgery. Following Mary's weekend at home in the care of her mother's sister, and her mother's safe return home from hospital, she began the session by alluding to pleasurable activities with her aunt and cousins which had occurred in recent days. Her therapist wondered if the fun she had been having helped her not to think about her worries about what her Mummy had been through.

2) Reversal of affect of other towards the self: The child may report the affect of other individuals, disguised by its polar opposite. The child thus brings material concerning his experience of another's feelings towards him, perceived or misperceived.

Robert aged six described how on visiting his father's office he had drawn several pictures in the space of a 20 minute visit and stuck them with sellotape onto the windows and the bookcase. Robert said that his Daddy was sure not to remove them as he was bound to think them well drawn. The therapist commented that it seemed that Robert sometimes felt that his father did not pay much attention to those things that were important to Robert.

3) Reversal of affect that the child feels about himself: The child may bring feelings concerning his current experience of himself but disguise these affects by presenting their polar opposites.

Johnny aged four, whose parents were in the throws of a divorce, arrived for his session dressed as Batman and instructed his therapist to assume the role of Robin. After staging several scenes in which Batman and Robin...
performed superhuman feats against criminals, Johnny began to climb
dangerously onto the window-sill. When his therapist stopped him he broke
into tears of rage and said: "You can't stop me. You don't live in my house
and you can't live there anyway."

4) Reversal of affect about events and activities: Affects experienced about events or
activities inside or outside the analysis may be expressed by the child in terms of the affect's
polar opposite.

The therapist of Lucy aged eight arrived late for Lucy's session and
apologized that she had been held up in traffic. Lucy said that she did not
mind waiting, adding that if only she had known she would have picked her
analyst some flowers while she was waiting.

b) Reversal of roles

The child may bring material concerning the nature of his relation to another person,
disguising it by inverting the role relationship. As with reversal of affect, reversal of role
relationships may occur in a number of contexts.

1) The child takes on a role so as to embody desired aspect of a person: In the course of
treatment, the child may assume personal feelings, characteristics, or activities which enable
him to reverse his role in relation to a significant other. In such role reversals the child is
simultaneously likely to express a view of himself in which a quality of the perceived self is
reversed.

Joe, aged six, was having considerable problems attending to his arithmetic
lessons and was receiving negative reports from school. In his sessions he
repeatedly insisted on domineering an imaginary class of dunces, not one of
whom could add as much as two plus two.

2) The child takes on a role which reverses an unacceptable attribute: The child may
disguise the perception or misperception of an attribute in himself by taking on a role which
embodies the precise opposite of the attribute.

Roger, aged eight, was in analysis for the treatment of overwhelming anxiety
in response to insulin injections for the treatment of his diabetes. In his
sessions he pretended to be a ghost and terrorized the figure of a doll with
threats of painful and ill-measured dosages of poison injections. In response
to his therapist's comment that he sometimes had not understood why
doctors, nurses and his Mummy poked needles into him, he recalled his
confusion upon being put on an intravenous infusion in the hospital.

3) The child's role relationship to the therapist: The child may ascribe the therapist a role
which enables him to assume an altered stance vis-a-vis the therapist. Commonly, this new
role is in some way opposite to the role the child actually perceives himself to embody.
James, aged nine, introduced his therapist to the 'brilliant code' he had devised over the weekend. In explaining the information required to translate the code, James omitted essential information leaving the therapist unable to comprehend the system. The therapist commented that she was having difficulty understanding and James suggested that this was probably because she was too stupid. "Have you ever felt stupid like me?" inquired the therapist. James admitted that he felt stupid when his brother tried to teach him to programme the computer.

The child may himself assume a characteristic of another person to reverse a perception of himself in relation to that person, most commonly the therapist.

Janie, aged five, put a ruler between her legs and danced around the room saying she had a willy. When her therapist commented that she seemed to feel that it was sometimes better to be a boy she berated her therapist saying: Do you have a motor cycle? Can you play cricket? Can you go to bed whenever you like?

c) Reversal of actions

Material may undergo disguise through the child's attempt to reverse the nature of his behavior by substituting an act which negates the intent of the original action. The child's actual behavior thus precludes the performance of the repudiated act.

Fred, aged seven, was a keen footballer and he arranged the treatment room so that he could engage his therapist in modified games of football suitable to the treatment room. When he took the wing and his therapist took the goal he became anxious and reluctant to kick the ball. When his therapist commented on this he instructed her to face the goal rather than keep her back to it. When the therapist commented that such a ball could not hurt her, he replied: It might if it hit you between the legs!

d) Initiation of a preventative act

The child performs an action in the analysis to prevent the fulfillment of an unconscious wish. The preventative act thus successfully disguises the repudiated intent.

Robert, aged nine, arrived for his mid-winter early morning session drenched by the sleet. When he arrived in the treatment room he was in his socks. He explained to his therapist that his shoes and galoshes were in the waiting room because he had been troubled following the previous days.
session about the puddle that had formed under his snowy shoes. He was concerned that the water might make the floor slippery and cause his therapist to fall down and break her leg.

**Disguise by Exclusion**

The analyst may identify material in striking omissions in a child's narrative. These omissions may include memories, emotions or ideational content. The child's apparent inability to produce a coherent account enables the analyst to infer the presence of conflict leading to the excluded mental content. Disguise by exclusion may be identified in a number of contexts.

**a) The forgetting of information**

Children in analysis frequently forget events or details which are associatively linked to thoughts or feelings. The omission from memory helps the analyst in her attempts to elaborate the nature of the repudiated thoughts and wishes.

The content of the forgotten event may inform the analyst about the presence of a repudiated wish which may be seen to motivate exclusion of mental content.

Jimmy, aged nine, dismissed his analyst's suggestions that he minded missing sessions. He took the same attitude to his analyst's suggestion that he objected to the cancellation of his session on a day when the Centre was closed to patients because of a meeting. Having forgotten that the Centre was closed and turning up for the canceled session, Jimmy arrived for the following appointment oblivious to the matter. In referring to his activity with the analyst the previous week, Jimmy mistakenly referred to being together with her on the day of the missed session. This enabled his analyst to suggest that while a part of him did want to come to his session, he seemed to feel uncomfortable about admitting this to himself.

Forgetting may occur repeatedly within a particular dynamic context. Children may communicate anxiety concerning a particular wish by peremptorily forgetting information associatively linked to a particular repudiated wish.

Joey, aged seven, was for a period in his analysis preoccupied with anatomical differences between boys and girls. Contemporaneously Joey began to forget information which was normally easily accessible for him, for example names of various members of the English cricket team, the make of his cousin's motorcycle and on one occasion he even forgot his father's first name. His analyst commented that it was boys things that he tended to forget. Joey reacted to this by beginning to shake his hands wildly and in a panicked way grabbed his toy sword from the locker.
The act of forgetting may communicate awareness of traumatic aspects of an event or the entire event. In such instances the forgotten information may be seen to be in some way linked to the trauma and the examination of the particular information excluded offers analytic material concerning the nature of the experience of the trauma.

Lucy, aged eight, experienced a regression to soiling and wetting as well as panic attacks at the age of four in response to the combination of the birth of her brother and a move into a somewhat dilapidated house. After some months of analysis it was necessary to use a different room at the Centre for her analytic sessions for a period of two weeks due to building works. This change of circumstance precipitated marked disorientation. She forgot repeatedly which room she was supposed to be going to. In the treatment room she painted in an extremely messy fashion requiring the analyst to place limits upon her. The analyst linked the uncharacteristic messiness to her anxieties about the change of room. In response Lucy recalled feeling lost and angry when her parents moved house.

b) The active denial of Information

When the child's experience of repudiated content is close to conscious awareness, they frequently adopt a number of maneuvers to turn their attention away from the emerging unacceptable experience. The use of this strategy alerts the analyst to the presence of affect linked to the information denied. It may also help her to elaborate the precise nature of the material disguised in this way. There are a number of ways in which this mechanism may be found to occur in the psychoanalysis of children:

1) The blanket specific disclaiming of content: Children may at times verbally deny some specific aspect of reality in contexts where the analyst may justifiably assume that the child has appreciation of the contrary of his assertion.

Mary, aged nine, found it painful when her mother decided to remarry. As the wedding date approached and the plans for the ceremony became fixed, Mary felt increasingly unhappy about the situation until she arrived for a session to disclaim the proposed arrangements stating: "My Mummy's not getting married! She's just not!"

2) The long term exclusion of a pertinent category of ideas or affects: Children often display an aversion to being induced to think about specific areas of their lives which arouse disturbing thoughts and painful affects. This manifests as a striking absence of a particular category of content and ideas or affects which may be related to it. When such categories of experience spontaneously enter the child's play, or verbalizations, or when the analyst touches upon them purposely or inadvertently, the child may employ measures to disclaim the relevance of such experiences.
Peter, aged ten, was an only child. Though garrulous on a wide variety of topics over the first year of his analysis, he made no spontaneous reference to his mother. Even when Peter described his pleasure during a week's holiday in the country, alone with his parents, he made no reference to his mother, despite the fact that she had accompanied him and his father on various excursions. During a time when his father was away on a business trip, Peter was low-keyed in the sessions and failed to talk about happenings at home as he normally did. There developed a period in his analysis when he became anxious at the end of sessions, checking repeatedly in the window for his mother's car, to see if she has arrived to fetch him. When his analyst said that she was struck by his worry about whether his mother was waiting for him, Peter said: "I'm just looking to see when the street lamps come on".

3) The counteraction of reality by creating an alternative reality: Painful psychological situations, past, present or anticipated, may cause children to dwell on fantasy or fantasy play to aid them in turning their attention away from a painful psychological situations.

Louis, aged nine, had cherished his doting grandmother, Christabel, until she died when he was aged-six. When he entered analysis his sessions were completely dominated by a fantastic space war between the bountiful galaxy of Christabel and its progressive civilization and the destructive race of the 'Evilians'. Louis would simply not permit the introduction of any subject outside of this fantastic drama.

4) The disowning of disguised expression: After a period of analysis, the analyst will become acquainted with various disguises characterizing material such as those described above. Therapeutic progress in terms of clarification and interpretation of disguises will lead to a shared understanding between the analyst and the child of the meaning of specific aspects of the material. Frequently therapeutic progress is obstructed by the patient's need to disclaim the meaningfulness of analytic material, previously recognized as such.

Jimmy, aged seven, and his analyst came to the mutual understanding that his clowning in school and in the waiting room were often related to feeling humiliated in various contexts. When he arrived for one session with a bowl on his head and carrying his father's umbrella like a rifle his analyst was able to say: "I wonder if someone hurt your feelings recently". Jimmy complained that she was always saying that but it soon emerged that he had been bullied in the playground during lunch time at school.

5) The exclusion of repudiated content by its incorporation into a rational account: Children endeavor to make plausible inner fears and preoccupations by providing accounts which employ 'rational' arguments that seek to validate their worries. They perceive this mode as being more acceptable to others. In this way aspects of their anxieties which are not comprehensible to them are selectively excluded so as to disguise the underlying repudiated wishes.

Georgina, aged 10, showed evidence from early on in the analysis of a preoccupation with her parents' sexual activities. More recently, her anxieties concerning sexuality were heightened with thoughts about the onset of her
menarche. In an uncharacteristically matter-of-fact manner, Georgina requested her analyst’s help in laying out her Life Studies project which concerned reproduction in mammal species. She showed what appeared to be a remarkable, if somewhat parroted, understanding of the anatomical structure and function of the uteri of various species. Her analyst complimented her on her understanding but wondered if thoughts of her own bleeding worried as well as interested her. Georgina took umbrage at her analyst’s comments and explained that her analyst did not appreciate that menstruation was about the unfertilized eggs having to be got rid of. When the analyst reminded her of her worry two weeks before when a girl in her class suddenly experienced the onset of her period, Georgina added that after gym class today the teacher told them about the disposal of sanitary towels.

**c) Disguise by exclusion of affect**

Children may manifest a striking lack of affect concerning events or ideas in contexts where it may be assumed, on the basis of previous knowledge of the child and his circumstances, that the child is likely to be making an active effort to deny the emotional implications of their mental experience.

Jane aged nine, was observed during her analysis to have reacted with anxiety attacks verging on panic in preparation for dental surgery. Analytic work at the time had established links between her fears of the surgery and her previous experience of her mother’s stay in hospital for the birth of her baby sister. Many months after the dental surgery Jane would frequently introduce fantasy play with dolls which featured visits to hospital and the dentist in response to verbalization by her analyst of various of her conflicts and other fears. What was striking was that there was an extremely muted expression of affect in describing the most dangerous and chaotic stories of surgery.

At times the child’s exclusion of affect is augmented by the excessive elaboration of the event or idea in which appropriate affect is also absent. In such instances children may seek to make plausible the absence of affective response by reference to rational arguments which account for the events and their responses to them.

Lucy, aged nine, was given to frequency of micturition at times when she was anxious or excited. After she left a session to go to the toilet for the second time she explained that she had been drinking a lot during the day. When her analyst wondered if perhaps her worry about her ballet exam might have something to do with her frequent need to go to the toilet, Lucy berated her analyst for trying: “to turn a simple need to go to the loo into feelings, feelings, feelings.”
d) Disguise by exclusion of the source of an affect

Children may manifest affect in response to events, circumstances or thoughts wherein the magnitude or quality of the affect is a poor fit with its apparent source. The discrepancy between the manifest affect and the apparent source may be explained by the link between the affect and the disguised source.

Joanna aged nine, was very fond of her grandmother and her distress appeared to be muted when her grandmother was admitted to hospital following a stroke. Some weeks later, Joanna was weepy and preoccupied with starvation on the African continent. This theme of distress continued until her analyst commented that it seemed that her worry about starving people in Africa reminded her of her unhappiness about matters closer to home about which she also felt helpless. "You mean my grandmother, don't you", she replied.

e) Disguise by infantile expression

The developmentally adequate level of expression of an idea or wish which is repudiated may be replaced by an expression at a more infantile level which is felt by the child to be less threatening.

Joe, aged five, was enjoying a game of snakes and ladders with his analyst. When Joe's piece landed on the head of a snake his analyst commented that it was very difficult for him to feel that he might not win. Joe complained about his daddy not letting him handle his tools whilst working in the garden, not even his hammer or saw. Suddenly Joe became excited and related a garbled fantasy in a babyish voice about wanting to fill a wheelbarrow with mud and dump it on his daddy's desk.
CHAPTER 5
THERAPEUTIC ALLIANCE

Definition:

The therapeutic alliance (also known as the treatment alliance) is the product of the child’s conscious or unconscious wish to co-operate with the declared aims of the analysis: the understanding and overcoming of internal difficulties and the dissolution of resistances. It implies the readiness of the child to accept the analyst's aid in achieving these aims. In simple terms it may be said that it implies a recognition of personal problems, a wish to be helped with these problems and a belief that the analyst and the treatment she recommends will be able to provide this help.

Treatment alliance must be more than the child's conscious wish to attend treatment for the pleasure gained. To a certain degree it implies that the child has accepted the need to deal with internal problems. It further implies the acceptance of the analytic method of treatment, conscious or unconscious perception of its value and the willingness to persevere with it in the face of disinclinations deriving from unconscious (inferred) resistance and/or the interference of external factors such as the demands of school and family obligations.

It is difficult to distinguish the therapeutic alliance from transference in terms of either objective or subjective signs as far as the child is concerned. The treatment alliance may be conceived as a basic form of transference which is the only form to be fostered actively by the therapist. It is, however, more than positive transference because it exists side by side with negative feelings towards the analyst who in her therapeutic work may arouse anxiety and discomfort. In fact at times of intense negative transference the basic trust which underlies the working alliance may well be only preconscious, so that the child may consciously hate or denigrates the analyst, while at the same time demonstrating his trust by arriving punctually and observing the analytic rules. This, a reliably established therapeutic alliance is a form of transference with a measure of autonomy which makes it impervious to variations in the transference relationship.

The treatment alliance exists at many levels. In one sense it is a mature wish for help, at another it is clearly an aspect of positive transference wherein the analyst is the representative of important adults by whom the child feels understood and helped. The alliance might contain feelings of wishing to please the person who is interested in worries and also anxieties deriving from fears of loss of love from significant others. The alliance may contain certain pleasurable feelings linked to being with a new and significant other who offers a fresh understanding of feelings and actions. Some aspects of the treatment
alliance derive from very early experience and reflect a basic trust in the object as one who ensures that emotional needs will not go unmet. This may manifest as an attitude towards the analyst as lacking malevolence and as a potential source of support. Such expectations may be engendered by the analyst's relative permissiveness and sensitivity to the child's needs. These experiences appear to be rooted in early experiences of being protected and well cared for as children who have had particularly deprived early relationships with their primary caretakers often have considerable difficulties in establishing a therapeutic alliance.

In very young children there is little chance of a treatment alliance based on the child's recognition of internal problems and of needing help with them. For children under five the positive emotional tie to the therapist probably forms the main basis of the therapeutic work. The young child's attachment to the analyst grows out of her ability not only to recognize and interpret the child's conflicts, but also to help the child's developmentally based difficulties in the emotional, physical and cognitive realism. With older children, the analyst may expect a more direct awareness of problems and a wish to work towards their solution.

Notwithstanding the positive transferential component of the therapeutic alliance, analysts must show care not to allow directly sexual components of the positive transference to invade into the therapeutic alliance. The treatment alliance contains the so-called aim-inhibited or desexualized aspect of the positive transference. It is preferable to consider it an ego attitude which is distinct from an instinctually derived attachment. The treatment alliance mobilizes something other than a sexual attachment in the form of a liking for the therapist which becomes a constant background factor and does not contain a significant measure of the gratification of instinctual needs.

Similarly it may happen that a child will engage in therapy because of the available attention from an interested and concerned adult. These and other forms of direct or indirect gratification do not constitute a treatment alliance since the child's wish to come to treatment is not linked with an awareness of his pathology.

A further contribution to the treatment alliance may at times come from the child's conscience; the child may come for treatment because of a feeling that he ought to, or out of an unconscious need for punishment. In this case he might feel guilty for missing sessions. Handling this guilt in such a way as to avoid complying with the wish of the child to elicit implied criticism from the analyst may be a technical problem. In such a case missed sessions are not properly understood as enactments of resistance and if interpreted in this way the analyst is merely complying with the role set for her by the child. The analyst's
subjective reaction may provide a clue concerning the nature of the child's motivation for unnecessarily missing sessions. A subjective feeling of disapproval on the part of the analyst or wishing to criticize the child may suggest that the analyst is unconsciously responding to a transference role which the child is unconsciously attempting to assign to her.

**Promoting the Treatment Alliance**

The analyst should actively promote the treatment alliance from the very beginning of the treatment and when necessary continue to foster the alliance alongside the interpretative work.

1. **Increasing the child's awareness of a painful Internal situation:**

   Early on in therapy the analyst may aim to enhance the treatment alliance by making the child aware of anxiety arousing or painful internal situations. This awareness may in itself lead to an increased wish on the child's part to find relief through treatment. To be effective, however, the analyst most often is required to interpret defenses against self-awareness particularly externalization, in an effort to enhance the child's capacity for self observation.

   The analyst may wish to bring to the child's attention the causal relationship between internally felt painful situations and external events which whilst causing no direct anxiety or mental pain to the child negatively effect the attitude of others towards the child. A child with temper tantrums for example may initially have insufficient insight into his disturbance to form a treatment alliance, but if the analyst can successfully link the occurrence of tantrums with states within the child which precede them, the child's awareness of unpleasurable internal states may be fostered.

2. **Promoting the child's curiosity**

   The analyst may bring the child's natural curiosity into the service of the analysis by arousing the child's interest in finding clues which might explain why things that neither the child nor his parents can explain occur. Analysis can in this respect take on the form of detective work in which the patient and analyst are engaged in an attempt to try and find and put together clues that may explain the child's anxiety or unhappiness.
3. Promoting the idea of therapeutic efficacy

The analyst will at times need to promote the idea that the analysis is something that will lead to an improvement in the child's subjective state. This may be effective even in the case of children with unpropitious external circumstances as well as those with internal problems. A child who legitimately sees some of his problems as primarily deriving from his mother's neglect of him may as a result of analytic work improve his capacity to identify, hear and deal with environmental deprivation.

This focus on therapeutic efficacy may accompany interpretative work by identifying for the child feelings of relief or comfort associated with successful interpretations. Thus it might be appropriate for an analyst to make the following suggestion after an interpretation concerning the child's guilt about his anger: 'I can see that it seems to make you feel better when we understand these things'. In part such a statement is educational in so far as it helps to identify for the child the mechanisms by which analytic treatment works.

The child will be unlikely voluntarily to participate in the analytic process unless he has an accumulation of personal experience that good interpretations provoke an improved internal state. The feeling of relief associated with interpretation is the most powerful promoter of treatment alliance. Towards the beginning of the analysis this is most likely to be achieved for the child through interventions aimed at clarifying the child's affective state. For example showing a child that his temper tantrums are directly linked to his fear of a particular situation, may decrease a child's anxiety and help him to curb its discharge in further temper tantrums. In a similar vein it is crucial that the therapist verbalize the child's anxieties about treatment and their joint attempt to reduce the anxieties to more manageable proportions.

Statements pinpointing the efficacy of the analysis may be more general in character aiming to identify medium term improvements to strengthen the child's commitment. Whilst this approach may not be legitimate for adult analytic patients, it may be appropriate for children because they may forget, if not reminded, how things were before their referral for treatment or at earlier stages in treatment.

4. The analyst's attention and understanding

The setting of the psychoanalytic process with its uninterrupted focus on the child, the provision of attention and understanding and the encouragement to discuss things which
are not talked about in other settings invoke in the child a special feeling about analysis that promotes a positive emotional investment in the treatment.

This investment in the treatment is best conceived as a by-product of analysis and not true treatment alliance. It may however be seen as a sine qua non of the treatment alliance which can be further promoted with accurate interpretative work.

5. The parents' promotion of treatment alliance

At times when the child's resistance is increased a sound relationship between the child's parents and the analyst may serve to promote the treatment alliance. At the start of treatment the analyst warns the parents that their child may at times wish not to come to treatment, and assigns responsibility to the parent(s) to help the child to attend. It is natural for a child to fall back on the parents' help in maintaining a commitment as in other situations where his immaturity requires a dependence on parental support.

Problems with the Treatment Alliance

1. Mistrust:

For some older children, positive attachment to the analyst and the recognition of internal problems will not be sufficient to counteract a prevailing negative stance towards adult figures as manifested in: suspicion, skepticism and mistrust. Also in such children parental support for the treatment is likely to lead to its further rejection.

In addition, unwillingness to enter treatment may derive from mistrust which is a defense against the formation of a positive attachment. This is not to be mistaken for an absence of basic trust and is motivated by an expectation of being dropped or rejected. This is often characteristic of adolescence and in that sense is part of a developmental phase, but not solely associated with it.

The timely and individually tailored interpretation of mistrust at appropriate times can help to deal with the problem of establishing a treatment alliance in some children. In particular bringing into the child's awareness the fear of affectional ties may remove the need for a defensive posture. Some children, most notably adolescents, are lost from treatment because of this defensive attitude.
2. Basic unwillingness to enter treatment:

Sometimes children will show extreme anxiety about treatment which will not disappear despite interpretations but will fossilize in a basic unwillingness to co-operate. There may be specific reasons for this such as the existence of family secrets which the child fears may emerge in the treatment, perceived loyalty conflicts between the analyst and the parent or far more deep-seated disturbances in object relationships. In particular, when the child's disturbance is linked to disturbance in one of the parents the treatment threatens this collusive relationship.

It should be the analyst's primary aim to identify and address the conflicts which underlie anxiety about the treatment and its avoidance. For example, the child may be avoiding entering the treatment because of the fear that the analyst will boss him about in the same way he feels bossed about at home. Such a child may bring material where he asks the therapist to play teachers and pupils and boss about the analyst to whom he assigns the role of pupil. The analyst may note this and address the child's anxiety by saying 'Oh, it is horrible being bossed about in this way. Do you hate to be told what to do sometimes?' It should be noted that this does not constitute an interpretation of the transference. It is rather a verbalization of the child's feelings in displacement.

3. Basic mistrust:

In some cases mistrust arises as part of the revival of a basic disturbance of earlier object relationships. In such cases positive transference may take years to establish and analytic work cannot properly commence until the basic mistrust is to some extent ameliorated.

The analyst confronted with this problem is faced with a form of character transference. Simply interpreting this form of transference will not be sufficient to change it and the child might need lengthy experience of the analyst, attending treatment day after day for many months before there is any sign of a change. During this period it is the analyst's task to clarify the child's affects (see above) as far as is possible. She cannot expect cooperation with the analysis until a positive alliance has been established. This will happen sooner for children whose mistrust develops later and whose object relations have more numerous positive historical and current features.
4. The child using the analysis as a form of gratification:

In cases where the child uses the analysis more or less exclusively in pursuit of gratification one can assume that a treatment alliance does not exist. This may not be obvious from the start and the analyst may note that the child is pleased to come as she tries to get the child interested in the analysis but after a while realizes that little analytic material or process is occurring. The difficulty is that at a superficial level the child may appear to be co-operating insofar as he lets the analyst talk but nothing in his reactions could lead the analyst to believe that progress in terms of the development of analytic themes or the appearance of links between the child's past and present experiences are being made. The analyst's subjective reaction may be that she is becoming bored and despite the child arriving regularly the analysis is not moving forward.

In these cases the analyst should assume in the first instance that the child is showing some kind of basic unwillingness to enter treatment and thus look for conflict around engaging in the analysis and concomitant forms of anxiety. If this search is fruitless and the child repeatedly stresses enjoying the toys and other aspects of the analysis and wishes for more toys and play, the analyst may choose to confront therapeutically the child with the nature and purpose of the treatment and in a limited way reduce the immediate gratification that the child derives from the treatment. These cases often however require discussion with other people before the analyst feels confident to handle the confrontation in an appropriate way. Such discussion is necessary because the most likely account for these events is the analyst's failure to identify an important source of conflict.

5. The child is not enjoying the treatment:

In some cases problems will emerge because the child is deriving insufficient gratification from the treatment. As was stated previously, it is not the aim of child analysis to deprive the child of gratification, and the child requires some pleasure in treatment in order to ensure a sound treatment alliance. It is not implied here that the child should be bribed to come to treatment. Nor should the child be deprived of normal gratifications. There is no reason for example why a small child should not eat his mid-afternoon snack during the session.

If a child seems reluctant to come to treatment from the start because it is lacking in pleasurable gain then the analyst should double her effort to arouse the child's interest in facing the therapeutic task. This form of failure of the therapeutic alliance may again be due to some basic unwillingness to enter the treatment associated with anxiety. If the analyst has
failed to pick up a plausible cause for the anxiety and the child persists in expressing
dissatisfaction it is possible that a way needs to be found to arouse the child's interest and
then it is particularly important to make sure that the analyst has not overestimated the
child's capacity to be aware of internal problems and to reflect on these.

6. The child has major environmental problems:

Children in the midst of parental divorce or those experiencing significant parental
failure to provide continuity of care may feel consciously or unconsciously that the onus for
change is not upon them but upon their parents. This attitude may be incompatible with the
establishment of a sound treatment alliance. The child may wish for his circumstances to
change rather than him.

In these cases the therapist must acknowledge the reality of the child's position
whilst at the same time stressing for the child that whilst he might not feel he has internal
problems but he may have problems which prevent him from achieving an optimum
adjustment to the situation. In some cases it may be appropriate to say that the child may not
be seeking a change in his situation because of internal problems when this is in reality
required. Thus, the analyst must take great care not to collude with the child's defense of
externalizing his difficulties.
CHAPTER 6
CLARIFICATION AND ELABORATION OF THE MATERIAL

Definition:

Clarification is one of the verbal interventions available to child analysts. In child analysis the work of interpretation (see below) is often preceded by explaining certain internal or external events or processes to the child. These are not interpretations. They simply explain in a language comprehensible to the child aspects of reality as distinct from fantasy or factual information about which the child may be perplexed or confused. Clarifications frequently pave the way for interpretations by helping the child to understand the context and meaning of the analyst's remarks, although at times clarifications may supplement or elaborate interpretations. When clarifying children's material the analyst to some extent takes on a parental role. For this reason clarification may be particularly important when one or both of the child's parents is seriously disturbed emotionally. This of course may include discussion of the parent's disturbance per se.

A key technical problem confronting analysts concerns how to clarify misconceptions and ensure that the reassuring component of the explanation is given in such a way that it does not prevent the child from bringing further material deriving from the anxieties and conflicts underlying the child's material. If the therapist feels that this is ensured it is quite appropriate for her to offer a clarification prior to exploring the child's fantasies, as it is sometimes essential that the child is clear about an aspect of reality before the child can usefully explore related fantasies.

Certain considerations should limit the readiness with which clarifications are given. Clarifications make the analyst into a real person by linking her with reality and may then interfere with the development of transference. At times requests for clarification may be part of a patient's attempts to disrupt the free flow of material, i.e. resistance. The analyst must also be wary that clarifications do not lead to loyalty conflicts for the child between the parents and the therapist.

In general, reassurances and clarifications are most appropriate for younger children. They may help to create an atmosphere in which the child feels protected from anxiety arising out of misunderstanding and motivated to understand his anxieties and conflicts.
Forms of Clarification

1. Reassurance

A reassurance is most appropriate when it addresses a misunderstanding of factual reality. It is most inappropriate when the reassurance addresses a fantasy which is the elaboration of pleasure seeking wishes and defenses against them. Misunderstandings which require reassurance are not motivated by internal needs. They are fairly readily corrected and sometimes such corrections will have profound effects. For example a child who is manifestly anxious that his mother will not wait until the end of the session and wishes to check that she is there may be told: 'Mummy isn't going to go away', and if necessary the child should be allowed to visit his mother in the waiting room. It may be appropriate to reassure a young phobic child that the phobic object is not present in the therapeutic environment - especially if this reassurance is given in the context of an explanation that the analyst realizes that there are things of which the child is frightened. Talking about these may be of help. For example the analyst might say, 'There are no dogs here. So you are safe to tell me why you are afraid of them'. With smaller children these reassurances may frequently need to be concrete and involve demonstration.

Reassurance must be used cautiously since it runs the risk of ignoring the child's internal reality for the sake of temporarily reducing the child's anxiety. For example, an initial reassurance to the child that the analyst will not become angry whatever the child does will only help the treatment alliance temporarily. The child may at times perceive the analyst as angry and furthermore the analyst may well become angry with the child with regard to something the child says or does. Similarly, the reassurance that the analyst will always be there for the child's sessions will soon run unto difficulties when a session needs to be canceled or when the analyst has to end the session early if, for example, the child is out of control. Thus great care has to be taken that all reassurances are as far as possible realistic.

Besides verbal reassurance the analyst may at times wish to give non-verbal forms of reassurance and in certain infrequent circumstances with young children may allow physical contact. This may take the form of holding the child so that he does not hit or kick the therapist or offering comfort to a very distressed young child on the therapist's lap. The criterion for providing non-verbal reassurance must be the same as for verbal reassurance; in other words it is desirable in so far as it promotes the spontaneous emergence of analytic maternal and should be avoided if it is likely to strengthen resistance or to be experienced by the child as coercive or seductive.
To distinguish between misunderstandings of reality and anxiety laden fantasy, the analyst needs to rely on her experience and the context within which the particular piece of material emerges. The analyst should assume that unrealistic anxieties derive from conflictual fantasies unless they do not fit the context of the rest of the child's material. An anxiety which is different in nature from the majority of the child's concerns may be understood by the analyst as a misunderstanding and tackled by reassurance. It has to be admitted that the two forms exist on a continuum and at times may be difficult to distinguish. Furthermore, the distinction is often made post ipso facto i.e. if the child was not reassured, the anxiety was fantasy based.

If the child is reassured in appropriately this will frequently result in him being frightened when the reassurance is found not to quell his anxiety. The reassurance may also be inappropriate in the sense of missing the point of the child's anxieties. Reassuring a dog phobic child that dogs are not really dangerous will cause the child to feel misunderstood. Furthermore, such an attempt at reassurance is inconsistent with the aim of analysis which is to discover the latent meaning of the dog phobia.

Reassurances should not constitute an attempt to reason with the child about the nature of his anxieties. At no stage does the analyst attempt to elaborate the logical factual fallacies made by the child rather, reassurance involves the use of the therapist's status as an adult to have privileged knowledge about aspects of the world. Even when a concrete demonstration is involved, this aims simply to show to the child's satisfaction the facts as the adult stated them are correct.

2. Explanations

a) Clarification of past events:

As with reassurance, timely clarification of external events may be warranted by the child's misunderstanding. Clarification of events may concern current or past happenings which the child has misconstrued or is in the process of misconstruing.

A relatively common indication for clarification of past events concerns the emergence during analysis of 'family secrets', events of which the child is dimly aware but because of the interference of his own anxiety of because he has been given insufficient information, he is found to be preconsciously preoccupied with a fact or situation which he does not understand. For example, a deceased sibling, major parental illness, or the circumstances of a parent's previous marriage may all constitute family secrets about which
the child is ill-informed or confused. In this connection the analyst will carefully take note of the various determinants of the child's preoccupation with the secret. The child may feel responsible for the 'secret', or ashamed, or he may have distorted the nature of the secret according to his own conflicts and anxieties. Verbalization of feelings and conflicts may lead to interpretations which free the child to clarify the secret and come to terms with it. Alternatively, the analyst may develop a hypothesis about such events from the child's material and, given an adequate working relationship with the parents (see below), may confirm the hypothesis and arrange for the clarification to come from them.

b) Clarification of current events:

In certain cases it may be a feature of the child's analysis that the child receives inadequate information concerning major life events and brings his anxiety and concern about these into analysis. This tends to happen if parents try and deal with anxiety-provoking events by denial. If, for example, a member of the family is ill and the parents fail to discuss this, the child may nevertheless surmise that the parents are anxious and this may lead to a proliferation of worries. A paradigmatic example of this may be a parent's stays in hospital when the child is not told in advance and is made highly anxious by the secretive atmosphere and the related separation. The anxiety may be intensified by any number of past experiences which the child remembers in response to the current anxiety, and the current external event may emerge in the analysis in terms of a sudden predominance of in the material of anxieties associated with past, as well as recent present events. The clarification of past and present events in these cases may usefully come from the analyst as a result of her work with the child and the parents.

There is a potentially infinite variety of external events which might call for clarification. What differentiates this category from the previous one is that, generally speaking, the material which requires clarification represents a discontinuity in the analytic material. In clarifying the external event the analyst links the child's affective response to it and, where necessary, offers factual information concerning the event. Frequently the analyst may face the need to offer a simplified account of the parent's behavior in connection with the event as well as working with the child concerning his response to it. As noted above, clarification of present events cannot avoid consideration of similar experiences in the past. Any current anxiety will have its roots in the past and thus a genuine analytic intervention combines clarification and reconstruction. The more past events determine the experience of a currently stressful experience, the more likely it is that the child's current anxiety will be rooted in his pathology. To the extent that this is the case,
clarification is inappropriate. Clarification should in any case involve no more than the presentation of reality to mitigate anxiety associated with external events about which the child has insufficient information.

As stated above, the events requiring clarification are frequently interwoven with the interpretative work of the analysis. For example, the analyst may recognize that the child's fear derives from misconstruing the parents' sexual behavior as violence. In this case the analyst may decide to offer an interpretation concerning the child's anxiety about whether what mummy and daddy do in bed together is nice or nasty as well as a well-timed clarification in which she lets the child know that sexual intercourse is not hurtful. A clarification of this sort may not have been necessary the parents' own anxiety had led them to fail to provide their child with appropriate information about sexual life.

c) Clarification of bodily experiences:

Particularly in the case of children with chronic illnesses, the child may need clarification concerning the nature of his bodily functions and experiences associated with illness. The analyst may observe the child becoming anxious about physical changes or physical treatments about which he has developed irrational ideas and which have come to evoke intense anxiety. In these instances the analyst is in a good position to provide information for the child which clarifies the nature of the bodily changes as reasons for medical treatment.

Children may at times ask the analyst directly about an illness and if the analyst senses confusion or misperception it may be appropriate for the analyst to offer clarification if this does not make the child feel that his confusion and anxiety are somehow illegitimate. A dramatic instance of this is provided by a child of 4 who had been hospitalized for precocious puberty at the age of 2 years and who had asked the analyst about the many confusing accounts she had over-heard. This gave an opportunity to the analyst to explain to the girl that her Mummy had been worried because she was growing very fast and took her to the hospital to find out why. There they were told that she was rather a special baby in that she grew faster than other children. She was ahead of them at the moment but in time they would catch up with her and she would be like the other girls.

d) Clarification of psychological processes:

Most commonly the analyst may find it necessary to provide clarifications concerning the nature of psychological processes which may explain to the child his own
reactions. The analyst may find it necessary to explain psychological processes in a number of contexts.

It may be necessary for the analyst to link the child's bodily experience to external events, particularly physical symptoms of anxiety. For example a child who has gastric pain upon leaving for school in the morning may be relieved to understand that such pain may be linked to various experiences of separation from his mother and related feelings of anxiety and anger.

Most commonly the analyst is required to clarify the child's affective state. Children, especially small children, are greatly helped by the precise labeling of their subjective experience. Thus a child who is about to go into hospital who is destructive but also clearly distressed may be greatly helped by the analyst explaining that he is feeling frightened about going into hospital. The analyst may add that little children often do naughty things when they feel frightened.

More complex versions of the same process begin to border on interpretation. Nevertheless the recognition and labeling of the child's affective state is an explanation which has a reassuring quality since a child may find affective states in themselves inexplicable and confusing and the child may have insufficient experience to know whether his feelings are acceptable.

e) The treatment situation:

The analyst may need to clarify and reassure patients concerning aspects of the treatment. A very common reassurance concerns the confidentiality of treatment with children who are concerned about the privacy of the analytic material and the privileged nature of the communication. There is justification for reassuring a child about the confidentiality of treatment, especially concerning the therapist's role vis a vis the parents. For such children explanations may be given initially, followed by interpretations concerning their suspicions if anxieties about confidentiality persist.

Another form of clarification that is sometimes needed in the treatment situation concerns the extent to which the therapist will allow the child to behave as he chooses. It is untrue and inappropriate for the analyst to give a blanket reassurance to the patient to the effect that he will be allowed to do anything he wishes. It may however be appropriate for the analyst to reassure the child to the effect that he is not going to let the child damage the property in the consulting room. Such a reassurance is called for when, for example,
interpretation of hostile and aggressive wishes leads to an increase in the child's anxiety, coupled with a tendency towards the enactment of destructive wishes.

It is important for the analyst to recognize that analytic work, in particular interpretations, at times leads to anxiety and hostility from the child. In this context it is appropriate to meet this anxiety with reassurances and explanations to preempt and contain the child's affective response. At times this may be achieved paralinguistically by talking to the child in an understanding, well modulated tone. At other times, the negative impact of an interpretation may be reduced by helping the child to anticipate his response with a comment such as: 'I am aware this may make you angry but I think it is important for us to recognize that...'

Towards the beginning of the analysis the child may need a number of explanations concerning the analyst's role to avoid confusing her intent with the intent of other familiar adults such as doctor, teacher, uncle, aunt etc. Whilst these explanations are legitimate and desirable at the beginning of the analysis, it is inappropriate to offer the same explanation after the initial phase of treatment when the child's reaction is likely to be a manifestation of transference.

As the analysis progresses the child may need clear warnings which will help him anticipate his emotional reactions to treatment. In particular, it may be useful to warn a child towards the end of a session in which he was particularly expressive, that he may feel he revealed too much and that he may not feel like attending the next day. A special case of this is warning the child that he may not feel like coming back to treatment after a weekend or a holiday break because he may feel angry about it. Such warnings are more likely to be effective if they form part of an interpretation of the reasons a child may feel angry about a break in treatment and point to pattern of avoidance or other evidence that the patient is angry either in or out of treatment, following disruptive breaks. Thus the analyst should attempt to clarify for the child what the analysis is causing the child to feel so that he can increasingly anticipate and prepare for his reactions both in and outside the treatment situation.

A similar class of explanation concerns accounts of unforeseen interruptions, both those brought about by the analyst and those created by the child or his parents. Minor unforeseen interruptions such as noises, the telephone ringing or somebody entering the room may also require explanation. In such instances it is usually best to wait for the child's response to emerge in his material before offering an explanation. This provides useful information for the analyst in formulating her understanding of the child and planning her
interpretive strategy and will allow her to incorporate the child's emotional reaction into the explanation for the interruption. The analyst's 'misbehavior' may also require clarification. Thus if the analyst starts the session early or arrives late the child is entitled to an apology and an acknowledgment. A lengthy explicit account however is not required unless there is a very good reason to give it. Reality information concerning the reasons for the analyst's unexpected behavior should, generally speaking, be minimal because it interferes with the analyst's role as object of transference.

**Analyst's Requests for Clarification**

At times the analyst will be in need of information from the child to clarify her thinking concerning the phenomenological details of the material. There is no need for the analyst to remain puzzled about the factual nature of the child's material unless giving unclear accounts are an habitual mode of relating or symptomatic feature of a particular child. Normally, the analyst should feel free to ask the patient to explain or elaborate. This may be particularly important for smaller children who have difficulty in perceiving the analyst's problems in understanding. In this connection the analyst may at times usefully help to differentiate fantasy and reality. Clarification of the child's material also may be achieved simply by asking the child to provide more details.

There are circumstances when requests for clarification by the analyst are inappropriate. Children may sometimes intend to confuse the analyst in the same way in which they confuse themselves for purposes of defense. The meaning of such behavior needs to be understood and interpreted, not clarified. The analyst should take care not to turn the session into an interrogation by excessively questioning the child about his experience. With small children especially the analyst should also be mindful not to be misperceived by the child as valuing reality over fantasy material within the context of the analysis by exerting pressure on the child to specify whether a particular experience was real. This is particularly important when the analyst suspects that the child may feel guilty about wrong-doings, real or imagined.

**AIDS TO INTERPRETATION**

Whilst material for interpretation is defined not in terms of its external parameters but in terms of what makes sense for the analyst, and which she can usually communicate to this child, there are some general characteristics which identify material for interpretation. The best criterion for analytic material is what is relevant to the picture of the child's anxieties, conflicts and developmental problems which the analyst gradually builds up.
Definition

Whilst adult analysts may hope to communicate their perceptions of their patient's preconscious thoughts directly by interpretations, child analysts have to make use of various verbal and non-verbal devices which will help the child understand the interpretation. Aids to interpretation is the label for the variety of procedures which facilitate progress towards the acquisition of analytic insights. The techniques share the features of displacement and externalization of mental content and concomitant affect, and thus mitigate the impact of making conscious anxiety provoking representations of self, important others and the interaction between them.

When To Use Aids To Interpretation

Aids to interpretation in psychoanalytic work are employed in the context of the child's activities in treatment which include play with toys, doll and role play, the use of stories and a variety of verbal devices (Sandler et al., 1980). They are to be used with considerations (see below) and represent a key feature of the analyst's therapeutic repertoire. Aids to interpretation are used to prepare the way for direct interpretations which would otherwise lead to excessive anxiety within the child. The child tends to bring material (see above) modified by defenses, particularly displacement and externalization. It is a natural continuation of this process for the analyst to follow the child's lead and make use of the defense in interpretative work. If, for example, the child has revealed something about himself in terms of a doll, it is desirable for the analyst to continue using the figure for displacement (i.e. the doll) in formulating interpretation with reference to the doll figure, thus using the play character as a substitute for the child's own thoughts and feeling in the situation being represented in play.

However, aids may potentially become part of resistance in that they collude with the child's defensive wish to locate the cause of conflict and anxiety outside the self, and it may be hoped that with the progress of therapeutic work, the use made of them will gradually decrease. The greatest value of aids to interpretation lies in their face saving and anxiety reducing qualities during periods of treatment when the child is unable to perceive wishes and fears as his own, but can accept them as characteristics of figures in imaginative play or stories. Nevertheless there will be some children in analysis who will accept interpretation in no form other than ones which are distanced from the child with the help of such therapeutic devices.
In using aids to interpretation the analyst must take into account the child's own mode of expression and the child's need to defend himself. For example, a child whose cognitive capacities are limited or a child whose self esteem is vulnerable may require more aids to interpretation than the average child in analysis. The particular aids used must also be matched to the child's level of emotional development and pathology. Thus, a narcissistically vulnerable child may not be helped by interpretations which are phrased in such a way as to encourage the child to observe himself via recognizing a quality of himself in another child who the therapist has known, whilst a child with intense feelings of shame may feel relieved by such forms of interpretation, as they may make whim feel more acceptable.

**Functions To Aids To Interpretation**

Aids to interpretation have two major functions. The first concerns the child's level of cognitive functioning. In this context aids to interpretation ensure that the child understands the analyst's communications. Thus the construction of a calendar by the analyst may be used to explain time-related concepts to young children to enable clarification and later interpretations concerning the child's feelings and reactions to weekends or other breaks in treatment. Aids are employed to facilitate the child's understanding of abstract emotions characterizing interpretations by using concrete forms of illustration. Thus the analyst must find concrete ways of expressing complex feelings, such as the wish to be looked after which may, for example, be represented in terms of a story of mummy being out, and a toy figure having "to wait and wait, and wait for her to return." The length of the wait may be concretized using drawings, gestures or stories as supplementary illustrations.

Aids may help communication between the analyst and the child, not only in terms of reducing for cognitive complexity, but also in fitting the analyst's communication into the child's preferred mode of relating. Thus, a child who speaks little but draws well may be more effectively reached through the use of drawings to aid communication than through the verbal modality.

The dynamic functions of aids to interpretation are manifold. In general terms the function of aids is to circumvent specific defenses and avoid engendering increased resistance. Aids reduce the shame and humiliation that interpretations sometimes engender when they refer to repudiated wishes. For example, giving an interpretation referring to another child of the analyst's acquaintance may help reduce guilt feelings by effectively informing the child that other children have similar problems. Aids to interpretation also at
times have the dynamic function of distancing the child from affects. By using stories or role play or humor the immediate affective impact of confronting preconscious material is reduced. Some aids enable the child to feel more in control of preconscious processes. Aids also enable the analyst to adapt her interpretive work to the child's particular defenses without arousing unmanageable anxiety. By, for example, making use of the child's own displacements, the analyst is able to approach the defended content by diminishing the child's resistance to recognizing previously warded off mental content and feelings without challenging the defenses directly. This, according to the view embodied in the manual, is the appropriate way of dealing with the child's defenses. We take the view that the child's therapeutic acceptance of repudiated feelings about himself is necessarily a gradual process, and that the selection of aids to interpretation and the timing of interpretations proper are critical to successful analysts techniques.

An independent dynamic function of aids to interpretation may be containment. When intense affect is generated within the analysis, the appropriate use of interpretation in displacement may offer the child a measure of defense which will help contain the potentially overwhelming affect. Thus, for example, helping a child in a temper tantrum to make a set of drawings of a child kicking the therapist offers to the child the opportunity to express his aggressive wish via to pictorial representation in a way which will help him to manage and control his anger.

Forms Of Aids To Interpretation

Aids to interpretation may take many forms and the specific forms used are of no particular significance beyond ensuring that the aid is appropriate to the child's level of emotional development, cognitive capacity, personality and pathology. The following is a list of some commonly used aids to interpretation.

1. Displacement onto toy figures:

If the child uses play material in a way which reveals something about himself the analyst may enter into the play making comments which are attributed to one of the toy figures.

2. Referring to 'parts' of the child:

The analyst may distinguish between different parts, that is different thoughts and feelings of the child which may be contradictory or conflictual. Interpretations can then be
made referring to a 'part' of the child. For example: 'You know I think there is a part of you which does not like to know about the angry thoughts which you sometimes have.' 'Pans' may be personified, and the analyst may refer to the 'big Johnny and little Johnny' who have different views of persons or circumstances.

3. Referring to other children of the therapist's acquaintance:

   The analyst may help the child from feeling overwhelmed by addressing her comments directly to the child through stories about a particular person who is in many respects similar to the patient. Thus the analyst may say: 'I know a little boy called Peter who always felt angry and terribly worried when he was angry with his Mummy.'

4. Using drawings:

   This is a combination of the first and the third aid and is appropriate when the child brings material in the form of drawings or figures. These may be personified and interpretations may be made with reference to them. For example, drawings may be used to concretize anxieties or defenses against them. The analyst may add to or alter the drawings or indeed produce new drawings in order to lend emphasis to an interpretation.

5. Using role play:

   The analyst may use role play initiated by the child or the analyst in order to reflect the child's current thoughts and feelings about himself or others. The child may communicate by assigning specific roles to the analyst. Conversely the analyst may communicate with the child by feeding back the feelings experienced by the analyst in that role and by elaborating on a situation in play. The analyst may be more active in creating the role play if she thinks this may improve communication with the child. For example, she might use a pretend telephone conversation and give the interpretations over the telephone. Such role play helps the child to distance himself somewhat from the material as well as from the interpretation.

7. Using humor:

   The analyst may deal with problems of resistance by using humor to reduce the immediate impact of interpretations. Making a joke of something can help the child to adopt the analyst's point of view, to observe himself and to reduce the gravity of a therapeutic issue.
8. Interpretive stories:

The therapist sometimes may make up stories to help distance the child from the immediacy of the interpretation. This aid has much in common with referring to other children with whom the analyst is acquainted, but is a more comprehensive approach offering the analyst greater latitude. These stories can include members of the child's family, important others such as teachers and friends, as well as personifications or allegorical representations of the analyst's understanding of aspects of the child's personality and functioning.

Problems In Using Aids To Interpretation

Aids to interpretation are not without inherent problems and the analyst must weigh and monitor their usefulness over the course of the analysis.

1. Provoking resistance:

Aids to interpretation sometimes run the risk of provoking resistance. If the child feels belittled or humiliated by the drawing of analogies or telling of stories the impact of the interpretation may be lost.

2. Undermining reality testing:

In very young children the child's reality testing may be undermined if the analyst enters too readily into the child's fantasies or imaginative play or dramatizations so that the child may become uncertain as to why the analyst treats real issues as if they were pretend and thereby become anxious about his own ability to differentiate fantasy and reality.

3. Outgrown aids:

Some aids to interpretation become outgrown and meaningless through overuse or constant displacement of interpretation of the child's feelings on to others, for example, can augment the child's tendency to externalization of inner criticism of self. In this way the child also experiences less and less of the impact of the interpretation. Rather than facilitating therapeutic communication, the predictable form of the interpretations weakens their effect.
4. Collusion with the child's defenses:

Aids to interpretation may lead the analyst to collude with the child's defense without analyzing them. For example if the child experiences difficulty in accepting direct interpretations, it may be appropriate to tackle the resistance in terms of how much the child prefers to talk about somebody else's problems rather than his own.
APPENDIX 2

INSTRUCTIONS TO JUDGES, CLASSIFICATIONS AND RATING SCALES

STUDY 1
VALIDATION OF MANUAL I
Enclosed is a section of a Manual for child analysts entitled "Therapeutic Alliance", a list of clinical examples, and a Comments sheet. Judges will attempt to classify the examples in terms of the ways an analyst promotes the therapeutic alliance based on their understanding of the manual and their ability to use it as a guide, rather than on their own conceptualisation of the concept. Read the section, then look at each clinical example and rate it according to the applicability of each classification as outlined in the manual. The classifications are as follows:

TA1: Increasing the child's awareness of a painful internal situation  
TA2: Promoting the child's curiosity  
TA3: Promoting the idea of therapeutic efficacy  
TA4: The analyst's attention and understanding  
TA5: The parent's promotion of treatment alliance

Place the appropriate rating in each box using the following 3 point scale.

++ very applicable  
+ applicable  
0 not applicable

Write your impressions of this section of the manual on the Comments sheet - what you found useful, interesting, impossible, etc., and any suggestions. Your participation is greatly appreciated.
### Therapeutic Alliance

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Enclosed is a section of a Manual for child analysts entitled "Clarifications", a list of clinical examples, and a Comments sheet. Judges will attempt to classify the examples in terms of types of clarifications based on their understanding of the manual and their ability to use it as a guide, rather than on their own conceptualisation of the concept. Read the section, then look at each clinical example and rate it according to the applicability of each classification of clarification. The classifications are as follows:

C1: Reassurance
C2a: Explanations - Clarification of past events
C2b: Explanations - Clarification of current events
C2c: Explanations - Clarification of bodily experiences
C2d: Explanations - Clarification of psychological processes
C2e: Explanations - The treatment situation
C3: Analyst's requests for clarification

Place the appropriate rating in each box using the following 3 point scale.

++ very applicable
+ applicable
0 not applicable

Write your impressions of this section of the manual on the Comments sheet - what you found useful, interesting, impossible, etc., and any suggestions. Your participation is greatly appreciated.
Classification - #2

Clarification

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Enclosed is a section of a Manual for Child Analysts, a list of clinical examples, and a Comments sheet. Judges will attempt to classify the examples in terms of the unconscious meaning of the content of actions and the way meaning is conveyed based on their understanding of the manual and their ability to use it as a guide, rather than on their own conceptualisation of the concepts. Read the section, then look at each clinical example and rate it according to the applicability of each classification as outlined in the manual. The classifications are as follows:

The unconscious meaning of the content of actions
2.1: Prototypical
2.2: Symptomatic
2.3: Compulsion to repeat
2.4: Attempts to ward off anxiety
2.5: Expression of wishes and feelings towards the analyst and/or to elicit a specific response from the analyst
2.6: Motivated by pleasure in using physical capacities

Ways unconscious meaning of actions is conveyed to the analyst
3.1: Meaningful distortions - Distortions of single actions
3.2: Meaningful distortions - The style of actions or sequences of actions
3.3: Literal interpretation of acts - Literal meaning of acts
3.4: Literal interpretation of acts - Literal meaning of action sequences
3.5: Literal interpretation of acts - Special meaning of particular acts
3.6: Context specific meaning of acts - Meaningful units of action within a sequence
3.7: Context specific meaning of acts - Linking of two distinct actions
3.8: Interpretation of repeated action sequences

Place the appropriate rating in each box using the following 3 point scale:
++ very applicable
+ applicable
0 not applicable

Write your impressions of this section of the manual on the Comments sheet - what you found useful, interesting, impossible, etc., and any suggestions. Your participation is greatly appreciated.
The Nature of Analytic Material - Modes of Expression

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Enclosed is a section of a Manual for child analysts, a list of clinical examples, and a Comments sheet. Judges will attempt to classify the examples in terms of the ways words convey unconscious meaning and special forms of expression based on their understanding of the manual and their ability to use it as a guide, rather than on their own conceptualisation of the concepts. Read the section, then look at each clinical example and rate it according to the applicability of each classification as outlined in the manual. The classifications are as follows:

The analyst's understanding of how words convey unconscious meaning
1.1: Level of sound
1.2: Separating words into meaningful components
1.3: Literal meaning of a word
1.4: Unconscious use of homonyms
1.5: Breakdown of the meaning of compound words
1.6: Breakup of syntagmas
1.7: Interpretation of idiomatic expressions
1.8: Literal meaning of phrases and sentences

Special modes of expression
2.1: Verbal slips
2.2: Action slips
3.1: Symbolic expression of material - Association by contiguity
3.2: Symbolic expression of material - Commonality of function
3.3: Symbolic expression of material - Commonality of attitude
3.4: Symbolic expression of material - Commonality of sensory experience

Place the appropriate rating in each box using the following 3 point scale:
++ very applicable
+ applicable
0 not applicable

Write your impressions of this section of the manual on the Comments sheet - what you found useful, interesting, impossible, etc., and any suggestions. Your participation is greatly appreciated.
Classification - #3.2

The Nature of Analytic Material - Modes of Expression

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Enclosed is a section of a Manual for child analysts, a list of clinical examples, and a Comments sheet. Judges will attempt to classify the examples in terms of some of the aids provided to analysts to understand clinical material based on their understanding of the manual and their ability to use it as a guide, rather than on their own conceptualisation of the concepts. Read the section, then look at each clinical example and rate it according to the applicability of each classification as outlined in the manual. The classifications are as follows:

Context provided by known event
1.1: Current events in the child's life
1.2: Significant events in the child's past
1.3: Past analytic material

Contiguity of content
2.1: Elaboration of a narrative sequence
2.2: Adjacent content provides affective background
2.3: Representing both sides of a conflict
2.4: New meaning derived from linking two distinct themes

Combination of contents in a single element
3.1: Disguise function
3.2: Multiple expression of wishes
3.3: Expression of conflict

Pictorial language
4.1: Direct representation
4.2: Transposition of the context of the image
4.3: Concrete representation

Place the appropriate rating in each box using the following 3 point scale:
++ very applicable
+ applicable
0 not applicable

Write your impressions of this section of the manual on the Comments sheet - what you found useful, interesting, impossible, etc., and suggestions. Your participation is greatly appreciated.
## Classification - #4

**The Nature of Analytic Material - Aids to Understanding**

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Enclosed is a section of a Manual for child analysts, a list of clinical examples, and a Comments sheet. Judges will attempt to classify the examples in terms of the ways a child disguises his/her material based on their understanding of the manual and their ability to use it as a guide, rather than on their own conceptualisation of the concepts. Read the section, then look at each clinical example and rate it according to the applicability of each classification as outlined in the manual. The classifications are as follows:

Disguise by substitution - involving perception and/or action
S1: Substitution of a perception
S2: Substitution of an action

Disguise by substitution - self and object
SO1: Self to object substitution
SO2: Significant other to object substitution
SO3: Significant other to self substitution
SO4: Substitution of one aspect of the self for another
SO5: Self to object to self substitution

Disguise by reversal - affect
RA1: Reversal of affect about another person
RA2: Reversal of affect of other towards the self
RA3: Reversal of affect that the child feels about himself
RA4: Reversal of affect about events and activities

Disguise by reversal - roles
RR1: The child takes on a role so as to embody desired aspects of a person
RR2: The child takes on a role which reverses an unacceptable attribute
RR3: The child's role relationship to the therapist

Other disguises
R: Reversal of actions
P: Initiation of a preventative act

Place the appropriate rating in each box using the following 3 point scale:

++ very applicable
+ applicable
0 not applicable

Write your impressions of this section of the manual on the Comments sheet - what you found useful, interesting, impossible, etc., and any suggestions. Your participation is greatly appreciated.
Classification - #5.1
The Nature of Analytic Material - Modes of Disguise

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</table>
Enclosed is a section of a Manual for child analysts, a list of clinical examples, and a Comments sheet. Judges will attempt to classify the examples in terms of ways a child disguises his/her material based on their understanding of the manual and their ability to use it as a guide, rather than on their own conceptualisation of the concepts. Read the section, then look at each clinical example and rate it according to the applicability of each classification as outlined in the manual. The classifications are as follows:

**Disguise by exclusion - forgetting**
- EF: Forgetting of information

**Disguise by exclusion - active denial of information**
- ED1: Blanket specific disclaiming of content
- ED2: Long term exclusion of a pertinent category of ideas or affects
- ED3: Counteraction of reality by creating an alternative reality
- ED4: Disowning of disguised expression
- ED5: Exclusion of repudiated content by its incorporation into a rational account

**Disguise by exclusion - affect**
- EA1: Disguise by exclusion of affect
- EA2: Disguise by exclusion of the source of an affect

**Disguise - other**
- DIE: Disguise by infantile expression

Place the appropriate rating in each box using the following 3 point scale:

<table>
<thead>
<tr>
<th>Rating</th>
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Write your impressions of this section of the manual on the Comments sheet - what you found useful, interesting, impossible, etc., and any suggestions. Your participation is greatly appreciated.
## Classification - #5.2

### The Nature of Analytic Material - Modes of Disguise

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APPENDIX 3

RESULTS

STUDY 2
CLASSIFICATION OF CHILD PSYCHOANALYTIC MATERIAL
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| patient: of: analyst's comments - 1 |
| interpretation - 2 |
| remaining difficulties - 1 |

| patient: of: reality - 1 |
| treatment alliance - 1 |

| analyst: interpretation of - 1 |

| analyst: interpretation of - 1 |

| patient: available affect - 1 |
| communication re - 1 |
| defence against - 12 |
| expression of following: |
| interpretation - 2 |
| verbalisation - 1 |
| increased affective range |
| flexibility - 1 |
| recognition of - 3 |
| rejection of - 1 |
| reversal of - 6 |
| splitting of - 3 |
| in transference - 1 |

| analyst: acceptance of - 1 |
| clarification of - 4 |
| contains - 1 |
| empathise with - 1 |
| interpretation of - 6 |
| linking: |
| of affect - 2 |
| with defence - 1 |
| recognition of - 1 |
| verbalisation of - 13 |
AGGRESSION: 107

type: aggression - 19
aggressive destruction - 1
aggressive sexuality - 1
anal - 2
anger - 5
aspect of exhibitionism - 1
competition - 1
destructive - 1
drive - 1
feelings - 1
murderous - 1
hostility - 4
rage - 6
sadism - 2
phallic - 1
toward: analyst - 2
couple - 1
object - 3
self - 1

patient: anxiety re - 1
conflict - 4
enactment of - 1
fantasy, aggressive - 2
fear of - 7
identification with aggressor - 4
mastery of - 1
projection of - 4
response to:
confrontation - 1
felt threat of humiliation
with clarification - 1
undermining defence - 1
transference of - 1
turning against self - 5
wish - 7
death wish - 2

analytic: avoidance of - 1
link with fear - 1
interpretation - 8
supporting benefits of mastering - 1

AMBIVALENCE: 31

type: ambivalence - 17
anxious - 1
re: curiosity - 1
towards analyst - 1

patient: avoidant ambivalent attachment - 1
relationship - 4
conflict - 1
transference of - 1
expressed through wish -

analytic: interpretation of - 3
interpretation of so as to locate in child - 1

ANAL: 38

type: anal - 2
aggression - 2
castration - 2
character - 1
derivatives - 1
deroticism - 2
hoarding - 1
narcissism - 1
possessive - 1
regression - 1
withholding - 1

patient: battling - 1
concern - 1
conflict - 4
retention - 1
excitation - 1
fantasy - 3
fixation - 3
masturbation - 1
regression to - 2
wish - 3
regressive - 1

analytic: metaphor - 1
ANALYST, OTHER: 109

use of by patient:
accommodates to what feels analyst expects - 1
aggression toward - 2
ambivalence about - 1
contrast parent and analyst - 1
curiosity about - 1
defensive response to break in treatment - 1
demand for approval and reassurance from - 1
denigration of - 1
eexternalise onto - 3
fantasy re - 2
fear of - 2
for control - 1
for projection - 1
for reassurance - 1

analyser's function:
alters role ascribed by patient to - 1
analyse: defense - 2
as: ego auxiliary - 7
new object - 4
real object - 4
superego - 1
asks questions - 2
attempts to establish a relationship - 1
avoids: aggression - 1
anxiety - 1
builds: treatment alliance - 1
colludes: with defense - 1
confirms: through interpretation - 1
contradicts: fantasy with reality - 1
creates: conflict - 3
describes: defense - 1
dilutes: transference - 1
disentangles: family defenses - 1
distinguishes: transference from external object - 1
draws patients awareness to:
what patient does - 1
enables patient to:
distance self from parents - 1
explores issues - 1
facilitates: regression - 1
self observation - 1
helps patient conceptualise: conflict - 1
ignores: progressive aspects - 1

idealisation of - 1
identification with - 4
internalisation of - 1
jealousy re - 1
negative therapeutic reaction - 1
reproaches - 1
sees as: fragile - 1
other grown-ups - 1
protector - 1
wanting analyst
to depart from analytic role - 1
to be real object - 1
wishes about - 8

makes unconscious conscious - 1
makes value statement - 1
metaphor: anal - 1
mimics - 1
modification of technique - 1
motivates: patient to change - 1
neutrality: breaks - 1
plays - 2
prepares: for treatment alliance - 1
provides patient with alternatives:
to feeling humiliated - 1
responds: through actions - 2
reviews: changes in patient - 1
rewards: mastery - 1
seeks: fantasy material - 1
sets stage: for treatment alliance - 1
stresses: analytic function - 1
takes a different stance - 1
takes up: wish - 1
undermines: defense - 1
use of role playing - 3
works on: treatment alliance - 1
works toward: treatment alliance - 1

ANALYTIC PROCESS: 11

analytic process - 1
aided by observing ego - 2
patient: fear of - 1

analyst: engage ego in - 3
engage observing ego in - 3
set stage for - 1
ANXIETY: 94

type: anxiety - 32
      anxious ambivalent - 1
      castration - 10
      core conflict - 1
      ego - 1
      masturbation - 3
      oedipal - 1
      persecution - 1
      primal scene - 1
      primitive - 2
      separation - 6
      superego - 1
      unbearable - 1

g: aggressive impulse toward object - 1
      being discovered - 1
      being separate - 1
      fantasy - 1
      growing up - 1
      loss - 1
      loss of object - 2
      revealing: aspects of self - 1
                 wishes - 1
                 thoughts - 1
      self - 1
      triumph over object - 1
      wish - 1

patient: anxious avoidant attachment - 1
         attempt not to experience - 1
         control of - 1
         defence against - 2
         defensive exclusion of - 1
         externalisation of - 2
         enactment of - 1
         mastery of - 1
         relief from - 1
         thoughts provoke - 1

analyst: avoidance of - 1
         contains - 2
         holding as response to - 1
         interpretation of - 1
         verbalisation of - 2

CASTRATION: 23

type: anal - 2
      female - 1

patient: anxiety - 10
         concerns - 1
         fears - 5
         feeling castrated - 3
         wish - 1

analyst: fear of - 1
         lack of wish for - 1
         resistance to - 2
         response to - 2

CHANGE: 20

g: affect, greater range/flexibility - 1

defence:
         understanding of - 1
         progressive - 1
         intrapsychic - 1
         patient - 3
         progress made - 1

due to: treatment - 1

patient: fear of - 1
         lack of wish for - 1
         resistance to - 2
         reviews - 1
         verbalisation of - 3

analyst: motivates pt to - 1

CLARIFICATION: 28

clarification - 12

by analyst of: affect - 3
              conflict - 2
              ego ideal - 1
              fantasy - 2
              past and present feelings - 1
              patient's communication - 1
              reality - 1
              resistance - 1
              self object confusion - 1
              view of self - 1

patient: follows with felt threat of humiliation
          humiliation - 1

analyst: mistimed - 1

641
COMMUNICATION: 6
patient: communication - 1
preverbal - 1
unconscious - 1
re affect - 1
analyst: clarified - 1
of ability to bring fears - 1

COMPETITION: 9
type: aggressive - 1
destructive - 1
oedipal - 3
phallic - 1
sibling - 1
patient: fear of - 1
analyst: interpretation of - 1

CONCERNS: 3
type: anal - 1
castration - 1
masturbation - 1
CONFLICT: 188
type: conflict - 61
adolescent - 1
anal - 4
bisexual - 3
core - 1
divergent - 1
external - 1
fed by superego - 1
feminine - 1
internalised - 4
loyalty - 1
masturbation - 10
oedipal - 13
structural - 1
patient: defence against - 1
enactment - 2
enactment in transference - 1
transference of conflictual relationship - 1
analyst: clarification of - 2
creates - 2
helps pt conceptualise - 1
helps pt recognise - 1
interpretation of - 17
locates in pt by means of interpretation - 1
verbalisation - 4

CONFRONTATION: 9
analyst: confrontation - 7
with reality - 1
patient: aggressive response to - 1
CONTAINMENT: 17

analyst: containment - 2
holding - 1
as response to anxiety - 1
by: function of auxiliary ego - 1
limits/restrictions - 1
physical holding - 5
verbalisation - 1

patient: fear of loss of

of: affect - 1
anxiety - 2
frustration - 1

CONTROL: 13

control - 2
of: anxiety - 1
impulse - 1
instinctual - 1
analyst: offers greater control through analytic understanding - 1
ego auxiliary to control - 1

patient: loss of - 1
fear of loss of - 2
use of analyst for - 1
wish for - 2

COUNTER-TRANSFERENCE - 3

CURIOSITY: 13

curiosity - 3
re: analyst - 1
self - 1
sexual - 4

patient: ambivalence re - 1
conflict re - 2

analyst: encouragement of - 1

DAMAGE: 7

type: body - 1
internal - 1

patient: fear of - 1
fear of body damage - 1
fear of mental or physical
to self - 1
fear of threats to integrity of body - 1
wish to attack and damage - 1
DEFENCE: 332

**type:**
- defence - 42
- active into passive - 1
- aggression turned against self - 5
- avoidance - 9
- avoidance, phobic - 1
- boredom - 1
- defensive disidentification - 1
- defensive exclusion - 1
- defensive homosexuality - 3
- defensive identification - 4
- defensive investment - 1
- defensive inhibition - 1
- defensive narcissism - 1
- defensive sublimation - 1
- defensive use of games - 1
- denial - 36
- disavowal - 1
- displacement - 25
- externalisation - 27
- family defences - 2
- identification with aggressor - 4
- negation - 1
- obsessional - 2
- omnipotence - 2
- passive into active - 17
- projection - 10
- projective identification - 4
- rationalisation - 1
- regression - 3
- reversal - 1
- reversal of affect - 6
- reversal of roles - 1
- scotomatisation - 2
- splitting - 1
  - between home and treatment - 1
  - of affect - 3
  - of self - 1
- use of humour - 1
- withdrawal:
  - defensive - 1
  - into fantasy - 1
- as secondary defence - 1
- dramatisation - 2
- flight into external world - 1

**against:**
- affect - 15
  - disappointment, oedipal - 1
  - pain - 1
  - pain and humiliation - 1
  - feelings about self - 1
  - feeling excluded - 1
  - feeling small - 1
  - feeling vulnerable - 1
  - helplessness - 2
  - aggression - 4

**quality:**
- inadequate - 2
- ineffective - 2
- interferes - 1
- maladaptive - 1
- progressive - 1
- uneconomic - 1

**patient:**
- begins to give up - 1
  - of affect - 15
  - of disappointment, oedipal - 1
  - pain - 1
  - pain and humiliation - 1
  - feelings about self - 1
  - feeling excluded - 1
  - feeling small - 1
  - feeling vulnerable - 1
  - helplessness - 2
  - aggression - 4
- consciousness - 1
- lack of appropriate reaction - 1
- illustrates fixation - 1
- insight into - 1
- need to defend - 1
- progressive defences - 1
- understanding of - 1
- used to enhance self esteem - 1

**analyst:**
- analysis of - 2
- collusional - 1
- describes - 1
- disentangles patient's and mother's - 1
- link with affect - 1
- link with fantasy - 1
- interpretation of - 28
- interpretation of need to defend - 1
- interpretation of motive for - 1
- misunderstands - 1
- undermines - 1

DEPENDENCE: 2
- dependence - 1
- conflict re - 1

DEVELOPMENTAL HELP - 6

DIFFERENTIATION: 5
- differentiation - 1
  - between:
    - infantile wishes and mature self - 1
    - objects - 1
    - self and object - 2

anxiety - 4
- defensive exclusion of - 1
- conflict - 1
- child parts - 1
- loss - 3
- lowered self esteem - 1
- narcissistic blow - 1
- reality - 1
- sexuality - 1
- wish - 1
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  superego/ego - 1
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  ego strengthening - 1
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  to control - 1
  clarification - 1
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  promoting ego strength - 1
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  feelings and wishes re object - 1
  internal object relationships - 2
  object relationship - 1
  past relationship - 1
  punitive internal object - 1
  tension between instinctual forces and superego - 1
  transference - 1
  wish - 2

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  by analyst of: curiosity re self - 1
  expression of regressive wish - 1
  regression - 1
  transference - 1
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  - in analytic process - 3
  - in self observation - 1
- observing ego - 1
  - in analytic process - 3
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  - penis - 6
  - oedipal - 1
- of: adult sexuality - 1

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- conflict - 1
- phallic - 1
- with aggressive message - 1

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- patient: expectation - 1
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  - analyst expects - 1
  - unrealistic of self - 1
- analyst: conveys to patient - 1
  - introduction of developmentally appropriate
    ones to patient - 1

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- of: limits of analysis - 1
  - to pave the way for interpretation - 1

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  - anal - 2
  - homosexual - 2
  - intercourse - 4
  - masturbation - 3
  - anal - 1
  - oedipal - 1
  - primal scene - 2
  - sexual - 4
  - starvation - 1
- re: aggressive destruction - 1
  - analyst - 2
  - infantile sexual theory - 1
  - intercourse: damage in - 1
  - sadistic - 1
  - violence in - 1
- patient: anxiety re - 1
  - guilt re - 2
  - withdrawal into - 1
- analyst: clarification of - 2
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  - links: with defence - 1
    - two fantasies - 1
    - interpretation of - 1
    - seeks - 1
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of:
- aggression - 6
- aggressive drive - 1
- analytic process - 1
- analyst - 1
- being the analyst - 1
- being cheated - 1
- being discovered - 1
- being found inadequate - 1
- being hurt if separated - 1
- being out of control - 1
- being overwhelmed by drive - 1
- being replaced by sibling - 2
- being seen/looked into - 1
- being small - 1
- being stupid - 2
- being taken over - 1
- body fluids - 1
- castration - 5
- change - 1
- closeness - 1
- competition, oedipal - 1
- damage:
  - damage - 1
  - body - 1
  - self being - 1
- threats to integrity of body - 1
- dark - 1
- envy - 1
- failure - 2
- falling - 2

patient: conflict re - 1
analyst: communicates patient's ability to bring - 1

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humiliation - 4
intrusion - 1
loss:
  - loss - 2
- of attachment - 1
- of control - 1
- of holding/containment - 1
- of identity - 1
- of love of object - 1
- of object - 5
- of self - 2
- of parent's unity - 1

masturbation - 1
narcissistic - 1
oral longings - 1
poisoning - 1
rejection - 5
retaliation - 6
self discovery - 2
sexuality - 1
adult - 1
aggressive - 1
heterosexuality - 1
solutions, omnipotent oedipal - 1
success - 1
talion - 1

wish:
  - wish - 2
  - death - 1
  - omnipotent oedipal - 1

FIXATION: 8

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patient: defence illustrates - 1
analyst: interpretation of - 1

FOSTERING: 6

by analyst of:
- self observation - 1
- treatment alliance - 5

FREE ASSOCIATION: 2

FRUSTRATION: 4

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patient: tolerance - 1
analyst: containment of - 1

GRANDIOSITY - 2
GRATIFICATION: 8
  type: masochistic - 1
  vs active anger - 1
  regression to infantile - 1

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  paranoid - 1
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  defensive disidentification - 1
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  with: aggressor - 4
  analyst - 3
    use of analyst as model for - 1
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      parent - 3
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  type: feminine - 1
  patient: fear of loss of - 1
  preoccupation with sexual - 1

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  sexual - 1
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  insight - 9
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    into behaviour - 1
    into defences - 1

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  development - 1
  patient: control - 1
    enactment of tension between instinctual forces and superego condemnation - 1
    fear of - 1
    fear of being overwhelmed by drive - 1
  analyst: interpretation - 1

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acting out - 1
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aggression - 5
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rage - 1
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anxiety - 1
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exploitation - 1
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of aggressive wishes - 1
of loss - 1
of loss of object - 1
of loss of parent's unity - 1
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gratification - 1
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instinctual - 1
loss - 1
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reality - 2
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distortion re objects - 1
infantile - 1
object relationship - 1
past - 1
sadomasochistic - 1

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in displacement - 5
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make acceptable to patient - 1
pave way for thru explanation - 1
via nonverbal means - 2
to confirm ego strength - 1
to locate conflict within patient - 1
to locate ambivalence in pt - 1
to further analytic work - 1

**aim:**
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wish being expressed - 1
leading to:
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resistance to - 2
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**patient:**
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resistance - 2
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separateness - 1
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- feeling rejected - 1
- hostility toward parent - 2
- analyst seen as persecutory - 1

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- aggressive impulses toward
  - object - 1
- being separate - 1
- loss of object - 2
- separation - 7
- triumph over object - 1

**attachment:**
- anxious avoidant - 1
- avoidant ambivalent - 1
- disorganised - 1
- through punishment - 1
- to ambivalent rejecting parents - 1

**capacity for disturbed - 1**

**conflict:**
- core conflict - 1
- between internal object
  - representations - 1
  - autonomy - 1
- dependency - 1
- relationship - 2
- triumph over object - 1
- wish for closeness vs separateness - 1
- defence as way to identify with - 1
- depleted - 1
- deprivation, oral - 2
- differentiation - 1
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- self and object - 2
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- past relationship - 1
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- loss of: attachment - 1
  - love of object - 1
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  - parents unity - 1

**analyst:**
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- clarify self object confusion - 1
- disentangle patient's and mother's defences - 1
- enable patient to distance self from parents - 1
- interpretation - 4
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- confrontation with - 1
- orientation - 1
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- patient: of affect - 3
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  of affect - 1

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analyst: acceptance of - 2
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CHAPTER 1
THE PSYCHOANALYTIC UNDERSTANDING OF CHILDHOOD
PSYCHOLOGICAL DISTURBANCE

Introduction

Within a psychoanalytic model, childhood psychological disturbance is seen as initiated by conflicts. The manner in which children adapt to such conflicts provides the basis for our understanding of childhood disturbance.

Incompatible wishes may generate unpleasurable affective states (anxiety, guilt) which in turn lead to the wish to reduce the incompatibility. This may be accomplished through mental adaptation of one or both wishes (e.g. the defensive distortion of turning a wish into its opposite), or a fundamental interference with affective or cognitive mental processes related to the conflict (e.g. inhibition of imaginative capacity). Consider, for example, a young girl, Sally. Her wish to mother her baby brother brought her into conflict with her need to be looked after herself by her mother. Faced with the incompatible wishes described above, Sally lost her spontaneity in relating to others and became a controlling, unpleasant little girl who became intolerant of change and greatly distressed and out of control whenever she felt excluded. For instance, Sally was enjoying feeding the baby from the bottle, priding herself on having arranged for her brother's comfort. When her mother suggested that the baby needed winding, she berated her mother for not paying attention to the baby and had a tantrum when her mother took the baby.

Psychoanalytic metapsychology and the terminology it employs (e.g. ego, super ego, id, signal anxiety) often obscures the clinical phenomena it aims to clarify. This is because the underlying structures and dynamics it describes are several conceptual levels removed from the experiential situation in which patient and analyst find themselves. We suggest that it may be useful to use a conceptual model which corresponds as closely as possible to this experience, in order to make quite clear what patients and analysts actually say and do, i.e. in order to discuss technique. We have thus chosen to reduce and simplify the meta-psychological model to those essential ideas that are required to describe our clinical practice. In so doing, we have identified aspects of our clinical work which do not correspond well to the structural model. This led us to reformulate some concepts from ego psychology and developmental theory to encompass within a unitary theoretical formulation all major aspects of our clinical work.

In this section we delineate two psychoanalytic models of childhood disturbance. The first (the representational model), rooted in Freud's structural model of the neuroses,
concerns the exclusion from consciousness of threatening ideas and feelings and the distortions of mental content brought about by the defenses which ensure this exclusion. The second model (the psychological process model), rooted in Anna Freud's developmental approach, focuses on the pathological effects of the inhibition of developing psychological processes. Both models, drawing on different explanatory mechanisms, account for similar symptomatology: fears and phobias, rituals and obsessions, difficulties in relationships, difficulties in learning, impulsiveness and other disorders of conduct etc. However, the models identify two distinct, potentially pathological, means available to the child to deal with psychological conflict. They have in common the function of reducing unpleasure by the constriction of conscious mental life. The purpose of these models is not formally to distinguish one group of children from another, nor do we expect them necessarily to overlap with categories within a psychiatric nosology. Nevertheless, in understanding the psycho pathology of a particular child the usefulness of one model may outweigh that of the other. The value of the distinction is in explaining the differences between children in the accessibility of their psychological problems to treatment, and the relevance of specific techniques in bringing about changes in experience and behavior. We will now delineate the models briefly in turn, and then describe them more fully with case illustrations.

The representational model of psychological disorder focuses on the distortion or repression of the mental representations of one or other of the conflicting wishes. These distortions represent an attempt at a compromise which serves to reduce anxiety and other forms of psychic pain. Psychological disturbance arises, not because these manipulations take place but because they are only partially successful and anxiety and guilt continue to interfere with the child's functioning. In the case of Sally, her unacceptable longing to be cared for like a baby was obscured by her controlling matronly attitude. Her bossiness represented a compromise in that it encompassed her wish to be in charge as well as her infantile demandingness. The disguise of her feelings by attempts at reversal was ultimately unsuccessful because of the persistence of her childhood needs for care and attention and her anxiety that these would not be met.

The psychological process model can equally well account for the manifest signs of Sally's disturbance. Within this framework, the psychic pain associated with conflicting mental representations is reduced by the inhibition of a psychological capacity which plays a part in the creation of these mental representations. Such drastic maneuvers appear often to be associated with unusually intense conflict in the context of an unpropitious environment. In this context it is relevant that Sally experienced inconsistent and multiple
caretaking. In order to preserve her wishes to be looked after, she inhibited her capacity for self-reliance. In this context, her demanding and controlling stance can be understood as protecting her from and compensating for the vulnerability of her self-representation.

The Representational Model

The concept of mental representation has been successfully used to clarify the nature of certain childhood disturbances and psychic change in the psychoanalytic treatment of children.

The imagined gratification of a wish is invariably linked to the mental representation of a sought after affective state. For example, the wish to be in a mutually recriminating and hurtful relationship with a mother may derive from the pleasure and illusory sense of safety brought about by the belief that battling with the mother will ensure her continued availability. In this way affects and wishes are intrinsically linked in the construction of mental representation. In many instances the individual's anticipated emotional experience associated with the gratification of a wish is also beset by negative affect (e.g. sadness, anxiety, guilt etc.). Such negative affects are at the behest of mental representations of situations particularly those associated with the absence or the displeasure of the caretaker. The multiple emotional implications of a wish are what we refer to as conflict. Thus even a young child who is as yet unable to anticipate the outcome of the gratification of a wish may experience conflict, because the mental representations generated will raise both positive and negative affect. Negative feelings initiate or trigger psychological mechanisms aimed at preserving a conscious mental state free from unpleasure. This is achieved through denying access to consciousness of those mental representations linked to negative affect (i.e. repression).

Conflictual wishes thus pose a particular problem for the child. This is because the exclusion of mental representations to reduce negative affect also entails the loss of anticipated positive/pleasurable emotional experience. The range of wishes that may be entailed in conflicts leading to childhood disturbance covers the full spectrum of human motives. Wishes may be generated by biological needs (e.g. hunger, sexual drives), by dependency upon social relationships (e.g. wish to be close to important figures, to communicate with them and be understood by them) or by needs to establish the self in particular relationships with others around one (e.g. competitiveness). The provision of a comprehensive list of conflicts that occur in child psychoanalysis is beyond the scope of this manual. Here we provide a brief list of common conflicts which child analysts encounter in the course of their work.
A. Conflicts related to the child's body and drives:

- Conflicts subsumed under the perception of the body as vulnerable to damage: numerous situations in the child's life may make him feel that his body, particularly the sexual organs, is vulnerable to damage.

- Conflicts subsumed under the fear of aggression: the child's limited understanding of the consequences of his destructive wishes will often lead him to fear and wish to suppress his aggressive thoughts and fantasies.

- Conflicts subsumed under bisexual wishes: the child may wish to be of the opposite sex as part of a fantasized solution to other conflicts.

B. Conflicts related to the self:

- Conflicts subsumed under dependence versus independence: the child strives for autonomy and mastery which may entail anxiety about losing the reassuring presence of the object; the quality of the anxiety will vary from primitive fears of being devoured or engulfed to more structured fears for the absent object's safety.

- Conflicts subsumed under living up to a desired perception of oneself: the child may acquire through its relationship with the parents a set of internal standards which are inconsistent with its wishes or desires.

- Conflicts subsumed under the desire for a sense of stable identity: under the pressure of intense affect, the child's sense of self may be greatly threatened.

C. Conflicts related to object relations:

- Conflicts subsumed under pleasing the object versus pleasing the self: normal development leads to many situations in which the child will wish to please the object to preserve its love when this is not consistent with his own wishes for himself.

- Conflicts subsumed under wishing to acquire the unique affection of the parent of the opposite sex by displacing the parent of the same sex: such wishes are accompanied by fear of retaliatory punishment.
- Conflicts subsumed under the wish to possess and control: the child may frequently wish to possess and direct the object which provides it with safety, love and nourishment but may fear that its greedy wish may damage the object.

D. Conflicts directly caused by the child's environment:

- Conflicts subsumed under childhood sexuality: the child's sexual urges will inevitably conflict with the attitudes of his parents and the reality of his situation.

- Conflicts subsumed under the wish to mess and soil: the child's natural pleasure in messing will bring him into conflict with the external world and will eventually generate internal pressure.

- Conflicts subsumed under the child's legitimate expectation of a facilitative environment in the face of an obstructive one: the child's environment may put him in intolerable conflicts, e.g. of loyalty between parents hostile to one another or to a parent who is abusive.

In order to retain some semblance of pleasurable affect, the mechanisms used by the child to exclude mental representations from consciousness are applied in a less than comprehensive fashion. In this way, mental representations of wishes may be distorted so as to hide from consciousness aspects of anticipated negative affect. For example, Sally's attempts to take pleasure in feeding her baby brother were spoiled by the intrusion of her own longing to be fed. She experienced her baby brother as someone who displaced her and thereby deprived her of her special relationship to her mother. Simultaneously, in providing for the baby, she enjoyed feeling grown-up and competent like her mother. Sally's compromise involved assuming a demanding and controlling attitude aimed at keeping a tight reign on her own feelings of sadness and rejection. Her mental representation of mothering was distorted to exclude negative affect arising from seeing the baby as a rival. In this way she could see herself as not at all in need of care, and thus superior to and in complete control of her mother and baby brother. Distortions to mental representations, such as these, are referred to as defenses.

Anxiety and other unpleasant affects initiate defense which leads to the division between conscious and unconscious mental experience. By distorting her mental representation of herself in the manner described, Sally succeeded in excluding from consciousness her representation of her brother as a rival and of herself as vulnerable and needy. Representations deliberately excluded from consciousness are not integrated with the child's increasing knowledge of his world, and permit the child to maintain a large number
of contradictory beliefs and expectations. With development, unconscious mental representations will be more and more incompatible with representations maintained in consciousness. Consequently the threat of the return into consciousness of these representations will be experienced as more dangerous because it implies a general return to an earlier childlike mode of thinking. In this way, Sally's mental representation of herself as needy infant remained unchanged despite her considerable growing competence in her day-to-day life, (e.g. she learnt to read and write remarkably early). In any situation which might involve perceiving her brother as a potential rival and herself as a neglected and helpless infant became a cause of intense danger to her fragile sense of self. At the age of nine, when her four-year-old brother was sent to private school whilst the family planned for Sally to stay in the state system, Sally started having nightmares and temper outbursts during the day. In these symptoms she betrayed the earlier repressed representations of herself as needy and unable to control her actions, just like a baby.

Thus, the child with the representational disorder responds to his failure to adapt to the demands of progressive development by attempting to resolve his conflicts in a regressive manner. Neurotic compromise formations engender anxiety because they are only partially successful in keeping repudiated aspects of mental representations of experience out of conscious awareness. These unwelcome representations may include distressing perceptions of the self (e.g. as needy and demanding), of the object (e.g. as unavailable and unloving), or of the self and object in interaction (e.g. as hostile).

This model provides a description of the way in which the psychoanalytic process brings about psychic change through the integration of previously unacceptable aspects of experience into the child's current mental organization. The child's behavior and play in analysis often express the repressed internal representations of current and past events, and the thoughts and feelings surrounding them. For example, Sally was preoccupied in her analysis about what to do with a doll she found in the treatment room. Whilst she happily and competently fed the baby at certain times, there were other times when she expressed the feeling that the baby was a terrible burden. She bullied the analyst insisting that he should "care" for the baby but all the time criticized him for failing to do it properly. On occasion she resentfully accused the analyst of secretly harboring the wish to get rid of the doll.

The ambiguity of the situation which the analyst presents to the child serves to activate, i.e. to make current, unacceptable mental representations. When the child behaves in a distinctively individual way, the analyst reacts to this distinctiveness with the assumption that communication about the adaptation the child has made underlies it. Interpretations
serve to integrate developmentally primitive mental representations into higher-order organizations, and sustain the analytic process. The analyst's response to the little girl who accused him of wanting to get rid of the baby doll was: "I think it is difficult for you here because, of course, you want me to look after the baby. But as soon as I do, it makes you feel cross that I am not looking after you." Sally replied, "Maybe yes, maybe no". The analyst then commented that maybe Sally sometimes felt cross when her Mummy looked after her brother. Despite the child's resistance, the analyst's interpretations can gradually enable the child to achieve a greater tolerance for previously warded-off mental content and thus to construct a better integrated and more stable self representation. It is in the nature of mental representations to alter with emotional experience. Child analysis, with its focus on the patient's current emotional state, creates the potential for lasting and pervasive modifications of the child's internal representational world. The day after the above session Sally was slow to leave the Waiting Room to attend the session, opting instead to carry on playing with her brother. When the analyst commented on her hesitation, Sally replied: "Maybe it makes you cross when I pay more attention to my brother than to you."

**Case Illustrations**

We give two clinical examples which illustrate psychological disturbance and its modification through the analytic process readily conceived of in terms of this model. The first aims to illustrate these features over the course of the analysis, whilst the second aims to show the way unconscious mental representations are subjected to analytic scrutiny within the microcosm of a single session.

**Case A**

Jane began analysis at the age of 14. She was failing in school and her experiments with drugs and sexual relationships with boys made her feel frightened and out of control. Her brothers, who were one, two and four years her junior, were excelling academically and athletically. Her jealousy and envy of her brothers' relationships with her mother were mitigated only by memories of being special to her father. Her conflicts in relation to her mother and brothers were made worse by the fact that her parents divorced when she was six.

In the analysis Jane complained of wanting to look attractive and yet feeling compelled to dress scruffily. She felt frumpy, unfeminine, like a 'beached whale' and incapable of attracting a boyfriend. She recalled feeling inadequately helped by her mother to enjoy being a girl and brought memories of playing boys' games in ill-fitting and dirty clothes. The transference interpretation of Jane's conflict between her view of her male analyst as an empathic ally who would encourage her to look pretty, and a seducer who wished to humiliate and exploit her, caused Jane to remember numerous traumatic experiences in relation to her father. She recalled episodes of sexual exhibitions between father and his second wife when, for example, he demonstrated his circumcised penis. However, she also recalled feeling loved and looked after by him following the births of her siblings. In working
through these conflicts she alternated between views of her father as disturbed, weak
and deceitful, with herself as horsey and unfeminine; on the other hand she could
see her father as a shame-inducing seducer who nevertheless caused her to feel
feminine and loved. Her analysis helped Jane to come to see her father as someone
with his own difficulties, and her increased awareness of her guilt feelings over her
excitement over her father allowed her to accept herself as well as her body as
feminine and sexually appealing.

The interpretation of Jane's adolescent conflicts and their transference onto
the analyst was combined with the reconstruction of the events of Jane's early
childhood, in which she felt ashamed and guilty over her sexual excitement, i.e. dirty
and ungainly. The emergence of the representations wherein she felt disapproved of
and punished by her mother for excited play with her brothers and her wish to have
her father to herself were reinforced by her father's sexual over-stimulation. The
psychic change brought about by the integration of previously repressed childhood
fantasies, memories and conflict-inducing feelings was rapid, self-sustaining and
generalized to many areas of her life. Her school performance improved
enormously, her friendships became mutual and stable and she began to experiment
sexually in ways which enhanced her pleasure in femininity.

Case B

On his sixth birthday, to everyone's surprise, Sam announced that he was:
"the unhappiest person in the world". During the assessment Sam said that
everything had been bad since he was six. The diagnostician was forced to agree that
"things" were not good for Sam. At six, he was still sleeping in the same bed as his
mother. He had not yet given up the bottle and he "insisted" on keeping a wide
strand of his hair waist-length at the back. Notwithstanding his remarkable
intelligence (he tested at 151 IQ on the WPPSI), his school performance was
average, and his teachers' reports indicated that he was withdrawn and passive at
school and bullied even though he was in stature inches above the rest of his class.

Sam's family history was his greatest burden. His mother Priscilla, a
beautiful, petite 40 year-old woman of Swedish descent with a child-like appearance
and frankly infantile diction, was herself deprived of a loving childhood. Her mother
died when she was four, her father, a Circuit Judge, never remarried yet she had no
recollection of individual housekeepers who would have looked after her. She had
two terminations before having Sam at the age of 35. Sam's father was in the
process of a painful divorce when he had his brief affair with her. After Sam's birth,
he remarried and started a third family, although he kept in contact with Sam and his
mother during Sam's earliest years. Priscilla has no qualifications, no private means
but a curious expectation of a right to assistance reminiscent of the values of past
centuries.

Fred is the provider. He has known Sam's mother for at least 15 years. The
relationship may have once been of a sexual kind, but this had ended many years
before Sam's father made his brief appearance. In fact, even at the time of the
pregnancy, the three of them often holidayed together and Sam's mother invited Fred
to be present at the birth together with Sam's father, an offer which Fred
uncharacteristically was able to decline. Fred is a somewhat ineffectual, indecisive,
sadly unsuccessful man. He bought a house with Sam's mother because of his
fondness for Sam. He fulfills the role of a substitute father with affection, yet
strangely he has his own children, both Sam's juniors by several years, by a
girlfriend whom he visits briefly at weekends, braving Sam's mother's at times fierce
protests. He is clearly frightened of her; an attitude which he unequivocally revealed
when, in a telephone conversation with the analyst, he said: "Well, as Priscilla isn't
here, I don't mind telling you that Sam has been a great deal better since you have been seeing him".

Sam's relationship with his mother is a complex one. Evidently in one way he is her pride and joy, "her little cavalier". She has the capacity to provide him with overt affection and physical comfort albeit in a highly seductive manner. On the other hand, she is a woman suffering from chronic depression. She has frequent rages with Sam and walks out of the house leaving Fred to cope with the entire daily routine at the expense of his business commitments. Her sentimental concern for Sam is combined with total ruthlessness, verging on cruelty. On one occasion when the analyst saw both parents for their regular monthly meeting, she said she was fed-up with Sam for taking up room in her bed and for his lack of respect for her privacy. Fred timidly suggested that Sam might consider Priscilla's bedroom his own, since after all he sleeps there every night. She said that that was nonsense, he knew perfectly well that his bedroom was two floors down (a floor where nobody else slept), after all he had slept there once before, two years ago for part of the night. She went on to suggest, without a hint of irony, that the best method of dealing with the problem might be to imprison Sam in his room and let him cry, if necessary all night, until he becomes accustomed to his new home.

Priscilla's insensitivity to Sam's concerns would be hard to disguise. She refused to accept the suggestion of the diagnostician that Sam's "sadness" on his sixth birthday may have been linked to his father's departure for Australia with his new family just before he turned six.

Sam has been in analysis for nearly two years. The analyst has come to understand how heavily his burden of having to affirm his mother's existence and provide a route out of her depression sits on him, and impedes the growth of his sense of identity and self-esteem. For the first year he was frequently babyish. He dribbled, he asked the analyst to feed him, he smelled everything, but his infantile role protected him from the humiliation and terror he feared in his relationship with his mother. He told the analyst that his ambition was to grow into a six-month-old baby girl, and the analyst told him that he felt that as a baby he would be protected by him and his mother, and then secretly he could keep a tiny part of what was Sam.

The analyst was struck with his play with tiny, almost invisible specks of dust and fluff which he would call "cars", push round the table, "park" overnight and eagerly look for at the beginning of the next session. He was visibly relieved when the analyst explained that he understood that Sam sometimes wished to be as small as the cars so that he could be overlooked, but also that he could feel he could get inside people and things, because inside it would feel safe and protected.

He used many primitive defenses to control his anger. He played a game with the analyst of cutting up a large piece of paper into halves and then each half into halves; first 2, then 4, then 8, then 16, then 32, 64, 128, 256. Then they would both have to count after each "round" that all the pieces were there. His anxiety was only relieved when the analyst found a way of saying how frightening it was to feel that he had good and bad feelings inside him; how he was frightened of the analyst, like his mother, noticing his bad angry feelings and how, even inside, sometimes everything could feel unsafe unless he could be quite small, quite helpless and incapable.

A session may help to illustrate some of these issues. One Friday Sam behaved very strangely. He was unsettled, he did not want to get involved with anything. The games he started he quickly left. He spent a considerable time, however, in climbing up on the table and jumping off onto the carpet. The analyst did not understand his mood, and wondered aloud if perhaps the long weekend (there was a Bank Holiday coming up) felt to Sam like the gap into which he was
jumping from the table. Sam replied: "I am jumping into the unknown". At this stage the analyst had little idea what he was referring to, but detected his anxiety and said he wondered if Sam wasn't practicing for something that seemed frightening. He said: "Maybe". To the analyst's surprise, Sam repeated this word as they said good-bye to each other when Fred came to collect him. Fred was also surprised and said: "What do you mean? I know that it is half-term, but you are coming on Tuesday as usual. That is what we agreed with Dr. Fonagy". Sam had thus prepared the analyst for the message from his mother which was left on the answer-phone on Sunday night. She had decided not to bring Sam on Tuesday, despite their agreement that Sam would come to analysis during the half-term break as the analyst had been away for a few days some weeks before.

On the Wednesday Sam arrived on time. The analyst saw him from the top of the staircase. Unusually, he did not kiss his mother good-bye, but shut the door very carefully behind him and came up the staircase much more slowly than usual. The analyst greeted him and he responded smiling and swinging his head cheerfully from side-to-side. But the analyst had a sense that Sam was pretending. He sat down at the table, laid his head on it, stuck his fingers in his ears and started "making a concert" (making a concert is what he and the analyst call him humming, usually a popular classical theme, when he is not too keen to hear what the analyst has to say). The analyst said: "Sam, I wonder what it is that you think I am going to say, that you don't feel like listening to?" He said crossly: "You are going to say that I am angry that you were not here yesterday! I am not angry and that's that!" He then changed his voice from the angry tone of the previous exchange to a 'sleepy' voice: "I am very sleeepy and tiiired. Very, very tiiired. So tiiired that I can't keep my eyes open." To prove the point, he rubbed his eyes violently and shook his head as if wanting to shake the sleepiness out of it. As he did this the analyst noticed that he had had his hair cut. His unusual pony tail had been much shortened although not yet conventional.

The analyst said: "You know, I think you are wondering if I've got my eyes open to notice some important changes." He said: "We had our hair cut." He smiled for a moment, then with considerable vehemence he said: "I will kill the man who cut so much off. He cut off two and a half inches or two centimeters or even two millimeters." His voice trailed off into uncertainty. He then told me about the holiday that had been arranged in Tunis for the summer. His mother and the mother of a friend of his were planning to take their children together. He described the hotel and seemed particularly excited about the swimming pool. He looked out of the window to point out how big the pool was. "It is as big as the gap between the houses over there and the houses over there", pointing to the two rows of houses separated by about 50 meters of garden. The analyst said: "You know Sam, sometimes very small changes like the two days we missed yesterday and the Bank Holiday can feel like very big gaps, even if they are not the summer holiday, and I think that your house and my house felt like they were a very great distance from one another over the past few days." He was tiiired and sleeepy. He decided that he wanted to sleep on the table. He climbed on the table and grabbed the cushion from the chair. He lay down and pretended to sleep. He told the analyst that he wanted to take a rest and to "think". The analyst should let him think and not disturb him all the time. The analyst talks to him in psychoanalese and is always wrong. He sounded like Greta Garbo saying that she wanted to be alone. The analyst remained silent and Sam went on to tell him how hard he had worked on Sunday. It was a long and complicated story and the analyst did not quite understand it, but the gist of it was that he had helped Fred to send out a flyer about a new product and he had earned £26.25.

The analyst said: "It is very hard for you. It makes you feel very bad about yourself to think that I didn't see you on Tuesday because I was too tiiired and I didn't want to work. I just wanted to take a rest and it didn't matter how much it
would upset you." He sat up on the table sharply and said: "I didn't think that.
Mummy said that you didn't want to see me because you were probably tired." Then
sitting on the table, dangling his feet over the edge he showed me a new game which
he called 'Dead Fingers'. He leant on the palm of his left hand and with his right
hand pulled up his fingers in turn letting them slap back on the table. For a few
minutes he seemed absorbed in the game. The analyst did not understand the game
and so stayed silent. From time-to-time he would change the order in which he
picked up the fingers. There seemed to be a pre-determined sequence which he
apparently kept on getting wrong. He said: "I am confused which dead finger is
next". The analyst looked a little bit more closely at what Sam was doing. He then
realized that each time Sam went round the five fingers he would pass one by
without picking it up. The analyst said: "I think I know how terribly confusing and
frightening it is when you feel that you may be forgotten or overlooked. I think you
want me to know that it feels almost as if you were dead inside - a little bit like
feeling very, very tired". He responded by picking up two "dead" fingers and letting
them slap down with a painful thump. The analyst said: "I think that the most
terrifying thing is that you feel that not only do you feel dead-tired inside but that
somehow I am dead too. So dead that is not safe to do anything else with me but
sleep". He stopped the game and sat back on his chair. He told the analyst that he
had had a dream about Emil and the Detectives. Sam does not often tell dreams, so
the analyst listened attentively to a somewhat muddled narrative. "Emil had money
stolen in a bus by a wicked man when he fell asleep and Emil had many friends.
And there were three evil men and they all ganged up against him. And Emil and the
boys discovered all the money from the bank. They found the bank robbery money,
and Emil's money". Then he told the analyst about being frightened of robbers who
are in the cupboard at the top of the stairs at home, and how Fred was not there on
Saturday night to take him to the loo past the robbers. He then turned to the analyst
and asked as if it was the most obvious sequence: "How old are you?" The analyst
said: "Sam I think that you are very frightened that when I am away and you feel
cross with me that I took something away from you when you were not looking. I
might turn into somebody quite wicked and evil like a robber. Then it would feel
very nice if you had friends like Emil who would come and get me. But I had
abandoned you and you feel sad and quite alone".

When the analyst said this, Sam cheered up a little bit. He wanted to play
"Word Gi", a complex word game which they sometimes play. One part of it is like
the hang-man game when the analyst has to guess a word by suggesting letters. This
time the word had four letters and it turned out to be FEET. In the process, however,
the analyst was almost 'hanged' because Sam cheated and said that there was no F in
the word. The nearly-hanged figure was filled in with black pencil at the end of the
game and then Sam smudged, it covering the whole paper. "It looks horrid" he
commented, sounding satisfied, but then looked glum again. He dreamily pushed the
smudged piece of paper around the table with his index finger. The analyst said:
"You know it is very hard not to feel that you hadn't done something wicked and evil
when you get angry with someone whom you also like very much, and sometimes
when you get so angry with them they seem to turn nasty and horrid and then
everything seems to turn nasty and horrid and dangerous." He said in a child-like
voice: "Naughty Dr. Fonagy [analyst's name]" and pushed the piece of paper off the
table, looked up and smiled.

His tiredness now not at all evident, Sam ran over to his box and suggested
that they should play family trees again. He dragged out the large piece of paper on
which over many previous sessions they had painfully written in the different
branches of his confusing family going back two or three generations. They went
over the whole diagram again, naming everyone. Sam said: "I have understood
something. There are three families. There is Priscilla's family, Fred-Dad's family
and Peter's family. But Fred-Dad's family and Peter's family are not really families
because they have other children". Then listening for the noises in the house: "How
many children do you have?" The analyst replies: "You know Sam, I think I now understand well why you feel so angry when we don't meet. You feel so easily that there will be no family for you here as soon as we are not here together. And of course you are very frightened because you feel that you have done something that made me leave you. And then it may not even be safe to feel angry". He replied: "If you have babies then they require a lot of attention". At the same time he dribbled but quickly wiped up his saliva with the sleeve of his jumper. The analyst continued: "As long as you can stay a baby, then Mummy and I can only concentrate on you. But if you are a seven year-old with short hair and angry feelings, then no-one will have time for you". He said as if explaining something rather obvious: "There are three kinds of tiredness". There is, it seems, sad tired which is when he lies on the table putting his feet at the far end and his head near where the analyst am sitting. There is tired tired when he has his feet at the analyst's end, and there is happy tired and then he sleeps on the carpet. The analyst said that he thought he understood that when Sam wanted him to help with what was happening inside Sam's head then he wanted his head to be near the analyst, so that he could look into it to see why Sam was feeling sad, just like today. He said: "Exactly". Then he said that he may want now to write another story with the analyst like the Volcano adventure we wrote some months ago. This story would be about how SNOSP grew up. (This is the name that he sometimes uses for himself, which combines his two initials and the initial letters of the surnames of his three families.) It will be to do with how Snosp went to karate and learned to be brave and beat up all the robbers and the serpent monster.

Although they haven't yet started writing this story, (he apparently forgot about the suggestion at the next session), the analyst felt that adventure will be the story of Snosp's analysis as it moves uncertainly towards a more enduring representation of himself as a boy and as an individual.

In the vignette of Sam we can see how repudiated mental representations are verbalized by the analyst and transformed and reintegrated into Sam's self and object representations. Sam's perception of himself in relation to his mother as a six-month-old baby girl is enacted in the analysis in his dribbling, smelling things and requests to be fed. His is a pathological solution to a conflict about what kind of relationships he can safely have with his disturbed mother, represented in his mind as dangerous, and father, seen as abandoning. Aspects of these representations are taken up in the interpretations at different times in the course of the analysis and in the session reported in detail; his wish to be protected (not abandoned); to be small enough to get "inside" where it is safe; to be helpless and incapable as a defense against his anger; his fear that he has driven his objects away; his anticipation of retaliation by the angry father.

In the session given in detail he also demonstrates in his sleepiness a mental representation of the father-analyst who he feared was tired of him, and when this was interpreted, Sam was able to clarify what his mother had told him. This illustrates how the verbalization of repressed mental representations can help in the re-integration of current and past experience in the context of a less distorted and developmentally more advanced set of mental representations. Then in the dead finger game he elaborated further upon this
mental representation, demonstrating that it contained the fear that the analyst was dead. Once this was verbalized he went on to tell a story which demonstrated a related repressed mental representation of his anger with his father and his wish to rob him; together with the hangman game, a derivative of the same set of representations, the analyst was able to interpret Sam's fear that it was his own badness that turned his world nasty. His anger to his love objects turns his mental representation of them into dangerous people, i.e. the externalization of his own superego. The interpretations served to relieve his conflict indicated by his tiredness and freed him to use his more mature, seven-year-old intellect in speaking of the reality of his three families, trying to understand it; he also indicated his transference fear of exclusion from the analyst's family. When the analyst, for the second time, verbalized Sam's expectation that his anger made the analyst leave him, Sam's reply in word and action confirmed that in his perception the safe solution was to remain a baby. After the analyst interpreted this representation, Sam further illustrated the liberating effect of such interventions on the child's mental capacity. He could explain his own tiredness as "sad-tired", which required the analyst's intervention, and distinguished it from two forms of normal tiredness which do not require analytic aid. He demonstrated not only how more advanced representations in this way become accessible, but also how his mental capacities, his intellect and capacity for self-observation could be readily reactivated through being helped to understand the pathological aspects of his more childlike conflict bound mental representations.

As children develop more sophisticated ways of representing experiences of external reality, they tend to exclude more primitive mental representations. These primitive forms remain active but only unconsciously. The problem with the child's functioning arises when the more primitive, unconscious, representations are activated by internal or environmental demands. The child analyst, in making interpretations of unconscious forms of earlier experience, opposes the child's natural tendency to favor more complex forms of mental representation. However, he does this with the knowledge that the regressive experience within the analysis will facilitate the integration necessary to free the child's inherent tendency to progress developmentally.
The Mental Process Model

Above we have described how the distortion of mental representation can account for childhood psychological disturbances. In this section we will examine the ways in which the abnormal development and function of mental processes can lead to distinct forms of psychological disturbance in children. Mental representations cannot be separated from the processes which create and organize them. Just as it is necessary to think of light in terms of both particles and waves, one cannot conceive of mental life other than in terms of both mental representations and the mental processes which operate upon them.

Mental representations are best conceived as the products of mental processes. Mental processes refer to all the diverse ways available to the human mind to create and act upon its mental representations. These processes include inference, attributions, categorization amongst many others. Such processes are not only relevant to but are prerequisites for all developmental attainments referred to within psychoanalysis. So, a fantasy (a mental representation) is the product of the mental process of fantasizing. The act of perception, for example, the means of creating a mental representation from an external event, necessarily involves numerous mental processes such as the categorization of the event, linking it to similar previous events, and placing it within the context of other events perceived at the same time.

Many mental processes have been addressed in the psychoanalytic literature under the heading of ego functions. However, descriptions of ego functions have often obscured clinical phenomena through imposing a single term over a heterogeneous group of psychoanalytic observations. Terms such as 'reality testing' are too global to permit subtle clinical distinctions between mental states. For example, reality testing can be said to be deficient in a child who consistently attributes his parents' quarrels to his own thoughts and actions. The same term would be used to describe a child who becomes easily overwhelmed in fantasy play and confused between whether the imaginary characters he creates are real or 'pretend'. The mental states and processes in these two instances are not identical. Reality testing reflects the quality of congruence between numerous mental processes and the external world. It does not correspond to a single psychological function. Thus, dependable reality testing characterizes the accurate understanding of the affect signals in others, the evaluation of one's own performance, the capacity to build a realistic construction of future events not unduly distorted by wishful thinking, the accurate identification of the consequences of ones actions and the products of many other mental processes.

A further problem arises from the fact that ego functions are at very diverse levels of generality. For example, signal anxiety refers to an individual's capacity to anticipate internal
threats, while secondary process thinking refers to a great many qualities of rational thought. In both these respects, conceiving of psychological disturbance in terms of deficits of ego function will lead to explanations which lack the specificity required to illuminate the clinical phenomena fully. In this manual we will refer to a limited set of mental processes which have clear links to observable phenomena in the clinical context.

The development of processes which create and permit the manipulation of mental representations accounts for the increased sophistication of psychic experience. The development of a child's belief that his mother will continue to be available following separation, for example, rests on the evolution of psychic processes which create and integrate mental representations of her. Once the child is able to integrate emotionally incompatible perceptions of the object (the mother as abandoning and the mother as gratifying) into a functional object representation he can feel more secure about her return despite his anger with her for leaving him. Beyond a certain point in development, the absence of the capacity to integrate multiple affect-laden perceptions of the mother can lead to rapid shifts in viewing her as ultimately gratifying and profoundly threatening.

In the early stages of the evolution of a mental process, its further development may be influenced by the balance between pleasure and unpleasure contained within the mental representations upon which the process acts. In later development, mental processes occur automatically and outside awareness, and with the development of defense mechanisms the child will have the capacity to bar from access to consciousness those specific mental representations associated with the experience of unpleasure. Earlier in development, the child is able to prevent unpleasurable mental experiences arising by inhibiting the mental process itself. The curtailment of a mental process has more drastic consequences for development, than does the repudiation of specific mental representations. The stunting and distortions of mental processes which result from such inhibitions of functioning are apparent in the limitations of the child's capacity for mental representation. Within this model of psychopathology, we refer to the absence of psychological functions which may descriptively be thought of as deficits. The term deficit, however, is inaccurate insofar as it fails to denote the causal relationship between intrapsychic conflict and certain types of mental function. In the present context, failures of mental process are invariably seen as defensive in function because their inhibition, stunting or distortion performs an economic function whereby the child is able to avoid specific classes of painful mental representations.

Mental processes are known, broadly speaking, to evolve according to a biologically determined timetable. However, the child's environment, particularly his object relations, makes a vital contribution to the security with which a specific mental process is established.
Developing mental processes may be defensively inhibited at the time of their formation if the mental representations to which they give rise create unbearable mental pain. Object relationships are crucial during early childhood: in determining the pleasurable or unpleasurable quality of many mental representations, the child's relationships with others indirectly serve to promote or hinder the mental processes which generate the representations. In this regard it is important to emphasize that there is a limited number of others on whom the young child is able to depend. Relationships with primary caregivers will be pivotal in determining the ontogenesis of mental processes.

The importance of the quality of early experience for later psychological functioning derives in large part from the fact that it is only at this stage that the general functioning of mental processes is normally vulnerable to the effects of external experience. For example, calling upon mental representations of the self as close to a loved other will bring disappointment and mental pain when the object is inaccessible or rejecting. This may lead the child to wish to avoid such images of relationships and inhibit his capacity to represent himself in close relation to another. The development of a mental process essential to the forming of affectionate ties is thus stunted and mental representations of relationships which depend on affectional components will be distorted. Thus, representing the object as loving, valued, and the self in relation to the other as responsive, desirous, and acceptable, are inadequately established.

Individuals differ in the extent to which specific mental processes have fully matured. Psychological disturbance is associated with relative immaturity of selected mental processes. Under-developed mental processes give rise to distorted object and self representations. Thus, from the clinical material of an individual child, it is not initially possible for the analyst to know whether he is confronted by derivatives of a defensively distorted representation or the product of an inarticulate mental process.

The comprehensive enumeration of mental processes pertinent to psychoanalytic models of psychological disturbance is not possible at our current state of knowledge. Furthermore we lack sufficient information even to allow us to specify those mental processes which account for particular psychological capacities. It is largely through the psychoanalytic study of psychological disturbance that the precise nature of the malfunctioning of mental processes may be ascertained. In such cases it is helpful to make an initial approximation ("a guess") as to the dysfunctional mental process. Such approximations are only a little way beyond restatements of the observed phenomena. They denote classes of mental processes which come to be grouped by their common function which is notable by its absence in the clinical material. It is for this reason that the
understanding of certain aspects of childhood psychological disturbance in terms of mental processes constitutes an appropriate level of analysis for this manual.

Here we are only able to give a handful of examples of mental processes which are of relevance to the psychoanalytic model of psychological disturbance:

**The organization and control of impulses and wishes**

- The mental processes involved in delaying gratification of biological impulses.

- The mental process involved in elaborating fantasies deriving from sexual and aggressive wishes.

- Mental processes which generate plans for action on the basis of wishes and implement these in the external world.

- The mental processes involved in the monitoring of the gratification of needs and the regulation of activity related to their fulfillment.

**The organization and control of affective mental states**

- Mental processes involved in altering unpleasurable ideas and affects to reduce unpleasure.

- Mental processes involved in the activation of unpleasurable affect in the service of controlling behavior.

- Mental processes involved in organizing and maintaining one's affective responses within an appropriate range.

- Mental processes involved in deflecting, avoiding or suppressing affects when these interfere with adaptive functioning.
Reality oriented mental/ego functions

- Reality-testing: processes involved in recognizing fantasy and comparing it with realistic possibilities; distinguishing exaggerated ideas from realistic ones; minimizing omnipotence.

- The mental process of curiosity, of taking interest, in the external world and in the activities it stimulates.

- The mental process of identifying aspects of the environment which may be facilitative or helpful to one's aims.

- The mental process needed for accurately linking a specific event with the actions of others which had preceded it.

- The mental process responsible for judging the realistic risks involved in activities.

- The processes involved in building a realistic construction of future events on the basis of past experience.

- The mental process which allows the individual to reorganize mental representations into new configurations, manifesting as flexibility in problem-solving and adaptation.

Object relations: external

- Mental processes involved in understanding affect signals in others.

- Mental processes which permit a broad range of emotional responsiveness to the affective states of the other.

- The mental process responsible for the accurate identification of the beliefs and desires of the other person.

- Mental processes involved in the capacity to estimate what one may legitimately expect to receive in the context of particular affect-laden relationships.

- Mental processes that permit the setting aside of self interest in the service of attending to the emotional and physical needs of the other.
Object relations: internal

- Being able to create within oneself mental representations of significant aspects of an important other.

- Processes responsible for the capacity to maintain mental representations of others in a stable form.

- The mental processes involved in the capacity to sustain strong positive affects for another individual.

- The mental process responsible for being able to adopt the viewpoint of another.

- Mental processes which permit oneself to maintain independent aims in the context of representations of relationships with others.

- The mental process responsible for distinguishing between one's own reactions and those of the other.

- The mental processes involved in temporarily adopting a mental frame of reference from an earlier developmental level.

Self-organization

- The process of integrating one's actions, thoughts and affects with the aim of creating a coherent mental representation of the self.

- Mental processes responsible for elaborating an integrated image of oneself.

- The mental process which safeguards the integrity of the self image from powerful internal and external influences.

- Mental processes which permit appropriate emotional response to the other whilst maintaining a distinct self representation.

- Mental processes which permit the continued functioning of the self in the absence of support or interaction with others.
- The mental process involved in construing oneself as effective and putting oneself forward on that basis.

**Self-monitoring**

- The mental process of monitoring one's own capacities in order accurately to estimate what one is capable of achieving.

- The process of observing one's mental life, reflecting upon it and coming to conclusions.

- The mental process of accurately identifying the causal significance of one's feelings thoughts and actions.

**Self-evaluation**

- Mental processes involved in identifying the norms and values of the social environment and integrating these with one's own standards.

- The process of evaluating one's own performance and comparing it with that of others and one's expectations of oneself

- Mental processes involved in creating and maintaining a stable set of standards to which one's own and others' behavior can be adjusted.

- The mental process of differentiating the approval or criticism of others from one's inner evaluation of oneself

The above list of mental processes is provided as a preliminary heuristic device. It is not our intention to reify these processes (to assume that they have an independent existence outside the context in which they are inferred - the clinical psychoanalytic situation). The model itself is not one of psychopathology or metapsychology; rather, its usefulness is limited to clarifying how child psychoanalysis can be seen to work. In fact, these mental processes are oversimplifications of the psychological functions which they denote. Were we to try to employ this concept to form a model of the mind, each of these functions would require elaboration as a complex, hierarchical set of sub-processes and their interdependence specified.
Children whose pathology derives from the inhibition of psychic processes, such as the one responsible for a permanent representation of the figure of the caretaker, differ from cases where the disorder stems simply from the loss of aspects of a mental representation. A child who inhibits his psychic process of curiosity and consequently appears as profoundly bored and boring provides an example. There may be children superficially similar who present a picture of neurotic avoidance of intellectual or play activity consequent upon, for instance, a masturbation conflict. In that case the child's apparent lack of interest is selective and anxiety driven. The more profound disturbance of a mental process is unrelated to anxiety and has widespread implications for psychic functioning. A pervasive inhibition of knowledge acquisition, for example, will lead to withdrawal from relationships, persistence of infantilisms, failure to acquire information, to show an interest in developing the skills necessary to benefit from education, and a lack of concern about the new opportunities for affective experience and understanding which the analysis has to offer, amongst other symptoms. While mental processes are most often 'automatic' in the sense that they occur with very little or no attentional effort, they are extremely important determinants of psychopathology in developmental disorders.

We now turn to how the analyst may distinguish these two models of disturbance within the clinical context. We consider the following as 'hallmarks' of psychological disturbance related to the inhibition of psychic process: 1) the mental capacity corresponding to a process frequently appears to be lacking in a patient's material; 2) this lack is pervasive across divergent situations; 3) the interpretation of distorted mental representations does not lead to a change in the nature of the mental representations or the mental processes which gave rise to it; 4) the patient is unaware of the absence of a capacity and may regard his mental functioning as adequate; 5) the analyst may preconsciously 'compensate' for the patient's lack of mental capacity and may even find himself emotionally invested in the patient's adequate mental functioning; 6) the patient does not apparently benefit initially from the analyst's implicit use of those processes which are inhibited within the patient.

Disturbances involving significant degrees of deficit or distortion in the development of mental processes include those usually diagnosed as borderline, some forms of narcissistic personality disorder, and those known at the Anna Freud Center as "developmental disturbances", as well as the psychoses. We can begin to identify some of the specific mental processes which have failed to develop or have become distorted in each of these forms of disturbance. Some so-called borderline patients, for example, may be deficient in their ability to identify accurately their own beliefs and desires as well as those
of others. They may also be lacking in mental processes responsible for being able to identify with or adopt the viewpoint of another. These deficiencies combine with the more commonly cited inability to delay gratification of needs and wishes.

Children with narcissistic character disturbance will not only have substantial difficulties in comparing their own performance with that of others, but they also may well have difficulties in integrating their actions, thoughts and affects in the service of creating a coherent mental representation of themselves. For patients in whom mental processes responsible for elaborating an integrated image of the self have been inhibited, the patient's self image will be distorted. For example, it may alternate between a derogated and an omnipotent representation.

In addressing therapeutically disturbances deriving from the inhibition of mental processes, the patient's active mental involvement is elicited by the analyst's attention to the elaboration of the preconscious mental content of the patient. This mental involvement gradually brings about a reactivation of inhibited mental processes and thus leaves the child open to a gradual restructuring of distorted mental representations through further analytic work. The analyst's interpretation sets the patient's mind a challenge to identify connections and integrate the interpretation with his current view of himself, his desires and his preconscious beliefs. In order to link the analysts interpretation of the content of his mind to his current mental state, the patient will be obliged to reinvest his inhibited mental capacity. In the best of situations the patient's mental work recapitulates that of the analyst, albeit within the limitations set by the child's level of development. The patient's passive observation of the analyst's use of the capacity may further encourage the patient to reactivate inhibited modes of mental function.

We now return to the topic of children with narcissistic character pathology and aim to describe therapeutic action with regard to disinhibition of mental processes. Interpretations of the defensive function of the patient's distorted self image and reconstruction of events leading to it will not, however, in themselves bring about substantial change. The analyst's attempt to clarify the preconscious sources of the patient's current perception of himself will however 'exercise' the patient's mental capacity to represent

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1Omnipotent representation of the self may sometimes, but not invariably, arise in this way. An equally plausible mechanism to account for such a representation of the self, not involving inhibition of mental processes, is a defence against the internalisation of the intermittent denigratory appraisal of a primary object, for example an alcoholic father. A manner in which the analyst may distinguish between these possibilities is in terms of the readiness with which the patient's arrogant behaviour responds to the analyst's interpretations of the patient's mental pain in the face of a derogated self-image.

2It should be noted that, in this context, the interpretation does not need to be accurate in order to be effective, although one may assume that accurate interpretations are most likely to be inherently challenging for the patient and thus lead to his mental involvement.
himself as a coherent and stable mental entity. The successful engagement of the patient in trying to work out how the analyst arrives at stable constructions of the patient's self experience provides the route by which the patient's own mental processes become disinhibited. Over a prolonged time period, diverse interpretations concerning the patient's perception of himself will force him to attempt to create a mental representation of himself to integrate the analyst's understanding. In so doing the analysts forces the patient to exercise the mental capacity for forming an integrated mental representation of the self.

Below we outline a case where the presenting disturbance of aggressive behavior was apparently brought about by the child's distorted representation of the thoughts and feelings of others. The distorted nature of his mental representations were not simply the result of defenses against aggression with projective mechanisms, and against anxiety with the introjective mechanism of identification with the aggressor. Rather, this child showed a lack of mental processes involved in the capacity to identify accurately and locate the beliefs and desires of those around him, to understand their affect signals and to create within himself a reasonably accurate depiction of the significant aspects of their mental world.

It has often been suggested that disorders of conduct are explicable in terms of an unusual intensity of aggression. However we take the view that aggression in such cases derives from the disorientation arising from the inhibition of mental processes concerned with the accurate identification of the beliefs and desires of the other. As the normal child's capacity to form a clearer idea about the intentions and emotions of his objects develops, the extent to which he is able to ascribe his destructive impulses to others is diminished. Children in whom this process has become distorted are left with an inadequate representation of the mental world of the other. This can lead to a terrifying experience of absence that is likely to engender desperate confusion which can only be reduced by aggression.

Case C

David, aged seven, was referred for the treatment of his violence in relation to family members, children at school and himself (his rage was frequently marked by attempts to tear his own hair out). He could not be left alone with little girls for fear that he would molest them sexually. He was provocative and difficult to like.

David entered treatment and soon began to attack and provoke his analyst. In quieter moments, he shared with his analyst his experiences of being harangued by his mother and beaten by his father. The analyst's work with David was often in action-play. David's ability to communicate through language was frequently impaired. He would withdraw from affective contact with the analyst and mutter obscenities in the corner of the room.

David perceived his analyst as frightening and potentially violent. Interpretations of David's projection of his aggressive wishes onto the analyst were
rarely effective in curtailing his attacks and he often had to be restrained. At times he would look at his analyst and say: "What's the matter with you then? Do you want some bother?" The danger of harm from the analyst seemed ever present in David's mind. David's retaliation for what he perceived as threats from his objects often took the form of acts of considerable cruelty and vindictiveness.

More helpful than interpretation of his conflicts over destructiveness was a game which emerged in the course of the second year of treatment. David wished to repeat it day after day for months. The game consisted of David and his analyst making notes on "what I think you think I am thinking about you today". Increasingly he would call for a round of the game at times of heightened anxiety during his session. The content of what the analyst and the patient wrote evolved to include a large variety of feelings, wishes and fantasies. The useful aspect of this initiative was that David became better able to differentiate fears and wishes within himself and between himself and his analyst.

The game, together with analytic work on David's anxieties about being attacked and his terror of disintegration as a consequence of abandonment, helped him to settle into primary school. The move into puberty, however, overthrew his adaptive capacities and he was forced to accept a placement in a boarding school for maladjusted children. His analysis, which lasted four years, was successful insofar as his outbursts were gradually reduced in frequency and intensity and his attempts at deliberate self-harm ceased. His object relations remained limited and his sexuality failed to become normal.

We know that the aetiology of conditions such as David's is complex. From the point of view of his environment, at least, we can see a number of factors which may explain David's apparent reluctance to use his capacity to represent other people's thoughts and feelings. His parents' remarkable lack of empathy throughout his childhood seemed to lead to a failure on David's part to utilize his capacity to understand the mental states of others. By the time he entered treatment his parents clearly wished to be rid of him. Whether this wish preceded or followed his 'bad' behavior was not possible to determine. Whichever the case, it was evident that it was no longer safe for David to think about his parents' thoughts about him as these thoughts all too clearly entailed their wish to actually harm him.

David's interactions with his parents go some way to explain how it came to be intolerable for him to exercise his capacity to think about his parents' attitudes and actions towards him. His disavowal of his parents' intentions also inhibited a process of internalization which would otherwise have led to the perception of the self as thinking and feeling; hence he showed a limited ability to reflect on his own intentions and participate in the analytic process.

David's internalized relationship to unempathic parents and its externalization in the relationship with the analyst may be usefully considered from a psychological perspective in which it is viewed as arising from an inhibition of a vital psychic process.
David's theory of mind was latently present though it was dynamically inaccessible. David came actively to seek the analyst's cooperation to overcome disinhibition in initiating the 'who is thinking what' game. In this game David invoked his mental processes to identify the beliefs and desires of his analyst in order to make sense of interpretations. He thus came to realize within the analysis that it was safe to identify the other's intentions and differentiate them from his own beliefs and desires.
CHAPTER 2
THE DEVELOPMENT OF OBJECT RELATIONS

General Background

The concept of object relations derives from one aspect of Freud's early drive theory, when he distinguished four important aspects of drives: source, aim, pressure and object. In that context the term "object" had only a limited meaning; the person, part of a person, or inanimate object through which the drive achieved discharge or satisfaction. His later work developed this concept in two directions; relationships in a broader sense with real people in the external world were understood as an attribute of ego-functioning; at the same time the concept of internalization developed the notion of relationships as having a role in the building up of the inner world, the sense of self, conscience and other personality attributes, through the individual's identification with aspects of important people, especially their precepts and prohibitions. This latter concept was extended to include not only identifications with real people, but with perceptions of those people distorted by one's own desires, fears and fantasies; and the interactions between the individual's own ego, superego and id was partly explained as a recreation of previous relationships with other people. Through all phases of Freud's theory his emphasis remained on drives as the prime motivators in the building up of both external and internal relationships. Subsequent theorists have shifted the emphasis wholly or partly away from drives onto the detail of the interaction between the individual and his real or fantasized objects especially in the early years of life. The development of relationships has been studied in detail, and the development of the relationship to oneself has also been elaborated in parallel with relationships to objects. The term "object", with its connotations of the non-human, remained just about appropriate as long as the emphasis was still on the object's function as a target for the drives. But the term has been retained even though it seems scarcely appropriate to use it to refer to people, or even to parts or functions of people, such as the breast or penis, or the holding function of the mother. The continued usage of the term "object relations" serves to emphasize that we are dealing with internal representations rather than actual, externally existing people, even when the representations are relatively undistorted versions of the real people on whom they are based. Throughout life, earlier relationships set patterns for later ones. The repetition of these patterns is seen in analysis in the child's play, accounts of interactions with other people, and in his relationship to the analyst, including the transference.

The interactions between a child and important people in his life from birth onwards are normally assumed to be the most important of the environmental factors influencing personality development. Not only do the modes of relating which the child develops in his
relationships with parents and other caretakers provide models for subsequent relationships, but relationships play a crucial role in the development of psychic processes. Many aspects of psychic functioning (among which defense and affect expression are especially important) are partly modeled on the examples provided in these early relationships; and the child's relationship to himself, i.e. his view of himself, as well as his aspirations and his conscience, are influenced by the way his early caretakers view him and respond to him, and the demands they make on him. These external influences interact with the child's own inner experiences, fantasies and projections to determine his modes of relating.

The development of object relations may be described from a number of viewpoints, and is very complex. But a simplified synthesis of the approaches currently in general use at the Anna Freud Centre may be attempted.

Levels of Object Relations: Birth to Latency

Level 1

The infant is born with a number of basic capacities for recognizing and interacting with his own mother, which are complemented by reciprocal capacities in the mother. Biologically based, these capacities in the child rapidly evolve into processes of emotional involvement and communication, the effectiveness of which depends partly on the child's constitutional endowment, partly on the mother's capacity to understand the child's signals and the appropriateness of her response.

Simultaneously with this initial interaction with the external world, other psychic processes are set going: the internal world of the child begins to develop with the initial differentiation and development of drives, emotions and the precursors of thought and fantasy; these developments may be facilitated or inhibited by the response of the external object (which may, of course, include caretakers other than the mother).

These initial interactions with the external world and the early developments in the internal world begin to combine into representations which will serve as the basis for the subsequent development of self and object representations and their modifications: a crucial early stage in the evolution of processes to do with object relations and self-organization. Manifestations of this level of development are occasionally recognizable in the relationship
to the therapist, most often in the form of primitive and overwhelming anxieties about helplessness or feelings of disintegration, but they are more often subsumed into later phases.

Level 2

The earliest level of relationship which is sufficiently organized to be fairly frequently recognizable in the transference is the need-satisfying phase, which may also be viewed as an essentially narcissistic relationship. Its main characteristic is that the infant perceives the external object as a satisfier or frustrator of the infant's needs and wishes, which include ego support as well as bodily and drive needs. The infant is not, at first, aware of the needs, wishes and other characteristics of the object. In the internal, representational world the self-representation is developing, and may at times be differentiated from the object representation, at others the object may be perceived as part of the self. These representations are not yet stable or unified, e.g. "bad", frustrating mother may not be experienced as the same person as "good", gratifying mother, and the child may be unable to sustain the sense of being in a safe relationship if the real, external object is absent for any length of time, or is not attending appropriately to the child's needs. In addition, the development of omnipotent thinking and more organized, though still primitive fantasy permits the beginning of distortion of self and object representations. The earliest identifications with the caring and controlling functions of the object begin to influence the style of the child's developing ego-functioning and conscience.

These two early levels of relating fall within the oral drive phase, hence their manifestations in therapy are apt to be expressed in oral imagery, e.g. the child may portray himself as devouring or spitting out his object.

Level 3

Bridging the transition from oral to anal drive phases, and hence able to be cast in the imagery of either, is a stage in which the increasing coherence and stability of self and object representations, together with the child's maturing motor competence, permits a move towards independence and separateness from mother, which results in battles between mother and child. The child may, for instance, refuse to take in food, or to produce faces when his mother wishes; characteristically he wishes to do things by himself and in his own time, but also to have mother at his beck and call. The way such interactions are handled by the pair in the external relationship may then become built into the further development of internal representations, where they may set a pattern not only for subsequent relationships,
including that to the therapist, but for the child's ego style. An example of this would be reluctance to take in or give out information, a common cause of learning disturbances, also a common form of resistance in analysis. The anxieties, shame and guilt, and pride the child experiences at this level often have a powerful influence on his developing conscience, which is characteristically presented in analysis in sadistic bullying of the therapist, or in exaggerated fear of punishment by the therapist for real or imagined attacks. Exaggeratedly omnipotent idealized and denigrated self and object representations may develop at this time and are often portrayed in analysis. Relationships with peers reflect the child's self-centredness, with battles for possessions and priority in activities and the attention of adults.

Level 4

The sufficient resolution of the battles for independence and separateness permit a more balanced relationship with mother, in which the conflict of interests and ideas can be tolerated, and a modus vivendi can be negotiated; compromises can be reached in the external relationship because the internal representations include a sufficient sense of strength, stability and continuity of self, and some awareness of the needs, wishes and rights of others; reciprocal relationships with other children begin to develop. To pride in being able to do and produce things alone is added pride in bodily and mental prowess, and the wish to be admired is an important addition to the wishes from the earlier levels to be loved and served by the object. "Showing off", if successful, enhances the child's self esteem, but failure lowers it. Ideals become somewhat less based on omnipotent fantasy, and somewhat more on possibilities of potential real achievements.

This level of relating coincides with the shift from anal to phallic phase; in therapy the image of either phase may be used to express such manifestations as competitiveness and wishes to be admired by the therapist. At this level, whether the child copes with failure by trying again or by giving up, depends to a large extent on the object's ability to give the appropriate help and encouragement which the child can then internalize in his own ideals and conscience. Gender identity, already established at an earlier level, develops into a specifically sexual identity, which may become the focus of self pride or denigration as well as envy or denigration of objects.

Level 5

Thus far the child may have developed many relationships with different individuals. Now, at the oedipal level, he becomes more acutely aware of the existence of relationships between other people from which he is excluded, and is specifically interested in sexual
relationships. He longs for one parent for whom he is in rivalry with the other, and he fears retribution; his allegiance may change from one to the other; concern for and protectiveness to the love object develop; at this level the often prolific and complex fantasies played out among the self and object representations in the internal world find only a pale reflection in the child’s external relationships; they are often, however, the easiest elements to spot in the transference reflecting, as they do, the nodal point for neurotic conflict. This is the level of object relationships at which the consolidation of conscience and ideal self and object begins, subsuming elements from earlier levels; self and object representations also begin to consolidate their final form, and the internal relationships between all these representations and personality structures become more fixed.

Level 6

Next comes the so-called latency stage, a term deriving from Freud’s concept of the biphasic nature of human sexuality in which the early infantile surge of sexuality subsides with the resolution of the Oedipus complex, not to be re-aroused until the advent of puberty and pre-adolescence. In practice such a subsidence is found to be only partial in most normal-neurotic children, and not to occur at all in children with weak defenses and/or high levels of excitability, or in those who are exposed to over-stimulating environmental circumstances. In favorable developmental circumstances (internal and external) the consolidation of defense, social awareness, conscience and ideals, usually results in diminution of observable, explicit sexual and aggressive fantasy as well as a change in the content of fantasy. In therapy this is often manifest as a reluctance to let the therapist know about the fantasies, or to be themselves aware of the underlying sexual implications of their fantasies, and those that are told or played out are increasingly displaced away from the child’s own body and from himself and his family. Children often prefer to engage the therapist in formal games with prescribed rules and structure rather than in free fantasy play, so that it becomes more difficult than with younger children to discern the underlying transference. What these games often reveal is the child’s developing relationship to his own conscience and ideals, in the way he applies, observes or bends the rules, as well as in what is externalized onto the therapist; and the fluctuations in self esteem are often observable in his reactions to winning and losing. The intellectual development of this period and entry into school provide the child with a wider range of interests and opportunities for learning. Particularly in the early stages, the child’s curiosity and developing interests often reflect the sexual curiosity and fantasies of earlier levels of relationships, sometimes fairly obviously, often symbolically, e.g. prowess and skill in computer games may replace bodily forms of exhibitionism and more direct aggression. The inner struggle to subdue infantile sexual fantasies, combined with increasing capacity for independence is reflected in the widening
range of the child's external relationships; peers become increasingly important as sharers
of interests and activities, as role models, confidantes, companions and moral support in new
situations; other adults, as alternative role models and caretakers, become valued for the help
they can give the child both in developing his interests, skills and intellect, and in beginning
the long process of disengaging from his family.
CHAPTER 3
THE PSYCHOANALYTIC PROCESS

Definition

The psychoanalytic process consists of changes occurring within the analysand's mind which arise from changes in mental representations and/or the freeing of developmental processes; ideally this is due to increasing insight into the determinants of past and present experiences and behavior, which opens up possibilities for changes in adaptation. It can, however, also occur without obvious or explicit insight, arising from the patient's experience in interaction with the analyst.

The interaction between analyst and patient is the external setting which facilitates the (intrapsychic) changes in the patient's inner mental economy and functioning. The analyst's role is to facilitate or intervene in this process of inner change, by addressing those issues of which the patient was not hitherto aware, but which are contributing to the patient's difficulties. The psychoanalytic skills required to recognize, understand and interpret these issues to the patient derive from the analyst's lengthy clinical training and experience combined with his thorough theoretical grounding in the intricacies of mental functioning. The impetus for the process of change can only come, however, from forces which already exist, at least potentially, within the patient; these forces cannot be created from nothing by the analyst's interventions, but they can be liberated, enlarged and facilitated. In other words, the analyst's interpretations may offer the patient alternative or "new" representations, but psychic processes cannot be offered in the same way, only set free if they are potentially available in the patient.

In classical adult analysis the psychoanalytic process involves changes in mental representations via the revival in the transference of earlier conflicts, usually now unconscious; linking these in an explanatory way with present day experiences, feelings, symptoms and other problems; the re-evaluation of these past conflicts in the light of present-day understanding; and the re-integration of this new insight into the individual's mental functioning and behavior. The tendencies towards adaptation and integration (the synthetic function of the ego) provide the impetus for this process once the earlier, maladaptive conflict solutions have been dismantled by the analyst's interpretations and the patient's resulting insight. The revival of past conflicts involves the reduction of present-day character traits, symptoms, affective states and conflicts to their infantile determinants in early relationships and experiences. The now more mature individual can reassess and react differently to situations for which his understanding and adaptive resources were developmentally, psychologically or socially inadequate at the time of their original
occurrence. This is the process which occurs in the analysis of adults or children whose disturbance lies primarily in the realm of representations, those whom we usually call "neurotic".

In cases of borderline, narcissistic or developmental disturbance, involving significant degrees of deficit or distortion in specific groups of psychic processes, the psychoanalytic process must also include the restarting of stunted processes, and returning deviant processes to the path of normality. This may sometimes be done by the simple removal of inhibitions which then allows stunted development in specific areas to restart; but often much more laborious work is required to build up missing representations once the process of creating them has been released. In these cases the processes or growth that occur within the analytic setting are equally or more important than the gaining of insight.

Child analysis is generally more complicated than adult analysis. Children have rarely given informed consent to therapy, and, in the early stages of treatment, are not willing partners in the search for insight. They may, however, come to understand and cooperate as they experience the benefits of treatment. Although they may lack the wish for self-understanding, children may have other motives which will bring them to therapy, such as a wish to feel better (e.g. less worried or more worthwhile), or to please their parents, the relief of being understood, pleasure in playing or in the undivided attention of an adult, or pleasure in exercising developing processes and achieving new developmental steps.

Because normal development and maturation are still proceeding simultaneously with the analytic process, normal developmental and psychoanalytic processes intertwine. The advantage of this is that developmental processes give a powerful additional impetus to the process of change; the major disadvantage is that children lack, in varying degrees according to their stage of development, the cognitive and affective capacities needed for fully mature self-understanding and for active collaboration in the process of self-observation and gaining insight.

Because their capacity for relationships is still maturing, and because relationships play a vital role in the development of psychic processes, even in the analysis of neurotic children whose main difficulty lies in the distortion or suppression of specific representations the analyst may be used not only for transference reworking of past conflicts, but as a new relationship within which the child may proceed to new levels of
development. Thus the interaction between patient and analyst may acquire greater importance in its own right, playing a more important role in the psychoanalytic process than simply providing the setting for inner changes to take place.

In process disturbances, the major difficulties are not based on conflictual representations but on the actual inhibition or stunting of growth of specific psychological processes; this stunting of growth may have originated as an extreme form of defense against intolerable conflict; alternatively it may be due to constitutional deficit or hypersensitivity in the child, or to parental failure to provide for certain developmental needs. In such cases the therapeutic process required may be one in which the interaction between analyst and patient becomes the central feature, making use of the fact that the development of psychic processes is facilitated by the child's object relations. The first task will be to establish a sufficiently trusting relationship for the child to feel safe enough to confront whatever situation gave rise to the original inhibition of functioning: e.g. to face a hitherto intolerable conflict; or to become aware of failure in himself, or disappointment in or fear of his parents; or to bear and manage hitherto overwhelming affects. In order to get stunted development going again, the analyst may temporarily have to supply missing aspects of the child's own functioning, and/or of parental relationships (those which are needed to support the development of deficient processes or to correct deviant ones), as well as interpreting conflicts. Such work is to be distinguished from what is commonly understood as the classical psychoanalytic process (in which reviving and rearranging maladaptive conflict solutions results in changes in mental representations), since it is aimed at restarting the processes which create these representations, or which determine the way representations are manipulated. Different techniques are therefore required in this type of developmental assistance, which is an important part of the work of child analysts.

Even in basically neurotic disturbances there is often some degree of interference with processes as well as representations, so that even in "classical" child analysis the psychoanalytic process must be viewed as including not only the internal psychic sequence; revival, re-evaluation and re-integration of earlier, and sometimes of current conflicts, but also the removal of obstacles to development via interaction with the analyst as a new object who offers the child new possibilities for viewing and handling his experience. This is what Anna Freud referred to as the neurosis being underpinned by developmental difficulties.
Aims

To set the psychoanalytic process in motion at the beginning of the analysis and to keep it going towards the desired conclusion, whilst allowing the patient sufficient freedom to express and pursue his own ideas within the analysis. It needs to be recognized that the overall aims for the outcome of analysis in ideal terms may not coincide with the aims of a particular analyst for a specific patient, or with the aims of the patient or the patient's parents. While the overall aim of every analysis is for the patient to achieve optimal functioning (according to his own limits) in relationships, in instinctual life, in working life (which in the case of children includes learning through play and study), and in creativity, the specific aims of analyst, patient and patient's parents may differ, and compromises may have to be negotiated.

In representational disturbances the main technical aim is to facilitate the revival in the transference of past conflicts and relationships, where they can be understood, reexamined, and reworked into better adaptations, and, in the case of children, to facilitate the adaptive resolution of current conflicts, and the overcoming of obstacles to development. In process disturbances the main aim is to create a setting in which the child can lift inhibitions on developmental processes and confront the previously intolerable conflict or situation. In this work, it is sometimes the analyst's aim to create conflict where none was previously allowed to exist.

In addressing therapeutically disturbances deriving from the inhibition of mental processes, the patient's active mental involvement is elicited by the analyst's attention to the elaboration of the preconscious mental content of the patient. This mental involvement gradually brings about a reactivation of inhibited mental processes and thus leaves the child open to a gradual restructuring of distorted mental representations through further analytic work. The analyst's interpretation sets the patient's mind a challenge to identify connections and integrate the interpretation with his current view of himself, his desires and his preconscious beliefs. In order to link the analyst's interpretation of the content of his mind to his current mental state, the patient will be obliged to reinvest his inhibited mental capacity. In the best of situations the patient's mental work recapitulates that of the analyst, albeit within the limitations set by the child's level of development.\(^3\) The patient's passive observation of the analyst's use of the capacity may further encourage the patient to reactivate inhibited modes of mental function.

\(^3\) It should be noted that, in this context, the interpretation does not need to be accurate in order to be effective, although one may assume that accurate interpretations are more likely to be inherently challenging for the patient and thus to lead to his mental involvement.
At the Anna Freud Centre psychoanalytic processes are tracked by criteria which refer to the extent to which the child is returning to the path of normal development. There are externally observable criteria e.g. whether the child is capable of age appropriate levels and forms of relationships, of phase-appropriate expressions of curiosity, sexuality and aggression, of age-appropriate affect-expression and levels of thinking. However, more important are the internal criteria, the changes in his inner world, upon which the external changes depend, i.e. in his needs and wishful impulses, his conscience, his self-evaluation, his ideals, his cognitive and intellectual functioning, his internal object-representations, and the interactions between all of these.

These changes, which constitute the psychoanalytic process, may be viewed in macroscopic terms of a sequence of major shifts from beginning to end of the analysis; or they may be viewed in microscopic terms of minor shifts within one session.

**Means**

The establishment of a trusting relationship which will allow the child to overcome fears of using his functions and capacities and of experimenting with new ways of being and acting, leading to a treatment alliance within which the child can attempt to cooperate with the analyst. Interpretation: the analyst's commentary on the child's talk and play which draws attention to underlying feelings and motives of which the child is unaware, or is avoiding recognizing; followed by working through: the repeated examination of similar difficulties in a range of situations and from various points of view. Interpretation is especially directed to the transference: the way in which the child's relationship to the analyst is dominated by real or fantasized earlier experiences and interactions between the child and the primary objects; to resistances: the refusal to pursue a line of thought felt to be dangerous and/or to take in or think about ideas offered by the analyst; to conflicts: the presence of contradictory wishes, aims or ideals; and to the child's self-evaluation: the evocation of feelings about his own "goodness" or "badness", i.e. about the acceptability or unacceptability, safety or danger of aspects of the self. Verbalization of affects: feeling states which are primary organizers of the child's mental functioning. Developmental assistance: which includes interpretation but also other forms of intervention drawing attention to delays or distortions in psychic processes and assisting the child to modify these processes, especially those to do with appraisal of the self, of relationships, and of other situations. All of these interventions must be adjusted to the child's level of development and comprehension. These "means" are all discussed more fully in the sections which follow.
Limitations

The extent to which the psychoanalytic process can be set in train and kept going depends on: the patient's capacity and willingness to participate in the process; the analyst's capacity to understand the patient's material to keep its direction and movement in mind, not allowing the analysis to get stuck, go in circles, or become diffuse or disorganized. In particular it depends on the analyst's capacity to distinguish between repression due to representational conflict, and the absence or stunting of psychological processes. In cases where the stunting of psychological growth is severe and widespread it may be difficult or impossible to restart growth. In child analysis the understanding and support of the parents is also required to keep the child coming during phases of resistance, or through other difficulties which might interrupt the process.
CHAPTER 4
CONFLICT

Definition

Conflict is a normal part of mental life and occurs whenever contradictory wishes, aims or ideals are simultaneously present. Such conflicts only become problematic for the individual and material for the analytic work when they become linked with basic unconscious anxieties and no adaptive solution can be found in reality. There are characteristic conflicts for each stage of development, as well as more particularly individual ones. In normal development, for each conflict that arises, some form of compromise is reached which allows the individual to feel and behave in a way acceptable to himself and to the culture in which he lives. There are three forms of pathological development: (1) the conflict may remain unresolved; if it also remains unconscious the individual then feels inexplicably uneasy, anxious or depressed; if it reaches consciousness in some form (derivatives), the individual finds himself experiencing contradictory feelings or wishes; (2) An unconscious solution may occur which is, however, unacceptable to the individual and/or people in his environment (symptoms, character traits, behavioral or affective disturbances). Unresolved or pathologically resolved unconscious conflict is the basis of all neurotic disorder and plays an important role in most other forms of emotional disturbance. (3) The anxiety aroused may be so overwhelming that the individual can find no way of surviving it except to abandon functioning: i.e. to avoid all processes which arouse or attempt to solve conflict. This results in stunting of development and personality deficits.

Aim

The Analyst's aim is to recognize and revive, preferably in the transference, past and present conflicts which are causing problems for the individual, and to interpret their unconscious elements in sufficient detail to allow the individual to find a better adapted solution; this may involve the re-starting or correction of stunted or deviant processes.

Means

The Analyst scans the patient's material (play, talk, expressions of feelings, attitudes and towards the analyst) for signs of contradictory wishes, feelings, aims or ideals, for evidence of defense, and for inappropriate reactions. He also pays attention to what is missing in the child's behavior; this would include both lack of control due to insufficient conflict, and over-control producing inhibition, as well as missing processes. The analyst gradually builds up in his own mind a picture of the way the child has resolved conflicts or
ailed to resolve them; as he judges the time is right he gradually communicates this understanding to the patient. The analyst traces themes for the patient, spelling out the ramifications - (working through).

Case Illustration

Case D

Derek, aged 3, was referred for a sleep disturbance, dating from the birth of a younger sister, in which he frequently managed to separate his parents by getting one or other of them to sleep in his room. When he began treatment he clung to his mother, refusing to let her leave the room. Early material included games about children being sent away from home, and he often sang a nursery rhyme: "Tom, Tom, the piper’s son, stole a pig and away did run", his main concern being Tom’s going away. From this and similar evidence the analyst concluded that Derek feared being sent away from his mother, probably because of conflict over oedipal wishes, or because of the fear of talion punishment for wishing to get rid of the new baby. The analyst first interpreted only Derek’s fear of being sent away, but as this released further material it became possible to interpret other elements in the conflicts. For instance, Derek played games of stealing various possessions from the analyst which could be taken as his wish to steal a big penis or a baby. He played games in which a mother got angry about father cluttering up the house with rubbish, and threatened to throw father and rubbish out. In the treatment room he several times made a pile on the floor of his own toys and sat on it, so that the analyst could not have any of his belongings. Both his wish that his own mother would get rid of his father and baby sister, and his fear of talion punishment, himself being sent away or robbed of his precious penis, could be interpreted from such material. As such ideas were made conscious, he could begin to make connections for himself, e.g. he told the analyst a story about a clown whose nose was cut off, and began to stammer as he did so. (The stammer was another of his referral symptoms, which was, however, intermittent). The analyst voiced Derek’s conflict; he enjoyed this story of another person losing his nose/penis, but felt that it was bad to wish such a thing, so he held back the words. Next day Derek came saying he wasn’t going to tell that story any more because it had given him a sore throat (minor ailments were a frequent occurrence). This could be seen as a potential tendency to stunt or distort imaginative processes. The analyst spoke of Derek’s belief that he deserved punishment for his bad thoughts. The working through of material such as this gradually reduced the sleep disturbance, allowed Derek to separate from his mother, and cured his stammer, as well as protecting the development of his imaginative processes.

Limits

The analysis of conflicts is most efficacious in neurotic disturbances, where it constitutes the main area of analytic work. It also plays a part in some forms of developmental, borderline and psychotic disturbances where conflict has led to the stunting of developmental processes. However, in these disturbances it is not, by itself, sufficient to effect amelioration; other techniques are needed to restart the processes.
CHAPTER 5
AFFECTS

Definition

Affects are regarded as complex states which are rooted in biology and have important psychological functions. Affects are primary organizers of the child's mental functioning, insofar that they provide the basis for attributing meaning to experiences. They are thus used to monitor, evaluate and direct action, thought, defenses and symptoms. The conscious or unconscious experience of affect acts as a signal which can set in motion the child's adaptive capacities. Thus they serve to prevent the individual from becoming overwhelmed by a state of helplessness associated with earlier experiences of massive discharge.

Aim

Affects are essential in the routine search for unconscious meaning in the child's verbal and non verbal behavior in psychoanalysis. They are central to clinical work with children because they guide the analyst to the child's conflicts and fantasies, and they are relatively experientially accessible to the child. Therefore understanding of the child's affect serves to encourage the child to bring analytic material. Identifying and accepting the child's affect helps the child to listen to and elaborate the analyst's interpretations and therefore has a further role in facilitating communication and understanding between the child and the analyst.

Means

The most basic interventions consist of labeling, describing and elaborating what it is that the child feels. The analyst will draw attention to the child's efforts to avoid unpleasurable emotions and the ways in which he seeks to protect himself from anxiety, guilt, shame, and other distressing affects, e.g. by altering or reversing certain feelings in favor of less distressing substitutes. Such interventions foster a feeling within the child of being understood by an adult who takes what he feels seriously or at least views it as important. This will increase the child's own interest in making sense of his emotional experience.

Affects which accompany unconscious conflict and thus form an integral part of unconscious fantasy have a priority for the analyst and are often addressed in terms of the way in which they function to arouse or reduce anxiety. Certain negative affects such as guilt, shame, feelings of humiliation are often discernible in derivatives of unconscious fantasy,
whether in dreams, the transference or other aspects of the child’s material. Interpretations which refer to these affects and their important motivational role in the formation of defenses are crucial in that such interpretations reduce anxiety. However, such interpretations of negative affects also engender resistance. The accurate identification and their appropriate repetition in various contexts are essential in the process of working through conflict. Affects generated by the child’s experiences in the external world and outside of the analytic situation are also addressed particularly with children who live in environments which fail to meet legitimate developmental needs.

Clarifying or interpretive interventions will arouse specific affects within the child and the analyst will attend to these. This process facilitates the child’s emotional investment in the person of the analyst and is thus an important prerequisite of the development of the transference.

In some child analytic treatments the analyst will be confronted by affects of overwhelming intensity. In others, there may be a striking absence of affect. Both these situations signal the presence of inhibited mental processes, particularly those governing affect regulation. The intense affects arise as a result of the failure of the child to create mental representations necessary to deal with a particular environmental challenge. Intense and unforgiving rage at the holiday break may alert the analyst to the child’s incapacity to create within himself a mental representation of significant aspects of the analyst in the analyst’s absence. In such cases the interpretation of the overwhelming quality of the affect and the helplessness this engenders may be the most useful aspect of the interpretation.

Case Illustration

Case E

Tom, aged four, was referred for analysis because of his reckless self-injurious behavior, his aggression towards his baby brother and his difficulty in adjusting to nursery school.

In analysis he was sometimes wild. On one such occasion early on in treatment the analyst said: “I think you are secretly worried that I am going to hurt you and that is why you become so angry and frightened”. In this way the analyst became able to reduce Tom’s anxiety and Tom again became able to engage the analyst in complex fantasy play. These games contained derivatives of the unconscious fantasy of disposing of his brother, castrating his father and hurting the analyst in the transference, for example, giving babies to the rag-and-bone man, constructing airplanes ‘to fly into big men’s eyes’ or staging burglaries from his locker.
When his aggressive wishes towards the analyst and his anxiety about these were verbalized, Tom sometimes became wild and threatened to hurt himself, for example climbing up on to the furniture and threatening to jump. The analyst interpreted how Tom felt bad about himself (guilty) for some of the nasty things he imagined doing to his brother, father and the analyst. Later in the treatment when Tom referred to, rather than impulsively enacted, self-injurious tendencies the analyst was able to show him how his wish to hurt himself came about when he feared feeling hurt by the analyst no longer loving him. Through their relationship with one another Tom and his analyst came to understand that Tom’s rough and aggressive to his depressed and confused mother was a consequence of his fear that if he gave up the aggressive part in his relationship with her he would have no relation to her at all.

Limitations

While the long-term aim is to identify and label affects with a view to enhancing the understanding of experiences and facilitating adaptation, this is a lengthy aspect of the analytic process. At any particular moment it may not be appropriate to verbalize affect if, for example, it could disrupt defenses which are, at the moment irreplaceable, such as reaction-formations; or at a point when the child is certain to take the intervention as criticism which would lower self-esteem catastrophically.

The child’s wish to control his affect should be reflected by the interpretation which should avoid the implication of an invitation to express affect.

Of course in various circumstances the analyst may use the affect as a guide without necessarily interpreting it. Affects may be stunted in certain children with particular process inhibitions and interpretations of affects in such cases will not lead to relief.
CHAPTER 6
DEFENCE AND RESISTANCE

Definition

Defense is an aspect of normal psychological functioning (ego-functioning), usually unconscious, the aim of which is to protect the individual from the danger of being overwhelmed by anxiety and/or catastrophic loss of self-esteem. These affective states are expected to result from the adverse effects of recognizing and/or acting upon feelings, instinctual or other wishes or attitudes. The most important adverse effects are: guilt, shame, helplessness, loss of an important person or of that person's love, loss of self-cohesion or well-being. Defense is thus mainly directed against aspects of the internal world, but may also be directed against aspects of the external world if these threaten to arouse overwhelming anxiety or loss of self-esteem. Normal defense is directed against specific representations, and results in the individual having sufficient self-control and adaptability. In normal development there is a range of defense appropriate for each stage (age). In pathological defense the range is restricted or is inappropriate for the child's age. This results in major interferences with normal functioning, e.g. excessive inhibition or phobic anxiety. In cases where the danger of being overwhelmed by anxiety or catastrophic loss of self-esteem is unusually great, defense may be directed against the processes of thinking and feeling, resulting in a stunting of development and deficits in all subsequent functioning.

In the analytic situation, defense becomes manifest as resistance: the refusal to pursue a line of thought felt to be dangerous, and/or to take in or think about ideas offered by the analyst. The most serious resistances are unconscious; in addition, children often consciously withhold thoughts and feelings.

Aim

The analyst's long-term aim is to modify pathological defense by broadening the range of defenses available to the child and reducing the use of excessively restricting defense so as to allow the patient greater freedom, through more efficient self-control and adaptability. The short-term aim is to demonstrate to the patient the operation of each defense as it occurs, on the assumption that awareness is the first step towards modification. In cases where defense has resulted in stunting of the general development of feeling and thinking, development has to be re-started.
Means

The analysis of defense against specific representations is done by drawing the patient’s attention to examples in his play, in his descriptions of experiences, and in his attitudes and behavior towards the analyst, especially his resistances. In this way the analyst spells out for the patient the nature of the defense, what he is defending against, and the effects the defense has on his functioning. This usually allows the patient to see alternative ways of handling the situation, but the analyst may also draw the patient’s attention to such alternative ways. Thus, over time, the analyst repeatedly and in different ways demonstrates how specific defenses interfere with particular aspects of functioning.

Case Illustration

Case F

John, aged 9 1/2, had reacted to egocentric, divorced parents and unpredictable changes at home by becoming anxious, passive and miserable. Amongst other problems, he had difficulty in learning at school, in spite of excellent ability. Two aspects of the work on this were: the recognition of anger and confusion experienced in relation to his parents and teachers, and the understanding of his incompetence and dependence as a way of holding on to relationships.

John was often frustrated with people such as teachers, or his therapist, for making mistakes, and not providing him with what he needed. The therapist noted that John was anxious about his own mistakes and muddles, and was always alert to this around him. She also linked his complaints, on many occasions, to his frequent experiences of being painfully let down by each parent. He protected them from his anger, initially by rationalizing their and blaming himself, then by displacing the anger on to other people, such as teachers, which then interfered with being able to learn from them. John began one session crying uncontrollably because a master had finished a class late, and John did not have time to read a comic in the waiting room. The therapist was able to help him see that his misery and anger was really about some recent confusing and unreliable arrangements to visit his father. This link led to the recovery of painful memories of neglect by each of his parents, following his father's departure when John was 3 years old.

John brought many examples of his passive, dependent attitude to parents and teachers. He needed the to take responsibility for his homework, clothes, and so on, and blamed them for his muddles. He felt that his teachers and his therapist failed to explain things in the right way. He was frequently anxious about not being able to understand his homework, but on going through it with an adult it became clear that he already knew what to do. The therapist suggested to John on these occasions that he seemed to be frightened that if he could manage more independently, then people would cease to notice him or care for him. He became jealous of the baby of his father and stepmother, who got more attention through his dependence and incompetence. It emerged that a beloved nanny had left the family at the same time as John’s father, and that she had left to look after younger children. He became anxious that his therapist really preferred younger patients.
The therapist was able to help John see that he expected growing up to be accompanied by loss of support and interest including the termination of his analysis. As these anxieties were worked through, John became more creative and outstandingly successful academically.

When processes have been defensively stunted there may be nothing to draw the patient's attention to except the absence of functioning, and techniques may first have to be used to make the patient aware of these gaps. Mary, for example, by age three, had given up expressing nearly all her wishes, and had become apathetic, incurious, disinterested in most things around her. Before any actual analytic work could be done the analyst had first to watch Mary carefully for faint signs of the presence of any wish, interest or bit of curiosity, and not only verbalize these but often provide or actively help Mary to achieve gratification, so as to encourage further expressions. Then the analyst began encouraging Mary to find ways of handling her wishes, interests or curiosity herself. Only with this did Mary begin to experience frustration, anger, anxiety, guilt and shame, whose origins in conflicts could then be explored.

Limits

The analysis of defense is especially appropriate for conflict-based (neurotic) and some narcissistic disturbances in patients in whose defenses against specific representations are overly strong and rigid. In psychotic or borderline patients with weak defenses it has to be used sparingly and with caution. In older children, with rigid and excessive defenses already being built into their character, the modification of defenses will require lengthy working through in intensive treatment. In children whose thought and feeling processes have been stunted, analysis of specific defenses against specific representations will not by itself be sufficient to re-start development. In children with more moderate defenses, especially younger ones who are still changing developmentally, defenses can often be modified more quickly, even in brief, non-intensive therapy.
CHAPTER 7
OBJECT RELATIONS IN THE CLINICAL CONTEXT

Definition

The term object relations refers to: (1) the child's actual relationships with real people in the external world; (2) the processes of creation of mental, i.e. internal representations of himself and other people. These representations can be used for further processes of conscious and unconscious fantasizing, thinking and feeling about the interactions between himself and others; they develop as a mixture of perceptions of reality and projections of the child's own wishes, impulses, feelings and anxieties; (3) the processes of modification of these internal representations to produce versions of himself and objects which are idealized, denigrated, good, bad, etc., and the part they play in the development of conscience.

Aim

The overall aim is to make the patient aware of pathological features in his relationships to self and others, by demonstrating to him maladaptive identifications, distorted perceptions, inappropriate expectations and fears, thus helping him to modify not only his current modes of relating, but other aspects of his behavior derived from pathological aspects of relationships. As in any other relationship, the patient's relationship with the analyst reproduces aspects of the child's earlier as well as current relationships with important people, real and fantasized, as well as the interactions between the child's own self and conscience. A subsidiary analytic aim is to encourage this repetition, since it serves to reveal most vividly how the individual perceives important people in the past and present, what he expects and fears from them, and in what ways he is identified with them. These factors may also be explored in the child's accounts of relationships with other people, and in his play and other activities in treatment. But the relationship to the therapist is usually the most emotionally alive and immediate situation both for the patient to convey his feelings and ideas, and for the therapist to interpret them. The general transference reveals the influences from important past and present relationships which are likely to be found in all the child's external relationships; while the transference proper conveys especially the pathological and regressive elements which are responsible for the child's problems and therefore most require interpretation.
Means

Almost everything that happens during an analysis may be viewed in the context of the patient’s self and object relationships. There are two closely linked analytic tasks; the first is to pick out those features which are particularly useful at any given moment for helping the child to understand the problem areas in his functioning. (What is "useful" will vary at different points in the analysis according to how much the child already understands, how strongly he feels about it, how reluctant or willing he is to understand more, etc.). The second is to select the most effective way of interpreting these features to the child; directly in relation to the real external objects; in whatever displacement or projection onto other people, toys, or imaginary characters the child may be using; or in relation to the analyst, i.e. a partial or full transference interpretation. The possibilities for pathology in object relationships are almost limitless, but for each patient there will be areas of particular importance.

Case Illustration

Case B

In the vignette of Sam we can see that a central feature of his self and object relations is his verbalized wish to be a six-month-old baby girl, enacted in the analysis in his dribbling, smelling things and requests to be fed; it is a pathological solution to his dilemma about what kind of relationships he can safely have with his disturbed mother and deserting father. Various aspects of it are taken up at different times; his wish to be protected (not abandoned); to be small enough to get "inside" where it is safe; to be helpless and incapable as a defense against his own anger; his fear that he has driven his objects away; his conscience’s threat of retaliation. (It is presumably also a retreat from oedipal conflicts made excessively difficult to resolve because of mother’s treatment of him as her "little cavalier", and his success in taking father's place in her bed).

Limits

The exploration of pathological aspects of internal and external object relations is appropriate in any form of disturbance. However, the approach to be used, e.g. via interpretation of unconscious internal interactions as reproduced in the transference, via clarification of the dynamics of real, external relationships, etc., depends on the capacity of the patient to make use of the various approaches.
CHAPTER 8
SELF REPRESENTATION AND SELF EVALUATION

Definition

For clinical purposes the self may be defined as a grouping of experiences: bodily sensations, physical and mental feelings, and perceptions which, in the course of development, become increasingly organized into coherent self-representations, and acquire an increasingly important ideational content (including fantasy as well as rational thought about oneself). People are usually consciously aware of some aspects of the self, but other aspects are unconscious.

Self-evaluation can begin to develop only once there is a rudimentary sense of self, and sufficient perceptual-cognitive capacity to perform the evaluation. Deficit in either of these areas prevents the capacity from developing.

Self evaluation occurs on both conscious and unconscious levels. It consists of some form of self-contemplation which evokes feelings about what is observed; these feelings then serve as a guide to the "goodness" or "badness", acceptability or unacceptability, safety or danger of the aspect of the self under scrutiny, and consequently provide motivation for subsequent mental actions to modify that aspect of the self. This is a normal aspect of development essential to healthy growth, which works best when accompanied by only small (signal) amounts of affect. When the feelings involved become too strong they may distort the individual's judgment about himself, lead to premature or precipitate attempts to modify or rigidify the self, or even become so intolerable as to cause inhibition or distortion of the whole process of self-evaluation.

The content of self-evaluation becomes increasingly varied and complex in the course of development, and has to be understood in the context of the child's relationships to objects and self (see The development of object relations). Over time, the factors influencing self-evaluation come to include: the child's pleasurable and painful experiences of his own body and its functioning; the positive and negative feelings he experiences in connection with his own activity (mental and physical); the explicit and implicit attitudes, reactions, and demands of his parents and other important people; his fantasies about himself (what he feels he is, would like to be, or fears to be); the "commentary" he receives from his internalized objects, including his ideal self and objects and his own conscience; his realistic appraisal of his own behavior and achievements; and the conflicts which arise among all these.
The most easily observable results of self-evaluation are variations in certain broad categories of affect and attitudes such as self-esteem, self-denigration, anxiety, guilt, shame, pride, self-confidence, arrogance.

**Aims**

Most adults seek treatment because of dissatisfaction with some aspect of themselves; many child patients, even though they have not voluntarily sought therapy, express dissatisfaction with themselves during the initial assessment or early in treatment, and the hope of improving whatever dissatisfies them provides an important motive for the establishment of a treatment alliance. The primary aim of treatment then is to examine the causes for dissatisfaction and assist the patient either to change what he deems unsatisfactory, or to accept it by changing his evaluation of himself. For example, a child who feels stupid at school work may need help to understand and overcome defensive interference with intellectual functioning, so as to improve his performance if he is actually underfunctioning; but if he is setting himself impossibly high standards, he needs help to lower his sights (modify his ideals), and to be content with and proud of "lesser" achievements.

Children are most likely to be aware of dissatisfaction with themselves when their difficulties lie in discrepancies between ideal and self representations, and when there is relatively little stunting or deviation in the processes subsumed under 'self-monitoring' and 'self-evaluation'. What such children are aware of may range, according to their level of development and areas of psychopathology, from vague feelings of being bad or somehow wrong, through shame about aspects of themselves or their behavior or achievements, to guilt about bad thoughts or behavior. Many children, however, are not aware of dissatisfaction with themselves because they externalize all their problems, and are dissatisfied only with people or situations in their environment. The aim in this case is to help the child recognize his internal situation, i.e. what is going on in his representational world, how he unconsciously feels about himself and other people, and how this is influencing his behavior in and feeling about the external world. This understanding of his own contribution to his difficulties gives him the possibility of modifying the relations and interactions in his representational world and, therefore, to find better ways of handling his relationships and interactions with the external world. For example, a child who persistently complains of being unfairly treated in comparison with his brothers and sisters may be adamant in this belief, in spite of his parents pointing out the evidence that he is, in fact, receiving his fair share of love, attention, and material gifts. He may also be unable to enjoy the occasions when he is the one who is given preferential treatment, or may spoil outings.
and treats for the whole family by his dissatisfied moaning. With such a child, the therapist's first aim is to find ways of engaging the child's interest in his own self-representation as a neglected, ill-treated, unfavored member of the family, and in the reasons for such a biased self-evaluation. It might be, for example, a talion punishment meted out by his own severe conscience for his unconscious wish to have total possession of his parents and all that they have to give, which means depriving, or even getting rid of his brothers and sisters. Alternatively his self-esteem may have suffered an intolerable blow from perceiving and exaggerating a real deficiency, such as being smaller and less competent than his older brother or sister, so that this deficiency has come to dominate his self-representation to the extent that everything he has or is given by his internal objects seems inadequate. Being made aware of the possibility of reducing guilt or improving self-esteem may provide the child with a motive for working on changing the way he treats himself, rather than vainly demanding a change in the way other people treat him.

It should be noted that a certain amount of externalization is normal in young children (up to level 2 to 3 of object relations) while they are still sorting out the boundaries between self and objects, and before reality orientation is firmly established. Very young children who are not seriously disturbed may, therefore, need only minimal help to further normal development away from the use of externalization. Only in the case of older children, where it persists to an excessive extent and amounts to a defense against awareness of one's self-evaluation, is more extensive work required.

Other children have not developed a self-evaluating capacity, or it has become so permanently distorted that all attempts at self-evaluation go awry. In this case an essential aim is to help the child develop or free the capacity, without which he will never be able to make realistic assessments of his own strengths and weaknesses, the nature and quality of his relationships, his present achievements or future prospects. For example, some children with extreme forms of narcissistic disturbance beginning from an early age (see The development of object relations; level 2) may suffer from a stunting of development both in their object relationships and in their thought processes, so that they combine egocentric, need-satisfying relationships with omnipotent thinking and lack of reality-testing. Their inability to be aware of the real motives, feelings and attitudes of external objects, together with their belief that they control people and events by wishing and fantasizing, mean that at best they persistently misunderstand other people and events, and are bewildered when things do not go as they expect. At worst it means that they may become quite out of touch with the real world, and retreat into fantasy life, or fly into rages at the slightest threat to their belief in their own omnipotence, or become terrified at minor mishaps since they do not distinguish these from major catastrophes, and hold themselves responsible for everything.
that happens. Such children need, in addition to the exploration of their representational world and the opportunity to rearrange it, time enough to catch up on missing development with the help of the therapist who may have to supply the object's normal role in development, particularly if the child's own parents are deficient in some of the necessary capacities.

Means

Examining one's self-evaluation is always a delicate and painful matter; revealing the "bad" aspects of oneself to another, including (perhaps especially) an analyst, feels, to many children, even worse. Great tact is therefore required of the analyst: this does not mean allowing the child to avoid painful topics, but approaching them in a way that is sympathetic to the child's suffering, minimizes the possibility for the child to feel accused or criticized, and offers hope of change for the better. In the case of children who are already dissatisfied with themselves, it may be sufficient to acknowledge the child's painful feelings whilst offering some thoughts about what has gone wrong in the inner world to cause such feelings, thus opening up the possibility of putting it right.

For example, Sam (Case B), on his sixth birthday announced that he was "the unhappiest person in the world". In the Diagnostic Interview he put forward the implausible explanation that his misery stemmed from the number 6 and his new association with it. In treatment it was immediately evident that he located the source of his unhappiness outside of himself or anything within his control. When his analyst first commented on the importance of working together to understand the causes and meaning of his sadness, Sam looked perplexed and later said that they were going to understand his sad feelings by reading one of the books in the analyst's consulting room. When he drew a baby bird falling out of its nest in a tree, the analyst suggested that sometimes perhaps he too was frightened that he might suddenly feel terribly lost, like the baby bird. Sam replied that he would always be able to find his way home.

Children who externalize their difficulties are often quite comfortable with this solution; so that any approach which aims to make them take responsibility for their situation is likely to make them feel worse, at least temporarily, as repressions and other defenses are undone, and the child becomes aware of the unpleasant feelings which originally gave rise to the defense. In this case the therapist has to watch for areas where the child is already experiencing some unpleasant feelings which might provide a motive for wishing to change, and a starting point for further exploration. For example, J. was referred at age 6 for encopresis. The diagnostic assessment also revealed him to be physically
clumsy and neglected-looking, doing badly in school, and finding it difficult to make friends. These latter difficulties steadily improved during the first two years of treatment through the analysis of conflicts giving rise to shame and guilt. But he remained quite unable to contemplate his soiling as an issue, consciously insisting that his mother and au pair did not mind cleaning him up, unconsciously deriving much secondary gain from the gratifications of these regressed aspects of his relationships, and ignoring his father’s clearly expressed anger and disgust at the symptom. It was only when he one day arrived at a session convinced that on the way there his analyst had driven past him and failed to offer him a lift, that he for the first time revealed some distress, believing that the analyst had been afraid he would make her car smelly. For the first time he could listen to the analyst saying that it must indeed be a great worry to feel that she and other people might avoid him because of his smells, and perhaps he wished he could do something about it.

The therapist must also establish himself as a person who can be trusted to understand the child’s fears and help him face them, different from those who try to change him by criticizing or instructing, but also different from those who assume he cannot or should not change. This trust may be promoted in part simply by allowing the child to experience the therapist’s attitude to him; but it will usually also require interpretation of the inevitable externalizations in the transference. For example, we commonly find that at the beginning of therapy, or even during the diagnostic assessment, a child will bring material indicating an expectation of surgical or medical “attack”, since he is coming for “treatment”; or will refer to his sessions as “lessons”, seeing the analyst as a strict teacher who will tell him what he must or must not do, without consultation about his own wishes and needs; or will fear being told that he is so bad that nothing can be done about him except to send him away (for many children a not infrequent parental threat, or actual experience). Interpretation of this generalized transference helps the child to explore the analytic situation as a different experience.

Sometimes children who externalize are not comfortable with this solution because they then feel unhappy about the “badness” of others towards them. This sometimes provides a motive for self-examination, since it may come as a surprise and a relief to the child for self-examination to the clinic to be shown a different point of view, which offers him the power to change the unhappy situation by altering something in himself, as an alternative to changing others. Derek, for example, at age three, was afraid to let his mother out of his sight, and his material indicated many fears of her becoming angry and sending him away. He was also beset by fears of giants who lurked in cupboards waiting to jump out and grab him; he had to hold tight to the therapist’s hand in order to get past the danger. Initial attempts to explore the nature of these giants resulted in their transformation into
policemen who would pursue Derek and imprison him for naughty things he had done. The therapist told Derek that perhaps the policemen were not really outside chasing him, but inside him, a bit of himself that thought he was bad. Derek literally danced for joy, singing, "I've got a policeman inside me. I've got a police car inside me". He became enthusiastic about exploring the workings of this internal policeman.

Children who use extreme forms of externalization, aimed at avoidance of awareness of self-evaluation, in which their main defense is projection of all bad aspects of the self onto objects, pose particular difficulties. They readily experience any new person as "bad", and almost any approach is threatening; the transference will largely consist of such projections, and simple experience of a different object is of little value in counterbalancing such a strong, immediate transference. Only consistent interpretation of the child's distorted perceptions of the object, and exploration of the feelings, conflicts and experiences which have contributed to such extensive use of projection has any chance of being effective. The task is slightly easier if the child has a more benign object representation available which can be activated in the transference. But in the most extreme cases (paranoid personalities) the whole self-evaluating process seems to have been hijacked into the service of projection so that the child persistently misperceives every object's behavior and distorts all object representations.

In such cases, in addition to examining and correcting distortions in the child's representations, the therapist has to engage the patient's interest in the actual processes involved in self-evaluation, and in the minutiae of how these processes get distorted. For example, if the child lives with a disturbed parent who habitually insists on the child's conforming to the parents view of what is "good" and "bad", the main process involved may be the child's identification with the object's ideals and superego, in which case the child has to be helped to reduce this identification with the parent. Alternatively, if the parent's reality-testing is faulty the child will require specific help with the process of reality-testing, or perhaps with aspects of the development of secondary process thinking, such as giving up his belief in his own or the object's omnipotence, so as to perceive the external world and himself more realistically. In such cases the parents will usually also require help.

Robert, for example, entered nursery school at age 3 1/2, where he was found to be intellectually precocious, and his speech had an oddly adult quality. However, his control over impulses and feelings was poor; he was restless, tense, distractible and easily overexcited. He seemed to enjoy teasing and interfering with other children, and often frightened them with his threats and physical attacks. He frequently went into a screaming panic for no observable reason, and he was mistrustful of the teachers. It was soon clear that
much of this represented reactions to and identifications with his mother. He lived alone with her in a one-room flat following his parent's separation when he was 6 months old. She was a very disturbed woman who reacted to Robert on the basis of her own needs, not his, and who expected his feelings to coincide with hers. She identified Robert with his father whom she saw as a dishonest, sexually promiscuous, murderous psychopath. It seems likely that her view of her husband was as distorted by her own projections as was her view of her son. Her terror that Robert would become antisocial or criminal made her berate him constantly for being "bad": which meant failing to comply instantly with her wishes, e.g. abandoning his play immediately she called him for a meal or for bedtime. But if anyone else criticized Robert, she defended him with the ferocity of a tigress raging at the teachers and blaming the trouble on other badly brought-up children, or on antagonistic adults. She usually spoke in a loud, hoarse voice, sometimes lost her temper and hit Robert quite viciously, or threatened to send him away. She was also sexually seductive, allowing him to see her naked and share her bed, and encouraging much kissing and cuddling. She denied, however, that he was ever sexually curious or excited, in spite of evidence such as his frequent erections and attempts to look under the skirts of little girls.

In his therapy, much of the work centered on his fears of punishment and rejection for his "bad" sexual and aggressive wishes; it proved particularly important for the therapist to help him understand the distinction between neurotic anxiety resulting from projection of these wishes, and realistic anxiety about his mother's behavior. Especially important was the distinguishing of various processes of identification: first, identification with various aspects of his crazy mother - a normal process but modeling on an abnormal object; second, defensive identification with the aggressor, which included both his mother's real, hostile behavior to him, and aspects of his own aggression projected onto various people, i.e. creating a vicious circle; third, an identification with his mother's view of him as murderous and dangerous - which derived initially only from her own projections, but was in danger of becoming a self-fulfilling prophecy as he took over and enacted her view of him. The processes of identification were themselves becoming more and more distorted, with the build-up of increasingly biased self and object representations, and the whole process of self-evaluation was consequently becoming more and more deviant. The therapy helped Robert feel better about himself, and more securely in control of himself. His aggressiveness and panics in the nursery school diminished, but his relationships became rather distant; he became more settled and able to concentrate, so that he could find pleasure and relief in intellectual pursuits, and managed the transition to primary school fairly well. His therapy was ended prematurely because he was no longer giving trouble in school, having been throughout under the constant threat of interruption because of his mother's fear that he would be labeled a "psychiatric case". She had accepted regular interviews for herself which,
however, could do little more than protect Robert’s treatment for a time, and help her to channel some of her anxiety, hostility and seductiveness away from Robert.

When the problem is not related to parental disturbance, but has its origins in purely internal experience so intense as to result in permanent distortion of some basic piece of self-evaluation, then reconstruction of this (traumatic) experience is required, followed by lengthy working through of all the developmental repercussions of the initial distortion on other interlinked areas. Such a case, for example, was Joan who had had a bone disease beginning at age 5 weeks and persisting throughout the first two years of her life. She suffered from pain which spoiled all the normal pleasurable physical interactions with her mother; being cuddled, washed, dressed and fed all hurt; additionally her mother had to help in painful and frightening medical procedures. This resulted in a deeply ingrained view of mother as attacker and of herself as hurt, damaged and deprived (i.e. distorted object representations). The mother, in turn, felt helpless and inadequate. Even more seriously, because the early mother child interactions were painful rather than pleasurable, it gave rise to severe distortion and stunting of processes not only in the development of object relationships, but also of communication, thinking and self-observation. Further, the steroids which eventually cured her disease, bloated and immobilized her as a toddler. This interference with mobility restricted her capacity to discharge or control any form of aggression, excitement or affect, especially to displace it away from mother, thus also interfering with the processes of impulse control. She was referred for therapy at age eleven because of her constant verbal and sometimes physical abuse of her mother, and her readiness to engage in battles over many issues of daily living because she so easily felt slighted or unfavored and reacted with rage. She particularly envied the good relationship between her mother and younger sister, who was a much easier, cuddly baby, more rewarding for the mother.

Joan began treatment unwillingly, with no wish to communicate with her analyst about her inner world, no awareness of problems in herself, no wish for insight or exploration, no sense of achievement in understanding herself. She spent most of the first two years abusing and blaming her analyst. Verbalization of affect and interpretation of conflict had little meaning for her, and she denigrated the analyst’s attempts to think about her or make sense of her experiences. Externalization and projection were her favored defenses and she felt attacked whenever her analyst tried to address Joan’s own contribution to events. She could never admit to feeling worried or upset, she could only fly into a rage with anyone who crossed her. She suffered from frequent minor illnesses such as colds and hay fever, but could not recognize when she was ill. It fell to the analyst to give some meaning to Joan’s rages, illnesses and other states by trying to sort out, for example,
whether she was ill or in a bad mood. At first Joan was far from grateful for such interventions, but her minor illnesses did diminish in frequency, and prolonged experience of her analyst as a person who cared about her well-being and made strenuous efforts to understand and ameliorate Joan's somatic and psychic states, eventually helped her to begin to modify her suspicious and hostile attitude to objects and to develop the beginnings of a treatment alliance. At this point her conflicts became more available for analysis, especially the conflict between her very strong wishes for passive dependence and for the care of which she felt she had been deprived, and an equally strong belief that her needs could never be met because she was so damaged. At first the analyst had to do most of the work of understanding these conflicts, as well as Joan's distorted self-evaluation, and the role of Joan's early illness and consequent difficulties with her mother; subsequently Joan was able to move to a slightly more active role in exploring her inner world.

In some cases the self-evaluating process is not so much distorted, as completely stunted, and this is usually to be found in children with a general stunting of thinking, including the suppression of fantasy and reasoning; such children may give the impression of being dull and mentally defective; but they are to be distinguished from children with innately low intelligence. In such cases the therapist has to create a setting in which the child can feel that it is safe to begin thinking and imagining, and to find out what has gone wrong with himself.

Mary, for example, came from a large, disadvantaged, disorganized family in which all the children were intellectually underfunctioning. She entered nursery school at age three with two of her brothers. They were active and impulsive, prone to noisy tantrums, but at least fought for what they wanted. They were capable of quite strong relationships, and of enthusiastic albeit unruly involvement in activities. Mary, by contrast, was passive, prone to whining rather than tantrums, never knew what she wanted to do, and easily lost interest in activities; she could neither compete for attention nor hold on to her possessions; she looked, and apparently felt neglected and unlovable, often dirty and smelly with a runny nose. Unlike her brothers she did not form a strong attachment to particular adults in the nursery school, nor did she seek out other children to play with; instead she indiscriminately wanted to sit in the lap of any available adult.

When she was aged four, a therapist began working with her, not expecting her to be able to use classical analysis, but with the brief of finding out what sort of help she could use. The therapist's first task was to follow whatever interests, needs or wishes could be discerned in an attempt to find a pattern in them, and to gratify them whenever possible so as to encourage further expression of them. This helped Mary to form a more positive and
specific emotional attachment to the therapist, within which she could make more specific demands. What then became clear was that she had many disparate wishes and interests, but rarely made these known spontaneously, apart from the wish to sit on a lap. She could initiate nothing herself, only wait for it to be provided for her.

The next therapeutic steps involved the gradual limiting of gratifications and encouraging Joan to try doing things for herself. She then began to experience feelings of frustration, anger, sadness, and eventually even guilt and shame, and it became clear that she very easily felt defeated and worthless if she could not immediately succeed at an attempted activity. Now it became possible for patient and therapist to explore why she felt so frightened of the object’s refusal to comply with her wishes, and so afraid to try things out for herself.

The analytic delineation of Mary’s chaotic inner world was now under way. Recognizable conflicts and defenses emerged, and their effect on her development could be traced. For example, one of Mary’s own contributions to the impoverishment of her self-representation proved to have been the excessive use of primitive defense mechanisms of externalization; she disowned any aspect of herself which she disliked, or which could arouse shame, anxiety or guilt. One defensive element in her passivity proved to be the need to shift responsibility for approving and gratifying her wishes onto the object.

Mary’s consistent disowning of wishes and her renunciation of aspirations had rendered the nursery teachers powerless to mobilize active and progressive forces within her. But this changed as her therapy enabled her to accept these wishes and aspirations as part of herself, and to find better ways of handling them. It was an important moment when Mary’s sense of identity and her growing awareness that she might be able to feel good about herself reached a point where she could formulate the question to her therapist: “How do I be proud of myself?”

In these cases where the actual process of self-evaluation has become permanently distorted, or those in which it has been stunted, interpretative exploration of the child’s self and object representations and the transactions between them is insufficient to permit rearrangement of the inner world. Indeed, the representations often cannot be discerned until the process itself has been examined, corrected or set going again, by devising ways of drawing the child’s attention to what he or she is doing.
Limits

The extent to which pathological self-evaluations can be corrected depends on several factors:

1) How widespread the distortions are in the representational world. In the classical neurotic situation, only some aspects of the child’s self-representation are “bad”, fail to match up to an ideal self which is slightly beyond the child’s reach, and are criticized by an unduly severe conscience. This is the situation which is most easily corrected through psychoanalytic exploration of the origins of the mismatch. The psychoanalytic process becomes harder and longer if the total self-representation is “bad”, if the ideals are impossibly high, and/or the conscience is excessively severe.

2) Whether only specific representations are distorted or whether all representations are liable to distortion because the self-evaluating process has itself become distorted. In this case extra psychoanalytic work is required on the skewing of the process of self-evaluation itself e.g. if it has become sexualized so that the child derives masochistic gratification from feeling abused by the object, or from the abuse his own conscience directs at his self-representation; or if all self-evaluation is performed in the service of preserving narcissistic omnipotence, so that the child can tolerate only praise from objects or from his own conscience, and cannot contemplate the possibility of even minor corrections.

3) Whether the self-evaluating process is stunted as well as distorted. The earlier the stage at which the process became stunted, the harder it will be to set it going again and to help the child catch up on all the missing development.

4) How widespread is the overall disturbance which forms the context for the pathological self-evaluations.

5) The extent to which the patient derives secondary gain from the distortions.

6) The extent to which the child’s family reinforces or counteracts the child’s pathological self-evaluation.
CHAPTER 9
THE TREATMENT ALLIANCE

Definition

The treatment alliance refers to the child's conscious or unconscious acceptance of a need for help with psychological difficulties from the analyst. This acceptance will be called upon to sustain itself in the face of resistance to the analytic process and from sources of interference emanating from outside the analysis, e.g. the demands of school or resistance emanating from the parents. The treatment alliance assumes the presence of certain psychological capacities including the capacity to tolerate a degree of frustration, to regard oneself as one might be regarded by others, a capacity to view others as having benign and helpful intentions, and to be able to perceive, understand and identify with the aims of treatment.

Aims

The analyst's aim, with regard to treatment alliance, is to establish a relationship with the child which will permit treatment based on interpretation of conflict and insight into the ways in which the child endeavors to defend against anxiety or mental pain. Initially, the analyst will need to assess the child's capacity for forming a treatment alliance and devise strategies, based on this assessment, to instill sufficient motivation within the child to continue to participate in the analytic process in the face of wishes to take flight from analysis or to sacrifice the analysis in order to pursue other activities.

Means

An essential ingredient in the establishment of a treatment alliance is the evolution of a basic trust in the person of the analyst as a helpful figure for the child. The analyst's reliable availability and individual attention combined with his readiness to participate in play and verbalize and understand the child's thoughts, feelings and conflicts will elicit an attachment to the analyst as a trusted adult.

The establishment of a viable treatment alliance is as much dependent upon the analyst's skill as the patient's capacities. The analyst is thus required to communicate in an emotionally convincing way a tolerance of the patient's unconscious striving and an acknowledgment of the importance for the patient of his defensive activities. Children often find it belittling and humiliating to have to rely on the help of an analyst. The analyst is
required to balance the wish to appear a basically friendly and safe person with the wish to present the child with a sufficiently ambiguous situation to allow the analytic process and transference to develop.

Maintaining this balance does not obviate the need for active measures which aim to engage the child in the analytic process. Essentially, this requires the child analyst to "follow the child's material" by which is meant interacting with the child so as to convey appreciation of and interest in what goes on in the child's mind and his individual mode of self-expression. Techniques for achieving this aim are difficult to specify independently of an analyst's individual style of relating to others. Thus spontaneity, imagination, playfulness and a sense of humor are not to be ruled out as effective means of enlisting the child's interest in the analytic process.

Unlike adults, children often appraise features of their emotional disturbance as agreeable, rather than as symptoms they wish to overcome. An important component in the establishment of a viable treatment alliance will be interventions which alter the child's perceptions of his symptoms and cause him to come to wish for change. In this regard the analyst will wish to help the child to appreciate that the effort and discomfort required to face anxieties and tolerate awareness of repudiated wishes will help him to overcome external and internal difficulties. For example, sensitive interpretations of a young child's shame over bed-wetting will promote a wish to overcome a symptom and increase his capacity to tolerate interpretations of castration anxiety, the wish to remain a baby and/or disturbing fantasies of phallic powers.

Many attitudes in child patients may appear to be components in treatment alliance; for example, a disadvantaged child deriving gratification from his interaction with a caring and concerned adult. While such factors may have a beneficial effect on the building up of a treatment alliance, they may also bring with them wishes and defenses which require interpretation. Numerous transference manifestations may contribute to the child's pleasure in being with the analyst; for instance, the development of sexual wishes, or the evolution of a view of the analyst as magically able to redress the child's problems.

There are other elements in the child's response to analytic treatment which more effectively masquerade as components of the treatment alliance. A child's participation in treatment may signify a compliance with the expectations of others to defend against various fears or hostilities. Conversely, there are children whose hostile and derogatory attitude towards interpretations serve to conceal active participation in the analytic process because of anxieties related to the expression of loving or trusting feelings. There may thus be
specific resistances to the establishment of a working alliance which require understanding and interpretation. For example, a child may simply fear the loss of self control associated with the lack of external limitations in the treatment situation and the regressive experiences which this may engender. This anxiety will have multiple determinants which must be understood before a treatment alliance can be firmly established.

Limitations

Some patients, for example those with overt psychotic symptomatology, do not have the capacity to set aside their hostility or suspiciousness to establish a treatment alliance with a therapist. However, even among such patients, there are some who appear to recognize their need for help and can make an 'exception' of the person of the therapist.

Children with disorders which centrally concern self-esteem may experience overwhelming shame about needing help from another person.

Some children may be unconsciously invested in the idea of making the analyst fail, perhaps in order to demonstrate their own omnipotence or to maintain the image of a parental figure as perfect and unassailable.
CHAPTER 10
INTERPRETATION

Definition

Interpretations are a form of commentary offered by the analyst on the child's verbalizations and behavior. Typically they draw the child's conscious attention to an aspect of his experience which he has a motive to avoid or repudiate. The content of an interpretation is formulated on the basis of the analyst's understanding of the child's behavior based upon his theoretical knowledge of psychoanalytic psychology as tempered by his clinical experience and is informed by knowledge of the background of the particular patient.

Aim

Psychoanalytic interpretation aims to bring the patient's conscious understanding to bear upon conflictual aspects of his behavior, including thoughts and feelings, and in this way to show him how perceptions of himself as well as of others in the environment may be distorted by internal conflicts and their attendant affects. Thus the primary aim of interpretation is to bring the child's awareness to parts of his mental world which he previously construed as unacceptable, threatening or painful, and thereby to enhance his mental representation of himself as worthwhile, effectual and having a greater degree of choice in relation to others and his environment.

Psychoanalytic interpretation also aims to strengthen mental processes which, as a result of inhibition, create distorted and dysfunctional mental representations. Interpretations address stunted mental processes only indirectly. When the analyst makes an interpretation he engages the child with an implicit invitation to identify connections and integrate the interpretation with his desires and his preconscious beliefs, i.e. with his view of himself. In order to link the analyst's interpretation of the content of the child's current psychological state, the child will be motivated to employ his inhibited mental capacity.

Ideally, the child's response to interpretation recapitulates aspects of the analyst's mental activity which fall within the developmental capabilities of the child. The child's passive observation of the analyst's use of the process may further encourage the patient to reactivate inhibited modes of mental function. For example interpretations can serve 1) to increase the child's experience of control over overwhelming affect and hence a reduction in the feeling of helplessness through the labeling of emotional states; 2) to reduce the inhibiting consequence of psychic conflict through an understanding of the incompatibility...
of ideas or wishes; 3) to improve the child's ability to appraise reality by helping him to
differentiate his fantasies from actual occurrences in the outside world; 4) to provide the
child with a sophisticated implicit theory of how the mind his and others' functions
including ways which he and others use to cope with unpleasurable or threatening aspects
of experience; 5) to strengthen the child's ability to adapt to noxious environmental
influence through highlighting his capacities and the alternatives open to him.

Means

Ideally interpretations include three critical features: a) they have as their focus the
child's affective experience; b) they are formulated in a way which emphasizes the child's
struggle with repudiated wishes in the context of conflict; c) they refer to immediately
accessible aspects of the child's experience. For example, when the analyst aims to help the
child accept repudiated aggressive wishes towards an ambivalently regarded important
person, he will emphasize the difficulty the child experiences in reconciling his hostile
feelings with his positive ones and the anxiety or mental pain which accompanies his sense
that such thoughts and feelings are reprehensible.

In order to remove internal obstacles to the recognition of repudiated mental
representations the analyst has to specify those distortions of mental representation which
the child employs to avoid unpleasant affect. This view reflects the technical importance of
interpretation of defense and resistance.

Interpretations are based on the analyst's assumptions about how unconscious
mental content reveals itself indirectly in conscious mental content in the analytic situation.
The manifestation of preconscious wishes and the defenses against them are both inferred
from the child's play and verbal production. As the relationship of the inferred unconscious
mental content and the child's manifest behavior is an indirect one, the analyst is frequently
restricted to approximations of the nature of the child's concerns and will be prepared to
alter his assumptions in the light of the child's responses to interpretations. The 'rules' used
by the analyst to identify links between the child's overt (the analytic material) and his
unconscious concerns are complex, and are based on the following theoretical assumptions:
1) affects and wishes may be displaced from one context to an other; 2) representations of
affects and wishes may appear with an opposite valence to that unconsciously intended; 3)
mental content may be communicated through metaphoric use of the language or other
symbols (including physical objects); 4) manifest behavior may reflect the condensation of
a number of unconscious mental representations; 5) the child's unconscious affective state
may be communicated by the quality of his non-verbal behavior; 6)
Whilst the analyst may often be able to make important connections between the child's analytic material and his past experiences, in the first instance interpretations should be restricted to the current conflicts experienced by the child in the context in which the child brings it into the analysis. However, in the long run the analyst will aim to help the child develop an effectively meaningful understanding of the relation between past experience and current conflict.

Interpretations must be seen within the broader context of the analytic process. Thus they must be varied and repeated at different times and with variable emphasis over the course of the analysis, i.e. worked through. A good interpretation provides an explanation to the child and the analyst of his recent experiences with particular reference to his feelings and behavior in the session. At any one time the analyst may have a number of possible interpretations available to her and the choice of interpretation must be made with due regard to the child's conscious understanding of the current state of the analytic process as well as his current affective state. The implications of this are that the analyst will gauge her patient's treatment alliance, the status of his resistance and transference and current external circumstances.

Indications of an appropriate interpretation include: a shift in the patient's feelings and behavior in the analysis, sometimes closely associated in time with the interpretation; the repetition of a recognizable theme; the emergence of new pertinent material which the analyst can link to previous work; the recovery of relevant memories from the patient's past; transference links which bear on the interpretation; an enhanced curiosity about the analytic process and a clear thirst for further involvement with the analyst.

Clinical Illustration

Case B

The bell rang more than five minutes late. Sam lingered downstairs with his mother, fussed about his jacket and came upstairs particularly slowly. He sat down at the table and said that he had nothing to say. The analyst said that he wondered if there weren't so many things to talk about that it seemed difficult to know where to start. Sam said that he didn't want to talk and that was that! He turned his head and shoulders away and, with his hands clasped tightly together, placed his extended arms on the table, stretching and resting his body on one shoulder. He said: "When it's like this I can't take my hands apart". The analyst said: "You feel tense inside and it feels especially frightening to let go of things and talk". He turned his head

4 This is an interpretation of the child's presumed current mood or state of mind based upon the child's general behaviour.
5 The analyst treats the child's body language and comment as a metaphorical reference to his current internal affective state.
towards the analyst but kept his hands locked together. He said: "I don't want to talk and I don't want you to talk!" When the analyst attempted to reply he simply put his index finger to his lips and said: "Psst".

He took a biro out of his box, screwed its end off and took out the plastic refill. He put the refill at the wrong end of the biro and put a staple in the other end and, bending the refill, shot the staple out. He went immediately searching for it on the carpet and when eventually he found it he stuffed it inside the plastic shell of the biro, replaced the refill and screwed the cap back on. The analyst said: "It seems important to get everything back inside quickly at the moment". He said: "That's right". He opened the biro up again and tried to get the staple out. He shook it and poked at it from both ends with the refill, but it wouldn't come out. He seemed quite distressed and eventually handed the analyst the shell saying: "You do". The analyst said that he thought Sam felt upset at the moment because there were all kinds of feelings stuck inside him but it seemed that he could not get them however much he wished to, without help from the analyst. Sam replied, pointing to the task in the analyst's hand: "You don't say, you do!" The analyst managed to extract the staple which Sam took back together with the large paper-clip the analyst had used to free the staple from the shell of the biro. Sam used the paper-clip as a missile and shot it aimlessly across the room. He retrieved both the staple and the paper-clip and stuffed the former into the shell and the latter into the cap and screwed the biro together. He shook the biro, apparently pleased that the missiles were back inside. Then he took it apart again but now was unable to extract either the staple or the paper-clip. The analyst said that Sam seemed worried by dangerous thoughts and feelings, and that while part of him wanted to share them with the analyst another part of him felt that it was safer not to. Sam said nothing but handed over the cap and the shell, gesturing that the analyst should remove the missiles. Sam said that he had "a lump inside". The analyst said that Sam had very much wanted to shoot out the lump but had been frightened that he or the analyst would get hurt in the process. Sam climbed under the table and proceeded to stuff the staple and the paper-clip he had just extracted back into the biro. He said from under the table that today was not a good day for talking.

Sam went on playing at stuffing the missiles back into the biro shell, mostly under the table. The analyst reminded Sam of their discussion the previous week about how babies are made and how one could be more sure who the mother was than the father. (The analyst recalled to himself that this discussion had been prompted by Sam's anticipation of a visit by his biological father with whom he had had little contact since his birth.) The analyst added that it was very hard and confusing for Sam at the moment to feel that he had two fathers and that it felt a little

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6 The child precludes the necessity of interpreting his resistance by formulating the interpretation himself.

7 Through observing carefully the child's behaviour the analyst interprets the child's displacement from a nonspecific wish to withhold mental content onto the play situation with the biro.

8 Having already recognised the child's resistance, the analyst interprets the child's wish for help from the analyst in making sense of his thoughts and feelings. He assumes that the staples represent the child's feelings, his deliberate and intense efforts to force the staples inside the pen communicate his wish to hold these back and his request for help from the analyst is an expression of his preconscious wish for assistance with his sense of being stuck.

9 The analyst is able to build upon his previous remarks and clarify Sam's conflict in relation to the analyst. There are symbolic suggestions as to the unconscious sexual fantasies revealed in the play behaviour. Through his comments, the analyst endeavours to reduce Sam's anxiety about elaborating these further.

10 The analyst is more specific about the apparent reason for Sam's mixed feelings about expressing his thoughts and links these to the physical danger Sam unconsciously fears for himself and the analyst in connection with his sexual fantasy.
bit like having to fit both a staple and a paper-clip inside the biro. Sam dropped the biro and said: "I am not coming out from under the table if you don't stop talking to me!" He became even more desperate to push both the staple and the paper-clip into the biro shell. The two would not fit in at the same time and when they were both in he could not screw the cap back on. He repeatedly pushed one in which would make the other fall out and seemed increasingly overwhelmed with anxiety and frustration. The analyst said that Sam felt that he couldn't talk to the analyst about his father coming because Sam feared causing the analyst to feel pushed out as he feared he had made his stepfather feel when he became so excited about the arrival of his father.

Sam's tension momentarily eased and he climbed out from under the table. He reported a dream. But his account was garbled and he spoke deliberately quickly so that the analyst would not understand what he said. The analyst gathered that Sam dreamt that he was standing by a window and knew that he had to jump. There were two people standing underneath the window and only one of them could catch him. He could not make his mind up which way to jump. The analyst said that perhaps the terrible guilty feeling of having to choose between fathers was the awful lump he was talking of earlier. Sam said: "perhaps".

Sam insisted on playing "hide the pen". The analyst had to shut his eyes while Sam put the biro amongst the books on the bookcase. He took an unusually long time to choose a place. The clue was: "CK065, not the old version, 452". The analyst was unable to locate the pen from this clue. Sam seemed to be relieved by the analyst's puzzlement. The analyst said: "It seems to feel better now that I don't know what you are thinking". Sam smiled: "That's right". Sam showed the analyst where the pen was. It was between page 452 and 453 in a copy of Don Quixote. There are two copies on the shelf, an old edition and a new one, which has the number CK065 printed on its spine in tiny letters. The analyst said: "You did not really want me to find this book just the same way that a part of you prefers that we don't understand your conflict about having two fathers. But we know that it feels that there are two versions of everything at the moment and it is so hard to try and choose between them." He said: "May be?". When the bell rang, indicating that his mother arrived to pick him up and it was the end of the session he jumped up and pressed the buzzer to let her in. The analyst rarely had seen him in such a hurry to end the session.

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11 The analyst understands Sam's tense and frenzied play with the biro to incorporate various sexual elements but he feels most confident about the link between Sam's fantasies about intercourse and conception and his confusion about his conflicting affections for his two fathers.
12 The analyst brings together Sam's sexual excitement and anxiety with his current conflict vis a vis his two fathers in the transference of this conflict in relation to the person of the analyst. The interpretation also bridges past and present insofar as it begins to specify Sam's early childhood sexual theories and the anxieties expressed within them.
13 The analyst is able to be more specific about the object-related hurtful element in the unconscious fantasies expressed in the derivative play with the biro.
14 The analyst acknowledges the anxiety that his interpretation engendered in Sam and his renewed wish to hide from the analyst the thoughts and feelings associated with his confusion about his father (symbolised by the pen).
15 The analyst begins to help Sam work through the important conflict they have discovered and the resistance to it.
Limitations

The nature of preconscious processes is such that invariably the analyst could make more than one interpretation concerning the child's behavior. A single piece of behavior could have many analytic meanings. The analyst will usually take that meaning which is most closely related to the conflicts which he is currently discussing with the child. He will give priority to preconscious mental representations and affective states which represent obstacles to further elaboration of the child's thoughts and feelings.

Extrapolating to the child's preconscious mental state from the child's overt verbal and non-verbal behavior is hazardous. The analyst will not invariably be accurate about what the child is thinking and inaccurate interpretations are common. The analyst will usually sense if his interpretation was accurate from the child's affective response (see above).

Interpretations aim to help the child understand that the distorted nature of his mental representations and will only rarely have an immediate effect. Representations will change only slowly. When a mental process is substantially inhibited distortions will recur even more forcefully and interpretations will have apparently little effect in terms of changing the nature of the child's mental representations.
CHAPTER 11
TRANSFERENCE

Definition

Transference refers to special aspects of the relationship the patient develops with the analyst in the course of psychoanalytic treatment. Transference is characterized by a process where feelings and attitudes emanating from the patient's childhood relationships are revived and directed specifically towards the therapist. Thus the child's current feelings, fantasies, thoughts and behavior towards the analyst will not only reflect many aspects of current relationships to his parents but become increasingly dominated by real or fantasized early experiences and interactions between the child and the primary objects.

Transference elements enter to a varying degree into all relationships and these are often determined by some characteristic of the other person who represents some attribute of an important figure in the past. It is important to distinguish between dominant aspects of internal representation of current relationships and the clinical situation and procedures of psychoanalysis which facilitate the development and exploration of transference and where this process reaches an intensity and focus that does not usually occur in other relationships.

Aims

The elucidation of transference is of crucial importance in clinical work. Transference provides a source for unconscious representations (fantasies, memories, experiences) to reveal themselves powerfully through changes in the patient's relationship and attitudes to the analyst in the course of treatment. The psychoanalytic process facilitates regressive shifts and with it the re-emergence of earlier mental representations (wishes and modes of relating) and numerous mental processes characteristic of earlier stages of development. These will intensify the development of transference.

Transference can also become a source of resistance to the analytic work when it is not recognized, understood and appropriately interpreted. The patient is not aware when transference elements enter into his relationship to the analyst and experiences his feelings as appropriate to the present and to the person involved. The analyst permits this illusion to develop and find expression, and tries to respond to it only as analytic material and not as part of an ordinary interaction. This is facilitated by the analytic setting for adults where the analyst is out of sight and action is restricted.
Means

In child analysis the patient's unconscious attempts to manipulate or provoke the analyst to interactions which represent repetitions of earlier experiences or wished for ways of relating often find expression in play scenarios. When this involves role play where the analyst is assigned a special part, he will attempt to attain a fine balance by eliciting fantasy material in a mode natural to the child's level of functioning and self expression but not providing too much gratification or excitement for doing the analytic work itself.

Transference will be better understood by the analyst if he distinguishes the various elements that enter into the child's relationship towards him, e.g. the child's habitual mode of relating, the extensions of current relationships, the use the child makes of him as a real object etc. But the analyst's technique will be focused on facilitating the development and understanding of transference. Opportunity for transference distortion is enhanced by the therapist refraining from feeding back information about his own life in order to correct the child's misperceptions, but instead by reflecting on the child's wishes, intentions, conflicts and concerns without adding value judgments. Most importantly instead of accepting the role the child unconsciously assigns the analyst, he will interpret what the child is trying to enact. For example "You are trying to get me to throw you out as your mother threatened to do" etc.

With younger children transference can often best be explored by temporarily accepting the role the child assigns the analyst in his play scenario (e.g. the victimized child or the overstrict father) but stepping out of this role, at appropriate times, in order to reflect and interpret.

Case Illustration

Case B

The vignette of Sam provides an example of the use of transference interpretation (session given in detail in 'The Psychoanalytic Understanding of Childhood Psychological Disturbance'). Sam demonstrates in his sleepiness his identification with the father he fears is tired of him, and when this is interpreted in relation to the analyst, Sam is able to clarify that his mother had told him this. He seemed aware that she had lied to suit her own convenience. Then in the dead finger game he can take the issue further, demonstrating his fear that the analyst was dead. Once this is verbalized he goes on to tell a story which demonstrates his projection of anger and wishes to rob father; together with the hangman game it permits the analyst to interpret Sam's fear that his own badness is what turns his world nasty, his anger to his love objects turns them into dangerous people, i.e. the externalization of his own conscience. All of this relieves his tiredness and frees him to use his more mature, seven-year-old intellect in speaking of the reality of his three
families, trying to understand it; he also indicates his transference fear of exclusion from the analyst's family. When the analyst again verbalizes Sam’s fear that his anger makes the analyst leave him, his reply in word and action confirms his belief that the safe solution is to remain a baby. After the analyst interprets that, he can explain his own tiredness as "sad-tired", which requires the analyst's intervention, and distinguish it from two forms of normal tiredness which do not require intervention. Here again he demonstrates the freeing of his intellect and capacity for self-observation or a more mature level as he is helped to understand the pathological aspects of his more regressed, babyish mode of relating.

Limitations

The analytic work itself should enhance the child's capacity to test reality against the illusory quality of his transferences, but especially with young children, or children whose reality testing is not well developed, the analyst will have to provide auxiliary support for this to occur, e.g. "Yesterday I think you were so frightened that you thought for a time that I really was a witch".
CHAPTER 12
COUNTER TRANSFERENCE

Definition

The term counter transference refers to processes in the analyst's mind that arise in response to the patient, his analytic material and/or his transference relationship. These processes may interfere with or enhance the analyst's appropriate understanding of the patient and therefore require special attention.

Freud only noted the negative aspects of counter transference. He understood these processes in the analyst's mind as responses akin to the patient's resistance and/or his transference (i.e. counter transference as the counterpart to the patient's transference). Such responses are due to the arousal of unconscious conflicts by what the patient says, does or represents to the analyst and if not recognized could lead to psychological 'blind spots' in the analyst. In Freud's view, such conflicts in themselves were not counter transference, but they could give rise to it. There may be other reasons for the analyst's failure to understand the patient's material (e.g. limitations to his theoretical understanding, or limitations in getting empathically on the patient's wavelength, etc.)

Developments in psychoanalytic thinking since Freud have led to the recognition that counter transference responses can also facilitate the understanding of the patient's material. This is based on the assumption that the analytic work with a patient establishes a rapport on an unconscious level which enables the analyst to use his own mind as a tool, to gain understanding. Thus by monitoring his own associations while listening to the patient, the analyst can become consciously aware of processes occurring in the patient. However, such material always has to be treated with caution and a high degree of self-scrutiny.

The term counter transference is sometimes broadened to include every thought, feeling and even mood change in the analyst as he pursues his daily work with patients. Careful distinctions have to be drawn here in order not to make the concept clinically meaningless. Analysts are human beings and their inner state can be affected by various experiences. The analyst may be upset or preoccupied by events in his personal life and these may intrude on his capacity to give full attention to his work. This is not caused by the patient or his material but in extreme situations the patient may become aware of something being different.

The child analyst's responses to being physically hurt by an aggressive child (e.g. kicked or by objects thrown at him) are also in the realm of ordinary human response, but if
such attacks become especially frequent or vicious they may sometimes lead to counter transference responses.

Aims

The analyst's training equips him with special skills to monitor and scrutinize his responses to the patient at all times. This self scrutiny, or at times self-analysis, will not only ameliorate the negative impact of the counter transference but provide important cues for his understanding of the patient.

In monitoring his responses the analyst will become aware that his responses during the analytic hour are usually derived from the dynamic interaction between himself and the patient and only sometimes from conflicts within himself.

Means

Built into psychoanalytic technique is the attempt to allow the patient to externalize and project aspects of his intra-psychic life. Aspects of the patient's transference will be understood through the analyst's monitoring of his 'role responsiveness'. In his attempt to 'actualize' an 'intra-psychic' role relationship the patient will attempt to manipulate the analyst to take on a special role or attitude towards him. In child analysis this manipulation can find expression in imaginative role play where the analyst is coerced to play a role in the child's scenario. The child's resistance to analysis can then manifest itself by an insistence that the analyst only play the role instead of offering an interpretation, this he has to desist. The analyst utilizes his capacity of maintaining free-floating attention to all aspects of the patient's material and the associations engendered in his own mind, and submits this to his higher order thinking processes to clarify his understanding of the patient's material. He has to find ways to communicate his understanding in a way that will be meaningful to the child's level of functioning. Under favorable conditions such intervention will also facilitate changes in the child's level of functioning. Counter transference blind spots are as likely to apply to the analyst's unconscious awareness of an inhibited mental process as to specific unconscious mental representations. The analyst may unconsciously compensate for the failure in the child's mental functioning. The analyst may thus attribute mental capacities to his patient which in fact he unconsciously provided the child with in an attempt to protect himself from the painful awareness of the absence of capacity in the child. For example, the analyst may unconsciously make a particular attempt to moderate the intensity of his affective responses with a child who he realizes, if only unconsciously, lacks this
capacity. Although this adaptation may serve a constructive clinical end in some situations, the analyst's failure to appreciate consciously the patient's inhibited mental process will decrease his effectiveness in other clinical contexts.

Limitations

Counter transference can lead to difficulties in the appropriate handling of the analysis of a patient. This will occur when the analyst fails to become aware and deal with aspects of his counter transference responses.

The analyst's training analysis, supervision and continuing self analysis will act as a certain safeguard only.
APPENDIX 6

MANUAL II CHAPTERS

STUDY 3
VALIDATION OF MANUAL II
DEFENCE AND RESISTANCE

Definition

Defence is an aspect of normal psychological functioning (ego-functioning), usually unconscious, the aim of which is to protect the individual from the danger of being overwhelmed by anxiety and/or catastrophic loss of self-esteem. These affective states are expected to result from the adverse effects of recognizing and/or acting upon feelings, instinctual or other wishes or attitudes. The most important adverse effects are: guilt, shame, helplessness, loss of an important person or of that person's love, loss of self-cohesion or well-being. Defence is thus mainly directed against aspects of the internal world, but may also be directed against aspects of the external world if these threaten to arouse overwhelming anxiety or loss of self-esteem. Normal defence is directed against specific representations, and results in the individual having sufficient self-control and adaptability. In normal development there is a range of defence appropriate for each stage (age). In pathological defence the range is restricted or is inappropriate for the child's age. This results in major interferences with normal functioning, e.g. excessive inhibition or phobic anxiety.

In the analytic situation, defence becomes manifest as resistance: the refusal to pursue a line of thought felt to be dangerous, and/or to take in or think about ideas offered by the analyst. The most serious resistances are unconscious; in addition, children often consciously withhold thoughts and feelings.

Aim

The analyst's long-term aim is to modify pathological defence by broadening the range of defences available to the child and reducing the use of excessively restricting defence so as to allow the patient greater freedom, through more efficient self-control and adaptability. The short-term aim is to demonstrate to the patient the operation of each defence as it occurs, on the assumption that awareness is the first step towards modification.

Means

This is done by drawing the patient's attention to examples in his play, in his descriptions of experiences, and in his attitudes and behavior towards the analyst, especially his resistances. In this way the analyst spells out for the patient the nature of the defence, what he is defending against, and the effects the defence has on his functioning. This
usually allows the patient to see alternative ways of handling the situation, but the analyst may also draw the patient's attention to such alternative ways. Thus, over time, the analyst repeatedly and in different ways demonstrates how specific defences interfere with particular aspects of functioning.

Limits

The analysis of defence is especially appropriate for conflict-based (neurotic) and some narcissistic disturbances in patients in whose defences against specific representations are overly strong and rigid. In psychotic or borderline patients with weak defences it has to be used sparingly and with caution. In older children, with rigid and excessive defences already being built into their character, the modification of defences will require lengthy working through in intensive treatment. In children with more moderate defences, especially younger ones who are still changing developmentally, defences can often be modified more quickly, even in brief, non-intensive therapy.
CONFLICT

Definition

Conflict is a normal part of mental life and occurs whenever contradictory wishes, aims or ideals are simultaneously present. Such conflicts only become problematic for the individual and material for the analytic work when they become linked with basic unconscious anxieties and no adaptive solution can be found in reality. There are characteristic conflicts for each stage of development, as well as more particularly individual ones. In normal development, for each conflict that arises, some form of compromise is reached which allows the individual to feel and behave in a way acceptable to himself and to the culture in which he lives. There are three forms of pathological development: (1) the conflict may remain unresolved; if it also remains unconscious the individual then feels inexplicably uneasy, anxious or depressed; if it reaches consciousness in some form (derivatives), the individual finds himself experiencing contradictory feelings or wishes; (2) An unconscious solution may occur which is, however, unacceptable to the individual and/or people in his environment (symptoms, character traits, behavioral or affective disturbances). Unresolved or pathologically resolved unconscious conflict is the basis of all neurotic disorder and plays an important role in most other forms of emotional disturbance. (There are also types of pathological development in which insufficient conflict occurs, but these will not be dealt with in the present manual.)

Aim

The Analyst's aim is to recognize and revive, preferably in the transference, past and present conflicts which are causing problems for the individual, and to interpret their unconscious elements in sufficient detail to allow the individual to find a better adapted solution.

Means

The Analyst scans the patient's material (play, talk, expressions of feelings, attitudes and towards the analyst) for signs of contradictory wishes, feelings, aims or ideals, for evidence of defence, and for inappropriate reactions. He also pays attention to what is missing in the child's behavior; this would include both lack of control due to insufficient conflict, and over-control producing inhibition, as well as missing processes. The analyst gradually builds up in his own mind a picture of the way the child has resolved
conflicts or failed to resolve them; as he judges the time is right he gradually communicates this understanding to the patient. The analyst traces themes for the patient, spelling out the ramifications (*working through*).

**Limits**

The analysis of conflicts is most efficacious in neurotic disturbances, where it constitutes the main area of analytic work. It also plays a part in some forms of developmental, borderline and psychotic disturbances but in these disturbances it is not, by itself, sufficient to effect amelioration.
AFFECTS

Definition

Affects are regarded as complex states which are rooted in biology and have important psychological functions. Affects are primary organizers of the child's mental functioning, insofar that they provide the basis for attributing meaning to experiences. They are thus used to monitor, evaluate and direct action, thought, defences and symptoms. The conscious or unconscious experience of affect acts as a signal which can set in motion the child's adaptive capacities. Thus they serve to prevent the individual from becoming overwhelmed by a state of helplessness associated with earlier experiences of massive discharge.

Aim

Affects are essential in the routine search for unconscious meaning in the child's verbal and non-verbal behavior in psychoanalysis. They are central to clinical work with children because they guide the analyst to the child's conflicts and fantasies, and they are relatively experientially accessible to the child. Therefore understanding of the child's affect serves to encourage the child to bring analytic material. Identifying and accepting the child's affect helps the child to listen to and elaborate the analyst's interpretations and therefore has a further role in facilitating communication and understanding between the child and the analyst.

Means

The most basic interventions consist of labeling, describing and elaborating what it is that the child feels. The analyst will draw attention to the child's efforts to avoid unpleasurable emotions and the ways in which he seeks to protect himself from anxiety, guilt, shame, and other distressing affects, e.g. by altering or reversing certain feelings in favor of less distressing substitutes. Such interventions foster a feeling within the child of being understood by an adult who takes what he feels seriously or at least views it as important. It is hoped that this will increase the child's own interest in making sense of his emotional experience.

Affects which accompany unconscious conflict and thus form an integral part of unconscious fantasy have a priority for the analyst and are often addressed in terms of the way in which they function to arouse or reduce anxiety. Certain negative affects such
as guilt, shame, feelings of humiliation are often discernible in derivatives of unconscious fantasy, whether in dreams, the transference or other aspects of the child's material.

Interpretations which refer to these affects and their important motivational role in the formation of defences are crucial in that such interpretations reduce anxiety. However, such interpretations of negative affects also engender resistance. The accurate identification and their appropriate repetition in various contexts are essential in the process of working through conflict. Affects generated by the child's experiences in the external world and outside of the analytic situation are also addressed particularly with children who live in environments which fail to meet legitimate developmental needs.

Clarifying or interpretive interventions will arouse specific affects within the child and the analyst will attend to these. This process facilitates the child's emotional investment in the person of the analyst and is thus an important prerequisite of the development of the transference.

Limitations

While the long-term aim is to identify and label affects with a view to enhancing the understanding of experiences and facilitating adaptation, this is a lengthy aspect of the analytic process. At any particular moment it may not be appropriate to verbalize affect if, for example, it could disrupt defences which are, at the moment irreplaceable, such as reaction-formations; or at a point when the child is certain to take the intervention as criticism which would lower self-esteem catastrophically.

The child's wish to control his affect should be reflected by the interpretation which should avoid the implication of an invitation to express affect.

Of course in various circumstances the analyst may use the affect as a guide without necessarily interpreting it. Affects may be stunted in certain children with particular environmental deviations and interpretations of affects in such cases will not lead to relief.
TRANSFERENCE

Definition

Transference refers to special aspects of the relationship the patient develops with the analyst in the course of psychoanalytic treatment. Transference is characterized by a process where feelings and attitudes emanating from the patient's childhood relationships are revived and directed specifically towards the therapist. Thus the child's current feelings, fantasies, thoughts and behavior towards the analyst will not only reflect many aspects of current relationships to his parents but become increasingly dominated by real or fantasized early experiences and interactions between the child and his primary objects.

Transference elements enter to a varying degree into all relationships and these are often determined by some characteristic of the other person who represents some attribute of an important figure in the past. It is important to distinguish between dominant aspects of internal representation of current relationships and the clinical situation and procedures of psychoanalysis which facilitate the development and exploration of transference and where this process reaches an intensity and focus that does not usually occur in other relationships.

Aims

The elucidation of transference is of crucial importance in clinical work. Transference provides a source for unconscious material to reveal itself powerfully through changes in the patient's relationship and attitudes to the analyst in the course of treatment. The psychoanalytic process facilitates regressive shifts and with it the re-emergence of childhood wishes and modes of relating which facilitates and intensifies the development of transference.

Transference can also become a source of resistance to the analytic work when it is not recognized, understood and appropriately interpreted.

The patient is not aware when transference elements enter into his relationship to the analyst and experiences his feelings as appropriate to the present and to the person involved. The analyst permits this illusion to develop and find expression, and tries to respond to it only as analytic material. This is facilitated by the analytic setting for adults where the analyst is out of sight and action is restricted.
In child analysis this is more difficult to deal with because children often enact transference manifestations via unconscious attempts to manipulate or provoke the analyst to interactions which represent repetitions of earlier experiences. The analyst has to develop special techniques in dealing with such role assignments.

Means

Transference will be better understood by the analyst if he distinguishes the various elements that enter into the child's relationship towards him, e.g. the child's habitual mode of relating; the use the child makes of him as a real object etc. But the analyst's technique will be focused on facilitating the development and understanding of transference.

Opportunity for transference distortion is enhanced by the therapist not feeding back information about his own life in order to correct the child's misperceptions, and by reflecting on the child's wishes, intentions, conflicts and concerns without adding value judgments. Most importantly instead of accepting the role the child unconsciously assigns the analyst, he will interpret what the child is trying to enact. For example "You are trying to get me to throw you out as your mother threatened to do" etc.

Limitations

In the course of time the child's capacity to test reality against the illusory quality of his transferences will increase, but especially with young children, or children whose reality testing is not well developed, the analyst will have to provide auxiliary support for this to occur.
OBJECT RELATIONS IN THE CLINICAL CONTEXT

Definition

The term object relations refers to: (1) the child's actual relationships with real people in the external world; (2) the processes of creation of mental, i.e. internal representations of himself and other people. These representations can be used for further processes of conscious and unconscious fantasizing, thinking and feeling about the interactions between himself and others; they develop as a mixture of perceptions of reality and projections of the child's own wishes, impulses, feelings and anxieties; (3) the processes of modification of these internal representations to produce versions of himself and objects which are idealized, denigrated, good, bad, etc., and the part they play in the development of conscience.

Aim

The overall aim is to make the patient aware of pathological features in his relationships to self and others, by demonstrating to him maladaptive identifications, distorted perceptions, inappropriate expectations and fears, thus helping him to modify not only his current modes of relating, but other aspects of his behavior derived from pathological aspects of relationships. As in any other relationship, the patient's relationship with the analyst reproduces aspects of the child's earlier as well as current relationships with important people, real and fantasized, as well as the interactions between the child's own self and conscience. A subsidiary analytic aim is to encourage this repetition, since it serves to reveal most vividly how the individual perceives important people in the past and present, what he expects and fears from them, and in what ways he is identified with them. These factors may also be explored in the child's accounts of relationships with other people, and in his play and other activities in treatment. But the relationship to the therapist is usually the most emotionally alive and immediate situation both for the patient to convey his feelings and ideas, and for the therapist to interpret them. The general transference reveals the influences from important past and present relationships which are likely to be found in all the child's external relationships; while the transference proper conveys especially the pathological and regressive elements which are responsible for the child's problems and therefore most require interpretation.
Means

Almost everything that happens during an analysis may be viewed in the context of the patient’s self and object relationships. There are two closely linked analytic tasks; the first is to pick out those features which are particularly useful at any given moment for helping the child to understand the problem areas in his functioning. (What is "useful" will vary at different points in the analysis according to how much the child already understands, how strongly he feels about it, how reluctant or willing he is to understand more, etc.). The second is to select the most effective way of interpreting these features to the child; directly in relation to the real external objects; in whatever displacement or projection onto other people, toys, or imaginary characters the child may be using; or in relation to the analyst, i.e. a partial or full transference interpretation. The possibilities for pathology in object relationships are almost limitless, but for each patient there will be areas of particular importance.

Limits

The exploration of pathological aspects of internal and external object relations is appropriate in any form of disturbance. However, the approach to be used, e.g. via interpretation of unconscious internal interactions as reproduced in the transference, via clarification of the dynamics of real, external relationships, etc., depends on the capacity of the patient to make use of the various approaches.
INTERPRETATION

Definition

Interpretations are a form of commentary offered by the analyst on the child's verbalizations and behavior. Typically they draw the child's conscious attention to an aspect of his experience which he has a motive to avoid or repudiate. The content of an interpretation is formulated on the basis of the analyst's understanding of the child's behavior based upon his theoretical knowledge of psychoanalytic psychology as tempered by his clinical experience and is informed by knowledge of the background of the particular patient.

Aim

Psychoanalytic interpretation aims to bring the patient's conscious understanding to bear upon conflictual aspects of his behaviors, including thoughts and feelings, and in this way to show him how perceptions of himself as well as of others in the environment may be distorted by internal conflicts and their attendant affects. Thus the primary aim of interpretation is to bring the child's awareness to parts of his mental world which he previously construed as unacceptable, threatening or painful, and thereby to enhance his mental representation of himself as worthwhile, effectual and having a greater degree of choice in relation to others and his environment.

Psychoanalytic interpretation also aims to strengthen mental processes which, as a result of inhibition, create distorted and dysfunctional mental representations. Interpretations address stunted mental processes only indirectly. When the analyst makes an interpretation he engages the child with an implicit invitation to identify connections and integrate the interpretation with his desires and his preconscious beliefs, i.e. with his view of himself. In order to link the analyst's interpretation of the content of the child's current psychological state, the child will be motivated to employ his inhibited mental capacity.

Ideally, the child's response to interpretation recapitulates aspects of the analyst's mental activity which fall within the developmental capabilities of the child. The child's passive observation of the analyst's use of the process may further encourage the patient to reactivate inhibited modes of mental function. For example interpretations can serve 1) to increase the child's experience of control over overwhelming affect and hence a reduction in the feeling of helplessness through the labeling of emotional states; 2) to reduce the inhibiting consequence of psychic conflict through an understanding of the incompatibility
of ideas or wishes; 3) to improve the child's ability to appraise reality by helping him to differentiate his fantasies from actual occurrences in the outside world; 4) to provide the child with a sophisticated implicit theory of how the mind his and others' functions including ways which he and others use to cope with unpleasurable or threatening aspects of experience; 5) to strengthen the child's ability to adapt to noxious environmental influence through highlighting his capacities and the alternatives open to him.

Means

Ideally interpretations include three critical features: a) they have as their focus the child's affective experience; b) they are formulated in a way which emphasizes the child's struggle with repudiated wishes in the context of conflict; c) they refer to immediately accessible aspects of the child's experience. For example, when the analyst aims to help the child accept repudiated aggressive wishes towards an ambivalently regarded important person, he will emphasize the difficulty the child experiences in reconciling his hostile feelings with his positive ones and the anxiety or mental pain which accompanies his sense that such thoughts and feelings are reprehensible.

In order to remove internal obstacles to the recognition of repudiated mental representations the analyst has to specify those distortions of mental representation which the child employs to avoid unpleasant affect. This view reflects the technical importance of interpretation of defence and resistance.

Interpretations are based on the analyst's assumptions about how unconscious mental content reveals itself indirectly in conscious mental content in the analytic situation. The manifestation of preconscious wishes and the defences against them are both inferred from the child's play and verbal production. As the relationship of the inferred unconscious mental content and the child's manifest behavior is an indirect one, the analyst is frequently restricted to approximations of the nature of the child's concerns and will be prepared to alter his assumptions in the light of the child's responses to interpretations. The 'rules' used by the analyst to identify links between the child's overt (the analytic material) and his unconscious concerns are complex, and are based on the following theoretical assumptions: 1) affects and wishes may be displaced from one context to an other; 2) representations of affects and wishes may appear with an opposite valence to that unconsciously intended; 3) mental content may be communicated through metaphoric use of the language or other symbols (including physical objects); 4) manifest behavior may reflect the condensation of a number of unconscious mental representations; 5) the child's unconscious affective state may be communicated by the quality of his non-verbal behavior; 6)
Whilst the analyst may often be able to make important connections between the child's analytic material and his past experiences, in the first instance interpretations should be restricted to the current conflicts experienced by the child in the context in which the child brings it into the analysis. However, in the long run the analyst will aim to help the child develop an effectively meaningful understanding of the relation between past experience and current conflict.

Interpretations must be seen within the broader context of the analytic process. Thus they must be varied and repeated at different times and with variable emphasis over the course of the analysis, i.e. worked through. A good interpretation provides an explanation to the child and the analyst of his recent experiences with particular reference to his feelings and behavior in the session. At any one time the analyst may have a number of possible interpretations available to her and the choice of interpretation must be made with due regard to the child's conscious understanding of the current state of the analytic process as well as his current affective state. The implications of this are that the analyst will gauge her patient's treatment alliance, the status of his resistance and transference and current external circumstances.

Indications of an appropriate interpretation include: a shift in the patient's feelings and behavior in the analysis, sometimes closely associated in time with the interpretation; the repetition of a recognizable theme; the emergence of new pertinent material which the analyst can link to previous work; the recovery of relevant memories from the patient's past; transference links which bear on the interpretation; an enhanced curiosity about the analytic process and a clear thirst for further involvement with the analyst.

Limitations

The nature of preconscious processes is such that invariably the analyst could make more than one interpretation concerning the child's behavior. A single piece of behavior could have many analytic meanings. The analyst will usually take that meaning which is most closely related to the conflicts which he is currently discussing with the child. He will give priority to preconscious mental representations and affective states which represent obstacles to further elaboration of the child's thoughts and feelings.

Extrapolating to the child's preconscious mental state from the child's overt verbal and non-verbal behavior is hazardous. The analyst will not invariably be accurate about what the child is thinking and inaccurate interpretations are common. The analyst will usually sense if his interpretation was accurate from the child's affective response (see above).
Interpretations aim to help the child understand that the distorted nature of his mental representations and will only rarely have an immediate effect. Representations will change only slowly. When a mental process is substantially inhibited distortions will recur even more forcefully and interpretations will have apparently little effect in terms of changing the nature of the child's mental representations.
THE PSYCHOANALYTIC UNDERSTANDING OF CHILDHOOD PSYCHOLOGICAL DISTURBANCE

Introduction

Within a psychoanalytic model, childhood psychological disturbance is seen as initiated by conflicts. The manner in which children adapt to such conflicts provides the basis for our understanding of childhood disturbance.

In this section we delineate two psychoanalytic models of childhood disturbance. The first (the representational model), rooted in Freud's structural model of the neuroses, concerns the exclusion from consciousness of threatening ideas and feelings and the distortions of mental content brought about by the defences which ensure this exclusion. The second model (the psychological process model), rooted in Anna Freud's developmental approach, focuses on the pathological effects of the inhibition of developing psychological processes. The models identify two distinct, potentially pathological, means available to the child to deal with psychological conflict. The purpose of these models is not formally to distinguish one group of children from another. The value of the distinction is in explaining the differences between children in the accessibility of their psychological problems to treatment, and the relevance of specific techniques in bringing about changes in experience and behavior.

The Representational Model

The representational model of psychological disorder focuses on the distortion or repression of the mental representations of one or other of the conflicting wishes. These distortions represent an attempt at a compromise which serves to reduce anxiety and other forms of psychic pain. Psychological disturbance arises, not because these manipulations take place but because they are only partially successful and anxiety and guilt continue to interfere with the child's functioning.

The imagined gratification of a wish is invariably linked to the mental representation of a sought after affective state. In this way affects and wishes are intrinsically linked in the construction of mental representation. In many instances the individual's anticipated emotional experience associated with the gratification of a wish is also beset by negative affect (e.g. sadness, anxiety, guilt, etc.). Such negative affects are at the behest of mental representations of situations particularly those associated with the absence or the displeasure of the caretaker.
The multiple emotional implications of a wish are what we refer to as conflict. The range of wishes that may be entailed in conflicts leading to childhood disturbance covers the full spectrum of human motives.

In order to retain some semblance of pleasurable affect, the mechanisms used by the child to exclude mental representations from consciousness are applied in a less than comprehensive fashion. In this way, mental representations or wishes may be distorted so as to hide from consciousness aspects of anticipated negative affect.

Anxiety and other unpleasant affects initiate defence which leads to the division between conscious and unconscious mental experience. Representations deliberately excluded from consciousness are not integrated with the child's increasing knowledge of his world, and permit the child to maintain a large number of contradictory beliefs and expectations. With development, unconscious mental representations will be more and more incompatible with representations maintained in consciousness. Consequently the threat of the return into consciousness of these representations will be experienced as more dangerous because it implies a general return to an earlier childlike mode of thinking.

The child with the representational disorder responds to his failure to adapt to the demands of progressive development by attempting to resolve his conflicts in a regressive manner. Neurotic compromise formations engender anxiety because they are only partially successful in keeping repudiated aspects of mental representations of experience out of conscious awareness. These unwelcome representations may include distressing perceptions of the self, of the object, or of the self and object in interaction.

The Representational Model - Aim and Means

The ambiguity of the situation which the analyst presents to the child serves to activate, i.e. to make current, unacceptable mental representations. When the child behaves in a distinctively individual way, the analyst reacts to this distinctiveness with the assumption that communication about the adaptation the child has made underlies it. Interpretations serve to integrate developmentally primitive mental representations into higher-order organizations, and sustain the analytic process. Despite the child's resistance, the analyst's interpretations can gradually enable the child to achieve a greater tolerance for previously warded-off mental content and thus to construct a better integrated and more stable self representation. It is in the nature of mental representations to alter with
emotional experience. Child analysis, with its focus on the patient's current emotional state, creates the potential for lasting and pervasive modifications of the child's internal representational world.

As children develop more sophisticated ways of representing experiences of external reality, they tend to exclude more primitive mental representations. These primitive forms remain active but only unconsciously. The problem with the child's functioning arises when the more primitive, unconscious, representations are activated by internal or environmental demands. The child analyst, in making interpretations of unconscious forms of earlier experience, opposes the child's natural tendency to favour more complex forms of mental representation. However, he does this with the knowledge that the regressive experience within the analysis will facilitate the integration necessary to free the child's inherent tendency to progress developmentally.

The Mental Process Model

Mental representations cannot be separated from the processes which create and organize them. They are best conceived as the products of mental processes. Mental processes refer to all the diverse ways available to the human mind to create and act upon its mental representations. Such processes are not only relevant to but are pre-requisites for all developmental attainments.

Many mental processes have been addressed in the psychoanalytic literature under the heading of ego function. However, descriptions of ego functions have often obscured clinical phenomena through imposing a single term over a heterogeneous group of psychoanalytic observations and are at very diverse levels of generality.

In the early stages of the evolution of a mental process, its further development may be influenced by the balance between pleasure and unpleasure contained within the mental representations upon which the process acts. In later development, mental processes occur automatically and outside awareness, and with the development of defence mechanisms the child will have the capacity to bar from access to consciousness those specific mental representations associated with the experience of unpleasure. Earlier in development, the child is able to prevent unpleasurable mental experiences arising by inhibiting the mental process itself. The curtailment of a mental process has more drastic consequences for development, than does the repudiation of specific mental representations. The stunting and distortions of mental processes which result from such inhibitions of functioning are apparent in the limitations of the child's capacity for mental representation. Within this
model of psychopathology, we refer to the absence of psychological functions which may **descriptively** be thought of as deficits. The term deficit, however, is inaccurate insofar as it fails to denote the causal relationship between intrapsychic conflict and certain types of mental function. In the present context, failures of mental process are invariably seen as defensive in function because their inhibition, stunting or distortion performs an economic function whereby the child is able to avoid specific classes of painful mental representations.

Mental processes are known, broadly speaking, to evolve according to a biologically determined timetable. However, the child's environment, particularly his object relations, makes a vital contribution to the security with which a specific mental process is established. The importance of the quality of early experience for later psychological functioning derives in large part from the fact that it is only at this stage that the general functioning of mental processes is normally vulnerable to the effects of external experience.

Individuals differ in the extent to which specific mental processes have fully matured. Psychological disturbance is associated with relative immaturity of selected mental processes. Under-developed mental processes give rise to distorted object and self representations. Thus, from the clinical material of an individual child, it is not initially possible for the analyst to know whether he is confronted by derivatives of a defensively distorted representation or the product of an inarticulate mental process.

To distinguish these two models of disturbance within the clinical context we consider the following as 'hallmarks' of psychological disturbance related to the inhibition of psychic process: 1) the mental capacity corresponding to a process frequently appears to be lacking in a patient's material; 2) this lack is pervasive across divergent situations; 3) the interpretation of distorted mental representations does not lead to a change in the nature of the mental representations or the mental processes which gave rise to it; 4) the patient is unaware of the absence of a capacity and may regard his mental functioning as adequate; 5) the analyst may preconsciously 'compensate' for the patient's lack of mental capacity and may even find himself emotionally invested in the patient's adequate mental functioning; 6) the patient does not apparently benefit initially from the analyst's implicit use of those processes which are inhibited within the patient.

Disturbances involving significant degrees of deficit or distortion in the development of mental processes includes those usually diagnosed as borderline, some forms of narcissistic personality disorder, and those known at the Anna Freud Centre as "developmental disturbances", as well as the psychoses.
The Mental Process Model - Aim and Means

In therapeutically addressing disturbances deriving from the inhibition of mental processes, the patient's active mental involvement is elicited by the analyst's attention to the elaboration of the preconscious mental content of the patient. This mental involvement gradually brings about a reactivation of inhibited mental processes and thus leaves the child open to a gradual restructuring of inhibited mental representations through further analytic work. The analyst's interpretation sets the patient's mind a challenge to identify connections and integrate the interpretation with his current view of himself, his desires and his preconscious beliefs. In order to link the analyst's interpretation of the content of his mind to his current mental state, the patient will be obliged to reinvest his inhibited mental capacity. In the best of situations the patient's mental work recapitulates that of the analyst, albeit within the limitations set by the child's level of development. The patient's passive observation of the analyst's use of the capacity may further encourage the patient to reactivate inhibited modes of mental function.
APPENDIX 7

DEFENCE AND RESISTANCE INTERVIEW

STUDY 4
THE DEFINITION AND APPLICATION OF PSYCHOANALYTIC CONCEPTS
INSTRUCTIONS TO THE INTERVIEWER

Let each subject know beforehand the topic of the interview will be defence and resistance. Explain to them you are not interested in a theoretical discussion of the concepts, rather the interview is clinically focused. You are interested in examples of their work with defence and resistance. The examples should be of children in analysis, not adolescents. It will be helpful if subjects can be thinking of various examples of patients with different pathologies, and, if possible, different ages (e.g. under five, latency).

Five subjects need to be interviewed for this concept. As with other interviews, this one should take between 1 and 1 1/2 hours.

The format is an unstructured interview. Therefore, what follows is a guideline which includes areas to cover within the interview. The order of the questions is not important, nor is it crucial the exact words are used. The interview structure gives the interviewer ideas of how to word questions, how to get at what it is the subject means, and areas of importance to pursue. It is the task of the interviewer to help the subject expand on the information and examples she gives, and to gain further clarification. Some subjects need more prompting than others. Keep the interview as clinically focused as possible. As the subject gives examples help them expand on what it is the patient presented, what the analyst did, and how the patient responded.

INTERVIEW

I would like for us to talk about defence and resistance from a clinical perspective. My aim is for us to think about the role of these two concepts in your analytic work with children and specifically in relation to your technique.

To begin with, can you give me your working definition of defence? What purpose do defences serve for the child?

What is the result of a normal defence for the child? Of a pathological defence?

Can you now give me your working definition of resistance? Are there differences and/or similarities between defence and resistance?
I would like us to think about child analytic patients of yours and speak in terms of examples as we discuss issues of technique. (Get the interviewee to be as specific as possible - e.g. what would you say, what words would you use, etc.)

How do you take defence into account in your analytic work? Resistance?

What is it in the child's material that you would pay particular attention to in thinking about defence or resistance? What clues in the material would you look for that would indicate that defence was in operation? Resistance?

Some begin by acknowledging a defence/resistance to the child or drawing the patient's awareness to the defence/resistance? Is this how you would begin? What would you do next?

When you interpret defence do you always talk about what the patient is defending against as well? When would/wouldn't you? Can you give an example? Do you ever discuss the effects the defence has on the patient's functioning? When would/wouldn't you? Can you give an example?

Can you think of a patient of yours and a particular defence that was pathological that you analysed. What was the defence and how did it interfere with functioning? Can you describe the process you went through with this patient in analysing the defence?

(Get interviewee to start at the beginning and go through - e.g.: How did you know this was the child's defence? How would you begin, i.e. what were the first things you did? And then?)

What about another patient whose pathology/age was different from the first?

Can you now do the same in terms of resistance?

Are these things that you do once, or is it necessary to do them several times? What is the purpose of going over these things, or interpreting a defence more than once for the child?

In analysing defences what is it that you are aiming for? What is it that you are trying to accomplish? Are there short terms aims as well as long term aims?
Some people would point out to the patient alternative ways of handling situations as a way to help the patient build new defences. Is this something that you would do? If so, can you give an example?

Are there ever circumstances where you would purposefully not analyse a defence or leave that defence alone? Expand. What about resistance?

Some think that patients can defend against the transference whereas others think that transference itself is a defence or a resistance? Do you agree with either of these views? Can you give an example of one or the other or both?

How does your developmental viewpoint impact your definition of defences? Some think that there is a developmental line of defence. Would you agree with this notion?

How does your developmental viewpoint impact your aim and technique?

Are there certain children, certain ages or pathologies where you would not do as much defence analysis? Resistance analysis? If so why? (include neurotic, borderline and psychotic, developmental disturbances, narcissistic - latency and under five)

Is analysis of defence only possible in analysis? In what instances is analysis called for and when isn't it in this regard? Would there be a difference in how you handled defence/resistance analysis in psychotherapy vs. analysis? Expand.
APPENDIX 8

CONFLICT INTERVIEW

STUDY 4

THE DEFINITION AND APPLICATION OF PSYCHOANALYTIC CONCEPTS
INSTRUCTIONS TO THE INTERVIEWER

Let each subject know beforehand the topic of the interview will be conflict. Explain to them you are not interested in a theoretical discussion of the concept, rather the interview is clinically focused. You are interested in examples of their work with conflict. The examples should be of children in analysis, not adolescents. It will be helpful if subjects can be thinking of various examples of patients with different pathologies, and, if possible, different ages (e.g. under five, latency).

Five subjects need to be interviewed for this concept. As with other interviews, this one should take between 1 and 1 1/2 hours.

The format is an unstructured interview. Therefore, what follows is a guideline which includes areas to cover within the interview. The order of the questions is not important, nor is it crucial the exact words are used. The interview structure gives the interviewer ideas of how to word questions, how to get at what it is the subject means, and areas of importance to pursue. It is the task of the interviewer to help the subject expand on the information and examples she gives, and to gain further clarification. Some subjects need more prompting than others. Keep the interview as clinically focused as possible. As the subject gives examples help them expand on what it is the patient presented, what the analyst did, and how the patient responded.

INTERVIEW

I would like for us to talk about conflict from a clinical perspective. My aim is for us to think about the role of conflict in your analytic work with children and specifically in relation to technique - how you deal with conflict analytically.

To begin with, can you give me your working definition of conflict?

Are there pathological and normal conflicts?

What is it that makes a conflict problematic for a child?
If a child finds a solution which is unacceptable to them how does this manifest itself? What about the manifestation of an unresolved conflict? Is the conflict conscious or unconscious in these instances, or what happens if the conflict becomes conscious?

Are problematic conflicts an aspect of all disturbances? Expand.

I would like us to think about child analytic patients of yours and speak in terms of examples as we discuss technique.

In thinking about both conscious and unconscious conflict, how is it that you go about identifying a conflict that the child is in? What clues would you look for that would give you indications? Would you ever wonder about things which were not evident in the material? Can you give an example?

Are you only looking for what the conflict is, or ways the child has resolved or failed to resolve the conflict? Example.

How would you go about communicating your understanding of the conflict to a child? Example.

Can you think of a patient of yours and a particular conflict that was analysed. What was the conflict and how did the resolution or conflict itself interfere with functioning? Can you describe the process you went through with this patient in analysing the conflict?

(Get interviewee to start at the beginning and go through - e.g.: how did you know this was the child's conflict? How did you know about the ways the child attempted to resolve it? How would you begin, i.e. what were the first things you did? And then?)

What about another patient whose pathology/age was different from the first?

Is there a relationship between analysing conflict and the transference? Expand with example.

When you interpret a conflict do you always talk about both sides of the conflict? Why and example. How is it that you would say this to a child? Would you ever not do this? Why and example.
Do you ever make interpretations that are not conflict based? Or that talks about both sides? Why or why not with example.

Would you ever give the child an alternative way to resolve his conflict? Expand.

In analysing conflict what is it that you are aiming for? What is it that you are trying to help the child accomplish?

How does your developmental viewpoint impact your view of conflict? Your aim or technique?

Are there certain children, ages or pathologies where conflict analysis is more applicable than others? Expand. (neurotic, borderline, psychotic, narcissistic, developmental disturbance - under five vs latency)

Are there any circumstances when you have assessed the child is dealing with a conflict in a problematic way that you would leave it alone? Explain.

Is analysis of conflict feasible only in analysis? What would the difference be in working this way in psychotherapy?
APPENDIX 9

AFFECTS INTERVIEW

STUDY 4
THE DEFINITION AND APPLICATION OF PSYCHOANALYTIC CONCEPTS
INSTRUCTIONS TO THE INTERVIEWER

Let each subject know beforehand the topic of the interview will be affects. Explain to them you are not interested in a theoretical discussion of the concept, rather the interview is clinically focused. You are interested in examples of their work with affects. The examples should be of children in analysis, not adolescents. It will be helpful if subjects can be thinking of various examples of patients with different pathologies, and, if possible, different ages (e.g. under five, latency).

Five subjects need to be interviewed for this concept. As with other interviews, this one should take between 1 and 1 1/2 hours.

The format is an unstructured interview. Therefore, what follows is a guideline which includes areas to cover within the interview. The order of the questions is not important, nor is it crucial the exact words are used. The interview structure gives the interviewer ideas of how to word questions, how to get at what it is the subject means, and areas of importance to pursue. It is the task of the interviewer to help the subject expand on the information and examples she gives, and to gain further clarification. Some subjects need more prompting than others. Keep the interview as clinically focused as possible. As the subject gives examples help them expand on what it is the patient presented, what the analyst did, and how the patient responded.

INTERVIEW

I would like for us to talk about affects from a clinical perspective. My aim is for us to think about the role affects have in you analytic work with children and specifically in relation to your technique - your technique in relation to a child's affects as well as how they relate to other analytic interventions.

To begin with, can you give me your working definition of affects. I realise it is a broad term used by analysts in reference to many things, but how would you define it?

Would you include anxiety in your definition of affect? Is anxiety an affect? Is there a special distinction to be made between anxiety and affect? What about guilt?
There has been controversy over the years about whether affects can be unconscious or not. What are your thoughts about this?

Overall analysts tend to think that anxiety has a signal function. Do you think affects in general have a signal capacity? If so, what function does this signal capacity serve for the child?

Do you find the term "negative affects" useful? What does it mean to you?

What use does the child make of his affects? What purpose do they serve?

Are affects important to your analytic work? Why?

I would like us to think about child analytic patients of yours and speak in terms of examples if that is possible as we discuss issues of technique.

What use does the analyst make of a child's affects?

What clues do you look for in the analytic material which provide you with evidence as to what the child is feeling, or the nature of his affects? Give examples.

Some begin by labeling a child's affects? Would this be your method? What would you do next?

Can you describe in an example of one of your patients how you go about working with a child's affects?

(Use the steps the subject has outlined - e.g. labeling, interpreting. Try to get at specifics about what they would say, what words would they use.)

Do you only interpret the affect or is it in relation to other things? Give examples. In other words - are affects related to or part of other analytic concepts or techniques? Which ones? Are some of these more important to others?

Does understanding a child's affects by the analyst serve a function for the child? Expand. What function does interpretation of affect serve? Other interventions?
Do you address a child's affects in relation to the external world as well as the analytic world? When and why? Are there certain circumstances when addressing affects in relation to the external world might be of special importance?

In general, in thinking about the work that you do and how you do it as we have discussed, what is it that you are working towards? What is your aim?

Is there ever a time you think it is important not to label or interpret a child's affect? Expand with examples.

Are there certain circumstances where you would interpret differently or emphasise one aspect over another - say the expression of affect or the control of affect? Expand with example.

Are there certain circumstances where the interpretation of affect does not provide relief? Give examples.

Do you think there is a relationship between interpretation or labeling affects and the development of the transference? Are there other links between affect and transference? Expand with examples.

Would your technique or aims vary in relation to anxiety? What about shame or guilt? Give examples.

Does your developmental viewpoint impact your aim and technique when it comes to working with a child's affects? How? Examples.

Are there certain pathologies or ages where work with affects is more applicable than others? Why? (Include here neurotic, borderline or psychotic, narcissistic, developmental disturbances - under five vs. latency.)

Is work with affects only applicable to analytic patients? What would the difference be, if any, with psychotherapy patients?
APPENDIX 10

TRANSFERENCE INTERVIEW

STUDY 4
THE DEFINITION AND APPLICATION OF PSYCHOANALYTIC CONCEPTS
INSTRUCTIONS TO THE INTERVIEWER

Let each subject know beforehand the topic of the interview will be transference. Explain to them you are not interested in a theoretical discussion of the concept, rather the interview is clinically focused. You are interested in examples of their work with transference. The examples should be of children in analysis, not adolescents. It will be helpful if subjects can be thinking of various examples of patients with different pathologies, and, if possible, different ages (e.g. under five, latency).

Five subjects need to be interviewed for this concept. As with other interviews, this one should take between 1 and 1 1/2 hours.

The format is an unstructured interview. Therefore, what follows is a guideline which includes areas to cover within the interview. The order of the questions is not important, nor is it crucial the exact words are used. The interview structure gives the interviewer ideas of how to word questions, how to get at what it is the subject means, and areas of importance to pursue. It is the task of the interviewer to help the subject expand on the information and examples she gives, and to gain further clarification. Some subjects need more prompting than others. Keep the interview as clinically focused as possible. As the subject gives examples help them expand on what it is the patient presented, what the analyst did, and how the patient responded.

INTERVIEW

I would like to talk about transference from a clinical perspective. My aim is for us to think about the role of transference in your analytic work with children and specifically in relation to technique.

Some have defined transference as a universal phenomenon whereas others see it as something unique to the analytic situation. Do you agree that transference can be universal and, if so, how would you define it in this sense?

Within the analytic situation would you differentiate between this universal type and transference which is unique to the analytic situation? What would be the difference?

What is your working definition of transference?
Is working in the transference an important aspect of your clinical work with children? Why?

I would like us to think about child analytic patients of yours and speak in terms of examples as we discuss issues of technique.

Are all aspects of a child's relationship with the analyst classified as transference? If not, what are the other aspects and would you differentiate between these clinically? How does this impact your work?

What clues do you look for in the analytic material that provide you with evidence that a transference has developed?

How do you then go about working with this material? What would you say, how would you word your interpretations?

Do you ever try to facilitate the development of a transference? Why and how do you go about doing this?

To what extent do you link the transference to important objects in the child's life? Do you ever not do this? When and why? To what extent do you link the transference with internal object relationships? When and why? Examples.

Do you ever answer a child's questions about you? Why and when or why not? Examples.

Is there a relationship between transference and enactment? Expand.

Do you ever correct a child's perceptions about you? Expand.

In working with children do you ever have a sense that the child is trying to get you to act in a certain way? Give examples and the clues you got from material, as well as how you handled the situation - words of interpretation.

What is meant by resolution of the transference? Expand.

What do you think the child's perception of the transference is?
Do the terms interpretation in the transference and of the transference mean different things? Expand.

In analysing the transference, or working in the transference, what is it that you are aiming at. What are you trying to accomplish?

What do you think the differences might be in working in the transference with children as opposed to adults, if any?

How does your developmental viewpoint impact your aim and technique in transference work with children? Are there special techniques you use when working with children in regards to transference? Expand.

Are there certain pathologies or ages where transference work is more applicable than others? Why? (neurotic, borderline, psychotic, narcissistic, developmental disturbance - under five vs latency)

Is transference work only applicable to analytic patients? What would be the difference in the development of transference or your work with the transference with psychotherapy patients?
APPENDIX 11

OBJECT RELATIONS IN THE CLINICAL CONTEXT INTERVIEW

STUDY 4
THE DEFINITION AND APPLICATION OF PSYCHOANALYTIC CONCEPTS
INSTRUCTIONS TO THE INTERVIEWER

Let each subject know beforehand the topic of the interview will be object relations. Explain to them you are not interested in a theoretical discussion of the concept, rather the interview is clinically focused. You are interested in examples of their work with object relations. The examples should be of children in analysis, not adolescents. It will be helpful if subjects can be thinking of various examples of patients with different pathologies, and, if possible, different ages (e.g. under five, latency).

Five subjects need to be interviewed for this concept. As with other interviews, this one should take between 1 and 1 1/2 hours.

The format is an unstructured interview. Therefore, what follows is a guideline which includes areas to cover within the interview. The order of the questions is not important, nor is it crucial the exact words are used. The interview structure gives the interviewer ideas of how to word questions, how to get at what it is the subject means, and areas of importance to pursue. It is the task of the interviewer to help the subject expand on the information and examples she gives, and to gain further clarification. Some subjects need more prompting than others. Keep the interview as clinically focused as possible. As the subject gives examples help them expand on what it is the patient presented, what the analyst did, and how the patient responded.

INTERVIEW

I would like for us to talk about object relations from a clinical perspective. My aim is for us to think about the role of object relations in your analytic work with children and specifically in relation to technique.

To begin with, can you give me a working definition of object relations? What does the concept refer to?

Some people speak about internal object relations and external object relations. Is this a distinction you find useful? What is the relationship, differences and/or similarities between the two?

How do internal representations develop? What contributes to their development?
In your view are internal object relations set or static, or are they changing or modified? If you think the latter, for what purpose are they modified? I'm not talking about modification in relation to the analytic process and psychic change, but on a day to day or moment to moment basis.

What use does the child make of internal representations? What is their purpose?

Is there a relationship between internal representations and conscience? If so, what do you think it is?

I would like us to think about child analytic patients of yours and speak in terms of examples as we discuss issues of technique. Try to use two different analytic patients if you can.

How did you formulate your view of your patient's object relations?

What led to this formulation? In other words, what were the clues which led to your formulation and where did they come from?

What else would you want or need to know in order to build up a picture of the child's object relations? What else would you look for and where?

What sorts of interventions did you make in regards to the child's object relations. (Try to get at the steps in the process, i.e. what did they say first, then later, etc. What were their words?)

Why did you choose to intervene in this way, rather than say an interpretation of the transference, interpretation in displacement, keeping the intervention with the child's external objects, a verbalisation, etc.?

When might you have intervened differently and why?

How do you present the idea of internal object relations in an interpretation?

What is it that you are working toward with these patients as it pertains to object relations? What is your aim? What are you trying to demonstrate to the patient? What change are you trying to accomplish?
Is an object relations viewpoint an aspect of your work with all of your patients?

Is there a relationship between transference and object relations? Expand. What about in regards to other aspects of the relationship with the analyst?

Do you ever encourage the transference? How and for what purpose?

Some people make a distinction between transference general and transference proper. What would the distinction be?

Is there a relationship between object relations and fantasy? Explain and give examples.

Is there a relationship between object relations and thinking? Explain and give examples.

Is there a relationship between object relations and affect? Explain and give examples.

Does your developmental viewpoint influence your understanding and formulations in regards to object relations? How? How does it influence your technique? How does it influence your aim?

Are there certain pathologies or ages or circumstances when object relations does not come into your work with children? (For e.g. borderline, psychotic, developmental disturbance, under five vs latency)

Do you take the viewpoint you have described only with analytic patients or also with psychotherapy patients? What would the difference be, if any?
APPENDIX 12

INTERPRETATION INTERVIEW

STUDY 4
THE DEFINITION AND APPLICATION OF PSYCHOANALYTIC CONCEPTS
INSTRUCTIONS TO THE INTERVIEWER

Let each subject know beforehand the topic of the interview will be interpretation. Explain to them you are not interested in a theoretical discussion of the concept, rather the interview is clinically focused. You are interested in examples of interpretations they have made to their patients. The examples should be of children in analysis, not adolescents. It will be helpful if subjects can be thinking of various examples of patients with different pathologies, and, if possible, different ages (e.g. under five, latency).

Five subjects need to be interviewed for this concept. As with other interviews, this one should take between 1 and 1 1/2 hours.

The format is an unstructured interview. Therefore, what follows is a guideline which includes areas to cover within the interview. The order of the questions is not important, nor is it crucial the exact words are used. The interview structure gives the interviewer ideas of how to word questions, how to get at what it is the subject means, and areas of importance to pursue. It is the task of the interviewer to help the subject expand on the information and examples she gives, and to gain further clarification. Some subjects need more prompting than others. Keep the interview as clinically focused as possible. As the subject gives examples help them expand on what it is the patient presented, what the analyst did, and how the patient responded.

INTERVIEW

I would like us to talk about interpretation from a clinical perspective, in other words interpretations you have given to patients. My aim is to think about the role of interpretation in your analytic work with children and specifically in relation to technique.

To begin with, can you give me a working definition of interpretation. What is it and what does the concept mean?

What informs your interpretation, or how do you decide what the content of your interpretation will be? In other words, where do you get your information that prompts you to make a certain interpretation at a specific time?
To Interviewer: Have the subject give an example of an interpretation they have made to a patient. Do this with two different examples. Also ask the subject if they have an example of an interpretation that would fall under what is often termed "developmental help". In all likelihood the subject will give vignettes, not just the interpretation alone. Following each example try to explore with the subject the areas outlined below. Your questions may be to clarify - "so you mean...", or they may be more explicit and used to help the subject expand. Some of the questions may have been covered in the definition.

What led you to make this interpretation at this specific time?

What is it you were aiming at by making this interpretation? What were you trying to accomplish, or get the patient to do/see/understand? Is the aim different with all of the examples given? Is degree or type of pathology a factor in the aim?

Children communicate to the analyst their unconscious concerns in many different ways. What is it you looked for in this patient's material which aided in your understanding of the communication and thus led you to your interpretation?

Analyst's make choices about what they are going to interpret and when. Sometimes one could see in the material more than one interpretation that could be made. Do you have an example of this? What led you to interpret one thing rather than another?

To Interviewer: Using the examples which have been given you can ask what is pertinent to that specific example to gain further information. For example:

What led you to make a transference interpretation rather than an extratransference interpretation?

Or: defence rather than conflict?

Or: oedipal interpretation rather than preoedipal?

Or: to interpret one conflict rather than another?

Along the same lines, there are times one can see from a patient's material two different levels of operation, e.g. oedipal and preoedipal. When and why do you decide to interpret one rather than the other?

Patient's will usually let you know in one way or another whether your interpretation was on target or whether you missed the boat. How, in the examples you have given, did your patients let you know this?
Some say that interpretations **enhance the flow of the material**. In other words, an interpretation which is appropriate or on target will be followed by further material? Do you agree? Give examples.

Some say there are times an interpretation is **not at all helpful** to the patient. Do you agree? Give examples. If you agree, is this linked to the degree or type of pathology?

What do you think an interpretation **needs to include**?

Is there such a thing as a **partial interpretation**? A **complete interpretation**? What, if any, is the difference? Give examples of each.

Some say that an interpretation, to be complete, needs to make a **reference to the past**. Do you always make a reference to the past, or when would you and wouldn't you?

There is a school of thought about **here and now interpretations**, that is interpretations should always be placed in the present or refer to the present situation. Elaborate your thoughts about this.

Are interpretation always of **conflict**? When you do make interpretations of conflict do you make a point to include both sides of the conflict?

What is the difference between **verbalisation, clarification and interpretation**?

What is the relationship between **interpretation and working-through**?

Does the **technique or aim** of interpretation **vary** dependent on:
  - Certain pathologies?
  - The phase of treatment?

How does your **developmental viewpoint** influence the interpretations you make? Include: how it influences the technique, formulation of interpretations, and aim.

Do you adhere to the same philosophy about interpretation with patients in **psychotherapy** as you do with those you described of analytic patients? Explain.
APPENDIX 13

DEVELOPMENTAL DISTURBANCE INTERVIEW

STUDY 4
THE DEFINITION AND APPLICATION OF PSYCHOANalytic CONCEPTS
If one took a global view of the Anna Freud Centre's understanding of childhood psychological disturbance the outcome would be one of two types. First are "Neurotic Disturbances", the type of disturbance on which child psychoanalytic techniques were originally based. The second type is "Developmental Disturbance". This includes such disorders commonly known as borderline, narcissistic personality disorder, atypical, psychosis, and even developmental disturbance as a subtype. With these patients analysts sometimes think in terms of "developmental help" and/or techniques and concepts which may vary from those used when the diagnosis of neurosis is given.

For this interview I would like you to think of child patients (not adolescents) whom you have treated in psychoanalysis. I am looking for one of two things. Two patients with different pathologies, who might fall under the two broad types outlined above is one possibility. Additionally, as patients do not tend to fall purely under one type, especially young children, you may think of patients who constitute a mixture of these two types and with whom your techniques were also a mix.

This interview is an attempt to delineate, based on clinical material, the techniques used with these types of disturbances. It will be clinically focused rather than a discussion of theory. The purpose of preparing you beforehand is to give you time to mull over cases in your mind prior to the interview, but not to ask you to do any further preparation. As always, the interview is confidential. Thank you for your time and cooperation.

INSTRUCTIONS TO THE INTERVIEWER

The format is an unstructured interview. Therefore, what follows is a guideline which includes areas to cover within the interview. The order is not important, nor is it crucial the exact words are used. The interview structure gives the interviewer ideas of how to word questions, how to get at what it is the subject means, and areas of importance to pursue. These are broad areas which look at what is wrong internally with the child. You need to get the subject to be as specific as possible and to illustrate clinically. It is the task of the interviewer to help the subject expand on the information and examples she gives, and to gain further clarification. Some subjects need more prompting than others. Keep the interview as clinically focused as possible. As the subject gives examples, help them expand on what it is the patient presented, what the analyst did, and how the patient responded.
Five subjects need to be interviewed for this concept. As with other interviews, this one should take between 1 and 1 1/2 hours.

Have the interviewee give one example, then discuss, then the second example. The examples may be of the two different patients or the same patient, but different aspects of the analytic work. The idea is to compare and contrast the two examples. Try to get the subject to be as explicit as possible about what they mean. For example, if they talk about "ego deficits" get them to define what they mean by that, or better yet, to show it through a clinical example. Or, if they talk about "developmental help", have them illustrate through their work with the child what it is that means. Etc.

INTERVIEW

Describe the patient in terms of the nature of the child's disturbance.

What do you think the etiology of the child's disturbance might be? You can talk in terms of the environmental influences, but also include your model of the child's internal world. Illustrate through clinical material.

What psychic processes or mechanisms maintain the child's disturbance? Or account for the child's disturbance?

I would like us to think about child analytic patients of yours and speak in terms of examples as we discuss issues of technique. Describe and illustrate your responses to the following questions.

What sorts of interventions did you make?

What were you trying to do?

How did the child respond?

Compare and contrast the two examples.
Note to Interviewer: If it hasn't yet come up through the clinical examples ask:

How would you define and/or characterise:
- an ego function
- an ego deficit
- developmental help

Note to Interviewer: After the clinical examples have been looked at ask:

Anna Freud (1965) said:
...in actual experience few individual child patients present us with the pure clinical picture which, alone, would justify a therapy directed toward one specific factor. In most cases, the disturbances consist rather of mixtures and combinations of elements which contribute in varying degrees to the final pathological result.

Would you agree or disagree with this statement? Elaborate and discuss.

Anna Freud went on to say:
It is the mixed psychopathology of childhood for which the comprehensive method of child analysis is needed. Only in child analysis proper is the whole range of therapeutic possibilities kept available for the patient, and all parts of him are given the chance on the one hand to reveal and on the other to cure themselves.

Would you agree or disagree? Elaborate and discuss.

Following on this point, some years later Sandler, Kennedy and Tyson (1980) said:
The therapist departs from child analysis and enters the realm of psychoanalytic psychotherapy when he intentionally limits himself to specific procedures and avoids following the material into certain areas or avoids making use of any of the wide range of child psychoanalytic techniques available when such techniques are indicated. Child psychotherapy is a modification imposed by analysts or therapists on the basis of an a priori selection of techniques.

Would you agree or disagree? Elaborate and discuss.
Taking what we have discussed in relation to your clinical examples, are these types of disturbance and techniques which could very well fit with one patient? Elaborate.

Would you have worked differently with the patients you have presented if they were in psychotherapy rather than psychoanalysis? Could they have been treated in psychotherapy? What do you think the differences would have been in terms of technique and outcome?