

**WHAT IS THE IMPACT OF INTERMITTENT STRABISMUS
UPON THE THERAPEUTIC RELATIONSHIP?**

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**A thesis submitted in partial fulfilment of the requirements
of the University of East London for the
Professional Doctorate in Child Psychoanalytic Psychotherapy**

July 2014

Abstract

This study asks: ‘How does intermittent strabismus impact upon the therapeutic relationship?’ A template organising style has been used to analyse child psychotherapy process records of children who suffer from intermittent strabismus during assessments for child psychotherapy. The research utilises ideas from the field of ophthalmology in order to assist in the development of a psychotherapeutic understanding of this condition. The themes that emerge from the analysis of the clinical data, together with an exploration of the relevant ophthalmic, psychoanalytic, and child development literature, have elaborated how intermittent strabismus might influence the transference and counter-transference, in a way that potentially promotes a fragmentary quality of emotional relatedness. It is suggested that this may challenge the child’s ability to maintain their relationship with the external world. It also illustrates, thematically, how child psychotherapists might respond to this negative influence by emphasising their own visual reciprocity, thereby aiding the child’s visual and emotional coherence. Also, when they do this, it might appear to correspond with the child’s ability to explore both their inner and outer environment reflectively. It is suggested that the findings might beneficially influence practice within the consulting room.

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Acknowledgements:

With gratitude to Anne Alvarez, Tanya Nesic-Vuckovic, Janet Shaw and Patrick Eason.

CHAPTER ONE

Introduction

Strabismus is the misalignment of eyes. In intermittent strabismus, the misalignment is experienced as fluctuating. This research concerns the study of intermittent strabismus within the context of child psychotherapy and asks: ‘How does intermittent strabismus impact upon the therapeutic relationship?’

I saw a young boy of about six years of age who, in his first psychotherapy assessment session, suffered from what appeared to be a hallucination of wasps in the consulting room. With anxious, widened eyes and a quivering voice he told me that wasps were ‘coming out of the walls’, and that they would attack my eyes and my face. The boy hovered in front of me wielding a plastic ruler and I worried that he, not the imaginary wasps, would attack my face. Alarmed, I intuitively took the ruler from his hands and pretended to ‘get’ the wasps with the ruler. He looked incrementally calmer, and more so when I spoke to him about how ‘I was the one to be really worried about the wasps getting me’. Eventually, he thought that we had got rid of them and he began to play in a more ordinary way, and this corresponded with his eye contact becoming warmer and less urgent.

When, after this session, I met with the boy’s mother, I noticed my difficulty in meeting her gaze. I became aware that she suffered from strabismus and it was difficult to place my eyes in correspondence with hers. Consequently, when I left the session, I noticed that I had a headache and eye strain. This was not typical for me and so I suspected that there was something being expressed through the eyes counter-transferentially. Upon meeting her again, and after she had undertaken a short period of psychotherapy with a colleague, I noticed that the difficulty in maintaining eye contact with her had shifted, and it was a much more ordinary experience.

At the time, I didn’t have a ready explanation for these experiences but I suspected in the session with the young boy, I was being exposed to an experience akin to the one I’d had with his mother; that in both sessions, but in different ways, my eyes had been under attack which had made contact difficult to achieve.

Although he did not have strabismus himself, I imagined the young boy had, in the session with me, conveyed something of his experience of being with a mother who on occasion had eyes that communicated a profound visual sting; it seemed that the strabismus was implicated in this. I suspected that, what might have caused a headache in me, might have been a very powerful and developmentally damaging experience for him as a young infant.

This experience continued to puzzle me. It seemed very difficult to disentangle what might be the impact of strabismus from what might be an emotional difficulty. I was also interested in how the mother's strabismus had seemed to reduce after a period of psychotherapy and wondered how this was possible. My colleague, whom she had seen in psychotherapy, felt equally curious and was unable to proffer an explanation.

This unexplained encounter stayed with me throughout the following years in practice. So when I found myself to have not one, but unusually over the course of around four years, four patients in therapy who suffered from strabismus, my interest was re-ignited. The patients were children rather than adults with strabismus, but I suspected that similar dynamics to the ones that I had previously experienced might also be observed in this group.

As a child psychotherapist, with a long standing interest in infant mental health, I had a professional interest in the nature and the quality of eye contact as a form of non-verbal communication. I also appreciated its importance for the development of maternal reciprocal relationships. How strabismus impacted upon this kind of early relational system could have been a starting point for this research; it would have been very interesting to study infant-parent dyads where either the child or the parent suffered from strabismus. However, I was more interested at this juncture in how the child's inner experience of reciprocity, whilst growing up with their own strabismus, may have in turn manifested itself within the therapeutic relationship. Given that I was considering undertaking a professional doctorate, I was also interested how this might be studied in a clinical population. This seemed like a very complicated proposition.

As a result of my involvement with a cohort of children who I had worked with over a number of years, I became preoccupied by the nature of the transference, the counter-transference, challenges in emotional containment, and how a psychotherapist might best

respond within the context of having a child who suffered from strabismus within psychotherapy.

One challenge that came fairly early on was to understand what strabismus was. This meant that I had to begin to research a very different professional field, one which generally covered ophthalmology, optometry and vision science. I found that the array of technical terms, jargon, and complexity of the area which covered the physiology of the eye, the visual system, the functionality of the eye and neuroscience, quite overwhelming. My initial reading in neuroscience for instance was dense and detailed, and seemed to bear little relationship or relevance to the lived experience of a child with strabismus, or a child in psychotherapy. Moreover, many of the strabismic conditions had several terms for the same problem. I thought it was little wonder then that most of the psychoanalytic texts that I had come across avoided any comprehensive description of the nature of or explanation of strabismus. My initial efforts to marshal an understanding of the problem therefore resulted in an oversimplification to the detriment of the study. I had not fully appreciated the difference between intermittent strabismus and constant strabismus for example. However, upon reading the psychoanalytic texts again, I suspected that I may not have been alone in this possible misunderstanding. I think that there may be confusion about this that begins with Freud and Breuer (1893, p.89) as they claimed that they had ‘talked away’ a ‘convergent squint’, only for it to be reported by others several years later (Kaplan, 2004). Alternatively, Leira (1984), who curiously never even referenced Freud and Breuer (1893), in her title described the outcome as an ‘amelioration’ rather than cure. Both saw their patients as suffering from profound strabismus that had a psychological cause and was subsequently helped through psychotherapy. None of these writers considered the possibility that the strabismus itself was having an impact upon the emotional functioning of the individual rather than the other way around. Although other authors did explore this area (Lipton, 1970; Hertel, 2003), they were limited in their exploration of how it might impact upon the transference and counter-transference. This was, therefore, an under-explored area within the literature and worthy of further study.

I consequently decided to avoid a research question that seemed to aim at any notion of an expectation of a cure for strabismus. Secondly, I decided to focus my studies upon those children in my case load that were known to suffer from intermittent strabismus, as confirmed by a consultant ophthalmologist. Whilst there is little to suggest in the ophthalmological literature that constant strabismus has an emotional component, there

is evidence from the literature that ophthalmologists believe that there is some indication that intermittent strabismus could have an emotional dimension. Clinically, my experience was that all of the children I saw had a variation in the way their eyes functioned corresponding to the emotional atmosphere. However, I considered that it would be more beneficial for the research to concentrate upon those children who might be expected to display emotionality through the dis-fluency in their eyes, as supported by the ophthalmological literature, rather than those who did not, hence the focus upon intermittent strabismus.

The ophthalmological literature is very clear that strabismus has its foundation in a combination of genetic, developmental and environmental factors (such as maternal health). There is no expectation that it has a psychological aetiology. Therefore, the research question had to be shaped so that there was no implication that strabismus was caused by emotional difficulties, as is suggested by some psychoanalytic authors such as Winnicott (1958). In this way, I have applied ideas from the ophthalmological field to the psychoanalytic field, in order to inform the psychoanalytic understanding of this condition.

The title of this study is: ‘What is the impact of intermittent strabismus upon the therapeutic relationship?’, whereas the question was formulated as: ‘How does intermittent strabismus impact upon the therapeutic relationship?’

The psychoanalytic literature suggested that fluctuations in eye movements in strabismus could be seen to manifest in a matter of a few sessions (Leira, 1984). I had an expectation, informed by both the psychoanalytic and ophthalmological literature, that anxiety was implicated in the manifestation of intermittent strabismus, so it seemed reasonable to use assessments of psychotherapy for this study.

I was able to use two children from my regular case load who suffered from intermittent strabismus in this study; obviously neither had been referred for the problem of strabismus. I chose to study them in a natural, non-intrusive way within child psychotherapy assessment sessions and through the analysis of closely observed process recordings.

My initial inclination was to use a grounded theory form of organising and analysing the data. However, upon investigating this further I realised that it would be difficult to

eschew my prior knowledge as required by this method. I had an expectation that I might observe a fluctuation in the children's strabismus according to the emotional atmosphere within the session. I knew that I wanted to examine the nature of the transference and the counter-transference, and the challenges to emotional engagement, and therefore expected to be looking for these kinds of psychoanalytic themes. My discovery of template analysis, which is not usually applied to child psychotherapy research, enabled me to make use of these prior ideas or themes in order to develop a template. The template was built generatively and culminated in the construction of both overarching and sub-themes and, therefore, it can be argued retains a multi-perspective view of the data: the child, the therapist, and the strabismus.

The template was applied to the two case studies and data was used to illustrate these findings. The findings were then discussed in relation to the literature and the developmental history of the children in order to extend and elaborate the meaning from the template of themes.

Overview of dissertation

The dissertation will continue with a review of the relevant literature that describes an understanding of intermittent strabismus according to the field of ophthalmology. It will explore the dynamic nature of visual distortion that may be associated with strabismus. It will also explore aspects of visual development, eye contact, and its importance to the emotional development of the child. It will look at the possible impact of visual impairment upon development. It will consider the area of strabismus and psychiatry and, finally, it will explore psychoanalytic perspectives.

In the methodology chapter, I will describe the context of the research project, how the research question was formulated, the assessment experience, and the children being studied and associated ethical considerations. I will discuss the choice of methodology and then I will discuss the case study method and its application to research. Following this, I will deliberate on data collection and observational process recordings as data. The position of the researcher, choosing data sets and data analysis, will then be considered. I will then describe the development of template analysis as a qualitative method and its application to psychotherapy, isolating themes and coding processes in template analysis, and 'immersion' in the data. I will describe the *a priori* influences and emerging themes, choosing the data, developing the template and a constant comparison method. I will

discuss the relevance of researching particularity, code development, quality and trustworthiness of the research, and finally the strength and weaknesses of the study.

The chapter containing the findings is entitled 'Case Studies: What we can learn from them.' Within the chapter there will be a discussion of the themes arising from the two individual case studies, this will include links to the literature and how it might apply to the themes, and this also utilises examples from the raw data. Following this there is a comparison of the two children.

Finally, in the conclusion, I will discuss the purpose of the research, a summary of the findings, implications for child psychotherapy practice and for the multi-disciplinary arena. Then I will go on to discuss implications for future research before offering a critique of the study.

CHAPTER TWO

The literature review

To answer the question, ‘How does intermittent strabismus impact upon the therapeutic relationship?’ it is helpful first to look at the ophthalmological literature in order to give an overview and a medical context to the disability and, ultimately, to be able to apply this knowledge to the psychoanalytic field. It will provide a basis for detecting both the overlap and the divergences between an ophthalmic and a psychoanalytic view. The literature has been selected in order to help define the nature of the disability, to give an understanding of its genetic and developmental aetiology, and to show how an emotional component might relate to these areas. I have chosen to offer a summary of the complexity of strabismus, in order to include those aspects that are of relevance to this research. A wider set of descriptions would be highly technical and ultimately unnecessary as this is not a study about eye disorders *per se*.

Following this, I have looked at the research concerning visual disability, visual development, and the importance of eye contact for the developing mind. I have only briefly touched upon the neuroscience literature concerning strabismus. It is highly technical and expansive and, although potentially important to the general study of strabismus as it pertains to the visual system, my initial research has suggested that it is less applicable in order to answer the research question. I have, however, touched upon an aspect of the neuroscience research that informs the development of the personality and the growth of the mind, and set this in relation to discussions concerning child development and the importance of eye contact.

I have surveyed the psychoanalytic field which, starting with Freud and Breuer (1893), illustrates a long-standing interest in strabismus. I have included relevant papers from attachment research, not as a review of the field, but as part of the broader discourse around child development.

The majority of the research that concerns the emotional and behavioural aspects of intermittent strabismus is clinical, both from an ophthalmological and psychoanalytic perspective, often in the form of case studies, occasionally a case series. Following each section of the research, I have given a summary and drawn out the conclusions that are relevant to the research question.

Childhood strabismus

Strabismus, more commonly known as a squint, is described as affecting around 2.1% of the UK child population (Taylor, 2012, p. 4), but this figure may vary internationally (Freidman, 2009, p. 3). Strabismus is defined as a 'pathological misalignment of the visual axes' (Taylor, 2012, p. 3).

The onset of strabismus is usually detected before the age of 5 years (Taylor, 2012). It usually occurs within a context of otherwise normal general health, however, rarely, it can be associated with neurological diseases (Taylor, 2012). Strabismus may also be associated with conditions that include Down's syndrome, prematurity, developmental delay, craniofacial features, fetal alcohol syndrome, unilateral ocular disease and cerebral palsy (Taylor, 2012). Whilst strabismus is often considered to have a significant genetic basis (Michealides and Moore, 2004; Oystreck and Lyons, 2012), some types can also be associated with a complex mix of environmental factors: low birth weight, prematurity, assisted or caesarean delivery, smoking and maternal ill health during pregnancy, maternal ethnicity and socio-economic status (Pathai *et al.*, 2010). Physical trauma can also lead to such difficulties as sixth nerve palsy; this is a paralysis of the abducen nerve (Harper, 2010).

Relevant categories or features of strabismus

The presentation of strabismus can vary according to the type and the severity and the Royal College of Ophthalmologists in the UK categorises strabismus in children in a number of ways (Taylor, 2012). The following descriptions represent a summary of the various aspects of strabismus which are pertinent to this study. (There are sometimes a variety of terms used for the same condition but throughout the dissertation I have used UK terms unless within a quote.)

- **Exotropia or divergent**

Children who present as having eyes that drift outwards have exotropia or divergent strabismus.

- **Esotropia or convergent**

Inwardly turning eye misalignment is called esotropia or convergent squint.

Esotropia in infants is not uncommon and it frequently resolves spontaneously. However, there are diagnostic difficulties in identifying which infants will go on and develop strabismus and are therefore at risk of further eyesight difficulties (Dobson and Lawson, 1989). The choice of whether to treat by operation, for either cosmetic reasons or in order to protect future visual development, is therefore problematic (Dobson and Lawson, 1989; Taylor, 2012). Although of great importance to the individual child, this study will not be exploring the emotional impact of surgery.

- **Comitant**

Strabismus might also be delineated as comitant strabismus, where the angles of misalignment are ‘approximately equal in all directions of gaze. The individual extraocular muscles are functioning normally, but the 2 eyes are simply not directed toward the same target’ (Harper, 2010, p. 120). The aetiology of comitant strabismus ‘remains unclear’ but it is associated with a complex mix of several factors that are ‘part hereditary and part environmental’ (Oystreck and Lyons, 2012, p. 1).

- **Incomitant**

Those who suffer from incomitant strabismus have eyes where the degree of misalignment varies with the direction of gaze. Incomitant strabismus is often associated with a ‘limitation’ of eye movements or ‘mechanical aetiologies’ (Oystreck and Lyons, 2012, p. 1).

- **Constant strabismus**

It is very common to have a minor degree of latent strabismus (Harper, 2010) and many people would be unaware of this in normal life. In the case of manifest, constant strabismus, the disability is usually very obvious and consistently present. There is no evidence in the ophthalmological literature that it has any emotional component.

- **Intermittent strabismus**

Some strabismus can vary in its manifestation and therefore its appearance fluctuates. Intermittent esotropia, (eyes turning inwards intermittently) is less common than intermittent extropia (eyes turning outwards intermittently) (Harper, 2010).

To summarise, strabismus is a multi-factorial and immensely complex condition (Barrett, 2014). It is a term that covers many entities and therefore an attempt has been made to

précis the field in order to produce a description of strabismus in terms of its relevance for this study.

Intermittent strabismus and emotional aspects

The ophthalmic literature would suggest that, unlike constant strabismus, the intermittent variety of strabismus may have an emotional and possibly motivational component in its presentation. It is acknowledged that this clinical belief is based upon anecdotal evidence and observations within the ophthalmologist's consulting room. There is no evidence of any contemporary systematic ophthalmic studies to contribute to these assumptions.

Hall, writing in the *Lancet* (1836, p. 102), stated in the case of 'spasmodic strabismus', 'the eye may be perfect except on certain occasions of excitement'. He went on to tell his readers: 'In one interesting little girl, aged about three years, the strabismus came on whenever a stranger came into the room, whenever she was asked to read etc.' (Hall, 1836, p. 102). It could be argued that today we might use the term anxiety instead of 'excitement'. Additionally, a contemporary reader would be interested in the ocular disturbance associated with the 'stranger' arriving. One might speculate that this behavioural observation may be similar to those systematically studied within the Strange Situation Test. In this research, the most emotionally disadvantaged children (disorganized attachment) are seen to physically 'collapse' (Hesse and Main, 2000, p. 1) following their reunion with the temporarily separated mother. In the protocol they are briefly cared for by a stranger in the mother's absence. One child referred to as 'Dorian', upon 'seeing the stranger he collapses prone on the floor, turning his face to the side. His eyes are open but blank and staring, and he stays huddled and stilled in this anomalous posture for thirty seconds' (Hesse and Main, 2000, p. 7). In both examples the child's eyes are understood to be affected by the emotional context. There is no evidence that anything further is written in the ophthalmological literature about the impact of the 'stranger', however the impact of the therapist as a 'stranger' within a psychotherapy assessment is explored within this research study.

It is suggested that when a child is 'sick', when eye muscles are more lax, that strabismus can become manifest (Clarke, 1999, p. 534). Presumably, just like other muscles in the body, the performances of the muscles involved in strabismus are influenced by energy levels and motivation. It is uncertain as to how much this extends to understanding the impact of low mood, as it is well known that tiredness can be associated with depressive

states (Smith, 2003). This point is important for this study as the research is concerned with the mood of the child within the therapeutic relationship as it progresses throughout the session (are they engaged or withdrawn), and as it corresponds to the intermittent strabismus.

Writers make particular comment about strabismus manifesting when a child is 'daydreaming' (Clarke, 1999, p. 534), though the literature does not offer any explanation of why daydreaming is associated with strabismus. However, one could extrapolate that, when the mental focus is on the inner world, a child has less reason to hold their muscles taut and their eyes coordinated; they may have less need to maintain external visual focus which may lead to a manifestation of strabismus. This area is particularly interesting psychoanalytically, as there is an implication that intermittent strabismus might manifest when the child is withdrawn into their internal world and to some extent caught up in their phantasies (Klein, 1932, p. 151). What this means for the child when they are caught up in their internal world, what the therapist might make of this occurrence in a therapeutic setting and how they might respond to it, are important aspects of this project.

Other ophthalmologists such as Pratt-Johnson and Tilson (2001) are explicit in their belief that anxiety plays its part in the manifestation of intermittent strabismus. Pratt-Johnson and Tilson (2001, p. 106) wrote that 'Any type of physical or emotional stress tends to make the spasticity and hyper-tonicity worse'; indeed one of the book chapter headings is entitled 'Emotional Esotropia'. In this chapter they stated that, 'a child under emotional stress may suddenly exhibit an increase in esotropia' and added, 'emotions can clearly be seen to play a large part in how severe their strabismus is. The more nervous and uptight they get, the more the eye tends to turn.' (Pratt-Johnson and Tilson, 2001, p. 115). They wrote that:

The emotional state of the patient may affect the amount of esotropia present. This is commonly seen in our society with much social upheaval at a family level. A child under emotional stress may suddenly exhibit an increase in the esotropia. An esotropia that was in satisfactory cosmetic alignment may suddenly go out of alignment and look unattractive and even give rise to double vision, if the patient has fusion ability, purely on the basis of increased emotional tone. It is essential to be aware of this in order to avoid unnecessary treatment and even surgery. The effect of the emotions is particularly likely

to be exhibited in patients with a high AC ratio, but all types of esotropia may be increased by emotions.

Pratt-Johnson and Tilson, 2012, p. 121

This research study will explore the impact of ‘emotional stress’, or perhaps anxiety, on the presentation of strabismus, and the possible contextual meaning within therapy. Although the Pratt-Johnson study differentiates between divergent and convergent intermittent strabismus, other authors do not and therefore I will consider both forms.

Many authors have pointed to the initial difficulty in detecting intermittent strabismus (Simon and Kaw, 2001). Authors have described that parents have reported to them how they notice the strabismus when their child is ‘tired, or daydreaming or in bright sunlight’ (Clarke, 1999; Taylor, 2012). Clarke (1999, p. 24) suggested that, ‘Parents are unable to describe accurately the abnormality that they see in the child’s eye and will often say that the eye looks ‘funny’ or ‘glassy’’. The reason given for this is that the ocular deviation presents initially only from a distance. Clarke (1999, p. 534) goes on to say that ‘Parents will notice the misalignment and ask the child to look at them, and of course from near distances the eyes are perfectly straight’ which leaves the parent puzzled. The authors do not seem to appreciate the powerful emotional impact of a parent drawing the child near and engaging in mutual gazing. In this study I will consider the parallel of the parent-child gaze, with the therapist-child gaze. I will look at the impact of the therapist’s gaze upon the quality of the therapeutic engagement, specifically, how it might impact upon the child’s ability to feel connected to the external world in a coherent way.

In summary, there is no evidence in the contemporary ophthalmological literature that strabismus has a psychological aetiology. However, there is a belief expressed by some authors that the intermittent form of strabismus has an emotional component, and that fluctuations correspond with a number of emotional factors. For the purposes of the research question, the emotional factors implicated in intermittent strabismus can be interpreted in the following ways:

- that anxiety and mood may have an effect on both the presence and extent of the strabismus;
- one reference implies that a child being anxious about being with a ‘stranger’ might lead to strabismus;

- on occasion, the manifestation of strabismus may correspond to the level of engagement with inner versus outer experiences (daydreaming);
- the quality of visual responsiveness from a caregiver (looking closely into a child's eyes) may be important to consider in relation to these factors.

The dynamic nature of visual distortion associated with strabismus

Visual development is complex. Studies found that where there was uneven ocular deprivation caused by strabismus, the effects upon general vision became considerably worse (Lewis and Maurer, 2005). In particular strabismus can be associated with the problem of amblyopia, which is a loss of visual acuity in one eye as a result of favouring the fixation of a dominant eye. A child suffering from amblyopia may be treated by patching of the dominant eye to encourage the use of the poorer eye. This is in order to compensate for its previous sensory deprivation. Amblyopia produces an imbalance leading to monocular vision if not treated promptly. In contrast, where there is the presence of an alternating fixation within the strabismus which can produce double vision, the patient may be advised to fixate with the dominant eye in order to resolve this problem. Pratt-Johnson and Tilson (2001, p. 107) suggested a process of 'deprogramming the patient and parents' to advantage the dominant eye.

The age of eight is often taken as the limit of the visual brain's plasticity and the onset of visual maturity (Taylor, 2012). For this reason, surgery to adapt the pulley muscles is often undertaken before the age of eight. This is, however, a developing area of research. There are strong suggestions that instead of one critical period for development (Hubel and Wiesel, 1970), there are in fact 'multiple sensitive periods' (Lewis and Maurer, 2005, p. 163). The research suggested that even after normal visual development is complete, there is a period of vulnerability and, additionally there is also a 'sensitive period for recovery'. These periods vary according to the area of vision such as peripheral vision or motion perception. Research into light sensitivity, for example, suggests that although normal development stops at around eight years, a period of vulnerability continues up until at least fourteen years of age; this may imply greater plasticity than hitherto thought possible (Lewis and Maurer, 2005. p. 178).

Where the strabismus is intermittent as opposed to constant, there is more evidence in the literature that many children can develop binocularity (Baker and Gerald, 1979).

However, the quality of binocularity may depend upon a number of factors, one of which is the nature and age of onset in infancy of the strabismus. The plasticity of the brain allows for adaptations to preserve or establishes alternative pathways to gain binocularity. However it also means that the presence of strabismus more easily disrupts these patterns of development (Baker and Gerald, 1979).

We need two coordinated eyes, receiving visual stimuli equally, in order to have stable binocular vision; without binocular vision we are unable to see, or rather perceive, depth. The presence of binocular vision helps us understand our world in three-dimensions, aiding us to negotiate its contours and recesses in the external environment.

It is very hard for those who take their binocularity for granted to imagine what it must be like to live life from a monocular view. Sacks (2010, p. 129) explored these experiences through his case history of 'Stereo Sue'. She had suffered from strabismus from being a baby, though it was partly corrected by operations when she was a young child. There was evidence to suggest that Sue, who 'alternated her eyes to see', had experienced binocularity in fleeting ways as a child, but this had become lost over the years. After her vision began to deteriorate in her forties she sought help from a vision expert, apparently resulting in Sue re-acquiring the sensation of binocularity. After eye exercises, the car steering wheel 'popped out' from the dashboard in 3-D and she re-discovered a new aesthetic world of depth. In her personal communications with Sacks she wrote:

I had to develop a new choreography for my own eye movements, how to move my eyes in harmony before I could tap into latent binocular circuits and see in stereo depth.

Sacks, O. (2010, p. 137)

A behavioural approach to visual difficulties, one that uses visual exercises such as in the previous example, is a contested area within behavioural optometry practices. A recent literature review suggested that apart from a small number of case studies, for example one concerning intermittent esotropia which was successfully treated using peripheral awareness training, there is an absence of evidenced based research to suggest that behavioural vision therapy is effective (Barrett, 2009). How much a child or adult can recover or develop under-stimulated pathways in order to enhance their vision is a controversial area, but the research does imply that when it comes to intermittent

strabismus there is possibly more scope for improvement. This research is quoted here, not just because of its inherent interest, but because it does imply that an individual's motivation to see, and to see well, may be a significant factor in the development of visual acuity in some situations. This research might therefore suggest the importance of early intervention in cases where emotional factors are impeding a child's capacity to seek external visual stimuli.

In summary, one of the compounding factors of the disability of strabismus is the potential for loss of visual acuity in the under-stimulated area of the brain and retina. This can often lead to a loss of binocularity in constant strabismus. Intermittent strabismus may, however, allow more potential for the development of binocularity but this is uncertain. The research shows how difficult it is to be confident about the existence of binocularity in the presence of various forms of strabismus that have acted to reduce visual stimulation.

Some ophthalmologists recommend the development of a 'dominant eye' in order to manage double vision; however this may also lead to the loss of visual acuity in the other eye. The research, therefore, implies that some experience of visual distortion may be potentially experienced by the sufferer of intermittent strabismus, in the form of double vision, or the loss of visual acuity, or even a disturbance in the development of binocularity. This may depend upon a number of developmental factors, including the frequency of the strabismus and the age of onset. How a child relates to their eyes may be a factor in terms of managing and developing their visual relationship with the external environment, for example through the use of a 'dominant eye'.

The literature leads one to ponder how the purposeful or intuitive use of a 'dominant eye' might influence the child's capacity to be in full contact with external reality as opposed to retreating or collapsing into their internal reality. This study will consider how this might then impact upon the nature of the visual engagement within the therapeutic relationship.

In summary, the main ideas from the field of ophthalmology that are relevant to consider for this study are: that there is no evidence that strabismus has a psychological aetiology; that intermittent strabismus is considered as having an emotional component, unlike constant strabismus; the child's potential use of a 'dominant eye'; that visual distortion, including double vision and loss of binocularity are all potential consequences of strabismus; that the angle of the strabismus may increase with emotional anxiety and

stress, and that daydreaming may be associated with the manifestation of strabismus. Extrapolated from the comments in the literature, there is a passing suggestion that the visual reciprocity of a caregiver may be a factor in the reduction of the strabismus.

Strabismus and neuroscience research

Clearly we ‘cannot appreciate the powers and limitations of eyes without considering the brains they see’ (Gregory, 2009, p. 52). However, the neuroscience underpinning the experience of strabismus, and how it connects to the muscular pulley system, is complex and poorly understood (Barrett, 2014). Researchers suggest that the location of strabismus within the brain has yet to be refined, and it is likely that ‘multiple areas of the brain are altered’ (Hoyt and Good, 1994, p. 325). This together with the occurrence of multiple sensitive periods in the development of vision mean that ‘two eyes competing for cortical connections’ may lead to scrambled connections’ (Lewis and Maurer, 2005, p. 176).

In summary, the research concerning the neuroscience is highly complex, technical and is fast changing (Carmen, 2014). Given, therefore, that my focus of interest is with regard to the manifestation of the strabismus within the therapeutic relationship, rather than its aetiology, I have taken the view that the body of neuroscience literature is mostly out of the scope of this study. This would include the substantial research into Eye Movement Desensitisation and Reprocessing (EMDR) undertaken by Shapiro and Laliotis (2011). Exceptions to this are a brief exploration of the development binocularity and a very concise discussion of neuroscience with regard to child development.

Visual development, eye contact, and its importance to the emotional development of the child

Increasingly, we are aware of the dynamic nature of the development of the foetus and its importance for future development. It is strongly suspected that emerging capacities and senses are inter-related in the foetus; that there is, for example, coordination between heart rate, body movement and eye movement before thirty-six weeks. Also, animal experiments show the capacity for cross modal plasticity, which suggest that information from the auditory pathway can process visual information; one sense is being processed across another sense (Vries and Hopkins, 2005). So, although we know that only the brightest of lights can reach the eye of the foetus, through the 'dark cushioned environment of the womb' (Pallas, 2005, p. 7), we also know that the voice of the mother can permeate the intrauterine environment. Research implies that both auditory and visual pathways might be being stimulated and might be linked together.

Furthermore, research shows that foetuses had already learnt about the prosody in their mother's voice and so could differentiate between happy and sad speech patterns post-delivery. The design of the research involved observing eye-opening behaviour in the infant and it was postulated that this was as an indicator of recognition of maternal mood (Mastropieri and Trurkewitz, 1999). It is interesting to speculate about the connection between sound and vision (both pre-term and post-delivery) and the fortuitous evidence of a natural tendency of infants to open their eyelids and pay attention visually when their mother is happy. Moreover, given that the research suggests eye opening in infants can be regulated by their mother's mood, one might wonder whether there possibly could be any connection with the emotional aspect of intermittent strabismus. This is of course a highly speculative question.

Another body of research, that may be important to briefly touch upon within this context, is the psychology research that investigated eye movement and gaze patterns in relation to reasoning, imagination and memory. Studies suggest that it may be ordinary to avert gaze in order to support cognitive skills, but more so after the age of eight. In one study, a comparison of two groups, one of eight year olds and another of five year olds, gave both groups verbal reasoning and arithmetic problems to solve. The younger children were considered to gaze avert much less consistently, and the research concluded that children under eight had not achieved 'adult like patterns of gaze aversion in response to

cognitive difficulty' (Doherty-Sneddon *et al.*, 2002, p. 1). Another study directed participants to withdraw eye contact and search for a blank external area, in order to imagine a scene that is verbally described. The eye movements around spatial areas were subsequently observed to be similar to when the actual scenes were being viewed. The authors suggested that these results

... point to a concrete embodiment of cognition, in that a construction of a mental image is almost 'acted out' by the eye movements, and a mental search of internal memory is accompanied by an oculomotor search of external space.
Spivey and Geng (2001, p. 1)

The Doherty-Sneddon *et al.* study (2002) advised caution when applying research conducted on adults to younger children (as in the case of the Spivey and Geng (2001) study) as their visual systems are still developing. However, it does raise questions about how, or indeed whether, intermittent strabismus might have an impact upon imaginative capacities given that eye movement is important in order to scan the internal environment in a coordinated manner.

It will be some six months after birth when the infant comes to achieve maximal acuity, colour vision and binocular depth perception (Held, 1991) but, nevertheless, the importance of eye contact for the young infant and for their eye/mind system cannot be underestimated. Researchers have studied, in both naturalistic settings and in laboratories, how minute movements in eye-to-eye reciprocity (Brazelton, 1974) are central to the effectiveness of emotional regulation (Tronick, 1989; Trevarthen, 2011), between the caregiver and infant (Douglas, 2007). For example, research suggests the importance of the caregiver being able to flexibly accommodate the turning away movements of the baby's eyes, as well as enjoying the lively reunion (Brazelton, 1974; Stern, 1977; Beeb, 2005). The duration and quality of mutually delighted gaze, where infants can experience looking towards and looking away from their mother, promotes learning and emotional communication through mutual vitality in the relationship (Trevarthen, 2011). Reciprocal gaze is essential for the promotion of elaborate neural networks and for an integrated personality (Schore, 1994; Rhode, 1997; Guastella, 2008).

Psychoanalytically, we may place particular emphasis upon the internal and unconscious processes involved in the eye contact between the mother and her infant that underlie the vivacity or otherwise of reciprocity. Bion's (1959) concept of emotional containment and

Klein's concept of projective identification are invoked by many psychoanalytic writers when they refer to these processes For example, Copley (2000) wrote:

A mother, in what Bion refers to as the expression of love for her infant, attends to the baby's feelings in her reflective reverie. The infant, through cries, looks and bodily activities conveys his or her fearful primitive states of feeling and bodily sensation to the mother. Bion here extends the usage of the term Klein (1946) has called projective identification, describing how a part of the self can be located in someone else.

Copley (2000, p. 120)

and went on to add that:

The mother receives her infant's primitive, chaotic expressions of feeling and by her loving, thoughtful attentiveness, gives them shape and meaning. The infant can in consequence re-introject its, now modified and hence more bearable fears, together with an experience of being thought about. This process has become known as an experience of containment.

Copley (2000, p. 121)

One could question, what if, if anything, happens to the emotionally interactive processes when a child suffers from the potential perturbation of intermittent strabismus. We might recall that if the child is encouraged into lively contact by maternal eyes; the parent's eyes are described as literally 'pulling' the child's eyes into alignment (Clarke, 1999, p. 534) and, therefore, into focus. One might question whether this can be interpreted psychoanalytically as an action that is a consequence of emotional containment?

It is hardly surprising therefore that research suggests that eyes convey complex mental states, which imply that there is a 'language in the eyes' (Baron-Cohen *et al.*, 1997, p. 311). Others have shown how this language can be experienced literally by both the viewer and the viewed, as it not only modulates 'the intensity of the experienced emotion', but also that eye contact acts as a trigger to elicit 'an embodied simulation' in the other Niedenthal *et al.* (2010, p. 9). This will be important to consider when discussing the impact of strabismus upon the intricate visual interactions between the therapist and the child within psychotherapy.

The achievement of joint gaze attention, by the caregiver and their infant, is particularly important in child development research. This involves the eyes and the whole of the face, and it specifically encourages the infant to orientate towards important features of the environment (Striano *et al.*, 2006; Trevarthen, 2011). Declarative pointing, which encourages a shared gaze direction is understood as reflecting ‘an understanding of the other’s mental agency and in addition a desire on the infant’s part to share psychological states’ (Liszkowski, 2006, p. 174). There is, however, a lack of research to help us understand the experience for a mother and her infant when the infant’s eyes do not consistently gaze in the same direction towards the mother’s eyes, or towards external objects. It is not possible to know how, or indeed whether, strabismus impacts upon the mother’s ability to emotionally contain or regulate her baby through her eyes. Neither do we know its impact upon the development of inter-subjectivity. This is important when we consider that the capacity to emotionally contain and to be emotionally contained, are important factors in the development of a therapeutic relationship.

Using research from child development and adapting psychotherapeutic technique as a response has become an expanding area of child psychotherapy practice, and the following clinicians’ work are examples of this approach: Alvarez (1985, 2006), Reed (1997), Rhode (1997) and Green (2003). This study does not allow for anything other than this brief acknowledgment of its influence within the profession.

In summary, it is also possible to contemplate possible inter-relationships between the development of the prosody of speech and eye patterns, maternal mood and the correspondence with strabismic fluctuations and how this might manifest in the transference. It is also possible to question whether intermittent strabismus may influence the natural rhythms between a baby and their caregiver and, if so, whether this might also play out in the transference.

The interference in the ordinary and expected rhythms between a mother and her baby as a result of intermittent strabismus could, one might speculate, potentially produce difficulties in eye contact between parent and child in infancy. It is conjecture, but in certain situations there may be an impact upon the mother’s capacity for reciprocal and mindful eye contact. This might be particularly so if the mother and baby relationship is compromised in other ways, such as where there is maternal depression affecting the prosody in the mother’s behaviour (Cohn and Tronick, 1983). In turn, this may affect her

ability to tune into her infant in order to emotionally regulate and emotionally contain her infant. Alternatively, one might assume that this disadvantage might be reduced where mothers intuitively take account of their infants' need for adaptive reciprocity through an increased sensitivity towards their infants that maximises their visual ability (i.e. pull their child in to align their eyes). Although this is obviously conjecture, it helpful to bear in mind when considering the nature of the eye contact between the therapist and the child, and how this unfolds within the transference and counter-transference of the therapeutic relationship; specifically in relation to the child's expectation of finding and maintaining an emotionally containing relationship.

The possible impact of visual impairment upon development

During the 1960s and into the 1970s, there was a burgeoning of interest in visual impairment both in terms of understanding developmental factors in ego development and in finding ways to assist development (Burlingham, 1965; Fraiberg, 1968; Wills, 1970). This research suggested that the conceptual ability to search and find was reduced in the blind infant. That this led to profound difficulties in the development of their imaginative capacities and confidence in their environment.

Unlike severe forms of visual impairment, such as blindness, there is no research to suggest that children with intermittent strabismus may have difficulties with exploratory behaviour and object constancy. However, it is possible to speculate as to whether there might be a difficulty where intermittent strabismus is a more profound visual disability, rather than just an occasional occurrence. (This possibility was briefly explored by Lipton (1970).) One might speculate that, without consistent and reliable environmental clues gleaned from the unhindered ability to explore the environment, social situations might be difficult to negotiate, particularly those involving separation and transitions between people. If this is so, then we might assume that some children with intermittent strabismus might have greater difficulties developing a secure internal sense of security, resulting in greater separation anxiety (Bowlby, 1997). They may need a richer environment in order to compensate; for example, extra sensitive maternal behaviours that promote mindful transitions (Sorenson, 2005). Without a secure internal ability to identify with a capacity to manage transitions, one might conjecture that a difficulty in this area may develop.

In summary, it may be useful to consider the potential bearing upon emotional development where there is visual distortion which may limit the child's contact with the

external environment. Although it is a leap to compare blindness to intermittent strabismus, one could imagine that in some cases of more chronic intermittent strabismus, a reduced capacity for the achievement of object constancy might theoretically result. If this were so then such a child might have particular deficits in terms of their ability to negotiate separations and transitions. This might produce an increase in separation anxiety due to the difficulty in holding in mind the idea of a returning therapist or caregiver. One could consider then that separations might potentially be difficult to negotiate for a child who has suffered from more chronic forms of intermittent strabismus, particularly where their engagement with external reality has been affected.

Strabismus and psychiatric views

A recent quantitative multi-disciplinary study which included researchers from ophthalmology and psychiatry, examined the ophthalmological and psychiatric case notes of an entire population in Olmstead County, Minnesota, USA. It concluded that, 'Children diagnosed as having strabismus in this population, especially those with exotropia were at increased risk for developing mental illness by early adulthood' (Mohney *et al.*, 2008, p. 1033). The researchers found an association between strabismus and mental illness. Children who were diagnosed with exotropia (eyes turning outward) were 3.1 times more likely to develop mental illness compared to those who suffered from esotropia (converging eyes) who were no more likely to develop mental illness than the control group. There was a particular association with intermittent exotropia which was linked to a higher incidence of mental health disorders, emergency department visits, suicidal and homicidal tendencies and associations with mental health services (not just psychiatric diagnosis). The authors suggested that other population studies would need to be conducted in order to ascertain any international generalisability.

There was speculation as to a possible link between strabismus and the underlying genetic factors in schizophrenia and other studies which, although limited in their number of subjects, would support this association (Toyota, 2005). A later study found that this effect was greater for males than females, though females were larger in number. Females with intermittent exotropia were more likely to have had mothers who had experienced a difficult pregnancy, or who had had a history of chemical abuse whilst pregnant, and have a family history of 'mental disease' compared to the control group or the male group. 'Depression not otherwise specified, major depression, attention deficit/hyperactivity

disorder, adjustment disorder and drug or alcohol abuse were the most common disorders diagnosed' (McKenzie, 2009, p. 745). There were no qualitative elements to the research designs and there were no opportunities to glean an understanding of any possible interweaving of factors that contributed to this psychiatric vulnerability and how it impacted upon the individual. The research leads one to question what particular kind of family or social environment might promote or mitigate against the potential expression of this psychiatric vulnerability as the child develops.

In summary, the research suggested that the intermittent form of divergent strabismus is more associated with psychiatric vulnerability. This research lacked replication and may not transfer to other populations and, furthermore, it tells us little about the relationship or developmental vulnerabilities of the individual. The research, however, may be important to bear in mind given the concerns about the possible impact of strabismus upon developmentally crucial early relationships and, moreover, how this might unfold within a therapeutic relationship. Given that children who suffer from intermittent divergent strabismus have an increased psychiatric vulnerability, then sensitivity to this information would be a helpful attitude to have within a therapeutic relationship.

Psychoanalytic perspectives upon strabismus

Freud and Breuer (1893) in their classic case study 'Fraulein Anna O' elaborated their ideas about hysteria and the early notions of transference. A squint was part of a long list of quite extraordinary and dramatic symptoms that 'Anna' faithfully reported to Breuer, her physician. The backdrop to the development of these phenomena was her father's terminal illness and her 'intellectual vitality' within a 'monotonous existence' which had led her to retreat into her 'private theatre' (p. 74) of daydreaming. 'Anna' developed a convergent squint that 'markedly increased by excitement' (p. 75) and which was subsequently sympathetically 'talked away' (p.89). By a process of detective work the convergence of the eyes was traced back to the moment that her father had asked the time and she had focused upon the clock; this had been during the depth of his illness and shortly before his death. The squint was part of a plethora of physical and visual disturbances that eased during Breuer's long visits. The symptoms, including squint, were understood as responses to the trauma of her father's death. The squint was understood as a symptom of hysteria.

Freud's subsequent appreciation of transference phenomena, and more modern interpretations of what constitutes therapeutic action (van de Kolk, 2000), might emphasise the emotional aspects of the encounter, rather than a rather mechanical notion of 'talking away' (p. 89). 'Anna' nevertheless was understood to have benefited from the 'talking cure' (p. 95) and the symptom was assigned as a purely psychological phenomenon.

Later studies question the notion of 'cure' as 'Anna O' was said to have needed sporadic psychiatric treatment due to a continuation of hysterical symptoms (Kaplan, 2004). Alternatively, some authors question a psychological component and suggest a variety of medical explanations for the symptoms. One could speculate whether she possibly suffered from intermittent rather than constant strabismus given that it was described as being 'markedly increased by excitement'. Then the strabismus could be considered as more of a fluctuating disability, suggesting a more complex inter-relationship between organic and emotional factors.

Building on this work, however, contemporary researchers have used a Freudian understanding of a conversion symptom to highlight the preponderance of psychogenic difficulties presenting to eye hospitals. In a controlled study, authors illustrated how many of the emotional symptoms that were experienced by the adolescent patients had a basis in unresolved bereavement (Wynick and Hobson, 1997). Although strabismus was not one of the symptoms being researched, it does show the continued psychoanalytic interest in eyes as carriers of emotions.

In 1921 W.S Inman, an ophthalmologist and a psychoanalyst, devoted much of his career to exploring the connection between eye disorders, particularly strabismus, and the inner life. He was convinced that many eye symptoms had, at their root, psychological explanations, and that the prescription of spectacles arose out of the truth being obscured by the unconscious, or as a result of shame and secrecy.

Inman (1921), in his role of school ophthalmologist, observed many children with strabismus, and he concluded that they could not bear to see their own deprived home circumstances. He observed how the strabismic angle varied according to the emotional wellbeing of the child. He wrote with a great deal of sympathy for children whom he also believed had developed a squint as a result of fear, often emanating from physical or sexual abuse:

A little girl of five, was brought to me by her sister, aged ten. The younger child, who had a convergent squint, was cowed and shrinking, the older was more courageous and self-possessed, and being able to give a vivid account of the situation at home. The father, a bully, showed his irritation at his child's squint by beating her, which made the squint worse. I took the child upon my knee, petted her and comforted her, won her confidence, and in a few minutes the squint of about 25 degrees had disappeared. Nor could it be induced to return before we parted.

Inman (1921, p. 65)

In 1921 Inman had investigated a total of one hundred and fifty cases where squint was present, and by 1939 he reported that he had seen over a thousand cases of squint. As a result of these many clinical observations he concluded that squint was also related to stammering and left-handedness, and all of these symptoms were a consequence of fear. He strongly believed that strabismus was a symptom of emotional difficulties emanating from early relationships.

Pugh (1934), a Medical Officer, in charge of the Squint Training Department of Royal London Ophthalmic Hospital, and who acknowledged the influence of Inman (1921), suggested that nearly a quarter of all squints have a psychological cause. She analysed five hundred subjects, and devised a list of different kinds of psychological squints, and she concluded that they were a consequence of trauma or anxiety. As with Inman (1921), the author is not explicit about how the cases were analysed, therefore making it very hard to interrogate these conclusions. Additionally, there seems to be little distinction drawn between the different types of strabismus, in particular no differentiation is made between intermittent or constant. These are also obviously very old papers, and therefore not written with the benefit of a contemporary scientific context.

Unlike Freud, who often dealt with the wealthy middle classes of cosmopolitan Vienna, Inman was exposed to the deprived families of the mining towns of South Yorkshire, during the Great Depression of the 1920s. Although Inman clearly assumed that deprivation was an important factor, unlike Freud, they were, however, both in agreement that anxiety was the most significant factor in the manifestation of strabismus. Interestingly, the contemporary literature is also unclear about the impact of socio economic factors. A very large epidemiological study based upon the population of

Cardiff, for example, found no association between strabismus and social class (Graham, 1974). The researcher looked closely at other epidemiological studies and suggested that a difference in the level of, and categorisation of, deprivation, might account for some of the misunderstandings. However, other authors do suggest that socio-economic circumstances are implicated in the development of strabismus (Pathai, 2010).

Practicing around a similar time to Inman, Huebsch (1931) saw the eye as an organ to be equated with sexual matters:

The 'intimate connection' is more firmly established by a case of strabismus in a four year old boy who eyes remained permanently set close to the nose after constant masturbatory play with his teddy bear.

Huebsch (1931, p. 166)

The goal of the psychoanalysis was to uncover the sexual component and loosen the literal connection to the strabismus by bringing it into consciousness. Later he wrote:

... the blinking eye which might properly be called eye stuttering, must be regarded as an indecision or doubt as to whether the outer world shall be permitted to occupy attention or whether the inner world, the daydreaming world, shall have the upper hand.

Huebsch (1931, p. 166)

The case study paper is otherwise a mechanical and now very dated account of a psychoanalytic understanding of eye disturbances, but in these two excerpts there is a very interesting shift to a more contemporary appreciation of states of mind, illustrating the individual struggling with sustaining their grip on reality. This work foreshadowed later writers such as Winnicott (1974), Meltzer (1992) and Steiner (1993).

Winnicott particularly wrote about the psychological influences upon eye disorders and in particular strabismus. In a speech to a group of ophthalmologists, he asserted that 'squint can have a purely psychological cause' (Winnicott, 1958, p. 89). He described three different presentations of squint within in a paper entitled 'Ocular Psychoneuroses of Childhood'. It is unclear as to how much Winnicott was influenced by the work of Inman; their careers would have overlapped in the psychoanalytic society of the 1950s

and 1960s. However, he was clearly influenced by the work of Klein (1946) in relation to understanding how primitive processes impact upon personality structures:

There is one kind of squint, usually external squint, in which the trouble seems to be that two eyes do not seem to work with one aim, this being associated with a division of the personality. It is as though the individual dramatized the split in the ego in a lack of coordination between his eyes.

Winnicott (1958, p. 80)

Winnicott presented a very interesting example of a woman whose eyes worked independently, the left eye representing her relationship with her father and the right eye representing her relationship with her mother; her parents ‘had very little in common’. The second kind, also under the heading of psychosis was a:

‘... more serious un-integration, and in that case I think that one eye is identified with the strongest part of the personality, and the other a hopelessly wandering eye, represents the other parts. An external squint that is not clearly due to a physical cause is difficult to cure unless there is a reintegration of the personality.’

Winnicott (1958, p. 80)

Winnicott’s insights foreshadow the work done in the ‘Minnesota Study’ (Mohny *et al.*, 2008) which found that the external or divergent squint correlated significantly with psychiatric illness.

Under a heading of ‘depression’ Winnicott (1958, p. 81) explained his final category of strabismus:

A third psychological type of squint, one which can appear very early, seems to be that which accompanies an acute introversion phase, the internal squint (convergent) being a dramatization of a preoccupation with internal phenomena or inner world reality.

Winnicott (1958, p. 88) also suggested that a momentary convergence of a squint could be a way of a child recreating the close experience of feeding at the breast (like thumb sucking) and so ‘insure against depression’. This view resonates with the case study of

‘Anna O’ (Freud and Breuer, 1893) who fixed her eyes on the clock face during her father’s terminal decline and produced a convergent squint.

Unlike Inman (1939), Winnicott (1958) gleaned his hypothesis from a combination of analytic and paediatric work rather than from any kind of systematic study as such. He gave very little background to the cases in this paper and although his capacity for insight is quite tantalising he does admit that:

The subject of squint is one that needs research from the psychological side. I have good evidence that squint can have a purely psychological cause, and I think that most ophthalmologists would agree. However, when it comes to describing the actual mechanisms I am not on sure ground.

Winnicott (1958, p. 80)

Rappaport (1959), writing in America, did not reference Winnicott when he wrote many years later; though he was impressive in his literature list that went back as far as 1650BC. Rappaport argued that the fusion of an image required a process of motivation and imagination, as much as anatomy. Many years later, McDougal (1989, p. 84) would write about how the inability to imagine leads to the body ‘dispensing’ emotions via psychosomatic illness, rather than the mind thinking about it, or indeed converting it as with hysteria.

Rappaport (1959) regarded strabismus as something that was acquired as a result of psychological trauma, which often emanated as a result of severe difficulties within the parent-child relationship. His views are based upon a small number of consultative interviews with parents and their medical practitioner, rather than from any direct observation or from clinical work. Nevertheless his case studies and the resulting hypotheses are very compelling and in many ways they resonate with Winnicott’s views, even when the conclusions are different. For example; Rappaport (1959, p. 482) suggested that those with inward turning eyes, (convergent strabismus) have a ‘tightening of the ego defences’ and are gripped by anger. However, those with divergent strabismus have ‘turned out their eyes in despair or for search in an unknown vacuum’. Again, there is an assumption in the psychoanalytic literature that divergent strabismus can be associated with a severe psychological state, a finding that is supported by contemporary ophthalmological studies (Mohny *et al.*, 2008).

Heaton (1968), writing nearly ten years later, was interested in some of Rappaport's ideas but suggested more work was needed to confirm them. He was, however, very impressed by the idea that the emotional life of the individual and his or her family are significant in the action and maintenance of the strabismus. Moreover, he suggested that psychotherapy might often be helpful before any physical treatment commenced, and this was supported by later writers in the field (Garnet, 1977).

Heaton (1968) makes some interesting points about the impact of sensory deprivation, especially upon infants who have been brought up in poorly lit surroundings, but also miners who have spent too much time underground. Both can suffer from a condition called *nystagmus* which involves random spasmodic eye movements. He felt that degrees of emotional, physical and sensory deprivation were the cause, and the alleviation of them could also be the cure. We would not expect infants in a contemporary society to be exposed to such deprivation without the intervention of social care, though in recent years similar symptoms have been witnessed in institutionalised infants in Romania (Kreppner, 2010).

Lipton (1970) asserted a very different view to the previous psychoanalytic writers. He was not arguing that there was a psychological aetiology, but he was confident that the emotional lives of his patients could be played out through ocular behaviour. Lipton based his opinions upon six case studies, three adult and three children. He used the case examples illustratively rather than in any systematic way. His main clinical example was 'Mr T', who conveyed to Lipton how anxious he felt when having 'two simultaneous feelings and thoughts and did not know which to verbalise' (Lipton, 1970, p. 4). His capacity to suppress one idea, in order to concentrate on another, failed him. Lipton (1970) conjectured that he might have suffered very similar difficulties related to his ocular behaviour when very young, i.e. not being able to choose with which eye to focus. The interpretation opened up a hitherto hidden set of experiences, where the patient remembered he had experienced objects drifting or one image vying with another. It transpired that he had also been bewildered, unable to sort out bodily experiences from psychological confusion. Eventually, through analysis, Lipton appreciated how his patient had feared that these were symptoms of madness and had hidden them. Lipton was able to reassure him that these phenomena were in fact ophthalmological, rather than signs of insanity. Lipton reported how his patient subsequently gained confidence upon the realisation that he could actually develop an ability to firm up his muscles, and

manipulate these images in an adaptive way. Lipton (1970) wrote with great sympathy about his patients' visual disability, and he very much appreciated their challenges.

Lipton (1970, p. 16) was also very aware of strabismus as a social stigma and he postulated that for the parents this was a 'narcissistic wound' that affected their response to their children in detrimental ways. He suggested that the viewer of the child with strabismus might feel 'repulsion' or 'discomfort' (p. 9) due to the effort in achieving steady eye contact in response to the strabismic child. Continuing this theme, he believed that there might be an activation of 'castration anxiety' (p. 9) as if the damaged eye might be in phantasy a warning of what might befall the viewer if they were not careful. He considered these elements to be at the root of difficult inter-relations, particularly between parent and child.

However, only in a footnote did he acknowledge the 'revulsion' that could be felt in the counter-transference by the analyst towards the person with strabismus (Lipton, 1970, p. 19). He suggested that this 'revulsion' unconsciously influenced the analyst to avoid noticing the patient's strabismus in order to resist identifying with someone who might be considered 'defective'. He also recognised that the use of the couch meant that true gazes were easily avoided. I would suggest that modern day psychoanalytic psychotherapists would actually regard these as important observations and, as such, as being central to the understanding of the patient (Wright, 1991) rather than as an afterthought; especially those who work with various forms of disability (Sinason, 1992).

Following on from Lipton (1970), Hertel (2003, p. 1) wrote movingly about 'Analysing the traumatic impact of visual impairment'. His paper was based upon a sample group of three adult patients in psychoanalysis. His saw his main task as helping his patients firstly acknowledge their visual disability, which had been prominent within their childhood, and then helping to differentiate in the transference this experience from other conflicts.

Hertel (2003, p. 8) described the quality of their visual distortions: one patient, 'Mr A', described 'living in a fog' as a child, not being able to either recognise the faces of nursery staff or in turn feel himself to be recognised by them. Another patient, 'Mr B', reported dreams 'where houses moved down hills' (p. 13) which were linked in the analysis to the inability to stabilise an image. This patient spoke about the experience of seeing double and how he would 'feel paralysed' (p. 10), unable to prioritise one image over another, and also unable to prioritise one thought above another. The third case, 'Mr

C', had suffered from strabismus following childhood measles encephalitis; his visual disturbances had come on suddenly like a 'bomb blast' (p. 13). Hertel (2003, p. 18) subsequently described how 'his greatly altered visual representation of reality had deeply shaken his sense of reality constancy.'

None of his three patients had been referred because of visual impairment and, indeed, the symptom of strabismus were often not appreciated by Hertel (2003) himself until well into treatment, or even just as treatment was coming to an end. All his patients were considered as being traumatised either by the confusing disabling experience of the visual disturbance, or by perceptions of parental emotional unavailability based upon their lack of recognition of the problem. He called this 'The damaging psychological impact of the unremarked symptom' (Hertel, 2003, p. 3).

Unlike in adult analysis, children do not generally lie on the couch and therefore the nature of their eye contact is more immediately apparent to the child psychotherapist. This I imagine was not Hertel's experience; he might have only seen his patient's eyes at the beginning and end of a session and then their sight was largely corrected by spectacles. It is hard not to speculate therefore how much the professional attachment to working with a couch had contributed to the lack of appreciation of the visual disturbances, rather than the patient not sharing the information until the end of the analysis. Hertel (2003) was very certain, however, that once a foundation of psychoanalytic work had proceeded, the analyst should try to actively seek a disclosure from the patient to ensure that this important difficulty was brought out into the open.

Hertel (2003, p. 5) was candid about his uncertainty about sharing his views, worrying that his psychoanalytic colleagues would not believe his assertions that 'visual confusion leads to psychological confusion'. He then came to suspect that this was an indication of the counter-transference phenomena and illustrated again the anxiety that was associated with the element of disbelief that his patients suffered from.

This study lacked a systematic approach to the process notes which might have revealed something more of the quality of the non-verbal interplay between patient and analyst, which would have been useful for this study. For instance, Hertel did not comment upon the impact upon his own eyes as Lipton (1970) had implied previously. It is important also to acknowledge that Hertel (2003) did not fully explain whether the strabismus was intermittent or constant but it is likely that it was the latter. It is difficult to be sure

therefore how much we can conflate these assumptions and apply them to intermittent strabismus.

The psychoanalytic literature, as one would expect, attempts to explore the individual and internal view of the experience of strabismus in the way the ophthalmic literature rarely does. Leira (1984), a child analyst, whose father she acknowledged was a professor of ophthalmology (Dr Hakon Leira), published a detailed description of clinical work concerning a child with strabismus. In her paper she evocatively describes her sensitive work with 'Arne' a boy of three and a half years. At the start of treatment 'Arne' suffered from 'an extreme fluctuating divergent squint'. By the end of two years of therapy, it lessened to such an extent that it became hardly noticeable; only reappearing during moments of 'anxiety'. There was 'a drastic reduction of strabismic angle and an ensuing establishment of parallel eye axis' (p. 175). Leira (1984, p. 174) reported that, to begin with, 'one eye looked out of focus and saw completely to the side, giving me the impression that he was looking backward. 'Which eye was squinting at any given time was not possible to assess by general observation' (p. 176).

Functionally the squint disappeared (according to nursery and therapy observations); ophthalmic assessments, however, showed that it remained latent. At the start of treatment 'Arne' was described as a boy who was: 'Very restless, contactless, distant and without language. Bladder and intestinal control had not been established.' 'He feebly roved around the room, howling like mad' and 'he was in a chronic state of panic' (Leira, 1984, p. 177).

It was hardly surprising to learn that 'Arne' had been subject to abusive experiences by his parents, in particular his mother often hit him on the head. Leira saw his strabismus as 'an evasive action of the eye' (p.180) and illustrated this experience by the following example:

He drove an aeroplane in such a manner that the propeller rotated at a high speed. Then he wanted the therapist to drive the aeroplane straight towards his eye. He said 'Cut' and, 'Now the scythe is coming.'

Leira (1984, p. 184)

Leira was very influenced by Rappaport (1959) whom she referenced in relation to her patient's sense of hopelessness, hence his outward turning eyes. She convincingly

suggested that 'Arne's' play might symbolise the painful experience of his eyes that hitherto had not been able to tolerate seeing his mother's hand, as it swooped down to hit him. Leira suggested that 'Arne' could now symbolise and so convey his overwhelming experiences rather than avoid them.

In many ways she was building upon the work of Fraiberg (1982) who had published her seminal paper concerning pathological defence mechanisms only two years earlier. Leira (1984) was suggesting that the young boy's eyes were 'evasive' and that 'Arne' would 'avoid focusing on the threat' and this was contributing to the presentation of strabismus. Leira (1984) noted that, long after the squint had improved, it would re-appear when he was 'scared' and both she and the nursery staff noted that it lessened when he felt himself to be in a safe environment.

Leira also linked this with the 'occurrence of breakdown of binocular vision in aerial gunners' during combat (Meltzer, 1982 cited in Leira, 1984, p. 184) and seemed to be suggesting that the strabismus may also represent a collapse of the visual capacities due to overwhelming experiences. More recent advances in the understanding of physical consequences of trauma and the power of dissociation would give support this assumption (Cozolino, 2010).

After around sixty sessions in psychotherapy, the ophthalmologist reported that 'Arne's' 'eyes move parallel on focussing a definite object' (Leira, 1984, p. 181) and it was considered that he was now capable of binocular vision. He was seen as a child that could integrate his senses and enjoy the experience of seeing. A different ophthalmologist a few months later, however, diagnosed 'constant divergent strabismus right eye/uncertain fixation?' and Leira (1984, p. 181) noted that the first examination was with a clinician with whom he was familiar, whilst the second was in a hospital setting with a stranger. Leira concluded that when his strabismus was limited to certain situations, it became intermittent. The strabismus was, she strongly assumed, mediated by anxiety. The overall improvement in the coordinated use of his eyes, in the author's view, corresponded with a greater evidence of internalisation processes and psychic depth.

Although Leira (1984) did not name her technical approach as such, she did describe her style and technique with 'Arne'. Whilst he was 'restlessly busy with the small cars', she said that she 'followed him with my eyes, and that I was cautious not to be too interfering, I made sure that he was bathed in my glance all the time'. Eventually she noticed how he

started registering her ‘from the corner of his eye’ (Leira, 1984, p. 177). Leira described how she was ‘constantly available to him in this dreamy state’, without words, a state that reflected his own ‘hypertonic remoteness’ (p. 178). Leira then went on to suggest that her capacity to focus upon ‘Arne’ brought out his ability to use his eyes in a focused way himself, which led to a decrease in his strabismus. In a sense then, she used her eyes in a relatively passive but available way.

Similarly, working in group psychotherapy many years later, Italian analyst Federici-Nebbiosi (2003), caught a small but significant observation of an interaction with a teenager called ‘Mario’. Following an important interpretation the analyst writes; ‘Mario nods with a smile and turns towards me with his face more relaxed, and I notice with surprise that his left eye, which usually has a squint, is now perfectly aligned’ (Federici-Nebbiosi, 2003, p. 730).

The analyst suggests that Mario felt that there was increased ‘affect regulation’ which then helped him be better at organising his body in order for his eyes to become ‘perfectly aligned’. The paper is not about strabismus, but it captures a fleeting observation illustrating how Federici-Nebbiosi (according to her reference list) had been influenced by psychoanalytically-informed child developmentalists. For example Stern (1985), who used still and video photography to show how micro moments can be captured and interpreted.

Both Leira (1984) and Fedici-Nebbiosa (2003) imply a relatively passive visual approach, and so one of the elements of this research study is to examine the therapist’s more active use of her eyes in supporting patients who suffer from strabismus, in addition to the ‘bathing’ quality mentioned by Leira (1984, p. 177).

Leira (1984) was writing before neuroscience had emerged as an organising force within psychotherapy (Shore, 1994), and in particular its contribution to the understanding of trauma. Shore (1994) suggested that the fear and shame that could be associated with trauma and that may be communicated through eye contact (or by an absence of it), could limit the development of neural systems. Also, opposite of this, the shared experience of delight, through lively eye contact, could alternatively encourage the elaboration of neural networks. Leira (1984 p. 177) wrote that she was careful not to ‘interfere’ with her gaze, implying that she was very careful not to be intrusive with her eye contact. More

contemporary writers influenced by Shore (1994) also warn against the risk of re-traumatisation (Wilkinson, 2010) through intrusive behaviour towards clients.

Leira (1995) returned to her work with 'Arne' as part of a case series and in this she explored the non-verbal aspects of therapy which are supported by close observation and quiet attentiveness. Her work foreshadowed advances in neurobiology research that showed that 'mere observation elevates physiological reactivity to environmental changes' in infants (Cacioppo, 1990, p. 1). This research implied that infants (and possibly older children), react in a positive way to being observed or being 'bathed' in a therapist's glance; suggesting that observation is an intervention in itself.

More recent psychoanalytic studies that deal with eye contact have developed systematic observational methods, combined with video recording, to capture quantitative data. The research shows how minute changes in eye contact can change over the course of psychotherapy, and how this can be quantified according to the duration and frequency of 'odd looks' (Alvarez and Lee, 2004, p. 504). The child featured, Samuel, looked 'fleetingly at the therapist' (p. 505) and showed 'strange widening and rolling of his eyes' at the base line measurement. This changed over the course of psychotherapy to looking into the 'clinician's face in a leisurely manner' and 'focusing on her face from greater distances' (p. 507). Samuel appeared to become more focused visually and emotionally. Although it was not acknowledged in the study, it is probable that Samuel suffered from strabismus (Alvarez, 2011) and that the research is demonstrating an improvement in this as he becomes more emotionally contained by the therapist.

One of the aspects that is absent from the psychoanalytic literature is an acknowledgment of the impact of strabismic eyes upon the therapist. Gregory (2009), a perceptual psychologist, briefly explored a perceptual effect which he termed 'jazzing'; he described the effect of two superimposed, but slightly overlapping images of eyes, upon the viewer's eyes and brain. The eyes and the brain cannot rest on one image, but neither can they tolerate both and they 'jazz' or move about in attempting to accommodate the image. Gregory (2009, p. 156) tells us that 'this curious jazzing shows us the importance of seeing eyes' and particularly the importance of 'seeing eyes' that conform to the brain's expectations of how eyes ordinarily function; working in unison and straight. This research study intends to explore the impact of the child's visual disability upon the

therapist, paying particular attention to the notion of ‘jazzing’ and how this might link to counter-transference phenomena.

In summary, one of the main themes postulated by psychoanalytic literature is that trauma is a feature of the experience of strabismus. This can be categorised in three different ways: the traumatising impact of the physical disability of strabismus upon the developing individual (Hertel, 2003), the secondary effects of this upon early relationships (Lipton, 1970), and finally that strabismus arises as a response to emotional trauma; (Freud and Breuer, 1893; Inman, 1921; Winnicott, 1958; Rappaport, 1959; Leira, 1984). Most of the research implicates childhood experiences of trauma.

Contemporary research would support the proposition that strabismus can be a defect that can contribute to discrimination (Satterfield, 1993), can impact upon the social identity of the individual (Nelson *et al.*, 2008), and can also effect early relationships (Pathai *et al.*, 2010), but there is no evidence within contemporary research to support the notion that emotional trauma might literally cause strabismus.

One study (Mohny *et al.*, 2008) evidences a psychiatric association with intermittent exotropia but the authors do not ascribe any psychological causation. It is possible to speculate that many of the case examples that are put forward as evidencing the psychological aetiology of strabismus, are actually sufferers of intermittent strabismus rather than constant strabismus, and a psychological ‘cure’ has been confused with intermittent manifestation of strabismus. It is possible that the case of ‘Anna O’ (Freud and Breuer, 1893, p. 74) might be an example of this confusion.

There is some support in contemporary ophthalmic literature for the notion that intermittent strabismus, though itself genetically based (Michaelides and Moore, 2004), can manifest itself at moments that might correspond with emotional experiences such as daydreaming, or tiredness, and anxiety (Clarke, 1999; Pratt-Johnson and Tilson, 2001; Taylor, 2012); Pratt-Johnson and Tilson (2001) coined the term ‘Emotional exotropia’. It has to be acknowledged that the research base for these assertions, though proffered by medical practitioners who are very eminent in the field of ophthalmology (Pratt-Johnson and Tilson, 2001; Taylor, 2012), would seem to be based upon anecdotal observations. There is no evidence that there have been any systematic data gathering studies to support this. It has not been possible to find any specific explanation for the actual manifestation of strabismus, though there have been comments about the difficulty in detecting

intermittent strabismus (Clarke, 1999). There is no organic explanation of why sometimes it is present and sometimes it is not. Explanations of 'stress', 'daydreaming' and 'tiredness' are, however, explanations that imply to a psychotherapist that there may be for some children an emotional and or motivational component. These themes are relevant to the current research.

From a contemporary psychodynamic view it is possible to see that more recent child psychotherapy literature concerning strabismus includes observations of the way that children's eye coordination can alter within a therapeutic context (Leira, 1984; Federici-Nebbiosi, 2003; Alvarez and Lee, 2004). One author used ophthalmological resources to test the angle of the eye before and after psychoanalytic treatment. The treatment was aimed at reducing the impact of trauma, and found a dramatic improvement in the strabismus; she noted how her patient's eyes would respond to fear by becoming strabismic (Leira, 1984). Another author explored the reduction of 'odd looks' in psychotherapy with a young autistic boy. She discovered, post publication, that the child's strabismus had also improved (Alvarez, 2011). Interestingly, neither author acknowledged the classical case study of 'Anna O' by Freud and Breuer (1893) who also noticed a similar reduction in eye symptoms during the experience of emotional support in psychotherapy. One author suggested that improvement in strabismus was possibly evidence of emotional regulation (Federici-Nebbiosi, 2003).

In conclusion, the psychoanalytic literature implies that the manifestation of intermittent strabismus may sometimes have an emotional component. Although a psychological aetiology would not be supported by a contemporary scientific understanding, the psychoanalytic literature, based upon a variety of case studies, suggests that there is a strong association with the manifestation of intermittent strabismus and the anxiety resulting from emotional trauma. This may imply that this is especially significant for children with emotional and behavioural difficulties, such as those referred for child psychotherapy.

The research into visual disability and psychoanalysis implies that children with a reduced contact with external reality may have the development of object constancy less solidly established. It is possible to speculate, following Hertel (2003, p. 18), that for some children with more pronounced intermittent strabismus, that their ability to negotiate transitions in relationships may make them more vulnerable to anxiety.

The research implies that engagement with inner versus outer experiences may be implicated in intermittent strabismus; that the strabismus might therefore be hindering the child's ability to fully engage in emotionally containing relationships.

Research has established the importance of eye contact and gaze in early mother-child reciprocity, and therefore one might assume that aspects of this may have a parallel in the therapeutic relationship. One might therefore consider that the nature of eye contact, between therapist and child, may be potentially significant in terms of promoting a child's engagement in the therapeutic relationship. There is also evidence that the impact of strabismus may cause visual confusion in the therapist ('jazzing'), and that this might also be relevant for the development of the therapeutic relationship.

There is some evidence in the child psychotherapy literature that it is possible to use observational process recordings to track changes in eye coordination. It is also stated that changes in eye contact can be observed, not only in long term psychotherapy, but also in a few sessions. This suggests that it is possible to look systematically for changes in eye coordination within psychotherapy assessments. This study will therefore explore the emotional significance of strabismus within a brief therapeutic relationship: a psychotherapy assessment. This may also provide the opportunity to study strabismus within the context of beginnings and endings and the consequential anxiety associated with them.

There is, however, surprisingly sparse comment within the psychoanalytic literature about how strabismus might potentially influence the quality of the transference or the quality of the counter-transference. The focus of this research therefore is the exploration of the manifestation of intermittent strabismus within child psychotherapy and how this impacts upon the therapeutic relationship, particularly the nature of the transference and counter-transference. In the next chapter I will describe how I designed and conducted the research study in order to investigate this area.

CHAPTER THREE

Methodology

The context of this research

As a child psychotherapist often working in the area of infant mental health, I have a clinical interest in understanding the nature of the gaze between a baby and their parents, and how their responses to each other's eye contact contributes to the quality of their developing emotional relationship. Similarly, when over several years, I came to have children in long-term psychotherapy suffering from strabismus, an inherent disability in terms of coordinating and directing their gaze, I was interested in how this impacted upon the quality of the therapeutic relationship. Clinically, I had observed how the eye contact seemed to vary according to the emotional atmosphere within the session. By further research into this area I realised that there were different types and presentations of this disability. I also discovered that the intermittent form of strabismus was considered by the ophthalmological community as possibly having an emotional element to its presentation (Pratt-Johnson and Tilson, 2001).

At the time of this research, I was a senior clinician within a 0-16 years multi-disciplinary CAMHS based within an acute hospital trust. The subjects of my study, two children, Lily aged seven years and Liam aged five years, are drawn from my ordinary case load. Both children had a formal diagnosis of intermittent strabismus but the reason for the original referral was due to their emotional and behavioural difficulties. They were both seen for a psychotherapy assessment and were chosen for this study as both displayed evidence of their strabismus within the context of the therapeutic relationship. The more recent psychoanalytic literature (Leira, 1984) points to the variability of strabismus and how changes can occur in only a few sessions. Due to the setting, clinical notes as well as child psychotherapy process notes would be available as raw data. Within this clinical setting, I became interested in how visual difficulties possibly interacted with the emotional difficulties that had initially prompted the referral to child psychotherapy, and how this impacted upon the therapeutic relationship.

The formulation of the research question

Although it is interesting to speculate about the impact of strabismus upon the developing individual and their sense of themselves within relationships, in formulating the research question I was keen to avoid any misunderstanding about the aetiology of strabismus. Given that contrary to early psychoanalytic writing, there is no evidence of psychological causation of strabismus, I wished to have a question that avoided any suggestion otherwise. However, I still wanted a question that firmly planted the research project within an exploration of the possible emotional significance of the manifestation or absence of a strabismic episode. I wanted a question that could investigate my clinical hunch that there could, at times, be a psychodynamic element to the manifestation of intermittent strabismus and that potentially there may be technical responses from the therapist which might impact upon the strabismus. However, I was also anxious that the question should not sound too linear, as the research study was not aimed at proving or disproving a correlation of variables or any specific theory. Instead, the question was aimed at producing possible inter- and intra-relational themes that may emerge from this particular data within this particular context.

The research question

How might intermittent strabismus impact upon the therapeutic relationship?

The assessment experience

The children were seen in the same room, at the same time, every week, as part of a child psychotherapy assessment process. Typically, children are seen for introductory sessions with their parents and then individually for three consecutive sessions. This is then followed by a review session which is usually held with either the parents or the child or, if more appropriate, just the parent. Often, a separate professional will see the parent alongside the child's session in a separate room. Usually it is appropriate for the parent-worker to undertake consultation with the system around the child and to then join in the review with the child psychotherapist. This liaison both informs the assessment and also acts as a way to embed any future work within a supportive system. Sometimes assessments of this kind will result in an agreement about further possibly regular psychotherapy for the child. At other times, psychotherapy is not considered to be an appropriate intervention at this juncture, and other work may be suggested. An assessment

will then function as a brief intervention, and here an impression of a child's state of mind is articulated in order to enable all parties to hold the detail of a child's experience, especially their internal world view, central to their understanding (Rustin and Quagliata, 2000).

This assessment work was undertaken as part of my usual practice as a child psychotherapist; this offered me several advantages for this research:

- As a piece of retrospective research I had known that both children who were chosen had shown manifestations of their strabismus within the short life of the assessment. It was therefore more efficient and probably unnecessary to use data from longer term psychotherapy.
- In all forms of psychoanalytic psychotherapy an assessment functions as a stand-alone piece of work, and has the rhythm of a beginning, middle and an end. Even when there is a fair degree of confidence that longer term psychotherapy will result, until the assessment is complete there will be a level of anxiety around the decision. This contributes to the experience of the third session representing an ending, even if not actually being one. This was an important point, as my previous work in this area had suggested to me that anxiety around transitions, for example children returning after breaks or just before a holiday, or the transition between parent and therapist, might correspond with an increase in their strabismus. The importance of anxiety around transition therefore became an *a priori* theme.

Long after the assessment work had been completed, I remained curious about my therapeutic experiences with these children. There was, therefore, a sense of desire about studying the data and trying to increase my understanding of the nature of the emotional relatedness when strabismus was implicated.

The children being studied

I chose to use two children for rather pragmatic reasons; I happened to have seen two children for assessments who had suffered from intermittent strabismus. This was in a sense serendipitous theoretical sampling (Glaser and Strauss, 1967); both children were referred to a Tier 3 Child and Adolescent Mental Health Service (CAMHS) due to concerns about their emotional and behavioural development, and both were then referred

internally for a child psychotherapy assessment. There was no mention of the pre-existing diagnosis of intermittent strabismus prior to the actual assessment, though it transpired that both had been diagnosed formally by the local hospital Consultant Ophthalmologist several months prior to their arrival at CAMHS.

The first child, Lily, was diagnosed as suffering from a divergent intermittent strabismus in the right eye and possible sixth nerve palsy. This is considered as a neuro-ophthalmological condition which can sometimes be associated with physical trauma (Harper, 2010).

Liam, the second child, had been diagnosed as suffering from intermittent convergent strabismus of the right eye, and no explanation was offered as to possible aetiology. Neither of the two children had had corrective eye surgery, though Liam was being considered for it in the future. Both children had been prescribed spectacles though Liam only occasionally wore his.

Both children had suffered from degrees of emotional trauma and were similar in that they had endured parental separations and had parents who suffered from mental health difficulties. Both were in mainstream schools, but had some degree of struggle with social relationships and academic learning in that setting. Although they happened to have many similar aspects to their development and family background, no claim is being made in terms of them being representative of any kind of population.

I could have chosen to concentrate upon one child, but I suspected that the differences in their personalities would offer different and individual presentation and that this would enrich the research.

Ethical considerations

This study was discussed within the hospital Research and Development Department and I was advised that I would not be required to present the research to the ethics committee or to seek ethical approval as it was considered that the research was conducted as part of my normal professional practice. The research proposal progressed through the University of East London (UEL) and Tavistock ethics process and permission was granted there.

The only stipulation from the local Research and Development Department was that I seek written consent from the parents and that the clinical material should be anonymised; all of which was done. Parents were given a standardised description of the study and time to consider their responses. They understood that there was no requirement to take part and that permission could be withdrawn at a later stage. Contact with the service continued with the families who continued to be happy to give consent and there were no concerns raised. The notion of their children giving consent was carefully discussed with the parents, as well as the case manager; there was a consensus that, due to their young ages, the request for consent would make very little sense to them. Moreover, it would be considered to be intrusive to the clinical process in this particular situation.

All material has been anonymised.

Choosing a methodology

Given that I am researching within the, necessarily, highly subjective and interpretive arena of the therapeutic relationship, it is appropriate that this is a qualitative study. Qualitative research aims to acknowledge the subjective views of both the researcher and, if possible, the researched. Some would argue, that in any case, within modern research ‘The ideals of objectivity are largely disenchanted’(Flick, 2006, p.13).

Post-positive qualitative research often embraces the open reflexive stance of the researcher rather than holding a tight preoccupation with the control of variables. It could be suggested that this makes qualitative research closer to the everyday life of the psychoanalytic psychotherapist and their patient; working with the not yet known is often the lifeblood of the process.

Rather than manufacturing large homogeneous sample groups that may be compared and contrasted, qualitative research can be more easily suited to smaller groups or individuals; where the particularity or peculiarity of a small group or, as in the case of psychoanalysis, an individual, is considered intrinsically worthy of in-depth investigation.

Qualitative research attempts to embrace the complexity of reality by producing rich data which then can be systematically handled and analysed in order to achieve a coherent but generative set of responses to the research question. The aim, therefore, is not to test theory but to build towards theory incrementally, inductively and, possibly,

hermeneutically. The aim might, therefore, be to attempt to capture something of the world that is more nuanced and more grounded in lived experience, rather than the pursuance of knowledge about laboratory experience or ‘fact’. Notions of generalisability are therefore different, as the knowledge journey is not intended to be laboratory to life, but more reciprocally held within a particular paradigm, which in this case is child psychotherapy.

This research project borrows from the tradition of qualitative research that emanated from ethnology, sociology and then a psychological application of these methods (Richardson, 1996; King, 2012a).

To summarise: because this research enquiry concerns the inter-subjective arena of relationships, it is considered that it is best located within a qualitative methodological tradition. In particular, that which prioritises a reflective interpretive stance, accepting that there may be multiple meanings that could be generated within naturalistic contexts. In this enquiry there is no search for absolute truth, but rather there is an aim to generate ideas that might be useful to other child psychotherapists. The aim would be to continue to generate further explanation, building a wider and more in-depth understanding of work with children with strabismus.

Case study method

Case studies have a long tradition within psychoanalysis and they have been central to the development of child psychotherapy (Rustin, 2003). They tell more than just a narrative of a treatment and are often used to explore a theoretical or technical direction within clinical practice. Much is owed to the case study approach for disseminating both received wisdom and communicating new ways of working (Rustin, 2009). They are a vehicle for teaching and debate and for professional networking. It is possible to use a single case study method to focus upon an in-depth understanding of an individual’s experience within a nuanced exploration of the development of the transference relationship. Case study research provides context and illustrates development over time. Case studies are therefore the obvious method for child psychotherapists to use.

As a research method, the relevance of the case study has, however, been much maligned in the contemporary landscape of randomised control trials and quantitative outcome studies (Midgley, 2006). It could be argued that the child psychotherapy profession has

lost its confidence in this form of research, as it is thought to lack a capacity for generalisation and suffers too much from the bias of the author (Midgley, 2006).

New ways of approaching case studies and tackling these perceived deficits have, however, more recently emerged. Midgley (2004) and Philips (2009) suggested that looking towards other disciplines, such as sociology and psychology, and borrowing from their qualitative approaches can extend the case study research to make it more relevant to an external research audience.

The application of the case study method to this research

Child psychotherapy research is about children and the therapists that work with them. Strands of data without individual contextualisation might be in danger of being denuded of meaning, liveliness and clinical conviction. In order to be able to communicate a narrative which holds the background information and also the developmental and clinical context, a case study approach was chosen. The analysis and illustration of clinical data is therefore placed within a case study.

Data Collection

There are many methods of conducting research but, as I have touched upon in the previous section, my aim was to study the actual psychotherapy process. Therefore it was necessary to ensure that the chosen method would not interfere with the psychotherapy process or add any additional layers that would impact upon the integrity of the work. In order to explore the impact of strabismus on the therapeutic relationship, the aim of the method would be to capture subtle, fluid, and dynamic patterning that may represent possible moments of ocular significance between and within individuals.

Observational process recordings as data

The focus of this study is the psychoanalytic session and how themes may emerge that relate to the impact of strabismus upon the therapeutic relationship. The aim is to capture natural data, within a naturalistic child psychotherapy setting as opposed to constructing artificial and additional methods, such as interviews. This research project aims to contribute to the craft of child psychotherapy, that is, something that is refined over time (Rustin, 2009), and that works with the peculiarity of its materials; the therapist and the child.

As a lone clinician researcher, with a clinical task as a priority, it was apparent that the everyday tools of a child psychotherapist would represent the best method for this research. Traditionally, child psychotherapists make use of very detailed written process recordings to capture fleeting impressions which can potentially represent an encapsulation of general patterns or themes. Process recordings do not need any special facilities, they are a non-intrusive method, taking advantage of the skill of writing down in an emotionally informed way after the event (Reid, 1997).

The advantages of capitalising upon the availability of potentially rich and detailed data from clinical process recordings are obvious but, nevertheless, there are difficulties and challenges. Remembering is always a representation of an event seen from a particular viewpoint and within a particular context, and this can be open to various interpretations. However, there is an acceptance within psychoanalytic work that differing interpretations are possible and, indeed, are hoped for as they are considered to be part of a reflective practice. Process recordings will always contain idiosyncratic elements that relate to the author's professional interests and preoccupations (Midgley, 2006). These will differ between psychotherapists from different theoretical backgrounds and also within the same theoretical approach but, one would assume given the apprenticeship process of training, that there is more commonality than otherwise (Rustin, 2003).

Process recordings even with their limitations, it could be argued, are one of the most authentic ways of examining the psychoanalytic process. The view from within the therapist cannot easily be caught on tape but, like poetry, the 'natural language' (Hammersey, 1996, p.162) chosen by the therapist in the recording can convey essences of the emotional atmosphere.

The core element in the child psychotherapist's training is the observation of babies and (usually) their mothers over a two-year period. The skill of being a participant-observer, that is, to be in a relationship and at the same time develop the capacities to mentally note the nature of a closely observed interaction, is a key skill acquired by the child psychotherapist in their pre-clinical period. Seemingly incoherent streams of non-verbal interaction can be captured in this way for later reflection and analysis. The tradition of developing the discipline of omitting hypothesis at this stage, aiming for pure observation, allows for it to be worked on at a later date. It also allows for independent scrutiny of the material and keeps in check the sway and imagination of the observer at the point of writing up. The seminar leader, along with the group of peers, acts as another eye on the material in order to ask questions of the material and of the observer; often helping them to appreciate a different perspective or further layering of meaning. The overall experience is expected to be regarded as if in parenthesis within the context of the other parts of the training. This is in order to resist applying theory to the raw data, certainly until the whole observation is written up within an academic paper. The internalization of this capacity is a resource for the qualified child psychotherapist in their clinical practice. Reid (1997) describes this as a 'standardised protocol' and describes how it complements focused child development studies arising out of lab conditions. In professional practice, these kind of process recordings are used for a variety of purposes; they form the basis for producing clinical reports that describe the development of the therapeutic work, they are used for clinical supervision and, increasingly, they are used for purposes of research (Reid, 1997).

Although clinical note writing based upon observations and research writing can be compatible tasks (Charmaz, 2007), they do present challenges within qualitative research. I would argue that clinical process records are necessarily placed within the prevailing working clinical hypothesis that informs the management of the case, and are therefore not as neutral as one might wish for research purposes. An example of this might be where there is a concern around self-harm, the clinician is bound to have a heightened anxiety and be pre-occupied by the need to capture and record any reference to self-harm, despite the possible detrimental impact of observational attention to other matters. These challenges need to be considered in an ongoing way and the clinical researcher needs to be mindful of these intrusions when written recordings have a dual purpose as research data.

Making notes of transference and counter-transference impressions is a particular challenge to child psychotherapists. Recording the data caught by this kind of 'receiving apparatus' (Money-Kyrle, 1952, p. 3) is crucial to psychoanalytic work, but obviously problematic in healthcare settings. Interpretations offered to support the child's thinking capacities are crafted as a result of information registered emotionally by the therapist and, whilst they may be recorded, the counter-transference may not be. If transference or counter-transference is recorded, it may require special drafting and explanation in order to sit within clinical notes; failure to do so could result in a serious misunderstanding or misrepresentation. Noting that a therapist feels 'sleepy' or 'frightened' might be crucial in order to understand the nature of the counter-transference, but may need careful wording when there is the possibility that notes might be read by non-psychoanalytically informed colleagues or, if legally requested, by parents. The potential for misunderstandings when process notes have multi-purpose uses makes it a very challenging area. It is appreciated within the psychoanalytic tradition that knowledge about therapeutic material often comes through re-examination via discussion and reverie well after the actual session (Brenman-Pick, 1985). Moreover, in all walks of professional life, 'after thoughts' inform judgments and are a resource for the next encounter.

Although it could be said that video and audio recording might be alternative ways of capturing information from therapy, these are not free from editing processes. It also could be argued that they lack the emotionality that informs the choice of words within process recordings. Additionally, video and audio machines represent an intrusion to what is often a delicate process of engagement. Some studies do show how this can be potentially overcome and illustrate how powerful a tool it can be (Alvarez and Lee, 2004). Videotapes of an interaction can also allow a researcher to literally go back to the session and re-look at details with the potential of making a different analysis or in order to introduce independent scrutiny (Stern, 1977). It might be debateable, however, whether video can in practice, without the sophisticated use of close up, really catch the moments of eye activity between two people in a naturalistic way (Midgley, 2006). It is quite possible that technology has already advanced (Spivey and Geng, 2001) but in practice, with such a modest research project as this, process recordings are more economical and accessible.

The position of the researcher

Philosophically and technically, there are similarities with the use of process records as data within child psychotherapy and ethnographic research. In ethnographic enquiry the researcher goes 'native' (Flick, 2006 p. 230) and submerges themselves in a particular setting. It would seem highly appropriate to be a 'native' child psychotherapist researching child psychotherapy in a naturalistic way. The research challenge however would be to 'systemize the status of the stranger at the same time' (Flick, 2006, p. 223).

How the researcher relates to the data as it is being collected, and how they position themselves in relation to it, are all crucial questions technically and ethically. In a clinical context, as a researcher-clinician, it would be ridiculous to assume a position of being 'blind' to the data. Neither would it be ethical to attempt to make the production of data fit fixed and premeditated ideas that match favourite theories. In many qualitative research techniques this tension is actively exploited by developing a circular approach to data collection and analysis which aims for enrichment rather than rigid delineation. For example, Addison (1999), a clinical psychologist, entitled his style a 'grounded hermeneutic editing approach'. He had followed physicians through the night, closely identifying with their struggle to remain alert and manage complex medical procedures. As he became 'immersed' in hospital life and perhaps in identification with the physicians, he recognised his own fear of 'survival' as a researcher. He also scanned observational texts to pick out key phrases that elucidated the experiences of resident trainee physicians, as well as his own experience, and eventually came to realise that the theme of 'survival' was present in the text; which eventually became the overarching theme within his research (Addison, 1992, p. 14).

Although Addison (1992) mentioned his background as a psychotherapist in reference to his use of process notes, he did not acknowledge the concept of counter-transference; though in my view it clearly informs his experience and ultimately his subsequent recognition of the major themes in his research. Instead he refers to the process as 'immersion' (p. 14). The process that Addison described is very familiar territory to child psychotherapists as we have to 'immerse' ourselves within the process of therapy in order for ideas about the child to emerge in our minds. Unlike Addison, we also have to make interventions alongside this process. My intentions in this project were for the 'clinician' and the 'researcher' perspectives to inform each other as the research moved forward;

working as partners that would illuminate ‘each other’s’ work but avoiding task confusion.

Other authors describe the complexity of a reflexive approach to research as a battle to ‘untangle this sticky, intricate web’ (King, 1996 p. 176). King (1996) like several others (Smith, 1996; Flick, 2006) suggests:

... the need for a research design to incorporate a ‘paper trail’ in order to provide a way out of defining different perspectives of the work. In this research the ‘paper trail’ is mainly the observational accounts of the therapy, but also supervision notes and case notes that have been used to build the case studies.

King, (1996, p. 176)

To summarise: observational process recordings, which are as verbatim as possible, are a traditional way of collecting clinical data within child psychotherapy. They aim to capture observations of the inter-subjectivity between the child and the therapist in a detailed and non-intrusive way so they can be easily exploited for the use of research. They communicate the ‘natural language’ of the child psychotherapist and the child and therefore offer an authentic representation of an actual therapeutic encounter. Acknowledgment is given to the complex position of the researcher *vis à vis* the clinician, and reference is made to an ‘immersion’ process (Addison, 1999, p. 14), as well as the ‘systematized status of the stranger’ (Flick, 2006, p. 223), and how this might be transformed into illumination without task confusion.

Choosing data sets

Although I had previously had an interest in understanding strabismus, many of the dilemmas explored above were side-stepped as the process notes were made for clinical purposes, and only returned to several years after to be used for the current analysis. This research project therefore is a retrospective study using data from two sets of three observational clinical process recordings concerning two children’s assessments. These total six process records, from six fifty-minute sessions. The sessions were written up as soon as possible afterwards. The sessions represent all of the fully written up available detailed observational session material concerning the children. One of the sessions, involving Lily, was an initial introductory session and a parent was present. This was

included in lieu of an individual session, but mainly because it was a significant session in its own right. Sessions with Liam also include brief observations of him with his mother at the beginning and end of sessions; these observations were also felt to be significant and interesting.

Additionally, I also used notes taken from clinical supervision concerning counter-transference and transference comments; these were often written in the margins of the actual sessions in order to inform practice and may also have been written some weeks after the clinical work. Although I would argue that this approach is authentic and reputable within psychoanalytic practice, clearly they are not contemporaneous notes and are open to a variety of influencing processes; not least the frame of mind of the therapist and the clinical supervisor at the time of supervision. These notes were not coded alongside the process records, but they were used to influence the analysis of the template and are used for subsequent discussion of the templates. In a similar way, notes from liaison with colleagues or schools, etc. have not been coded, but their conclusions have been used to influence the analysis. They have been particularly useful for the case study description, but are not therefore part of the data set being examined systematically. The main reasons for their exclusion are that they are less detailed than session notes, rarely contain information about eye contact (apart from the school visit with Lily) and, moreover, say less about the intricacies of the therapeutic relationship and more about external therapy background information. In a different kind of study there might be good reason to include them.

When looking back at process records, one always wishes that more time had been spent in describing in ever greater detail. The author is rarely satisfied and asks questions of the material about what was not recorded as a result of learning post- construction of the notes. Yet, I would argue, they are authentic representations of a lived experience between the therapist and the child. Re-reading them for the purposes of research generates a lively and emotionally rich experience that can still, several years later, put the therapist in touch with the original emotional dilemmas that emanated from the clinical work.

To summarise, only process records that were from the actual child psychotherapy sessions were included in the data set. Other notes were included as part of the material for the case study, but not analysed as part of the data set. Obviously, both kinds of notes

would later influence the analysis and generation of themes in a reflective and interpretive research context.

Data Analysis: finding an appropriate method of handling and analysing the data

The search for a data analytic method began with a consideration of grounded theory (Glaser and Strauss, 1967). Grounded theory is a popular tool for child psychotherapists and, like others (Anderson, 2006; Hindle, 2007), I was attracted to the inductive and process driven method of continual analysis.

I began by experimenting with observational data and by trying to keep an open mind in order to let themes appear unhindered by prior theory. However, I found that all the while I was wrestling with a legitimate interest in particular themes that had arisen from my previous clinical work. A grounded theory approach insists that the researcher eschews theoretical preconceptions, a view that might at first seem to echo with a well-used piece of advice by Bion (1967, p. 17), who suggested the analyst should hold in check their 'memory' and 'desire'. He was suggesting to analysts that they should be open to new experiences in order to respond to their patients in the moment, and so grounded theory and psychoanalysis might seem sympathetic 'partners' (Anderson, 2006, p. 329). Anderson, an exponent of grounded theory, argued that keeping an open mind 'is both difficult and important' (p. 334).

I had previously seen a number of children in psychotherapy suffering from strabismus, I already had a clinical hunch that their strabismus varied according to the emotional atmosphere within the session, and that this had an impact upon the development of the therapeutic relationship. This situation immediately presented dilemmas: should I deny previous knowledge, experience and clinical ideas or should I find another more philosophically congruent way to approach the data? Grounded theory is widely discussed and praised (Charmaz, 2007; Bryant and Charmaz, 2007) and criticised (Hammersley, 1995; Smith; 1996; Flick, 2006) and many tussle with the problem of how to deal with prior information and theory. One author concludes: 'it might be simplest to ignore this dilemma' and to 'recognise that it makes no sense to claim that that research can proceed either from testing prior theory alone or from a pure inductive analysis of data' (Pidgeon, 1996, p. 82). Indeed some authors suggest that thinking without theory is impossible (Jackson and Mazzei, 2013).

Rather than attempt to modify grounded theory, I decided to find an alternative style of thematic analysis. I briefly considered interpretative phenomenological analysis (Smith, 2010) and, although very sympathetic to individual case design, I again found it problematic in terms of the acknowledgement of prior themes. My discovery of template analysis, however, offered a compromise position whereby ‘a priori codes’ and theoretical frameworks could be acknowledged, but flexibly managed King (2012). This is a pragmatic approach to data analysis and it may have developed because a proportion of template analysis researchers have arisen from within the health and social services sector (Kent, 2000; King, Thomas and Bell, 2003; Stratton *et al.*, 2006; Rafique, 2010; Shine and Westacott, 2010; Perry *et al.*, 2013). This research, it could be argued, brings with it pressures to fit a particular clinical or strategic remit; asking the researcher to explore within a certain parameter rather than being fully open-ended. Given that my research study is located within the health services and within the theoretical frame of psychoanalytic theory, and that this will inevitably influence the interpretation of the data, then I would argue that, at least for this research study, template analysis is potentially a more congruent and therefore a ‘well-suited partner’ (Anderson, 2006, p. 329).

The development of Template Analysis as a qualitative method

Crabtree and Miller (1999) described how templates were used in anthropology from the 1950s and then later within educational research. Like grounded theory, (Glaser and Strauss, 1967) template analysis adopts a similar inductive approach in order to gain an understanding of phenomena through a close examination of text. Usually, the text is an interview transcript (Shine and Westacott, 2010) but it is noted that any text can be used (King, 1998). Unlike grounded theory, template analysis does not require all the data to be scrutinized line by line; only the data that is related to the focus of the study needs to be considered. This is therefore an efficient way of editing and reducing the amount of superfluous information that the researcher has to deal with. grounded theorists might be philosophically opposed to such editing, fearing that gems of insight might be lost or that deductions have been too quickly foreshortened. Some form of thoughtful editing however is vital in any system.

Crabtree and Miller (1999) used a template organizing style to study primary care settings in Ohio, USA. Research nurses were initially directed to note down their impressions at the end of each day (Crabtree and Miller, 1999). Although this was initially designed to

be a way of contextualizing the primary quantitative data, which was being collected by other means, it soon became apparent that this was a valuable part of the study in its own right. The nurses were then trained to observe in a more detailed and systematic way and, in turn, these observations were analysed in order to produce a template (Crabtree and Miller, 1999).

King *et al.* (2002) used a template organizing style to research into the experiences of patients with diabetic renal disease. They used transcripts from 20 individual interviews covering such topics as the participants' health history, reaction to their diagnosis and their hopes and expectations for the future. The interviews were conducted in an open-ended way and there was encouragement for the participants to tell their own stories. There was no attempt to include the observations of the interviewers, unlike Addison (1999) and Crabtree (1999). King *et al.* (2002), however, were clearly committed to finding in-depth ways to uncover authentic emotional and behavioural responses from a given group of people whilst still retaining the perspective of the individual.

Template analysis and psychotherapy

There is a small body of research work that uses template analysis for the purposes of exploring themes in psychotherapy, though none that I know of within psychoanalytic psychotherapy. One group of authors use template analysis in order to examine the relationship of family therapists to their use of outcome scores; typically they use structured questionnaires (Stratton *et al.*, 2006). The template in this study could be criticised for reading like a list, rather than a presentation of themes which could be questioned by the reader. This can be a problem with this procedure if applied to very structured interviews, as in this case.

The research also seemed to take on a quantitative stance when commenting upon how many therapists responded to a particular question: 'There were some areas of consensus: all 9 therapists viewed item 16 relating to 'hope' as useful' (Stratton *et al.*, 2006, p. 203). However, King (2004) warns against the misunderstanding that frequency of a code can be seen as relevant and that it is the analysis of the researcher that must decide what is significant.

The second study that concerns psychotherapy research attempts to understand the process of change in therapy, and uses template analysis to capture an understanding of

the participants experience of a particular technique used within cognitive analytic therapy: ‘the reformulation process’, which involves the use of a therapeutic letter (Shine and Westacott, 2010, p. 161). This study used a mixed methodology combining a quantitative approach to examine the effectiveness of the use of the letter. Whilst the quantitative research element failed to show any statistical impact of the letter, the template thematically highlighted the participants’ thoughtfulness in regard to the technique.

Both of these studies used small sample groups compared with most other template analysis studies: Stratton *et al.* (2006) used nine, Shine and Westacott (2010) used five; these were smaller than most other template analysis studies (Crabtree and Miller, 1999).

Child psychotherapy has been slow to explore methodologies and apply methods from other disciplines, such as sociology and psychology (Midgley, 2004), and consequently there are few models to draw upon. The use of template analysis is relatively novel within psychotherapy generally, whereas the use of a form of thematic analysis seems more common.

Isolating initial themes and coding processes in template analysis

King *et al.* (2012) encourages the template analyst to draw out ideas from their knowledge of the area under study which they deduce might come up in the material. These ‘*a priori* themes’ are not meant to be definitive, but more of a way to make an informed start to the research. As such these may potentially be discarded or reformed as the coding proceeds. This is perhaps more obvious when conducting structured or semi-structured interviews, as the questions themselves may form part of the *a priori* coding. Another way is to begin by close reading of a sample of texts (King, 1998) to see what themes emerge, and then using this to construct the ‘*a priori* themes’ that are then, in turn, applied to the subsequent texts.

The language of thematic analysis can be confusing and at times seems interchangeable. Essentially themes arise out of the text to inform the production of codes. Codes are descriptive markers. Gradually as themes are sorted and developed into a hierarchy of categories and codes, a collection of primary and subsidiary codes evolve. King (1998) suggested that most templates develop into either two or four levels and clarity can be

lost if too many levels are developed. However, there is no insistence upon any fixed levels of coding (King 2012a).

Coding a template is an integral part of the analysis and so as the template develops there is the possibility for inserting codes or indeed deleting them (King, 1998) or a change from higher order to a subsidiary order. The template is constantly worked on and worked through to completion of a final template. Even when satisfied that no more codes can be sensibly gleaned from the data, the researcher is warned that it is possible to continue elaborating in an endless way (King, 1998).

‘Immersion’ in the data

My approach at the beginning of this data analysis was to first to acknowledge my ‘pilot’ research experiences: I had seen at least two children in long term child psychotherapy as well as two children in brief assessment that happened to have suffered from strabismus. I had collected data from these children and had developed templates. In a sense, my experience of this process led me to become ‘immersed’, if not drowned in great amounts of data.

In an effort to clarify and produce a much more manageable response to the data, I chose to reduce the sample of children to two. These were the children who suffered from intermittent strabismus which is considered to have an emotional component. These were also the children who were seen in brief assessments and therefore produced fewer observational process records. The larger original group had contained children with constant strabismus, and they were less likely to suffer from strabismic fluctuations, and they were therefore considered less applicable to this research. The larger group also included a child who ultimately became diagnosed as suffering from Autistic Spectrum Disorder, a disorder that includes difficulty with eye contact. I therefore constructed a small sample group that better reflected my focus of study concerning the fluctuations of strabismus within therapy. A closer reading of the literature supported the notion that intermittent strabismus might manifest itself within a short number of sessions and it therefore seemed unnecessary to persevere with tens of sessions.

***A priori* influences and emerging codes:**

- The *a priori* background to the research was that I was trained in psychoanalytic theory as a child psychotherapist in the NHS, and that the production of data would be imbued with that theoretical underpinning. Specifically, I would have evolved an approach that would look for emotional significance in any kind of behavioural presentation in an attempt to speculate as to whether it might have emotional meaning within the therapeutic relationship.
- My clinical hunch, as a result of the early ‘immersive’ work, was that there would be occasions of emotional significance in the manifestation of strabismus and that this would impact upon the response of the therapist. In a sense this is an *a priori* theme. Within this idea there were a number of more specific provisional themes I anticipated might arise, such as:
 - Strabismic moments;
 - Intermittent strabismus related to the child’s transition between parents and therapist;
 - The impact upon the therapist’s eyes;
 - Difficulties relating to the external world associated with strabismus and visual distortion;
 - The nature of the transference and counter-transference as it corresponded with intermittent strabismus.

The research question, ‘How does intermittent strabismus impact upon the therapeutic relationship?’ was formulated as a result of this preparatory work.

Developing the template

Unlike some of the other examples of template analysis, I felt it would be important to analyse the whole of the observational record, in order to gather in as much of the ‘to and fro’ of the session. I could do this practically as I had a relatively small number of sessions to analyse (six). I began by attending to the text line by line and underlining in pencil any strands of text that involved ‘anything to do with eyes’ for either the child or the therapist. In underlining the text, I highlighted blocks that included the description as fully as possible. This often included a sequence of interaction.

In my previous attempts, because of the sheer amount of data, I cut out lines of text. I then sifted through and literally built piles of similar categories; this was a lot of scissor work. Familiarity with the data and an ability to hold in mind three sessions per child meant that I could avoid the literal ‘cutting’ and I could underline the text instead.

The first overarching category: ‘anything to do with eyes’, was a purposefully wide category and was aimed at gathering as much data as possible to begin with. Following this, I asked myself whether I should only code ‘strabismic moments’ and ignore any text that related to ‘ordinary eye contact’, i.e. co-ordinated eyes. At this point I took the decision to continue to keep my coding as wide as possible to see if there was anything significant which might arise and might inform the study at a later point. This was subsequently helpful as it led me to think more closely about what I meant when I found myself looking and thinking about ‘strabismic eyes’ or ‘good eye contact’. Often eye contact was not recorded: ‘we were just getting on with things’ and the ‘eye contact was just taken for granted’. I had only commented in the recordings when there was something unusual or special about eye contact; in a sense this had been initial coding.

I asked myself questions about the accuracy of my interpretations of the observations. I often had to remind myself that I was not an ophthalmologist, and the purpose of the research was to understand the significance of eye coordination within the context of a relationship; it was not an eye examination. This was a relief.

So, returning to the pencil highlights, I began delineating categories of ‘eye activity’ within ‘anything to do with eyes’. I used colour coding to gather the sequences of text together in order to form smaller categories of text. This involved a trial and error process until categories coalesced around particular codes.

This process again led me to consider more closely what the observations meant in terms of the perceived quality of the eye contact that they were describing. I decided that I would categorise in terms of my perception of the nature of the eye contact rather than worry too much about what anyone ‘objectively’ might consider to be ‘good eye contact’. This position allowed me to re-think myself back into the session. I came to the realisation that, occasionally in the observations, I was possibly, intuitively, privileging my perception of the shine, or light of the child’s eye, rather than the presence of strabismus: ‘when eye contact was perceived as more reciprocal and there was less of a barrier’. The opposite was true: that when eyes were strabismic and accompanied with flatness or

glazed over, then the strabismus seemed more pronounced; it was ‘felt as a barrier between us’.

The following example shows an observation that acknowledged the importance of the light in the child’s eye in terms of ‘the emotional nature of the eye contact’; whilst there is an awareness of the strabismus, it is not experienced as a barrier to ‘good eye contact’.

Following a conversation about the toy box the therapist wrote:

‘It’s a very big box,’ I said with emphasis, in touch with how small she seemed to be in relation to it. Lily looked right up into my eyes and held really warm eye contact, as if she was looking deeply into my eyes with a sense of pleasure. She seemed delightful. Her eyes, I thought, were ever so slightly sunken and her right eye was slightly inward turning, however they sparkled. Lily’s mouth was wide open. (27th January 2010: Session Two)

In constructing the template, I also questioned the level of visual distortion a child might experience accompanying a ‘strabismic moment’. If one assumes that a child is struggling with visual distortion when strabismic, or has struggled with it in the past (which has affected visual acuity) as is suggested in the literature, then one could infer that a child might possibly be struggling with the equivalent to visual distortion on an emotional level too. This conjecture led back to the question about how much a child might be ‘relating to their internal view of the world when their eyes are obviously strabismic’, and this became one of the areas that I explored with the use of the template.

These examples show how multi-faceted this area of research is. Also how the reflective and imaginative stance of the researcher comes into play when attempting to delineate and develop possible themes and construct codes. It also shows how the perceptions of the researcher need to be questioned and re-questioned in order to strive for authenticity.

I have illustrated how the reflective self-conversation during the code production is a way in which codes are developed and ultimately either kept, shaped or discarded.

Constant comparison

The initial set of categories that arose from the first session was then applied to the next session, and then to the third, resulting in an aggregation of ideas. From this set an initial template was fashioned. I then went on to the first process record of the second set of three sessions and applied a copy of the template (constructed from the first three sessions). I then added and refined and built in the same inductive way using the subsequent sessions. The final template was constructed from categories that were both common and individual to the children, and so an inclusive approach was taken.

In summary, each session in turn was subjected to the growing template. This constant comparative method produced an aggregate of codes. The thematic structure was continually interrogated for its accuracy as it grew. Codes were generated through close inspection and active reflective questioning of the material, as illustrated.

Researching the ‘particular’

There is no attempt to count codes within this research project; in many ways it is a study of the ‘particular’ and potentially isolated or fleeting occurrences. There are categories of text that only occurred occasionally, or even once within the text. An example of this was the observation of a child using what I came to realise was her ‘dominant eye’ to possibly manage the visual distortion caused by the strabismus. Her use of her eyes in this way only seemed to occur twice within the whole assessment, but I would argue that it was very significant within the life of the assessment, and indeed it came to provide a basis for thematic developments associated with supporting a relationship with external reality. The previous text example also illustrates the child’s possible use of her ‘dominant eye’ which I suggest in my analysis may be a way of organising her vision to maximise her visual focus. This can be compared to an example of the second child, Liam, where neither eye seemed dominant and the strabismus often seemed to diminish his visual relationship with the external world.

Code development

A back-and-forth between a close reading of the text and a re-assessment of the template led to a reflective approach to the wording and final formulation of the template. At times, this was a frustrating task as it seemed similar to the experience of looking into an optical

illusion, and begged the question whether a description should be in the background or the foreground. There was a continual need to keep going back both to the data and to the template, until a level of satisfaction emerged that was based upon a clinical conviction that the template was authentic, trustworthy, and not overly complicated.

A 'finished' template as a 'finding' provides an 'end product' that potentially is available to apply to ever more new data, opening up the possibility for ongoing code or thematic development at any time in the future.

Quality and trustworthiness:

Many authors (Yardley, 2000; Smith, 2010) argue that the very language of ensuring quality in qualitative research is often contaminated by, or at least ingrained in, a prior allegiance to quantitative methodologies. The principles behind validity, generalisability and reliability are considered by many qualitative researchers as less appropriate concepts for use in qualitative methodology (Silverman and Marvasti, 2008). I would, therefore, like to discuss quality issues with reference to concepts that have begun to emerge from the relatively newer tradition of qualitative research.

Transparency and presentation of evidence

It is hoped that the reader will surmise from the reflective stance in the writing of this chapter that an authentic representation of the story of the research journey has been illustrated. Moreover, the appendices include two sample sessions (one from each child). These represent full copies of an actual session. Annotations show a representation of some of the 'workings out' of the data analysis that led to the final template. In this way the study allows the reader to take part in the 'interpretative dialogue with the data' (Smith 1996, p. 192). It allows the reader to examine the text and invites them to evolve alternative explanations. It could be argued that process recordings, kept in order, provide a form of 'audit trail' that is potentially available (within ethical limits) to an independent viewer.

Subject validation

With older children, in longer term psychotherapy, it might be possible to imagine that spontaneous references to their perception of their eyes and eyesight might appear. It would have been interesting, but not ethically or clinically appropriate, to intervene with questions about their view of strabismus and how it might impact on their emotional connectedness, or their view of the therapist. This kind of enquiry might extend theme development; however it would not necessarily increase validity.

Triangulation

Triangulation can be another way of continuing to extend analysis and theme development and it can also be considered a way of ‘fixing’ the data. There were a number of ways that this concept was applied to the research process. Firstly, as is required by the professional body for child psychotherapists (ACP), I undertook regular clinical supervision with a senior clinician. This involved close scrutiny of the text. Additionally, I received regular supervision associated with this research project.

Secondly, the session notes were scrutinised by peer colleagues for their interpretations. An example of this involved a colleague looking through a whole session (this is presented in the next chapter), where there was an instance where the child’s eyes became strabismic and I commented upon the ‘turning away eye’. My colleague however, noticed the eye that was ‘shooting me a look’. Re-reading the ophthalmological research enabled me to extend my understanding of the possible use of a ‘dominant eye’ as a way to coordinate the eyes during the strabismus. It implied that the vision in the ‘turning away eye’ was minimised to prevent visual distortion: diplopia. These sessions were also looked at and discussed by a different colleague, who had subsequently undertaken the long term psychotherapy with the child, following the assessment and so had an in-depth view of the child. She confirmed my view regarding the impact of emotional trauma and how, not only her eyes, but her whole body would appear to lose an ability to function in situations of anxiety. The use of the ‘dominant eye’ therefore may have represented a more assertive and coherent part of her personality.

Thirdly, I made use of experts: colleagues who had themselves used template analysis in their family therapy practice (Farrington, 2010), experts in template analysis (King,

2012c) and grounded theorists to discuss the challenge of utilising prior information (Bryant, 2010).

Given the focus of the study was the impact of strabismus upon the therapeutic relationship, it was a challenge to introduce additional information that might give a 'fix' on the data. In consulting records from family reviews, school discussion, observations, etc. there were probably no observations of the strabismus. However, it was interesting how there was an absence of the acknowledgement of the strabismus generally. This stands in stark contrast to my evident preoccupation with it in the clinical setting and led me to consider whether I was assigning far more significance to what might after all be random eye movements. I will return to this question in the analysis of the data. However, my conclusion was that other observational data from other sources might have limited applicability, as there was unlikely to have been spontaneous observation of the strabismus, and it would have been a different design to use interviews to elicit information.

Generalisability and transferability

The expectation of generalisability within the practice of child psychotherapy is perhaps to provide further insights, to contribute theory building rather than proving fact. There is the potential for this study to contribute to the nuanced understanding of non-verbal interaction within child psychotherapy, of children who suffer from intermittent strabismus, rather than test out a theory. I think that it might also be of interest to ophthalmologists who are interested in the child's emotional experience of strabismus. I also think that there is modest potential for cross-discipline transferability in the area of Autism research (Hobson, 2011).

Strengths and weaknesses of the study

Any researcher that attempts to examine an area that has a cross-discipline element may have anxiety about achieving an accurate understanding, especially where a seemingly simple visual disability actually turns out to be immensely complicated. The area of strabismus has many multi-disciplinary facets: neuroscience, vision development, perceptual development, physiology, ophthalmology, surgical intervention, health screening, neuro-psychiatry, foetal development, etc. The limitation of the researcher to understand the complexity and depth of another field is a problem. I have tried to

minimise this as much as possible by two means, firstly researching the area as much as possible, reading and re-reading relevant ophthalmological texts, seeking the views of my own ophthalmic optician, meeting with the consultant ophthalmologist that diagnosed both children and attending an ophthalmic conference where the subject was strabismus. Nevertheless, I cannot claim any expertise in the area of ophthalmology. It is however understandable that a number of psychoanalysts who previously trained as ophthalmologists also became very interested in the problem of strabismus (Inman, 1939).

Another way of minimising the effects of my lack of expertise in medical perspectives of strabismus was to remind myself that I was not conducting eye examinations, and that my focus was on the therapeutic relationship.

As to the question of bias, I think that this played out in a number of subtle areas. Because I had become preoccupied with movements of the eye, due to my research interest, I did find that my eyes became especially sensitive to ocular changes in all of the children that I saw in therapy. In a sense, although the session notes represented work as normal, they could not help but be influenced by my preoccupation. In some ways though, this could be expressed as the effects of learning rather than bias.

It is impossible to predict when a child will manifest their strabismus (intermittent strabismus) and the moments are sometimes very fleeting, leaving a mere sensation that something wasn't right, but without a conviction of what that something might be. The observations of strabismus are therefore not mechanical but relational. I will have inevitably seen the strabismus on some occasions but not on others. I would argue that this is a fairly authentic way of capturing resonances of strabismus as it presents within a therapeutic relationship. It is not accurate in the sense of counting occurrences. The observations therefore represent what was noticed and something of the context within which I noticed it; other child psychotherapists may well have noticed or experienced this phenomenon differently. This could be said to be true for any observation within psychoanalytic psychotherapy, not just strabismus, and therefore I am researching within a specific context.

The two children chosen for this study were incidentally traumatised children who had been referred to child mental health services in the NHS, no generalisations can reliably be drawn about the CAMHS population, or the general population. However, the study

does ask questions about the interplay between trauma, anxiety and the manifestation of strabismus, and what significance might unfold within the therapeutic relationship. My sense is that there was enough to be learned from these two children in order to construct a coding template which, in principle, could be applied to the psychotherapy of other similar children, in order to develop and extend the ideas. I think therefore that the sample group was of an appropriate size and nature.

Lastly, I tussled with the construction of the template to fit a representation of a relationship. One concern had been that the language might risk sounding too deterministic. I tried to address this and I hope that I have sufficiently conveyed the associations that I observed, or inferences that I made, as themes, not as absolute truths. My aim was to systematically capture a set of flexible ideas that convey the authentic 'feel' of the therapeutic relationship and how strabismus has impacted upon it. I therefore needed to develop the template in a way that might represent a multi-dimensional view: the child, the strabismus and the therapist.

To summarise: efforts have been made to assure that the research was appropriate to the context and subjects under scrutiny. A sample group of two children was chosen both for pragmatic and theoretical sampling purposes. Careful thought was given to children as subjects and issues of consent were considered. A post positive methodology was chosen to reflect the inter-subjective nature of the study which involved a reflective and interpretive stance. A case study method was used to provide a developmental and contextual frame. Observational process notes were utilised as they were considered to be data that was the closest to the subject of study. A choice of template analysis as a tool for analysis provided philosophical and practical justifications, particularly in relation to the acknowledgement of prior theoretical frameworks and '*a priori* coding'. The chapter illustrates the analytic stance of the research in the construction of the template by the use of speech marks to highlight transitional coding descriptions. An approach of constant comparison was used to develop the template. Data sets were chosen for pragmatic reasons i.e. six sessions allowed easier handling and these were readily available. This data was purposefully chosen in order to explore the impact of anxiety related to relational transitions in therapy. The trustworthiness of the research was discussed in respect to the selection of ideas/criteria that have emerged from the relatively newer tradition of qualitative research: ideas such as transparency of data and triangulation. Lastly, the strength and weaknesses of the study were discussed: this questioned the acquisition of

specialist knowledge when the research moves across disciplines, and also highlighted the authenticity of the template, and as such its success in being sensitive to the purpose and the context of the study.

The following chapter will present the findings of the study which is the final template. The themes from the sections of the template will be contextualised within the case studies. Examples of clinical data will be used to illustrate the template, and these will be placed alongside a discussion of them in conjunction with a consideration of the literature.

CHAPTER FOUR

Case studies: What can be learned from them?

The following two case studies are constructed from the contemporary clinical case notes. These include: observational process recordings, notes from meetings with parents, and consultation notes taken from liaison with the system around the child. The case studies cover an introduction, a background history, and an overview of the assessment process as it relates to the research study. Whilst there were a variety of themes that emerged from the assessments which were clinically relevant, if they did not pertain directly to the research question then they have not been included in this analysis.

Below is the template which has been formed as a result of a close analysis of the clinical process recordings (raw data). Notes from supervision sessions containing comments on the counter-transference have been used in order to increase further analysis and the development of the categories; they were not however coded as raw data.

Each emergent theme is given as a heading and this is followed by a brief contextualisation before illustrative examples of the data strands are given. Following this there is an identification and exploration of the findings and a discussion about how the findings relate to both the research question and to the literature.

The setting

The setting for the research was a hospital-based community CAMH service; I worked here as a child psychotherapist in a multi-disciplinary team. One of the children- Lily, I saw as a lone clinician. I had a prior relationship with Lily's mother as I had supported the work of another psychotherapy colleague, who had seen her other child for psychotherapy. The second child in this study, Liam, was part of a joint case with another colleague who undertook the parent work. Both children had been referred by the G.P. though the referral for Lily had been instigated by her mother as a result of previous work. Liam's referral had been promoted by his school. These referrals were not untypical of referrals to child psychotherapy in this child mental health team.

The children

The children were chosen for this study from a larger group of children who suffered from strabismus and whom I had seen in psychotherapy over a number of years. All of the children were part of my ordinary practice; they had been referred due to their behavioural and emotional difficulties, rather than the strabismus.

As a result of a close reading of the literature concerning strabismus, I decided to use the data from just two of these children as they specifically suffered from intermittent strabismus; a form of visual disability which can be associated with the emotional life of a child. It would have been entirely possible to choose just one of these children; however, an early scrutiny of the data revealed that these two children used their eyes in very different ways, and therefore both together offered a wider variety of data. Liam suffered from convergent intermittent strabismus and Lily from divergent intermittent strabismus; thus they covered the two main forms of intermittent strabismus.

Child	Age in therapy	Description of strabismus	Clinical formulation
Lily	7 years	Divergent, intermittent strabismus – right eye.	Emotional difficulties linked to relational/developmental Trauma
Liam	5 years	Convergent, intermittent strabismus – right eye.	Emotional difficulties linked to relational/developmental Trauma

The two children were of a similar developmental age: five years and seven years, and both were in primary education. Interestingly the two children were also similar in that neither child would at this point have reached visual maturity, i.e. the limit of their developmental potential. According to the literature, developmentally, they would not have been likely to avert their eyes in order to solve cognitive mental challenges; this capacity is more associated with the children over the age of eight years (Doherty-Sneddon et al. 2002). These children, therefore, may still have had the tendencies of younger children in terms of the quality of their gaze.

Both of the children had suffered early trauma, abuse, deprivation and separation from their primary attachment figures. All these factors would be expected to have a significant impact upon their emotional and relational development and make a significant contribution to their level of anxiety and emotional stress. If we recall, the literature

suggests that anxiety is often implicated in the presentation of intermittent strabismus (Pratt-Johnson and Tilson, 2001).

Both of these cases therefore represented an opportunity for data gathering in relation to exploring the research question: How does intermittent strabismus impact upon the therapeutic relationship?

The final template emerged from the data as follows:

1. The child's anxiety becomes overwhelming and harder for the therapist to emotionally contain and the child's eyes may become strabismic.

- Possible collapse into strabismus which appears to correspond with anxious transitions.
- Lapsing into strabismus with possible visual distortion associated with the child's preoccupation with their internal world.
- Strabismus may function as a way of managing visual distortion in order to be in contact with external reality.
- The disconcerting impact upon the therapist's gaze.

2. The child's emotional state may be more easily contained by the therapist and the child's eyes work in unison, or are perceived as doing so by the therapist.

- This may correspond with the therapist's active attempts at emotional containment by using her visual availability.
- This may correspond with the child's capacity to explore his or her external and internal environment in a reflective way.

Case study one: Lily

Reason for referral

Lily was seven years old and she was referred for a psychotherapy assessment because her parents were worried that she presented as an 'emotional puzzle' to them. She was described by them as 'determined', 'self-possessed', 'bossy' and often 'stubborn'. On occasions, however, she would display extreme outbursts of fury that had seemed to come 'out of the blue'. At these times she was said to be 'out of control' and could become unaware of her surroundings, so much so that she was a danger to herself. At school, she was considered to be 'shy' and 'withdrawn' and was said to 'cling' to her friends, and they in turn 'babied her'. It was noted by her parents that she would suddenly stop 'open-mouthed' and forget what she was saying, or lost the ability to recall ordinary and common words. They were very worried about her academic abilities, though in maths she was said to excel and they were proud of this.

My impression of Lily was that she looked like an extremely petite seven year old girl, much more fragile looking than her robust peers at school. She could give delightful smiles, showing her gappy teeth and wide, shining eyes. At other moments Lily could look much smaller, withdrawn, and assume a frozen stance, and at these moments her slightly sunken right eye became more apparent.

Brief background history

The couple had adopted Lily, along with her older brother, when she was eighteen months old. Her earlier infancy with her birth parents was characterised by chaos, neglect, deprivation, drug dependency and maternal depression. The birth parents had rejected her before she was born and she had finally been placed in care when she was three months old. She was then fostered with a large family and the local authority suspected that she was again left for long periods, overlooked, and under-stimulated. Her parents described how, when they first visited her, she was slumped on a settee and looked like a 'blob'; she was unresponsive and initially unavailable to their attempts to engage her. She was considered by the local paediatrician to be a baby that was 'failing to thrive'.

I was given a copy of video footage by her parents of her arrival at her new adoptive home. The video footage showed her encircled by toys and lively parenting, and initially,

she seemed surprisingly bright and engaged in her surroundings. When, however, her new parents called her name, she was observed to hesitate, look away and freeze. This was described by her parents as her being in ‘suspended animation’. When they patiently waited for her, she responded with vivacity and delight. At this point she was able to seek out and interact with her environment, but could be easily sent back into a wary and traumatised position. This powerful emotional and behavioural response seemed to be re-enacted in therapy and was accompanied by a strabismic response. This is explored within the discussion of the template. On the other hand, her capacity to explore the environment, both internal and external, in the absence of anxiety, corresponded with better eye coordination. This is a theme explored within the research.

An overview of the psychotherapy assessment

My direct assessment consisted of introductory meetings with Lily’s parents, with Lily and her mother, three individual sessions, a school observation and consultation, and a final review with her parents.

I learnt from her parents that Lily was physically healthy apart from suffering from eyesight difficulties. She had a divergent strabismus in her right eye that was associated with a sixth nerve palsy and she sometimes wore spectacles to assist her sight. Her right eye was very slightly sunken giving her face a lack of symmetry which was initially difficult to read. This discrepancy was enhanced by the slightly off-centre position that her eyes seemed to adopt from time to time. The strabismus varied from not noticeable to an extreme angle. None of these factors were mentioned in the referral. Her parents seemed nonplussed by her occasional strabismus, and they only latterly acknowledged that she was under the care of a consultant ophthalmologist. The parents neither gave an interpretation nor offered any observations of Lily’s strabismus; in fact they gave the impression that they saw very little significance in it.

When asked to give consent for the session data to be used for this research, her parents were happy to agree, but again showed minimal curiosity and were bemused that I might be interested. My impression was that the parents did not attach any emotional meaning in the manifestation of the strabismus and their relationship with Lily was not seen to be affected by it. They regarded her strabismus as an indication of the pre-natal damage to her development resulting from drug use by her birth parents. The strabismus was seen as part of Lily’s vulnerabilities, due to her past neglect, but it held no significance in terms

of their ongoing relationship with her. Lily's adoptive mother was observed to have lively eye contact with her daughter, and Lily showed a great deal of enthusiasm and engagement with her mother's face and gaze.

I agreed to undertake a psychotherapy assessment of Lily to see if it could provide some understanding of the way that she functioned emotionally, and in order to assess if psychotherapy might be a helpful and a suitable form of treatment.

In my first meeting with Lily and her mother, Lily had been pleased to meet me. Unfortunately, I disappointed her by inadvertently walking past on an errand and not taking her into the consulting room straight away. When we began the session she seemed to react by going into 'suspended animation'. It was very uncomfortable, for both me and her mother, and at first there seemed to be no means of reassuring her into a more relaxed position. My conjecture was that her response was a reaction to the extreme worry of the initial meeting, where she could not be sure that she had come to a safe place and was meeting with a safe person. After several exploratory comments, I noticed that her eyes became strabismic. I suspected that Lily's eye muscles were unable to contain their strength in the face of her anxiety. I questioned whether this possible muscular collapse into her latent strabismus was a consequence of her high anxiety and that her anxiety was a consequence of her having experienced a very traumatic early history. As we shall see, however, the development of the template offered a very different possible explanation.

In the subsequent individual assessment, Lily continued to present as a fragile girl, she looked very small and in my counter-transference I easily felt myself to be a giant therapist, very large and imposing. I found myself intuitively assuming a smaller position or a quieter voice. This counter-transference remained as something I felt that I had to monitor and contain throughout the period of assessment.

In the subsequent session, however, Lily was able to find a comfortable place in my room, and she spent the time drawing and enjoying me paying close attention to her. Sometimes, she would draw lines of numbers as if she was 'being a teacher'. I learned that if I was patient, and careful not to risk any comment or movement that might be interpreted as intrusive, allowing her the time to initiate comments for example, she seemed to be more reflective and exploratory. Her drawings also seemed to be more symbolic. During these sessions the strabismus was slight or hardly noticeable, and instead I found myself noting the 'sparkle' in her eyes in the observations.

By the final session, Lily had become far less anxious about me and my room, and was much more able to explore both her external environment and her internal world. Her comments seemed to show that she could use psychotherapy in a thoughtful way, exploring beginnings and endings, rather than being thrown into traumatised states. The assessment suggested to me that, in future therapy, Lily could be helped to reflect and extend her capacities for both visual and cognitive fluency if the therapist was able to learn about her and attune to her particular emotional disabilities. I suspected that the absence, or the perception of absence, of the strabismus corresponded with a reduction in anxiety and a better sense of an emotionally contained internal object. Subsequently it will be shown that these clinical observations and thoughts become extended by the development of the template and the analysis of data in relation to it.

My visit to the school which followed the individual aspect of the assessment, confirmed the view that Lily needed a great deal of emotional scaffolding whilst there in order to help her to keep functioning. An example of this was my observation of the end of the games lesson: everyone was dressed and leaving for the break, but Lily stood limp, her tangled tights were inside out and half way on her legs. The class teacher was in a hurry, and when she went to help Lily, instead of sorting out the tangle of leg and stocking, Lily's unresponsiveness entangled them both. The teacher clearly felt foolish and she became short-tempered. This sent Lily further into her withdrawn state. It was not possible to see if she was strabismic. The teacher consequently gave up and turned away seemingly busy with a different task. The painful situation resolved itself when one of the other pupils took on a motherly role and patiently helped Lily to look closely at the tights, resolve the tangle and find her way free.

From this small incident it was possible to make a number of interpretations of Lily's emotional tangle. One interpretation evoked a mother that could bear an emotionally tangled baby in order to work towards a resolution. Another was of a mother and baby becoming stuck in what might seem stupefaction or fury. One might interpret this as a recreation of the original mother and baby experience, and the lack of an available internal containing mother to pull her gently into cognitive and visual focus. Lily's collapse seems like an indication of the lack of internal cohesiveness, which was mirrored by her difficulty in maintaining both her mental and visual capacities, at the same time.

Through the consultation with Lily's parents we were able to begin to understand how fragmented Lily was, and how the different aspects of her personality often seemed at odds with one another. She was a delightful, vivacious, determined girl, who had eyes that 'sparkled', but she could also be completely lost and frozen, severely damaged and traumatised, who had eyes that seemed to part company in the face of anxiety. Her parents had thought that she was a 'puzzle' and this did seem a very apt metaphor for the nature of their parental task, thus helping her to be in a relationship with the different aspects of her personality to produce a more coordinated whole.

In summary, the assessment confirmed my impression of Lily as a young girl who had probably been exposed to frightening and emotionally intrusive experiences and had been severely traumatised in her infancy. Patterns of relating, emanating from her infancy, were easily perpetuated and could confirm her internal view of the world as a potentially terrifying place. Panic-like states could be evoked very easily, resulting in her mind and body becoming frozen in 'suspended animation'. Active attempts to pull her out of these traumatised positions could easily have the opposite effect of pushing her back even further. The therapist needed to constantly monitor the emotional atmosphere to make the therapeutic experience tolerable and productive. My sense, clinically, was that the therapist's use of her eyes was key factor in helping Lily really believe that she could feel emotionally connected with a lively internal object, as opposed to an overwhelming, frightening sense of an object-lessness. I suspected that this deficit might exist with or without the presence of strabismus. These ideas will be explored further within the discussion of the template.

The experience of the assessment suggested to me that when she could believe herself to be with someone who was emotionally and visually available to her, she could make use of a more philosophical and integrated part of her personality. Additionally, Lily was still only young and of an age where, through reciprocity and symbolisation, it could be hoped that a more coherent course of development could be promoted, alongside the opportunity to process some of these desperate states of mind and body that were so debilitating for her.

The analysis of the template: Lily

The data is multi-layered and therefore several themes have often arisen within the same segment of observation. Where possible I have tried to capitalise on this by using the

same piece of observational example in different areas, as this helps to communicate the narrative experience.

1. The child's anxiety becomes overwhelming and harder for the therapist to emotionally contain and the child's eyes may become strabismic.

- Possible collapse into strabismus which appears to correspond with anxious transitions.

The following is an excerpt from my very first meeting with Lily. As already stated, I had previously worked with her mother supporting the psychotherapy of her other child who had seen a colleague, and so we knew each other well. Lily had been likely to have seen me in the clinic whilst she had been waiting with her brother, so I was a known figure. In many ways she was far more prepared than most children who arrive for the first meeting with a therapist. This made her reaction to entering the therapy room far more worrying.

First session with Lily and her mother: 20th January 2010

‘As I was walking past the waiting room, on an errand, I was greeted by a small face with pigtails, gappy teeth, glasses and an eager face, and I realised this was Lily.

‘I returned to collect Lily and her mother from the waiting room but by now Lily looked withdrawn and I was struck by how very small and thin she was. She travelled down the corridor with her mother but on entering the room she immediately stood still, she remained in the same space, unmoving and frozen on the spot. Her mother and I had found comfortable chairs, but Lily seemed awkwardly lost in the space of the playroom. I spoke to her about the chair behind her being quite big, but the chairs near the table were more her size. She still looked unsure and remained on the spot. Her mother brought the chair out for her and tried to reassure her that it was her size.

‘In an effort to make this more tolerable for Lily we acknowledged that it had been a long time since we had both met, and that it might be hard to come here after such a long time. Meanwhile Lily's mother recalled how she used to visit

the clinic when coming with her brother and they would play with the 'Connect Four' game (together we were trying to help Lily get connected).

'As Lily sat down, I commented that the box of toys was for her to play with, and I mentioned that there wasn't a 'Connect Four' but other things in there. The box looked so big now and she stared up at it. I took it from the table and put it next to her so that she could see inside it, and meanwhile I commented upon my actions as I did this.'

There could be many ways of understanding this data, but my analysis of it is that Lily showed that she had the capacity to believe that she might be meeting someone interesting, and someone who would want to see her: 'I was greeted by a small face with pigtails, gappy teeth, glasses and an eager face'. Her eyes were co-ordinated and functioning and able to fully take in the new experience, but this capacity was fragile. I suspected that Lily felt utterly abandoned by my apparent turning away from her in order to finish my errand. The emotional atmosphere had changed dramatically upon my return, and this time I was not greeted but feared. Lily was 'frozen on the spot', and 'Lily seemed awkwardly lost in the space of the playroom'. This behaviour is reminiscent of the emotional defence mechanisms described by Fraiburg (1982) as responses to overwhelming anxiety. They also seem very similar to those behaviours reported in the strange situation test that were described as a 'Collapse in behavioural and attentional strategies', where it would not be unusual for the eyes to be part of the behavioural response (Hesse and Main, 2000, p. 1).

My counter-transference comments, about my sense of largeness versus her smallness, illustrate the intimidating giant therapist that I had very quickly seemed to have become in the transference. Neither my, nor her mother's, attempts at using our voice or words to soothe, seemed to have much influence initially, and Lily's eyes seemed to react to this. Lily seemed to lack an internal sense of a maternal object that could help her with the transition into the new environment and with a new person (Sorenson, 2005). Leira (1984) makes a similar point when talking about her patients, that 'Arne' lacked a secure internal object and that there was a parallel with visual and psychic coordination. Following this very anxious beginning something very complicated seemed to happen with her eyes:

First session with Lily and her mother: January 20th 2014

‘I said to Lily that she seemed ‘unsure about the things in there’. (I noticed how the box seemed big and full in comparison to her slightness.) Lily turned away from me but she was still looking into the box. Then I noticed her shooting me a look with both eyes and then her right eye drifted away and her left eye became straighter.’

In this section of data I am proposing that I have observed elements of a strabismic episode, but that it is not possible to know when the strabismus began. I am proposing that what occurred was an emotional difficulty in focusing both eyes, that there may have been visual distortion present, and that she used her ‘dominant eye’ in order to achieve focus (Pratt-Johnson and Tilson, 2001). I will address the first two interpretations within this section and the third idea, the use of the dominant eye, under a different thematic category which I shall turn to later.

To begin with I am suggesting that, emotionally, Lily had immense difficulty negotiating the transition into therapy, and making a beginning with a new person, a ‘stranger’, and the result was a ‘collapse’ of functions, including her eyes (Hesse and Main, 2000). What quickly became stirred up in the transference was perhaps the overwhelming re-enactment of both desire and abandonment, which had been such a painful feature of her young life. Whilst I might regret my insensitivity around my mishandling of our first meeting, I am nevertheless convinced that my feelings of clumsiness were, more significantly, part of the projections that I was ready to receive around stupidity and rejection. I suspect that there was a maelstrom of emotional responses circulating around in the context of these first few moments, which produced so much anxiety that all our functions became tested- her mother’s, especially Lily’s and my own. My conjecture is that this resulted in Lily’s eyes losing their ability to function, and she visually collapsed into strabismus much like other muscles in the body that may react to stress and lose their capacity to function. My suspicion was that the visual collapse mirrored an internal state collapse and so her ability to maintain coherence, in the face of anxiety associated with the trauma of the transition, was severely compromised.

We know from the literature that the manifestation of intermittent strabismus may be associated with the experience of less stable binocularity, (depending upon age of onset, etc), and possibly double vision (Baker and Gerald, 1979). One might assume that if visual distortion is associated with Lily’s experience of strabismus, then one can only be

concerned how it may impact on her emotional life – although there is no way of really knowing this in the research study. It is possible to speculate that her strabismus could promote her fearfulness about being with a new person if they were seen in a distorted way. This may act to emphasise the negative transference and make the therapist, who may be already imbued with hostile or frightening associations due to her perceived abandonment of Lily at the beginning of the session, be even more frightening and to be avoided? One might also wonder how a therapist could possibly help to support Lily to manage her fears if the therapist was suspected to embody these fears in such a potentially nightmarish way.

In this situation the therapist is not someone who is considered to be helpful but someone to be kept at bay. Along with the avoidance of the therapist we might also consider that reality is also being avoided at these moments. It is entirely possible that an accumulation of these experiences would impact upon the child's capacity to negotiate the transition between imagination and reality, and in particular to negotiate the transition from one person to another, or one situation to another.

In summary, stirred up in the transference, within the experience of the transition towards a new relationship with a 'stranger'-therapist, was the possible re-enactment of an experience of overwhelming desire but also then, of abandonment. This had been a painful feature of Lily's young life and it presumably contributed to a loss of an internal object that could offer her mental and muscular coherence, and may have been associated with the manifestation of the strabismus. The data suggests that the therapist had to work very hard on a number of levels in an attempt to emotionally contain Lily's anxiety and establish a therapeutic relationship. The therapist had to monitor their counter-transference and edit their responses according to the emotional atmosphere. The therapist had to contain powerful projections which insisted that the therapist represented a damaging object of the child's internal world. As the themes suggest, it is postulated that the experience of the strabismus promoted negative projective processes and thus anxiety, which made the therapist's efforts to offer emotional containment much less effective and harder to achieve.

One would assume that the particularity of the child's developmental experience will influence the quality and content of the potential visual distortion, which potentially might colour her phantasies. A child who has suffered major emotional trauma, such as

Lily, may experience visual distortion very differently to a child who has grown up in a stable and emotionally available family. Therefore, although the data might suggest that intermittent strabismus was associated with anxious transitions, one might question how much the content of the possible visual distortion is influenced by the context of the Lily's individual circumstances.

1. The child's anxiety becomes overwhelming and harder for the therapist to emotionally contain; the child's eyes may become strabismic.

- Lapsing into strabismus: possible visual distortion associated with the child's preoccupation with their internal world.

An analysis of the data overall led me to draw a distinction between strabismus as a visual collapse that may be associated with fearful phantasies, as opposed to 'lapsing into strabismus in a preoccupation with their internal world' as a theme. There were no obvious examples within Lily's data. I believe that Liam's data did, however, contain examples of 'lapsing' or slipping into an internal world or phantasy, and I shall discuss this in the next case study.

1. The child's anxiety becomes overwhelming and harder for the therapist to emotionally contain and the child's eyes may become strabismic.

- Strabismus may function as a way of managing visual distortion in order to be in contact with external reality.

Still concentrating upon the initial part of our first meeting, I would like to return to the last section where Lily used her 'dominant eye' in order to achieve focus. I interpret the data showing her earlier strabismic behaviour (before the use of the dominant eye) as 'collapse' rather than 'lapse'. I am, therefore, putting emphasis upon the capacity for Lily to emotionally and visually connect to the external therapist rather than to her internal phantasy.

The following process recording is from the moment when the strabismus was observed, and what happened afterwards; it appears to show the shift in relating.

First session with Lily and her mother: 20th January 2010

‘Lily initially peered into the box with her eyes and face, but then suddenly she sat upright looking uncomfortable. Her mother continued to speak about Lily’s brother and how he had told Lily that ‘she would like coming, that there were toys and that she could do colouring’. I added that there were ‘paper and pens in there too’. Lily again peered into the box. I said to Lily that she seemed ‘unsure about the things in there’. (I noticed how the box seemed big and full in comparison to her slightness). Lily turned away from me but she was still looking into the box. Then I noticed her shooting me a look with both eyes, and then her right eye drifted away, and her left eye became straighter. This felt disconcerting as it was hard to know how and where to focus my eyes in response. Eventually, with continued reassurance from her mother, Lily was able to find a pencil from the box – but in a very tentative manner. Her mother looked very frustrated and puzzled with her daughter. She suggested that Lily could get out all of the pencils at once then she could choose, but Lily resisted this idea and took only one colour at a time from the box. She then steadily drew a tiny multi-coloured flower to which she added a label which said ‘this is a flower’. Then she wrote her full name in ‘joined up writing’.

For a long time after this session, my analysis had halted with the interpretation that this segment was solely about collapse. Then I showed the session to another colleague to see how they might interpret the session material. My colleague noticed a different aspect. She noticed Lily’s capacity for ‘shooting’ a look with both eyes, following my comments about how she might be afraid of what was in the box. She commented that ‘Lily wants to keep her eye on the therapist’.

On examining the material again it is impossible to know exactly when the strabismus had manifested, and, therefore, when and if, visual distortion had set in. However, it is possible to observe the moment when one eye drifts off and another looks straighter. This implied to me that Lily began to see me again as someone with whom it might be worth connecting. Also, I noticed that this had come after I had interpreted her fear of the ‘things inside the box’. In a sense I was locating the source of her anxiety away from us and into the box, whilst also communicating to her that I was sympathetic to her fears. I had gently persisted with a quiet, unobtrusive voice, and at this point I think she began to pick up on my efforts to be more substantially present for her.

Lily looked with ‘both eyes’ at my two eyes and at this point her wish to connect was, I imagine, a visual struggle. Her strength to hold them both in focus was probably depleted by now, but she resolved this by selecting one eye. The ‘drifting away eye’ was not therefore, as I had originally thought, the whole of the story. The literature implies that the use of a dominant eye allows the brain to focus its efforts and minimise the image from the ‘drifting away’ eye, therefore resolving any double vision (Pratt-Johnson and Tilson, 2001). There is no evidence that Lily has been ‘programmed’ or taught to do this, though it can be advised by ophthalmologists: (Pratt-Johnson and Tilson, 2001). One might assume that it was learnt through experience and represents not necessarily a dominant but certainly a more organised part of her personality.

It is possible to speculate whether Lily was also trying to integrate different visual and emotional views of the therapist at these strabismic moments. A child who has two eyes and possibly sees two separate images of the therapist, because both eyes cannot easily be coordinated and focused to produce one image, has a very complicated emotional as well as visual problem. Whether this process might offer a receptacle for psychological splitting (Klein, 1946) is a moot point. Nevertheless, the ‘dominant eye’ would seem to act as a preservative strategy which ostensibly allows the child to develop a way to give order to confusing visual and emotional experiences.

It does seem certain that Lily had to find ways of managing a plethora of overwhelming experiences from her birth onwards. To be born with a mild but arguably significant visual problem, such as intermittent strabismus, must have surely compounded any difficulty in relating to the outside world. As an infant, there were probably few experiences of emotionally available gazing faces to draw the eye of the child into a relationship with the eyes of another. As previously mentioned in the literature review, the natural musicality between the mother and her infant, which is believed to be one of the things that provides a foundation for the rhythms of future relationships, was lacking (Trevarthen, 2011). Therefore it is especially impressive that she was able to latch on to my attempts at emotional containment and seek me with her eye. An indication that she was able to connect with me, whilst supported by her mother, was the way that she was able to be free enough to draw. Interestingly, her insistence to use the crayons in turn (she ‘took only one colour at a time from the box’) seemed like an echo or resonance of her determination to use only one eye at a time.

From this point on in the assessment she showed an increased ability to manage emotionally and visually and her occasional strabismus was slight and her eye contact was more often than not accompanied with liveliness. This implied to me that she had recovered herself emotionally following the very demanding first meeting. An example of this came in the first individual session which was our second meeting. Again, this segment is taken from the very beginning of the session:

First individual session: 27th January 2010

‘We came into my room, and she sat down on the same chair as the previous week and looked up at her box. ‘It’s a very big box’ I said with emphasis, in touch with how small she seemed in relation to it. Lily looked right up into my eyes and held really warm eye contact whilst looking deeply into my eyes with a sense of pleasure. She seemed delightful. Her eyes were slightly sunk and her right eye was slightly inward, however they sparkled.’

Again the suggestion in the process recordings is that she was fending off any anxiety associated with the beginning, and from the transition from her mother to me, and using her dominant eye in order to latch on to my eyes and increase her visual availability. By the end of the assessment, Lily can be seen to be much more able to explore her internal and external environment and specifically process the impact of beginnings and endings in a much more mindful way, showing much less anxiety and more displays of fluency and liveliness in her eye contact.

In summary, this data suggests that there is a theme of an active strabismus, one which manifests in order to avoid a collapse into visual and emotional confusion by exploiting the use of a ‘dominant eye’. If the therapist is able to frame the child’s ocular behaviour in this way, they may be more able to respond to the child’s possible efforts to connect with them and the external world. Missing the opportunity to recognise the use of a ‘dominant eye’, with this particular child, might have risked inadvertently sending her back into her abandoned and collapsed state.

1. The child’s anxiety becomes overwhelming and harder for the therapist to emotionally contain and the child’s eyes may become strabismic.

- The disconcerting impact upon the therapist’s gaze.

Returning to the first segment, we can note the following observation:

First session Lily and her mother: 20th January 2010

‘Then I noticed her shooting me a look with both eyes and then her right eye drifted away and her left eye became straighter. This felt disconcerting as it was hard to know how and where to focus my eyes in response.’

It is very difficult for the viewer to know where to focus when presented with eyes that look in different directions. The therapist, even momentarily, is struggling with visual confusion which on some level may be a parallel with the child’s visual confusion and possibly constitutes a form of counter-transference. Disconcerted eyes are eyes that are not in concert with each other, and, though I doubt that my eyes became strabismic in response, I do not doubt that this was certainly an unsettling and uncomfortable experience. This was very reminiscent of the experience that first led me to be interested in the area and which I refer to in the introduction regarding the ‘stinging eyes’ of a mother who suffered from strabismus. One could question whether this is a form of projective identification? Whatever explanation one might give, it is a challenge to know how to respond without turning one’s eyes away from the child and risking the promotion of shame. This emotion is, as we know from neuroscience research, possibly one of the most harmful of emotions as it contributes to the failure, if not the deterioration, of neural development (Shore, 1994). It is perhaps very important then, with children such as Lily who have experienced the shame associated with abandonment, that the therapist is aware of the danger of re-enacting this experience with the child.

In summary, under states of high anxiety, it is suggested that children can lose their ability to have dual functioning eyes that provide a combined image. Beginnings in therapy, in particular, can be potentially threatening and compromising to the child’s integrated bodily state. The ability of the child to galvanise the use of a ‘dominant eye’, from which they can find focus, can help the child manage their distorted vision and possibly their emotional ambivalence. However, it can have a profound physiological and psychological impact upon the therapist affecting their ability to use their eyes as a means of communication. The impact upon the therapeutic relationship can, potentially, be quite troublesome and can, for moments, disable the therapist making them struggle to decipher communication from the eyes (Baron-Cohen, Wheelwright and Jolliffe, 1997). These aspects are rarely commented upon within the literature.

2. The child's emotional state may be more easily contained by the therapist and the child's eyes work in unison, or are perceived as doing so by the therapist.

- This may correspond with the therapist's active attempts at emotional containment by using her visual availability.

This section relies on a certain amount of inference based upon the evidence from the child's responses. There were various descriptions that imply the nature of the visual availability, rather than explicitly state it. This together with supervision notes make up the evidence for the analysis.

First session with Lily and her mother: 20th January 2014

'Lily was now writing a line of numbers, and her mother noticed this and said how good she was at numbers, adding that she always asked for extra sums after school. Lily sat up and looked at me in a very proud fashion, and I responded with a look of being impressed. Her mother added that Lily will often tell her how many letters there are in a word, and I commented that 'maybe Lily was a bit of her own teacher sometimes'. Lily looked at me made good eye contact, as if really pleased with this idea.'

Although in these examples there is no explicit comment about what the therapist's eyes were doing, I think it is plausible from the process data that the therapist's eyes were being responsive to eye contact. During these times the strabismus was not noticeable, and the sense was that eye contact was strong and directed between both parties. The therapist's eyes and face 'responded with a look of being impressed' and the interpretation that followed gave both a conceptual and non-verbal emphasis to the sense of achievement and self-esteem that Lily needed to hold on to in the face of her overwhelming anxieties. The therapist and the parent were also joining together to support Lily in her efforts to fend off her fragility and prevent her returning to the state of emotional breakdown previously characterised by her collapse into 'suspended animation' and visual dis-coordination.

In some sense this was reminiscent of what Leira (1984 p. 177) described as 'bathing the child in her glance at all times'. However, this data illustrates a much more active gaze rather than 'glance' from the therapist, one that provides amplification linked to an

interpretation in this instance. It is possible to see this as an active enhancement compared to the rather more passive ‘constantly available to him in this dreamy state’ that Leira (1984) described.

Another example comes from the first individual session.

First individual session: 27th January 2010

‘It’s a very big box’ I said with emphasis, in touch with how small she seemed in relation to it. Lily looked right up into my eyes and held really warm eye contact looking deeply into my eyes with a sense of pleasure.’

In this example the emphasis is provided in a number of ways: the tone and pitch of the therapist’s voice, and the probably matching with emphasised eyes of both the therapist and the child. In this segment Lily’s capacity to look ‘deeply’ into the therapist’s eyes in a coordinated manner (the data did not mention that they were not coordinated), shows her expectation of being in touch with a lively and reciprocal object. In her counter-transference the therapist felt that she dare not risk disappointing or leaving her visually and psychologically abandoned, and so offered her eyes freely. The therapist, however, did not experience the visual confusion in the counter-transference as had happened in previous moments when Lily had been strabismic.

The stance of the therapist is influenced by contemporary psychotherapy which is developmentally informed (Alvarez, 1985; Rhode, 1977; Stern, 1977; Green, 2003) and which puts the emphasis upon supporting deficits within the child’s emotional functioning. Close attention is paid to the therapist’s choice of words or intonation, for example, so that this awareness informs the therapist’s ability to enliven rather than deflate the child (Alvarez, 1985). This style is considered most appropriate for children who have experienced extreme deficits within their environment, such as a result of trauma (Lanyado, 1999), maternal depression or developmental delay (Sinason, 1992). The therapist’s active attempts to emotionally contain the child through her visual availability, could be considered to be part of the developmentally-informed technical responses available within the therapeutic relationship with children who suffer from intermittent strabismus.

In summary, the therapist became very alert to Lily's eyes, almost vigilant, to ensure that she communicated her emotional availability to avoid the child's potentially calamitous anxiety and possible subsequent strabismus.

2. The child's emotional state may be more easily contained by the therapist and the child's eyes work in unison, or are perceived as doing so by the therapist.

- This may correspond with the child's capacity to explore both their external and internal environment in a reflective way.

Third individual session: 11th February 2010

'Lily looked up at me warmly and less hesitantly than in previous weeks; her eyes seemed more coordinated. Lily looked deeply into my eyes for a moment, and then she turned to the pot of stationery. Her hands hovered around the pencils as she carefully scanned them and considered them. She then looked back at her paper that she had selected from her pad – then back at the pencils before beginning her flower drawing.'

Lily seemed able to use her coordinated eyes freely for exploration, both of the environment and myself. She was able to scan both the therapist as well as the objects on the table, take them in and then create something; a flower, a symbol of herself. The therapeutic relationship was unhindered by strabismus. There was a flow of eye contact between the child, the therapist and the external environment that allowed the child to develop a fuller perspective that included an internal view of herself as creative. There was no evidence of anxiety and there was a sense that she was linked to an integrated internal object.

Third individual session: February 11th 2010

'Lily told me about how when her dog does a 'wee or a poo and is naughty' she is sent into the kitchen, but when she is 'good' she is 'allowed upstairs'. The dog is 'naughty' when she 'kills rabbits'. Lily then told me that, Rosie, like her other dog, would die sometime and go to heaven, 'but I don't know where that is' she added. I said that 'I think that you're telling me that things didn't last forever, a bit like your times here with me' and 'dying and heaven

are a bit of a puzzle'. Her eye contact through this section was 'easy and comfortable'.

'Shortly after this Lily looked at all the empty pages in the sketch book and commented upon how there were fifty pages. She looked up and met my eyes warmly and then for a moment sadly as she returned to her empty pages. I commented that there were so many empty pages that she could fill it with her drawings if she only had the time'.

In this section, it can be seen that Lily was capable of exploring ideas about death and loss and these were expressed eloquently and reflectively, especially for such a young child. Interestingly the idea of death was associated with naughtiness and the content concerning the 'killing of the rabbits' suggested that, with care, there would be an opportunity in psychotherapy for her to symbolically explore her sense of her own aggressiveness. One might expect that, in common with many adopted children, her fantasies might relate to her suspicions of feeling herself to be implicated in the loss of her other birth siblings, real or imagined. In these more exploratory symbolic states, where the strabismus was absent (or perceived as absent by the therapist) Lily seemed able to express ideas about aggression more openly. This was a very different state of mind compared to when her eyes were strabismic and where one might suppose that aggression was internalised. One could speculate that, whereas the strabismus might represent a form of aggression, the absence of strabismus might represent a capacity to think and a wish to link with both an internal and external object.

It can also be seen that Lily was coming to terms with the session as being the last of the assessment sessions and that she had the capacity to acknowledge the drawings she would never make. Symbolically, in this final session, Lily was able to make use of the brief assessment to begin to explore her philosophical understanding of death, loss and opportunity. It seemed to me that, the experience of the finite number of sessions associated with the assessment, invited a working through of her understanding of the limits of time. Working through, rather than being in a confused cut-off state as she appeared at moments when strabismic, towards the very difficult transition into therapy.

During this segment her eye contact was reported as 'easy and comfortable' and the strabismus was not evident. Lily was able to explore her mind freely, unhindered by anxiety. She was able to respond to the therapist's efforts of emotional containment and

to develop a thoughtful relationship with the therapist. The strabismus was either minimal or not perceived by the therapist and therefore the intermittent strabismus was not having any discernible impact upon the therapeutic relationship.

Third individual session: 11th February 2010

‘Lily looked at the small sketch on the cover of the drawing book and then at me, then she told me that she would like to do a sketch like this, it was a picture of a bridge. She delved into her drawing book and found a sheet, looked at it and then looked at me. She stopped and looked thoughtful for a moment before reaching for the scissors. She tried to cut the same size square as the front cover; however she couldn’t manage the angle of the scissors. I was surprised by her lack of dexterity. Lily looked stuck but accepted my help and showed that she was pleased with it. She then compared the cut out square, to the square on the front cover (that had a picture of a bridge on it) and she then showed her pleasure in this by looking up at me and smiling.’

Lily wanted to make her own picture of the bridge, which was perhaps a symbol of the connection that had built up between her and the therapist. It showed her inner capacity for hope and connectedness and that the therapist and the child had formed a bridge between them. This was in contrast to the confusion and fragmented states seemingly more associated with strabismus. Moreover, it was a strong connection which allowed her to safely be in touch with her own weakness, namely her lack of dexterity, without being overwhelmed and collapsing.

Lily showed a capacity to re-create a mother and baby en-face position, a dependant position, which allowed her to experience a contingent relationship where she was able to be received by another. The therapist was however quite active in enabling Lily to be emotionally contained by the use of amplification in the tone and sound level of her voice, and by allowing her own eyes to be available for the child to find. Indeed the therapist had to emotionally contain Lily through her use of the counter-transference which suggested that there may have been a risk that Lily could return to a traumatic state of mind.

This material contrasts with the earlier material that describes the use of the ‘dominant eye’. This is a complicated area and open to different interpretations, but I suspect that

prioritising one eye and one view over another was in order to achieve stability of image under emotionally demanding conditions. The theme under discussion describes a more relaxed and integrated emotional atmosphere which was the backdrop for a more unified visual and emotional connection.

In summary, the data thematically suggests that when Lily was in a more relaxed, lively and fluent engagement with the therapist, when her eyes were coordinated or seemed to be mainly coordinated, that she was free to explore both her external and her internal landscape. Lily was able to scan the array of materials in front of her on the table, she was able to freely scan her mind and reflect upon ideas concerning the limits of time and the inevitability of loss. These were very important areas for Lily to explore given both the circumstances of her life and their impact upon her personality. This suggestion is consistent with comments made by Leira (1984, p.182) in discussing the amelioration of 'Arne's' strabismus and how she saw that it corresponded with an 'exploration of his surroundings'.

The data suggests that when Lily was in touch with a sense of internal coherence, was more visually coordinated and, vice versa, that strabismus did not impact upon the therapeutic relationship in any obvious way. However, the worry about the possibility of the overwhelming anxiety returning, along with the strabismus, was held within the therapist's counter-transference.

Case study two: Liam

The reason for referral

Liam was five years old and had been referred for psychotherapy assessment due to what was described as 'extreme violence' towards his mother and other family members. The referral made reference to Liam's sudden attacks on his mother; specifically 'without warning' he would punch her face with his fist. Liam had not apparently shown this level of aggression in school; however, he was seen as a child who was agitated and easily distractible. The referral specified that Liam needed to be seen in his own right as there were concerns that there was something 'psychiatrically wrong' with him. There was no reference to strabismus in the referral.

Brief background history

The family were described as ‘settled’ in the referral letter but in the past had experienced difficulties. The letter was brief and we learned later bore little resemblance to the extreme experiences which Liam had actually been exposed to in his young life. His mother had initially told us that Liam had experienced an ‘ordinary birth’, had fed well and was a contented baby; we were not entirely convinced about the accuracy of this statement when we learned more about his infancy.

It emerged during the assessment that Liam had been conceived following the death of a sibling; a baby who had died under suspicious circumstances. Following Liam’s birth, he had been taken by the Local Authority and put into the care of a relative, and therefore had become separated from his parents. Eventually, after years of litigation, no charges were brought against the mother. Liam was subsequently returned to his parents’ care but by this time he was a toddler. During the period away from his parents, it transpired that his carer (a close relative) had developed a severe drinking problem and was often violent.

An overview of the psychotherapy assessment

Following the initial meetings with Liam’s mother, it became apparent that very little of the reported narrative had actually been emotionally processed and therefore she appeared disconnected to the meaning of it all. Possibly as a result, she seemed emotionally withdrawn and depressed and consequently, she showed poor eye contact with her son and appeared unable to notice him properly. She repeatedly referred to him by her dead son’s name. Liam, however, did not seem to react to his mother’s mistake. Though physically he seemed quite a stocky child, he actually gave the impression of being fragile and disconnected.

We learned from his mother that Liam had ‘a squint just like her’ and should have worn spectacles to help him see, but rarely did. Liam suffered from a right convergent strabismus and it was still being deliberated whether an operation might be offered to correct this. We were told that she didn’t think that the squint was a problem to him; however, she displayed little curiosity about his visual disability. It seemed that her eyes were not available to gaze into his eyes and, therefore, she was not registering very much about the way he used his eyes either from a strabismic or a more general eye communication point of view. I assumed that, at these moments, she was literally caught up in her confusion between the dead child of her internal world, and the living child who was absent from her mind and her eyes. Indeed when retrospectively asked for consent

for the research, his mother was happy to give it but did not offer any additional thoughts about the intermittent nature of the strabismus or Liam's use of his eyes. His strabismus, it seemed, was considered unimportant given the nature and extent of the family's other difficulties.

In the first individual session with me, Liam wore a thick cardigan; he was wrapped up tight in it, despite it being a very warm room. He talked to me about a school trip in a very complaining way, saying that he had been to a 'hot room', a 'bit like this one', where he had seen 'a tiger that bit his finger'. I experienced him as hardly being able to contain his anxiety about me. His eyes seemed to fall into a visual haze, which included strabismus, and this didn't seem to help him discover that, despite his fear of me, I wasn't in reality such a frightening 'tiger' lady. For most five year olds, an understanding of real and pretend can be an oscillating state of affairs, making the world of imagination rich and exciting. My sense of Liam, however, was that he was often on the edge of a frightening world, one where he could not be sure where the real world might end and his fearful imagination might start. He seemed easily overwhelmed by his anxiety. His speech was very immature and often indistinct which added to the confused and 'on the edge' atmosphere.

Liam showed a fragile capacity for symbolic understanding and when I commented that 'I had brought him animals in his box' he looked petrified, prompting me very quickly to explain that they were toy animals to pretend and play with, 'not real ones'. When Liam was in this kind of confused and anxious state, I noticed that his eyes were often flat and unfocused, or they easily dissolved into strabismus.

By the second and third sessions I had begun to realise that I was experiencing Liam in the counter-transference as very menacing, particularly in relation to my eyes. For example, he played very near my face with the toy animals whilst speaking in a very demanding and threatening tone of voice. I felt worried that he would attack my face and particularly my eyes, just as he had previously punched his mother in the face. I had to find a way to tolerate and therefore contain the threat of aggression; finding a position that was neither reactive nor submissive to the actual threat, but still alive to his responses. I noticed that as I tolerated this atmosphere, allowing his play to unfold and for him to be free enough to notice the communicative possibilities of play, Liam began to engage in a freer way. He seemed to literally be able to latch on to my available gaze and to my ideas

and coordinate his eyes. He then began tentatively to explore the toys and the therapeutic environment in a more symbolic way. I also noticed how Liam began using his spectacles as the assessment moved on and how this also helped him gather in his eyes. Subsequently, by conducting the data analysis, I was helped to explore the impact of the therapist's visual availability more thematically.

My emotional experience of the assessment communicated to me that I was with a frightened and frightening child. This seemed due to the impact of relational trauma, violent disruptions to his life, and the lack of the availability of a lively maternal mind, as communicated through the unavailable eyes of his mother. Liam was likely to have had a mind that had been marinated in trauma, being inextricably linked to a dead child in his mother's mind. My interpretation was that his very violent punching of his mother's face was a mixture of differing elements: an attempt to enliven deadened eyes, combined with a furious and anxiety driven attack on the images of the dead sibling which were likely to be preoccupying her mind. Liam's intermittent strabismus seemed to be in this mix in a very complicated way.

The observed moments before and after the psychotherapy sessions, however, suggested to me that his mother's eyes had become less preoccupied following her own appointment. This seemed to give her an opportunity to process her own emotional experiences. Therefore, when she was met by Liam following her sessions, her tentative visual availability was matched by his growing confidence in being able to pull in and latch onto her eyes, as I had perhaps done with him in his therapy. This resulted in our being able to observe what seemed like a kindling of mutual gazing between them.

Following the assessment I suggested that, in principle, the best course of action would be to offer to work with Liam and his parents together, focusing upon their relationship and their availability with each other. However, due to difficulties in the wider family that threatened again to consume his mother's mind and devouring all of her attention once more, the timing for this work was not yet right. The clinical work then shifted to a multi-agency consultation/child protection arena; this was, however, informed by the direct experience of this child, his state of mind, and the way he used or was unable to use his visual resources.

In summary, Liam had been referred for an assessment due to his severe aggression. Amongst other issues, the assessment revealed that he had a severe difficulty in

coordinating his eyes which contributed to a difficulty in apprehending the world in a reality-based way. Also, the frightening quality of his external experiences and relationships meant that he would be unlikely to have any motivation to actively coordinate his eyes to focus. I assumed that this maintained both his emotional confusion and, in a circular fashion, his lack of interest in using his eyes well. This dynamic seemed to influence the therapeutic relationship in a number of ways which are explored in the presentation and discussion of the following thematic findings.

The analysis of the template: Liam

1. The child's anxiety becomes overwhelming and harder for the therapist to emotionally contain and the child's eyes may become strabismic.

- Possible collapse into strabismus which appears to correspond with anxious transitions.

The intensity of the transition from one person to another is heightened, as one might predict, at the first meeting. Liam's ability to manage these transitions, however, seemed to increase over the course of the assessment and the strabismus appeared to have correspondingly reduced.

This section of process data is taken from the beginning of the first individual assessment session. Liam's mother was seen in parallel by a colleague.

First session: 21st April 2010

'I collected Liam from the waiting room and his mother followed my colleague. Liam repeated back to me my words of reassurance that his mother would be waiting for him when we had finished our meeting. He looked slightly bewildered but followed me.

'Liam sat opposite me on the couch, and I noticed his cropped blonde hair that framed a chubby but frightened looking face. He was a stocky-looking child who looked as if he could be confident, but actually he sat on the edge of the couch, seemingly very uncertain about firmly sitting on it. Underneath his zipped up cardigan it was possible to see that he was wearing a school

uniform. It was a hot room, but he was obviously reluctant to literally and emotionally uncover himself.

‘Liam met my eyes with a slight ‘laziness’ (perhaps out of focus) and an inward turning of the right eye. His left eye also seemed to lack focus and it was hard to work out how to be with his gaze.’

It is possible to see how Liam entered the play room in a state of anxiety and was unable to meet my welcoming gaze. Liam’s eyes quickly became both strabismic and unfocused, giving me the impression that he was unable to gather his eye muscles in order for his eyes to respond reciprocally. In a sense, his eyes muscles may have collapsed into the strabismus due to the overwhelming quality of his anxiety at this moment. This was potentially similar to infants studied in the strange situation test (Hesse and Main, 2000), but particularly to a child with a pre-existing strabismus. This was of course one possible explanation, although it is also conceivable that Liam’s motivation was also influential. It could have been that an inclination to collapse into strabismus, and to therefore not see clearly, might also have been a way to protect himself from greater collapse and his loss of sight could be considered as being collateral damage.

Furthermore, it is plausible to suggest that when the convergent strabismus manifested itself, leading to a loss of external focus, that there was a temporary breakdown in clear vision. It is not difficult to imagine that at this moment his perception of the therapist might have been vague and distorted and in this way may have particularly influenced the negative quality of the transference. Thus, in a circular manner, producing more anxiety and compounding the difficulty in emotionally engaging with the therapist.

The above theme, however, suggests that the anxiety aroused during the transition of leaving his mother and being with me was experienced as emotionally and physically overwhelming. It is possible to postulate that this anxiety contributed to the manifestation of the strabismus and my words of reassurance at the beginning of the session, which were attempts at helping him be more emotionally contained, were insufficient in the face of his overwhelming anxiety. His anxiety could not easily be managed and he became both strabismic and visually un-focused. I am assuming, therefore, that without the actual presence of his mother his mental capacity was insufficient to manage the separation and sustain his functioning, and his contact with external reality was reduced. I am reminded here of the research into the impact of blindness upon object permanency (Fraiberg,

Siegel and Gibson, 1966), and speculations in the literature review around the potential for an under-developed sense of object permanency in relation to visual distortion associated with intermittent strabismus.

Liam had experienced a great deal of loss in his life and he specifically suffered from the unresolved maternal grief emanating from the traumatic loss of his brother before he was born. In the literature 'Anna O' suffered from a convergent strabismus that was associated with the death of her father. Apparently this was 'talked away' when the grief had been emotionally processed through her work with Breuer (Freud and Breuer, 1893, p.89). Interestingly, more contemporary researchers found that many children seen in ophthalmology clinics for visual conversion disorder had also suffered from major bereavements in the family (Hobson *et al.*, 1997). This research did not, however, refer to intermittent strabismus.

In Liam's case, the initial strabismic episode was not repeated at the beginning of the subsequent sessions. On the contrary, it could be observed that he came easily with the therapist into the play room, giving his mother a warm and gentle hug before he left her, and verbally confirming with the therapist that she would be seeing someone herself, and that he would see his mother again after our meeting. Liam had become able to identify a capacity within himself to reassure both himself and his mother and therefore helping them both manage the transitions (Sorenson, 2005).

In summary, it is possible to interpret that strabismus was particularly associated with the re-experience of loss and with both internal and external collapse. Moreover, this experience may have led to the creation of a distorted therapist within the transference which had an immediate impact upon the ability of the therapist to offer emotional containment.

1. The child's anxiety becomes overwhelming and harder for the therapist to emotionally contain and the child's eyes may become strabismic.

- Lapsing into strabismus: possible visual distortion associated with the child's preoccupation with their internal world.

The following observation was taken from the third session and may suggest how aggressive phantasies interweave with a sliding into strabismus and Liam's eye muscles became lax in response to the slipping of his spectacles:

Third session 5th May 2010

'He lay on the floor looking at the tiger, then up at me, and he spoke in muffled tones about the tiger and looked up at me with good bright eye contact. I then became aware that his spectacles had slid off his nose slightly and I noticed how his right eye turned inwards. Liam found all of the tigers and told me that 'They were coming to bite me'. I replied by saying that 'Ooh, those tigers are going to get me'. Liam then roughly put the tiger on my lap and he vocalised that they were 'biting me'. The 'tigers' bit my hands and I became a little concerned that this might spill over into something more real. The tigers 'bit' my 'face off' and again I was concerned that I might be actually attacked. 'Oh, I've got no nose or eyes' I responded, 'or mouth', he added. I said that I was to be 'all bitten up'. He carefully looked at me then back down at the tigers and then he had the mother and baby tiger interact with each other in a mildly aggressive way'.

To begin with Liam spoke in muffled tones, as if internally preoccupied. He looked up at the therapist with 'bright eye contact' as if in touch with a warm reciprocal child-mother relationship at that point. Quickly this changed as he allowed his spectacles to slip from his nose revealing his strabismus, and this then seemed to become associated with a biting, devouring phantasy. The therapist's amplification of the phantasy possibly allowed it to be acknowledged and processed and helped the action move back to the symbolic arena with the toys. However, Liam's grip on his capacity for symbolic functioning was fragile and so the literalness of the play meant that it had a frightening edge. This was worked through within the counter-transference as the therapist was allowed to become a thinking object, even whilst being attacked, and thus presumably allowed him to return to a more playful way of relating.

My inference is that Liam lapsed into strabismus at this point, rather than collapsing in to it, and this led to a lapse into his destructive internal world view. My interpretation is that there was some element of motivation, or preference, to lapse or slide into a phantasy state rather than to use his eyes to strengthen his external view. It could be possible that

experiences of collapsing into an anxious strabismic state, such as at the beginning of the first session, had developed more control over time. It may be that these observations represent the potential development of a pathological addiction to his internal world; where his apparent control over his strabismus is used to promote this way of relating.

The ophthalmological literature makes several references to the manifestation of strabismus when children ‘daydream’ (Clarke, 1999; Taylor, 2012). Daydreaming is an ordinary word that might imply a conscious, imaginative, narrative. It may also encompass more of a psychoanalytic notion of being withdrawn into an unconscious phantasy world. Whilst it may be that we draw upon daydreaming in order to be creative, some children, and indeed adults, may submerge themselves in their phantasies in order to defend against external reality (Steiner, 1993). It is possible to suggest that in Liam’s case, the strabismus may have originally provided a temporary relief from the fearful situations that he was exposed to as an infant, and as he has grown older this way of functioning had become elaborated.

Psychoanalytic writers have suggested that the intermittent nature of strabismus was an indication of the ‘indecision or doubt as to whether the inner world, the daydreaming world, shall have the upper hand’ (Huebsch 1931, p. 116). Other writers have also suggested that convergent squint is a ‘dramatization of a preoccupation with internal phenomena or inner world reality’ (Winnicott, 1958, p. 81). These ideas are consistent with the themes arising out of the process data with Liam.

In this excerpt, reality and aggressive phantasy seemed to become fused and the strabismus seemed to promote this confusion by altering the view of the therapist into an ‘all bitten up’ or fragmented object. The therapeutic relationship becomes quite tricky to negotiate as there is the risk that real aggressiveness towards the therapist will break through, as opposed to being communicated symbolically within the transference. The following excerpt is taken from near the end of the third and final individual session and it illustrates these points further.

Third session: 5th May 2010

“Where’s the fat-gobbed one?” Liam asked. ‘The ‘hippo’, I suggested and I pointed to it. He inspected its mouth for a few moments and then moved his interest to the box and found a large crocodile. He asked me to close my eyes

and became very insistent, especially when I half-closed them but we managed to reach a compromise by my shielding my eyes. He placed the large crocodile on my lap and then told me to ‘open my eyes’.

‘Liam wanted to keep repeating this and each time he looked deeply into my eyes and face and delighted at my responses. Soon his interest receded and he became preoccupied. I noticed how his eyes had seemed strong and focused whilst looking at me, but now as he became preoccupied with his own ideas his eyes lost their coordination and his right eye drifted inward.

‘Liam then asked again where the ‘fat-gobbed one’ was, though I could see that it was directly in front of him. I asked if he could see it, but he seemed convinced that he couldn’t and he vaguely looked around, unable to see the animal that was actually in his visual field.

‘Liam then became attracted to the toy telephone and began ringing it and asking me to answer it. I said ‘ring, ring’ and just as I was going to answer it he put the phone down. He repeated this. It was as if we just couldn’t get connected and kept missing each other and I spoke to him about this.’

Playing with crocodiles was a feature of all three sessions, and often they would be biting crocodiles that would threaten to really hurt the therapist. Consequently, the therapist needed to keep a watchful eye on the proceedings so as to not allow herself to be in too vulnerable a position. It is possible that this counter-transference was a reflection of how Liam had probably needed to be vigilant as an infant in order to potentially defend himself from the unpredictable experience of violence within his family.

The early part of this observational data seemed like a ‘peek-a-boo’ game and he was interested in my eyes appearing and disappearing under his control. Liam’s eye contact was coordinated during this section; he was excited and enjoyed observing my responses. It was a playful exploration of the nature of absence and reunion, which I suspect could not be sustained in the face of the nearing end of the assessment. The accentuation of an internal preoccupation and move away from proper contact seemed exemplified by the lack of the external focus of his uncoordinated eyes, presumably this blurred the external view and he appeared to become lost in his own phantasy world.

For example, at one point in this excerpt Liam seemed blind to the external view and he could not see the ‘fat-gobbed one’ that he wanted, which was literally before his eyes. Liam had moved from a mindful symbolic position, exemplified by his reciprocal eye contact, to the preoccupation with a ‘fat-gobbed’ phantasy which suggests a primitive oral eye that can devour and destroy. This had perhaps been foreshadowed earlier in the session by Liam using the tigers to ‘bite’ my ‘eyes’.

There is, however, evidence to suggest that Liam could also move back away from damaged views of his therapist (all bitten up), to more symbolic states, whereby he could imagine the therapist being more coherent and available. Also, more able to emotionally contain his phantasies about her: ‘I noticed how his eyes had seemed strong and focused whilst looking at me’. However, the data might suggest that strabismic moments for this child might contribute to the therapist, in the transference, being experienced as being particularly fragmented and distorted, over and above how they might have been experienced emotionally without the presence of strabismus: ‘but now as he became preoccupied with his own ideas his eyes lost their coordination and his right eye drifted inward’. For Liam, who has been emotionally traumatised, strabismus did appear to compound the task of differentiating an internal damaged world, from external world damage. It could be argued that strabismus is unlike any other disability because it affects the ability of the eyes, and therefore the mind, to function in a fluent and coherent manner.

Some authors have given substantial clinical evidence of their patient’s visual disturbance associated with the experience of strabismus (Hertel, 2003). However the current research would suggest that this is very individual and dependent upon many developmental factors (Hubel and Wiesel, 1970; Baker and Gerald, 1979; Held, 1991; Braddick, 1996; Sengpiel and Blakemore, 1996; Lewis and Maurer 2005; Sacks, 2010; Taylor, 2012). It is not possible for us to know to what extent, and in what way, Liam experienced binocularity, and whether when his eyes were momentarily strabismic he had double vision. Common sense might suggest that, when experiencing strabismic moments, his eyes were unlikely to be seeing the world in a straightforward way and that it might be reasonable to assume some level of visual distortion, even if temporary.

Without doubt, Liam was subjected to severe and unpredictable violence from the time of his infancy onwards; this would be hard for him to see. Compounding this was the presence of maternal depression, which itself can be a form of trauma and can have an

impact upon children's use of their eyes (Cohn and Tronick, 1983). One question is how much intermittent strabismus may also have represented an 'evasive action of the eye', which the literature suggested was a way of defending against overwhelming threat (Leira, 1984, p. 180).

A question for the assessment was to what extent had he become invested in his retreat from perceived threats in the environment and into his phantasy life (Steiner, 1993). Also in what ways might he be helped to relate to the world in a more fluent way both visually and emotionally? There was, however, evidence that he could be helped through the therapeutic relationship to communicate through play, such as in the example of the disconnected telephone, rather than be literally disconnected as in the strabismic moments.

To summarise, there are thematic indications from the data that it might be conjectured that strabismus became manifest in relation to an inclination to slip into or 'lapse' into a daydreaming or phantasy world. The possibility that this formed part of Liam's defence mechanisms, to keep out views of a frightening world, as well as the result of previous experiences of emotional collapse, was explored. It was also conjectured that this led to an emotional confusion regarding internal and external reality. It was also postulated that some element of pathological control might have manifested itself in relation to a possible motivation to submerge into phantasy. It was suggested therefore, that for Liam, strabismus may have been a significant and particularly complex emotional as well as physical disability.

1. The child's anxiety becomes overwhelming and harder for the therapist to emotionally contain and the child's eyes may become strabismic.

- Strabismus may function as a way of managing visual distortion in order to be in contact with external reality.

This theme was less evident within Liam's data.

1. The child's anxiety becomes overwhelming and harder for the therapist to emotionally contain and the child's eyes may become strabismic.

- The disconcerting impact upon the therapist's gaze.

If we return to the previous example from the first session, we pick up a further observational thread that illustrates how, in certain situations, strabismus can have a physically detrimental impact upon the therapist's own eyes.

First session: 21st April 2010

‘Liam met my eyes with a slight ‘laziness’ (perhaps out of focus) and an inward turning of the left eye. His right eye also seemed to lack focus and it was hard to work out how to be with his gaze and I felt visually confused. It was hard to hold both of his eyes, with both of my eyes.’

In this sequence the therapist observed a difficulty within her own visual apparatus in direct response to the child's strabismus. The therapist became aware of her difficulty in coordinating her eyes in response to the dissonant gaze of the child. Lipton (1970) acknowledged the ‘discomfort’ in achieving steady eye contact with his patients, whilst Gregory (2009) termed this ‘jazzing’; he described the importance of the eyes and brain needing to rest on the eyes of others, which conform to expectations of how eyes should function, i.e. in unison. Liam's eyes were not conforming to the therapist's expectations and this had a very disconcerting and unsettling effect upon her eyes. It made it difficult for the therapist's eyes to correspond with each other, almost as if the therapist's eyes might have become strabismic in response to his.

This visually painful experience was intolerable for the therapist, so one can only wonder what this might have been like for Liam and his mother when they were looking at each other, both at times through strabismic eyes. One might question whether they had possibly developed a way of gazing at each other that avoided the visual confusion observed in the therapy session, or whether the experience of discomfort had continued to dominate. One might also speculate whether there were aspects of Liam's eye contact that represented an unconscious recreation of a particular maternal-gaze relationship, which the therapist with her non-strabismic eyes did not match.

One might suggest this is a form of somatic counter-transference or an embodied counter-transference. One might possibly imagine that similar processes are involved in those described by Spivey and Geng (2001, p. 1) when they wrote of ‘concrete embodied cognitions’ related to eye movements, but experienced dynamically within a relationship. However, this is very speculative.

In summary, the sensory confusion and fragmentation that was described in relation to strabismus was potentially felt by both the therapist and by Liam simultaneously; both may have been temporarily lost in sensory confusion. It is possible that the strabismus, possibly accompanied by a lack of visual focus, had a psychosomatic effect upon the therapeutic relationship.

2. The child's emotional state may be more easily contained by the therapist; the child's eyes work in unison, or are perceived as doing so by the therapist.

- This may correspond with the therapist's active attempts at emotional containment by using her visual availability.

If we return to the example from the first session, we can follow the sequence and see that the data might suggest that Liam's capacity for coordination and emotional connection is increased as a possible response to the therapist's use of her own eyes.

First session: April 21st 2010

'Liam met my eyes with a slight 'laziness' (perhaps out of focus) and an inward turning of right eye. His left eye also seemed to lack focus and it was hard to work out how to be with his gaze and I felt visually confused. I looked deeply into his eyes to figure out which one to focus upon and as I looked I found that his eyes looked more in concert, then his left eye looked more focused and I concentrated upon this. It was hard to hold both with both of my eyes. I think that Liam noticed that I had been looking purposely and there was a hint of extra sparkle to his eyes in response and they looked more ordinary.'

I have made a judgement about not interpreting this interaction as the use of a dominant eye, though it could be said that for a moment one eye did seem to take priority, but my sense was that this was more in the service of getting the eyes to work together, rather than in competition.

In this data, the therapist, rather than staying with the confused fragmented sensation, galvanised her own visual capacities and 'looked deeply into his eyes' and found a 'good eye' with which to connect. The therapist's eyes seemed to provide assistance for Liam's,

they supported his ability to use his eyes in ‘unison’, and be focused and lively. If Liam’s internal expectation was of a flat eye response, the impact of maternal depression, then the therapist’s lively searching eyes offered a different model of relationship; possibly as a new ‘developmental object’ (Green, 2003, p. 15). Indeed, I learned to concentrate my attention upon his ‘good eye’ in order to capitalise upon his visual capacities. In a similar, but more intuitive way, I found myself searching for a place to rest my eyes and in doing this realised that I was possibly pulling his eyes into coordination.

First session: 21st April 2010

‘Liam brought over the two crocodiles towards me in a faint mock attack, but this time he accompanied it with a slight noise to represent the crocs. I responded ‘Ooh, grr, the crocodiles are coming for me.’ He looked at me with a blank expression but we had good strong eye contact and I noticed that his squint was less obvious and he seemed more focused.’

It is possible to interpret the ‘blank expression’ in a number of ways but the more obvious way is as a response to something that just cannot be comprehended. It was as if my playful interpretation was a new concept to him. Although Liam was engaged with me and was really taking in the offer of my eyes with his eyes, perhaps I had put a little too much life into the crocodiles and it disturbed his fragile capacity for symbolic functioning. Overall my visual availability seemed very important in engaging Liam in a collaborative venture. I was actively seeking out his eyes, or providing my eyes for his eyes to rest upon, in a very open way and the data would suggest that he collaborated with me.

Most psychoanalytic authors write in a way that implies that they would support the proposition that the therapist should be sensitive to their patient’s vision and visual impairments, however they did not remark upon the active use of their eyes (Inman, 1921; Winnicott, 1958; Lipton, 1970; Hertel, 2003). The therapist’s seeking out of Liam’s eyes was active, hopefully not intrusive, but it was probably qualitatively different from Leira’s (1984, p. 178) approach. She suggested that she ‘bathed’ her young patient in her gaze and was ‘constantly available in a dreamy state’. My approach to Liam was more similar to Clarke’s observation: ‘parents will notice the misalignment and ask the child to look at them, and of course from near distances the eyes are perfectly straight’ (Clarke, 1999, p. 534). The visual availability of the therapist, which illustrated to Liam that the therapist was present and was available to him emotionally, could be said to have

provided an aid; an aid to support the visual disability and therefore to promote his ability to relate to the world more fully. Moreover, the data suggests that this active visual availability might have assisted in the process of emotional containment in Liam's case. It could be argued that these experiences actively contradicted his internal expectation that eyes were unavailable to him and confirmed that he did not need to attack them in order to gain a lively response.

The next segment took place in the middle of the assessment process:

Second assessment session: 28th April 2010

'He stuck the pencil with the tape, and figured out how to do it so that it captured the whole of the pencil. Then he asked me to cut increasingly larger pieces of tape, and began really enjoying this. When we did the longest piece so far, I compared it to my arm's length, he really enjoyed this and for the first time his eyes widened in delight and I made my eyes match in response.'

Liam enjoyed me following his play, and in particular my visually matching his responses, much like one might do with an infant. This example shows how Liam's senses could be integrated with one sense illuminating another; my wide arms resonated within his mind and became transformed into wide eyes. There was no hint of strabismus as both eyes were both aligned and lively.

I felt that it was very important for him to feel noticed by me as he was a boy who had struggled to have an individual identity within his family. What the assessment showed was that, given the experience of someone willing to absorb and make sense and tolerate his frightening biting primitive aggression, he did have the capacity to move beyond it into a more integrated and hopeful state of mind, with mindful and coordinated eyes.

Lipton (1970) spoke of the potential 'revulsion' that could be felt in the counter-transference in response to this physical sensation (of 'jazzing') and how this could make the psychotherapist turn away. By the end of the assessment, however, it was observed that Liam and his mother could be seen luxuriating in each other's gaze, in a way that was absent at the beginning of assessment. It is interesting to speculate whether the nature of the therapist's eventual response to this 'jazzing' experience, which was a purposeful

non-matching of Liam's negative expectations, eventually offered Liam an alternative and more enlivening model of communicating via the eyes.

In summary, the research implies that when the therapist maximised her visual availability through the active use of drawing the child's eyes into focus, or by amplification of her eye contact, or by concentrating upon the 'dominant eye', it may have helped Liam to optimise his own visual availability. This emerging theme highlights the significance of the therapist's visual sensitivity to the child's eyes. Although psychoanalytic authors imply that they would espouse sensitivity to the child's eyes, none of the psychoanalytic writers make any suggestions about visual availability other than Leira (1984). The ophthalmological literature is slim but it would seem to support an active 'pulling in' of the child's eyes (Clarke 1999), as well as supporting the child's emphasis upon their 'dominant eye' (Pratt-Johnson and Tilson, 2001).

2. The child's emotional state may be more easily contained by the therapist and the child's eyes work in unison, or are perceived as doing so by the therapist.

- This may correspond with the child's capacity to explore both their external and internal environment in a reflective way.

The session had been filled with biting animal play, but this receded following a sequence of reciprocity where my eyes had widened to match the delight in his eyes. The next sequence follows on from this.

Second assessment session: 28th April 2010

'After this point, Liam showed delight in his activities and he began writing random letters in a very purposeful way. He turned the paper over and then did a letter 'L' and looked at me and said 'L' and I said after him 'L'. We then did this with all the letters of his name – all of which produced his name but in reverse order. 'Ah, Liam,' I said, ignoring the backward way he wrote, and his face shone with delight'.

There is no evidence of strabismus in this segment. In this example Liam had a more productive state of mind and he really enjoyed my reading his name aloud. It was significant in the life of the assessment that Liam was able to actively reclaim his name

and feel that someone had noticed it; in the introductory meetings his mother had repeatedly referred to him by his dead brother's name. There was a playful and exploratory quality where he showed me how seemingly proficient he was in spelling his name. He was in touch with the more communicative and reciprocal element to his personality and he wanted to take things in with his eyes and his mind. Also, he was more expectant of the eyes and the mind of the therapist being receptive and he wished to communicate with the world and explore it. In a sense Liam had, at these moments, an expectation of the availability of the therapist which the data suggests corresponds to a capacity to gather himself psychologically and physically.

This example of reciprocity and exploration, associated with aligned eye contact, is relative to the lack of it in other moments within the session. The backwards spelling of his name points to a very severe lack of fluency and coherence within his functioning.

At the beginning of the assessment Liam did not seem to have a reliable concept of regularity or schedule and he seemed to lack a temporal understanding of time. Looking at the clock was a feature of all three sessions. By the third and final individual session he seemed to have grasped, with delight, that there were shared rules which governed time and were separate from either of us; that life could be coordinated. When he was in touch with his capacity for coherence and coordination then his eyes would also appear to be better coordinated.

Second session: 28th April 2010

‘Liam unglued his eyes from the clock and looked at me. I had the sense of Liam being spellbound and really thinking about these concepts. This resonated as next we talked about us having three sessions; ‘One, two, three,’ he announced, showing me his three fingers. Then he suddenly remembered the clock and pointed to the black hand moving.’

The experience of three assessment sessions, in a regular and reliable form, seemed to have a powerful impact upon Liam's ability to conceptualise time as something separate from either himself or, in the transference, the therapist. During the assessment Liam seemed to experience a developmental leap into discovering the idea of time and appreciating therein a boundary between internal and external reality. The family context was one where grief had contributed to a confusion about dead and alive, past and present,

where the rhythm to life was disrupted (Stern, 1977). This segment shows how much freer Liam's imagination had become. He now displayed his capacity to know about the continued passage of time, which proceeded regardless of his desires or fears. During the life of the assessment he seemed to have discovered an ability to order his mind, and at these times he seemed unencumbered by disordered vision.

The clock face, my face, and his face seemed like a representation of a triangular experience of thinking. He shared an experience of his mind, the therapist's mind and a cultural mind, represented by the knowledge of time. This connectivity and order meant that he could recognise a good working 'clock face' therapist as opposed to the 'all bitten up' therapist of his violent internal imagination. The coordination of mind and eyes in a whole, rather than in pieces, or strabismic, seemed to be linked with a delight in the discovery of the external world and a move away from being submerged within his internal phantasy world.

In her work, Leira (1984) referred to her patient 'Arne' and the links between the development of psychic depth, binocularity and a reduction in strabismus. Leira's assertion in her clinical paper was that the development of emotional depth, as a result of a psychotherapeutic intervention with 'Arne' and his family, led to a greater capacity and willingness to coordinate his eye muscles to prevent strabismus. She saw strabismus as a way of emotionally defending from the knowledge of the abuse to which 'Arne' was subjected. Leira evidenced the reduction in strabismus through ophthalmic eye examinations in addition to nursery observations undertaken by other colleagues. Whilst no effort was made to quantify the manifestation of strabismus in Liam's case, the themes do point to there being similar psychodynamic elements at play that are consistent with this literature.

In summary, this data might suggest that an ordered vision in both child and therapist corresponds with the child's ability to explore and relate to a more reliable and ordered internal and external environment; the child feels more emotionally contained.

The therapeutic experience, it could be argued, provided Liam with opportunities to have his anxiety emotionally contained and thereby be freer to explore and learn about the external world. Correspondingly, when he was more in touch with a good internal view of the world, this provided him with more confidence to be interested in the eyes and the

inside of minds of others, as well as his own, and this allowed conceptual learning to take place.

In this state, the strabismus, which is either latent or reduced, would seem to have little effect upon the progress of the ongoing therapeutic relationship. Indeed, emerging themes from both the literature and from Liam's process data, suggest that emotional containment may correspond with visual coherency.

A comparison of the two children

The two children in this study, who were five and seven years old, and came from similarly painfully disruptive and traumatising backgrounds, both suffered from intermittent strabismus. Lily experienced exotropic or divergent strabismus where her right eye could turn outward. Liam, on the other hand, suffered from esotropia or convergent strabismus, where his right eye could turn inward. Both children had eyes that fluctuated in both the ability to correspond with each other, and presumably maintain focus; potentially the children may have suffered from occasional double vision and possible loss of depth perception associated with these fluctuations.

Both children in this study were understood to manifest strabismus in relation to anxiety; particularly anxiety that that could appear to be associated with the transition involved with leaving a parent to be with a largely unknown therapist. Lily seemed to appear to manage those moments that could be construed as a strabismic collapse, by galvanising her ocular muscles in order to make use of a 'dominant eye': 'Then I noticed her shooting me a look with both eyes and then her right eye drifted away and her left eye became straighter.' (20th January 2010 session). This was interpreted as a healthy response aimed at reducing the possible double vision and visual disorientation. It was understood as a way of helping her to strengthen her visual link with the therapist and also the external world.

This contrasted with Liam who was seen to have responded to similar anxiety by what might have seemed like a strabismic collapse, but then, rather than gathering his eyes, he seemed to lapse into his internal world. There was some speculation whether Liam had begun to develop pathological defences. He appeared to use his strabismus to aid his turning away from reality towards his aggressively populated internal world: 'He lay on the floor looking at the tiger then up at me and he talked in muffled tones about the tiger

and looked up at me with good bright eye contact. I then became aware that his spectacles had slid off his nose slightly and I noticed how his right eye turned inwards. Liam found all of the tigers and told me that ‘they were coming to bite me’. (April 28th 2010 session).

This apparent difference in the two children’s relationship with their eyes may well have been influenced by the different prevailing external circumstances whereas Lily’s gaze was now met by an eager and bright eyed mother in her external world. Lily, it appeared, had more reason to make her eyes function to see the external world. However, she struggled against the impact of the strabismus, which had made communication more difficult to establish. Liam, by stark contrast, initially at least, was met by a profoundly depressed and gaze-avoidant mother. It could be interpreted that Liam may have needed to defend against the overwhelming anxiety associated with significant death and loss in his family, and this contributed to a retreat into phantasy. He appeared to utilise the strabismus to avoid contact with reality. These observations extend and elaborate the previous literature (Lipton, 1970; Leira, 1984; Hertel, 2003).

The study highlighted how the therapist, at moments, might identify with the child’s eye coordination difficulties because at times her visual apparatus seemed to be interfered with in response to the child’s strabismic and unfocused gaze. In Lily’s case the therapist wrote: ‘This felt disconcerting as it was hard to know how and where to focus my eyes in response.’ (20th January 2010 session). Similarly, with regards to Liam, the therapist wrote: ‘It was hard to work out how to be with his gaze and I felt visually confused. It was hard to hold both of his eyes, with both of my eyes.’ (21st April 2010 session). Both children, it could be interpreted, produced a psychosomatic form of counter-transference in the therapist as expressed by the physical impact upon her eyes, a link was made in this study to the term ‘Jazzing’ which was coined by Gregory (2009, p. 156). It was as if the children’s eyes might have nearly produced a strabismus in the therapist, which could not be easily tolerated, and may have easily resulted in her turning away. One author suggested that strabismus could produce a sense of ‘revulsion’ in the counter-transference (Lipton, 1970, p. 19) which may have been a description of a similar sensation, though described in a different way to that observed within this study. Additionally, ophthalmological literature describes how teenagers and adults self-reported that they had trouble making eye contact and lacked self- confidence (Nelson *et al.*, 2008). One could speculate that all of these sources are reporting a similar experiential dynamic, but that

this present research study describes examples of the intricate detail of the interaction and frames it within the notion of a somatic counter-transference.

The data, however, suggested that when both children had felt emotionally contained by the therapist, in particular through her capacity for visual availability or reciprocity, then both children were in a better psychological position to explore their environment. When Lily's anxiety subsided her strabismus reduced, and she had more emotional capacity for reflection. For example: 'Lily then told me that Rosie, like her other dog, would die sometime and she would go to heaven, 'but I don't know where that is,' she added.' (11th February 2010 session). Her philosophical musings took place towards the end of the last session of the assessment and illustrated her ability to have awareness of loss without being overwhelmed by it. Similarly, with regard to Liam, it could be argued that, as a result of the assessment, he seemed to gain a grasp of a very profound sense of the passage of time. He was able to appreciate that life could be structured into past, present and future: 'Liam unglued his eyes from the clock and looked at me. I had the sense of Liam being spellbound and really thinking about these concepts. This resonated as next we talked about us having three sessions; 'One, two, three,' he announced showing me his three fingers.' 28th April 2010 session. Both children showed what appeared to be an improved capacity to understand the temporal quality of time when they were more emotionally contained, and this appeared to correspond with their eyes being coordinated.

The development towards a capacity for emotionally processing the experiences of profound loss was a crucial aspect for both children. Neither child, it could be argued, arrived into the world to be greeted by the lively expectant eyes of parents who would be available to assist them in negotiating the emotional demands of disrupted family life; instead both children probably lived in a state of privation. Whereas Lily did seem to be able to hold on to an expectation of lively, mindful eyes in therapy, Liam seemed to be initially mystified by their presence. The manifestation of strabismus, presumably with associated visual distortion, seemed to compound both children's fearful expectations that they would be left with a threatening giant therapist (Lily) or a 'bitten up' therapist (Liam) in the transference. Therefore, there is a proposition in this study that the development of the transference, particular the negative transference, may be shaped in a particularly distorted or fragmented way as a result of the fluctuating presence of strabismus. It is interpreted that when these two children were particularly anxious, such as in the presence of a 'stranger' therapist, their eyes not only failed them, in the form of a muscular

collapse, but this then added a certain fragmentary quality to the negative transference. In turn this made the task of offering emotional containment to either child particularly challenging. Although Leira (1984, p. 180) spoke of strabismus as a form of ‘psychic fragmentation’ she did not argue, as in this study, that the fragmentation may have been partly as the result of the compounding effects of strabismus, in addition to the traumatising circumstances of their life. Leira held back from exploring how this might be elucidated in detail within the transference and counter-transference arena. There have been an absence of previous studies that have described the impact of strabismus on the transference.

Both Lily and Liam appeared to respond to the therapist’s attempts to use her own visual reciprocity to support their ability to find a focused resting place for their eyes. Both could be observed to respond by increasing their focused attention through mutual gaze behaviour with the therapist. The therapist’s mindful, receptive and, at times, seeking eyes, appeared to support the children in their ability to hold their ocular muscles more firmly and to avoid collapse, or at times lapse into strabismus: ‘I looked deeply into his eyes to figure out which one to focus upon and as I looked I found that his eyes looked more in concert, then his right eye looked more focused and I concentrated upon this.’ (Liam, 21st April 2010); ‘Lily looked right up into my eyes and held really warm eye contact, as if she was looking deeply into my eyes with a sense of pleasure’ (Lily, 27th January 2010).

Some authors shared their observations of children’s responsiveness to therapy by their observations of children’s eyes becoming more aligned, but no authors specifically linked this with an active therapeutic attempt at visual responsiveness (Leira, 1984; Federici-Nebbiosi, 2003) and how this might equate to emotional containment. One author did describe her intuitive ‘bathing’ of the child in her ‘glance’ (Leira, 1984, p. 177). However, her descriptions at times lack the rigour of active seeking out of the child’s eyes, suggested as necessary in this current study.

In summary, there are many shared themes between these two children. However, the most significant difference was the degree of belief that each had in the possibility of getting connected to lively and coherent eyes, that in the transference could represent a coherent mind. Liam appeared to lapse into strabismus and therefore lapse into his violent internal world. By contrast, Lily could appear to respond to her anxious collapse into

strabismus by finding a ‘dominant eye’, and this provided a more coherent view of the therapist and the external world. Both of these responses to the possible distortions associated with the strabismus had an impact upon the quality of the transference and therefore the different capacities for building secure and responsive relationships.

In conclusion, in order to answer the research question, ‘How does intermittent strabismus impact upon the therapeutic relationship?’, an analysis of the process recordings from the case studies, using template analysis, was conducted. The findings were presented in the form of a template and this illustrated the emergent themes. Each case was then discussed in relation to the themes and illustrated by examples of the raw data.

The two overarching and contrasting themes suggested that the manifestation of strabismus could be associated with the child’s uncontained anxiety, or when the child’s anxiety is more easily contained the eyes could be more coordinated. This finding is consistent with the literature concerning strabismus.

An exploration of sub-themes allowed for a more detailed appreciation of the impact upon the therapeutic relationship:

- The research suggested that transitions, between a primary carer and the therapist, might lead to greater anxiety and therefore these could correspond with strabismic episodes.
- That when the anxiety was overwhelming, the therapist would need to contend with a child who may be experiencing visual distortion during their strabismic experience. Three possibilities arose: where the child’s strabismus represented a collapsed visual state, where the strabismus was associated with the child lapsing into their internal world, or conversely where the strabismus was increased by the child’s efforts to exploit the use of a ‘dominant eye’ in order reduce visual distortion, and to be more in contact with external reality.
- The template also highlighted how the therapist’s own gaze could be temporarily disabled by the child’s strabismus, and that it might be an advantage to consider this as a form of somatic counter-transference.

- The therapeutic responses that thematically arose from the data in many ways mirrored the child's responses to their strabismus. The themes highlighted the therapist's active use of her eyes and eye coordination in order to optimise, and possibly dramatize, her visual availability. A number of strategies were seen to be employed: seeking a possible 'dominant eye' in order to assist the child's ability to focus. Or by the therapist actively pulling the child's eyes into coordination, by the use of their own coordinated focused gaze, making their 'glance' or gaze available for latching on to. Additionally, a general amplification of gaze and intonation was recorded and this was used to increase emotional contact with external reality, as opposed to a possible distorted internal world view.
- The research suggested that when a child's eyes were more coordinated, this was associated with a greater ability to explore both their external and their internal environment in a reflective way. The child was then able to make a fuller use of the therapeutic experience.

Thematically, these findings would not support a suggestion that eye fluctuations are merely random movements. Overall the research findings suggest that the nature of, and the timing of, the child's coordinated or fleeting dis-coordinated eye contact with the therapist, is both a highly complex and highly emotionally significant behaviour. Likewise, the behaviour of the therapist in response, particularly her use of her own eyes, seems very significant. Visual reciprocity can appear to help the child's capacity to be in touch with external reality. Although not intended to be prescriptive, a number of responses from the therapist to the child, are suggested by these findings as a way of maximising the engagement process, and potentially supporting a child's visual disability. The overall conclusion is that, in the cases of these individual children, the presence of intermittent strabismus profoundly impacted upon the nature of transference, the counter-transference, the ability of the therapist to emotionally contain the child, and to such an extent that technical adaptations were developed in response.

CHAPTER FIVE

Conclusion

In this chapter I intend to revisit: the purpose of the research, the context of the study, and a summary of the findings. I will follow this with a discussion of the implications for professional practice, possible implications for a wider multi-disciplinary arena and a critique of the study.

The purpose of the research

As a child psychotherapist, I had come across several children in long-term psychotherapy whose eye movements and quality of eye contact had seemed to fluctuate. I came to understand that these children suffered from strabismus. The nature and the quality of the fluctuation, within a psychotherapy session and across treatment, seemed to imply an emotional component was involved. The potential meaning of this behaviour was, however, very difficult to understand without systematic study. Therefore, the motivation for this research was to have the opportunity to investigate these processes in a detailed and systematic way to discover what themes might emerge.

Researching into the ophthalmological literature, as part of my literature review, allowed me to decipher ideas from this field and utilise them within psychoanalytic psychotherapy. Specifically, it enabled me to understand that there was some belief that the manifestation of intermittent strabismus was considered to have an emotional aspect to it, although there was no evidence that this has been systematically researched. The suggestion was that the intermittent nature of this form of strabismus might sometimes relate to anxiety and sometimes to daydreaming. Constant strabismus, however, is not understood to have an actual emotional component; it is not considered to fluctuate in the same way or be linked to anxiety or other emotional factors. Other concepts from ophthalmology included: recognition of the child's use of a 'dominant eye'; the potential for visual distortion; the possible under-development of binocularity. There was an implication that there was a positive coordinating effect of the visual availability of another, but there was no evidence of any psychological aetiology. To investigate the potential emotional component, the children I chose to concentrate upon for this study were those that I had seen and knew to have suffered specifically from intermittent strabismus.

The psychoanalytic literature has long held a view that strabismus has a significant emotional component, but had a tendency not to differentiate sufficiently between the different kinds of strabismus so conclusions were conflated. Very few studies focussed upon children. The literature recognised an association with the internal world but rarely explored phantasy. There was a strong belief that strabismus had a psychological aetiology yet transference and counter-transference issues were rarely explored. Additionally, the clinical research in this area only occasionally looked at close observations of psychotherapy sessions and, more often than not, this was not done in any sufficiently robust, systematic way. There have been no replicated studies; indeed there was often a remarkable lack of cross-referencing of the existing literature between studies. Therefore, the aim of this research study was to uncover psychoanalytically-based themes derived from a systematic treatment of process recordings taken from psychotherapy sessions, and specifically of children with intermittent strabismus, and to place this study within the existing literature.

The overall purpose of the research was to discover how the child's intermittent strabismus could potentially impact upon the psychotherapy encounter, highlighting the potential barriers and opportunities for emotional engagement.

Summary of the findings

There are two overarching themes within this research study. One of the themes describe how the therapist appears to have successfully emotionally contained the child and connected with him or her in a productive way. This is a state of mind where the child can occupy a more reflective and exploratory position and may correspond with either a reduction of, or an absence, of strabismus. However, there may be other states of mind that appear to be associated with the manifestation of strabismus and where offering emotional containment may prove to be especially challenging. This may be due to the fragmented or defensive states aroused within the child which are then experienced through the negative transference. At these times a typical psychotherapy response may need modifications of technique in order to respond to the complexity of the presentation.

The findings specifically highlight the role of anxiety in relation to the manifestation of strabismus. This resonates with elements of the ophthalmological literature which touched upon more emotionally laden explanations of fluctuating strabismic phenomena (Pratt-Johnson and Tilson, 2001). The findings also echo the views of a number of

psychoanalytic writers who regarded strabismus as having an emotional component (Freud and Breuer, 1893; Inman, 1921; Lipton, 1970; Leira, 1984; Hertel, 2003).

Only one paper from the ophthalmological literature described anxiety related to new people entering into relationships with a child: 'strabismus came on whenever a stranger came into the room' (Hall, 1836, p. 102). Interpreted through an attachment lens, this can be understood as a 'collapse' in response to the presence of a 'stranger' (Hesse and Main, 2000, p. 102). This study interpreted that the transition between dependency figures (parent and 'stranger' therapist) aroused anxiety which in turn impacted upon the strabismus.

The psychoanalytic literature also makes links with the impact of loss (Freud and Breuer, 1893) and how this might influence the negotiation of relationships and the occurrence of strabismus. Additionally, the psychoanalytic and child development literature invites one to speculate about whether intermittent strabismus, as a visual disability, might have some sort of impact upon the development of object constancy and thus the ability to mentalize the continuation of an object that is absent, as can be the case with the blind child (Fraiberg, Siegel and Gibson, 1966). The research invites one to speculate about possible consequences of more severe intermittent strabismus upon the child's ability to tolerate and negotiate transitions in relationships.

Several papers, from both ophthalmology and psychoanalysis, touch on the potential for visual distortion during strabismic episodes (Lipton, 1970; Pratt-Johnson and Tilson, 2001). This study highlights the problematic nature of visual distortion in terms of the development of the negative transference and how this may pose an additional burden upon the child and also upon the therapist attempting to promote emotional engagement and emotional containment. Although there is some exploration of visual distortion within the literature, there is little acknowledgement of how this might specifically impact upon the transference. The study implies that the possible occurrence of visual distortion, associated with the strabismus, may compound a child's psychological vulnerability. For example: the data implied that Liam felt himself to be with a 'bitten up' therapist when he left his mother to begin his session. The therapist may have been experienced as a visually fragmented or distorted figure due to the impact of the strabismus, over and above the impact of the psychological difficulties that were likely to have provided the foundations for his aggressive or fearful phantasies.

This study found that the manner of the eye movements, the occurrence and the intensity of the strabismus, and the context within which the strabismus manifested itself, could be interpreted as having an emotional significance within the arena of psychoanalytic psychotherapy. This is particularly so in terms of how the child related to their internal world, as opposed to external reality. The literature also suggested that there may be a strabismic response in relation to a retreat into: a 'private theatre' (Freud and Breuer, 1893, p. 174), where the 'daydreaming world, shall have the upper hand' (Huebsch, 1931, p. 166) and where there was a 'dramatization of a preoccupation with internal phenomena or inner world reality' (Winnicott, 1958, p. 81). This research study confirms these aspects of the clinical literature, but also adds an appreciation of the ways that these children may retreat into their internal world within the context of the manifestation of intermittent strabismus.

In contrast, the study also speculates that anxiety, once managed, allowed the strabismus to be exploited by the child's use of the 'dominant eye'; thus galvanising the one eye into achieving focus rather than straining to make the two eyes and two images correspond. This was seen as a way of being in contact with the external world.

The study highlights how the strabismus might have a detrimental impact upon the therapist's visual apparatus – 'jazzing' (Gregory, 2009. p. 156). There is minimal recognition within the psychoanalytic or the ophthalmological literature of this phenomenon and, moreover, how this might be understood as a form of somatic counter-transference.

The study suggests that the therapist's visual sensitivity might enable her to find a way of counteracting this potentially detrimental impact, through purposefully increasing the level and intensity of her visual availability.

The study concludes that the therapist's visual availability seemed to help the child achieve coordinated eye contact and therefore became more able to separate the internal world from external reality; thus contributing to the child's emotional coherence. Specifically, this might be by concentrating upon the eye that seems to have more focus or liveliness, in order to offer the child's eyes something to latch on to. The therapist's eyes then become a physical representation of his or her willingness to provide emotional containment to the child.

This study also speculates upon the parent-child relationship. In particular, the context of maternal depression, where there is potentially less opportunity for lively prosody in speech or visual reciprocity. Therefore, this study raises questions about the impact of deficits in environments which otherwise might have compensated for the child's supposed lapse or collapse into strabismus. In order to compensate for potential deficits that may be exacerbating the strabismus, the study shows that it was helpful for the therapeutic environment to emphasise visual reciprocity.

In her clinical paper with 'Arne', a boy who was extremely fragile, Leira (1984, p. 176) was unable to capture the detailed moment to moment changes in the strabismus, admitting that, 'Which eye was squinting at any given time was not possible to assess by general observation'. Leira, however, did not comment on the effect upon her own eyes; a really interesting omission which may have been due to the prevailing theoretical preoccupations. For example, working in the counter-transference may have been less central to her work. Also, important papers concerning the technical use of counter-transference had yet to be published (Brenman-Pick, 1985).

The literature suggested that one of the purposes of therapeutic work (with adults) was to allow the patient to express their experiences of the strabismus, which might involve visual disturbances, in order to differentiate visual disturbance from psychological confusions (Lipton, 1970). It may be that for psychotherapists working with children, especially younger children within a short assessment experience, acknowledging the strabismus verbally might be less possible or appropriate compared to acknowledgment through the therapist's non-verbal behaviour.

The research suggests that the child's ability to coordinate their eyes corresponded with a capacity to explore both their external and internal environment. It appeared that it was less likely that they would have strabismic eyes when they were in a state of mind that was settled, less anxious and able to be free enough to interact in an unimpeded way. During these times, both of the children showed a capacity to appreciate and reflect upon aspects of their environment. The themes imply that these children, who had suffered traumatic separations and emotional deprivations which at times impacted upon their basic functioning, whilst in psychotherapy could coordinate their minds in a way that could apprehend a coherent view of their internal and external world. At these times strabismus was less apparent.

Implications for child psychotherapy practice

The implications of this research are multi-layered. Firstly, the research findings imply that intermittent strabismus can potentially manifest itself as non-verbal behaviour that may have an emotional component. Therefore, fluctuations in eye movements and coordination are worthy of consideration and interpretation within the context of child psychotherapy practice. In this way it can be placed amongst a host of other behaviours that may be interpreted in psychotherapy as having significance in terms of the appreciation of transference and counter-transference phenomena. Ocular behaviour, as far as intermittent strabismus is concerned, could then potentially be interpreted as an unconscious emotional communication about that child's state of mind rather than purely as a random action. Observing and interpreting behaviour is, of course, a central feature of the child psychotherapy training and practice, so paying attention to changes in ocular behaviour may extend and elaborate practice.

This research highlights how, when working closely with children who suffer from intermittent strabismus, momentary physical and emotional sensations might arise that disturb the therapist's eyes, and also possibly her thinking capacities. An awareness of this experience may be exploited if understood as a form of somatic counter-transference. This would be in order to both appreciate the experience of visual disturbance in the child, and to enable the therapist to regain their own coordination. If the therapist's visual disturbance is exploited in this way then it gives the opportunity to have an increased sensitivity to the child's ocular changes. The data suggests that the so-called 'jazzing' (Gregory, 2009, p. 156) effect can have a momentarily disabling consequence. Interpreting this as a counter-transference phenomenon might offer the therapist a more in-depth understanding of the sensory impact of intermittent strabismus, for both the child and the therapist.

The study implies that when this possible counter-transference phenomenon can be acknowledged, it could contribute to an active response from the therapist. It might be specifically helpful, for example, in terms of the therapist's own increased awareness of her own eyes and in establishing visual reciprocity. This awareness may prevent the therapist acting out their own counter-transference, by averting the gaze, and then risking the promotion of shame within the child. It is suspected that the experience of shame has

a profoundly detrimental impact upon neural development and future personality development (Shore, 1994).

The research suggests that, during the manifestation of strabismus, it is possible that the therapist might be perceived by the child as being visually distorted. Therefore, any enhancements that enable the therapist to seem more connected, emotionally and visually, to the child would be an advantage. This study does not offer a prescribed approach but it does highlight the importance of the therapist's eyes operating in a spirit of reciprocity towards the eyes of the child. Lily used her 'dominant eye' to stabilize her vision. The study implies that if a therapist is able to locate the child's 'dominant eye', or perhaps concentrates upon the child's in-focus elements of gaze, then fluency in the child's eyes may be supported. The responsive eyes of the therapist may then non-verbally affirm to the child that the therapist is present; mindfully as well as visually, acting as a bridge between the child's internal world and external reality.

Appreciating that the child with intermittent strabismus might be regarded as having a mild visual disability, which may impact upon the way that he relates to the world, may help a psychotherapist develop a deeper appreciation of the counter-transference and transference in operation. This might be particularly helpful when working with a child with complex relational difficulties, such as the children in this study. The presence of visual distortion that may be associated with intermittent strabismus might have a deleterious and compounding impact upon the quality of their internal world. This may be especially true when the external world had to be avoided due to the anxiety caused by violence and abuse. If the therapist, for example, is distorted in the transference, due to both the possible visual distortion as well as the child's preoccupation with their phantasy life, they may have to work especially hard to emotionally connect with the child. Also, the therapist would need to offer the child experiences of visual reciprocity in order to refute a distorted internal view.

The child whose strabismus might represent a 'collapse' (Hesse and Main, 2000, p. 1) into their internal world, or indeed object-less world, as a result of previous trauma, might require a great deal of sensitivity and carefulness to support them in becoming more visually and internally coordinated. Likewise, the data suggests that when a child is in touch with a sense of internal coherence, the strabismus tends not to be or not seem to be present and therefore has less immediate impact upon the therapeutic relationship.

The themes in this study suggest that child psychotherapists might seriously consider what factors might seem to disturb eye fluency, or promote it, to assist in the development and maintenance of a healthier state of mind.

Possible implications for a wider multi-disciplinary arena

I would consider that this research study might be of some interest to a wider multi-disciplinary arena. For example, to those who are concerned with differentiating autistic eye movements from actual visual disabilities, such as intermittent strabismus.

It is also possible to consider that those involved in supporting children with visual disabilities, such as Nystagamus, might also be interested in exploring the potential for an emotional component in a similar way; though like intermittent strabismus, there is no suggestion of any psychological aetiology.

There is a growing curiosity in the psychosocial impact of strabismus within the ophthalmological community. I think that there would be an interest in this study as it provides an interpretation of the importance of mutual gaze behaviour; something that is often missed within this kind of research.

Given that eight years of age is the generally accepted age of visual maturity, the research implies how important early intervention might be for children who have emotional difficulties and also have a possible problem in managing visual distortion associated with intermittent strabismus.

Implications for further research

The template of themes, in principle, could easily be used to replicate this study to see where the themes might be confirmed or dismissed when applied to new data. It could be utilised as a starting point to generate new thematic explanations of fluctuating strabismic phenomena which occur within the context of psychoanalytic psychotherapy. Additionally, it might be interesting to see whether these themes might differ according to whether the participants are child, adolescent or indeed adult.

It would be particularly interesting to establish an infant observation where an infant suffers from strabismus. It would be interesting to observe the gaze interaction between

the mothers, or for that matter the fathers, and their infants, in order to appreciate how they might (or might not) compensate, intuitively or purposefully, for the disturbed vision. It might be possible then to interview parents and to hear their experiences of their eye contact with their children and to put this data alongside the observations to see where themes correspond.

This study used data from a brief assessment where there was no verbal acknowledgement of the impact of strabismus. There are some suggestions from the psychotherapy literature with adults, concerning various forms of strabismus, which imply that verbal acknowledgement should be aimed for; the lack of recognition was thought to compound the disability. However, it was acknowledged that in the clinical examples this often took several years. This study does not explore this area but I suspect that work with older children in particular might lead to an appreciation of the relationship between non-verbal and verbal acknowledgement of the disability.

A critique of the study

I began this study by acknowledging the challenge of capturing, as data, moments of significance that could be interpreted as patterns of behaviour. So, whilst parts of my analysis involved inference about visual availability (the child's and mine) and I chose interpretations that seemed plausible, obviously there could be other ways of understanding the data. To make my findings more robust, I chose to triangulate the process notes with supervision notes and notes taken from discussion with colleagues.

Child psychotherapy practice involves testing assumptions and inferences of the therapist's perception of the child's internal world, but we cannot assume certainty in this area. An appreciation of the counter-transference, observation of the child's patterns of behaviour, as well as the content of their play, provide some triangulation but assumptions about the child's internal 'private theatre' (Freud and Breuer, 1893 p. 174) must remain tentative.

Whilst I have a personal conviction that the quality of the data conveys the essence of the interaction between the child and the therapist, there is inevitably some regret that that it was not possible to go back and delve a little further and glean more detail for inclusion in the process recordings. It is possible to look at the data and ask what happened in between the recorded observations, or ask what was missed, and this is especially so when

the data is concerning fast eye movements. A recording device of some kind could, in principle, have been set up to track eye movements in the child, but I doubt that it could capture the subtle interactions between the child and therapist. How would a machine capture the flatness of an unfocused eye, or the sparkle in a focused eye? How would it capture the therapist's visual reply? Although inevitably incomplete, written process recordings can capture the thread of meaning that the therapist took from the visual interchange and which continues to inform their work.

So, though it could easily be argued that the therapist's perception of the psychotherapy interchange which informs the writing of the process recordings is inescapably highly individual, it is also within a psychoanalytic context that brings with it general expectations of psychotherapy behaviour and meaning. This tension between the particular and the general is a constant dynamic within psychoanalytic psychotherapy and one which contributes to the organic growth of the profession.

There is no tradition of using a template organising style within child psychotherapy, and rarely within psychotherapy. Nor is there a tradition of using it to analyse observational process recordings; it is usually used to analyse interview transcripts. The method, however, enables a greater variety and delineation of themes as sub-themes can be identified and incorporated within the findings. This is in contrast to grounded theory where the findings are often distilled into a few words and sub-themes are discarded. In some ways this style sits well with observational process recording as it invites the researcher to capture the details, in the form of a theme, of an interaction between and within persons. However, it could be argued that this leads to a degree of complexity. Capturing this kind of multi-dimensional shape is difficult; the experience can be rather like figuring out a visual illusion, such as the Necker cube; it is hard to establish which aspect should be in the foreground and which in the background. As a result, to strive for coherence, the template was analysed well into the period of data analysis. Consequently, there have been numerous drafts of the template, many of which could have made interesting contributions. These were ultimately discarded in order to achieve one comprehensible template that still retained a multi-dimensional view of the area of study.

Template analysis makes it possible to capitalise on prior ideas and properly acknowledge the psychoanalytic frame of reference as a major influence in a way that other methods, such as grounded theory, it could be suggested, do not. Therefore, it could be broadly

argued that template analysis may be more philosophically congruent with psychoanalysis, especially compared to approaches which attempt to modify the open nature of grounded theory.

Template analysis enables the researcher to retain a focus upon the particular interest of the study, in this case, 'How does strabismus impact upon the therapeutic relationship?'. This method therefore offers an element of efficiency as it does not open the researcher to data that, though potentially interesting in its own right, is not relevant to the study. Irrelevant data can therefore be legitimately discarded and does not need to be analysed; though obviously it could be analysed for other purposes.

It is possible that mistakes can be made in the discarding process, for instance in this study it was tempting to discard examples of good eye contact, as this was not the area of study. A decision was subsequently made that this data provided a counterpoint to the area under study that highlighted the impact of strabismus and the context within which it occurred. It drew out a comparison between the child's state of mind and their eye coordination.

In conclusion, whilst it is not possible to generalise about any child or adult with intermittent strabismus from this very small study (or indeed any child with strabismus within child mental health), a number of interesting themes have arisen. These are that the manifestation of strabismus may have an emotional component, and that this could potentially have a significant impact upon the child's relationship with both external and internal world realities. It may have a particularly negative impact upon the transference and therefore the ability of the therapist to offer emotional containment. There may also be a potential for counter-transference phenomena to be expressed somatically through disturbed eye contact. A detailed understanding of the way that the strabismus appears to manifest itself, or not, in psychotherapy, might enable the psychotherapist to specifically adapt his or her behavioural responses to enable increased visual reciprocity in an effort to support the child's visual disability, and thereby offer support for his or her emotional vulnerability.

In this study, the themes that have arisen highlight and elaborate the concepts in relation to intermittent strabismus taken from the field of ophthalmology and link them with the professional field of child psychotherapy. These ideas have been particularly relevant in enhancing the concepts of transference, counter-transference, emotional containment and

the internal world, as they pertain to a child with intermittent strabismus. This, consequently, can assist the child psychotherapist's recognition and understanding of the challenges that intermittent strabismus might bring, and apply them to building a therapeutic relationship within the action of the consulting room.

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APPENDICES

Annotated draft analysis

APPENDIX 1

Sample session with annotations: Lily

Session one: Introductory meeting with Lily and her mother. 20th January 2010

As I was walking past the waiting room on an errand I was greeted by a small face with pigtails, gappy teeth, glasses and an eager face and I realised this was Lily. **[Comment: Lily's eyes are coordinated and she seems happy to see me – not anxious but enthusiastic.]**

I returned to collect Lily and her mother from the waiting room but by now Lily looked withdrawn and I was struck by how very small and thin she was. She travelled down the corridor with her mother but on entering the room she immediately stood still, she remained in the same space, unmoving and frozen on the spot. **[Comment: Eyes are still coordinated but child very anxious.]** Her mother and I had found comfortable chairs but Lily seemed awkwardly lost in the space of the playroom. I spoke to her about the chair behind her being quite big but the chairs near the table were more her size. She still looked unsure and remained on the spot. Her mother brought the chair out for her and tried to reassure her that it was her size.

In an effort to make this more tolerable for Lily we acknowledged that it had been a long time since we had both met and that it might be hard to come here after such a long time. Meanwhile her mother recalled how she used to visit the clinic when coming with her brother and they would play with the 'Connect Four' game (together we were trying to help Lily get connected).

As Lily sat down I commented that the box of toys was for her to play with and I mentioned that there wasn't a 'Connect Four' but other things in there. The box looked so big now and she stared up at it. I took it from the table and put it next to her so that she could see inside it, and meanwhile I commented upon my actions as I did this.

Lily initially peered into the box with her eyes and face, but then suddenly she sat upright looking uncomfortable. **[Comment: Child anxious but eyes still coordinated.]** Her mother continued to speak about Lily's brother and how he had told Lily that 'She would like coming, that there were toys and that she could do colouring'. I added that there were

paper and pens in there. Lily again peered into the box. I said to Lily that she seemed 'unsure about the things in there'. [**Comment: High anxiety and hard to receive efforts of emotional containment. May experience therapist as confirming her fears; that the box contains frightening things.**] (I noticed how the box seemed big and full in comparison to her slightness.) Lily turned away from me but she was still looking into the box. Then I noticed her shooting me a look with both eyes and then her right eye drifted away and her left eye became straighter. [**Comment: Anxiety has mounted and becomes overwhelming. Eyes lose fluency-managing visual distortion by focusing with one eye.**] This felt disconcerting [**Comment: very uncomfortable -impact upon therapist, especially in terms of her visual focus.**] as it was hard to know how and where to focus my eyes in response.

Eventually with continued reassurance from her mother Lily was able to find a pencil from the box – but in a very tentative manner. Mrs X looked very frustrated and puzzled at her daughter. She suggested that Lily could get all of the pencils out at once then she could choose, but Lily resisted this idea and took only one colour at a time from the box. [**Comment: This seemed to symbolise Lily's difficulty in dealing with more than one thing at a time; more than one view or one person at a time. Eyes are by now perceived as coordinated as there is no comment otherwise.**] She then steadily drew a tiny multi-coloured flower to which she added a label which said 'This is a flower'. Then she wrote her full name in 'joined up writing'. [**Comment: The mood had changed and she was able to manage connections better.**]

We then talked about the snow and Mrs X told me that her daughter didn't like the cold and how the boiler had broken down. Lily then joined in the conversation saying that she had slept in Dexter's bedroom. She carefully told me that she had slept in the bottom bunk bed, her mother added that they could only heat one room. Lily's face lit up and she briefly looked at me whilst telling me about this. [**Comment: Sense of reciprocity.**]

Then they mother mentioned that Lily had been seven in December and how they had been to the bear factory with her friends. She asked her to tell me about it; Lily opened her mouth but no words came out. Her mother filled the gap and told me that it was a fox. I asked about the colour and Lily seemed to painfully search her mind, she looked lost again and was unable to remember the colour. 'White' she eventually finally announced

and it had seemed to take forever. ‘Well’ her mother said a little archly, ‘I am pretty sure that it was brown’. Lily nodded, briefly looking up from the drawing to her mother.

Mrs X produced the individual educational plan from her bag and with raised eye brows told me that it had arrived shortly after my appointment had come through, implying that the school had been very slow and unresponsive until now. Shortly after this I spoke about how it might be hard for Lily to know what kind of person I was – that she might think that I was a teacher person. I told her that I wasn’t a teacher but someone who would try and understand what it was like from Lily’s point of view. Mrs X commented to me that she thought that Lily’s class teacher was caring but was incorrect in thinking it was just about Lily having the chance to settle into class, that she had deeper difficulties.

Lily was now writing a line of numbers and her mother noticed this and said how good she was at numbers and added that she always asked for extra sums to do after school. Lily immediately sat upright and looked at me in a very proud fashion and I responded with a look of being impressed. Her mother added that Lily is able to tell her how many letters there are in a word and I commented that maybe Lily was ‘A bit of her own teacher sometimes’. Lily looked at me and made good eye contact as if really pleased with this idea. **[Comment: Childs eyes are coordinated and there is a sense of emotional containment. The child’s sense of her own abilities are acknowledged (she teaches herself) along with her own attempts to contain her anxiety (by being the teacher person and not the unknowing child) in a positive way. Happy to accept exploration of her identity (inner world).]**

I looked at Lily’s numbers and asked her what was the biggest number she knew. She didn’t answer and struggled to make any response. I said that I thought that I had asked her a really difficult question and she responded by returning to her number list. I commented that some numbers might be more special than others – she looked lost – I said that number 7 might be special (her age). Lily didn’t respond to this with any kind of recognition and her eye contact was withdrawn. I regretted my ‘out of tune’ small talk. **[Comment: Therapist is ‘out of tune’ and the child withdraws her eye contact – not clear as to whether her eyes are coordinated or not as they are withdrawn. Theme that doesn’t make it into template.]**

I then said that maybe what I needed to do was some number work with her mother in order to sort out our meeting times if Lily was alright about coming to see me, and that

we could meet for three times? She looked pleased and scrutinised me closely when I said this. [**Comment: Child more contained by ‘analyst-centred’ interpretation and more able to take in therapist with her eyes and her mind. Eyes coordinated as otherwise would be noted.**] Her mother told me that Lily knew about this and was looking forward to coming. We then made the dates, said our goodbyes and ended the session.

APPENDIX 2

Sample session with annotations: Liam

3rd and final assessment session: Liam: April 28th 2010

As I walked into the waiting room I noticed how Liam was faced towards his mother and both were looking at each other in a very intense way. Liam was showing his mother a toy and his face seemed full of expression and in turn I noticed how his mother responded back to him with similar gusto and emphasis. Both wore their spectacles.

When I arrived at where they were sitting, there was little response to my arrival, and neither looked up at me. I smiled and said 'Hello' and Liam's mother smiled back in a halfway glance that seemed to strain to acknowledge me and certainly avoided a proper connection with me. Liam seemed to try not to acknowledge me and his face seemed uncomfortable, and then both focused their attention upon a book in front of them. I explained that we could start and that my co-worker would be on her way soon. Liam hesitantly looked at me and said 'Same again' and I said 'Yes, same again, just like last week'. Liam turned to his mother and said 'See another one' and she grunted a 'yes'.

As we walked down the corridor I acknowledged that his mother would see the other lady called X and he nodded. Liam then sped into the room and once getting inside he did a small but emphatic and exuberant jump, 'Yes, we are back' I confirmed to him. Liam then looked up at the clock and observed it intensely for a few moments and I spoke to him gently about how much time we had got today. I took my hand to the clock and traced the path of the big hand until the end of the session at 12:20pm. Liam seemed satisfied with this and turned to his box. He found the cow and rested it on top of the box and he pointed it towards me saying 'It was nasty'. I said that 'I was the one to be scared of that cow' Liam found a second cow and put them together. Then Liam turned his attention to the stable and asked me to put it up for him; 'Put it up, put it up' he said in an insistent way. I felt that he perhaps didn't easily have the capacity in terms of understanding or vocabulary to ask in a collaborative way. I put it together and whilst doing so described my actions to him. He picked up the cows and put one in each stall and then told me that there were five cows, I had a slight question in my voice and Liam picked up on this and began counting them; one, two, three, four, five, six, seven, he said 'Oh, lots of cows' and returned. He then counted them again more slowly and counted four (there were actually

three). He then looked at the cows more carefully again, registering that he might have it wrong and he then counted the correct number of cows. He repeated this again but this time found a fourth cow to add to the three and now was able to confirm that there was in fact four. 'Ah, four cows' I exclaimed.

Liam then began looking for more animals and found several in his box. He particularly looked for the tiger and asked for the baby tiger; however he eventually found it himself. He lay on the floor looking at the tiger then up at me and he talked in muffled tones about the tiger and looked up at me with good bright eye contact. [**Comment: Momentarily sense of emotional containment and good eye contact. Moment of reflection in relation to baby tiger.**]

I then became aware that his spectacles had slid off his nose slightly and I noticed how his right eye turned inwards. [**Comment: Lapsing into strabismus and visual distortion corresponding with preoccupation with a violent internal world.**] Liam found all of the tigers and told me that 'They were coming to bite me'. I replied by saying that 'Ooh those tigers are going to get me'. Liam then roughly put the tiger on my lap and he vocalised that they were 'biting me'. The 'tigers' bit my hands and I became a little concerned that this might spill over into something more real. The tigers 'bit' my 'face off' and again I was concerned that I might be actually attacked. 'Oh, I've got no nose or eyes' I responded, 'or mouth' he added. I said that I was to be 'all bitten up'. He carefully looked at me then back down at the tigers and then have the mother and baby tiger interact with each other a mildly aggressive way.

Suddenly Liam looked up at me and then to the clock, he saw that it was twelve noon and he looked delighted and pointed at it then looked at me and then back at the clock face and told me that it was time to finish. He looked at the clock in a fascinated way and he was clearly pleased that he had worked something out about time and how it was represented through a clock. [**Comment: Good contact with an ordered external reality.**] I gently said that he was right that last week we had finished at twelve noon, but this week we had started later so we now had twenty minutes left today and I pointed to the position on the clock. Liam looked a little unsure for a moment and I worried that he might insist on leaving but he settled. I spoke to him about how there was a Liam that was very interested in knowing about clocks and time and how it all worked. He looked up at me and then back to the tigers and resumed the aggressive play, the tigers 'bit my

fingers off". He used the tiger to bite my fingers off one by one, and I dutifully folded my fingers back in turn. His attention turned then to my arm and this was 'bitten off'.
[Comment: Aggressive play but no comment about eye contact.]

Liam looked at me with a menacing grin as if some nasty thought had just occurred to him. He turned to me and said that he would tie my hands up, however he found the glue stick and told me that he would 'stick my hands up'. He roughly swept my hand up and plunged it into the glue stick. I told him that he could pretend to glue my hands however he was rough and insisted that he would 'really glue' my hands. He once again pushed the glue stick into my hands and then pushed my hands together and laughed. I spoke to him about how he wanted to be sure that I was all stuck up. He then forcibly attempted to smear my hands with glue and a slight scuffle ensued. I spoke in a firmer louder voice and said that he didn't want to pretend but I would take the glue stick away if he continued. He retained the glue stick and walked away momentarily before returning to again attempt to push my hands together to be stuck. I straightened up a little more and found a firm but playful voice and said that 'I'm to be the one that is well stuck up and can't use my hands at all'. Liam seemed more satisfied with this and he moved away to the animals.

'Where's the fat-gobbed one?' he asked of me. 'Hippo' I suggested and pointed to it. He found the hippopotamus and inspected its mouth for a few moments and then moved his interest to the box and found the large crocodile there. He asked me to close my eyes and he became insistent on this, especially when I only half closed them. We seemed to reach a compromise by my shielding my eyes. He placed the large crocodile on my lap and then told me to open my eyes. I pretended to be surprised and worried. Liam wanted to keep repeating this and each time he looked deeply into my eyes and face and delighted at my responses. [Comment: The child's eyes are working in unison, or perceived as by the therapist, and the child's emotional state may be more easily contained. This may correspond with the therapists active attempts at emotional containment by using her visual availability.] Soon his interest receded and he became preoccupied. I noticed how his eyes had seemed strong and focused whilst looking at me but now as he became preoccupied with his own ideas his eyes lost their coordination and his right eye drifted inward. [Comment: Lapsing into strabismus and visual distortion corresponding with preoccupation with internal world.]

Liam then asked where the 'fat-gobbed one' was though I could see that it was directly in front of him. I asked if he could see it but he seemed convinced that he couldn't and vaguely looked around unable to see the animal that was actually in his visual field.

Liam then became attracted to the telephone that was in the box and began ringing it and asking me to answer it. I said 'ring ring' and just as I was going to answer it he put the phone down and this was repeated several times. It was as if we just couldn't get connected and kept missing each other and I spoke to him about this. It registered within me a sense of frustration and at that moment we became connected and had a simple conversation. 'Hello, who's that?' 'It's Liam' and then he put the phone down.

After a little while he moved back to the box and said 'let's play Santa' and his face brightened. I pointed out that we only had a few minutes left today and I pointed to the clock as I spoke. Liam continued with his play bringing two large boxes and putting them on my lap. I had to first 'wrap them up' then I could open them. I said 'Oh, look what Santa's brought me' and I opened up the box to find a small toy inside. This was repeated several times and Liam observed me carefully. I tried to talk to him about how today I had had a scary surprise of crocodiles on my knee but I'd also had lovely Santa surprises. He didn't seem to be taking this in. I then had to talk to him about how it was time to say goodbye now as we had met for three times and that is what we had agreed. Liam seemed to accept this and joined me in packing the things away and saying goodbye.

Liam returned to his mother who met his eyes and they greeted each other warmly. Again his mother's eyes were largely obscured by her long hair and also her spectacles and she to avoided direct eye contact with me.