Encounters in the Claustrum: An exploratory study of the Claustrum in contemporary Psychoanalytic Child and Adolescent Psychotherapy

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Abstract

Clinical encounters involving the Claustrum are complex, elusive and often feel almost impossible to decipher. This qualitative study explores how Child and Adolescent Psychoanalytic Psychotherapists experience clinical situations in which they feel that Meltzer's concept of the 'Claustrum' (1992) is helpful in understanding the patient's internal world.

The literature review explores the place of the Claustrum within contemporary Child Psychotherapy and the experience of clinical encounters with hard to reach patients. The study's methodology is Thematic Analysis. Data was gathered from semi-structured interviews from members across the Association of Child Psychotherapists.

Four themes were devised relating to the participant-clinicians' clinical experience and thinking. These were Symbolic Representations of Phantasy, The Therapist's Experience, Knowing How to Respond, and Clinical Practice and Clinical Theory. Clinical experience is viewed as paramount in making sense of Claustrum encounters. These clinical experiences include the counter-transference as containing a particular quality of inclusion and exclusion, the Claustrum as one aspect of the patient's presentation, clinical theory as helpful but secondary to clinical experience and its integration within one's clinical thinking.

This study includes various examples of Claustrum-like clinical encounters which may facilitate further discussion amongst colleagues about this clinical phenomenon. The Nowhere Place featured as an aspect of the both the patient and therapist experience

of the Claustrum. The clinical implications of the study include that a sensitivity to clinical technique is paramount until more sophisticated stages in a treatment, and how dream analysis can help illustrate the Claustrum experience.

The study also captures an experience of an aspect of the Tavistock's tradition of Child Psychotherapy training regarding Meltzer's continued influence on it. Personal experience as a Child Psychotherapy trainee and working with Claustrum-like patients allows reflexivity as a clinician-researcher.

KEYWORDS

The Claustrum; Meltzer; hard to reach patients; intrusive projective identification; Post-Kleinian; counter-transference; The Nowhere Place

WORD COUNT 300

Declarations

I declare that the content of this research is all my own unaided work and that ethical approval has been granted by TREC. Confirmation of this approval is in the appendices.

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Acknowledgments

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And finally I would like to express gratitude to my husband for being a part of the experience.

Chapter 1: Introduction

Background of Study

My study began with my interest in how to make contact with hard to reach children, because this was a dilemma I was faced with in my clinical work as a Psychoanalytic Child and Adolescent Psychotherapist in Doctoral training. My service supervisor was interested in the Claustrum (Meltzer, 1992) and they introduced me to Meltzerian thinking.

In these early stages of the training I described the work with several hard to reach mid-latency males as being with children who were 'on the ceiling'. I suppose it did not help that the room I practiced in had a big metal cabinet within, which a child if stood on their tiptoes, could indeed touch the ceiling which I suspect for these children was extremely tantalising.

As I was introduced to the Claustrum and its compartments (Head Breast, Genital, Anal) I began to think of how my patients seemed to be attempting to get inside the internal maternal object in an intrusive way. With these ceiling patients, Meltzer's description of "[T]he boy, in his masculine projective identification with this phallus must be big, muscular, powerful" (Meltzer, 1992, p. 88) seemed to make sense to me clinically. At the time I was also encouraged to read Racker to understand something of the background of the Claustrum experience. Racker observed a therapeutic experience that contained attacks that are "from above downwards" and where

> "[T]his situation is felt [for the patient] as an intense persecution, since according to the degree in which the patient admitted this relation, he himself felt poor, subjugated, and even destroyed" (1968, p. 82).

This seemed to match something of what I was observing with these patients: how they easily felt persecuted after their phallic act, and how attacking it felt towards me in my counter-transference.

I then began seeing an early adolescent child intensively. The clinical encounter was a difficult experience for me, and the usual places where a Child Psychotherapist might find help in their work seemed not to really help me, something echoed by the participants. In supervision we noticed that the clinical work seemed to be more akin to infant observation, where "the central tool is an intimate, one-to-one personal contact whose transactions subjected to self-reflective thought of a meticulous a nature as possible" (Rustin, 1989 p. 54). The clinical experience certainly did not feel like child psychotherapy in the way I was learning about it in seminars and workshops, yet the experience in itself did feel therapeutic. It was only later, when the work ended, and we began meeting at a less intensive frequency, that the Claustrum (something that was never discussed in supervision) seemed to emerge as something relevant to the experience.

This patient seemed to be helped by on-going contact with me, and now seemed to be outside the Claustrum. Whether the experience of being seen intensively ushered in their Claustrum states of mind, I do not know. Yet, like some participants observed, experiences of early trauma, maternal neglect and intergenerational deprivations were part of this patient's psychic experience. It is likely that they entered the therapy with Claustrum states of mind already firmly entrenched and that perhaps they needed the

therapy to facilitate an opportunity to address this problematic part of their internal world.

These early experiences in my training ignited my interest in the Claustrum. I wonder if my difficulties in working with these types of patients facilitated an interest and perhaps a desire to explore with others their experiences of working with such patients? Reflecting back I think it is likely that these experiences led me to devise this study.

Continued Meltzerian thinking in the Tavistock Child Psychotherapy training

A by-product of the study was that I developed an interest in how Meltzer's work continues to be important in the Tavistock tradition's training of child psychotherapists. In my Tavistock pre-clinical studies, we read several Meltzer collaborations such as "A psychoanalytic model of the child-in-the-family-in-the-community" (Meltzer & Harris 1976) and "A One-year-Old goes to Day Nursery – A Parable of Confusing Times" (Meltzer & Gelati, 1986). These papers give an impressive view of the importance of psychic experiences for the development of psychic life. Then, during the clinical training (first term of the theory seminar in year 1) we read "The Gathering of the Transference", published in Meltzer's seminal book, *The Psycho-Analytical Process* (1967). This left a deep impression on me. During the latter part of the training, I experienced substantial contact with his ideas through a half term of weekly theoretical seminars, focusing on his contributions through the reading of a wide variety of his most seminal papers. This seminar is taught by a previous analysand of Meltzer, Dr Alberto Hahn (personal communication, February 2019). Dr Hahn brings students in direct contact with the Klein lineage, and particularly with the post-Kleinian Meltzerian

tradition. I include these because they illustrate how valuable Melter's work continues to be in the Tavistock tradition of training of Child Psychotherapists, and how pivotal these experiences were for me. Meltzer's continued influence was observed by Rustin (2016) and I know from my experience that it has impacted on my own development as a Child and Adolescent Psychotherapist. Without these experiences it is also unlikely that I would have developed such interest in Meltzer's ideas and developed this study.

What is the Claustrum?

Meltzer attributes the beginnings of Claustrum thinking to Klein in relation to her patient descriptions of claustrophobia (Klein, 1932, p. 242) and to his own case work as well as that of Doreen Weddell. He expressed that these experiences "awakened my imagination to the qualities and meaning of the world inside an internal maternal object" (1992, p. 52). Yet the actual meaning of the Claustrum itself is obscure which I think mirrors the clinical phenomena of the clinical experience.

Oxford Reference delineates that claustrum is "Old French from the Latin *claustrum*, *clostrum* 'lock, enclosed place', from *claudere* 'to close'." (Oxford Reference, 2021). The definition of the claustrum as something locked and inaccessible is well established. In the neurosciences the Claustrum is

> "a thin, irregular, sheet-like neuronal structure hidden beneath the inner surface of the neocortex in the general region of the insula. Its function is enigmatic. Its anatomy is quite remarkable in that it receives input from almost all regions of cortex and projects back to almost all regions of cortex … You are not aware of

> isolated precepts, but of a single, unifying experience." (Crick & Koch, 2005, p. 1271).

The Claustrum then is a dynamic albeit obscure phenomenon. In this way, these neurobiological findings are similar to the clinical experience of Claustrum-like patients whose psychic lives reside within a particular hidden internal structure (insula), which is obscure and takes in all life experiences only to project them back out again. The therapist is left unaware of these isolated experiences but instead, when the Claustrum is most at work, feels a unifying experience which indicates that Claustrum states of mind may be at work. The Claustrum, according to Meltzer, includes modes of entry, the inclusion of masturbatory phantasies that lead to omnipotence, criminality and the idea that the intruding part of the personality experiences anxieties that are uninvited, and that chiefly concern intrusion into the maternal object (1992, pp. 71–72).

The Study

In this study I am interested in increasing an understanding of how clinicians find Meltzer's concept of the Claustrum helpful in understanding the patient's internal world. The interview questions were set to explicitly seek out in a predetermined way clinical experiences of the Claustrum to increase the understanding of clinical experiences which bring this clinical phenomenon to mind.

The study begins with a literature review, Chapter Two. I describe how the methodology arose and some of the dilemmas psychoanalysis faces in using the single case-study method. I then describe the main features of Kleinian psychoanalytic theory and include a vignette from my own infant observation to illustrate the processes of introjection. From introjection we move into considering Bion and

Meltzer's developments of projection, leading into Meltzer's construction of the Claustrum. The chapter also presents Meltzer as an immense clinician and how he influenced the Tavistock tradition of Child Psychotherapy, and his views on the Aesthetic experience and the Arts. Next the place of the Claustrum in relation to clinical practice is explored with a review of pertinent publications mostly centred on child analysis but includes adult psychotherapy papers and publications related to the Arts. In this chapter I begin the process of laying out what is known about the Claustrum through the single case-study method. I present a review of case studies which as data can be viewed as mini case studies within a clinical discourse.

This is followed by a description of the methodology chosen to study the clinical experience described above in Chapter Two. In Chapter 3, Methodology I include an assessment of the interviews, data selection, coding and reliability and verification issues, along with an examination of the meaning of the shared characteristics of the clinician-participants and clinician-researcher and ethical considerations I faced. The second stage of the study contains the analysis of data and outlines the application of Thematic Analysis (TA) to code and categorise the various properties that emerged from the clinical data. A discussion of why TA was chosen as the methodology over other approaches is included.

The next chapter, Chapter Four, features a microanalysis of the data, from which I derived four themes: Symbolic Representations of Phantasy, The Therapist's Experience, Knowing How to Respond, and Clinical Practice and Clinical Theory. There are 11 sub-themes that are explored in relation to these main themes.

The final stage of the study is described in Chapter 5: The Discussion. This chapter explores several areas of the participant's experience in relation to the relevant

literature. These areas include implications for technique; the therapist and the patient experience of inclusion and exclusion and how these can be considered as pivotal in Claustrum experiences; what internal life was observed to be for Claustrum-like patients; theoretical conflicts; and the counter-transference experience. This chapter also outlines the study's strengths and limitations and potential areas for future study. Chapter 6 offers a conclusion to the study and includes a personal reflection on the process of conducting it.

Hopes

My hope for the study is two-fold. I hope that this study generates further interest in this fascinating area of working with hard to reach patients, where considering the Claustrum may help illuminate perplexing or difficult clinical experience. It may lead to opportunity to participate in a clinical discourse about the Claustrum and to perhaps locate how and when thinking about the Claustrum could be used as something helpful as part of one's personal clinical toolbox.

My second hope is to capture an aspect of the Tavistock's tradition of Child Psychotherapy. I think this study gleans something of this experience through the participants observations of the uniqueness and individuality of the Tavistock Child Psychotherapy and what this training champions. Namely, the focus on learning from experience (Bion, 1962) and the primacy of the internal world (Meltzer, 1992b) that follows on in the post-Kleinian thinking and is valued as central in our work with all our patients.

A note on confidentiality

Great care has been taken to disguise clinical material, both the participant's and my own throughout the study to protect anonymity of patient and therapist. In a field as small as Child Psychotherapy, this is at best an effort, one that I have undertaken not only to comply with the ethics of the research project but also to respect my colleagues who have shared their experience so openly in the service of helping to make clear a phenomenon as recondite as the Claustrum in service to future generations of Child Psychotherapists.

Chapter 2: Literature Review

The aim of this chapter is to review the relevant literature that grounds the Claustrum in the practice of contemporary Child and Adolescent Psychotherapy in the post-Kleinian tradition. This necessitates reviewing relevant literature but also extends to exploring Donald Meltzer's own personal history, his contributions to the practice of psychoanalysis and the Arts, and his influence on the Tavistock Centre's training of Child and Adolescent Psychoanalytical Psychotherapists (CAPPTS). The literature review includes a narrative of Meltzer's impact on psychoanalysis which is relevant as this is an empirical study. The study attempts to capture something of the participants' experiences and in doing so also presents an account of the historical impact of Meltzer to the contemporary practice of Child and Adolescent Psychotherapy and beyond.

The chapter begins with describing the literature review process. The second part of the literature review outlines the development of an understanding of unconscious phantasy and of projective identification (as an aspect of unconscious phantasy) in the post-Kleinian tradition. I then outline Meltzer and Bion's development of Intrusive Projective Identification. Next I present an overview of his influence on the Tavistock tradition of Child Psychotherapy. I then chart Meltzer's development of the Claustrum.I include Meltzer's contribution to thinking about the Arts. The final section of the review describes how CAPPTS have utilised Meltzer's ideas about the Claustrum in their clinical encounters. It includes a summary of adult psychotherapy clinical papers and papers on the Arts.

Literature Review Activity

The literature review supports the study's interest in exploring clinical experiences, and the relationship between clinical experience and psychoanalytic theory. I devised a literature review utilising a three-pronged approach. I conducted two literature reviews using databases that specialise in psychological and psychoanalytic literature, namely APA PsycINFO® and PEP Archive. I have only included resources related to Child Psychotherapy and adult psychotherapy and commentary on the Arts. I omitted any resources where there were only abstracts available for, or which were not published in English.

I also searched the Tavistock Centre's library database to locate any unpublished lectures or resources stored in the library's archives. I also reviewed the Journal of Child Psychotherapy archive for any publications I may have missed through the other search means. During the interview transcribing activity I noted down any resources the participants mentioned and I sought them out and reviewed them.

I collected papers, chapters and books, along with noting down any ideas I had, or had received from colleagues of what resources could be relevant to the literature review during the lifespan of the study. I also purchased and downloaded as much of Meltzer's published and unpublished work, and any books written in tribute to his work that I could.

Psychoanalysis and the case–study method

Psychoanalysis has a long history of utilising single case studies as a source of understanding clinical material. For example, Freud (1896, 1900, 1909, 1911, 1918). In recent Child Psychotherapy research, the support for the continued use of the case study method has been advocated by Rustin & Rustin (2019), Philps (2009), Midgley (2006), Rustin (2009), Shallcross (2012) and Lush (2011). One of the case – study method's biggest proponents is Michael Rustin. He believes, in accordance with the methods of psychoanalytic enquiry, of the idea of the consulting room as the psychoanalytic laboratory. Within this laboratory the creation and maintenance of the consulting room by the analyst includes an experience of analytic space. Within this space the conditions for unconscious mental phenomenon arises between the patient and analyst. It facilitates an opportunity for these experiences to be *studied* by the analyst through the therapeutic endeavour (2019, p. 30).

In contrast to this, Fonagy argues that psychoanalytic practice has many inherent limitations in considering it to be a form of research. He suggests broadly that the way to improve child psychoanalytic therapy research would include working across the disciplines such as with psychiatry or neuroscience, and to produce evidence-based studies (Fonagy, 2009, p.29).

Through my increasing clinical experience, I find it more meaningful to orient myself to the idea that psychoanalysis is indeed on-going research within the consulting room despite any limitations. Therefore the literature review is aligned with the idea of the consulting room as a laboratory and is situated in the tradition of the case - study and

single - case study method. Rustin advocates that the single - case study method is apposite for psychoanalytic enquiry because “research methods need to be appropriate to their objects of study” (p.6, 2019). In the study I bring together clinician-participants’ experience with patients illustrating Claustrum material (see Results chapter). This shares a close relationship to the literature review where I bring together the author–clinician’s experience with patients through published literature that illustrate Claustrum-like material. In the few published clinical case studies I discovered, all of which have been published in clinical journals or books, there is no qualitative or quantitative studies on the Claustrum. This type of literature review has more in common with the tradition of a themed journal.

The Literature Review

Unconscious phantasy

Freud’s writings about fantasy occur largely throughout the first twenty years of his work (Freud, 1908, 1911, 1916-17; Bott Spillius, 2001, p. 361). Klein considered herself a close follower of Freud, yet she was clear when she was diverging from his line of thought (Klein, 1945, p.415; 1958, pp. 237-239). Klein’s developed the concept of unconscious phantasy as distinct from Freud. Bott Spillius and colleagues write:

> Freud introduced the concept of unconscious phantasy and phantasying which he thought of as a phylogenetically inherited capacity of the human mind. Klein adopted his idea of unconscious phantasy but broadened it considerably because her work with children gave her extensive experience of the wide-ranging content of children’s phantasies. She and her successors have emphasised that phantasies interact reciprocally with experience to form the developing intellectual and emotional characteristics of the individual;

> phantasies are considered to be a basic capacity underlying and shaping thought, dream, symptoms and patterns of defence (2011, p. 3).

Klein constructed a model of mental functioning that includes an emphasis on unconscious phantasy, projection, introjection, the super-ego, symbol formation and the defences of splitting and idealisation. Klein was concerned about how early relationships, along with one's constitution and experience in the external world shaped one's psychic reality. She viewed unconscious phantasy as principal to her understanding of psychic life and that unconscious phantasy underlies all mental processes and activities from birth. Unconscious phantasy is a central tenet in Kleinian psychoanalysis (e.g. Klein, 1959).

There is a particular emphasis on unconscious phantasy in Klein's early papers (e.g. Klein 1921, 1931, 1936). While she never defines what exactly unconscious phantasy is, descriptions of unconscious phantasy are found in most of her writings. Her lack of explicitly defining unconscious phantasy closely links to how her model of psychic functioning is essentially phenomenological in the broad sense of the term in regard to being concerned with the study of an individual's lived experience.

Hinshelwood addresses the ambiguity of what Kleinians understand unconscious phantasy to be in *A Dictionary of Kleinian Thought* (1991). In 2011, Bott Spillius *et al*. ambitiously undertook updating Hinshelwood's definitive text and in *'The New Dictionary of Kleinian Thought'* they list unconscious phantasy as the first entry and clearly map out its meaning, history and use.

They note:

> In Kleinian theory unconscious phantasies underlie every mental process and accompany all mental activity. They are the mental representation of those somatic events in the body that comprise the instincts, and are physical sensations interpreted as relationships with objects that cause those sensations. Phantasy is the mental expression of both libidinal and aggressive impulses and also of defence mechanisms against those impulses. Much of the therapeutic activity of psychoanalysis can be described as an attempt to convert unconscious phantasy into conscious thought (Bott Spillius *et al*., 2011, p. 3).

The Controversial Discussions

Klein's views were seen as radical by members of the British Psychoanalytic Society. Over time, Klein and her followers found themselves under mounting attack by members of the Society. The basis of these was that Anna Freud took the position that psychoanalysis and a true transference were not possible with young children. Children were seen to still be tied to their parents; she advocated instead a supportive and educational stance King & Steiner, 1992). Klein, in contrast argued for a neutral interpretation of the child's play, not dissimilar to the work with adults, and she believed transference was possible with children. There were criticisms made on Klein's views on unconscious phantasy, the early Oedipus complex and early object relations.

Disagreements within the society culminated with a series of monthly scientific meetings in 1943 now known as the "Controversial discussions" (Bott Spillius *et al*.,

2011, p. 286). The history of these events is mapped out in *The Freud – Klein Controversies 1941-45* (King & Steiner, 1992).

During the Controversial discussions Susan Isaacs presented a paper 'The nature and function of phantasy' (1948). This important paper contained a convincing argument of the importance of unconscious phantasy in the psychic life of children. It defines and catalogues the characteristics of unconscious phantasies. At the end of her paper, Isaacs gives a summary of her thesis with some points on the related evidence (observational studies, clinical studies, etc.). Out of the eight main points, five are relevant here:

a) Phantasies are mainly *unconscious*, the primary content of unconscious mental processes.
b) Phantasy is *psychic reality*, the mental representative and corollary of instinctual urges, which cannot operate in the mind without phantasy.
c) Freud's postulated *'hallucinatory wish-fulfilment*' and his '*primary introjection*' are the basis of the phantasy-life.
d) Phantasy is the *subjective interpretation of experience.*
e) Phantasies become elaborated into *defences* early, as well as wish-fulfilments. (Isaacs, 1948, p. 96).

In the paper, Isaacs gives an account of an eighteen-month-old child who was terrified by the loose sole on one of her mother's slippers. The child screamed in terror or moved away from her mother when her mother approached her wearing the slipper. At age two years and eleven months, the child succinctly described to her mother her

terrifying phantasy that the slipper would eat her. Isaacs illustrates through this clinical example that earlier the child had a primitive oral phantasy of being incorporated by the mouth of the dangerous slipper, but later the child is able to symbolise the experience, that is, put into words her anxieties about it (Isaacs, 1948, p. 85). Importantly we learn from this clinical example how an infant experiences objects as completely real, concrete, and not as imagined phantasy (Hinshelwood, 1994, p. 34). In addition, Isaacs delineates 'ph' to represent unconscious phantasy and its imaginative aspects and 'f' to indicate conscious fantasy, which is a significant development.

Ogden, in his paper 'Reading Susan Isaacs: Toward a Radically Revised Theory of Thinking', emphasises that Isaacs's paper is not only revolutionary in its emphasis on unconscious phantasy as being a central tenet in mental life; but that she also proposes a new model of psychic life: that phantasy is a process that creates meaning. Expanding on Isaacs, he advances that phantasying generates not only unconscious psychic content, but also constitutes the entirety of unconscious thinking. He proposes that the transference relationship between patient and analyst, a relationship that is considered a symbolic expression of internal object-relationships stemming from infancy and childhood, can facilitate the patient to experience, for the first time in relation to the analyst, an emotional situation belonging to the past that was too disturbing to be experienced at the time (2011, p. 930).

Phantasies of Mother's body

For Klein, infant phantasies were ubiquitously concerned with the mother's body and its contents (Bott Spillus *et al*., 2011, p. 364). These phantasies included getting into

the body, attacking it, being attacked by it, and phantasies of what is inside. Klein's ideas were formed through her observations of the play of young children whose phantasies often involved sadistic and aggressive attacks on the mother's body, accompanied by fears that the child will be retaliated against for these phantasies (Klein, 1930, p. 209). She observed, like Isaacs, that these phantasies in the child's mind are perceived as psychic reality.

Introjection and Projection

The processes of projection and introjection are also important tenets in Kleinian thinking. Projection in its simplest form relates to the general mental mechanism of transferring something unbearable from self to the other (Bott Spillus *et al*., 2011, p. 455). Klein describes the process of introjection as leading to the beginning of a mental and bodily experience. From clinical observation, Klein understood that the infant was concerned with bodily states. When the infant's communications are met with an inaccessible mind of their mother these communications locate into the mother's body. Klein believed that in the infant's phantasy, the infant can enter into their mother's body to control, deplete or torture her. In 'Object Relations in Clinical Practice' Joseph notes that "from the beginning of life; the impulses a child felt towards his object were projected into the latter, and the object was then taken in, introjected, as coloured by these projected impulses" (1988, p. 628). Introjection in this way includes both good and bad experiences, and both processes can be used as defences against anxiety (Klein, 1946 p. 6).

Infant Observation: an example of projective and introjective processes

Close observation of infants has revealed that phantasy does go on in their minds. For example; during my pre-clinical training I observed Alice at 6 weeks old attempt to conjure up the feeling of being with her mother when she woke after a nap.

> *Alice begins to move her left arm, raising it slightly as she wakes. She opens her mouth and protrudes her tongue out a few times. She forms a fist with her left hand and begins to raise it to her mouth. She opens up her mouth wide but cannot seem to get it in. She does this three times, each time opening her eyes wider. She then looks to the side of the bassinet and fully opens her eyes. She moves her eyes side to side while breaking out into a big smile.*

This observation, during the transition from sleep to wake, perhaps illustrates an infant phantasying about its mother's presence. Phantasies such as these, promote a feeling in the infant that the mother can be concretely located inside them (Shuttleworth, 1989, p.33). Perhaps Alice attempts to manage a state of aloneness through a phantasy that she can arouse the good, content feelings she has when she is indeed with her mother.

Perhaps she attempts this by bringing her fist to her mouth to have something to latch onto (in the absence of the breast). When she fails, she compensates for this by fixing her eyes on the side of her bassinet. She uses an experience of adhesively sticking to the object with her eyes as an aide to wake fully and tolerate being alone. She can do this through her feeling of an internalised mother presence. Her internalised maternal object, even at this young age, is built upon countless other prior introjective processes she has had since birth.

Outside of the nursery and inside the consulting room we observe that introjective processes occur when the child takes in helpful thoughts and experiences. This leads to what is described by Miller as a modification of pathological content of children's phantasies (1983, p. 135) through the therapeutic encounter. Both projection and introjection are intrinsic to all human relating and contribute to the development of one's internal world.

Projective identification

Differences between projection and projective identification are subtle and subject to some debate. Sometimes projective identification is not wholly understood and is used interchangeable with projection, however there are quite crucial differences between projection and projective identification as psychic and concrete processes. For example; with projection the therapist might feel "no I am not feeling" whatever might have been levelled at them by the patient. While with projective identification the therapist might feel confused or angry, or some other feeling that they have to disentangle. A projective identification communication gets inside the therapist in an insidious way (M. Lush, personal communication, February 3, 2021). In this study, I use projective identification in the way Klein considered it and was further developed by Bion and Meltzer.

Projective identification processes contain two mechanisms, the projective phenomena and the identificatory phenomena (Meltzer, 1986, p. 50). Projective identification is a defensive process where aspects of the self are split off and located in the object. This split off process frees the self from an unwanted disturbance of a

feeling or impulse. The object instead feels the effects. Projective identification phantasies involve projecting into the object in order to maintain a hold over it. The projection of any part of the self into an object is also a denial of a part of the self. The projecting serves to reduce psychic pain in the hope it will be managed by the object (A. Hahn, personal communication, July 24, 2019). The self inevitably becomes anxious of a retaliation due to these split off aspects of itself into the object. This activity communicates a state of mind.

Post – Kleinian development of projective identification: Bion and Meltzer

Bion and Meltzer, both followers and analysands of Klein, further developed her views of projective identification. Bion achieved this initially from group work and through the work with psychotic patients. Meltzer developed his ideas primarily from his work with children and adolescents, and also from observations of narcissistic patients.

Bion

In 1959, Bion described differences between normal and pathological projective identification. He observed how internal disturbances can lead to a breaking of links. The breaking of links disables the ability to think: to put thoughts together and to communicate, and it relies on the use of excessive projective identification. Bion illustrates how the force of these projections can cause the analyst to engage in counter-transference enactments. He stresses the need for the analyst to be aware of this occurrence in order to be free from the grip these intrusive projections can have on the analyst's mind. In doing so, it promotes an ability to regain the capacity to think.

Later, he describes a particular type of a violent projective identification process whereby projected unwanted aspects of the personality lead to the creation of “bizarre objects” (Bion, 1962, p. 11). These bizarre objects are menacing and particularly persecuting, even though they are now located outside of the self.

In 1962, Bion developed a model of thinking: container/contained. In this model the infant’s capacity for development of thought is dependent on the mother’s capacity for reverie. He describes reverie as the ability of a caregiver in being in a state of psychic receptivity of the infant’s communications. The caregiver, through this process, takes in these communications, and through their psychic capabilities can make sense of them and then offer them back to the infant with an experience of being understood. This ultimately leads to the infant experiencing a process of containment. Containment mitigates the reliance on projective identification to communicate distress. In this absence of containment the infant utilises a hypertrophic projective identification, which is a process of looking for a place, a container, to put things (Bion, 1962a).

Meltzer

Meltzer observed that some experiences of projective identification are felt in the analyst as a massive intrusion. Like Klein he thought that in phantasy the analyst represents the maternal body. Initially described as massive projective identification (1967) Meltzer later modifies this experience to be intrusive identification (1992). Intrusive identification is dependent on the quality of the patient’s phantasy of getting inside the internal maternal object. Meltzer, in accordance with Bion, also believes that

this intrusive identificatory process serves as a container, however for Meltzer it is a disturbing container. He suggests that intrusive identification should only be reserved for a pathological function of projective identification. Meltzer proposes that the term projective identification could then be reserved for a Bionic use of projective identification; one that is concerned with the primitive and largely unconscious mode of communication which is central to learning from experience (Meltzer, 1986, p. 67). Learning from experience is the bedrock of making sense of emotional experiences (Bion, 1962).

Meltzer noticed that the process of projective identification with internal objects was at least as important, if not more important, in developmental processes, than identification with external objects. He advanced that the process of intrusion inside the object was not always an active intrusion. In *The Claustrum* he describes how the phenomenology related to projective identification is divided into various dimensions: the dimension of internal/external objects that are the object of identification; the dimension of the differentiation between the identificatory part and the projective part; and the dimension of its occurrence as an active intrusion or a passive enveloping or swallowing up (Meltzer, 1992, p. 3). The ways which a person uses projective identification communicates something pivotal about the individual's state of mind and their internal objects.

Meltzer's Contribution as a post – Kleinian Thinker

Meltzer's influence spanned both child and adult psychoanalysis. He worked primarily in the UK, Europe and South America, where he influenced the teaching and practice of child and adult analysis. He initially studied and practiced child psychiatry in the United States where he was first introduced to the ideas of Melanie Klein. In 1954 he travelled to England as an extension of his military service in order to begin analysis with Klein. At this same time he began training with the British Society of Psychoanalysis in both Adult and Child Analysis. He was supervised by Segal, Rosenfeld, Bick and Joseph who were the leading Kleinians of the time (Astor, 1989, p. 1).

Meltzer became an influential, albeit controversial, post – Kleinian figure. He later broke ties with the British Society over the teaching methods and the selection of training candidates. He continued with his own private work, consultation, supervision and in the teaching of psychoanalysis and psychoanalytic history to many interested clinicians. Meltzer considered himself as following in the tradition of Freud-Abraham-Klein-Bion. From Klein Meltzer placed centrality on the geographic and epistemological aspects of mental functioning (Meltzer, 1992, p. 50). This is most vivid in his description of work with young children (e.g. Meltzer 1967; Meltzer & Gelati, 1986; Meltzer, 1988) and is echoed in many seminal Child Psychotherapy books such as *The Child Psychotherapist and problems of young people*, (Daws & Boston,1977); *Psychotherapy with severely deprived children*, (Boston & Szur, 1983); *Extending Horizons*, (Szur & Miller, 1991); and *Psychotic States in Children* (Rustin; Rhode; *et al*., 2002). These books reflect something of Meltzer's contributions to the Tavistock

Centre's Child Psychotherapy training from the 1960s to 1980s and of the influence his thinking had on a generation of Tavistock trained CAPPTS.

Meltzer's teachings, supervisions and analyses have continued to influence three generations of CAPPTS at the Tavistock, and others. As a result there is a small but growing amount of publications on his ideas. These publications include a number of books capturing and celebrating Meltzer's unique contributions to psychoanalysis, such as *Doing Things Differently: The influence of Donald Meltzer on Psychoanalytic Theory and Practice* (2017); *Exploring the work of Donald Meltzer: A Festschrift* (2000) or *Meltzer in Paris* (2020), to name but a few. In 2014, a conference was held at the Tavistock Centre in appreciation of Meltzer. This was marked by an issue of the Journal of Child Psychotherapy dedicated to it (Volume 42, 2016). Meltzer's substantial contributions to Kleinian analysis are listed on the Melanie Klein Trust, the Harris Meltzer Trust and the Institute of Psychoanalysis websites.

The Development of the Claustrum

Meltzer's keen interest lies in discovering the truth about the patient's psychic life (Meltzer, 1967, p. xii). Later on he extended his interest into developing the philosophy of the practice of psychoanalysis as an art, and in developing a new theory of dreams and their expression in symbolic processes (Meltzer, 1984). His clinical, philosophical and artistic interests made several unique contributions to the practice and theory of psychoanalysis and beyond. It is unfortunate that it not possible to review all the far-reaching effects of Meltzer's contributions to psychoanalysis as that itself would

require its own literature review. Instead I will describe how Meltzer developed his ideas about Claustrum.

Discovering the Claustrum

Meltzer's writings on projective identification span over thirty years of his professional life. They are particularly relevant to the line of enquiry of this study, as his ideas relating to the Claustrum as a form of an intrusive projective communication into the internal maternal object take shape over time. Initially Meltzer describes his thinking about patients with narcissistic defences in 1965 with 'The relation of anal masturbation to projective identification' and again in 1973 with 'Routine and inspired interpretations: their relation to the weaning process in analysis' and in 1976 in 'Delusions of Clarity of Insight', to name but three papers. He extends the experience of thinking about the clinical problems one faces in their work with patients with narcissistic defences to exploring the compartmentalised aspects of the interior world of the internal maternal object in *Explorations of Autism* (1975), *Dream Life* (1984) *Studies in Extended Metapsychology* (1986). Initially, Meltzer began formulating ideas of internal mother in *The Psycho-Analytical Process* (1967). These clinical ideas and observations culminate in *The Claustrum*. Ideas were also developed through seminars both at home and abroad where he was introduced to a plethora of clinical material as a supervisor and seminar lead. This granted him access to a wide and varied audience to discuss his clinical observations with, and opportunities for clinical material to be provided for him to think about.

The Claustrum

The Claustrum as a phenomenological experience describes the workings of the internal world of a person whose epistemophilic drive refuses to bear the pain of learning from experience, and instead seeks knowledge through intrusive projective identification (Freeden, 2012, p. 3). These narcissistic, borderline and psychotic patients become ensconced very concretely inside the object and have very little capacity for observing external reality. Meltzer attributes to Klein the early explorations of claustrum material (Klein, 1932, p. 242). He noticed that in her observations of the phantasied interior of the mother's body, *phantasied* also took on a meaning for the patient as physically real. In the Claustrum the concreteness of the internal object is akin to Klein's notion of the concreteness of psychic reality.

Meltzer's ideas are inextricably linked to his work with children. He observed the differing aspects of psychopathology in children, and the ways in which children augment and evolve. These processes involve major steps in a child's development. They move from infancy to childhood, childhood to school- life, school-life to puberty and adolescence, and these steps are interfered with through the activity of projective identification (Meltzer, 1992, p. 4). In *The Claustrum,* Meltzer moves away from notions that psychic life entails the interplay of the life and death instincts. Instead he observes three distinct narcissistic worlds in relation to phantasies of living in a compartmentalised internal mother (Meltzer, 2010, p. 190). He conceives the Claustrum as a life space: an internal landscape or world with a particular geography and with its own specific qualities and values associated with that geography (Sorensen, 2006, p. 45).

The reasons for residing in the Claustrum include as a means to avoid depressive position feelings; to maintain self-delusion; to maintain the Pleasure Principle (Freud, 1920) by avoiding psychic pain and receiving gratification; and importantly to become an inside baby where separation from self and object no longer exist. Willoughby (2001, p.15) describes intra-claustral life as containing a profound sense of hopelessness about development and a lack of real relationships based on sincerity, love and mutuality. It is in opposition to the Aesthetic Conflict where the “distorted vision of the world of the claustrum is the result of the search for knowledge through intrusive projective identification as opposed to the search for knowledge and beauty through imagination and experience.” (Caseses, 2002, p. 84). The pain of the Aesthetic Conflict can be circumvented through the use of intrusive projective identification, which creates a claustrophobic position as one finds themselves living within the internal object.

The Compartments of the Claustrum

Meltzer described the Claustrum as an expansion and elaboration of intrusive identification into three areas, known as compartments, of the phantasied internal mother's body. These are: head/breast, genital, and rectal (Meltzer, 2010, p. 192). Furthermore all three claustra are internally experienced as inherently stratified, hierarchical and political (Willoughby, 2001, p. 15).

The compartments can be described as follows:

- Top: the Head/Breast.

Here, there are difficulties in thinking and symbolisation. Acts of pseudo-maturity, omniscience, grandiose or fraudulent behaviour are rife. This omniscience he calls the *delusions of clarity of insight* which he describes as “the unconscious infantile phantasy of projective identification with the internal objects, especially the mother's breast and head, experienced as the font of knowledge and wisdom” (Meltzer, 1976, p. 146).

- Front-bottom: Genital.

Here, pathologies in psycho-sexual development are found, such as a reliance on erotomania. Individuals are perpetually at risk of feeling they will be seduced into perversity.

- Back-bottom: Maternal Rectum.

Addiction, perversion and sadomasochistic activity is found here. This compartment is ruled by tyranny and is coloured by despair. There is a risk of serious mental disturbance. The atmosphere is of terror and a fear of ‘nameless dread’ (Bion, 1962a). Finding a way to survive is of the essence.

Difficulties in the Clinical Situation

“When a patient feels it is possible to leave the claustrum and face the despair of a life wasted it is then possible for true analytic work to begin.”

‘Meltzer at the Tavistock’ video, [n.d] screened 5th May 2019.

The Claustrum as a particular type of container that attracts particular aspects of the patient. The Claustrum’s compartments link to the patient’s pathological disturbance.

The degree of such is reliant on the patient's rigidity within the compartments (Meltzer, 1992). Without psychotherapeutic intervention it is likely that the patient will have character development issues, as this type of projective mechanism hijacks the patient's ego functions.

Meltzer warns that the transference is problematic because it is narcissistic, perverse and anti-object relating. The task of getting on with analytic work becomes extremely difficult. The therapist is constantly harangued by the patient and needs an acute sensitivity to the motive of the patient's continued residence in the Claustrum. The patient is in despair which is defended against.

Narcissistic Organisations in the post-Kleinian tradition

The Claustrum is seen as distinct to other theories which attempt to understand narcissistic organisations. Yet because these theories have shared qualities it can be difficult to discern their differences.

Psychic Retreats

In *Psychic Retreats* (1993) Steiner describes a state of mind where a patient locates themselves when they need to retreat from intolerable anxiety. Like the Claustrum this impedes on psychic development and includes tyranny and sado-masochism (Steiner, 1993, p. 12). An important distinction between psychic retreats and the Claustrum is that psychic retreats are just that, a method of retreat from anxiety while the Claustrum is a getting inside the object motivated by pathological projective identification.

Narcissistic Organisations

Rosenfeld described the use of projective identification in creating a particular type of narcissistic object relationship, and in the development of narcissistic organisations. He conceptualises these as destructive acts and as being part of an internal gang (Rosenfeld 1964, Rosenfeld 1971; Britton 2008, p. 22). Williams, influenced by both Meltzer and Rosenfeld, wrote about internal gang dynamics with adolescences and its addictive qualities in her book *Internal Landscapes and Foreign Bodies*. She describes a patient who seems at times to be residing in the claustrum (1997, p.61). Segal, in her paper, “Some Clinical Implications of Melanie Klein's Work - *Emergence from Narcissism”* has written how narcissistic organisations are fundamentally hostile to object relationships (Segal 1997, p. 84).

These differing narcissistic organisations share with the Claustrum their function of serving against persecutory anxieties and includes the difficulties therapists have in being able to have meaningful contact with their patients. Different organisations at different times are utilised by the patient. It may be at one time a psychic retreat occurs while at another time an internal gang is at the fore. Depending on where the patient is in the treatment too, they might be stuck in the Claustrum while later on they may rely on a psychic retreat as described by Flynn & Skogstad in their paper, ‘Facing towards or turning away from destructive narcissism’ (2006).

Object Relationships and the Arts

Meltzer was also heavily interested in the arts, literature, philosophy and culture. In 1988, he wrote about aesthetic issues in *The Apprehension of Beauty* with Meg Harris Williams. He describes how the aesthetic conflict originates at birth in response to the enigma of the mother's moods and actions in which the baby has a tense relationship with. This idea fundamentally changes Klein's conceptions of Paranoid - Schizoid Position and the Depressive Position. Here Meltzer places the infant's experience of encountering the 'beauty and mystery' of mother as primary, and when it becomes unbearable for the infant, they retreat using a Paranoid - Schizoid defence. This conflict facilitates a capacity for creativity to emerge. Meltzer also believes that "the urge for development, knowledge, and creativity springs not only from the representation of the desired absent object, but from the need to discover the inside of the present object (Cassese, p. 78). The Claustrum is antithesis to the epistemophilic instinct in it's helpful aspects towards psychic development.

Meltzer developed ideas about the links between aesthetics and psychoanalysis (Freeden, 2012, p. 2). In exploring Barbara Hepworth's works of mother and child I observed how Hepworth moved away from carving the infant and mother from and contained within one piece of stone (e.g.1927, 1933), to carving the child and mother as separate entities (e.g. 1934; 1937; 1972). She executed this by carving the two figures from the one stone. She then displayed these individual figures together either through fastening the figures together, or apart, to illustrate the mother – child couple. (See figure 1).

It is as if Hepworth, following in the Kleinian tradition, understood something about the experience of the infant and child being connected through their relationship but ultimately not being one, from the earliest beginnings of life. Hepworth, having been a mother herself, likely fashioned her ideas through her own experience of motherhood, and perhaps she understood something about how an infant, at the breast, may experience an ambiguity: wondering whether mother and infant are one. Freud described this experience as oceanic, a being at one feeling, in *Civilisation and its Discontents*. He considered it related to an earlier phrase of ego-relating (Freud, 1929, p. 72). According to Meltzer the Aesthetic Conflict is established when the infant understands that his mother is both the source of pleasure and pain and has to find ways to negotiate this experience through finding an internal space that can tolerate both knowing and unknowing. Meltzer, in a move away from traditional Kleinian thinking where the artist is seeking the lost object in his creation believes:

> "in the creative process, rather than turning back to search for the recovery of the lost object, the artist expresses the emotions of the aesthetic conflict. These emotions stimulate the search for knowledge, which, through imaginative creativity, continually enriches and renews the object." (Cassese, 2002, p. 82).

He offers something more creative, complex and life affirming in his view of artist's creative process.

The Claustrum in Child Psychotherapy

The Claustrum in key Tavistock Child Psychotherapy training literature

There was a paucity of resources citing the Claustrum. To mitigate this I reviewed what was proposed to me by Senior Child Psychotherapy clinicians during the pre-clinical and clinical trainings as the seminal Child Psychotherapy books. These books were *The Child Psychotherapist and problems of young people*, (Daws & Boston,1977); *Psychotherapy with severely deprived children*, (Boston & Szur 1983); *Extending Horizons*, (Szur & Miller 1991); and *Psychotic States in Children*, (Rustin; Rhode; et. al, 2002). These books were published by the Tavistock Clinic from the late 1970s into the early 2000s and span the time Meltzer was most influential at the Tavistock Centre. Upon reviewing them, I noticed that his ideas about projective identification are credited throughout each book, however I found only two direct references to the Claustrum.

I discovered in *Extending Horizons*, that Hélène Dubinsky observed during a mother – child therapy that her child patient's play seemed to describe a state of being in a Claustrum (1991, p. 131). She used this insight to think with the child's mother about his internal world. While in *Psychotic States in Children*, Alex Dubinsky includes a description of the Claustrum in the theoretical overview of the book, complete with a clinical example. He also makes interesting links about the children's fairy tale Jack and the Beanstalk to his patient's state of mind of being in the genital and anal compartments (2002, p. 19-24). Dubinsky writes of how good internal objects need to develop somewhat through the experience of the therapist's caring attention before

the patient can relinquish their narcissism and emerge from the Claustrum (2002, p. 23).

Children who have been adopted or fostered

Creegan, in his 2017 paper, “A place within the heart: Finding a home with parental objects” explores how the Claustrum ideas may be helpful in clinical encounters with adoptive children. He writes of the difficulties adopted children may face establishing relationships with their adopted mothers because of disturbing earlier experiences with previous carers.

He succinctly describes the terrifying and horrendous experiences these children are at risk of because of their maladaptive internalised parental objects. While Rhode (2008) in a clinical commentary in the Journal of Child Psychotherapy describes how a fostered child’s internal world is coloured by claustrum like view. This process arrests the child’s ability to engage in more sophisticated thinking.

Children with autism

Kenrick in “The foot in the hole in the dress: The development and use of symbols in the psychotherapy of an eleven year old girl” includes a footnote about the Claustrum in her work with an autistic girl. When reviewing her patient’s drawing she wonders if she has observed the patient’s phantasied wish. The child’s drawing looks like both a tooth and claw. Kenrick views it as intrusive getting in and the impact on the violence of the intrusion (the claw), but also views it as a chewed up and sharply retaliatory state of mind of the maternal object (the tooth) (Kenrick, 1991, p.74).

Miller in ‘A kaleidoscope of themes’: intensive psychotherapy with a girl on the autistic spectrum’ describes her work with an autistic girl who she suspects lives in the Claustrum. She presses that, as Meltzer observed, how imperative it was to see that the child was lost and in an unliveable situation (Miller 2008, p. 10). This paper places emphasis on the child’s residency in the rectal compartment. Miller’s ability to withstand and find ways to think about her patient’s projective communications through the use of supervision helped Miller to find ways to make contact with her patient. She changed her technique to illustrate to the patient that she understood the child’s internal difficulties.

Durban in ‘From chaos to Caravaggio: technical considerations in the psychoanalysis of autisto-psychotic states in relation to sensory-perceptual fragmentation’ observes how the Claustrum can be conceptualised as an alternative way of describing psychic experience. He charts observations of several child patients with ASD who relied on listing colours to differentiate human emotions and interactions. He provides an interesting description of a child moving from a white, welded and devouring emptiness, through a brown or black suffocating anal claustrum to a land of well-defined and contoured green grass and blue sky. Once outside this Claustrum like space the child says he now feels human (Durban, 2020, p.4).

In ‘The damaged object: a ‘strange attractor’ in the dynamical system of the mind’ Shulman cautions that a child patient with autism may have confusions between self and other in self. This can lend therapists to think the child has difficulties with projective and introjective processes when it may not be so. He suggests it’s associated with the child’s mirroring of internal and external reality as apart from excessive projective identification (2010 p. 263). This is a good reminder that even

though something looks and feels like a projective identificatory process it may be something else.

Maroni's paper, 'Say hello to the scream extractor: working with an autistic child with psychotic mechanisms', describes a child taking refuge in claustrum-like 'lavatory place'. He later emerges from this space and develops a capacity to object to something. The process of being able to object to something can facilitate, for the patient, an ability to differentiate from animate objects. It promotes a capacity to think about experience (Maroni, 2008, p. 41).

Adolescents

Ciccone in his paper 'Psychotherapy of an adolescent presenting a mystical delusion: an illustration of splitting processes and their consequences' (2002) gives a description of the Claustrum as a place of refuge for a disturbed adolescent. The patient avoids a transference relationship through the denial of dependency on the therapist. The work depended on allowing enough time to promote the development of the transference relationship. Hindle, in her paper '"I'm not Smiling, I'm Frowning Upside Down": Exploring the Concept of the Claustrum and its Significance in Work with an Adolescent Girl' too writes of a disturbed adolescent but instead explores the meaning of the Claustrum communications. The Claustrum becomes a concrete place and is the antithesis of being nowhere (2012, p.151). Unlike Ciccone, Hindle does not focus on the development of the transference relationship, instead she charts something of her understanding of the moments of contact that occur between them and her understanding of the essential conflict her patient experienced. This

conflict involved Hindle's understanding that her patient's retreat to the claustrum in its various compartments, seemed based on an attempt to avoid all the confusion, disturbance, and internal conflict involved in establishing emotional links with others (2012, p. 153).

Whether the patient's refuge is in the Claustrum or a Psychic Retreat is described by Emanuel in his paper 'A-Void—An Exploration of Defences Against Sensing Nothingness'. He describes how patients do need to avoid contact with the void—the 'domain of the non-existent' or nothingness, conceived as an immensely hostile object, terrifying space or a place of 'nameless dread' (2001, p. 2; Bion, 1962, p. 309). Emanuel is clearly in touch with how terrifying this 'nameless dread' is and highlights how sensitive a therapist must be to help the patient move out of this refuge.

Claustrophobia as a marker of the Claustrum is discussed in two contrasting papers. In 'Letting Them Go: The Short-Term Treatment of an Adolescent at Risk', Mondadori's short-term work with risky adolescents describes how her patient, because of her claustrophobic anxieties, struggles to differentiate between death and separation (2000, p. 54). While Sanderson, in his paper 'Frustration and disappointment' observes that his counter-transference was freer from feelings of claustrophobia when his patient could tolerate some feelings of disappointment (2014, p. 38).

The Claustrum as a container is touched upon in Davies's paper 'Heroic deeds, manic defence, and intrusive identification: some reflections on psychotherapy with a 16-year old boy'. Davies, a Jungian therapist, describes feeling as though she was being treated like a claustrum for sadistic and perverse communications when she was

attempting to be a container (Davies, 1993, p. 90). She makes links with the patient's lack of containment of his sexualised projections in early childhood resulting in a need to employ intrusive projective identification mechanisms, which had dire consequences for him.

As a representation

In 'Negotiating time: the significance of timing in ending inpatient work' Gustavus Jones advocates helping the patient explore thinking about staying in the inpatient unit. This can mitigate the patient's passive feelings such as that they are too far in, as if they are being imprisoned in a Claustrum-like way (2007, p. 328). She also postulates that the unit can be considered as a transitional space. Her idea that the unit does not have to be either a too far in (Claustrum-like) or too far away (Psychic Retreat-like) experience but can instead be something psychically and developmental helpful. This accords to how Child Psychotherapy thinking is psychoanalytically, psychopathological and developmentally informed as something helpful to the patient (Alvarez 1992, 2012; Reid 2002).

Kenrick, in a clinical commentary in the Journal Of Child Psychotherapy (2007) makes a helpful observation about the technical difficulties in working with abused children. She describes how the therapist can be invited into places children construct, such as dens which seem cosy but rarely are. She observes how there can be a counter-transference feeling of hot, sometimes sexual, inside places, that feel more like a deeply ambiguous claustrum (Kenrick, 2007, p. 102).

Adult Psychotherapy Publications

Harrison relies on intrusive identification and the Claustrum to chart her patient's internal world at the beginning of her patient's therapy (2017). In Plänkers, 'Speaking in the Claustrum: The Psychodynamics of Stuttering' he observes that the function in stuttering seems to be related to the working out of intolerable experiences of separation from the primary object. He links this to attacks on thinking, and as a form of psychic withdrawal (1999, p. 239). Zaslavsky, in 'The impact of intrusive identification in the analytic process: Some implications of real trauma and phantasy' provides a clinical account of life within the maternal rectum and its roots in real trauma (2006).

In 2014, Feldman in 'Container to Claustrum: Projective Identification in Couples' observes how couples' pathologically project into each other, and how these deadly and encapsulating projections embedding into each other stifle healthy psychic growth between the couple. While Chassay (2016) considers the Claustrum in examining a particular form of sensory experience, a bodily dissociation with her patient and its links to both the patient's and analyst's bodily experience as key to emerging from these states. Unfortunately I was not able to access a copy of Hahn's 'The Nature of the Object in the Claustrum' for review due to current difficulties of accessing a copy of it (Hahn, personal communication, February 15, 2021).

Application to the Arts

Leoni (2000) straddles both the arts and clinical work in his paper, 'Living in intrusive identification'. He explores the intrusive parts that seek to live inside the object. Young (1997) in his paper 'Deadly unconscious logics in Joseph Heller's *Catch-22'* likens the

characters as living in the Claustrum where everyone lives perpetually in projective identification and the only value is survival. Apprey in his paper, 'A Pluperfect Errand/ A Turbulent Return to Beginnings in the Transgenerational Transmission of Destructive Aggression' advances that the Claustrum and Psychic Retreats can be applied to the analysis of a film and play (2014). While Sorensen, in her paper, 'Degrees of entrapment: living and dying in the claustrum' analyses two films where the degree of entrapment in a claustrophobic world and the possibility of emerging from it into a world of authentic intimate relationships is shown to be influenced by the internal relationship to a parental couple (2016, p.45). Fisher – Adams (2017) makes links between the Claustrum as featuring in Joyce's Ulysses (1922a). Mayer (2017) in his response to her paper agrees with Fisher – Adams but objects to how she applies the Claustrum to the reading of Joyce.

Why this study?

The literature review made clear that not only is Meltzer as tremendous and prodigious clinician, but that he made important contributions to the practice of post-Kleinian psychoanalysis. The literature review evidences how Meltzer's ideas on the Claustrum and his influence on generations of Tavistock trained Child Psychotherapists have created a particular way of viewing clinical encounters with hard-to reach patients, and how his ideas can be applied not only to clinical work but to the Arts. The dearth of published literature on the Claustrum likely points to how difficult it is to think about and write about these clinician encounters. As so little in this area is published and yet clinicians are able work with these hard-to-reach patients and make progress over time, it feels important to chart what the experience

of working with Claustrum-like patients is like, and how the Claustrum is helpful as a concept with these type of clinical encounters. The research question was crystallised through the literature review experience. I learned that there is so little published literature, and that there is not one study that brings together different clinicians' experiences of working with Claustrum patients. The literature review also pulls together published papers and chapters, which are in essence case studies, and offers for the first time, the opportunity to review the breadth of published clinical thinking in this area.

Hamilton's interesting book, *The Analyst's Preconscious,* was born out of a study she conducted. She attempted to "capture some of the philosophical beliefs, the personal relationships, the important psychoanalytic theories and experiences, that animate therapeutic responsiveness" (1996, p. 17). Her study captured "information about therapeutic efficacy—about what analysts are actually doing, how they respond, and why, given the chance to reflect, they do speak and think in their own unique ways." (1996, p. 18). In this vein, I am also interested in understanding something about clinician's thinking and ways of working. In particular I wanted to capture something of the uniqueness of the clinician-participant's way of thinking and their approaches to their work. How do they understand, and in what ways do they work with Claustrum-like patients. This was something not yet recorded systemically in any literature and could be addressed by my study.

Chapter 3: Methodology

This study explores the question: *'How do the patient's presentation and the therapist's experience and counter-transference in the therapy room with the patient, come together to lead the therapist to think that Meltzer's concept of the Claustrum would be helpful in understanding the unconscious situation?'* The study is interested in how Child and Adolescent Psychoanalytic Psychotherapists (CAPPTs) experience clinical situations where they feel that Meltzer's concept of the Claustrum is helpful in understanding the patient's internal world (i.e. a patient's thoughts and feelings, both conscious and unconscious). This study is concerned with exploring clinical experiences, and with linking clinical experience to psychoanalytic theory. It hopes to generate a discussion amongst colleagues about how we, as CAPPTs, think about clinical experience within and beyond theoretical frameworks.

The following chapter will describe the methodology utilised to explore the study's main research question. The methodological approach is qualitative and phenomenological. The method is Thematic Analysis.

Rationale for methodology of data analysis

Thematic Analysis

Thematic Analysis (TA) is an in-depth, exploratory and qualitative method. It is used to identify, analyse and interpret patterned meanings which can be developed into themes. I chose TA because it is phenomenological by design and can address lived

experiences and perceptions of a particular phenomenon (Braun, Clarke & Weate 2016; Braun & Clarke 2006). TA is suited to gathering up and exploring individual views and experiences in an accessible way. Braun & Clark's TA utilises a reflexive approach and they have recently revised their approach renaming it reflexive TA (Braun & Clarke, 2019).

TA is not considered a methodology (Braun & Clark, 2006; Joffe 2010). Nor is TA linked to any particular theoretical outlook. This offers an opportunity for TA to be applied to a range of theories and epistemological approaches. TA can illuminate the specific nature of a given group's conceptualization of a phenomenon under study which makes it apposite for this study. TA also allows for the potential of a nuanced, complex and interpretative analysis which is necessary in analysing data and comparing data across data sets (Braun, Clark & Weate, 2016, p.1). The vivid vignettes in the results chapter illustrate TA's grasp on nuanced data. Braun & Clarke write of Reflexive TA that "themes cannot exist separately from the researcher—they are *generated* by the researcher through data engagement mediated by all that they bring to this process (e.g. their research values, skills, experience and training)" (2020, p.3). This ethos is important as it acknowledges my position as a researcher – clinician as something valuable and inherent to the research process.

The researchers' acknowledgement and recognition about decisions they make during the process of using TA lend clarity to the process of using TA. The 'decisions' are seen as such in an effort at transparency of the method (Devi & Fenn, 2012, p. 323). Furthermore, Braun & Clarke advocate that it is good practice to make explicit the type of TA that is being utilised. They offer six approaches. These are: inductive/deductive, semantic/latent, and critical realist/constructionist or a mix of these (Braun, Clark &

Weate, 2016, p. 4). I chose a combination of an inductive and semantic approach because of its' ability to conceptualise data while also staying true to the participant's lived experiences.

TA is performed in a transparent and reflective way: the interpretation of the material is in itself a subjective experience. Data analysis in TA is an iterative and reflective process – the data was coded with the interview questions in mind, the analysis evolving as I returned to the data and redefined the emerging themes. The identification and analysis of these themes forms the narrative of the research and will be presented in the Results and Discussion chapters.

Consideration of other methodologies

I understood from my reading and participation in research seminars, and through discussions with my Research Supervisor, that I might need to be guided by the data in deciding what methodology to utilise. Indeed, it was not clear what methodology I would use until I began transcribing the interviews. I considered Narrative Analysis (NA) and Interpretative Phenomenological Analysis (IPA) approaches.

NA offers a flexibility of analysis because it has no set method and it focuses on the participant's expression of what they feel is important (Riessman, 1993, p. 53). This approach involves an interpretive activity, whereby the researcher is actively engaged in formulating meanings for participants' narrative expressions, often in quite different terms than the participants themselves would use (Smythe & Murray, 2000, p. 318). I felt it was important to remain close to the participants' experiences.

IPA offers “detailed, nuanced analyses of particular instances of lived experiences” (Smith, Flowers & Larkin, 2009 p. 37). Its application is well-matched to participants for whom the topic is meaningful, as IPA focuses on how individuals create meaning in relation to their life experiences (Pietkiewicz & Smith, 2014). Participants are usually similar and tend to have an understanding of the topic that is being investigated (Larkin & Thompson, 2012, p. 103). However, IPA has three potential limitations. These limitations are a reliance on language, description over explanation, and IPA not theorising reflexivity (Willig, 2013).

Setting up the study

Aims of the study

The first aim of the study is to explore in depth CAPPTs’ clinical experiences in which the concept of the Claustrum has been helpful in understanding clinical situations. The second aim is to explore how the understanding of Claustrum – like clinical material can contribute to a wider discussion amongst CAPPTs regarding the understanding and practice of Child and Adolescent psychotherapy. The third aim is to capture the experience of the Meltzerian - Tavistock tradition for future generations of Child Psychotherapists.

Rationale for choosing the research question

In keeping with the phenomenological spirit of the practice of Child and Adolescent psychoanalytic psychotherapy, the research question was born out of my experience of working with hard to reach children and adolescents in the therapy room. Working within a Child and Adolescent Mental Health (CAMHS) setting, I found that those children and young people whose communications are elusive or difficult to grasp tend to fit well into the clinical description of the Claustrum (Meltzer 1992, p. 69). The Claustrum is a type of intrusive projective identification operating at the level of unconscious phantasy with the aim of intruding into the internal maternal object. These complex patient presentations can often be seen in CAPPTs' clinical work because, in my experience, there is a trend in CAMHS settings to allocate the most complex cases to our discipline, based on an implicit understanding that our training equips us to understand complex and hard to reach patients. CAPPTs can usually offer the long-term work that is needed for these patients. In this study, participants saw 'Claustrum–like' patients in a variety of mental health settings including private practice.

There is a need to think about these kinds of elusive and complex presentations so as to offer interventions within the psychoanalytic consulting room that better support these patients in transitions from childhood and adolescence into adulthood. Our aim as CAPPTs is indeed to support young people in gaining greater psychic understanding of themselves, as this assists emotional regulation and psychic growth.

An exploration of what occurs within clinical encounters, and the way clinicians think about and share their insight with a patient, presents an opportunity to study a clinician's clinical experience, their links to a psychoanalytic framework and the patient's ability to use clinical interventions. This study presents an opportunity to investigate how a clinician might share their understanding with the patient, and how a patient might make use of any understanding offered to them.

To my knowledge, there has been no previous attempt to assemble different clinicians' experiences with patients illustrating Claustrum–like phenomena. This study captures, for the benefit of future child psychotherapists, the teachings direct from Meltzer which have been passed on to participants from either their direct contact with him (as a supervisee, analysand), or close contact with someone who was taught by him. The study thereby captures an experience of the Meltzerian tradition for future Child Psychotherapists.

The value of the a priori and circularity approach

This study is primarily concerned with clinical experience, clinical facts and the quest for 'a truth' that can be verified within the clinical landscape (O'Shaughnessy, 1994, p. 941; Bion, 1967). O'Shaughnessy describes clinical fact as part of the experience of being with the patient: "they are the lived facts of the shifting object relations between myself and my patient" (p. 944). These facts, in her experience, are bound up in the clinical experience, and are "subject to validation, as being a truth about the immediate emotional reality between patient and analyst" (p. 946). This study charts how the

participants share with their patient *clinical facts* about the emotional reality of Claustrum–like clinical situations.

Commonly in a study the researcher would avoid tensions in the areas of a priori hypothesis and circularity in order to avoid pre-determined outcomes. However I see these instead as something helpful and desirable because I am investigating how the experience and knowledge of the Claustrum is viewed as helpful when thinking about clinical encounters. The study's positioning surrounding a priori and circularity assisted in setting the research question, recruiting the participants and in gathering and analysing the data.

The Oxford dictionary defines a priori as "using facts or principles that are known to be true in order to decide what the likely effects or results of something will be" (Oxford Dictionary, 2021). I approached this study with a set idea in mind: how do clinicians consider the Claustrum as an aid to therapist and patient in understanding clinical encounters? The idea that the Claustrum is helpful in understanding clinical encounters is embedded in the research question and is viewed as being true. I recruited participants because of their interest in, and experience of, working with the clinical phenomenon of the Claustrum. Without this a priori knowledge the participants would not be able to speak of these types of clinical experiences that I wanted to understand better. The a priori approach helpfully provides a necessary framework to ensure that the specific aspects of the clinical experience under exploration can be gathered for later thematic analysis (Perez, Prick & Lawrence, 2015, p.663). Any potential self-selecting participants of the study would likely have had an experience where they felt the Claustrum was helpful and so took part in the study because they wished to talk about these experiences.

Hahn outlines problems with circularity such as citing that the evidence depends on the self-same claim it intends to support (2011, p. 173). However, she also debates whether or not circularities are damaging as depending on the pragmatic goals at hand. This can be measured by a change in belief, such as gaining an ‘‘increase of understanding” (2011, p. 180). My clinical interest, experience, and knowledge of psychoanalytic theory coupled with the participant’s interest, experience and knowledge challenges the usual view of circularity in research. In this study it is an advantage because it promotes a deeper level of understanding of clinical phenomena between us. Therefore, circularity is considered a core feature of the study design and is not considered as a limitation or as leading to problems of validity.

An ethnocentric bias

My study carries an ethnocentric bias that imposes the preconceptions of the researcher’s or theorist’s culture on the phenomena being studied (McGrath & Johnson, 2003, p. 35). In my study this is necessary because it adds depth to the phenomena being researched by a Child Psychotherapist interested in the interface of clinical experience with clinical theory. My clinical experiences facilitate me to understand the data in a particular way based on my previous experiences, yet this also leaves me vulnerable to interpreting the data through a particular lens. My understanding of the data was enriched by the new learning gained through the interview process and the data analysis however because the study attracted participants from similar social, class, gender, and ethnic and professional backgrounds, there is shared ethnocentric biases amongst the participants.

I had difficulties recruiting participants from more diverse backgrounds such as training, gender and ethnicity. Perhaps I advertised the study in such a way that attracted participants who shared the same ethnocentric biases as myself; for example, the shared experience of having trained at the Tavistock Centre, or perhaps it is something more inherent to the ethnocentric make-up of the profession. This professional and training culture experience may have blinded me to thinking more deeply about gender, ethnicity, age, seniority and class of the participants. For example, I may not have considered these issues in-depth because there of a broadly similar ethnic, gender and class background of Child Psychotherapists, and I wonder if this is entrenched as part of the cultural experience of training at the Tavistock Centre.

Generalisability

The participants taking part in the study were self-selecting because of their interest in the area. They brought with them their unique clinical experiences which they wished to share. It is likely that this study is not generalisable because its aim is to capture these participant- clinician's individual and unique experiences with their patients and supervisees in a profoundly complex area. However, this study can potentially help other clinicians gain greater understanding of the way Claustrum-like presentations manifest and can be worked with in clinical settings. It is also my hope that this study opens up further conversations between clinicians about experiences where the Claustrum might aid understanding of complex clinical situations.

Research Design

Setting the Interview Schedule

The method of data collection was using one to one semi-structured interviews with self-selecting participants.

I set the interview questions. I met with my researcher supervisor to think about the questions together. The outcome of this meeting was that six areas for exploration through questioning were clearly defined.

I met with a Senior Psychoanalyst who is a specialist in Meltzerian thinking. Together we reviewed the research questions. I was encouraged to think about the questions by discussing a clinical case with them. This experience was extremely helpful because I deepened my understanding of a Claustrum–like clinical experience through a clinical case discussion.

The interview questions sought to obtain specific information from the participants about clinical experience in order to facilitate comparisons of the data across the data set (Knox & Burkard, 2014, p. 342). The interview schedule was set to explore six main areas (see Appendix A). These areas were:

i) Exploration of the participant's experience of recognising when they felt they were meeting the clinical phenomena of the Claustrum over other kinds of theoretical clinical phenomena;

ii) An exploration of clinical experiences where the Claustrum was brought to mind;

iii) How the therapist's counter-transference experience was helpful in understanding a clinical situation where the Claustrum was brought to mind as something relevant;

iv) The experience of speaking to patients about Claustrum-like experiences;

v) The experience of thinking with patients about the compartments of the Claustrum;

vi) The transferential experience in a clinical situation that brings the Claustrum to mind.

Sub-questions were used in some interviews depending on whether it seemed that the question was being addressed by the interviewee in a rich way. Assessment of whether a question was addressed in a rich way relied on me internally reflecting on this experience during the in–the-moment engagement of the interview process.

I circulated the interview schedule in advance of the interviews. This gave the participants the opportunity to prepare beforehand if they chose to.

The Interviews

The interviews took place either at a room at my training school, the participant's consulting rooms or over video-conferencing. The interview held via video-conferencing occurred because it was not possible to meet in person due to the participant's logistics.

The interviews lasted between 36 minutes to 1 hour and 15 minutes. The interviews were tape recorded. After the interviews were completed, I transcribed them. (See Appendix B for a sample of a complete transcript). I read the interview transcripts while listening to the interviews to check for accuracy.

The data from the interviews was coded and then organised into themes. The themes were analysed and will be discussed in the Results and Discussion chapters.

Before interviewing the participants, I conducted a practice interview with a colleague. The purpose was to assess whether the interview questions in practice needed further refinement. The outcome of this activity was that the questions were congruous, and I felt more confident to begin the interviews having had some practice. The practice interview was not recorded and is not included in this study.

Participants

I recruited participants amongst the membership of the Association of Child Psychotherapy. Ads were placed in the association's monthly e-newsletter (September 2019) and in the termly membership publication 'The Bulletin' (Summer 2019 Edition) (Appendix C).

I discussed plans for my upcoming study with colleagues thus raising awareness amongst colleagues. Some colleagues found the topic interesting and spontaneously volunteered to participate in the study. I later followed up by formally writing to these colleagues with the Participant information sheet (Appendix D) and Participant Consent form (Appendix E).

The study's primary inclusion criteria were the participant's interest and willingness to discuss clinical situations where the Claustrum was helpful in understanding the clinical situation. Participants were deemed as self-selecting based on their motivation to participate.

I recruited seven clinicians from across the ACP membership. The range of clinical development ranged from newly qualified to senior. The participants were considered "experts by experience" (Midgley & Holmes, 2018, p. 55). Clinical experience and interest were seen as more important than where they might be in terms of their clinical development for inclusion in the study. In considering that some very senior clinicians opted to participate I wonder whether they were also motivated to pass on their knowledge to the next generation. Perhaps this would ensure that, through the study, Meltzer's teachings would have another home to reside in.

I interviewed two male and five female clinicians. This study is made up of the interviews of one male and three female interviewees.

All participants of this study are from a white British/European middle-class background and are all Child Psychotherapists trained at the Tavistock Centre. Despite each person's individuality there is a basic homogeneity shared amongst the participants and me through sharing a similar class, culture, and training experience. I am aware that these shared characteristics and positions may take on meanings and could influence my thinking about the experience. TA supports the participants' subjective experience and their 'taken-for-granted' view as something helpful (Joffe, 2012, p .20). Similarly, Rustin considers psychoanalysis (which he conceptualises as on-going research into the self within the consulting room) as something appropriate to an area of study (2019). In agreement with Joffe and Rustin, I view the participants' clinical backgrounds as desirable to enable exploration in the area the study is concerned with despite any ethnocentric limitations.

To maintain participant confidentiality and to lend cohesion to the presentation of the findings, the participants' identities are arbitrarily labelled by number. The excerpts in the Results and Discussion chapters were chosen with particular care to minimise any possible, unwitting disclosure of participant identity amongst readers who may be from our small, close-knit Child Psychotherapy community.

Setbacks during the study

As I began to transcribe the interviews it became overwhelmingly clear to me that the data obtained was extremely rich and dense and would produce many codes. I discussed this at my yearly research progress meeting (Spring 2020) with my

Research Supervisor and the Chair of the research panel. We explored how, in order to complete the study within the time limit, and because of setbacks due to the Covid-19 pandemic, it would be more manageable if the data set was smaller. I was encouraged to think about whether reducing the data might allow me to move forward with the research within the constraints I was facing.

I considered what shape the research might now take. Reducing the data set would inevitably form a smaller analysis and discussion. I understood this was necessary in order to complete this project within the time frame. However, I felt the risk in reducing the dataset was that some potentially interesting data would be lost, and that a cross-comparison of experiences would be reduced. Helpfully, Reflexive TA allows for a minimum of four dense interviews to be included for a paper which I felt was applicable to this project.

Ultimately, I decided to include data from four of the seven participants to make this study more manageable. I included the data from the four participants whose interviews had been coded by the date of the research panel meeting. All seven interviews had already been transcribed before I begun coding activity. The order of coding the interviews occurred randomly. That is, when I transferred the sound files to my computer, the interviews uploaded in a random order. I began coding in the order the files were displayed. When it was agreed that the data set was to be reduced, I stopped all coding activity and decided to move forward with the project with the data now coded as complete.

Data collection

Semi-structured interviews

Semi-structured interviews with open–ended questions were chosen as the data collection method. With semi-structured questions I could investigate the phenomenological experience of the participants' clinical experience of Claustrum-like experiences by exploring with the participants their clinical experience and clinical thinking in this area. I attempted to engage interviewees through my interest and capacity to attentively listen and to ensure that I understood what the interviewee was communicating. Techniques utilised to do this included: summarising, clarifying, and reflecting back my understanding (Long, 2018, p. 48). I was willing to be corrected if I did not understand something correctly and I respectfully challenged complexities and ambiguities in the interviewees' responses. I sought out, as far as possible, concrete clinical examples. I allowed for both interviewee and interviewer free associations to the interview material. I observed that at times it seemed that the interviewee and I could understand something together that led to a further understanding of a clinical example.

Interviews that occurred face to face seemed to have a different quality compared to the interview that occurred using video-conferencing. Face to face interviews provide an experience to both the interviewee and interviewer to access facial expressions, gestures, and other paraverbal communications that may enrich the meaning of the spoken words (Knox & Burkard, 2014, p. 345). I suspect that I may have unwittingly missed non-verbal communication through the video interview and that the interview

did not seem to leave the same sort of mark on my mind as face-to-face interviews did.

Ethical Considerations

This study received research consent from the Tavistock Ethics Committee. (Appendix F). To maintain participant confidentiality and anonymity, no identifying information about the participants or patients they discussed is included. I removed all identifying information from all documents before the data analysis. All transcripts of interviews are anonymised. All data is kept on password-protected digital files. Samples included in the appendices were chosen with care so that the participant's identity was not unwittingly disclosed to anyone in our small psychotherapy community.

Clinical Considerations and Ethics: An example

At several points during the study I faced ethical dilemmas that linked to clinical considerations. These include a follow up conversation I had with participants regarding their concerns that their patients may be recognised should the study be published. Participants were offered the opportunity to review their interview transcript and to redact areas from the interview if they felt it was necessary.

Two participants contacted me via email with concerns of patient anonymity. I discussed this with my research supervisor who also made contact with the Research

Leads to advise. My supervisor and both Research Leads were clear with the need to stick with the principles of the study: that the study is about clinicians' perceptions, views and experiences and not about the individual patients. I was also encouraged to remind the participants that all data would be anonymised and the participant could also withdraw should they wish.

I contacted the participants by telephone and this provided an opportunity to discuss their concerns and have me respond in the moment. What became clear as we spoke was that the participants were seeking a clear understanding of how the data was going to be used. I described in detail the anonymising, transcription, coding, analysing and writing up processes, and how the analysis would centre on clinical experience more so than clinical details. The outcome of the discussions was for the interviews to be included in full. I also made it clear that participant confidentiality in the study was paramount, particularly because we were such a small field and that I was ethically bound to protect both their identities and details from the material shared.

Speaking to the participants was a very helpful experience because it helped me to further make sense of the next steps of the project. It was also affirming to connect with the participants again (participants whom I enjoyed interviewing and felt I learnt a lot from).

Another concern arose after the study ended. I reviewed some of the participants' published work and became concerned that colleagues may be able to recognise the participants from their previously published work. I wondered if I should go through the study forensically and omit particular vignettes. Ultimately I think I have succeeded in

maintaining my participants confidentiality but there remains a risk that participants could be unwittingly recognised by colleagues who may be familiar with the participants work unbeknownst to either of us.

It is unlikely that the study would be published in full, and it is much more likely that I would shorten and adapt the study into a journal length article such as for the Journal of Child Psychotherapy or the International Journal of Psychoanalysis. During this process I would certainly be mindful of any matches between participants' previously published material and the material discussed in this study. I would omit or write about any such sections in a disguised way.

Analysing and managing the data

I utilised TA's six phase process in analysing the data. These steps are familiarising yourself with the data, generating initial codes, searching for themes, reviewing the themes, defining and naming themes leading to producing the report (Braun & Clarke, 2006; Nowell & Norris et al., 2017).

Familiarising the data and coding

First, I transcribed the data. Once that was completed, I read the transcripts while listening to the data to check for any inaccuracies. I made notes of any ideas that struck me from the data.

I coded all the data against the interview questions. I also coded any extracts that seemed particularly interesting. These interesting extracts assisted in locating vignettes for the Results chapter.

I verified the codes for each interview against the participant's interview transcript. I refined the codes as I returned to the individual data. After coding all the data, I listed all the codes under each question for each participant in a word document. I then made a table for each question and grouped the codes together under 'titles'.

I created tables for each question for each participant.

I wrote each question on an A3 paper. I cut out all the codes and any titles for each question. I placed them on the page matching each question. I did this for all the participants' codes so that each question paper contained all the codes from all participants. At this initial stage I had 536 codes and 123 titles. (See appendix G).

I reviewed all the codes and titles. I made further refinements by moving the codes around or deleting titles.

As I reviewed all the groups of codes and their titles across all the data, I began to conceptualise the themes and sub-themes.

Developing the Themes and Sub-themes

I placed the codes under headings that I developed into themes. I now had seven themes. As I returned to studying the data on the papers, I refined the themes down to five. These five themes contained two to five sub-themes each. Several of the

themes also contained descriptions from the interviewers which I grouped as non-thematic contextualising information.

Once I was satisfied with the initial setting out of the data, I entered them into an Excel spread sheet. I verified the themes and codes again against the interviews to see if they captured the essence of the data. I made refinements to the codes during this activity. I narrowed down the themes to four and collapsed some codes into the sub–themes. I reviewed the themes again against the data set, refining any ambiguous codes and examining whether the codes were apposite under the theme. (See appendix H).

Verification Process

Once the themes and sub-themes were developed, I met with my Research Supervisor to review them. This activity supported shared thinking and gave me the opportunity to verify with someone else whether the themes captured what I felt the participants were describing. Meeting a colleague to review the data supports Nowell *et al*.'s view that peer debriefing helps expose aspects of the research that might otherwise remain unspoken (2017, p. 10). However this activity is not prescribed by Braun & Clarke.

The data analysis activity established 267 codes, 4 main themes and 11 sub-themes. The themes encompass three distinct areas. These are: the participant's clinical understanding of the Claustrum; the participant's clinical experience; and the interface of clinical practice with clinical theory. The Results chapter presents the findings in detail.

Chapter 4: Results

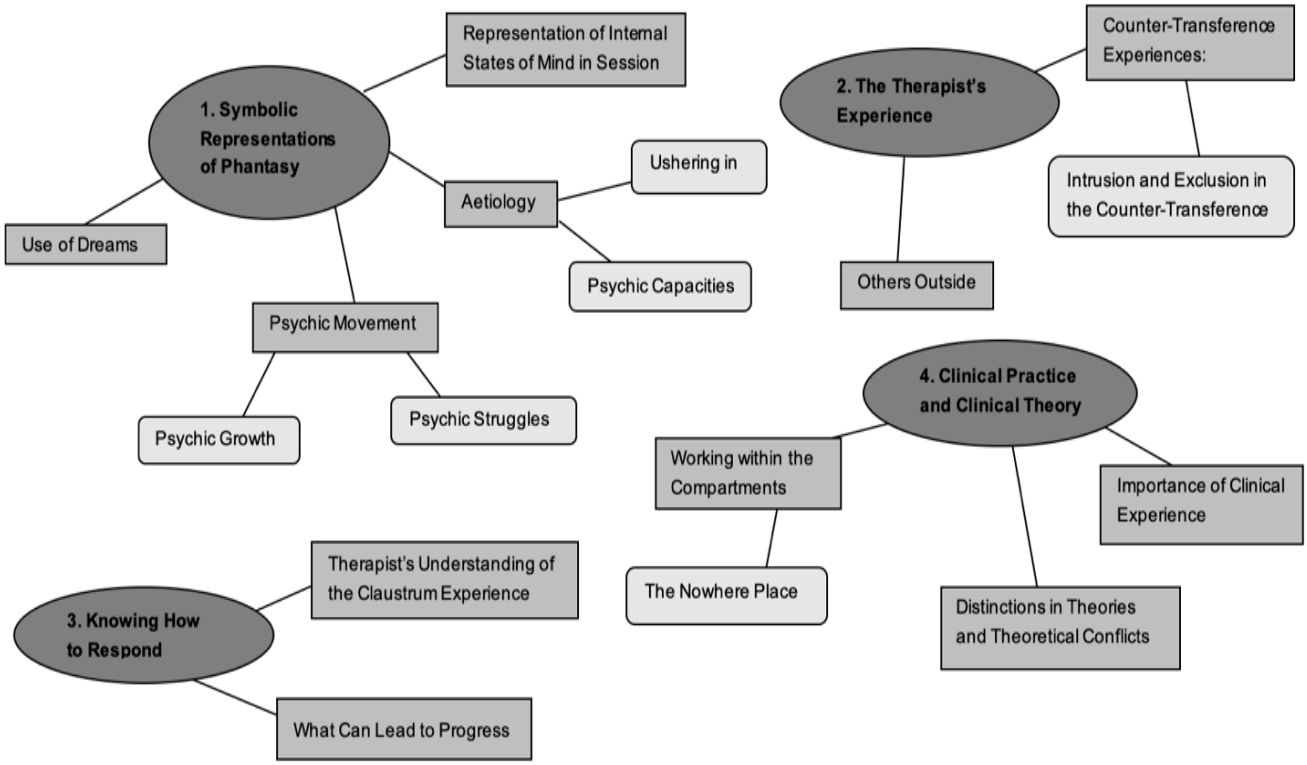
This chapter presents the findings from the semi-structured interviews that explored how CAPPT's experience clinical situations where they felt that Meltzer's concept of the Claustrum was helpful in understanding the patient's internal world. The aim of the interviews was to understand the clinicians' experience of clinical encounters where the Claustrum is seen as helpful in comprehending the clinical situation.

From the data collected, 4 main themes and 11 sub-themes were conceptualised. I will describe the findings in detail, with a focus on the observed commonalities and divergences amongst the participants' thinking. A commentary of the selection of excerpts pertinent to each theme will be included. These themes are unable to capture the full range of the data obtained from the interviews but reflect my overall sense-making of the data stemming from the data analysis activity. Not every theme included here was seen amongst all the interviews, however these themes were derived because I felt they illustrate the breadth of the participants' clinical experience.

Themes

The participant - clinicians were very experienced and their understanding of the Claustrum was very sophisticated. Therefore it came as no surprise that many codes were generated. I also coded all striking quotes from the participants. However, because of the participants' embedded understanding around key theoretical ideas there were categories of data that I considered as non-thematic contextualising information that did not become a theme. A tension in the study included considering

whether to take forward in the analysis process codes that formed categories which did not form a theme.



Theme 1: Symbolic Representations of Phantasy

The first theme captures the magnitude of the thinking shared by all the participants on the importance of internal phantasy within the patient's internal world, and how these phantasies were at the centre of the patient's Claustrum living. Within this theme I considered four sub-themes that are described below.

Representation of Internal States of Mind in Session

This sub-theme involved the ways the participant thought about the patient's internal world while in the Claustrum. All participants, in accordance with Melter's views of the Claustrum, described the patient's state of mind as being specific to a living inside the maternal object, and of containing a quality of intrusive identification in the counter-transference. These excerpts illustrate the clinicians' intricate understanding of the patient's experience of dwelling in the Claustrum.

> *"The idea of the Claustrum as a whole is a living inside. Living inside the maternal object, it's very specific Meltzer … it's not even the Paternal, the Maternal object: internal Maternal object."* Participant 2.

Participant 3 observed, through their supervisee's work, the patient's need for their therapist to recognise the patient's preoccupation with an internal maternal object. They said:

> *"She repeatedly draws representations of the inside of her old flat which have lots of different routes around the flat. It's all really quite unusual. She wants somehow for this therapist to fully visually engage in the kind of innards, if you like, of this flat."*

In addition to their earlier view, Participant 2 contemplated that external experiences can lend to Claustrum-like internal experiences for the patient. These external experiences related to the lack of firm boundaries or the feeling of separation between adult and child linked with intrusion into the child.

> *"… when children are being misused by their parents into living inside. Having to sleep with them. Having to be drawn into their world."* Participant 2.

The exploration of external experiences on the patient's internal world is also considered in the sub-theme Aetiology.

Participant 3 noticed that the quality and type of the patient's phantasies as:

> *"… where they need to reside" "… and there is a spatial dimension."*

They relied on this to differentiate the Claustrum from other post-Kleinian narcissistic organisations.

Participant 3 further elaborated on this:

> *"… you start to build a picture of something quite three dimensional rather than interpersonal."*

It is this spatial orientation that links to the patient's primitive experiences. These entrenched internal experiences culminate in an internal retreat in the patient. Importantly, in this therapist's mind, these experiences accumulate to register as a particular sort of three-dimensional space that they recognise as belonging to Claustrum-like clinical encounters.

Use of Dreams

Dreams were valued as holding a particular significance to alerting the therapist to Claustrum-like clinical encounters. Dreams were regarded as vividly illustrating the patient's experience of the Claustrum.

> *"Generally speaking dreams are very much related to experiences of prisons, living in a prison, living in a cave, living in a concentration camp, having especially Nazis around, not being able to escape. Or even worse, having people who could help but these people don't help."* Participant 4.

Participant 1 described how the patient's psychic movement of exiting the Claustrum was represented in a series of dreams over the life of the therapy.

> *"That was very helpful with this patient. That is what led us from volcanoes and sulphuric you know smell, of bubbling sulphur, this sort of holocaust in the airport to the dream of the bicycles and of his being on the bicycle and the parents - the suntanned parents being allowed to have their holiday. I think that for him the issue of whether the parental relationship has to do with a secret, or a mystery was a very important differentiation…"*

Participant 2 recounted their patient's dream to describe the patient's Claustrum-like experience and their movements between the compartments.

> *"Dreams are really helpful. She was stuck in a cave, you think a cave right, and what were the qualities of the cave and she was really trying to get out of this cave, and it was very persecutory being in this cave. She was trying to climb up and up this sort of narrow passages, so you feel that you are right inside the object here. And then she ended up in a place which was full of food. So you think she has gone from the Anal Claustrum because it did not have a sexualised [feeling]; the cave was dark and dirty and was pretty much a sort of Anal Claustrum but she ended up bypassed [sic] the Genital right into the Head Breast and then there is all this food and she has to steal the food."*

Aetiology

All interviews included the participants wondering about how Claustrum phantasies began to feature as part of one's psychic constellation. The sub-theme Aetiology includes the further sub-themes of Psychic Capacities and Ushering In.

Psychic Capacities

Participant 4 elucidated how a patient's intolerance to their psychic expressions impeded on using their therapy fully. The therapist thought this intolerance linked with separation anxieties.

> *"She was always on the edge to come three times but then she didn't want to come. She was too terrified because she had terrible, terrible dreams and this one was sort of a hallucination. Not a dream, it was a hallucination in the room, and again it was before the holidays."*

They later postulated that the Claustrum, when rooted in reality, is a preferable origin than when it is rooted in phantasy. They drew my attention to an unexplored area for further research.

> *"… it is better than if something is concrete because it has happened, there is always the possibility to show that it has happened. But [if] it has happened in the external reality, if one has a phantasy of having killed the babies, well you can go both ways, because the phantasy of having killed the babies and the babies really are dead is bad, but also if one has the phantasy and there is no baby dead, but it's so realistic inside, so I don't know. I think this is a field of research could be if the concreteness, which way it works [sic]."*

Ushering in

> *"When somebody is put in touch with something which [they] had not wanted to realise until then, that although they knew that there was something wrong inside themselves, it was only in the encounter - not so much about what the patient said, but the encounter - which makes it clear that the patient is, has something inside which is awful…"* Participant 4.

Participant 4 made explicit their perspective that it is through the therapeutic encounter that the patient's Claustrum-like experience is borne out.

Later, Participant 4 wonders about the origin of their patient's Claustrum. They made important links to their patient's own feelings towards her internal maternal object, and to how an inter-generational trauma experience within the family might impact on the next generation's psychic functioning in the below excerpts.

> *"I think it's very important about the Claustrum because Meltzer speaks about babies and that in this case she knew that her mother had an abortion before she was born, before she was married, and the abortion apparently wasn't done well, so the pregnancy went on and she had a dead baby. So this image of the dead baby was brought into the room, because before she lie on the couch, she was sitting on a chair, three times a week and she was absolutely in a foetal position in the chair, with all her hair covering her face and sometimes she slept on the chair. She slept, and then woke up, and it was almost an hallucination, and so my counter-transference, you can imagine, I was terrified. I was terrified of having a dead baby in the room!"*

The therapist's counter-transference was pivotal in deciphering this inter-generational experience and the experience crystallised the therapist's thinking about inter-generational trauma.

Psychic Movement

The final sub-theme is Psychic Movement. This describes sub-themes of Psychic Growth and Psychic Struggles.

Psychic Growth

Participant 1 expounded upon the patient's psychic movement away from the Claustrum and its links to healthier mental functioning.

> *"I think that there can be shifts you know like Bion imagined of the arrow, with the two points the S and E. I think in the same way there can be a being inside and being out. Obviously, one is more likely to be in a depressive state if one is out."*

> *"The Claustrum is not a very good place for thinking so that getting from one compartment from the basement, first floor, and then eventually to the loft or the roof of the loft to open, was a good sign. But also, we could join more in thinking together."*

They later described how they experienced the patient's improved psychic functioning within their counter-transference not as a dream symbol.

> *"I don't think I thought that's an image that comforted me, but it wouldn't have comforted me by seeing it in the dream, but it went together with something I was feeling".*

Participant 2 observed that their patient's psychic growth aligned with them working together.

"And often that's the case; the dreamers, not in the session if the dreamer can be in the session that is more powerful. That she was telling me about an experience so she could think about an experience and I think it did make sense to her. And why? We obviously had to look at what the pre-existing conditions were that led her into the cave. Why what led her into there which of course we did do. Or tried to do."

Psychic Struggles

Exiting the Claustrum and staying outside of it was a struggle spoken about by all the participants. They empathically recognised how difficult it could be for the patient to come out of the Claustrum and what the patient may potentially need to face within themselves.

Participant 1 identified how the patient may be tempted to revert back into the Claustrum as a protective defence.

"I think that if there are new anxieties, new defences are needed, and one returns to old ways of protecting oneself."

While Participant 2 observed how the patient may experience life outside of the Claustrum.

"They also can come out and then the idea of being out and being in this kind of sense you described of having regret how much time in their lives been wasted living inside. So there is a terrible depressive problem there. But also the idea that they don't know how to be in the outside world."

Theme 2: The Therapist's Experience

For the child psychotherapist counter-transference and supervision are the backbone of Child Psychotherapy practice. This theme comprises of a detailed exploration of the therapist's experience as a clinician in these areas. As child psychotherapists, we employ our counter-transference to inform our thinking, and we utilise supervision as an important space to discuss our clinical experiences. The sub-theme of Counter-Transference Experiences includes the further sub-themes of Inclusion and Exclusion in the Counter-Transference.

Counter-Transference Experiences

> *"Or another thing is something which is completely fake, so that what is said could seem right, but then there is an idea of fake and this can include lies or even not include lies. It can include sometimes feelings of being righteous. Or you have described before, about your patient that the feeling of the complete denial of what the person in the room can give the patient, so everything is totally wrong, everything is I feel that I can't do anything right. This, I think it's what starts putting me on guard that maybe we are in this situation."* Participant 4.

Participant 2 located shared concrete thinking between the therapist and the patient as part of this constellation of experience.

> *"There is something about the concreteness of the description, or the state of mind of the patient and the counter-transference experience which I think is hard to reach. The person is hard to reach because they are not there. They are somewhere else. But also the description of the place where they are, kind of leads itself in a kind of concreteness to think about the Claustrum."*

They later adeptly described the marriage of their understanding of neuroscience and psychoanalysis, along with their counter-transference, as signifying a Claustrum–like experience.

> *"I mean that it's always true that we have a sense, I mean the way the way emotions are processed, you know this but from a neuroscience point of view they are processed first in the body. It's actually an emotional experience; a bodily experience in yourself in the counter-transference. What happens [is that] concepts help make sense of that bodily experience; so first got to be senses. So my sense [was that] there was a repulsion in hearing about this case. He knew there was something so grotesque about what he was describing and how he lived his life; there was something so pathetic in the proper sense; so empty."*

Intrusion and Exclusion in the Counter-Transference

Feeling intruded upon is a characteristic of the therapist's Claustrum experience. Participant 1 recollected:

> *"She found photos [of the therapist online], and this really felt creepy-crawly and it felt more the type of getting inside that really makes you feel invaded and which has to do more with coming in from behind."*

There was a particular type of intrusive counter-transference associated with the content and quality of the phantasies.

> *"If in this context I feel dragged into a dark place - and with many ruminatory patients I feel at times that they are both getting right inside and trying to take me into - it depends on the subject's rumination but they have at times a masturbatory quality that can be associated in them with unconscious phantasies that have to do with the Claustrum sort of place."*

This is in contrast with Participant 4 who described a counter-transference feeling of exclusion from accessing their usual Child Psychotherapy resources. It resulted in an isolating and frightening experience for the clinician.

> *"The fact that when you feel that you are in front of a brick wall, or that another image which comes to my mind, you are on the edge of an abyss, because there isn't any safe place where to go because it's not safe to rely on professional experience, on counter-transference, on framework, or supervision, there is no safe space."*

Participant 3 described feeling excluded from the therapeutic relationship.

> *"I suppose what the projection is into the therapist or what gets stirred up in the counter-transference is a feeling of exclusion and not having access to this special place. That this special place is self-cultivated, so it's cultivated by the patient not through relationships."*

Participant 3 conceptualised the excluding clinical experience as:

> *"All those qualities you start to build a picture of something quite three-dimensional rather than interpersonal for me it's what helps me think."*

While Participant 2's sentiment was:

> "*You are just left out. You are in the excluded Nowhere Place; that is very often where the therapist is put."*

Others Outside

It was reported that there were great difficulties in understanding Claustrum – like clinical encounters as a trainee. For Participant 3, supervision was viewed as a helpful space.

> *"I remember thinking it's not quite right, but he looks friendly, things are quite friendly, genuine friendly [laughs] and I really was then surprised when [name removed] was more firm that is an absolute no he is heading down your back passage. This is about alternative entrance when the boundaries relating through the eyes. She absolutely helped me with the boundaries relating to the kinds of ways in."* Participant 3.

While Participant 4 noted their difficulties in the supervision group experience.

> *"Probably now I would have been more able than a trainee… it was very difficult - I was so surprised and I remember that then I discussed in supervision, and people were terribly surprised, so I don't think that then I was able."*

As a supervisor, Participant 2 observed the impact of the clinical discussion for the supervisee and their colleagues.

> *"I think it was a relief for him to be able to structure and conceptualise around the concept of the Claustrum. It wasn't so obvious to the other members in the group. I think that they being less familiar with that kind of conceptual apparatus to be able to bring, to bear on it. I think they would be trying, thinking in a much more traditional way to offer transference interpretations."*

Theme 3: Knowing How to Respond

This theme considers the therapist's sensitive awareness of Claustrum-like encounters and how one might consider making contact with patients in a way that is helpful for the patient. This theme includes two sub-themes: Therapist Understanding of the Claustrum and What Can Lead to Progress.

The interviews accessed the therapists' internalised views of Meltzer's readings or their personal experiences with him and included what they have gleaned from their own therapeutic endeavours. The willingness to share their hard earned knowledge derived from their clinical experience was striking. As I reviewed the codes, it was as if a primer for working in the Claustrum was forming. The participant-clinicians cumulatively seemed to be offering their experiences as something that could be gathered up within this study that could be shared with other generations of Child Psychotherapists.

Therapist Understanding of the Claustrum

Participant 1 described the importance of the therapist staying outside the Claustrum.

> *"It was useful to think of the world that the patient seemed to inhabit in the context of the dream, to talk with the therapist about the importance of taking a holding, containing and non-judgemental stance but staying what Meltzer has certainly written in places and also spoke about in supervision, the importance of staying in the fresh air, and that you can't take the patient out of the Claustrum with forceps, but if you stay in the fresh air there is this possibility that the patient might say 'how does it feel out there, let me have a try' - he might join you there."*

Participant 1's idea was supported by Participant 3 who emphasised the need to rely on the therapist's clinical expertise to reach the patient.

> *"I suppose you judge these things accordingly. I mean that girl the one I was talking about before in supervision she is less disturbed when the therapist is more straightforward."*

Participant 2 took the idea of clinical judgement a step further and considered the aetiology of the Claustrum for the patient.

> *"So you have to be very careful to make that distinction of the motivation of the intrusion. The to get inside to avoid the separation. All the kind of motives of getting inside or have you been hoovered in? And that's a very different, there is much more compassion for these children and adults."*

Participant 4 underscored how sensitive the therapist must be of the patient's need for the Claustrum as a defence mechanism.

> *"I've found it very important to be careful about not humiliating the person because this person is really in a very vulnerable position from this point of view."*

What Can Lead to Progress

All the participants were keen to share experiences of how to make helpful contact with patients whom they believed were residing in the Claustrum. The clinical work was largely described in one way or the other as being very difficult work. These descriptions included:

> *"It was quite horrific; it was one of the worse cases I ever had."* (Participant 3)

> *"… if the patient is in total denial because some patients don't want even to think that there is a separation. These are the worst cases."* (Participant 4).

Participants 2, 3 and 4 noticed that some patients had the ability to function fairly well outside of the Claustrum, outside of the sessions, while seemingly residing in the Claustrum within the session.

There were also accounts of how the therapeutic work ended because of the patient's inability to use the help being offered to them. Participant 4 reflected that it could be helpful to terminate a therapy, that is to end the enacted object relationship. Interestingly they later contradicted themselves by stating that these patients are helped by staying firm and involved with them for a long time.

In several interviews, as Meltzer advocated, participants described the patient's internal world over interpreting it.

> *"… the little boy, I did say to him that is not the way in."* Participant 3.

> *"… I clearly hadn't been able to say anything good to you, I always say things which were wrong."* Participant 4.

Participants stressed that communicative language should be accessible to the patient and should match the patient's level of psychic functioning and emotional development. Care was taken not to persecute the patient through interpretations. This was dependent on the therapist's understanding of their patient's internal world.

> *"I don't talk a lot about part objects or necessarily mention the word 'bottom' to say that somebody is trying to get in in a devious way. If I can put it in terms that are not necessarily very crudely anatomical, I prefer it, but the meaning is to get inside and scavenge."* Participant 1.

> *"… probably likely put a chair in front of me and said let's do something together. I mean sometimes it really is something physical. With very young children phantasy is physical. It is a physically embodied concrete experience."* Participant 3.

> *"She's more functioning so you could sort [of] say this could be a living inside; this world where you've got to get out of; you are trying to climb up and I might use words like: 'head; breast."* Participant 2.

It was regarded as helpful when the therapist was able to shoulder projections while being sensitive to the patient's internal world as to convey an understanding of the patient's internal experience.

> *"I encouraged him to say no wonder you don't like me, because she would have said how much she hates him, no wonder you don't like me, if you feel that I am just a smelly poo baby that nobody wants. That I live in this horrible poo place. To take on some of the characteristics but in a projected form, not that she is a poo baby. And I think to interest them, to give them some idea that you can intuitively sense that you know what it is like to be living in that kind of world."* Participant 2.

Along with illustrating the concreteness of the patient's internal world, these quotes also illustrate the way the therapist thinks about the meaning of their communication and how they might begin to address the phantasies so that the patient can feel helped, and it can bring the patient and therapist into more direct contact.

> *"I think that she thinks that the phantasy is real. I think the merger say of her poo and what she thinks it does to the world for example, she feels is quite literal. A discussion around that any kind of representation about that is a relief*." Participant 3.

However, being direct about the patient's phantasies can also come with a risk.

> *"I think describing what it is like to be in this world can help the patient to feel a bit less lonely. Somebody might know what it is like. Although there is a danger that they may think that you also live in that world."* Participant 4.

All participants reported that Claustrum patients are very concrete. When the therapist used physical communication with their patient it promoted a shared visceral understanding and promoted psychic growth.

> *"She and I did get into sharing a dance routine with our feet. And that was pretty much the only form of dialogue in. She caught herself having some pleasurable experience or a more ordinary kind at one point."* Participant 3.

> *"It is the patient actually who started showing me how she would get under my chair because she was in front of me, by showing me with her hand this movement of sliding on the floor and under. And now this movement is shared so if I feel there is a touch of getting a bit too much inside or she's also a very ruminating patient, so at times I have to stop her walks in the graveyard because the action of showing me that she's conscious, that she's wanting to get under the chair is very different from the way she can get unconsciously into walks in the graveyard that are meant to somehow envelop me in a cloud of sulphuric smell."* Participant 1.

Theme 4: Clinical Practice and Clinical Theory

This study primarily focused on exploring clinical experience, however clinical experience is related to previous experiences and individual theoretical interests. This last super-ordinate theme contains three sub-themes. The sub-themes describe how clinical and theoretical experiences come together or not, distinctions in post-Kleinian

thought, and whether the Claustrum could have an additional compartment: The Nowhere Place.

Importance of Clinical Experience

The importance of clinical experience is stressed amongst the participants as the impetus for their work, yet all participants discussed that their clinical understanding was enriched by being able to consider the Claustrum for particular patients.

Participant 3 eloquently remarked:

> *"I am related to theory so in the sense that as I therapist I feel that I am rooted into something theoretical, but I don't think that my patient is a theory."*

Shortly after they say,

> *"I approach every patient and get to know them over time and theory starts to make - be more meaningful over time."*

Participant 3 chose what aspects of post-Kleinian theory are helpful for their clinical understanding. They defined themselves as *"a needs-recognising therapist."* This presented an idea echoed throughout the study that the patients' use of the Claustrum serves a protective need.

In contrast Participant 1 described how their clinical experience is associated with clinical theory:

> *"I haven't got an idea before I come across some experience or material, but then there are times when a bell rings and something that is happening with the patient or something that the patient brings you can give - be given so much meaning by using a concept, then you can marry that concept with the experience, and that is extremely helpful."*

Three of the participants encountered the Claustrum as trainees and expressed that these experiences were pivotal. Participant 3 reflected that it was difficult to talk to the child about what they were experiencing, and that supervision was vital in recognising the Claustrum.

Participant 4 said:

> *"I was at the beginning very surprised that somebody could live in the Claustrum in this way"*.

They both described the need to reflect on what they have missed in the clinical encounter. They also both spoke of difficulties in piecing together the severity and complexity of the patient's presentation.

Theoretical Distinctions and Theoretical Conflicts

The ability to discriminate between different post-Kleinian theoretical viewpoints pertaining to narcissistic organisation elicited contrasting views amongst the participants. The participants explored their understanding of where the Claustrum sits in relation to other post-Kleinian thought.

The Claustrum was described as discernible from Steiner's Psychic Retreats (1993), and in opposition to ordinary adolescent processes. It was viewed as including

aspects of Adhesive identification (Bick, 1968), was not an enclave (O'Shaughnessy,1992), and as distinct from the Folie à Deux (Meltzer, 1992b) phenomenon.

Participant 3 stood apart from the other participants when they described:

> *"I wouldn't bring those things to the forefront of my mind and make a comparison …The Claustrum is for me when the patient is expressing an idea [of] where they take up residence."*

They conveyed how the quality of the phantasy signals the Claustrum. In their view these patient's motives are in:

> *"…conflict with the life instinct."*

Participant 2 declared,

> *"I think that we make an artificial distinction based for political reasons in the Institute of Psychoanalysis to try and distinguish between the two. I don't think they are always that distinguishable."*

They commented on the difficulties that polarise thinking within the Institute of Psychoanalysis.

Participant 2 disagreed with Meltzer based on their own clinical experience.

> *"He says there is no transference as such when someone is in the Claustrum, but I think there is something there in this way. In terms of being in that place. Which is this Nowhere Place. I think it is very often what is transference is the feeling of absolute lack of contact. You can't make contact with anyone. You can't make contact*

with your patient and what's it like for the patient to feel they can't make contact with anyone?"

Participant 4 also disagreed with Meltzer about technique.

"I know that Meltzer says it's important to be there for the moment [in the Genital compartment], but I think that it's very dangerous with children and adolescents... I think that it's very important to show a lack of interest, a lack of sexual interest."

Working within the Compartments

The final sub-theme recognises the importance of the role the compartments play in life in the Claustrum. It includes exploration of the Nowhere Place.

Striking descriptions of the three compartments are presented to illustrate the richness of the participants' clinical experience and understanding.

Participant 4 gave a vivid clinical example of life in the genital compartment. It includes the patient's psychosomatic expression which is reminiscent of Freud's *Studies of Hysteria* (1895).

"She went to a funeral of somebody and she met an actor, because she was involved with actors and actresses. This actor was much older than her, gave her a kiss on the cheek, nothing more than this and her cheek became paralysed. So it was very difficult to understand what happened, but clearly it was the mixture of the funeral, excitement of the death, because the death was a very important man that everybody knew, so she was in a way excited to be at that funeral, and on top of this this actor kissed her on the cheek so she went straight into the genitals."

Participant 2 evocatively described the Maternal Rectum compartment as something quite vile.

> *"Smell's an important thing in relation to the Anal Claustrum. I am sure you must have seen children that put their fingers down into their bottoms and they want to either smell them and idealise the delicious kind of smell. That's another thing that this guy did that linked, I am pointing there because he was sitting there, the therapist I was telling you about, the guy [patient]. He used to try and steal underwear or his own underwear [sic]. Always carry some of it and smell it. Really concrete and gross."*

Furthermore, despite illustrating a sophisticated comprehension of the compartments gleaned from their clinical experiences, the participants also described how it was not always possible to recognise what compartment the patient was in. When the patient commuted between the compartments it was experienced as disorientating for the therapist. Therapists adjusted their technique depending on what compartment they thought the patient was residing in.

In agreement with Meltzer, there was a general consensus that the compartments consisted of a hierarchy of unpleasantness, however there was not general agreement of which compartment was indeed at the bottom of the heap.

> *"I can imagine somebody who is in the Claustrum in the Rectum and then wants to come out and the best possible place is to identify oneself with the therapist, to go immediately into the Breast or the Head, and so become this top patient analyst, who gives suggestions and becomes the therapist, because it's better to be in the Head or in the Breast rather than to be in Rectum."* Participant 4.

> *"The Head/Breast is obviously less persecutory, there is even a hope that it might become something that opens up".* Participant 1.

While Participant 2 advanced that the Head/Breast is the Nowhere Place and it is here that the patient is most at risk psychically. They described:

> *"…that kind of Head Breast being inside."*

This Nowhere Place also shares features with the Maternal Rectum compartment but:

> *"… usually goes with the persecution. And there is always persecution and trappedness. And the 'no exit' as Meltzer calls it. No exit. Trappedness. The only exit is to the Nowhere Place which is expulsion, which is often where the therapist is relegated to."*

While Participant 3 differed from the other participants and said:

> *"I don't really think of compartments."*

They seemed to be illustrating how the theory has been integrated into their clinical thinking. They felt strongly that they are:

> *"recognising always the patient's need for what motivated them to act on one or another phantasy."*

The Nowhere Place

Participant 2 proposed that the Nowhere Place could become an addition to the compartments of the Claustrum. They described it as a place where no relating between therapist and patient occurs.

> *"A supervisee who was working with a small child he said he used to hold his head like this (cradling, covering head). And he said he used to just try and hold himself together like this. It was the only way that he could bear this kind of situation. He described it to me as a having a Munch's Scream without any Scream."*

Along with the patient's feelings of annihilation in the counter-transference, Participant 2 also described:

> *"You are totally and utterly abandoned. Without any possibility of contact. With the person they are just there, you are wiped out; it's much more concreteness that I am excluding."*

The counter-transference in the Nowhere Place was described as intolerable.

To avoid this feeling of nothingness, Participant 2 suggested that the patient would rather be in the Claustrum with its ensuing persecution than expelled into the Nowhere Place. The patient's only choice is:

> *"… to be there in a world of perversion, then with nothing. The sense, the nothingness in it, which is just awful."*

Participant 3, in a similar vein, described:

> *"when Meltzer talked about down the slippery slope, down to the wonderful desert island which I think interestingly in my mind always signified a very dark place, so I always thought a desert island in the dark is not actually very pleasant. And yet if that's all you got then of course it's a lot more pleasant than nameless dread."*

With these as the patient's only viable options for psychic survival, it is easy to see why the Claustrum indeed would become an attractive place to reside.

This chapter has described the results of the study with a focus on the participant-clinician's clinical experiences and clinical thinking. The next chapter: Discussion will explore how the results can be considered as forming part of a discourse on the practice of Child Psychotherapy with Claustrum-like patients.

Chapter 5: Discussion

In this chapter, the results of the analysis will be discussed in relation to the study's main aim. Through using a qualitative approach, based on semi-structured interviews, I hope to gain an understanding of the clinician–participant's experience of how the Claustrum was helpful in understanding the clinical situation. I am approaching this study as a Child and Adolescent Psychoanalytic Psychotherapist (CAPPT) with an interest in this area, and I asked the participants to reflect on their experience because of their interest in this area. The outcome of the study was that I conceptualised 4 themes along with 11 sub–themes from the data.

The results from the data analysis will be examined alongside the relevant literature. I will present the study's clinical and theoretical implications, discuss the study's strengths and limitations, and propose areas for further exploration.

Implications for Technique

This finding concerns the sensitivity to Claustrum–like clinical situations and awareness of how to respond to them. CAPPT are attuned to the need to modify their interpretations for their patients. For example, Boston writes of her understanding that therapists need to try to elucidate the kinds of relationships which are being enacted, which has technical implications (Boston, 1977, p. 59); while Alvarez describes three levels of calibration (Explanatory, Descriptive, Vitalising) that can be helpful in making contact with patients (2012; 2010). Following Alvarez, perhaps "Descriptive" maps on to the theme 'Knowing how to respond'; "Explanatory" can be viewed as an alternative

to ‘interpretation’ as something to consider technically; and “Vitalising” as linked to the theme ‘What can lead to progress?.’

Isaacs stressed in her paper, ‘The nature and function of phantasy’ that unconscious phantasy is a key driver of mental life (1948). With Claustrum–like patients we encounter a particular quality in phantasy life that makes working with these patients feel impossible. The participants all described how acutely sensitive the therapist must be to recognise Claustrum–like phantasy, and the need to recognise such phantasy in the therapeutic encounter as a defence against vulnerability. Participants emphasised the importance to such patients of descriptive observation over more traditionally explanatory interpretation. Like Alvarez, therapists may find that what they might ordinarily do with a patient cannot be relied on. With Claustrum-like patients it is unlikely that any transference interpretations are made for quite a long time. Meltzer noted:

> “I think that interpretation of the transference has a negative effect, for it presents the patient not only with the anathema of the unconscious but also seems to him an insistence of the analyst on intimacy and dependence.” (1992, p. 101).

The participants agreed with Meltzer that interpretations generally do not seem to reach the patient, and to offer interpretations is likely to be a useless endeavour.

The need for a degree of sensitivity and judgement on the part of the therapist in understanding the patient’s stage of disturbance includes taking care not to give the impression that they too are living in a Claustrum–type world. Meltzer observed “the

unchallenged assumption that this [the patient's] interior world is all there is and that the analyst is as much caught in its net as the patient" (1992, p. 102). I would want to add that this unchallenged assumption is disadvantageous to therapeutic growth for the patient. The participants shared an overarching view regarding how a collaborative experience is helpful in making contact with their patient where they stayed firmly outside the Claustrum experience. Contact included shared visceral experiences and making descriptive interpretations where the patient and therapist were located within the same psychic space such as:

> *"it seems as though we are both trapped, and both imprisoned."*

Contact such as this conveyed to the patients an understanding of their psychic experience.

Sensitivity and the Value of Pleasure

These approaches helpfully recognise how crucial attempts at contact with these patients are. Attempts at contact are described eloquently in Boston & Szur's book *Psychotherapy with Severely Deprived Children* (1983) and in Szur & Miller's book *Extending Horizons* (1991). In *Extending Horizons,* Williams' chapter 'Work with ethnic minorities' (1991) and Alvarez's chapter 'Beyond the Unpleasure Principle' (1991) illustrate succinctly the need to avoid pathologising the patient in making helpful contact with them. Williams describes the need for therapists to "familiarise themselves with "foreign" sets of values that informed a patient's way of life" (p. 204). This has parallels with working through an interpreter and with patients who are truly

foreign i.e. from different cultures and with different values, as much as patients in the foreign internal landscape of the Claustrum.

In contrast, Alvarez's approach focuses on the importance of pleasurable aspects for the patient of the therapeutic encounter as a factor for emotional growth. I suggest that these moments likely feel pleasurable for the therapist too. Bion has postulated

> "Is it permissible to enjoy a psychoanalytic meeting? I suggest that, having broken through in this revolutionary matter of being amused in the scared progress of psychoanalysis, we might as continue to see where that more joyous state of mind might take us." (Bion, 1980, pp. 94-95).

Music, in 'Neglecting neglect: some thoughts about children who have lacked good input and are 'undrawn' and 'unenjoyed'', observes that neglected children "have simply not been enjoyed very much and do not easily experience pleasure". He is aware of the tendency in psychoanalysis and in attachment theory for the therapist's emphasis to be on defences, stating that it "is a challenge to our technique, as it requires us to make a space to facilitate the positive as well as working with the negative." (2019, p. 151-52). He adds, we should use "every ounce of our psychoanalytic knowledge and experience in the service of nurturing fragile developmental possibilities." (2019, p. 151).

Music's approach was also advocated by one of the participants who described how:

> *"I started to get into dialogues that were more about 'Call and Answer' kind of communication, something rhymical."*

These approaches are psychoanalytical and developmental and aim to address deficits in development in a benign and thoughtful manner. In an ‘A conversation with Dr Donald Meltzer,’ Meltzer recalls in his analysis with Klein:

> “Yes, well she first of all talked a lot because she had a lot of thoughts and a lot of ideas and she was humorous, quite witty in her way of expressing things, and the sessions were almost always enjoyable.” (Astor, 1992, p. 6).

Meltzer observed that pleasure was something helpful in his own analysis. Later in the interview he adds, “I think a certain harshness has grown up in orthodox Kleinian circles which is not in the spirit of Mrs Klein at all” (Astor, 1992, p. 7). I would add that for some Claustrum-like patients a perceived experience of harshness may add to their sense of internal persecution and is not in favour of their psychic development. These patients may benefit instead, as Meltzer, Alvarez, Music and the participant note, from an approach that facilitates some pleasure through the relational encounter.

Tour guide of the mind

According to the Merriam-Webster dictionary a tour guide is “a person who takes people on trips through an area and explains the interesting details about it" (2021). Through sharing clinical observations the participants attempted to interest their patients into being curious about their internal worlds. The participants showed sensitivity to their patient’s developmental stage, their level of disturbance and their stage of ego-functioning in addressing Claustrum–like material, for example, through participating in a shared visceral experience (as described above). Yet, I wonder

whether these shared visceral experiences could also be achieved through the current experience of remote working or whether meeting face to face better supports this type of stance?

Participants also found that utilising psychoanalytic language to describe Claustrum-like experiences in a way that is accessible to the patient is helpful. One participant conveyed to their patient:

> *"you got right up into this Breast place; in fact it's stealing. So it's not a legitimate mouth on a nipple being offered to you. You are stealing the food because you are inside and it's all an inside place."*

They felt they could now use psychoanalytic language with the patient because the patient had gained greater psychic functioning during the treatment. The participant offered what Meltzer notes is a "model of the mind which depicts compartments within the interior of the internal maternal object [that] helps greatly to make an organised picture of a highly complicated situation" (1992. p. 139).

Patients' psychic capacities were impinged upon by their Claustrum–like relating (for example, by the concreteness of their thinking or the inability to differentiate phantasy and reality). Yet it was also noted that patients do indeed find ways to traverse these Claustrum-like experiences to form relationships and in some cases gain a better understanding of themselves, while also continuing to be in a Claustrum–like relationship with their therapist. The internal world seems to contain elements of being a deadly place, despite obvious gains in the patient's psychic functioning. Participants also illustrated how difficult it was for patients to exit the Claustrum, and that a risk remained for patients to return. Meltzer, in relation to dreams, observed that "the

dreams are rather equivocal in this respect, because they tend in both cases to represent, the infantile of coming out, encountering mental pain, and hurrying back in again" (1992, p. 106). Participants used dream material to help track the patient's progress in and out, and amongst the compartments.

Isolation In and Out of the Claustrum Space

The therapist's experience, both intra and inter-subjectively, and in relationship to their ordinary therapeutic resources included feelings of isolation and exclusion. These participant-clinicians described feeling isolated in their encounters with their patients, and of experiencing extremely unpleasant counter-transference feelings:

> *"I was completely frozen"; "felt creepy crawly"; "overwhelmed by a sense of something which is not only wrong, but something which is chilly, really chilly"; "[felt] myself going to be taken for a walk in the graveyard".*

There is something striking about these deadly and deathly counter-transference experiences, which likely links to how participants described feelings of terror and despair with these cases.

All the participants gave clinical examples of feeling intruded upon in the counter-transference. It brings to my mind a participant's description that:

> *"in so many of these cases I've seen babies in the background … I think that these dead babies will come very much into the therapy. I don't know. I don't want to say they will lead to Claustrum, but I am afraid that when there are these massive reality -*

because this is a concrete reality, it's not thinking about having killed babies, these babies were killed, were dead."

Perhaps the participant is describing that, for their patients with these particular external experiences who also have Claustrum-like encounters, it is as if these stillborn or miscarried infant siblings have intruded into the patient's internal lives even before they themselves were born. Meltzer noted that these experiences of intrusion "seem to be essentially steps on the way to intrusion into the maternal object (1992, p. 72). Yet intrusion in the counter-transference and into the patient's internal world facilitate the patient and therapist to share an experience of intrusion.

Multiple Experiences of Exclusion

The participants described not being able to make relational contact with their patients and the patients' seeming obliviousness to this. It was a universal experience shared by all participants, and I recognise it from encounters with a Claustrum–like patient I had, however it is absent from the literature I reviewed. Meltzer observed that Claustrum–like patients bring a rigid pre-formed transference to the clinical encounter (1992, p. 99) but he does not to my knowledge describe a feeling of exclusion as a Claustrum experience.

The sense of exclusion perceived in the counter-transference indicates on the patient's part an emotional investment in a maladaptive defence against the vulnerability of psychic contact, both within the patient's own mind and within the patient–therapist encounter. I suggest this counter-transference experience may be useful in identifying Claustrum-like patients. I also wonder in whom this experience

might have been evoked prior to the therapy and whether this feeling in other professionals may have prompted a referral for treatment. Perhaps there is a pattern of other people/professionals finding these children problematic, particularly when there may be very little self-awareness or desire to change. Yet Meltzer felt that it was pointless to donate time exploring what brings these patients to analysis and thought that they, like anyone else, "come voluntarily, and/or sent" and the heart of the matter concerns "the rigidity of the pre-formed transference which emanates from their view-of-the world" (1992, p. 98-99).

A second feature of exclusion related to the patients being out of touch with their feelings, as if they had excluded themselves from the emotional experience. Participants were unanimous that most often it was the therapist, therapist and supervisor, or the carers who were in touch with patient's despair, rather than the patient her/himself. As one participant said:

> *"I think it is very often what is transference is the feeling of absolute lack of contact."*

This experience fundamentally encapsulates the projective identificatory mechanism utilised in the Claustrum.

Exclusion and Contact

The experience of being excluded by a patient also speaks of the patient's deprived internal world. Yet the patient's wish for some emotional contact was also pronounced in the interviews. Participants described, for example, clinical material in which the patient attempted to seduce or lure them in. Supervision was helpful in implementing

firm boundaries around this. The participants recounted how previous Claustrum experience was pivotal in being able to recognise the potential for Claustrum–like material in other case work. Rhode, in a clinical commentary in the Journal for Child Psychotherapy, observed that, not only was her patient Finn's internal world a Claustrum–like experience, but so too was his lived reality (2008). A similar observation was made by Zaslavsky in 'The impact of intrusive identification in the analytic process: Some implications of real trauma and phantasy' (2007) where he links experiences of abuse to the formation of Claustrum–like organisations in his patients.

When discussing the Claustrum in relation to experiences of ritually abused patients, and in considering what the extra burden could be on such victims when they lived within a real external claustrum, Meltzer's view was that the internal situation was paramount (V. Sinason, personal communication, 7 March 2021). Meltzer recognised that he had "an overemphasis on internal values" (Astor, 1992, p.7). The ability to pick apart complex presentations of the Claustrum, adolescence and sexual abuse were recognised by the participants as a fundamental task by the participants. Meltzer proposed that, "when we meet genital dwellers who are still small children, we always suspect that they have been used, if not abused, by grown-ups or older children" (1992, p. 88). However, I also wonder whether the concreteness of both experiences makes it impossible to differentiate between presentations of trauma and the Claustrum.

The Role of Supervision

All participants learnt of the Claustrum either from working with Meltzer themselves or through a supervisor introducing it. In my case I was introduced to the Claustrum by a clinical supervisor who had an interest in Meltzer and the outcome of that encounter is directly linked to my interest in this area.

In some supervisory encounters, it was observed that other members of the group did not understand how the Claustrum was linked to the material presented by the supervisee. This links to the above finding, observed by Meltzer that traditional psychoanalytic methods such as the use of interpretations are not always useful. The group encounter, where fellow group members cannot understand and think about the material, creates a sort of Claustrum-like experience in the supervision. I wondered whether a sort of experience can occur where the supervisor and supervisee are in a particular place together in their thinking about the patient, while the others are outside the experience and may have difficulty accessing it because of how complex the experience can feel, particularly surrounding the transference feelings. Participants also noted that it was difficult to psychically locate the patient, particularly at the times when they were in motion (i.e. commuting between the compartments) which perhaps adds a further complication. The Claustrum experience may have implications on therapists regarding how to think about and present clinical material in supervision.

Reflecting on Shame as a Researcher

Participants described that work with these patients evoked feelings of awfulness, stuckness and hopelessness. It may be in supervision that these feelings produce shame in the supervisee as the clinical work can feel stagnant. Certainly I had an encounter like this which was difficult to talk about in supervision. This difficulty to discuss these types of clinical encounters, encounters where the therapist overwhelming feels that nothing is happening and is being degraded perhaps links to how there is a dearth of literature about the Claustrum. Perhaps it is difficult to reflect upon and write about clinical encounters that seem not to show progress or good contact.

Within the research encounter it is possible that I understood my participants' experiences with a shared feeling of shame from working with these hard-to-reach patients. Whether at times I limited my curiosity because of a shared feeling of shame that I wanted to avoid not only in myself but from being created in the researcher-participant encounter could be possible. This feeling of shame could also link to the experience of the patient population. A lively curiosity about themselves either internally or in the external word is something that's really lacking in a Claustrum patient. For clinicians it is very difficult to maintain a lively curiosity with these patients.

This feeling of shame also may have stopped me from being curious about why so little is written about the Claustrum. As if thinking about these clinical encounters would

evoke too much despair and shame not only in the author but those reading about these particular therapeutic encounters.

This feeling of shame and despair could possibly have led me to use TA as a methodology over other interpretative methods as it considers participants to be ‘experts by experience’ and this results in not adding a layer of interpretation to the data. As a researcher I may have avoided considering these difficult feelings that were evoked in me through my previous clinical experiences, and conducted study in such a way as to try to make sense of the Claustrum experience while simultaneously avoiding the dreadful feelings that are evoked in the counter-transference.

Charting the Patient’s Experience

Participants described how their patients encompassed varying levels of external world functioning while concurrently living in the Claustrum. Dreams beautifully illustrated how patients moved into, out of and within the Claustrum, and also highlighted therapeutic progress. The examples of dreams that were presented in the study were telling of the patient’s Claustrum–like experience. One participant described:

> *“it was a dream and had to be interpreted as a dream.”*

This is in contrast with the agreed consensus amongst the participants that interpretation should not be readily used with these patients. However, there appears to be a quite different stance when it comes to dreams. As Meltzer eloquently observed:

> "we can forget that our patients, and ourselves present a unique language in dreams, a language whose substance shapes the content, if not the aesthetic essence, of art. Dreams borrow the forms of the external world and suffuse them with the meaning of the internal world. We do, with practice, learn to read this dream-language in ourselves and our patients with some fluency, even at times with virtuosity" (1992, p. 74).

Being able to consider dream material offers an opportunity to approach the work symbolically despite the patients tending to be fairly concrete. I suggest this lends the therapist to feeling that they can access their psychoanalytic thinking mind as they are excluded for long periods with Claustrum–like patients. Moreover, because the patient's experience of the Claustrum is indeed about phantasy, and a state of mind where phantasy and reality are undifferentiated, being able to practise dream analysis and interest the patient in symbolic thinking in an otherwise concrete experience is highly significant. This is in contrast to more advanced stages of the therapy when interpretations may be possible.

A Transgenerational Experience

Questions were borne in each participant's mind about the aetiology of the Claustrum organisation. There was a feeling that the Claustrum was brought into the therapeutic encounter either through a good clinical experience (which then served as a safety net to further explore the Claustrum), an experience of separation in the therapy, or a transgenerational experience. Miller discovered something similar in her 2008 paper 'A kaleidoscope of themes': intensive psychotherapy with a girl on the autistic

spectrum' where she observed that transgenerational experiences seemed to be significant in her patient's material. She made a link to the findings of Fraiberg *et al*. in their seminal paper 'Ghosts in the Nursey' (1975) that a parent will recreate with their infant their own experience of receiving care at that stage. When considering how, according to Kleinian psychoanalysis, object relations are formed through early experiences, I wonder how past familial traumas might shape Claustrum–like experiences down the generations, especially when there are deficits in maternal containment that can lead to the "nameless dread" described by Bion (1962a).

Moves in the Claustrum

The participants voiced the importance of their clinical experience and how the Claustrum has been helpful in making sense of clinical situations. Their clinical examples are instances of clinical fact (e.g., O'Shaughnessy 1994; Rustin 2019). Theory, while seen as important, was secondary to one's own clinical experience. For example, one participant's approach was regarded as being "needs–based". This illustrates a sophisticated use of clinical experience with clinical theory, they have an overarching clinical framework in mind that includes the Claustrum, however they chose an approach that they feel will best help their patient.

Claustrum life: Not the whole presentation?

In addition to clinical experience being at the centre of the participants' thinking, there was also emphasis on the importance of distinguishing between various clinical theories in illuminating clinical understanding. As one participant noted:

> *"there are times when a bell rings and something that is happening with the patient or something that the patient brings you can give so much meaning by using a concept, then you can marry that concept with the experience, and that is extremely helpful."*

Emanuel illustrates this experience in his paper 'A-Void – An Exploration of Defences Against Sensing Nothingness' (2001), where he describes both Claustrum and Psychic Retreats as refuge containers patients enter into. Gustav–Jones in 'Negotiating time: the significance of timing in ending inpatient work' (2007) and Apprey in his paper, 'A Pluperfect Errand/ A Turbulent Return to Beginnings in the Transgenerational Transmission of Destructive Aggression' (2014) observe the states of mind that are viewed as Psychic Retreats and can also precipitate a retreat into the Claustrum. Flynn & Skogstad observe both enclave and Claustrum type of material in Flynn's patient Moira in their paper 'Facing towards or turning away from destructive narcissism' (2006). These papers evidence how psychic life is not static or rigid and the Claustrum-like experience is only part of one's overall psychic experience.

This important finding illustrates that Claustrum dwelling should not be viewed as the whole presentation. Ciccone describes this in 'Psychotherapy of an adolescent presenting a mystical delusion: an illustration of splitting processes and their consequences'. With his patient he observes a gang organisation which he links to what Meltzer described of the world the gang organisation inhabits in the Claustrum (2002, p. 357). Narcissistic states of gang formation are considered by Meltzer, for example, in his book *Studies in Extended Metapsychology.* There are the beginnings of ideas about pseudo maturity (1986, p.165) which he later views as a characteristic of the Head/Breast compartment. Rosenfeld considers Meltzer's paper, 'Terror, persecution and dread'(1968) as containing similarities with his view in his book

Impasse and Interpretation (1987) concerning the powerful omnipotent self in destructive narcissistic organisations. Narcissistic organisations are also expanded upon by Steiner (1993); Brennan (1985); and Sohn (1985). In Child Psychotherapy, Williams describes her experience of the gang with her patient Pekka in her chapter, 'On Gang Dynamics' in her book *Internal Landscapes and Foreign Bodies* (1997). However, an important caveat is that Meltzer's view differs from the others. For Meltzer the Claustrum is a retreat into the internal maternal object, as opposed to being solely a projective communication. These authors share a commonality of the patient's need to preserve aspects of the self from persecutory anxiety.

Theoretical Conflict

The participants advanced opposing views with each other, and with Meltzer, about the hierarchy of the Claustrum compartments. Meltzer implied that those residing in the rectum "are posed with a severe depressive problem, for they may have done real damage in the world by enacting this state of mind" (1992. P. 107). The participants' implicit view was that residing in the Claustrum was problematic more than residing in any particular compartment. Participants were clear about which compartment they each felt was the most troublesome, however there was no consensus amongst them.

Failure of Containment

Child Psychotherapists understand a failure of containment, and its ensuing impact on infantile development, as being fundamentally catastrophic. One participant noted:

> *"the classic example I think is not wholly mine - is the child who especially before the end of the session may push under the seat of your chair with clear intention of getting inside … Meltzer described how there is often this fantasy of entering the mother from behind because that fantasy comes when the mother is leaving and you see her from behind."*

This intrusive communication may be related to the impending separation, where a feeling of a failure of containment possibly leads the child to turn to the bottom as an alternative point of entry. As Meltzer noted, "every sense and orifice is a potential portal for the intruder" (1992, p. 71). This participant felt helped by their supervisor in learning about alternative modes of entry in Claustrum-like encounters.

The Nowhere Place

It is difficult to understand exactly what Meltzer considers the Nowhere Place but it is closely linked to an experience of nameless dread (1978, p.92). In *The Claustrum* Meltzer described the Nowhere Place as belonging to a delusional system. This system has origins to intrusive projective identification, with anxieties of being expelled. He postulated it as "the world of projective identification inside the body/mind of the internal mother, the claustrum" (1992, pp. 120-26). I attempted to think about this Nowhere Place as something belonging to the whole of the Claustrum experience where perhaps there have been failures of containment that may precipitate a feeling of being in a Nowhere Place. One participant described the experience of the Nowhere Place as:

> *"… not one of the compartments although it probably is. It should be thought of one because the Nowhere Place is the three - inside and the one outside and the world of intimacy that they have no idea about."*

Perhaps this is aligned with the feeling of exclusion in the counter-transference. While it is not completely clear to me, and I struggle to conceptualise this, I tend to think of the Nowhere Place as being preferable to a feeling of expulsion from the Claustrum into the terror of nameless dread, which is in some respects another type of Nowhere Place.

Possibly in the Claustrum the Nowhere Place is an experience with its own boundaries and functions, as if it is similar to a container created to avoid a catastrophic experience. In Sorensen's paper 'Degrees of entrapment: Living and dying in the claustrum' she describes the Claustrum as being like "an exclusive hotel, one you are dying to get into, only to find that you are nowhere, after all" (p.187 date). Sorensen concludes that the Claustrum encompasses the Nowhere Place. This made me wonder whether the latter might align with the exclusionary counter-transference described by all participants. I wonder if perhaps this counter-transference feeling of exclusion is linked to the patient's fear of expulsion and is associated to the patient's claustrophobic experience in the Claustrum. The therapist's feeling of exclusion in the counter-transference seems to me to be a feeling of being excluded from being in relationship. In this way this Nowhere Place counter-transference experience seems to be similar to what was described by a participant as:

> "*I think it's really awful to get that sense and it's useful. If you can tolerate it. Because the Nowhere Place is so feared."*

Possibly this feeling of exclusion and a possible link to the Nowhere Place experience may have particular value in understanding a Nowhere Place clinical encounter for the therapist.

The Study in the Research context

Strengths

The study offered an opportunity to consider an obscure but highly relevant concept as part of a dialogue on the practice of contemporary psychotherapy. It captures something of the Tavistock tradition of Child Psychotherapy and Donald Meltzer's unique contribution to it. It also captures the experience and wisdom of very experienced clinicians in the hope that their experience and knowledge can be shared with the next generation of Child Psychotherapists. It is my hope that the study might initiate new interest in Meltzer's ideas and provide an opportunity for further clinical discussions to be had. The study also stays true to the tradition of, and potential for, the case study method. Just as Rustin (2019) advocates the use of clinical material, particularly one's own, in psychoanalytic research, this study uses the clinical material of others in the same tradition.

To my knowledge no other study has reviewed all the theoretical resources pertaining to the Claustrum, nor has anyone brought together the available single case studies illustrating Claustrum phenomena. Psychic life does not fit neatly into boxes, and it is instead the kaleidoscope of psychic experience that this study tries to capture. The

study's validity centred on capturing the clinician–participant's experience which is evidenced through the rich and vivid discussions with the participants, both individually and across the whole data set.

The study illustrates some of the markers of Claustrum-like encounters. The results could possibly assist clinicians in thinking about encounters with patients where it feels impossible to make contact; encounters that might include counter-transference feelings of being invasively intruded upon, feelings of being excluded from the patient's experience, along with a sense of the patient having idealised places that the therapist is excluded from. Child Psychotherapists are already familiar with these experiences; however it is the accumulation of such experiences, along with their especial quality with particular patients, that suggest the Claustrum as helpful in one's thinking.

The data illustrates an emphasis on clinical theory due to the inclusion of such experienced clinician–participants who were extremely forthcoming about sharing their clinical experiences and thinking. Through discussing these clinical encounters with me, it allows not only their experiences and thinking, but the history of their experiences to be captured. In this way this study captures a historical event of Tavistock trained CAPPTs who have come into contact with Meltzer and Meltzerian thinking. Participants clearly articulated a feeling that Meltzer's work needs to be kept alive. There is useful and in depth material that I have gathered up both through the interviews and the data analysis process from an older generation of CAPPTs that will be of useful to the future generations of Child Psychotherapists.

This study is likely particularly helpful for psychoanalytic psychotherapists with an interest in exploring clinical practice and clinical theory. It is not generalisable and was not designed to be, neither does it measure efficacy of treatment as part of its design. Yet the study did encourage reflection and new thoughts about cases amongst the participants.

Limitations

This is a small-scale study. A larger sample size likely would have facilitated greater opportunities for similarities or divergences amongst the participants' views. It might also have allowed a greater variety of clinical work to be explored, for example in parent–infant work and family court assessment work.

The study's participants shared a similar training and professional background. This was desirable both to the study's aims and in its methodology; however it may result in the omission of a wider clinical picture amongst contemporary Child Psychotherapists. I attempted to mitigate this by advertising the study amongst the whole profession through two ACP publications, however uptake from these sources was very small. In this study it is likely that the data reflects ideas that are more prevalent in the Tavistock training because of the training's emphasis on Kleinian and post–Kleinian tradition. This shared culture of training and shared ethnocentric background may have blinded me to thinking more in-depth about the importance of difference and diversity. I was invested in understanding the Claustrum phenomena as a clinician-researcher and so may not have considered, within this lens, what it

meant for the study to have participants who shared similar backgrounds to my own. It is as if these similarities precluded me from considering what their impact may be on the analysis and results of the study. On reflection I may have set the interview questions and conducted the interviews in a particular way because of a shared experience of training at the Tavistock Centre along with my own ethnic and class background.

Furthermore none of the participants talked about the ethnic/cultural backgrounds of their patients. Within this lens we likely are to assume that all patients were white European. This lack of information about ethnic/cultural background leaves a whole area unthought about by both the participants and me. Now that the study is complete this is something I am aware with the benefit of hindsight, and I am now more cognisant of the importance of this clinically, professionally and personally.

Perhaps the inclusion of very senior clinicians evoked in me a particular analysis of the data and ensuing results. As part of the Tavistock training experience perhaps I feel that there is something reverent about the participants' views that I felt should be respected within a particular tradition, and perhaps the use of TA also supported this as TA clearly lays out the participants' experience without interpreting its meaning or exploring what may not have been said. For example, the participants brought a particular post-Kleinian view of considering clinical material which excluded consideration of external factors that might impact on clinical encounters. This is not to say that the participants did not consider their patient's external world but the focus in clinical understanding was primarily on the workings of the internal world. Had this study included Independent or Jungian clinicians perhaps there may have been

different understandings of what the Claustrum is. There is also the question of whether TA limited understanding of the data: would IPA have been a better approach with its interpretative approach? My feeling is that I did get to the heart of what I was interested using TA as it stayed close to my participants views and experiences which was what I wanted to learn about in an undiluted way.

Areas for further study

This study could benefit from being repeated with a wider sample size in order to expand on the findings and provide more opportunity for cross comparison of clinician–participant experience. It would benefit from having a diverse participant base who have different understanding of the clinical situation, but do value considering the Claustrum as a way to understand clinical phenomena.

Another idea for further study could be to examine other areas of work where the Claustrum could be used to understand an experience of life in an institution or life as part of a work organisation. For example, in Menzies Lyth's seminal study of the organisational life of a nursing system in her paper, 'Social Systems as a Defense Against Anxiety' (1988), one could possibly make links to Claustrum phenomena and extrapolate from her findings interesting similarities concerning her observations on the nurse's defences. She noted these defences as including an avoidance of emotional contact with patients, a disavowal of mental pain, and having ritualised behaviours. Her findings could be apposite descriptions of the markers of a Claustrum

encounter and I suggest that with Claustrum patients ritualised behaviours could be viewed as rigid or concrete thinking.

One participant suggested that an area of further study could involve the aetiology of disturbance and its links to concreteness of experience. In this way, a line of enquiry could explore whether Claustrum dwelling concerns a combination of internal and external experiences. For example, I wonder if internal Claustrum-like organisations may be dependent on a particular set of prominent depriving circumstances that may be found within the mother's thinking capacities that lend to a rupture of the infant's containment. Perhaps this rupture coupled with the child's propensity to experience the world in a particular way links to Claustrum-like organisations. The role of transgenerational experiences that lend to this phantasy stricture could also be explored as linking to the aetiology of the internal Claustrum organisation.

Chapter 6: Conclusions and Reflections

This qualitative study explores therapists' experiences of considering the Claustrum as helpful in understanding clinical encounters. I approached this study in a spirit of enquiry as a clinician-researcher. I was interested in understanding clinical experiences of working with hard to reach children that had a particular quality in the clinical encounter. These were the encounters where contact seemed fragile or non-existent, and where despite efforts in supervision and clinical seminars to make meaning of the encounters, I still felt perplexed. It was only in retrospect, quite some time after the encounters ended that I began to think that the Claustrum is helpful in reflecting theoretically on what seemed at the time as impossible clinical situations. My clinical experience was mirrored by the participants', in that these patients can often stay in therapy for quite a long while, therefore giving the therapist an experience of these Claustrum-like states of mind. In that way the Claustrum experience is shared.

Now that I have reached the end of the study, I am left with more questions than when I began. I think I succeeded in the research aim of exploring clinical experiences where the Claustrum is seen as helpful in understanding the clinical situation. With these highly experienced clinician-participants I am wondering whether I did indeed capture their experiences succinctly, as these experiences are nebulous yet contain a certain psychic quality that defines the whole experience. This was captured most cogently by the participants descriptions of the counter-transference.

Counter-transference

Meltzer did not write about the counter-transference experience in The Claustrum however the counter-transference experience was overwhelmingly described by the participants as being embedded in the Claustrum experience. The counter-transference is one of the most difficult aspects to talk about with others. In a clinical situation where the patient is intrusively seeking to get inside an internal maternal object, the therapist is left outside, excluded and not able to make contact as to get on with the work of therapy. The work was described by the participants as feeling impossible, horrible, the worst cases, and seemed to leave lasting impressions upon the minds of the participants. In my own experience I recognise aspects of the participants' experience. It may be that my interest in this area is linked to the ongoing experience of attempting to make sense of these types of clinical encounters. It was interesting that despite many years passing, these clinical encounters did remain firmly in one's mind. This is striking because the clinician-participants were long and well experienced. Another interesting finding was that nearly all the participants had Claustrum-like patients as training cases. It remains to be explored whether this is because these cases seem to be so difficult and complex that Child Psychotherapy may be viewed as the only option left to offer intervention before presentations become entrenched and a move from symptomology to characterology becomes crystallised.

Conflicts with Clinical Theory

The study captures that the clinicians value clinical theory and use it as part of their repertoire in understanding clinical experiences. However, participants were clear that

they did not always agree with Meltzer and had their own unique and finely honed ways of understanding clinical encounters. I think it is interesting that there was no consensus about what compartment was seen as most preferred, which is closely linked to which is most damaging for the patient. The patient experience of fear and attempts to avoid the Nowhere Place as a place to be avoided instead illustrates the participants sensitivity to what is seen as detrimental to psychic functioning and development. This is described in the counter-transference when the therapist feels excluded from contact with their patient. I wonder if an opportunity to think more about this Nowhere Place could possibly help shape future discussions about counter-transference experiences about this terrifying place as it was difficult to decipher what Meltzer exactly meant by it by his descriptions.

Clinical Experience as Paramount

Clinical experience with all its difficulties was prized by the participants as a hallmark of Child Psychotherapy. The participants spoke in great detail about what they thought was helpful and unhelpful in their own experience with these patients and this formed a sort of primer for working with Claustrum patients. Participants were keen to discuss how they thought, based on their own experiences, that contact could be achieved and what one may consider doing when it feels impossible. These included an explicit understanding of how to speak about the clinical encounter to patients. For example, when clinical understanding was described instead of interpreted at certain stages in the work, a shared visceral understanding between the patient and therapist could be established, and the therapist may observe within their mind a particular spatial

arrangement of the encounter. Participants noticed that the Claustrum may be only part of a clinical presentation, one that is dynamic and constantly in flux, and they attempted to distinguish between different patient presentations (i.e., other narcissistic organisations, presentations of abuse, and developmental of latency and adolescence). The importance of clinical experience in this area as something to be thought about and shared amongst colleagues, while not a categorical aim of the study, encourages others to find ways to start and enter into a wider discussion about the very difficult and complex work that is involved with Claustrum-like patients. This is particularly important for new therapists (nearly all the therapists had Claustrum patients early on in their training and needed supervisors to help them make sense of the experience) and therapists from outside Post-Kleinian traditions because familiarisation with the Claustrum could help therapists make sense of clinical experiences and support learning from others about what interventions might be helpful outside of how they might ordinarily think.

The Tavistock Tradition

The Child Psychotherapy training at the Tavistock centre values learning from experience (Bion, 1962) and is evolving within the Post-Kleinian tradition. Indeed the Tavistock training was the first to include infant observation (Bick, 1968) as a key component of the child training and has for generations had a thorough, thoughtful and intensive clinical training rooted within the Post-Kleinian tradition (Harris, 1987). The study captures an element of that tradition and preserves it not only for generations to come but offers a reflective-historical account of an aspect of the Child

Psychotherapy training at the Tavistock which is in itself is a historical record. The participants, through their participation in the study, construct this historical account that future generations can access.

A brief reflection on the experience as a clinician–researcher

I came to this study because of my own interest, and this study provided the unique opportunity to think with experienced clinicians (who, by definition are experts by experience) about their clinical experiences. As a subjective clinician-researcher I wonder whether my particular areas of interest, some which may have been unconscious, were demonstrated through the interview questions I constructed and how I engaged with the interviewees. I also wonder whether the way in which I coded and constructed the themes showed my particular interest in clinical experiences areas or moved away from them. I felt positively overwhelmed while coding and grouping the codes. These struggles seem concordant with Bion's idea of "learning from experience" (1962) which is particularly valued in the Tavistock training of Child Psychotherapists. It was important to me to honour this tradition as part of my research experience however difficult it sometimes felt to be.

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Appendices

Appendix A: Semi-structured Interview Schedule

Interview Questions

1. In your experience how do you know when you are meeting clinical presentations that make the Claustrum come to mind over other kinds of narcissistic defences or acts of latency?

2. In your experience in what kind of clinical presentations might the Claustrum come to mind? Can you tell me about an experience that has come to mind.
   Sub Question: In that example how did you get thinking of the Claustrum? That is -what made it seem to you to be very helpful in understanding the clinical presentation using that lens.

3. Sometimes a sense, feeling or intuition is helped by considering a theoretical structure to help the experience come together. In your experience can you tell me about a time that you felt the Claustrum has been helpful in making sense of a clinical experience.
   Sub question: i) Can you think of a time when a particular Counter-Transference experience has led you to think the Claustrum is helpful in making sense of this experience.
   Sub question ii) Something connected to what person has said

4. Have you found ways to talk about Claustrum like experiences that are accessible to the patient? If so can you speak about an example.
   Sub Questions: i) What kind of communicative language might you offer to the patient to facilitate a discussion with them about it.
   ii) When you address notions of Claustrum phantasies in the room what is the impact on the patient? That is can you say something about how your interpretation was received by the patient and what the impact was on them. Can you tell me about a time this has occurred that has come to mind.

5. The compartments of the Claustrum can offer a sense of an illusion of something dynamic in otherwise an intrusive and static way of relating to the therapist. Have you found that certain compartments of the Claustrum are easier or more difficult to talk about with patients? If so which ones come to mind, and with what kind of patient presentations.
   Sub question: i) Perhaps there have been times that you have noticed that a patient has commuted between compartments. Can you tell me of an experience where this occurred, what you noticed and how it manifested in the clinical presentation.
   ii) In your experience what do you think has promoted this commute?

6. Can you think of a time where the transference manifested in one of the compartments and where in phantasy you as therapist was placed to reside?
   Sub question: Can you describe your counter-transference at this time. Do you find that you use different techniques or methods depending on what compartment you suspect that the patient is residing in – please tell me about it.

Appendix B: Participant Transcript

Participant: 3
Interview on: 4.12.19
Length of Interview: 36 minutes, 37 seconds
Place of Interview: The Tavistock Centre

AV: Thank you so much for meeting with me today to be … and being part of my research. So the working title the title of the research is *Encounters in the Claustrum: An exploratory study of the Claustrum in contemporary Psychoanalytic Child and Adolescent Psychotherapy Practice.*

So what I'm interested in really is just your experience of being a child psychotherapist and your experience of thinking with or working with the claustrum.

AV: Okay. So, in your experience how do you know when you are meeting clinical presentations that make the Claustrum come to mind over other kinds of narcissistic defences or acts of latency?

P3: [Pause 3 seconds].

Well that is an interesting question because I would not necessarily make that division between other narcissistic defences or acts of latency. I wouldn't bring those things –

AV: Uh.

P3: To the forefront of my mind and make a comparison.

AV: Um.

P3: But what I would say is that my experience in supervisions or in you know in reflecting you know reflecting on clinical practice more than in in you know not necessarily more than in the here and now um it's the quality of the phantasy so it's a quality of the person's idea about where they need to reside that being valued in a very particular way by the patient and um so there is a spatial dimension for a start whereas others comparatively thinking about other narcissistic defences for me are more about the ego or the self or some identity about what I possess. The Claustrum is about for me when the patient is expressing an idea that when is that where they reside, where they take up residence is a valuable place and it doesn't include others.

AV: [Clears throat].

P3: Um and there is a value to it, which is omnipotent so I suppose for me whenever I hear about those cases where that the omnipotence comes to the fore around um sss [sucks teeth] ah ff ... an idea that they know where they should be ... I suppose it's quite hard because sometimes it's not a real spatial experience but it can be sometimes there are phantasies around about say [clicks mouth, laughs] idealised situations and I a suppose I am thinking about Meltzer himself talking on a recording that is in the library it's really interesting actually and he talks about kinda' phantasies

around .. umm ... desert islands say um that this is you know despite the fact this this is absolutely no nutritional value to the place or to the life force life giving experience it is overvalued and I suppose what the projection is into into the therapist or I suppose what gets stirred up in the Counter- Transference is a feeling of exclusion and not having access to this special place. Um and that this special place is self-cultivated so it's it's cultivated by the patient um not through relationships.

AV: Hm.

P3: All those qualities you start to build a picture of something quite three dimensional rather than inter – not just …

AV: Hm.

P3: Interpersonal um for me it's what what helps me think.

AV: So, in your experience in what kind of clinical presentations might the Claustrum come to mind? Can you tell me about an experience that has come to mind?

P3: Umm [long pause] I can I can speak of an experience of when I was trainee ah because it was my first my first helpful encounter in supervision umm I was having supervision with [name removed] and she very helpfully linked a piece of clinical material to the Claustrum um which helped me understand something as a therapist because the patient who was two and a half came behind my chair uh …

AV: Mm.

P3: In a syrupy fashion and suggested that he might wash my hair [laughs] which I was really ambivalent about in the session I remember thinking it's not quite right but he looks friendly, things are quite friendly [friendly laugh] and um I really was then surprised when [name removed] was more firm that is an absolute no he is um heading down your back passage. This is about alternative entrance um when the um then the boundaries relating through the eyes. She absolutely helped me with the boundaries relating to the kinds of ways in. Ah I suppose the experiences of for the patient when in fact there is always the loss when you actually can't get right in you you you are reliant on the dependency relationship for want of a better phrase and a perversion of that is to reject that face to face encounter and to try alternative and he literally used to try and go behind and try to lure me which is kind of seductive idea that you can seduce umm someone into the special place…

AV: Yeah.

P3: Which is not you know um so that's that's ya ya one example I don't know if it is helpful?

AV: It is … I mean you you are tell me that supervision was really helpful to think about the Claustrum, your supervisor was the one who introduced that to you?

P3: Yes yeah.

AV: Yeah and then it seemed helpful in understanding the clinical presentation in that lens.

P3: Yeah.

AV: So, what was it that that kinda really made you get it then is that it felt

P3: Right.

AV: Yeah.

P3: Yeah.

AV: Yeah [back and forth exchange of yeahs between us]

P3: So the reading it's a time when you are reading more as a trainee, you do most of your reading as a trainee um unless you go on to teach theory you start to do the reading again amm [as if a swallowing of the word] but what is really interesting and stuck in my mind about Meltzer's concepts are from two sources, three sources. One, one from the recordings of his seminars um which we given in fourth year theory, the other was the Psychoanalytical Process and the other is his commentary on Richard.

AV: Um.

P3: I don't really hold on to Meltzer's concepts from the core texts really particularly in terms of the Claustrum or the uh Autistic phenomena I can't even remember the name of the book really. Um although I've I've read them; they are not where um it's the dynamic quality of them that is more important to them for me when he is talking about clinical work.

AV: Ok.

Sometimes a sense, or a feeling or intuition is helped by considering a theoretical structure to help the experience come together. In your experience can you tell me about a time that you felt the Claustrum has been helpful in making sense of a clinical experience.

P3: So I supervise someone who sees a very damaged child actually, but the damage is in one of those situations where the damage is not so explicit to say in a psycho – socio for want of a better phrase point of view you know, wouldn't meet threshold in Social Services this child has quite clearly been emotionally abused chronically in a family situation that is quite pathological.

And it's quite frustrating piece of work, the therapist is seeing the child privately twice a week and um there isn't much of a network around. The case, parents, aren't really engaging in the parent work anyway. She repeatedly draws um representations of um the inside of her old flat [burps] which pardon me um have lots of different routes around the flat that. It's all really quite unusual. She wants somehow for this therapist to fully visually engage in the kind of innards if you like of this flat.

Emm and you could make links, meaningful links with her real life. So her parents divorced and left this property and went to live elsewhere and got into new relationships and both have newly um constituted families and there is something about really this flat being important to that history but actually I have always felt that it is something much more about the primitive sort of spatial orientation this girl has to earlier impressions to how she has sort of identified a very complex world that she has sort of developed through e mem it's an impression that she carries with her all the time. This this flat ah I believe it is a sort of retreat if you like. Umm but it is not very straight forward.

The staircases, the stairwells, the rooms the various different things so I felt. I mean there were the social and emotional aspects from the wider family; but I felt that this was much more about the child's internal world. And about um something about the internal world and where she resides in a more claustrum deadly place. I mean a place where the family had actually ended the place from where they ended but something about her own internal objects becoming quite stagnant these various different compartments. And um not being able to develop. She is also a child who em still struggles with toileting. She was never has never properly toileted. She didn't go through toilet training. She is nine or ten now still struggling and yet developmentally in other areas has really developed. And I think that those mismatches in development.

She is also what I feel what Meltzer was talking about where you know things become really unintegrated. You know there are parts of the primitive internal world that are still in part of these strange shapes and then there are these intellectual levels that children sort of move into but of course there is no integration.

AV: Is there a time when you felt either supervising someone within your own counter-transference in supervision someone or in a case yourself in your own counter-transference which actually made you think of the Claustrum?

P3: Probably loads em but I don't think of any that come to mind really umm ahh [thinking].

It's not far, it's not far from my mind when you know as I said before you know the quality of anything idealised and deadly anything idealised and deadly. Um I worked pre pre-training in a therapeutic community with young woman with a variety and actually young men actually with eating disorders and um. There is that kind of cross kind of contamination of something really repulsive with a just manic desire to be completely pure [laughs] and um these were like young women who really just could not manage for example their own um cleanliness [speech quickens] you know they had sort of bits of marmite on their white dressing gowns and they had sort of bits of food smudged in everywhere [laughs] and yet would want to appear pristine and yet in a pristine way and a I I think these are of the sort of border like qualities that you seem to think absolutely what he was talking about so these things I think for those types of presentations really do come to mind all the time.

AV: Yeah.

P3: Umm.

AV: Okay.

Have you found ways to talk about Claustrum like experiences that are accessible to the patient? And if so, you know how how do you do that? Can you tell me about an example?

P3: I can't probably give you a kind of clear example except as other than that that I would probably do talk about the how terrifying it would be to leave this place that has become ah so special and important. You know I think em thy really think … I can't think of an example actually.

AV: What about in supervision?

[pause 3 seconds].

P3: Gosh. There are probably loads of examples let me just try and gather one.

[pause 4 seconds].

Well I suppose there is that earlier example of that little boy I did say to him that is not the way in [chuckles for 3 seconds and then this develops in a hearty laugh].

AV: And what what was his response?

P3: [Talk almost over me as if recollecting to themself and with enjoyment].

You don't need, you know, I remember, what did I say about the hair washing when I was a trainee and also I was young myself and probably a little bit embarrassed about the whole thing myself as a new therapist thinking how do I talk to a two year old about a strange sexualised wish to merge his fingers with my hair um you know it is weird [small laugh] and um so I probably did say something not so weird about how important it was that we had a relationship with each other that was upfront. I probably literally said I mean something something like that and probably likely put a chair in front of me and said let's do something together. Something something like that. I mean sometimes sometimes it really is something physical. Em with very young children phantasy is physical. It is a physically embodied concrete experience. And so …

AV: To speak a communicative language might you might use?

P3: It is quite literal.

AV: Yup.

P3: Yeah, I mean. To be honest I think for anyone like it's like saying when Klein talks to Richard isn't it it's a little bit on the level of wowsers at the can you honestly believe that she said that and I think that she probably did but um I think anyone with a kind of greater self -consciousness to be faced with phantasy in that form would probably be quite appalled. The more disturbed you are the less appalled you are ya you know I think ah –
AV: Say more about that. The more disturbed you are.

P3: Well I suppose if you are living in those phantasies …

AV: Yeah.

P3: And you feel that they are literally they are reality.

AV: Yeah.

P3: You are probably less disturbed by ah references to the literal phantasy.

AV: Yeah.

P3: Where I think the more the more it is a pocket of your phantasy in the way that um [talks to self] who talks about pockets Bion? Em you know where there are moments where those phantasies are kind of more sort of present in others but by and large you are sort of ticking along all right. I think then then you feel really much more disturbed, equilibrium in your personality is really much more disturbed.

AV: Yeah.

P3: So, I suppose you judge these things accordingly. I mean that girl the one I was talking about before in supervision she is less disturbed when the therapist is more straightforward.

AV: Yeah.

P3: Actually, about the phantasy. Because I think that she thinks that the phantasy is real.

AV: Yeah.

P3: Yeah. I think the merger say of her pooh and what she thinks it does to the world for example she feels is quite literal. So, a discussion around that any kind of representation about that is a relief.

AV: And when you addressed notions of Claustrum phantasies in the room or noticed it in supervision what has been the impact on the patient? That is can you say something about how your interpretation was received by the patient and the impact on them.

P3: Well the hair washing guy [laughs deeply] was deeply disappointed.

AV: [I join in on the laughter]. Was he?

P3: Well he kept he kept trying again and again and you know I think he was a very damaged kid based on having had very early experiences of quite traumatic separation. So, you know catastrophic separation, so he was desperately trying to find that way in that secured him his place. You know he wanted to find his place he could not trust that finding his place was possible through ordinary means. That had

already broken down. So of course, he thought that there was another way in. Wowsers in phantasy you know um it doesn't feel like it is phantasy to him. What he was acting on was motivated by phantasy but of course it was also motivated by a very real need to feel secure. And um.

You know of course um being repeatedly told that that is not the way in but that there is another way in but yet it is not the one you can trust and that actually does mean that time and space and that it's real kind of reality of time and space means in fact there are em a not forever feeling of connectiveness you know that you have to go through hellos and good byes um stops and starts just like everyone else. You know actually that that brings back terror, so you know ah em the phantasies themselves I think uh em … humorous is not the right word but I think phantasyful you always think like ya you know like when Meltzer talked about down the slippery slope down to the wonderful desert island which I think interestingly in my mind always signified a very dark place, so I always thought a desert island in the dark is not actually very pleasant. And yet of that's all you got then of course it's a lot more pleasant then nameless dread if you like.

AV: You make it homely.

P3: Yeah. You you you take up you know and and and you start to feel that this is better than what's what's on offer. Um but of course it's not humorous really because um developmentally arresting taking up that place in the dark um you aren't able to take advantage of the nourishing experiences that are available to you because if you can't trust them because your fundamental belief in humanity in the world has been ruptured than you can see perfectly well the idea why becoming a perverse is aa hair dresser is at least you are in control.

AV: Yeah.

P3: Yeah.

AV: You have a place.

P3: Yeah you have a place. And you think you are having a kind of a a positive relationship with someone.

AV: Hmm.

P3: You are holding them there. Oh well If I use some kind of sexual seduction, they'll they'll want to stay with me. I think it's complicated.

AV: And I was thinking of something you said earlier of a child putting you in a position, he is doing something to you.

P3: Umm [tone rises].

AV: Instead of actually you doing something to him.
P3: Yeah.

AV: An encounter.

P3: Quite.

AV: He is taking control of it.

P3: He takes control of it.

AV: At two, two and a half years old.

P3: Yeah yeah and interestingly he was a kid whose mother did not cut his hair. Um and left him looking really awful actually. Um it was only when he was put in care that he got a haircut. And I am just wondering if that haircut felt an additional separation from his mother. But um yeah.

AV: Yeah okay. So now I want a bit about Meltzer's compartments of the Claustrum.

P3: Compartments [Unsure tone, laughs briefly].

AV: The compartments can offer a sense of an illusion of something dynamic happening -

P3: Yes.

AV: But actually, it's an intrusive and static way of being with the therapist. And I am wondering if you found certain compartments of the Claustrum are easier or more difficult to talk about with patients? If so, which ones come to mind?

P3: They just don't. This is where I can talk about the other thing, but I don't think in terms of those compartments.

AV: Yeah.

P3: In that example that we just discussed you know there are certain levels of that compartment and there are those patients aren't there where you think I have just been completely lured in, like an intellectual level of conversation –

AV: Like the head/breast.

P3: And it's exactly and I know it looks like this was engaging and nourishing and therapeutic and all of that, but it wasn't.

AV: Um hm.

P3: And I do but I don't use the actual ah they are not the terms that I think about.

AV: It sounds to me that the way you think about it something about the overall quality of being with somebody in the Claustrum -

P3: Yeah.

AV: Instead of what compartment that they may be residing in.

P3: Yeah. Yes. Absolutely.

AV: It's how I am understanding it.

P3: Yeah … I don't really … I think I suppose … the patients speak for themselves in terms of the quality of that actual compartment if you like.

AV: Yeah.

P3: And I am sure everything Meltzer drew on to come up with those concepts for him was completely … ah you know em [laughs] was reasonable.

[Continues laughing].

AV: You know because he talks of patients moving in between compartments or commuting in between compartments –

P3: Yeah. But for me is too sophisticated for me to get my head around when I am trying to work with a patient. But I do think conceptually you know when someone is in the service of the death instinct.

AV: Yep, yep.

P3: And or in conflict, more open conflict, with the life instinct. And that to me sort of seems to not and I I suppose I appreciate the three - dimensionality of it. You know the kind of idea of how the personality can become a kind of Claustrum in and of itself similarly John Steiner's Psychic Retreats. I sort of feel that it has a why certain personalities hold themselves together in that way, but I think I pay less attention to where I am geographically in relation to that that that patient's presentation.

AV: Hmm

P3: Yep, yep. I probably don't interpret in that Meltzerian way. At all.

AV: So how would you interpret? Or …

P3: I would probably just ahh so take the intellectual conversation that is not going anywhere. I'd probably refer to the um … the productiveness or not of a kind of particular conversation. In very simple terms.

AV: Um hm.

P3: Yeah. I haven't worked with huge amounts of people whose communication is sophisticated enough to get into other kinds of dialogue. I mean I have worked with a lot of people with quite severe learning disability and autism and how are possibly quite traumatised and you know I think I think for me body references and the quite literal bodily phantasies is more important and in a way I think I have come away, have

become a less sophisticated therapist by result. I also don't think very psychoanalytically [bursts out in laughter for some time].

Quite literally what yeah, I I don't really think of compartments do I?

AV: I think that you are talking something about trying to reach the patient where they are at.

P3: Yeah yeah.

AV: And I think it's it's particular with trauma work –

P3: Umm.

AV: That it is very very important.

P3: Yes.

P3: That the thinking is … well it's been … it's been traumatised, so I am thinking that it is about being in an experience.

P3: Yeah and I think about recognising always the patients need for – what motivated them to act on one or another phantasy. And I I am a needs recognising therapist if you like.

AV: Um hm.

P3: And sometimes …

AV: So, needs over wishes.

P3: Yeah so moreover the expression of phantasy as something more perverse.

AV: Okay.

P3: And I think that there are theorists and some who I am very interested in including Meltzer, but I think that they are also quite invested in what they think theoretically. And um … and I think … he was probably an immense clinician Meltzer ... but ah … I think … sometimes the theory is too heavily theoretical … I don't carry it around in my head.

[laughs, I join in].

AV: Um I don't I don't know if we will be able to get here or not, this is the last question because it is about thinking about a time when the transference manifested itself in one of the compartments and what where in phantasy you feel as the therapist placed but if it feels difficult to think about compartments perhaps it's helpful to think of the Claustrum experience as a whole.
P3: Yeah.

AV: And where you feel you were being placed and your counter-transference.

P3: Yeah.

AV: And do you, do you feel that you need to adapt you're your technique or your method to reach the patient depending on where you think their state of mind is in or?

P3: I mean I would do that anyway I would not generalise at all as in whether there are times in relation to the Claustrum, so I do this that or the other. I do nothing in relation to the Claustrum itself if you see what I mean. I do everything in relation to the patient first and foremost –

AV: Because you are not thinking theory.

P3: Not really.

AV: Yeah.

P3: Well I am motivated massively by theory, really, I am fascinated by theory, but I do not think theoretically about the patient in the here and now. Other than my skills as a therapist have found roots in some theoretical framework.

AV: Yep. Yep.

P3: So, I am related to theory so in the sense that as I therapist I feel that I am rooted into something theoretical, but I don't think that my patient is a theory. So [laughs]

I suppose I approach a patient always with some it's like that sort of [inaudiable] of nervousness when you see a patient because you absolutely don't know so it's that so it's that's how I approach every patient and we get to know them over time and theory starts to to make be more meaningful over time. And I suppose there was one patient who was deeply narcissistic who I don't know whether if it was all more Claustrumily or she em she had housed herself in in a phantasy in fact it was a brilliant example of something.

It was what her mother had said about her which was, she said, at the age of one she climbed the stairs so this child intellectually at the age of one according to her mother just like went whipping up the stairs. But she felt the mother that there was a very infantile part of herself left at the bottom of the stairs that had never caught up.

AV: Um.

P3: And em this part of the patient who was now at the top of the stairs eh let's say would absolutely denigrate this infantile more vulnerable dependant part and absolutely would refuse this aspect this part of herself and allow access to anything remotely um pleasant, nice.

Anyways so this part got projected into me as therapist am um um, I was was denigrated to beyond belief really. But um and eh technically I suppose if you I am thinking about what did I do? I started to do what you would do to that very early infant.

I started to do sort of em trying to get into dialogues that were more about em ah Call and Answer kind of communication, something rhymical. Very little conversation. She would also try to trump me or if I did anything that was remotely intellectual so there was absolutely no point.

I mean she em had an omnipotent phantasy for example that she wrote down on a piece of paper in lots of detail that she had been observing me all holiday. She had seen me go into a flower shop and buy some roses. She had seen me you know in various, and different various different places. She was all knowing like god basically. Um and eh she had been observing me. However, this ah sort of desperate part of herself really was excluded from this. So, you know I suppose that it does fit in terms of the compartments funnily enough. You know she had absolutely left this part of herself in a very dark, horrible place. Em, and I was to be kept in the dark all the time. In fact she also told me a story which was very interesting. She said that the light broke and dropped and broke into a bin and this is what she described in one of her stories. Which I think were quite concrete phantasies.

Um so in the transference it was of course I was a piece of crap, I was in the dark, but you know I was residing in a bin for quite a lot of the time. It was quite horrific it was one of the worse cases I ever had. And um she ah she and I did get into sharing a dance routine with our feet. And that was pretty much the only form of dialogue in ...

She she caught herself having some pleasurable experience or a more ordinary kind at one point. And I suppose the fear that this would lead to the catastrophic loss of this more idealised part of the self was unbearable. Which I mean unfortunately the therapy finally broke off and I think that it was at that point where something could come together and you know terrifying.

This was the idea that she could lose this you know heavily cultivated and yet really unable to live in relationships with that part of herself. She was isolated, she was so em superior. I mean she was so superior that she had no friends and em her parents were desperately worried about her rightly.

Em my supervisor and I used to think desperately in what she would end up doing. You know just horrible really. But that was … yeah. Is that, is that okay?

AV: But did it break off I am just wondering about her becoming more aware of where she has been residing.

P3: Ahh [questioning tone].

AV: Or was it you know.

P3: I think it was just the fear of contamination of this other part of herself that had been left at the bottom of the stairs.

AV: Yeah.
P3: That this piece of pooh could not touch this … you know I think the phant- the the idea of any integration was possible; it was just terrifying. Um.

AV: So, she wanted to protect that.

P3: Um.

AV: Yeah.

So we have come to the end of the questions and I want to thank you so much for being part of it and want to ask you do you have any comments or questions or anything you would like to say or know before say goodbye?

P3: No, I I don't. This was really interesting and um and really interesting subject and I am glad things came to my mind.

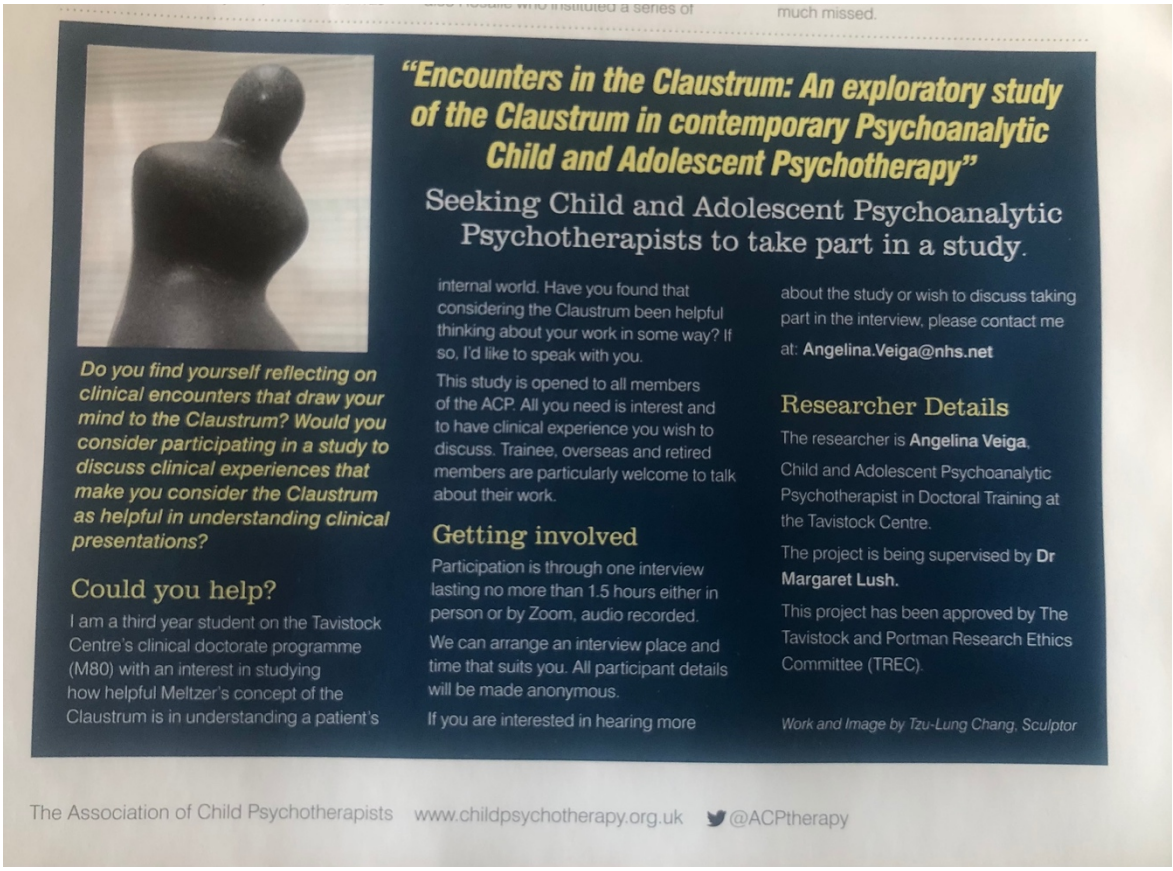
[laughs, I join in].

I wasn't quite prepared as you can see for all these questions; but I hope it was helpful.

AV: It was very helpful, thank you. Thank you very much bye bye.

[Ends both laughing].

Appendix C: The Bulletin Advert



much missed.

"Encounters in the Claustrum: An exploratory study of the Claustrum in contemporary Psychoanalytic Child and Adolescent Psychotherapy"

Seeking Child and Adolescent Psychoanalytic Psychotherapists to take part in a study.

Do you find yourself reflecting on clinical encounters that draw your mind to the Claustrum? Would you consider participating in a study to discuss clinical experiences that make you consider the Claustrum as helpful in understanding clinical presentations?

Could you help?

I am a third year student on the Tavistock Centre's clinical doctorate programme (M80) with an interest in studying how helpful Meltzer's concept of the Claustrum is in understanding a patient's internal world. Have you found that considering the Claustrum been helpful thinking about your work in some way? If so, I'd like to speak with you.

This study is opened to all members of the ACP. All you need is interest and to have clinical experience you wish to discuss. Trainee, overseas and retired members are particularly welcome to talk about their work.

Getting involved

Participation is through one interview lasting no more than 1.5 hours either in person or by Zoom, audio recorded.

We can arrange an interview place and time that suits you. All participant details will be made anonymous.

If you are interested in hearing more about the study or wish to discuss taking part in the interview, please contact me at: **Angelina.Veiga@nhs.net**

Researcher Details

The researcher is **Angelina Veiga**, Child and Adolescent Psychoanalytic Psychotherapist in Doctoral Training at the Tavistock Centre.

The project is being supervised by **Dr Margaret Lush.**

This project has been approved by The Tavistock and Portman Research Ethics Committee (TREC).

Work and Image by Tzu-Lung Chang, Sculptor

The Association of Child Psychotherapists www.childpsychotherapy.org.uk @ACPtherapy

Appendix D: Participant Information Sheet

The Tavistock and Portman NHS
NHS Foundation Trust

Participant Information Sheet

Date: 11.3.2019

Version: 2

Encounters in the Claustrum: An exploratory study of the Claustrum in contemporary Psychoanalytic Child and Adolescent Psychotherapy Practice.

What is the purpose of the study?

The purpose of this study is to investigate Psychoanalytic Child and Adolescent Psychotherapists' experience of clinical situations where they feel that Meltzer's concept of the 'Claustrum' is helpful in understanding the patient's internal world within their clinical practice.
This study is part of the researcher's Professional Doctorate in Psychoanalytic Child and Adolescent Psychotherapy.

What is the study about?

This proposed study is about how Psychoanalytic Child and Adolescent Psychotherapists experience clinical situations where they feel that Meltzer's concept of the 'Claustrum' is helpful in understanding the patient's internal world (i.e) a patient's thoughts and feelings both conscious and unconscious). This study is concerned with linking clinical experience with theory.

This study aims to investigate:

1. The experience of CPTs working with young people during the clinical situation.
2. How understanding of the Claustrum is helpful in understanding clinical presentations.
3. How the understanding of clinical phenomena considering the Claustrum can contribute to a wider discussion amongst CPTs regarding the understanding and practice of Child and Adolescent psychotherapy.

Who is undertaking the study?

The lead researcher in this study is Angelina Veiga, Child and Adolescent Psychotherapist in Doctoral Training at the Tavistock Centre. The study is supervised by Dr Margaret Lush, Child and Adolescent Psychotherapist. Contact details for the research team can be found at the end of this information sheet.

The Tavistock and Portman NHS
NHS Foundation Trust

What will happen if I choose to take part?

- If you decide to take part in the study you will need to complete a consent form. This will be completed just prior to the interview.
- You will be invited to an interview at the Tavistock Centre. Alternatively, the interview can take place over ZOOM. I can arrange an interview time that suits you.
- At the interview appointment, you will meet with the researcher for a semi structured interview, this is the data collection.
- It is anticipated that the appointment will take no more than 1.5 hours.

Confidentiality: how will information about me and data gathered in the study be used and stored?

If you chose to participate in the study your data will be held in confidence. You will be given a participation number by the researcher and this will be applied to all data collected from you.
Your anonymity will be protected in the analysis of data and the report of findings.
Data will initially be stored in a locked cupboard. It will then be transferred to an electronic file which will be password protected.
Data will be kept for no more than 10 years, at which point it will be destroyed.
Data generated in the course of this study will be kept in accordance with the University of Essex Data Protection Policy.

Please note: **The confidentiality of the information that you provide is subject to legal limitations in data confidentiality (i.e. the data may be subject to a subpoena, a freedom of information request or mandated reporting by some professions).**

What will happen to the results of the study?

The results of the study will be written up as part of the researcher's Professional Doctorate in Psychoanalytic Child and Adolescent Psychotherapy. The study's findings may also be submitted for publication in professional journals or presented as conference papers. The study's findings may also form the basis for future research or presented in workshops or seminars.

Is there a benefit to taking part in the study?

Taking part in the study will provide you with an opportunity to experience being a participant in a novel piece of Child Psychotherapy research which you may find interesting. It will provide you with the opportunity to participate in a wider professional discussion and share your experiences with someone who is interested in learning about your clinical practice and formulations.

Are there any risks or disadvantages to participating in the study?

There are no known risks or disadvantages to participating in the study. It is not anticipated that this study will be out of the boundaries of normal working experiences but in the unlikely event that you have any questions about the study please contact me.

The Tavistock and Portman NHS
NHS Foundation Trust

Further Support and Guidance:
Further support about the conduct of the research can be sought by contacting Simon Carrington who oversees the Tavistock Centre's Academic Governance and Quality Assurance.

Further support on debriefing or advising on adverse reactions can be sought by conducting Dr Lush, the project's Research Supervisor, or through your own professional support networks (colleagues, supervisors, analysts).

In the highly unlikely event that risk to self or other be shared during the interview; statutory reporting will need to occur. I would initially need to consult with my Research Supervisor and the Head of Safeguarding at the Tavistock Centre who would guide me in managing this highly unlikely situation.

Withdrawing
If you have a query about withdrawing your data please contact me or Dr Lush. To preserve the study's data collection time line, should you wish to withdraw your data from the study please notify the Researcher within 6 weeks of the interview, after that time the data will be included as it will be too late to recruit another participant.

Thank you for taking time to read this information sheet.

If you have any questions about the study please contact:

Researcher: Angelina Veiga, Child and Adolescent Psychotherapist in Doctoral Training
Email: Angelina.Veiga@nhs.net

Research Supervisor: Dr Margaret Lush, Child and Adolescent Psychotherapist
Email: MLush@tavi-port.nhs.uk

Any concerns about the conduct of the research:
Head of Academic Governance and Quality Assurance: Simon Carrington
Email: academicquality@tavi-port.nhs.uk

Appendix E: Participant Consent Form

The Tavistock and Portman NHS
NHS Foundation Trust

Consent Form

Date: 28.1.2019

Version: 1

Encounters in the Claustrum: An exploratory study of the Claustrum in contemporary Psychoanalytic Child and Adolescent Psychotherapy

- I confirm that I have read and that I understand the information sheet provided for this study. ☐
- I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
- I understand that my participation in this study is voluntary and that I am free to withdraw at any time, without giving a reason. ☐
- I understand that the interview will be digitally recorded and then transcribed. ☐
- I understand that information given in this interview will be written up as part of the researcher's dissertation. It may be used by the researcher in future publications, reports or presentations. ☐
- I understand that any personal data that could be used to identify me will be removed from the transcript of the interview and that I will not be identified in any publications, reports or presentations. ☐
- I understand that the data will be kept securely and destroyed within 5 years after the project's completion. ☐

Participant's name (Print): Participant's signature:	Date:
Researcher's signature:	Date:

Many thanks for your participation in this study.

This project has been approved by: The Tavistock and Portman Research Ethics Committee (TREC)

Appendix F: Ethical Approval

The Tavistock and Portman NHS
NHS Foundation Trust

Quality Assurance & Enhancement
Directorate of Education & Training
Tavistock Centre
120 Belsize Lane
London
NW3 5BA

Tel: 020 8938 2699
https://tavistockandportman.nhs.uk/

Angelina Veiga

By Email

21 March 2019

Re: Trust Research Ethics Application

Title: Encounters in the Claustrum: An exploratory study of the Claustrum in contemporary Psychoanalytic Child and Adolescent Psychotherapy Practice.

Thank you for submitting your updated Research Ethics documentation. I am pleased to inform you that subject to formal ratification by the Trust Research Ethics Committee your application has been approved. This means you can proceed with your research.

If you have any further questions or require any clarification do not hesitate to contact me.

I am copying this communication to your supervisor.

May I take this opportunity of wishing you every success with your research.

Yours sincerely,

Best regards,

Paru Jeram
Secretary to the Trust Research Degrees Subcommittee
T: 020 938 2699
E: academicquality@tavi-Port.nhs.uk

cc. Course Lead, Supervisor

Appendix G: Initial Coding

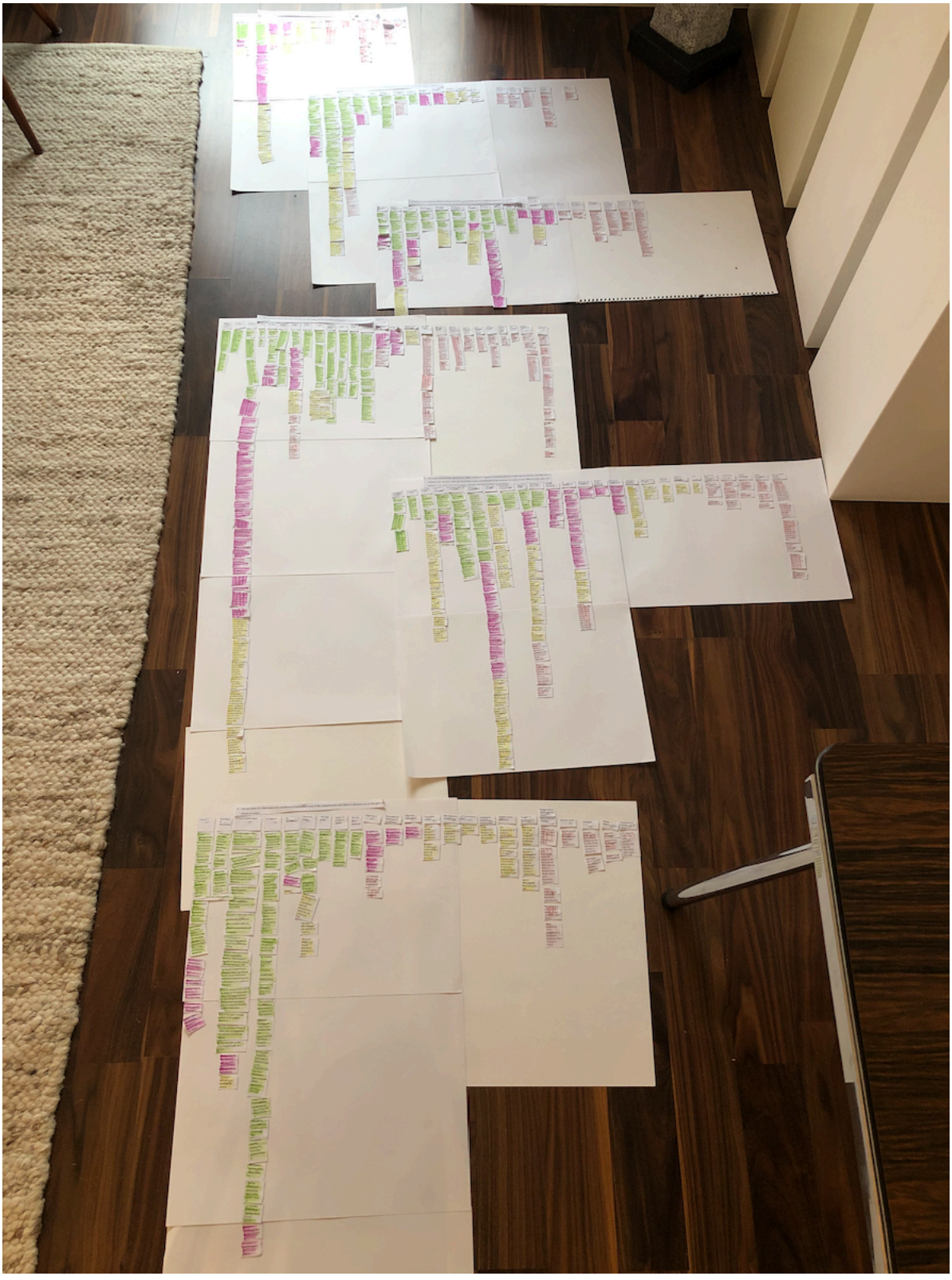


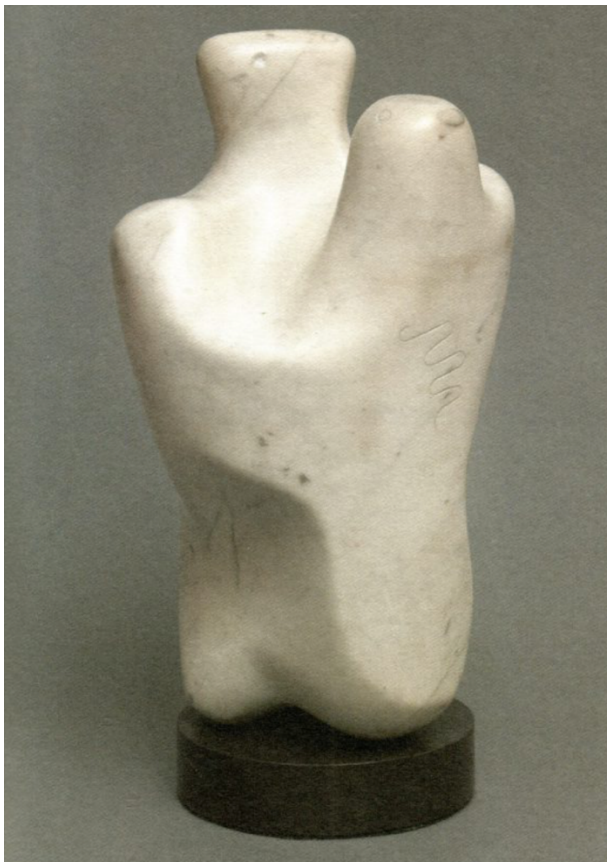
Table 1: Theme Table with codes

A	B	C	D	E	F
i) Representation of Internal States of Mind in session	*ii) Use of Dreams*	*iii) Aetiology*		*iv) Psychic Movement*	
CL as specific to a living inside the maternal object.	"The dream came ... this is very much related to the compartment".	Psychic Capacities	Ushering in	Psychic Growth	Psychic Struggles
Healthier person can differentiate between phantasy and external event: more difficult in CL	"it was a dream and had to be interpreted as a dream".	CL states that are rooted in external trauma seen as better than CL states stemming from phantasy because of the internal confusion between internal and external origins.	"something happens".	Transition to more traditional analysis enabled CL dream material because she trusted therapist.	CL viewed as a complicate
CL presentation in internal world may be absent in external world.	CL indicative in dreams.	"Premature trauma I think is the worst possible thing."	Absences and separation usher in CL states.	Patient's ability to use the therapy and support system around ("had good parents") helped patient move from CL.	Patient can easily fall back if new anxieties arise.
Physically embodied concrete experience.	Through a sequence of dreams over time therapist can track CL movement and processes of symbolisation.	Patients tolerance to their psychic expressions (dreams, hallucinations) impede on how they interact with help therapist offer.	Event that ushers in the CL for the patient.	Impact in discussing CL experience was helpful for patient because it helped the patient to face a truth in themselves.	Difficulty for patient to ge (pull back in) place.
Patient seeks an alternative entry.	Dream conveys CL transference.	Severity of CL based on patient's psychic capacity to deny separation between self and object.	Through encounter with therapist patient is put in touch with something awful, ushers in CL.	Patient could hear psychic truth being offered by the therapist and use it.	Disturbance of CL patients marked in comparison to c
Phantasy and reality are undifferentiated in the patient's mind.	Changes in material such as dreams indicative of a moving away from CL.	CL comes to mind when mismatch between what patient says and expression (expression of disgust and flash of pleasure).	Intergenerational experiences of CL living coming to the fore after an experience of psychic truth being recognised.	Facing a truth with the therapist brings insight to the patient.	Lack of alternative to live i way.
CL presence discerned by considering quality of phantasy "where they need to reside" "spatial"	Dreams signal CL.	Dichotomy of functioning think CL.	Therapist feeling that concrete experiences can potentially usher in CL experiences because of a previous	Coming outside CL is a sign of health.	Difficulties for the patient from the CL causes depres (regret) and inability to fu

1. Symbolic Repres of Phantasy | 2. The Therapist's Experience | 3. Knowing How to Respond | 4.Clin Practice and Clin Theory | +

Figure 1: Hepworth's depictions of the mother – infant relationship

1.



Barbara Hepworth, Mother and Child, 1933

2.

Barbara Hepworth, Large and Small Form, 1934