What is it like working with psychotic children and adolescents? A study of child and adolescent psychotherapists' experience.

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in

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All names and identifying details have been changed where possible to protect anonymity

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ABSTRACT

This study explores the lived experiences of a small sample of clinically experienced Child and Adolescent Psychotherapists regarding their work with psychotic children and young people. The research question is phenomenological in nature; the study seeks to understand *what it feels like* to work with these children. The method employed is IPA (Interpretative Phenomenological Analysis) owing to its compatibility with a small-scale qualitative study concerned with an idiographic approach, which aims to understand the 'world view' of individual participants. The following themes will be described:

1. Definition and Aetiology
2. Working with primitive states: the cost for the therapist, child, and family
3. Rival babies
4. What's required – setting, technique, and personal qualities

The themes will be discussed in relation to psychoanalytic literature. The study concludes that a sub-group of overtly destructive psychotic children continue to be under-represented in the literature and require significant individual therapeutic support in addition to the active involvement of a wider network. Psychotherapists require considerable support to sustain the work with these children and intense emotional involvement ensues. Recommendations are made for further research.

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CHAPTER 1

INTRODUCTION

The concept of psychosis in child psychotherapy is an intriguing, confounding and neglected area. The complexity of the topic relates to the developmental context specific to children, linguistic shifts within psychoanalysis, and changes to psychiatric diagnostic categorisation. Psychoanalytic figures in the 1950s began to take a keen interest in psychosis but there has been relatively little attention to psychosis in children outside the context of autism, with a notable exception in Houzel & Rhode (2018) and Rustin et al (1997).

This overlooked topic poses more questions than answers. My aim here is to provide a rich and deep idiographic exploration of the lived experience of child psychotherapists in their work with psychotic children and young people. It is a small project, but I hope the findings will contribute in a unique way to the profession. My interest arose out of clinical experience with once-weekly cases who I felt forced their disturbance into me and tested my capacity to tolerate intense countertransference states (Heimann, 1950); they also posed many technical dilemmas. I hoped the opportunity to explore the lived experience of qualified clinicians and immerse myself in the relevant literature would help me understand some of these things better. I anticipated that participants might give vivid and viscerally evocative accounts of their experience. I was, however, more in the dark about how they would make sense of their experience and the meaning they might ascribe to it.

To operationalise the research question, the key word, 'psychosis' must first be defined; it denotes 'any of a number of the more severe mental diseases that make

someone believe things that are not real.' (Cambridge Dictionary, n.d.). The literature review will acknowledge some pieces of literature from wider contexts; however, to gain some purchase on the research topic it was necessary to narrow the study's setting and scope of meaning to an exclusively psychoanalytic context.

The research topic focused on psychosis, but participants were also free to discuss psychotic states of mind (a common term within child psychotherapy) because exploratory conversations with colleagues prior to the start of this research revealed uncertainty about use of the term 'psychosis' for children and young people. This uncertainty was both linguistic and due to caution about the implications of such a diagnosis prior to emotional and neurobiological maturity. I hoped that flexibility around the research question would encourage a greater number of prospective participants to feel interested in joining this study, but I especially encouraged discussion of psychosis in a more chronic and enduring sense.

I originally intended to leave aside discussion of cases of psychosis within the context of autism, but a closer look at the psychoanalytic literature caused me to abandon this exclusionary criterion for autistic cases because it became evident that childhood schizophrenia disappeared from the literature. Houzel and Rhode (2018) state the ICD-10 (1993) and DSM-IV (1994) employ the term 'atypical autism' which clinically corresponds to the diagnosis of 'psychosis' in France (p.18). Thus, excluding cases whom participants described as autistic would have been somewhat arbitrary. The literature review will deal more extensively with psychoanalytic terms past and present associated with psychosis.

Rustin (1997) stresses that the wealth of literature by Meltzer, Tustin and Alvarez on psychosis in the context of autism produced new techniques for the psychotherapy of these children. She asks where this leaves the theorisation of non-autistic psychosis

in children. One might equally ask; where does it leave the clinical treatment of non-autistic psychotic children?

The research question seeks to shed light on the clinician's experience of the phenomena of psychosis. While I could not predict what data would emerge, I hoped psychotherapists would value the opportunity to reflect on their work in a different setting from supervision and peer discussion, perhaps to consider disturbing, intriguing, upsetting, mundane or alienating experiences.

From a mental health service perspective, the study may inform colleagues from other disciplines about the work of child psychotherapists, clarifying the level of need and the kind of resource required to work with children such as those discussed here. The study also acts as a record of the work that has been undertaken by a small sample but may be representative of a wider population of child psychotherapists. The findings may help clinicians understand the nature and technique of therapeutic work with these children and young people, and some implications for CAMHS (Child and Adolescent Mental Health Services) will be considered.

The focus is on the phenomenology of the clinician's lived experience. Rustin (1997) states that one element of the overall understanding of childhood psychosis is a deep description of the phenomenology of the child's experience. Exploring the clinician's experience can be seen as a complementary endeavour that may indirectly illuminate the former. Central to this study is a non-prescriptive approach and the freedom for participants to discuss their experience in their own way. It was, however, inevitable that I would come to the study with presuppositions of my own based upon clinical encounters and engagement with the literature.

In the next chapter, the literature review, various theoretical and empirical sources pertaining to psychosis and psychotic states of mind are discussed. In Chapter 3, I present the research project and the rationale for the selected methodology of IPA (Interpretive Phenomenological Analysis; Smith, Flowers & Larkin, 2009). The results in Chapter 4 and discussion in Chapter 5 present the findings in terms of the original research question and discuss it within the context of the literature. The conclusion summarises central findings and considers the strengths and weaknesses of the project and its implications for clinical practice.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

A brief outline of some historical junctures regarding mental illness frames the topic, followed by summaries of a small number of psychiatric texts since psychosis is the 'heartland of psychiatry' (p.191, Goodwin & Geddes, 2007). These general psychiatric sources pertain to adults. I will briefly discuss the philosophy of medicine owing to differences in ontological and epistemological approaches to mental illness. The main discussion focuses on psychoanalytic papers, literature regarding adult patients with psychosis are followed by child-specific papers on psychosis and psychotic states. In the section relating to children, I signpost a small amount of literature on child psychosis from the disciplines of psychiatry and psychology.

I conducted a narrative literature review which did not aim to cover all the literature present on the topic of psychosis in children. In order, however, to explore my research question within the present literature, a systematic search of the literature was undertaken using the PsychInfo database to identify experimental studies, clinical case study reports and theoretical writing.

As I started the literature search, I realised how the shifting linguistic changes regarding psychosis complicated it. I attempted to deal with the problem by initially taking a broad view to get a sense of the breadth and depth of available literature. I began with the following search terms, yielding the following results:

- 'psychotic state of mind' (98,105)
- 'atypical autism' (3, 793)
- 'psychosis' or 'schizophrenia' or 'psychotic disorder' (1, 658, 321)

These terms were searched for anywhere in the study/article, not only in the title or abstract. The terms most common to psychiatry generated by far the highest number of results, followed by the psychoanalytic term 'psychotic state of mind' and by far the least common was 'atypical autism'. This was not in the least surprising owing to the centrality of psychosis within psychiatry, the broad nature of the term 'psychotic state of mind' and the relative obscurity of 'atypical autism.'

I then attempted to delimit the pieces of literature to those that were likely to be most relevant and did so by combining the above search terms with 'children or adolescents' or 'youth or child or teenager' and 'psychoanalysis or psychoanalytic or psychodynamic'. Again, I searched for these terms throughout the articles rather than restricting them to the title and abstract as I was keen to narrow the search by subject area and population rather than potentially excluding interesting papers that had the topic of 'psychosis' as a subsidiary or secondary area of discussion in the main body of the text.

The process of excluding pieces of literature when it came to selecting those for discussion generally arose from observations of repeated thematic occurrences. For example, there was a vast amount of American literature, and it seemed pragmatic to retain a focus on UK and French papers because of the Object Relations approach to Psychoanalysis in the UK and the French history of psychoanalytic attention to psychosis and the limited scope of this thesis. Moreover, an enormous amount of literature pertained to psychiatry and a very high number were psychological studies. I therefore included a small number of these to represent those disciplines and to show context to the wider search, but otherwise left these aside.

In terms of selecting papers for the quality of their contribution, I frequently looked at the credibility of the publishing journal and peer review. The exception to this is

those outside the domain of psychoanalysis and therefore those subject areas in which I am less familiar, however, it was still possible to identify reputable sources with a little investigation, such as the BMJ (British Medical Journal).

My search was clearly far from exhaustive, undoubtedly there are interesting and important papers that I have not managed to locate or have failed to consider in depth, but I hope that there will be the opportunity for engagement with apposite sources of literature in the future. This may take the form of identifying new pieces of literature and revisiting and adjusting my search terms to unearth currently existing but overlooked papers.

2.1.1 The absence of a clear definition

The absence of a clear definition of psychosis in children was very apparent from the literature. Throughout this search I was reminded of a discussion with Rustin (personal communication) with which I now strongly agree. Her view was that it is a shame that the term 'childhood schizophrenia' fell out of the literature. My view concurs with this: her description of 'openly and actively destructive' children who are not in touch with reality, in my view are qualitatively and substantially different from psychotic children within the context of autism and/or those moving in and out of psychotic states along a more variable continuum. Naming these children specifically, such as by use of the term 'childhood schizophrenia' could restore their status in the literature and would be conducive to clinical discussion at various local, disciplinary, and inter-disciplinary levels. Being clear about *who* we are talking about is of paramount importance if we are to give these children the necessary level of theoretical and clinical attention and expand the conversation around their needs.

In this study, I decided to adopt Rustin's 'openly and actively destructive' definition of children who are not in touch with reality to describe psychosis from a psychoanalytic perspective.

2.2 History of Mental Illness

Horwitz (2019) provides an extensive account of mental illness, presenting theories of causation from ancient Greece to contemporary neuroscience, citing supernatural, psychogenic and somatogenic explanations that have been proposed throughout history. Supernatural theories began with primitive man's perception of all things being interconnected by inexplicable and enigmatic forces (Tzeferakos & Douzenis, 2014) and treatments can be traced back as early as 5000 BCE, evidenced by the finding of trepanned skulls from ancient cultures (Foerschner, 2010).

Horwitz (2019) discusses the later decline of medical thought from the fall of the Roman Empire through the Renaissance and Reformation alongside the increasing prominence of theologians and discusses the shift in the 17th and 18th century towards locating mental illness within a medical framework.

Crossley (2005) contextualises mental illness by discussing the emergence of 'madhouses' in the early eighteenth century and its link to the development of psychiatry. He cites Mechanic's (1969) theory that these madhouses were linked to industrialisation and contrasts Scull's (1993) different view, that change occurred because of the emergence of capitalist society; feudal order disintegration led to the 'mad' population becoming dislocated as social structures dissolved. Legislative changes produced a burgeoning system of public asylums, and Crossley reflects upon

their custodial function, stating that conditions were such that they deterred citizens from regarding it as a preferable option to the workhouse.

2.3 Modern Psychiatry

Beer (1996) states that in 1845 the term 'psychosis' encompassed various grave mental disorders and mental deficiency, and very shortly became interchangeable with 'psychoneurosis' and 'psychopathy'; various other psychiatric conditions were later gathered under its umbrella. Beer considers how 'psychosis' later came to be distinguished from neurosis and psychopathy, and outlines the ensuing pattern of dichotomies (including neurosis/psychosis).

Abou-Saleh and Millar (2016) cite Kraepelin's differentiation between manic depression and dementia praecox in 1887, and acknowledge the change when Schizophrenia was substituted for dementia praecox by Bleuler in 1911.

Moscowitz and Heim (2011) revisit Bleuler's concept of schizophrenia in light of current debates regarding classification of schizophrenia. They discuss the public recognition of Bleuler's notion of 'split personality', and his account of schizophrenia as more resembling a psychological deficit with an organic root than a thought-disorder; they suggest his attention to 'splitting' has been overlooked.

The current debate centres on renaming or abandoning the term 'schizophrenia'. Van Os (2016) suggests the term should be abandoned because of its association with 'hopeless chronic brain disease' (p.1). Van Os' view partly reflects a 2015 collaboration between families, patients and academics seeking an alternative diagnostic term, and he cites Japan and South Korea as having recently moved away from the term 'schizophrenia.' He suggests his view has strong support in recent

literature which makes the case for altering psychiatric classification. Abou-Saleh and Millar broadly agree but propose the eponym 'Kraepelin's disease', pointing to Lasalvia *et al.* (2015) who support changing the term schizophrenia but emphasise that broader adjustments are required to deal with public perception and work towards better treatment outcomes.

Maj *et al.* (2021) outline features of primary psychoses including hallucinations, delusions, confused thinking, disorganised behaviour, unusual motor actions, and negative symptoms. They cite several categories meeting this criterion, but lament inconsistencies between ICD-11 and DSM-5 in terms of the list of categories each contains and their varying definitions. Secondary psychoses evolved out of what Keshavan *et al.* (2013) described as an earlier erroneous classification of organic and functional psychoses; now referring to symptoms in the context of substance use or medical illness.

In terms of treatment, Schmidt Soares *et al.* (2013) claim psychosurgery for schizophrenia had a credible evidential basis before contemporary anti-psychotic drugs emerged in the 1950s, and suggest that because some patients remain unresponsive following first-line interventions, the effectiveness of psychosurgery should be investigated through controlled trials.

In the UK, NICE guidelines (2021) for adults and children recommend a trial of an oral antipsychotic in conjunction with family intervention and individual CBT (Cognitive Behavioural Therapy), or arts therapies for adults.

Crossley (2005) comments on the 20th century move away from incarceration towards a model of community care. Marshall and Rathbone (2011) sought to 'evaluate the effects of: (a) early detection, (b) phase-specific treatments, and (c)

specialized early-intervention teams in the treatment of people with prodromal symptoms or first-episode psychosis' (p.1). They conclude that some evidence supports specialised early-intervention services, but further research is needed.

An issue that caught my attention was that of racial disparity in diagnosis of psychotic disorders. A recent empirical review of the literature spanning 24 years (Schwarz & Blankenship, 2014) concluded that Black/African-Americans were diagnosed at 3-4 times the rate of Euro-American/White individuals, with Latino-American/Hispanic closer to the first group's diagnosis rate. Possible reasons cited by the authors are sociological in nature or influenced by clinical bias; they suggest further qualitative research.

2.4 Philosophy of Medicine and Psychiatry

Psychosis as a specific diagnosis is characterised by severe states of disorder in perceptual capacities and reasoning, manifesting in symptoms of hallucinations and delusional beliefs (NICE, 2021). To those unversed in the philosophy of medicine, psychosis therefore – along with other forms of mental illness – seems positioned within the domain of psychiatry in a relatively straightforward way. We know the discipline of psychiatry typically adheres to the 'medical model', promoting 'the consistent application, in psychiatry, of modern medical thinking and methods' (p.3, Black, 2005; quoted in Murphy 2020).

But does this disciplinary classification compel us to adopt a neurocentric view of mental conditions? Dominic Murphy alerts us to an important dispute where some sceptical theorists (those espousing a 'strong' interpretation of the medical model) deny that the DSM represents an accurate taxonomy of disease, since it is based on

observable symptoms rather than underlying pathological phenomena; disease, they propose, is necessarily constituted by bodily tissues subject to destructive processes. Advocates of 'minimal' interpretation, by contrast, advocate the categorisation of disease through the DSM as a group of symptoms based upon observable phenomena; they do not assume all instances of a given diagnosis – such as psychosis – share an underlying cause (Murphy, 2009; Murphy, 2020). The 'minimal' approach currently dominates, but the debate suggests even outside of psychoanalysis the subject of psychosis is not uncontroversial: its evasion of consensual understanding is not a uniquely psychoanalytic problem.

2.5 Psychoanalytic Literature on Adult Psychosis

Freud's (1911/2014) theory of psychosis was informed by Schreber's memoirs recalling his time in asylums, during which he was overcome by paranoid psychosis and strange delusions. Freud linked repressed homosexual desires with paranoia, and diagnosed that Schreber projected these impulses into his physician, and later into God, producing psychotic hallucinations. The catalyst for breakdown was Schreber's subjective experience of the world's end, with the psychotic symptom functioning as an attempted recovery as he reformed his devastated world. Freud's imaginative claim that the psychotic symptom aims at psychic survival, serving to bring the patient back into a form of object-related contact, continues to find support (Lewis *et al.*, 2003).

Crockatt (2006) states that Freud, Ferenczi and Abraham all struggled with the phenomenon of psychosis and, although Freud declared analytic treatment for psychotic patients impossible, it was from this early collaboration that Freud

developed his theories of narcissism (1914a) and melancholia (1917). In contrast, Kleinian analysts in the 1950's threw themselves into analysing psychotic patients, marking a new era of revolutionary psychoanalytic work.

Previously taken-as-read assumptions dismissing these patients as unanalysable were challenged by Bion, Segal and Rosenfeld, who not only thought it possible to analyse psychotic patients, but emphasised strict adherence to the central tenets of psychoanalysis (Spillius, 1988).

Rosenfeld (1947) presented a patient's state of depersonalisation as a defence-mechanism. These schizoid processes operate within the ego in reaction to destructive impulses, which the patient experiences as foreign. He claimed a connection between schizoid processes and depersonalisation. The understanding that splitting of parts of the self leads to ego-disintegration and depersonalisation is widely supported. In 1950 Rosenfeld considered the difference between confused feelings as an ordinary part of development, and confusional states as an element of many psychopathological conditions. He claimed attacks against the good object are motivated by envy.

Rosenfeld (1952) and Segal (1950) attempted to show that transference-analysis was possible, the former with a deeply-regressed schizophrenic patient, the latter through clinical discussion showing that she remained true to psychoanalytic technique and interpretation while accommodating the patient's defence mechanisms.

Segal later highlighted the great struggle experienced by schizophrenic patients to tolerate the depressive position, and their reliance on projection to tolerate depressive anxieties. It is testament to her unwavering belief in psychoanalytic principles that she (and other analysts) confronted patients with the painful facts of psychic life despite great disturbance and vulnerability.

Bion produced many ground-breaking ideas in quick succession (1954; 1955; 1956; 1957); focusing on the patient's use of language, and emphasising the peculiarity of the schizophrenic's object-relations, claiming that verbal thought is a secondary function that illuminates the object-relations of the schizophrenic. Bion believed the confusion between thought and action was a defining characteristic of schizophrenia, and brought the concept of projective identification into the work between patient and analyst. These ideas culminated in Bion's 1957 paper articulating the differences between psychotic and non-psychotic personalities. This stimulating area of psychoanalysis lost momentum when the psychoanalytic community began pursuing deeper understanding of pathological defensive organisations and borderline states (Spillius, 1988).

Freud's concept of psychosis as a defensive response suggests underlying fragility. Darian Leader (2012) discussed the treatment of an agoraphobic woman, whose removal of a symptom precipitated the onset of psychosis; the potential to de-stabilise the psychotic patient has also been acknowledged by Lewis *et al.* (2003).

Lacan (1953; 1958; 1966; 1975-76; 1993) made a sizeable contribution to the field of psychosis but space precludes detailed discussion of the Lacanian school of psychoanalysis.

2.6 Psychoanalytic Literature on Psychosis in Children

There is also a vast expanse of non-psychoanalytic literature reaching across multiple spheres, which falls outside the scope of this project but could in principle stimulate interesting cross-disciplinary debate. Sources from psychiatry include Van Winkel *et al.* (2013); Stevens *et al.* (2014); Bendall *et al.* (2008); Cutajar *et al.*(2010) and

countless others; while contributions from psychology come from Andrew *et al.* (2008); Bendall *et al.* (2011) Bucci *et al.* (2018) and McCarthy (2015) to name a few. Literature on childhood psychosis also encompasses less-common areas of co-morbidity such as learning disabilities (Friedlander *et al.*, 2004) and organic factors such as immune-mediated causes (Afnan *et al.*, 2016). Research yielding potentially new areas for exploration is emerging; for example, Durban (2019) highlights Larson *et al.*'s (2017) claim that some people with ASD may possess a neurodevelopmental susceptibility to developing psychosis. The literature here will concentrate on psychoanalytic contributions. There are interesting cultural and geographical divergences between the UK and international psychoanalytic organisations; space precludes discussion of all these and shall instead be confined to the UK and France's visions.

2.6.1 Historical roots and definitions

Progress has been made in clarifying childhood psychosis, but it continues to elude neat definition because of the unevenness of emotional and mental development in children and young people, and the ubiquitous tendency to inhabit – to some extent - primitive states of mind throughout the lifespan. Contributions from Houzel (2018), Rhode (2018), and Durban (2019) have summarised key junctures in the evolution of psychoanalytic definitions of psychosis.

Houzel (2018) states that at the end of World War II French analysts began to consider child psychoses, beginning with Serge Lebovici's (1949) paper. The term 'infantile schizophrenia' dominated the literature, informed by Potter (1933) and Despert (1983), until Mahler (1952) ushered in an influential change, transforming

the term into 'infantile psychosis'. This new term was subsequently adopted by the French Psychoanalytic Society. Houzel (2018) explains that attempts in France to differentiate purely-psychotic syndromes from those associated with various other pathologies took account of influences from structuralism and key figures including Saussure (1916) and Levi-Strauss (1976). He further explains that Lacan integrated these ideas with Freud's works in 1966, resulting in the following structural terms: psychotic, pre-psychotic, and deficit, resulting in Lacan establishing himself as a major contributor to the theory of adult psychosis (*n.b.* Lacan did not work with children). Houzel also discusses Joyce MacDougall (1969), a New Zealander who trained as an independent analyst in the UK, later moved to France, and joined the Paris Psychoanalytical Society where she established strong links between the UK and French psychoanalytic societies, introducing ideas inherited from eminent UK analysts. In Paris she began treatment with a nine-year-old schizophrenic boy called Sammy who initially presented in a very controlling way, demanding she write down his vivid stories and reproduce these for him at will. Their therapeutic journey was then published in MacDougall and Lebovici (1969), which details intimately the therapeutic process with intense transference and countertransference repetitions, and the development of a genuine fondness and affection despite a great deal of demanding behaviour. Sammy's analysis was cut short due to external circumstances, but his treatment inspired a sense of hopefulness about the potential for therapeutic work with children with psychosis to have a lasting positive effect.

Durban (2019), Houzel (2018), and Rhode (2018) all point to Melanie Klein's becoming aware of a diagnostic conundrum in 1930 while treating her child patient, Dick. The authors agree that today Dick would be clearly seen as autistic rather than a child schizophrenic, but Klein's diagnosis was prior to Kanner's introduction of

autism in 1943. Rhode states that Klein recognised Dick's inhibited development as opposed to the more typical regression associated with schizophrenia.

Durban (2019) stressed the long history of analysts who attempted to differentiate psychosis from autism. Rhode (2018) clarifies that since 1971 psychiatrists have categorised early-onset psychosis as pervasive developmental disorders, including autism, in contrast to manic depression and schizophrenia which are recognised as late-onset psychosis. Psychoanalytic views have not always been aligned with this; Rhode cites Tustin's view of autism as a 'straitjacket' to control psychosis (1990) as an example, which clearly conflicts with the notion of early- and late-onset.

Klein was not the only analyst struggling to align her patient's clinical picture within the existing theoretical framework. Tustin referred to childhood schizophrenia and observed these children recognising a degree of separateness between themselves and mother, but described them as locked together in a 'pathological system of interdependence' (p.111, 1994) marked by excessive and unrestrained projective identification (Bion, 1962). In this paper she used the term 'confusional entangled' to describe these children, having previously termed them 'confusional autistic' in 1992; amending this term owing to recognition that the nature of their problems and treatment requirements were different from those of autistic children.

Even this distinction is not entirely straightforward, however, because of Tustin's (1990) and Rhode's (2018) idea that autism sometimes serves as a 'straitjacket' for psychosis. Rhode described a patient who initially presented in a typically autistic manner with echolalia and a tendency to adhesively stick to surfaces, but later moved towards the use of projections and developed hallucinations. She reflected on earlier drawings supplied by the patient which evidenced covert fragmentation long before it became manifest in analysis.

Unlike the notion of a 'straitjacket' concealing or controlling psychosis, Haag has written about children who develop a post-autistic psychosis (1997), building on Meltzer *et al.* (1975).

2.6.2 Childhood psychosis as an under-theorised area

Rustin *et al.* (1997) compiled various psychoanalytic contributions that child psychotherapists in the Tavistock tradition found helpful in their work with psychotic children, a population they believe have been under-theorised. They proposed that these children, who experience extreme psychological pain, display obviously overt and vigorously destructive behaviours, confronting us with disturbing challenges as we face their predicament. This may explain their relative lack of theoretical and research attention. Rustin contrasts this with the wealth of research and subsequent advances in the treatment of autistic children; indisputably this substantial body of work with autistic children influences professional understanding, treatment needs, technique, and ultimately long-term prospects for autistic children. Possibly the same cannot be said with similar confidence about psychotic children. Rustin (1997) acknowledges considerable theoretical insights garnered from Klein, Bion, Segal, Rosenfeld, and Joseph whose concepts are drawn upon by child analysts working with serious psychopathology, and significantly affect the understanding of adult mental health.

In this edited collection (Rustin *et al.*, 1997) Dubinsky introduces the psychoanalytic theory underpinning psychotic states, emphasising the immature ego's fragility in the face of overwhelming mental pain, the child's lack of capacity to comprehend their felt experience rendering them reliant upon rudimentary coping mechanisms in the

form of projection. Other children split excessively, obliterating any sense of cohesion of their mental experience and self. Other ideas well-established within psychoanalysis are outlined including symbolic capacities, concrete thinking ('thing-in-itself'), confusional states, containment, omnipotence, oedipal conflict and more.

Case-material from a range of authors (Andreou; Briggs; Dubinsky; Haag; Miller; Rance; Reid; Rhode; Rustin; Sherwin-White; Sussman) is presented, with vignettes falling within three categories: children who have suffered sexual abuse, whose psychotic breakdown is believed to be linked to this cause; following sexual abuse, children diagnosed with severe developmental delay co-existing with psychotic problems; and those presenting with a mixture of intrinsic components and traumatic obtrusions. There is an abundance of rich clinical material with theoretical and technical aspects interwoven throughout. Reid (1997) remarks on her countertransference at the end of treatment, understanding her state of anxiety and exhaustion as a reflection of the patient's feeling of fragility about his capacity to maintain a lasting sense of sanity. Themes of persecution and states of helplessness are elaborated by Sussman (1997); her patient employed violent acts and perverse states of mind as protections against such vulnerability. She discusses her patient's struggle to remain in touch with her dependent aspects, instead seeking refuge in projective identification with a perverse narcissistic object. Miller (1997) takes up Rosenfeld's thinking on confusional states and discusses her patient's difficulty sorting out at a primitive level good from bad, relating confusion to the fact of disintegration prompted by acute levels of anxiety. She believes the child was primarily helped by introjecting from her the functions of containment and differentiation. Andreou (1997) wrote movingly about a patient's sense of abandonment and its effect on the transference relationship; intense

countertransference feelings were aroused, including one of helplessness. Andreou comments on technical considerations, including refraining from interpretation in some moments, taking care not to prematurely bring together good and bad aspects, using a blanket to physically 'hold' the young person in early sessions. He stresses the need for a strong network to contain the risk of acting-out where suicide attempts are concerned.

2.6.3 Ongoing efforts to refine psychoanalytic understanding of autistic and psychotic states

Alvarez (2005) explicates the subtleties and nuance in her work with autistic and psychotic children, detailing their differences but also highlighting some shared needs. Case-material focuses on aspects of autism (impact on family functioning and the network, therapeutic implications of deficits, and the technical need for amplification and tuning-in to the appropriate intensity-level), the possibility of elements of personality disorder in autistic children, and psychotic aspects, raising the issue of character as a supplementary consideration. Alvarez discusses the primitive aspects of a child patient, Barbara, arguing that children and young people who are autistic, psychotic or personality-disordered, all require clinical attention to the areas of personality, deviance, disorder, deficit and delay. This suggests that while certain clinical aspects can be distinguished, an encompassing view of the child or young person, accounting for the co-existence of developmental and personality factors, must be taken. Like Bion (1957) with psychotics, Alvarez refers to 'parts' of the patient and the need to address both autistic (or psychotic) and non-autistic parts.

Durban (2019) introduces a subgroup of children he describes as borderline autistic. Following ASD-diagnosis, these children 'move along an autisto-psychotic spectrum' (p.935) which mixes paranoid-schizoid anxieties and autistic anxieties 'of being'. He describes a child originally diagnosed with ASD and later childhood schizophrenia, and reflects on the internal dynamics associated with this subgroup and the requisite technical considerations. Like Alvarez, he draws upon Bion's (1957) differentiation between psychotic and non-psychotic parts to include overlapping autistic elements. He aims at an integration of a significant body of Kleinian psychoanalysis with French analysts' work based upon structural factors and attention to the role of corporality, language, deficits, and the Lacanian notion of desire of the other (Durban 2019, p.922). Durban describes the vacillation between paranoid-schizoid and depressive anxieties, and the difficulty analysts encounter during the process of the child's integration. Children in this subgroup are frequently overwhelmed by the emergence of 'bodily anxieties-of-being' and thwarted attempts at binary splitting (p.923). He clarifies that the manifest pathology is one of autism, constituted by withdrawal and preventing awareness of separateness, falling-apart and incoherence driven by the death-drive. Durban notes the common experience of witnessing floridly psychotic material when the borderline autistic child's defensive organisation loosens. He makes plain, however, that these children are a mixture of elements as opposed to the children Haag describes (1993, 1997) who are more stable and shift out of their autistic state towards schizophrenia, manic depression or obsessionality.

Durban raises the possibility that erroneous or too-all-encompassing diagnosis of autism is a problem, and implies greater stigmatisation of psychosis. Durban proposes two spectrums, a purely autistic one and an autisto-psychotic defined by the type of anxiety and attendant defences. The latter manifests in 'liquefying, dissolving…

freezing, burning, losing a sense of time and space,' and holes in the skin or having no skin (p.926, 2019). Rafael is a five-times-a-week patient whose material Durban uses to elucidate many of these issues and from which he bases technical recommendations, for example regarding levels of interpretation. He summarises the obliteration of time and space and confusion between inside and outside, self and object.

2.6.4 Papers on adolescent psychosis

Most of the papers specifically focusing on psychosis pertain to adolescence, and many cite Laufer's 1986 paper (Bronstein, 2020; Lut de Rijdt, 1995; Nicolo, 2015; Pestalozzi, 2003). Laufer questions the usefulness of a diagnosis of psychosis during adolescence, his scepticism arising out of a combination of clinical experience and psychoanalytic theory. Laufer sought more fine-grained distinctions between thoughts and actions in the context of psychotic functioning, and those which are comparable to adult psychoses in structure and form. He highlights how common an unrelenting quest to alter body-image is among disturbed adolescents, noting also that sexual changes associated with adolescence often give the appearance of psychosis. He posits that resolution of the Oedipus complex is critical for acquiring an adequate relation to reality including the image of one's body. Laufer suggests that for some adolescents the dawning of sexual maturity brings a revived attack on one of the parental objects, resulting in anxiety about the external world (owing to the projection) or an attack turned on themselves, manifesting as hatred of their own body, now experienced as the persecutor. The adolescent's struggle to face and accept the mature sexual body can sometimes precipitate a breakdown, with puberty experienced as unwanted evidence of a body which contradicts their previously self-image.

Laufer also goes on to distinguish between 'psychotic episodes', 'psychotic functioning' and 'psychosis'; the first characterised by a temporary break with reality taking the form of 'self-mutilation' or suicide attempts but retaining a relationship with internalised parental objects; in the second, quasi-melancholic depressions, addictions and eating disorders engage internal objects in conflict between reality and fantasy, but here, too, oedipal objects are retained. Finally, psychotic adolescents have lost the capacity to doubt, and unconsciously destroyed both their internalised parents and sexual body during their break with reality.

Like Laufer, Bronstein (2020) attends to more fine-grained distinctions, along with presenting the key issues underlying psychotic outbreaks in adolescence, and addresses some of the questions that arise concerning the terms 'psychotic functioning' 'psychosis' and 'adolescent breakdown.' Bronstein discusses developmental aspects characteristic of adolescence and its meaning in relation to a diagnosis of psychosis. Bronstein outlines Laufer's prominent earlier paper on psychosis, highlighting the role of the body, but also considers other theoretical perspectives. Many psychoanalytic concepts are discussed regarding psychotic breakdown, including economic factors, object-relations, early anxieties, unconscious phantasy, superego, trauma and identity. Bronstein advocates the use of psychoanalytic psychotherapy for disturbed adolescents.

Similarly, Lut de Rigdt (1995) explores the twice-weekly psychoanalytic psychotherapy of an adolescent seen during a psychotic breakdown; he advocates therapeutic treatment in this case, contrasting it with a pharmacological approach that obscures the underlying unconscious conflict, rendering it inaccessible for analysis. He describes this young person's movement from psychotic to neurotic functioning and its contingency upon recognition of separateness. He outlines the

framework for treatment, including the importance of parental support, the therapist's flexibility regarding allowing out-of-session contact, and the presence of a psychiatric colleague in the background. He also references Laufer and the role of the body, the potential for issues of identity and sexuality to become more permanently problematic, if left untreated in adolescence, essentially leading to a fixation of psychopathology. Interestingly, he believes there is little difference for Kleinian analysts in treatment process for psychotic and non-psychotic patients. This to me seems a rather simplistic view and it is unclear that this is now the case where treatment of psychotic young people is concerned. For de Rigdt, the young person's main problem results from inability to take ownership of his developing body and its maturational process, culminating in a deep split in his personality.

Pestalozzi (2003) presents a case-history of a patient described as a 'psychotic adolescent' which she clarifies as meaning 'psychotically functioning adolescent' (p.44) as defined by Laufer (1986). She focuses on the issue of symbolisation and concretism, suggesting that 'impairment of the symbolisation process in the adolescent or adult psychotic' links to the traceable inability to play in a symbolic manner in childhood (p.43), and emphasises the role of adverse events early in life and their consequent effect on object-relations and capacity for symbolisation. Like Freud, she believes psychotic patients return to concrete thinking in a desperate attempt to give meaning to a delusional inner world. Adolescence and its circumstances are discussed and like Bronstein (2020) and Lut de Ridgt (1995), she concludes that psychotic transference in therapeutic settings offers a significant and short window of opportunity for psychoanalytic psychotherapy to be effective for psychotic young people. Pestalozzi considers the differences between the

psychosomatic, neurotic and schizophrenic patients' use of language and its meaning.

Pestalozzi mentions the patient's unnerving ability to read the mind of others and notes technical points such as offering 'inner reinforcement' to his feelings (p.50). She cites various sources of literature describing something akin to Klein's annihilation (p.58) – Green, 1975; Grotstein, 1990; Kristeva, 1982; Jones, 1927; Winnicott, 1974 – and their link to traumatic incidences of monumental significance – Freud, 1926; Jones 1927; Tustin, 1981; Hopper, 1991. This suggests to me Rhode's (2018) observation that Mahler's 'overwhelming grief' often precipitates the total break from reality (p.706).

Later presentations seem to Pestalozzi to be delayed forms of existential and primitive states of mind from early life. She notes the therapeutic risk of a 'folie a deux' (p.747) and the necessary ingredients for successful therapeutic encounters where the patient can emerge out of a state of symbiosis with the therapist.

Nicolò (2015) describes psychotic breakdown as originating in the patient's childhood and the family's pre-history. Furthermore, there is a long process that culminates in the onset of psychotic symptoms. She too acknowledges the difficulty of making clear cut distinctions with adolescents. In this paper she contrasts perverse functioning with a defensive purpose from what she considers 'truly perverse', which takes the form of a structure that begins to arise after puberty (p.1335). Nicolò highlights the potential detrimental impact of an adolescent diagnosis that leads to hospitalisation, placing an additional developmental burden on the young person. She acknowledges ordinary aspects of adolescent functioning that resemble those of a psychotic, and discusses defensive measures used to manage decompensation. She comments upon several theoretical concepts of Winnicott's,

such as ‘freezing the failure situation’; withdrawal to protect a regressed part of the self, and the false self (1954; 1988; 1965). She also draws upon Bion’s conviction that anxieties reside in parts of the body (1957), and Rosenfeld’s description of ‘psychotic islands’ (1998). Nicolò’s own view is that a solution for decompensation is often found in the creation of a hidden identity, which she relates to Gibbs’ research on internet addiction where he describes ‘ordinary everyday psychosis’ (p.3, 2007).

2.6.5 Some phenomenological aspects of psychotic children’s birth experience

Didier Houzel (1989) presents an interesting hypothesis about the phenomenology of some psychotic children’s birth experience, suggesting they experience separation from their mother at birth as an ‘impetuous slide which so disrupt[s] the pre-natal proto-mental organisation’ that it cannot be reassembled as ‘a basis for post-natal mental life’ (p.105). He describes the attraction of the mother amid this trauma and its overwhelming nature, drawing a distinction between those infants who develop an autistic defence and ignore the mother and those who develop symbiotic defences characterised by confusion and entanglement. Houzel believes these psychotic children are prevented from seeing the world’s beauty because these precipitate birth-experiences preclude the dawning of aesthetic feelings (*cf*. Meltzer 1987). He explicates two case-studies with psychotic children, one of whom he saw for two years and the other for seven, both seen four-times-a-week, to evidence clinical observations underpinning his hypothesis. Existential preoccupations with endings and beginnings, birth and death, and oral functioning – such as likening the child’s experience of birth to the extraction of a tooth – were some aspects of these children’s states of mind.

2.6.6 Psychosis, psychoanalysis, and biological research

Houzel and Rhode (2018) make the case for cross-fertilisation of research and emphasise that because psychoanalysis is primarily concerned with the meaning of symptoms rather than cause, there is no inherent incompatibility between psychotherapy and biological research. Each discipline pursues its aim, with biology exploring brain-functions and risk-factors, cognitive science investigating how information is processed in psychosis, and developmental research synthesising these findings as applied to children and young people. The authors believe the aetiological root of psychosis is likely comprised of mixed factors, and stress that organic defects do not contraindicate a psychological approach since therapeutic interventions offer the possibility of altering brain structure and function.

The authors drew upon Schore's (2002) research, stating that development of higher-order neurological pathways through therapy may make it possible for children, including those suffering from psychosis, to tolerate and cope with experiences that previously would have overwhelmed them.

2.7 Conclusion

The phenomenon of psychosis has a complicated history in the psychiatric literature, having undergone many changes in categorisation. Conceptual debates are ongoing: one concerns the stigmatising effect of that history, and the case for renaming the condition to possibly beneficial effect; another debate queries the nosological case for treating it as a single unified condition in the first place.

Psychoanalytic theory and technique have developed greatly since Freud's initial scepticism about psychoanalytic treatment of psychotic people. The intensely

creative period beginning in the 1950s produced an impressive range of new ideas, and a depth of thinking, which has had significant clinical value for psychotherapists working with acutely mentally unwell patients. Freud's recognition of psychosis as an attempt at survival retains psychoanalytic support (Lewis, *et al.*, 2003), and the significant advances made by Rosenfeld, Segal and Bion shed light on the phenomenology of psychotic patients' inner worlds.

The literature on psychosis in children is primarily concerned with definition, as well as clinical implications. Many papers focus on adolescence, perhaps reflecting the intense fluctuations of the developmental period with strong pulls towards regression and revived oedipal struggles as sexual maturity is reached. Some papers were based on younger children, but I found myself curious about their relative absence. Most papers sought to formulate the psychotic patient's experience and balanced clinical description with theoretical understanding, but few gave detailed and in-depth accounts of the therapist's countertransference. Rustin's suspicion (1997) that the alarm and distress evoked in us by childhood psychosis might explain its lack of attention may also explain why I found myself, defensively, preoccupied by the question of definition.

The present research has therefore developed to further the understanding of Child and Adolescent Psychotherapists' experiences of what working with psychotic children and young people is like. I decided to adopt Rustin's 'openly and actively destructive' definition of children who are not in touch with reality to describe psychosis from a psychoanalytic perspective. All participants will be made aware of this specific area of interest and that I would especially welcome hearing about these cases; however, because the literature makes clear that psychosis is a term that evades consensual understanding and that it has changed considerably over time, I

will also make plain to participants that they may discuss any cases that they consider 'psychotic'. The aim is to balance focusing attention on a specific group of children while not excluding interesting and nuanced discussion of other children. There is, of course, a risk of generating too broad findings, but I think the alternative risk would be to potentially overlook interesting areas of debate and I may struggle to recruit psychotherapists able/prepared to speak only of this specific group of children.

CHAPTER 3

METHODOLOGY

3.1 Introduction

My interest in this topic derives from my experience as a Trainee Child and Adolescent Psychotherapist; the dread, despair and overwhelm that I felt at various points during my training while working with psychotic children is hard to overstate. The following is illustrative: one of my intensive cases came to see me first thing in the morning three times a week. He was a latency boy who seemed to me to function in a psychotic way most of the time and indeed he was recognised as such by the clinic's Psychiatrist who medicated him with an anti-psychotic. Early one morning, two years into treatment, I was rushing to get to the clinic on time and undoubtedly to some extent influenced by my agitated state of mind about seeing this violent and unpredictable child, I crashed my car on the dual carriageway. Somewhat miraculously given the flow of traffic and speed, I avoided serious injury. I had been *desperate* to get there and anxious about the consequences for him and for me of being late; but after the crash a feeling of immense relief washed over me as I extricated myself from the car. This was not only because I was alive and physically unscathed, in no small part it was also because I wouldn't have to see him that day. It is hard to believe now that this is how I felt, but at the time I felt indescribable dread about his sessions. This accident wasn't all about this child and our work together, but it was certainly a factor. Naturally this event led to a lot of fruitful analysis, but I still felt terribly stuck with this case in two senses. I could not work out how to move him forward and I felt stuck due to a perceived obligation to see through this case, to persevere, yet I had no idea how I could do that or how long it was reasonable to

continue. At what personal cost was I prepared to do this work? Why did I feel this obligation so intensely?

I wondered if other psychotherapists had felt similarly enmeshed with, abused by, and saddled with what felt like impossible cases whose demands felt utterly overwhelming. I designed this study with the personal hope that this study would make me feel less alone with this experience. Two main questions kept presenting in my mind; was I an inadequate trainee for feeling this way? What should I expect in the future and what could I learn from others?

I frequently felt confused about how to *be* with these children. Hundreds of subtle and more drastic adaptations in my state of mind, technique and the framework proved inadequate and ineffective. I was soon disabused of the notion that these children could be 'cured' or to any substantial degree improved symptomatically without taking a very long view of their treatment. Despite this, there *were* meaningful improvements that followed long periods of work with some young people, assisted by a wealth of supervisory and peer influences. I was curious whether other psychotherapists experienced an endless cycle of moments of hopefulness and despair with long impasses and backward steps and how they felt about this: how did they cope with it? Therefore, this led me to explore the lived experience of other psychotherapists working with similar patients.

This study investigates child psychotherapists' experience of working with psychotic children and adolescents. As far as possible I intended to approach the research question with an open mind; to some extent this was aided by the relative lack of existing data.

The mixture of theoretical and clinical common ground, and the singularity of participants' 'worldviews', co-mingled to create a clear and appropriate research question with the potential for meaningful engagement between myself and participants. However, given the extent of our shared professional background, it was crucial to guard against the temptation to assume more shared experience than was in evidence.

Since I wanted to understand something about *what it was like* for participants, a methodology allowing for rich descriptive experience led by the participant was required, and methodological approaches aiming to produce quantifiable results were clearly not compatible.

Despite some general presuppositions, I really had very little idea and few detailed imaginings about what participants would like to say, and in line with the very open wording of the research question, took an inductive approach (Bernard, 2011). I considered the research's theoretical perspective, and the ontological and epistemological approach relevant to the research question. It was necessary to consider which methodology best served the aims of the research, and which methods were appropriate for identifying and enlisting research subjects, acquiring and analysing the data. I also needed to think about issues of potential ethical concern. All these aspects will be considered in the sections of this chapter.

3.2 Research Question and Aim

A preliminary literature search revealed that existing papers on psychotic states of mind tended to consist of accounts of clinical work focusing on features of the patients' presentation considered in the light of psychoanalytic theory. There was

very little about the clinician's experience, beyond occasional indications of their countertransference. This led me to formulate a research question based upon the phenomenology of the clinicians' experience which I felt would be informative and might serve as an indirect source of understanding about the phenomenology of patients' psychotic states.

The research question formulated became: *what is it like to work with children and adolescents in a psychotic state of mind?*

I had in mind some supplementary areas of interest, but I chose not to make these formal secondary research questions because I was keen to preserve as far as possible an open enquiry. Perhaps in some ways this reflects the free-associative element of psychoanalytic clinical research in the consulting-room, but I also thought some participants might prefer some prompts, and therefore struck a compromise whereby I formulated some prompts in a generally worded way to use if required (Appendix A). I was, however, keen to dispel the idea that I was looking for something specific from the participants.

The prompts were as follows:

- Supervision
- Technique
- Interpretation
- The outside world
- Recovery
- The setting

This research was phenomenological in nature; I aimed to find out what it is like to work with children in psychotic states of mind.

3.3 Theoretical Perspective

As this is an inductive piece of research, no hypothesis is being examined here; however, I had certain general presuppositions in line with a psychoanalytic theoretical and clinical frame, *e.g*. that participants may naturally cover areas including supervision, technique, interpretation, the outside world, recovery, and therapeutic setting in their interviews.

Although the research question remained consistent, it was always a possibility that the interview process would lead me to adjust or alter the question to some degree and in this sense, there is a potential limitation to how far any study like this can be considered truly inductive.

3.4 Epistemology and Ontology

Steup and Neta (2020) summarise how epistemology has developed over time and observe that recent epistemology is focused on understanding how evidence rationally constrains our degrees of confidence, rather than defining 'knowledge'. Hofweber (2004) states that ontology is the study of what there is but caveats this statement by calling it a first approximation and acknowledging that it is contested.

The paradigm of this research is interpretivist, meaning it is not concerned with explanatory accounts and deductive methods, but gives primacy to *understanding* at an individual level and bound to the principle that people are 'self-interpreting beings' (Taylor, 1985).

Philosophical attitude was also considered and because the aim was to explore participants' descriptive experience, a phenomenologically-based approach

resonated. As a discipline, phenomenology investigated the structure of experience and was initially developed by Edmund Husserl (1999). I previously observed the need to avoid inadvertent over-estimation of shared knowledge with the participants; one defining feature of phenomenological technique is its 'bracketing' (*epoche*) of ontological questions concerning the 'real' nature of things, to focus instead on how we experience them. I therefore chose Interpretive Phenomenological Analysis (IPA) (Smith, Flowers & Larkin, 2009) as my research methodology. IPA is a method that reveals, and illuminates, examined phenomena and is particularly well-suited to small-scale studies; it also makes room for an interpretative element compatible with psychoanalysis.

3.5 Interpretive Phenomenological Analysis: Theoretical Approach

Principles from phenomenology, hermeneutics and interpretivism collectively give rise to the framework for IPA. It incorporates 'a set of flexible guidelines which can be adapted by individual researchers according to their research interests' (p.6, Pietkiewicz & Smith, 2012,). Phenomenology investigates the structure of our subjective experiences of things and leaves aside questions of what they are 'really' like. According to Martin Heidegger (1962), it therefore raises hermeneutical issues; phenomenological investigations are bound in a 'hermeneutic circle', because experiences must be interpreted in the light of their contexts, which are themselves only interpretable in terms of their characteristic experiences. This resonates with Harré's assertion (1979) that it is through the intensive analysis of the individual that one gradually becomes drawn to the universal structure.

IPA thus produces universal insights, not by aiming for broad or general conclusions, but by focusing instead, initially at least, on the idiographic. Data-analysis then involves interrogating the text rather than passively accepting its surface-meaning, alternating between a hermeneutics of empathy, and one 'of suspicion' (Ricoeur, 1970).

The methodology is therefore dually hermeneutical; the participant relates and interprets their own experience, while the investigator in turn relates and interprets the participant's testimony (Pietkiewicz & Smith, 2012). This makes the investigator's own phenomenological experience in the interview an inextricable element of IPA's findings, and open to interpretation just as much as the rest of the data. For this reason, psychoanalytic interpretation can be seen as part of, and supportive of, the wider interpretation of data in an IPA study.

The comparative suitability of IPA for this research, is largely due to its idiographic focus and detailed attention to the essence of the phenomenon as the subject experiences it (Eatough & Smith, 2017). In line with IPA's guiding principles, I refrained from the imposition of theory, and dwelled for some time, and in significant depth, upon the participants' individual lived experience of working with these children, to then discover the meaning held for them through an interpretative process.

3.6 Methodology and Methods

As this is a qualitative project (DiCicco-Bloom & Crabtree, 2006) I began by considering the most suitable method for engaging with the research question. I decided interviews would likely yield data of the required richness and depth;

alternative methods like focus-groups might not have facilitated the individual rapport with participants as easily. Interviews would therefore be most conducive to a setting in which I could get closer to the participant's experience. A semi-structured interview was created (Appendix B) to guide this process.

In relation to method of data-analysis, I felt IPA was the most appropriate method and more so than a thematic analysis because it prioritises individual experience over identifying patterns among a collective. The research question carried the potential for participants to discuss different cases based upon their unique definitions of psychosis and this lent itself a more individualised analysis in the first instance. The incoherent of nature of psychosis also made it seem more compatible with a fine-grained approach which could gradually evolve into overarching themes rather than a premature – and possibly more superficial – attempt to group findings together in a way that may have been too simplistic.

3.6.1 Sample

The sample for this research project consists of 5 qualified and highly-experienced Child and Adolescent Psychotherapists, with decades of experience treating children and adolescents in psychotic states of mind. All are of retirement age. In line with IPA I have selected my own participants in order to better answer my research question and this led to the selection of experienced and senior Child and Adolescent Psychotherapists.

Following IPA guidelines regarding sample size for professional doctorates (Clarke, 2010), I aimed to recruit between 4 and 6 qualified professionals. This was a purposive sample (Silverman, 2011). The sample size reflects IPA's primary concern

with achieving a fine-grained account of idiographic experience. Since its focus is on the quality of data, and since the experiences of interest are typically extremely rich and complex, it is usual for IPA studies to focus in greater depth on a comparatively small sample in the region of this size (p.47, Smith, Flowers & Larkin, 2009).

Inclusion criteria were being a qualified and ACP (Association of Child Psychotherapy)-accredited Child and Adolescent Psychotherapist currently working in either the NHS or a private setting in the UK, with experience of treating children and/or adolescents in psychotic states of mind.

3.6.2 Procedure

3.6.2.i Recruitment

I made child psychotherapy colleagues in my service aware of my project and interest was forthcoming; one psychotherapist from this avenue agreed to be interviewed. Concurrently a child psychotherapist I knew in a different professional context enquired about my research project and, when I explained it, volunteered an interest in participating. Moreover, this psychotherapist asked to put me in touch with two colleagues she felt would be interested in participating; both agreed to participate. One other psychotherapist was approached by me at the recommendation of another colleague and this person also became a participant.

Each participant received an informal explanation of the study, which was followed up with an information sheet (Appendix C), consent form (Appendix D) and my contact details. I made clear to participants that the time asked of them would not exceed one hour for a tape-recorded interview, but if participants wished to speak for longer that would be possible.

Before interviews, the nature of the investigation was made clear, and ample opportunity was given for participants to ask any questions or clarify any parts of the information sheet and consent form. Participants were told that they were free to withdraw from the interviews at any time.

3.6.2.ii Pilot interview

I carried out a pilot interview with a colleague before amending the research question to include children and young people in 'psychotic states of mind'. A crucial piece of feedback was that my colleague did not feel confident discussing cases of psychosis without my supplying a definition of it which she could then use to think about in relation to her clinical experience. Since this feedback chimed with informal feedback from peers and other qualified psychotherapists, I adjusted the research question accordingly. I emphasised to participants that I was especially interested in hearing about 'psychotic children and young people' and cited Margaret Rustin's definition, but also made clear that they were free to discuss any cases they considered to be in a psychotic state of mind. This pilot interview also highlighted the need for prompts, as the participant found it difficult to orientate herself to the open nature of the interview; she described feeling preoccupied by her wonderings about what I was looking for from her.

3.6.2.iii Interviews and data collection

I carried out five interviews. Due to the Covid-19 pandemic, all of these took place remotely via Zoom. Each participant received the semi-structured interview containing the prompts at least a week before the interview, often several weeks prior.

The interviews were spaced in such a way that transcription of each interview was possible prior to the next participant beginning.

The transcript was recorded verbatim, and care was taken to include all sorts of speech features; 'umm', 'err', *etc*. Where relevant I also annotated the text with non-verbal gestures and highlighted moments that especially caught my attention for various reasons; for example, some felt more meaningful, jarring or puzzling, other examples include where the rhythm or tone of speech changed.

After each interview I immersed myself in the material by listening through to it twice. At this stage I also made notes on how I felt the interview had gone, keeping a research journal (Vicary *et al*., 2016).

I followed up the interviews by emailing the participants and thanking them for their participation in the study. I undertook to send them a digest after I had analysed the data. One participant expressed some concern about anonymity, which we discussed in the context of the ethical requirements laid out in the proposal; the offer of the digest alleviated this anxiety. I hoped that participants would respond with feedback if they questioned the validity of the themes and made clear that any feedback would be welcome. It was agreed that all participants would be sent the final version of the research.

3.6.2.iv Inhibition and the student/teacher dynamic

Most of the participants were known to me to greater and lesser extents, not at a personal level but both at an academic or professional one, and I was aware that this would create a different dynamic between us than would have been the case with entirely unknown participants. Even those I did not know well, knew that I was linked with the training school where they teach and that, therefore, we share some

aspects of a similar cultural experience. I felt there was potential for this to lend itself to conversational 'short-cuts' and that it would be important for me to be cautious about not assuming common ground, though I knew there was a lot of it.

A further potential complication arising from our familiarity was the fact that many of these participants have made well-known contributions to the child psychotherapy profession, many of which formed an integral part of my learning experience and it was important that I adjusted to the researcher position. Although I do not tend to take their views and ideas uncritically and assume them as my own, I realised that there was the possibility that I could slip into relating to their data as a learning opportunity too prematurely, i.e before more objectively standing back from the data and considering it without unconsciously 'scanning' the material for insights.

In research interviews the impression can arise that the researcher is 'all-knowing', but in my case this dynamic was reversed as all subjects were very experienced and senior within the profession. This possibly influenced my stance as researcher in the interviews, perhaps finding it more difficult to probe the participants for more detail. I reflected that I found it difficult not to respond in the psychoanalytic way participants expected, which meant I was perhaps more anxious than necessary about not constantly maintaining a more objective position. IPA allows for an intersubjective exchange that takes account of the 'life world' of the researcher as well as the participant.

3.6.3 Data analysis

In all cases I immersed myself in the recording of the interview at least once on the day of the interview; in some cases this took place immediately and in other cases

later in the day. The second immersion into the material took place soon after the interview and prior to attempting transcription. I followed closely the guidelines set out by Smith, Flowers, and Larkin (2009).

For each interview, I read and re-read the transcript while allowing impressions and open-minded encounters with the text, along with remembrances of the interview, to arise; I recalled the setting, atmosphere, and emotional resonances from the meeting and those that occurred in the process of re-encountering the text. Exploratory comments in the form of adjectives, linguistic details, words from the transcript that I felt inclined to underline and things that seemed unusual or unclear to me were highlighted (Appendix E).

After this initial phase, I began to examine the transcript for structures of content and language (including repetition of meaning, pauses and metaphors). I also thought about powerful emotional responses evident in the interviews and considered our interview's context and the bearing our relationship may have had on the data.

Appendix E demonstrates the line-by-line references on the transcript which make it possible to see clearly how the emergent themes arose from and are grounded in the original text. The emergent themes were the culmination of recurring patterns in the text as well as conspicuous moments.

These emergent themes were then clustered together according to relationships between them, leading to the establishment of cluster-themes (Appendix F). The identification of themes was a seamless process since there were many conceptual similarities and many recurring and closely-related variations on areas and units of

meaning; thus the less common – albeit interesting – content from an earlier phase of analysis was set aside due to a weak evidential basis.

At this stage of transposing notes into emergent themes, I encountered a tension between the aim of approaching each aspect of the transcript attentively and singularly, and the fact that the entire transcript was by this stage very familiar to me, and even without purposeful scrutiny of certain structures and patterns within the text I had an overall sense of the distinct features of the interview. This is acknowledged as inevitable within IPA studies as an example of the previously-referenced hermeneutic circle (Heidegger, 1962). Each transcript culminated in superordinate themes.

This entire process was followed separately for each interview. Following this, I looked at the superordinate themes across cases and generated final themes based upon the most common tropes among the participants.

3.6.4 Validity and reliability

The use of a journal to record notes on my post-interview experience was intended to aid the reflective process necessary for rigorous research. The digest sent to participants was also a means of collaborating with participants and welcoming the opportunity for data validity to be challenged. Using a colleague to review my process of data-analysis added a further layer of validity to the results, as they were positioned to identify potential biases and check the consistency of my interaction with each transcript.

3.7 Ethical Considerations

The wellbeing of participants and maintaining the confidentiality of their clinical work was a priority. I did not anticipate that participants would encounter emotional difficulties during or after the interviews, because despite the potentially distressing topic arousing strong feelings, the participants owing to their profession are used to exposing themselves to such experiences and drawing upon avenues for supervision and other sources of clinical support. Moreover, the participants were experienced and senior psychotherapists, adept at reflecting upon and making sense of powerful emotional states. Had it appeared that anything more problematic or distressing than usual was occurring, I would have spoken to the participants about where they could find further support.

Soft copies of the transcript and research diary were kept in a locked file. Recordings of the interview were transferred to a password-protected laptop, and files were assigned a code instead of initials to further support anonymity.

The proposal for this study was approved by the Trust Research Ethics Committee on January 30th 2020 (Appendix G).

3.8 Embracing Complexity: Definition, Research Participation, Interviewing and Data Analysis

I expected this project to be complex because of the lack of clarity around definition. I thought this might make it difficult to recruit participants who shared an understanding with me of the specific subject under investigation and who would, therefore, all be able to speak about the same phenomena and be interested in doing so. This structural problem at the heart of project fed through to subsequent issues:

how to formulate specific prompts/sub questions pertaining to the kinds of specific cases I was hearing about without excessively closing the interviews down by narrowing the definition to the point of excluding arguably relevant data; after all, who is to say what counts as 'psychotic' when there is not a universally agreed upon definition? How could I clearly and succinctly describe the population that I was interested in hearing about?

I could, perhaps, have made this project easier for myself had I committed solely to one definition of psychosis and exclusively asked participants to focus on that, but as I researched the literature and became aware of its fluid definition, I realised that this itself was interesting. I did not want to foreclose the possibility of also understanding more about the multi-level complexity around the ontology of psychosis from a psychoanalytic perspective and the subtlety and nuance from a phenomenological perspective of overlapping presentations and linguistic confusions.

It was a shame that the interviews were all conducted remotely as I had imagined that a face-to-face meeting, especially in an analytic environment (consulting room, for example) may lend itself well to a deep exploration of the topic. There is, at least for me, a discomfort with online work and a belief that important intuitive and somatic sources of information are harder to access remotely. I also felt that it was more difficult to establish a more natural rapport and organic beginning to the interview since it felt like a meeting with a clear purpose that we were suddenly expected to 'switch on' at the agreed time. There was of course also the wider context of covid in all its disruptiveness to the sense of 'going on being' (Winnicott, 1965, 38) for us all. This must surely have played a part in the extent to which anybody at that time could either identify with the disintegrating nature of a psychotic mind or the

ways in which we felt we perhaps could not afford to access all the dark recesses of our psyches.

Due to the choice of leaving open the definition that participants made of psychosis, I anticipated that in the later stages of data analysis it may be difficult to move to a higher level of abstraction and to group together the findings and themes since the participants may have started from a position of talking about phenomenologically and definitionally different cases of 'psychosis.'

Before starting my analysis of data, I was also concerned that the chaotic and fragmented nature of a psychotic mind may manifest in the data in a way that would be difficult to translate into findings and digestible themes without losing the essence of the experience itself. There was little that I could do to prevent this, but this was another source of some anxiety. I worried that I might end up with a confused mess of data that was incomprehensible to me and that would prove somehow unusable.

I certainly did not approach the interviews as a blank canvas interviewer. I had too many strong feelings about my own experience of work with this population. I was immensely relieved to find a methodology that allowed – indeed encouraged – my participation and subjective experience. There were certain presuppositions that I had, for example that the work with these young people is harder than it is rewarding. I felt, however, that I had had a lot of supervision and analysis thinking about my training cases and was confident that I could take a stance in which I could bracket (epoché) this experience during the interviews without prejudicing the flow of conversation, while at the same time using my own reflexivity as a tool for data analysis. This was mostly achievable.

CHAPTER 4

FINDINGS

4.1 Overview of Findings

The content and process of each interview was highly idiosyncratic but at an abstracted level it was possible to see the emergence of commonalities in the areas of discussion listed below, where the numbers indicate the frequency within the five interviews:

- Statements around aetiology and definitions: - 5/5
- Statements pertaining to primitive states (terror, madness, oral preoccupations, cutting, savagery, brokenness, gore, cruelty, holes, threats, torture; persecution, the 'bizarre'; pre-verbal; incoherence; war zone): - 5/5
- The importance of technique and technical differences: - 5/5
- Reality dawns (rival babies; helping the child to see reality; transformation; meaningful moments): - 5/5
- Keeping the parents in mind (parental psychopathology, working with parents): - 5/5
- Intergenerational considerations (the needs of future generations; supervision; generational transmission of knowledge: - 5/5
- Political and cultural factors (cultural changes over time; children needing community; fighting for resource; early detection of problems; length and frequency of treatment): - 4/5
- Personal considerations (personal qualities necessary to the work; the role of the therapist's family): - 4/5

- ‘Inhuman’ or non-relational aspects of the patient or therapeutic encounter (anatomical description; lonely therapist; helping the patient become human): - 3/5
- ‘Tightrope’ comments alluding to a sense of precariousness (risks and benefits to treatment; technical challenges, danger of awakening the mind; barely surviving the work; not being able to bear more of the patient: - 3/5

4.2 Recurrent Overarching Themes

From the data-analysis, across the five participants collectively, four overarching themes recurred across the data set:

- Definition and aetiology
- Working with primitive states: the cost for the therapist, child, and family
- Life-changing work: the rewards for the therapist child and family
- What’s required: setting, technique, and personal qualities

In the following sections, the results illustrating each theme are presented with extracts from the interviews. Participants will are indicated by number; P1, P2, P3, P4, P5.

4.3 Definition and Aetiology

This is a large and diverse theme; participants had a vast amount to say with varying degrees of clarity and strength of opinion about the importance of definitions of psychosis and psychotic states in young people. Fine-grained distinctions were made, and participants contrasted presentations of children with autism and psychosis to elucidate their views.

Participant 3 clearly defined her experience with three types of children: psychotic young people; children *stuck* in a psychotic state of mind who present similarly but retain a more ordinary core; and ordinary children who fleetingly inhabit psychotic states of mind. She explains:

P3:…I mean in an ongoing pretty permanent way…people who would in an everyday way be thought of as rather mad and really not at all like ordinary children.

…children or adolescents where in a umm in a more fleeting or more protracted way you can feel you are stuck in a pretty psychotic place but where you wouldn't feel that's a basic description of the umm person.

…which of course could be something that would appear in many patients at times.

Participant 4 also introduced the concept of psychotic anxieties, possibly corresponding to the 'psychotic state of mind' category. She highlighted the pervasiveness of psychotic problems in childhood, something undoubtedly familiar to most people in its manifestations, and mentioned the developmental importance of splitting (Klein, 1946):

P4:…There had been lots of miscarriages after her and she was hugely persecuted by anything to do with other children so you wouldn't say she was psychotic, but you would say she has psychotic anxieties.

Mrs Klein did suggest that psychotic problems in childhood were very very common, and they just get camouflaged because you expect little children to be a little bit off beam as far as reality goes.

…he emptied a lemonade bottle and put it as far away from him as he could and he was obviously really frightened of it and that was a psychotic anxiety but from the beginning of my seeing him he had a good/bad split so he had gone a distance in development.

Outside the realm of ordinary and common psychotic anxieties, definitions and diagnoses become more complicated. One participant indicated that there can be multiple differentials to consider and another explained why these distinctions matter:

P2:…a boy who was diagnosed with autism, but one might wonder is it really a psychotic more schizoid even paranoid schizphrenic?

P4: If you just define psychosis as being out of touch with reality…the thing is that I don't think that in itself is enough because when we speak about a child being psychotic, we're actually assuming the child is in a schizoid 3-dimensional universe because if you think about it children with autism are not a dickens in touch with reality but you wouldn't call them psychotic in the sense you call the other ones.

Even if one agrees that identifying and separating diagnoses of autism and psychosis is important, it can sometimes be difficult to detect psychotic thinking because of a very subtle presentation which risks being overlooked:

P5: …you do get children who seem to be having what sounds like a rational conversation and the therapist responds in a rational way and then the patient says something totally unconnected, and I think the danger there is in behaving 'as if' 'oh that made sense'…

The same participant notes the pressure to differentiate psychosis from autism, her phrasing suggesting an external preoccupation. She also indicates that this

expectation jars with her clinical experience – where the line between psychosis and autism is much softer – and suggests that burgeoning contact between herself and autistic patients often leads to the uncovering of psychotic states:

P5: There was a tremendous feeling of we needed to make it terribly clear this is autism, this is psychosis…you find they blend and bleed into one another…as you start to build a mind together and some thinking process emerges you do sometimes discover really psychotic states of mind.

This 'discovery' of psychotic states suggests that psychotic phenomena underlay autistic presentations. Participant 4 considers the ontology of psychosis and considers whether an improvement in autism causes or merely reveals psychotic states:

P4: …some autistic children when they get better and less autistic and become Asperger's do develop psychotic states and sometimes that's a post autistic manifestation and sometimes I think it reveals what was there before…I'm sure was one of those because he did a completely incomprehensible drawing early on his treatment that I really didn't understand, it was a [shape] filled with lots of dots and he couldn't tell me anything about it and then later it became clear that those dots were actually cut up bits of people that he wasn't too keen on and obviously you know he did an identical drawing when he could talk about it in his psychotic state, the time when he was frightened of people, somebody coming out of the television and uh you could see it was the identical drawing he had done long before so obviously that constellation was there long before.

There are important considerations around diagnosing psychosis in the young because of their inherent developmental potential. Participant 4 made this point and

raised broader social factors concerning diagnosis – such as stigma, and linguistic shifts such as a specialist journal revising its title in accordance with broader cultural changes - indicating this was change for the better:

P4: …still have so much development ahead of them and it is felt to be very pejorative and not simply descriptive in the sense of being out of touch with reality you know the journal of autism and developmental disorders used to be called the journal of autism and schizophrenia so in that sense um in that sense even in this country things have moved a long way in the last few decades.

Participants mentioned changes to psychiatric diagnosis of psychosis since the 1970s, and questioned the significance of these distinctions in any case. The reliability of diagnostic criteria were queried:

P4:…childhood psychosis…was divided into early and late onset back in 1971, early onset being autism which people would now call developmental delay and late onset being umm bipolar manic depression and schizophrenia which typically have their onset later in adolescence and officially child psychiatrists now would say there is no such thing as childhood psychosis.

P5: …it was very interesting because very few children were referred to us as autistic, some were referred as sort of schizoid type psychotic or whatever but…I discovered that sometimes a child had been referred as psychotic
and actually it was much more like being with a child with autism and vice versa so it started me really thinking what's the difference and is there a difference?

P4: [child psychiatrist and psychoanalyst] has always made the point that the issue of hallucination is something that people tend to determine by asking children if they are seeing things that are not there. Now you try asking an autistic child if

they are seeing things that are not there and you might not get very far so that gets put down as a no but of course if you spend any length of time with them you know perfectly well they're having hallucinations.

Several participants also introduced the effect of character on the nature of psychotic aspects, as indicated by Participant 4 below, and Participant 5 raised something similar regarding the need to carefully assess suitability for treatment:

P4: I remember one who certainly had psychotic aspects remarkably lovely little boy…and he had a terribly nice nature, but I think there are others who progress and who don't have such nice natures and then it can be quite difficult to avoid something pretty malignant and you know you get into a pretty crazy sadistically split world…I think it really depends on character.

P5: There are some young people at the psychopathic end of the spectrum, and we have to be careful because if we engage them in therapy, we can release feelings that have been locked down and we have to think is this in anyone's best interest? Can we give them enough therapy for them to be able to integrate something of that?

Three participants compared psychotic and autistic children, remaining attentive to important aspects of divergence. These differences are not confined to theoretical discrepancies; one participant sometimes uses countertransference (Heimann, 1950) as a tool for identifying the type of presentation she is working with:

P4: I think one does need to add that they're living in a 3D universe, and they do project and the predominant thing that they do is splitting and cutting and that kind of thing rather than sticking or unsticking or dismantling.

P2: …whereas the material from the psychotic children, the ones I know, it can be very, and I shouldn't generalise, it can be not just frightening but horrifying grotesque elements.

P5: If I am with a psychotic child, I am metaphorically doing that (gestures) my head is about to burst or split…I'd be frowning and puzzled and leaning forward and if I think of an autistic state of mind, I think it is the absence of thought in the therapist…when you are with someone in a really autistic state you don't. have. lots. of. thoughts., at times you don't have thoughts at all and it's a bit like having your head wrapped in a blanket.

Participants shared views on the relevance of aetiology and acknowledged mixed factors as underpinning psychotic and autistic states:

P5: I think most of us are interested in aetiology only in as far as it informs the treatment but not as causal.

P4: I mean as we know with psychotic manifestations it isn't ever the child's nature or the environment it's both.

All participants were unequivocal about the detrimental impact of environmental failures in infancy on these children's states of mind. One participant linked this experience to the child's state of despair, another raised 'trauma' conceptualising a spectrum of types and emphasised the terrible effects on infants left languishing in poor conditions or denied the opportunity to develop a single attachment relationship:

P1: … she hadn't been attended to in that way in which babies need…I think she was an infant who cried but never believed the breast or the bottle would come.

P5: … one traumatic experience after another and by these I don't mean trauma with a big T but cumulative traumatic experience which nobody had time to recover from.

…And then there's a second group where there has been real neglect, all kinds of other quite serious things, sometimes there can be a physiological damage there, can be a traumatic birth and damage.

Participant 2 discussed her experience of more perverse environmental influences, in this case between mother and baby; others, like Participants 3 and 4 postulated that wider family and intergenerational traumas caused significant disturbance in the young person:

P2: …there are some where it's been a subtler more perverse relationship where it has just driven the child mad with frustration. Mothers who have been very sadistic with feeding or yeah, I think you get it in some very perverse families where it's a little subtler.

P3: There were experiences of madness of various kinds and that they were living in a kind of family place where there was a fear of madness which was so alive when they born.

P4: I think it probably had its roots in whatever it was that made the parents think of a termination linked to his mother's early state of mind which I think is a fair assumption on our part if you think what happened over the summer holiday.

These intergenerational traumas were not felt to simply cascade down to the infant in an indirect atmospheric way; participants stressed the forceful projection (Klein, 1946) into the child, as described by Participants 3 and 1:

P3: She was seeing this mad adult woman in this baby's face and the intrusion into this new family of this conviction that this was somebody else who was hopelessly mad was a very, very, serious aspect of psychopathology of the whole family system.

P1: These children are really, really, highly sensitive and I think they've been massively intruded upon umm and so their all those portals of entry and senses I think are just on high alert and highly, highly, sensitive.

4.3.1 Reflections and interpretation of the theme

After reviewing the literature, I began to feel more strongly that the child psychotherapy community should have a clear definition of psychosis. I was, therefore, primed to identify with the categorisations stated by P.3 in the interviews. I felt pleased that the participant started in this way as it alleviated my anxiety about the potential for us to get embroiled in an obscure, complicated, discussion about the linguistics of the topic and it relieved me of some of my own lingering confusion. It felt containing to me as a clinician to hear someone experienced laying out straightforward distinctions. I did not feel that P.3's categorisations were an over-simplification: they were considered, nuanced, and were borne out of her extensive clinical experience. They were also expressed in a wider interview context in which P.3 expressed hesitancy and open-mindedness as part of a range of discussions.

I felt sympathetic to the view expressed by P.4 that the term psychosis is felt to be pejorative, and of course that is problematic, but while I appreciated the view that renaming the journal had been beneficial, P.4's statement that this suggested 'things had moved a long way in the last few decades' struck me as too simplistic. This realisation came after the interview, and I began to appreciate in a live way the value

of follow-up interviews; I regretted that there would not be an opportunity to push this conversation with P.4 further.

During the interviews themselves I was surprised that none of the participants discussed the loss associated with 'psychosis' falling out of the literature. There was certainly space for me to ask them about this at the time and it was a missed opportunity. I attribute this to my reticence to deviate from my prompts, but perhaps I also felt a subtle obligation to leave this view unchallenged, to go along with what is possibly the cultural norm of a more cautious, hesitant, position.

I now think it's entirely consistent to propose that there should be a clear theoretical definition of psychosis while balancing this with a recognition that, as P.3 stated, 'these states of mind blend and bleed into each other' (a view expressed in various ways by several participants). I agreed with this statement, supported by my clinical experience, but on reflection later I wondered, as a profession, whether our leaning towards openness (possibly a corrective from the criticisms levied at Freud about the patriarchal analyst 'interpreting' and pathologizing) is sometimes a bit of a cop-out? For those working in CAMHS clinics, managing the interface between psychoanalysis and the medical model, there is a line to tread. Being able to define what it is that we are identifying in a population need not mean we adopt a diagnostic emphasis and abandon an open position that allows for uncertainty. It's possible to hold a definition in mind while retaining our conviction that such things often need to be held lightly and flexibly with respect for the dynamic potential for change, especially in young people.

4.4 Working with Primitive States: The Cost for the Therapist, Child and Family

Participants described feelings of bewilderment and otherworldliness at their patients' 'inhuman' aspects. They discussed the impact of primitive emotion at a bodily level and the huge toll taken on therapists working at the limit of their tolerance. Oral impulses, violent states of mind, and their effects were described.

It seems like an understatement to say that participants described non-relational aspects of their patients; some descriptions suggest an almost inhuman, utterly unrelatable quality, portrayed in eerily preternatural terms:

P5: I grew from feeling that I wasn't with a person so I couldn't pretend to be fond of him to a little boy of whom I became extremely fond, and it was interesting he became very fond of me…

…I had to start, and this is where the whole idea of building a mind, and it was such a shock to me, I thought you…don't…have… a…mind…(slowly)

The evocative description from Participant 1 of a patient's movements reinforces this sense of the patient as disturbingly unnerving in her bizarre movements.

P1:…She swayed a swaying that was almost imperceptible and it was almost mesmerising…that propelled her body forwards…it was incredibly unnerving

Participant 1 also used anatomical language to describe the primitive way she experienced the patient, her description conveying an essence of something so intensely primeval that even to crudely describe it as object-seeking seems to over-reach. There is something almost predatory about the description, whereas

Participant 4 described a different – less malignant – primitive presentation, that of adhesive identification (Meltzer, 1975):

P1: It was a feeling that somehow my cranium was somewhere which she wished to occupy, it was like sticking between my two eyes getting in there.

…What comes to mind is something more like that a protrusion from a body umm that's looking to attach but it's not it's not a desire to umm as a hook and an eye to link together you know this wasn't about anything to do with reciprocity.

P4:…[patient] talked about having hallucinations and he'd obviously heard other people talk about hallucinations when he'd heard other people…blue which is, incidentally is the colour of the overall I wore, but in that sense he was really doing something quite adhesive if you like, because he was sticking himself to the adult identity to hallucinations and what he said about it was not all that enlightening.

However sensitive and alert therapists are to the powerful resonances of infantile life, young people can be so severely developmentally delayed that it defies comprehension. Participant 5 gave a particularly expressive account of the patient's overwhelming state of discombobulation and her consonant feeling of bewilderment, but has asked that it not be included here.

Perhaps unsurprisingly, these patients affect their therapists at a level reflecting their level of functioning and the absence of a mind. For Participant 1 this arose predominantly as a falling sensation, and she stressed its bodily character, while Participant 3 cited a different unpleasant bodily symptom, linking it to her emotional state. She also reported a physical toll over an extended period, and fear of seeing the patient:

P1: I think my body reaction was falling, falling, falling, but the gaze did little to hold me there …I can only describe it as a feeling in my stomach of falling…

P3…some unthinkable aspect of the relationship we were having at that moment couldn't be turned into thoughts and words, and was lodged in my body, so I would feel sick with dread, dread is exactly the right word.

Physical and cognitive effects experienced by therapists were myriad; Participant 4 described disoriented feeling and transient memory loss, linked to the patient's rapidly changing states of mind:

P4: Dust. It was a little little child, a baby he talked about, a girl baby and she right after birth she was put into some kind of big vessel and spun around until nothing left just a sparkle. I remember talking about that once, and I began to feel peculiar, but I realised later his virtuosity in changing from one defensive structure to another ever so quickly made me feel my head was going round and round…you didn't know where you were.

It was very disconcerting not being able to remember anything of what he'd done in a session, it was bizarre…when you find that it has all gone it's very disconcerting and I used to take his drawings out and think that'll bring it back but it didn't…there was something very amiss with the symbolic function of these drawings, they were just marks on paper, they didn't bring anything back at all it was quite bizarre.

She recognised oral impulses in her patient and discussed the child's misattribution of these and his anxiety about the destructive potential of his impulses, noting its clinical manifestation and the use of interpretation:

P4:…frightened of me as somebody whose biting impulses had been projected into, he was also getting quite close to the fear of what he might do to the skin on the breast, on the milk, or whatever…

…He touched the toy lion a bit in passing in one session, and the next session he screamed his head off and refused to come into the room, so I talked to him about the toy lion and how perhaps he might be worried that I might be about to eat him up like a lion and he came into the room like an angel.

Several participants described patients' uncontrollability, communicating states of chaos, and a sense of being caught up in these rather than merely witnessing them. Yet Participant 3 also observed that when a clear boundary of consequence was implemented, the patient responded:

P3: He was doing whatever he wanted as it were running up the stairs, along the corridor, smiling, absolutely, absolute charming sweetness to everyone he met while I was DESPERATE!

P1:…when she became enlivened, OH MY GOODNESS, there just wasn't thirty seconds to kind of hold still you know, her drawings were frantic…

P5: Oftentimes you know you are with a psychotic child, it's like being in the middle of an explosion, you can't think, and you feel you're going crazy, and you can't make a coherent thought.

P3: Whenever I got to the point of feeling I couldn't cope in the room and had to talk to him about unless we could moderate something in some way, we would have to end the session he would stop immediately…

Violent phantasies and acts were raised by all the participants, including interpretations of the patient's state of mind, descriptions of attacks on the clinic-room as well as the therapist, and 'taunting' of the therapist suggesting a sadomasochistic element in the transference (Smith, 2008). Participant 2 introduced a different aspect by noting her patient's preoccupation with graphic and gory visual images:

P1: Inside her mind there was, there was murder and savagery and tearing and cutting to pieces…

…The room was ab-solu-tely destroyed just destroyed she was just hurling things across the room at me and whatever she could pick up was thrown in my direction.

P3:…to taunt me…holes in ceiling tiles or throw things at me from this position so you know various violent acts towards me or the room.

P2: he wasn't always psychotic but on the edge a lot of the time, with an amputated arm, horribly amputated blood, and gore everywhere…

Some participants gave examples of the kind of psychotic phantasies their patients exhibited; Participant 2 recounted an auditory hallucination, while Participant 4's disbelieving exclamation – 'oh God' – implied something of the vividness and conviction with which the patient held these phantasies:

P2: I did say about the clock because he could hear that ticking clock a lot of the time.

P4: I mean, oh God, he got into very psychotic states where he describes hallucinations of seeing you know pink [objects] at night-time or thinking that a

character on the telly was going to come out of the telly and choke him sort of thing so there was no doubt at all that he had quite florid psychotic phantasies.

Perhaps inevitably, psychoanalytic discussion of psychotic phenomena led participants to discuss states of fragmentation – several referred to Bion (1959) – and describe their felt experience during the sessions. Participant 1 also mentioned her patient's communications and the juxtaposition between easily-understandable communications (drawings) and disordered thinking:

P1: There is that sense of things being chaotic and surrounded by what Bion called beta elements, umm umm…sort of fragments really.

…incoherent story boards except there wasn't a story with a middle, beginning, or end, it really was chaotic and fragmented, she would draw a figure, or she would make clear that what she was drawing was me.

The concept of splitting and projection is central to object-relations theory, and considered a core feature of infantile states of mind (Klein, 1946); there were many descriptions of how this manifested and how therapists experienced it, as described by Participant 3.

P3: Receptionist - 'Andrew's here!' you know sounding SO PLEASED to see him…what I was getting for a very long time was anything but that!

…What I felt was that somehow my patient and this other person, that saw what was going on and how tormented I *was, were laughing at me. I felt so ashamed…the shame that this child had to feel about his mother's way of life was part of what was being acted out at that moment.*

…I think sometimes it is more to do with very, very, gross splitting, as I was saying what goes on in my room must not be allowed outside in ANY ANY way.

All participants described intense states of anxiety and persecution, sometimes in the form of feeling terrorised by the patient, at others overwhelmingly vivid anxieties about patients' potential to cause massive harm. Participant 4 described the incongruence between relatively benign destructive acts and the extent of her anxiety in the countertransference (Heimann, 1950), expressing intense worry about the potential to incur external judgement and intervention. She emphasised that her anxiety was a countertransference response; in reality colleagues were supportive:

P3: what I was going to tell you was another aspect of the way he tortured me…

P4:…really intense anxiety…he was doing was filling the sink but when you sat there and listened to it, it sounded like Niagara Falls coming into your head and it was never going to stop…I wasn't able to say anything because there was all this racket and…I would do was let him flood the sink for half the session and it overflowed and went all over the floor and flood the place.

P2: I was worried that he was going to become a Moors murderer it was during the years the Moors murderers were on the news all the time and I was afraid he could go out and start killing small children.

P4: Absolutely panic, a real panic, I thought here is this child and he's out of control and I've got to keep him safe so he doesn't do himself a damage which of course we can't allow to have happen, he's shouting out the window and everybody is going to feel flooded by it and they're going to come upstairs and tell me off, you know, so real persecution.

Such gruelling working-conditions can perhaps be managed by the therapist given adequate support. Several participants discussed this in their interviews; Participant 3 in particular highlighted its necessity at a professional and personal level, expressing both disappointment and incredulity when it was not forthcoming, and relating the profound effect on her daily life outside the sessions:

P3: I also umm quite often felt that after his sessions I needed to find a colleague you know to help me recover from them because I was in such a distressed state.

And one of things that upset me greatly….nobody helped ever. EVER. NEVER, any intervention from colleagues.

I remember umm you know because it was such a vivid experience and it was when I would get up in the morning obviously my husband became aware that it was Thursday, I had to be looked after quite a lot, he had a lot of confidence I could manage, in a sense somebody else needed to know it's not an ordinary day I don't feel the same as usual.

Participant 1 described an arresting scene in the therapy when the young person seemed to use her eyes to powerfully disable the therapist's movement:

P1: …intense stare as if pin pinpointing me to a time and place umm and what it reminded me of was the very pinpoint of where the hands on a clock meet, where the short hand and the long hand meet and it was sort of like her eyes were kind of like that at the centre of time that time doesn't move. It was incredible.

A theme of brokenness pervaded the interviews. Participant 2 recounted her patient's querying why decorators were in the building as reflecting his damaged internal world; she also discussed his preoccupation with a broken item which he felt

responsible for, and his anxiety about his conscience. Possibly the latter reflects a persecutory guilt (Waska, 2002):

P2: He said 'why are they here? Is the house all in bits?' he was facing a broken universe his internal world was broken and dangerous, poor kid.

But he was umm he often heard this clock ticking or thought about this broken clock that was all his fault.

He said that his conscience made him scared and then out of the blue he reassured us both that he hadn't broken granny's alarm clock.

The same participant described the child's inescapable circular sense of torment, painful intrusion, and total lack of confidence that his emotional experience could be robustly contained:

P2: Oh yes sorry it wasn't just the clock he had a hallucination of a terrible cog wheel spinning around and drilling into his head and he did also hallucinate seeing the clock with all its inner workings falling out.

Such damage naturally makes one consider what's possible and most participants discussed their expectations of treatment outcomes. Participant 3 described a powerful sense of despondency about being able to help at all, and her sense of futility about his future:

P3: I was full of pessimism about being able to do anything…I think umm the only thing that is going to happen with him is he will have to be in a residential institution…because he will become so unsafe, it was unsafe totally to me and to everything in the room and…you could see what would happen in adolescence.

Participant 5 recounted low expectations of a positive outcome with a particular case, but took the attitude that it was worth trying to help and seemed not to feel overwhelmed by the bleak prospects. Participant 3 suggested that experience brings comes a realistic appraisal of what might be possible:

P5: A colleague said 'will you have a go? I feel so sorry for his parents'. So, I took it on in the spirit of have a go.

P3: in a rather naïve way perhaps I so wanted to help her and change things for her…and I remember [supervisor] saying to me you know you can help this child but she will always remain mad you know…I could help her to be human alongside being mad as it were.

These children's internal worlds may be primarily marked by paranoid-schizoid type phantasies and part-object relating (Klein, 1946); Participant 2 also identified depressive elements (Klein, 1935). She described feelings of guilt about not recognising earlier the negative effect of her classical interpretations:

P2: He had another nightmare or a delusion was that mother goose had died of grief because she produced a rotten egg and there he is there's a depressive element there, well in a lot of it, that he was umm in fact in that sense he was less paranoid than some that she died of grief that it was his fault his mother had been made mad and I'm sure she made him feel that.

Umm one summer on holiday and I used to come downstairs and talk to my husband and be crying seeing these awful things I kept saying to this poor kid and making him worse.

The potential for contact with depressive feelings of loss and sadness was evident in another highly-disturbed patient. Participant 3 described a moving moment when

the child became uncharacteristically in-touch with his emotional experience and open to a reparatory encounter in the transference (Freud, 1911/2014):

P3:…there was a sudden sort of shift of atmosphere in the room, a very profound silence and he became quite still and he then said to me 'nobody looked after me when I was a baby' and that sort of probably conveys to you just how powerful that experience was, to feel that he was allowing me in the maternal transference to be somebody who did at that moment…

Despite the enormous disturbance many of these children displayed, Participants 3 and 4 felt there was something likeable about some of them, perhaps instilling a hopeful sense about some redemptive aspects of their internal worlds:

P3: Whenever he became more able sometimes momentarily to be in touch with his infantile self, I felt tremendous warmth and tenderness towards him. I loved him a lot as well as hating him (laughs).

P4: He was stocky, very fair-haired, sturdy; you can imagine him going out in the playground like this (gestures) he was a nice kid, I liked him.

4.4.1 Reflections and interpretation of the theme

Many aspects of clinical work discussed by participants resonated with me. I identified with the shock expressed by P.5 when she realised a child she was working with did not have a mind. That feeling of shock manifested for me in different forms while working with psychotic children, including one child who left me feeling chilled as I perceived I could see only emptiness and evil inside him. This feeling of shock on many occasions arose from being privy to something that nobody else (at least in that

moment) witnessed and I could relate to the sense of isolation expressed by participants. In a different form this was expressed in an understandable way by P.3 who described gross splitting as the child she was working with ran rings around her and amok throughout the building while presenting 'charming sweetness' to everyone he met while the participant was 'DESPERATE!'. This was for me a moment of light relief because it was clear that the therapist was remembering her experience, but no longer feeling tormented by it, this experience, too, felt so familiar to me. It does highlight, again, that so much of what the participants described is not seen/experienced by others in the clinic setting. Indeed, I was stunned that in this case this extended to child psychotherapy colleagues who P.3 described as never having helped 'Never Ever'. It is vital that we appreciate the burden of the task and ask serious questions about the level of support that is required to withstand this work.

I also felt an affinity to P.2 who expressed a sense of panic that her patient was going to become a moors murderer. She conveyed being bombarded by news bulletins about this high-profile crime at the time of the child's psychotherapy, the coverage reflecting her anxieties about her own patient's violent capabilities. I, too, had harboured real fears that my patient – who had killed his pet hamster during treatment - would one day go on to kill someone. Like P.2 this was not something that I could suspend outside the sessions: I used to dream about him on occasion and at other times I found myself in a state of quiet panic and intense anxiety in my waking hours between sessions, and at certain periods in the treatment filled with phantasies about him one day tracking me down and murdering me. P.2 communicated this sense of being taken over by her patient, as did participant 3 who described feeling sick with dread, 'dread is exactly the right word'. This made me

think about the need for professional support, not only 1:1 supervision but a forum beyond training for continuing to think together about what child psychotherapists are so routinely exposing themselves to.

Some of the participants were especially able to offer evocative descriptions and these moments offered fascinating insights. P.1 described her patient's 'imperceptible swaying' and her feeling of being mesmerised and 'incredibly unnerved' by the way the child propelled her body forwards. The way this was conveyed transported me into their session, for a moment I felt 'in it' with the participant. Similarly, I felt captivated by her discussion of a patient's stare 'pinpointing' her to a time and a place. The realm that the participant seemed to be revisiting was palpable and this to me felt like a moment in which the phenomenology of working with psychotic children was alive in the interview. I was left wanting much more of this from the participants and curious about the limited part these sections played in the interviews.

I felt quite often that the 'insights' presented by participants were meaningful and illuminating, but frequently they inevitably carried the quality of having already been processed, perhaps many times over. There was a dry feeling attached to what was fascinating content and some comments were expressed in a very matter-of-fact way. This elicited some feelings of disappointment in me. Does this reflect the nature of the taken-for-granted complex work that we do and the extensive role of supervision and analysis during training? Perhaps. But it's also possible that we employ our own defences to cope with such distressing material.

Gathering this data from a group of participants made me recognise afresh the extent to which we suffer doing this work. I knew it from my own experience, but hearing all the participants voice so vociferously the myriad ways in which the work has taken a

toll on them brought me to a new level of understanding. Each interview compounded a feeling of unease about my profession as layer upon layer of distressing accounts unfurled. I began to more sharply appreciate the fact that people outside the profession rarely understand what the work is really like. P.1's comment 'it was like sticking between my two eyes, getting in there' illustrated the intense intrusiveness inflicted on the therapist. Although we know what the psychotherapeutic work is about, it's value, the populations it can best support, and we are prepared and well trained, it still made me ask myself the question: who would want to do work like this? Is anybody able to tolerate it without becoming damaged themselves? I'd like to be able to go back in time and ask the participants these very questions.

P.3 clearly communicated a need for urgent support, and I empathised with this. My understanding is that P.3 did not necessarily need someone to think with her about the meaning of what she had experienced, she needed someone who could appreciate her distress and help her feel less alone with it. This chimed with my experience on many occasions when waiting for supervision felt too difficult.

I also felt surprised by the extent to which the participants discussed the role of their husbands in the cross-over between their personal and professional lives. It became abundantly clear during the interviews that these experienced psychotherapists were not only in need of care and support outside their working hours from the people closest to them, but it was crucial to their survival and the capacity to sustain themselves and the work with these children. It almost seemed plain to me to say that they would not have been able to do this work without that level of extensive ongoing personal support of quite an intense care-taking nature. Of course, this kind

of disturbing work not only affects the psychotherapists but unquestionably their family members, too.

All these sacrifices and the extent of the burden were made clear, but I also did not get a sense from any of the participants that they were regretful about their careers, nor did they discuss having serious doubts about their line of work. Perhaps the meaning and value of the work (and their own internal good objects) saw them through. It is worth keeping in mind other possibilities too; I reflected on my own analysis and extensive supervisions and training: how easy would it be to get to the end and to admit defeat? The guilt at turning away from certain populations, such as psychotic children, after such an immense investment preparing me for the arduous work would not be easy to reconcile.

4.5 Life-changing Work: The Rewards for the Therapist, Child, and Family

The experience of working with these children affected participants profoundly; professionally, personally, and politically. The memories they expressed show how their patients continue to live on in their minds long after treatment ended:

P3: The children where one reaches the psychotic aspect of them one feels about them with the same intensity as the two frankly psychotic children who have stayed so strongly in my mind, if you are working, and challenged at that really deepest level. Of course, you can remember the children, but they didn't cost you so much, didn't cost me so much so they are not I am talking about people I have seen over a period, the experience that they call forth from one analytically is so stirring it does have a particular impact on one's life.

P2: I'm not saying those emotions don't come into the work with every patient because every patient has a psychopathic psychotic bit of them, but it comes out in a more extreme form, and I would say that working with these patients changed me. Personally.

After treatment ends, therapists are left to reflect on what has taken place and continue thinking about these children. Participant 5 struck a hopeful note; when children can respond, the work seems profoundly meaningful, and the patient's transformation immensely satisfying. But Participant 3 expressed pain at not knowing what becomes of them afterwards.

*P5: It was extraordinary…it was just mind blowing, just extraordinary… one week it was priceless**…**Over time seeing this boy come to life, has been amazing.*

P3: Not knowing what happens to our patients is part of what as child psychotherapists we have to live with. I found myself the other day, a curious link, I just happened to be in touch with a colleague who lived in a part of London not near where I live where my first psychotic patient lived. The name of this borough always brings this patient to mind. She is well into middle aged now, if she has lived, which I think she has. It is very, very painful to put so many years into life path into these children and to not know.

4.5.1 Reflections and interpretation of the theme

I identified with P.3's conviction that working at the deepest level with psychotic children is deeply challenging and that 'the experience that they call forth from one analytically is so stirring', like P.3 I agree that it does have a particular impact on one's life. This seemed to me to capture something of the profound nature of learning

that can come from this type of experience; a learning that reaches far beyond theoretical understanding or refinement of technique, rather it has the potential to alter the psychotherapist's internal world and beliefs about being in the world. I also felt this conviction from P.2 by the way she stated so unequivocally that she was changed by the work. 'Personally.' The emphasis with which this was said felt to me as if it underlined exactly what P.3 had communicated. These comments felt very emotionally resonant and there was a clear sense in which the participants were emotionally in touch as they spoke about the effect of this work on them. In some ways it would be difficult to expand on P.2's proclamation because it is so significant: how would one even begin to articulate in what ways they have been changed?

I was somehow surprised and again felt quite touched by P.3's discussion about being in a part of London recently where her patient used to live and the revisiting this person in her mind. I felt this was meaningful because she was not reminded of her patient because someone had discussed a clinical case that bore a resemblance or because she saw an old supervisor, it was a more general link, something personal about where this patient was from, and I think it highlighted well the personal nature of these patients being woven into the ordinary fabric of the psychotherapist's inner world. I was also curious about her feeling that this patient has lived. Of course, we can never know, and P.3 described that as a very painful part of the relationship, but I wondered where that intuition (or hope) about her patient came from.

4.6 What's Required: Setting, Technique, and Personal Qualities

Participants felt it important to have realistic expectations and sympathise with parents, who need a great deal of support. The role of supervision, the passing-on of

knowledge, and the wraparound support of a network was emphasised. Since it is impossible to bypass early containment in the transference, participants believed some aspects of classical technique require modification. They discussed various personal qualities necessary for withstanding the therapeutic work with these children.

Participant 3 described a painful experiential learning-curve towards modifying her expectations regarding the child's capacity for change, while Participant 5 raised the responsibility to avoid giving parents false hope:

P3: So that was of course profoundly disturbing to me for a shocking thing for a sort of terribly hopeful young child psychotherapist to hear to know that we can help but we have to know what we can't do as well as we can do.

P5: all the time parents will say, parents I'm seeing now, 'will she always be like this? do you think she can change?' and I'm so careful, I say this has changed and this has changed which gives us cause for hope, but I can't tell you whether she will be able to do this and this and this. I just feel that's mean.

Verbal interpretations alone were thought to be often insufficient since they assume a level of sophistication frequently beyond the reach of these children. Participant 4 thought many of these children had missed out on basic containment from infancy and accordingly might need in therapy to attend to acting-out (Freud, 1914b) and to concretely contain by clearing-up.

P4: My strong feeling is…that you can't actually skip over the early level of physical containment that is just developmentally appropriate when children are babies and small toddlers, that's what you do, you sort them out physically…you might have long stretches of verbal containment and that's excellent and very useful and we

don't want to knock it but with kids who have missed out on that developmentally necessary step I don't think you can get away without going through that level.

P4: I'd interrupt and say it was time to clear up and we'd mop up for the remaining half of the session and we'd leave. I started to make sure there was enough time to clear up so that was a very, very, concrete physical form of containment. Very concrete and physical and that was all I could do because there was no way of getting a word in edgeways.

The necessity of supervision is well-recognised, and was endorsed by all participants, in myriad ways. Some emphasised its value, and its usefulness drawing the therapist's attention to an enactment; Participant 2 expressed a need for more specialist or individual help, Participant 4 highlighted the supervisor's capacity to help clarify the specific aim of treatment. Although supervision offers a formal arrangement for support, containment, and creative thinking, participants also often mentioned other crucial sources of help that sustained them during the work. This vital support not only ensured the therapist's survival but is valuable to all parties, including the child, family, and wider agencies, as described by Participants 3 and 2:

P3: the case was very well held in terms of the framework which made me feel I could just about survive it.

P2: umm I do feel what I learned when I went back to The Tavi in the late eighties was the importance of work with families and the wider network and that when you're working with iller people and I learned this from Sue Reid and other Tavi people like Margaret Rustin and Sheila Miller and Lisa Miller and Trudy Klauber was that it is an essential part of the work.

All participants saw parents/caregivers as integral to the child's therapeutic work, and were sensitive to the immense struggle facing the families; the need for sympathetic, sensitive parental engagement was stressed, as was the need to establish the right kind of support for parents:

P1:…it highlighted to me just how hard it is and what a struggle it is for parents with children who are in a psychotic state of mind.

*P4: It also taught me that you don't make interpretations to parents that you're seeing once a week for parent work and that was actually a really important lesson that stayed with me, you actually don't do that not until *and* unless there's a massive amount of foundation being laid and a massive amount of other kinds of work in the background to hold it.*

Just as the therapists find themselves learning and adjusting to the reality of working with these children, parents require sensitive support to help them gradually face the extent of problems their children exhibit. Participants stressed how long it may take for a clearer picture to emerge, assisted by parents' engagement with the therapeutic process over time:

P1: I'm talking two years down the line that then you start to gather crucial pieces of information because it has only just become conscious to the parents to report it or recognise its relevance and those are almost like missing links.

Participants described waiting to intervene verbally; sometimes this was forced by the patient's disturbance, but sometimes therapists need to show restraint and wait for fuller, deeper understanding of their countertransference (Heimann, 1950) before making an interpretation:

P4: Probably the best part of a term, I wasn't able to say anything because there was all this racket.

…the hardest thing is to wait those extra thirty seconds that one needs to wait in order to have something specific to say about the countertransference, you know that it's not any good just saying 'gosh I don't like this, or this is very difficult or whatever it is' and that's fine but it doesn't really give you the information. You know, one has to wait the extra thirty seconds until one's processed it enough to more specific and then it provides the information…I think that's really hard, but I think that's where the work gets done really.

Patience isn't the only quality or skill interviewees highlighted; Participant 2 emphasised the need to persist with the patient under very trying circumstances, while Participant 5 stressed something slightly different by talking about persevering with her interpretation over time and having confidence in her formulation when she felt it to be clear and awaiting the patient's readiness to hear and consider it.

P2: IT DOES TAKE STAMINA. I always had stamina, I was prepared to hang in there for a long time, I didn't lack that, but it takes you know a different kind of stamina to stay with someone not who is just suffering but who is making other people suffer or really wanting to.

P3: I sort of stuck with umm my line, my way of trying to take that up and umm I seemed gradually…Eventually I was able to somehow be heard and of course one never knows in retrospect exactly what it was that you said or the way that you said it which made any difference but to…my astonishment really.

Participant 2 listed the emotional states therapists need to draw upon, using vocabulary notably suggestive of struggle; sometimes even experienced therapists may doubt they have what it takes.

P2: What you discover is something that Meltzer referred to as the battle, the values of the battlefield; another set of emotional states that you need, you need courage, bravery, you need umm strength, you need to know when to be icily bored instead of interested in everything they are saying, these are very different sets of emotional states and some of us are not very good at it and I used to think sometimes with one psychopathic patient, gosh umm my husband would know how to handle this so much better, why don't (laughs) my husband was a [non-analyst], why don't I just hand him over to him?

Resilience is another necessary quality; participants observed the need to withstand violent, aggressive, and unnerving states of mind in every session, week-in, week-out. Such grave disturbance means sometimes therapists must prioritise helping the patient calm down:

P1: To be able to withstand that over a long period of time three times a week for nearly four years umm you have to have that resilience within yourself but also be aware of I think those areas where perhaps you feel you being drawn to in terms of retaliation.

P2: splitting and projection have healthy functions and that although you need to take account of that with a neurotic patient with these patients who are so desperate it really is very important to help them to calm down.

How to help these patients 'calm down' poses another question. Participant 2 insists it sometimes includes direct reassurance, but contrasts this with a borderline state

where reassurance is implied, noting that this reassurance really is considered a matter of psychic life or death for the psychotic child. Participant 4 acknowledged the departure from classical interpretations, but suggested one patient had enough symbolic capacity (Segal, 1957) to hear a conventional interpretation:

P2: we're taught not to reassure but in a psychotic state I would now reassure, with a borderline psychotic state I would take up a the rightful need for assurance and quite often that's enough, 'it's important that you understand, that you could imagine being safe here and you've learned that I keep you safe', but you might just go straight for reassurance 'it's okay I am not letting them in, you are safe here, we are okay, that door is locked', because the child is going into a psychotic hole and you really need to umm even offer reassurance a kind of lifeline.

P4: he was very accessible to interpretation when things weren't too bad…I remember I put it in terms 'you're frightened I might' instead of the way we might do now 'you can't believe I won't'. This was back in 1972, and I talked in terms of 'you're frightened I will' and he could deal with that so in that state of mind even when he was very, very, frightened he had enough symbolic capacity so that didn't make him worse and that was interesting.

Something all participants agreed was that help cannot just take place on a psychological and supportive level through supervision, the wider network, mentors, and analysis, but these children must also be seen in an appropriate, undamaged physical setting, with furniture that cannot be easily uprooted:

P2: Very very very commonly you have an acting out psychotic child who is eight years old or something like that and they've got to be held physically and you don't want to do something that's going to be exciting so I think it's terribly important to

have a room with a heavy desk and a heavy chair and you get them into the chair and you say legs under the desk and stand there until they can't headbutt you and without that kind of furniture to help you, I don't think you can do the work.

P4: If you see children in a room that has been massively damaged, that does them no good at all. You know I remember again when I was a student room 268, which is now an admin room, was the sin bin and it had lots of very ill acting out kids in it and they'd smashed holes in the ceiling, and they'd torn bits off the wall and every child who went in there got worse straight away.

Three participants discussed their patients' problems with 'rival babies'. Participant 4 explicitly linked her patient's improvement to the arrival of a sibling, disproving her anxieties; the arrival of the sister prompted dreams where the patient was being attacked, which the therapist related to the earliest level of psychic experience, at a skin level (Bick, 1968). Participant 2 reflected on her patient's increased sadism and its link to her interpretations which were detrimental because they focused on the patient rather the object's betrayal. Participant 4 described another patient who made a striking improvement after seeing his therapist with her children outside the session:

P4: You wouldn't have said she was psychotic but she got a lot better when the parents managed to have another baby and then she started playing really well and she began to have horrible nightmares about the baby with whom she got on very well in reality scratching her and actually scratching her skin off basically so that what was what the trouble was with her…You couldn't talk about it and my god it was necessary. And then after the little sister come along, she began to be able to have dreams about being scratched about her little sister scratching her skin off and again that was on the very very early skin level.

P2: I took the material to [supervisor] and he said, he said my interpretations were like beating the child because I was interpreting the child was jealous because I'd stopped to have a baby and that's why he wanted to kill these BABIES!

P4: He (patient) lived quite close to where we lived and he once happened to see me collecting my own children from school and after that he went places and all his own aggression against other children began to come out really vividly in terms of work with the toys…that seemed to be the transition point after which he really communicated by projection so things were much more three dimensional and he was projecting rather than throwing.

Very movingly, Participant 3 recounted the moment her patient responded to her baby's birth by asking its name. Previously the patient had only been able to conceive of the baby as having her own name:

P3: 'what's the baby name?' it wasn't Anna, it was a real baby, she wasn't saying Anna, she knew there was another baby and she was still my patient baby and that I was coming back.

Several external factors supporting the children's treatment were identified: Participant 4 thought patients needed to be seen beyond adolescence, while Participant 2 stressed the fact that traumatised children's whose whole personalities have been shaped by their experience require extensive treatment; mental health provision in the UK is inadequate:

P2: the idea that we can fix him in one year or two years when his whole personality has been distorted by it, I mean it takes YEARS and there's a book that came out a couple of years ago written by an analyst in, he's Jungian, but he's also quite psychoanalytic like us, in Milan called Francesco Bisagni…many of whom are

autistic some of whom are psychotic and every single one he has seen four times a week, eight years, ten years, fifteen years, and these are people who show real recovery but umm it's the time it takes if somebody is that damaged.

4.6.1 Reflections and interpretation of the theme

Participants were keen to discuss elements relating to these themes because certain fundamentals were felt to be vital to the survivability of the work. There also seemed to be a certain 'energy' to these parts of the interviews which might reflect that this area of technique and setting is one in which the participants felt a greater sense of agency. We know that work with this population is incredibly difficult to sustain but there is hope: knowing what's required and what we can have control over in terms of the frame is perhaps an important part of feeling that one can take on this task. I also felt that in this theme more than any other, the student/teacher dynamic was more apparent to me. Issues about approaching the work with this population realistically and managing expectations were not at all surprising and were worth underlining, however, at times in the interviews these discussion points seemed underwhelming or disappointing, perhaps because they are the kind of statements that could apply to any group of deprived or traumatised children. It did not feel like new or revelatory information, but it served as a helpful record of the uniformity of opinion in this area.

I feel very sad about the current national picture of deprived services and this was heightened by the participants' accounts of a different era in which joined up working was valued and common place. Their emphasis on the need for parent work and their conviction that this work cannot be done in isolation evoked feelings of

despair about the brutal cuts that have marginalised these essential elements of child psychotherapy in NHS services.

I had an interesting reaction to the qualities felt to be compatible with and important for psychotherapy, I found myself curious about which ones can be developed and to what extent. I wondered about the qualities of stamina and resilience and how these vital states perhaps tread a fine line between necessary robustness and perhaps something potentially altogether more defensive. Throughout the project I had a developing sense of the narrative from participants of this impossible task that could possibly 'break' the psychotherapist, but which could be overcome, presented in a way that seemed almost archetypally heroic.

CHAPTER 5

DISCUSSION

5.1 Introduction

Taking a Kleinian view, transient psychotic states of mind are of limited interest here. The aim was to hear about participants' work with children who presented in psychotic states in more entrenched and significant ways. The discussion focuses predominantly on their experiences of children who, to borrow a categorisation from Participant 3, find themselves in a psychotic state of mind much of the time or who they consider are psychotic in a characterological sense.

In the following sections I present a digest of findings discussed with the relevant literature, addressing each of the four superordinate themes. The first section regards definition and aetiological factors; here, the main discussion focuses on phenomenological descriptions of these children's primitive inner worlds and the therapists' experience including countertransference effects on the body and mind. The second discusses participants' experiences of working with primitive states. The third concerns an unexpected, interesting, finding regarding 'rival babies' (actual babies/children of the therapist). The fourth addresses the theme about what is required to carry out this work. In discussing the results there is a succinct summary of main areas of consensus, most of which fall within the 'What's Required' theme, while trying to attend to each individual significant experience of the participants. Many were expected findings, but their value was underlined, and participants were generally of the opinion that some of these aspects of the child's treatment demand meticulous attention. The discussion concludes with some participant remarks

describing how they have been changed by their encounters and acknowledging the lasting impact of these children on them.

Many unanticipated theoretical ideas arose at late stages of data-analysis and have been cited in the discussion; however, limitations of space prevented their inclusion in the literature review.

5.2 Definition and Aetiology

The question of how to define 'psychosis' was not of interest to me per se, but needed to be resolved so participants and interviewer would have a shared frame of reference. Rustin's (1997) description of psychotic children who are 'non-autistic' and vigorously and explicitly destructive fitted with the study's aim, but even cursory perusal of the literature revealed a longstanding linguistic muddle. Moreover, anecdotally colleagues expressed uncertainty about the definition of a psychotic child, which led me to broaden the research question to 'psychotic states of mind'; immediately some prospective participants expressed relief. One participant's anxiety emanated from a lack of confidence in defining childhood psychosis, possibly assuming there was a unified and agreed-upon definition of which she was unaware, causing her to doubt whether she had experience of these children. Another's relief reflected the fact that she – like most child psychotherapists – tends to think in terms of states of mind rather than definitions that imply a more fixed status. These issues are returned to later in the discussion.

As I familiarised myself with the literature, what started as curiosity about the theoretical change from a neurotic/psychotic dichotomy to a proliferation of more-nuanced definitions became a feeling of confusion amid a sea of definitions. This

began to feel like an obstruction to the research rather than an integral aspect of it, and I felt impatient to get beyond the fog so attention could be paid to the phenomenological aspects of the encounter between patient and therapist. Participants, however, had much more to say about definitions than expected, and gradually it became easier to see this debate as an intrinsic part of how participants experience the work with these children.

The theoretical starting point for childhood psychosis is Klein's diagnosis of schizophrenia regarding her patient, Richard, in 1930; a diagnosis that was given despite the absence of regression typical of schizophrenics (Rhode, 2018). Although the term lacks nuance, it straightforwardly captures the essence of what it is to be a non-autistic psychotic child, something clearly defined by a participant who described 'the schizoid 3-dimensional universe of psychotic children'. There are likely mixed views regarding the helpfulness or otherwise of the loaded word 'schizophrenic', but possibly something clinically valuable has been lost since its omission from the literature.

It would be anachronistic to suggest Klein should have diagnosed Richard with autism since Kanner only introduced this in 1943, but there is agreement that today Richard would undoubtedly be classed as autistic (Houzel, 2018; Rhode, 2018; Durban, 2019). Klein's diagnosis arose from the frame of reference available to her at the time, which was contingent upon prior theoretical attention, but some participants in this study took the view that various distinctions are not always clear-cut and easy to identify anyway. This was either because states of mind 'blend and bleed into each other' or because there are differentials to consider, such as one participant's doubt regarding an autistic child; 'is it really a psychotic, more schizoid, even schizophrenic-paranoid?'

The phrase 'blending and bleeding' implies different qualities to the movements between states of mind. My association to this was the ordinary symbiosis of very early infancy, when the receptive maternal object avails itself of the infant's projections, facilitating an illusion of the infant's control of the object (Winnicott, 1960); by contrast, 'bleeding' suggests a more violent incursion into the object, suggesting to me the intensification of sadism in infants who suffer excessive frustration in infancy (Klein, 1932). The participant here may have been unconsciously pointing to the spectrum of psychotic states ranging from ordinary to pathological.

Another participant concurred that it is not always easy to determine what sort of presentation one is dealing with, but also presented a different scenario marked by more subtle psychotic aspects, whereby child and therapist appear to be speaking rationally until out of the blue the child will say something totally unconnected. Although therapists are tuned-in to the latent content, these scenarios present such a powerful outer appearance of rationality that therapists, risk being momentarily seduced into normal conversational practice where we follow a principle of interpretive charity, which involves treating apparent non-sequiturs as though they are in fact relevant (Grice, 1975). This clinical experience certainly resonated, though I had not properly processed this notion prior to interview. This was an interesting comment because it is not something, to my knowledge, that has received much attention. This clearly demands a high level of alertness from the therapist. To my knowledge Lucas (2013) has not discussed precisely this but one of his main arguments is that the clearest indicator of psychosis is the patient's staunch denial and rational appearance despite evidence to the contrary, such as violent acting-out scenarios.

In contrast to the participants' view presented so far, another believed the distinction between autism and psychosis was crucial and clarified that although autistic children 'are not a dickens in touch with reality' they would not be called psychotic in the same sense. Presumably the distinction matters to this participant because the differences have clinical relevance. Separately, elsewhere in the interview, the participant cited the changes to technique in child psychoanalysis instigated by Alvarez which bring the concept of deficit and the requisite technical adjustments into the foreground (1992b; 1996; 1999; 2012).

At the time Klein was writing, analysts in France also used the term 'infantile schizophrenia'. In an interesting divergence, the term 'psychosis' has remained steadfast in France, whereas in the UK the definition has undergone many changes to the point of dropping out of the DSM entirely. One participant identified the turning point as 1971, when psychoses were divided into early- and late-onset, corresponding to developmental delay and bipolar and schizophrenia respectively. Possibly, the consistent inclusion of psychosis in children in France reflects the prominence of structural psychoanalysis which suggests a degree of permanence.

Depending on one's psychoanalytic orientation, the notion of characterological permanence might either be considered a given or felt to be at odds with the foundations of an object-relations approach, premised upon the notion of identifications and introjections to be worked through in the transference (Klein, 1946). I find it unclear whether these are mutually-exclusive models. Because of the disparate array of views in the literature, I began to appreciate the appeal of a state of clear-cut unchanging categorisation that the French perspective typifies. A similar relief arose when another participant explained, at the outset of her interview, a system of gradation in her mind ranging from fleeting psychotic states of mind to

children whose minds are often suffused with psychotic functioning, even getting stuck there for some time, to those who would be considered permanently psychotic, children who would in an everyday way be regarded as startlingly different from other children and widely considered 'mad'. Although this participant was not drawing on a Lacanian structural model, she seemed to suggest something at a more ingrained, characterological level. In terms of 'character' it was not clear in every discussion whether participants were referring to an innate constitutional element or the development of character in a relational context, but often the latter was implied as participants discussed the context of trauma in many of these children.

Various participants considered this issue of character relevant; for one, it determined the type of psychotic manifestations with more-or-less malignant potential, and another cited it as vital when assessing carefully with a view to ongoing treatment. The latter point is interesting to consider in light of CAMHS clinics operating within a medical model, prioritising what are supposed to be more objective measures regarding biopsychosocial functioning during assessments.

All participants were clear about the negative impact of environmental failures on the child's state of mind, with various privations and deprivations, different types and degrees of trauma, and the often-underappreciated impact of 'cumulative' minor traumas, perverse parental relationships and inherited multi-generational traumata cited. Although participants mentioned these factors, it was generally in the service of explicating their formulations about specific children, rather than hypothesising or making any claims about the aetiological root of psychosis. Rhode and Houzel maintain there is now consensus that a multifactorial aetiology is most likely (2018).

In 1994 Tustin distinguished autistic children whose presentation was marked by encapsulation from those she described as 'entangled', replacing the term

‘confusional autistic’ with ‘confusional entangled’ for clarity. Three participants compared non-autistic and autistic psychotic children, which might reflect their area of interest as well the historical context surrounding definitions of psychotic children. Participants’ discussion emphasised the difference from a psychoanalytic perspective: splitting and cutting common to psychotic children compared with sticking/unsticking and dismantling for autistic children. One participant also stressed differences in countertransference, namely a feeling of a splitting or bursting head and puzzlement, rather than the absence of thoughts as in the case of autism. This integration of observation skills and one’s own countertransference draws upon the established foundations of child psychotherapy practice. Fuller discussion of the divergent aspects between these clinical presentations follows in the section describing their primitive inner worlds.

Laufer’s taxonomy of ‘psychotic episodes’, ‘psychotic functioning’, and ‘psychosis’ (1986) occurs in many recent pieces of literature, most focussing on clinical discussion and theoretical formulations pertaining to adolescents and adolescence as a developmental phase. Interestingly, all participants chose to discuss younger children, so, although the literature emphasises adolescence as a precarious and tumultuous time in which regressive tendencies, puberty, rapid oscillations between revived infantile states, and oedipal conflicts combine to create a window when a psychotic breakdown is quite possible, younger children perhaps have the same constellation of forces to deal with but without the influence of puberty. The worrying nature and severity of the younger children’s psychotic functioning during the supposedly relative quiet latency years may have led some participants to consider a more structural basis for some children.

Rustin speculates that the under-theorisation of psychotic children may reflect a wish to avoid the painful feelings aroused by witnessing the damaged inner worlds of these children (1997). The prevalence of papers on psychotic functioning in adolescence could result from higher incidences during this developmental period, but might also indicate psychosis is even more distressing to think about in younger children. Furthermore, CAMHS clinics are increasingly disproportionately weighted towards adolescent patients, meaning younger children might nowadays not reach the attention of specialist mental health services until later. This is obviously a clinical concern but may also distort the academic picture.

The titles of papers on psychosis often cite 'psychotic functioning' or 'psychotic breakdown' *and* the word 'adolescent' or 'adolescence'; one can see how the wording implies that this struggle can be surmounted but the literature makes plain the acuteness of many presentations. Perhaps the collision of forces previously described primes young people for increased vulnerability towards psychosis in adolescence, but I believe we cannot presume that this is nearly always the case since, the results from this study – admittedly very small-scale - evidence a deep level of psychotic disturbance in younger children.

As described earlier, two participants expressed relief at the expansion of the research question, one related to an anxiety that she had insufficient experience with psychotic children and a lack of confidence that she knew what that meant. This resonates with Rustin's comment (1997) regarding its relative obscurity in the literature; possibly this accounts for a lack of confidence amongst child psychotherapists in defining such cases, but the lack of a solid, explicit distinction between psychosis and psychotic states may contribute to the side-lining of childhood psychosis as an area of interest over time. Its neglect possibly perpetuates

uncertainty about how to conceptualise the problems of these children, who have more-entrenched problems facing reality, with the result that child psychotherapists may feel confident engaging in clinical discussion with colleagues but tend not to articulate and develop their views more widely.

The second participant's relief at the expansion is probably, in part, related to the fact that all participants were trained within the British Object Relations school that arose from the ideas of Melanie Klein. One core tenet is the fact that primitive states of mind recur throughout the lifespan (Klein, 1946); so fluid states of mind rather than more fixed diagnoses may be a more natural fit with this school.

5.3 Working with Primitive States

5.3.1 Lifeless states and inhuman aspects

I was struck by the evocative descriptions some participants gave, suggesting that some of these children seemed utterly unrelatable and inhuman, apparently residing in another dimension altogether; moreover, the therapists exuded a sense of disbelief, as if fully comprehending the strangeness of their being was almost beyond them. One imagines this must be a near-constant experience of isolation for the child, but how alienating must it also be for the parents and family members who bear daily witness to this? The mind-bending strangeness suggests that sometimes words fail, as illustrated by a participant who expressed shock as it dawned on her that the child did not have a mind (this was communicated slowly, conveying her disbelief and incomprehension). This child was perhaps at the most primitive level, without even minimal mental apparatus; recalling Bion's conviction that the mind

develops in response to pre-existing thoughts (1967). This mindless state suggested an under-integrated, undrawn, child (Alvarez, 1992b).

Conversely, this rather android-like presentation – a term Bollas also uses regarding a psychotic patient's speech (p.76) – could be explained by a more defensive process (2015). In this respect Bollas points to Andre Green and Jean-Luc Donnet's theory of 'blank psychosis' (1973) whereby an inverse process to the stimulating production of thoughts takes place, with the patient evacuating mental contents until merely scant thoughts remain.

The participant communicated a feeling of helplessness, implying not having a map in her own mind for how to relate to this child, resorting instead to something rudimentary, 'like dot-to-dot.' The encounter with this child took place in a state of something like blindness for the therapist, so one wonders how the child navigated this sort of perplexing inner (and outer) world. This underlines the now-established view that we cannot assume the child has undergone basic phases of mental development; we may need to alter the clinical task to a more developmentally-focused one of facilitating the building of a mind (Alvarez, 2010)

Further evocative accounts came from a participant who described a child's peculiar swaying movements, so unnatural and almost imperceptible; the therapist was captivated as it was 'almost mesmerising.' To me this conveyed a sort of sinister lightness, a ghost-like appearance palpable in the participant's tone of voice and eye-contact with me. Despite this event taking place many years ago, its memory seemed indelibly imprinted; the participant could remember how she felt in the presence of this haunting child as if it were yesterday. At the end of this moment of 'reliving' during the interview, I found myself thinking about an unrecoverable loss; my

association was to an empty, postapocalyptic world, forever changed by what had taken place.

The patient's stillness and the moment of silence at the end of the narrative reminded me of this participant's description of an arresting moment when the child looked at her in a way that seemed to disable the therapist, rendering her almost paralysed and mute. Another schizophrenic patient of Bollas made a comment that chimes with this (2015); deep into their work this patient began to warm to her object and established more contact, at which point she reflected and endorsed his approach: 'it helped you never asked a question, and you could be silent forever without intruding' (p.69).

The penetrating eye-contact between child and participant was perhaps an unconscious attempt by the child to control the therapist by keeping her at a safe emotional distance. The patient may indeed have looked at the therapist much as prey keeps its eyes alert to potential predators, but the therapist's perturbance suggests she too felt in the presence of an aggressor, a powerful projective identification characterising this child's engagement (Klein, 1946). Given the 'unnerving' emanation from the patient, this scene was ripe with potential for an enactment with the therapist wishing to retain some distance from her patient, though it is unclear that was the case here.

Perhaps the eyes focussed the child's wariness regarding emotional contact and intrusion, but perhaps too there was more ambivalence than that because the child's gaze – however cold – may have been an attempt at contact, on the only primitive level available to her. After all, she had not turned away entirely. Much has been written about gaze and intersubjectivity in infancy (Nagy, 2008; Trevarthen & Aitken, 2001); it's natural to wonder what may have gone awry very early on for this

child. The participant's anatomical language further reinforces the impression of inhuman qualities, for example 'cranium' rather than mind and 'protrusion' suggesting a mechanical rather than relational attachment.

Bizarre movements also included this child tiptoeing across the floor in agonisingly slow, again imperceptible, movements. The child 'hovering' across the floor in such a way suggests a disembodied state, an insubstantial, frail, body-ego; what Haag describes as 'se sentir dans sa peau' (insufficient primary body representation) (Haag & Haag, n.d.). Alternatively, the child might have been terrified that one wrong step would have fateful consequences, moving carefully to avoid awakening some sort of primordial threat which she had projected into the room, in this case into the floor. This view accords with Bion (1957)'s experience of psychotic patients who move 'not in a world of dreams, but in a world of objects which are ordinarily the furniture of dreams' (p.275). This does not contradict Haag's statement, since Bion also cites the impoverishment to the ego resulting from excessive projective identification.

5.3.2 Unpredictability and disorientation

The participant noted the juxtaposition between the child's extreme stillness, her hovering spectre-like appearance, and the moments she would instantaneously flip into a frenzied state, giving the therapist a sense of always being on the precipice, that a sudden eruption of something actively destructive was afoot. Another participant echoed this, speaking of her child's 'virtuosity in changing from one defensive structure to another ever so quickly,' leaving her feeling 'peculiar.' This recalls Rosenfeld's (1987) hypothesis that even in-utero infants endure maternal projections, resulting in the infant being born into a world where they feel they may

suddenly and unpredictably have to defend themselves against something terrifying being forced into them.

The 'peculiar' feeling that overcame the participant also suggests she was taken out of her ordinary experience, that something interfered with her state of mind in a disorganising way, perhaps akin to Bion's notion of fragmentation (1957) and the proliferation of beta-elements (1984).

A current of disorientation ran through all the accounts with participants assailed by various unpleasant and visceral symptoms, including falling. One participant repeated this word three times for emphasis, *falling, falling, falling,* she felt words were inadequate; 'I can only describe as a feeling in my stomach of falling', pointing to a pre-verbal state. This account of 'falling' tallies with Winnicott (1974) and Tustin's (1986) notion of 'falling forever', corresponding to 'psychotic depression' and observations arising from work with autistic children respectively. Tustin argued that such autistic anxieties apply universally and not solely to autistic children; indeed, the participant clarified that she deemed her patient psychotic and not autistic.

Dizziness was cited by one participant, her head was 'going round and round' culminating in not knowing where she was, while another commented on a child's hallucination of a cog-wheel that spun dreadfully (not at all a playful implication). Hearing this, I imagined a circular inescapable torment, lacking any nominal notion of forward movement or creative potential for the child to identify any exit-points from this mental black roundabout. One could connect this to Freud's repetition-compulsion (1914), though these isolated pieces of 'data' mean any interpretation is underdetermined, and another explanation could just as easily apply, such as

Houzel's precipitation anxiety which Haag *et al*. cite as a factor underlying repetitive rituals 'such as whirling' in search of a dizzy sensation (2005).

Another participant described spinning, illustrated by her child patient's phantasy of a baby girl put into a vessel and spun to the point of disintegration, leaving just residual sparkle. To me this suggests active intentionality (Alvarez, 2006) and implies a defensive quality along the lines of Winnicott's notion of disintegration in the face of psychotic breakdown (1974); an essentially protective measure relative to what he terms 'primitive agony', its severity corresponding to the point of dependence at which a traumatic break occurred in the mother-infant tie (Ogden, 2014).

A differential would be something that implies less agency, like O'Shaughnessy's 'passive disintegration' which she links to Bion's agglomeration of dispersed psychotic parts (2006). In this case, it seems more likely the former because of the child's determined action; the phantasy clearly concerns a rival baby, and the child's notion of 'sparkle' connotes a fairytale quality, possibly minimising more aggressive impulses.

It became clear that participants were describing accompanying their patients to very primitive terrain where existential anxieties abound, assaulting mind, body, and cognitive capacities. This section of the discussion provokes many theoretical ideas, possibly showing the difficulty of appreciating the extent of such existential and primitive anxieties without leaning on familiar (steady) mental constructs. Notably the participants' narratives were also weighted towards theoretical formulations, with less time spent dwelling on the felt experience. This demonstrates that the 'life world' of participants working with these children takes place within a context which highly values psychoanalytic thinking.

Strikingly, one participant discussed the impact on her cognition, finding her memory obliterated after spending time with her patient. She felt disconcerted that she could not remember anything the patient had done in a session, even an attempt to refresh her memory by looking at his pictures failed. To her they were just meaningless 'marks on the paper', suggesting a total blank. This is notable for what we both feel is an absence of symbolic functioning (Segal, 1957) and the bizarre feeling it left her with. This suggests something especially unusual about this child; perhaps the participant's amnesia might have re-enacted the child's infantile experience of an object, completely and utterly unable to think about his affective experience and ascribe meaning to it. Bion understood memory to be a function developed in response to the reality principle (1957); something that was perhaps a universe away for this child.

5.3.3 'Nameless dread' and the deep unconscious

These symptoms of disorientation possibly reflect the child's inner state, stimulating a similar experience in the countertransference (Heimann, 1950). Relatedly, a participant's description of her patient's intense stare, pinpointing her to a time and place, suggests a possessive quality (Caper, 1999). It seems reasonable to hypothesise that, despite her wariness, this child's eye-contact also betrayed her desperate search for a container. My association to the participant's description was of an anchor to avert a slide into something like Bion's 'nameless dread' (1962).

This descent's catastrophic quality takes the discussion into another layer of the deep unconscious. One participant spoke slowly and especially thoughtfully while discussing her experience of the patient's gaze. Her words seemed to matter more at

this point than any other, and she appeared to be reliving an encounter, diving back into it, before resurfacing and trying to faithfully convey a profoundly-felt experience. With awe, she described the child's eyes as 'like at the centre of time.' She called this incredible. The atmosphere-shift in the interview seemed connected to her earnest wish that I understand something very meaningful to her, and was reflected in a change in her tempo of speech and tone of voice. The nature of what she described also opened other doors to thinking about the inner world of this child and what took place between them; in the interview it seemed as if the more ordinary, intellectual, thinking had been suspended as she described what possibly signals a different dimension that she and her patient found themselves in.

One possibility is that the arresting moment of eye-contact with the patient brought the therapist into contact with the patient's deep unconscious, which Freud posited was a timeless state (1915/2005). Noel-Smith (2016) summarises various developments of Freud's concept of time, which may be relevant here, including Green's hypothesis of 'anti-time', 'that is the illusion we have of being able to stop time; and the murder of time which takes place resulting from the death drive at work in the repetition compulsion' (p.7). Furthermore, she refers to Rosenfeld's (1971) conviction that the death-drive interferes with or obliterates the capacity to think. Did this happen during the moments when the participant was transfixed by the patient? There is no clear evidence of that, but the qualitative shift in atmosphere during the interview marked by an increase in affect perhaps suggests an alteration in the balance of her experience, with her affective experience in the foreground.

Was this moment of powerful wordless contact with the patient a re-enactment of a pre-verbal experience? Perhaps the participant's countertransference is informative in such instances for deciphering the nature of the experience: it could be something

like a ‘folie a deux’, similar to Tustin’s ‘confusional entangled’ (1962) where child and mother are bound together in mutual dependence and overwhelmed by extreme projective identification; or perhaps this scene was revived in the transference for communicative purposes. Did the child hope something of her infantile experience could undergo some degree of repair? From the participant’s account it is unclear, but she described the patient ‘sleepwalking’ into a break despite a great deal of preparation, suggesting that an acknowledgement of their separateness was either beyond the child’s comprehension or was at least something she was determined not to acknowledge. Bion maintains that the ego is never entirely removed from reality, rather its contact with reality is obscured by an omnipotent phantasy which seeks to destroy reality or knowledge of it (1957). Possibly this child had some awareness of the break but was determined to ignore the fact of an impending separation.

My inclination is to think the participant was gifted a valuable insight into her patient’s state of mind in a very specific and powerful way, one that could not be overlooked. Presumably the knowledge gleaned was somehow helpful to the therapist’s formulation of the child’s state of mind. Lear’s exegesis of Freud (2015) clarifies that repetition compulsions, from the perspective of the unconscious, are not a case of ‘the same thing happens again’, rather ‘the same primordial struggle endures’ (p.50). So, was the therapist’s special receptivity to meeting the patient the key factor that gave her access to this patient’s enduring primordial struggle on that day, or was there some other reason the child unconsciously brought this aspect of her experience into the transference at that point? Opportunities were sometimes missed to ask participants to elaborate their remarks, which was largely attributable to my inexperience and anxiety that I might inadvertently lead the participant, thereby jeopardising the integrity of the method. Many of the findings pose questions

more than generating hypotheses and conclusions, which to an extent reflects my inexperience; as against that, these discussions have disabused me of the idea that this confounding topic has any clear answers.

5.3.4 The psychotic 3D universe

At this point, focus turns to the children who 'live in a 3D universe', who a participant described as children who predominantly split and cut. The countertransference for one participant was a significant indicator of the child's type of presentation; those she considered psychotic gave her a feeling of her head 'splitting' or 'bursting'. She also likened it to 'being in the middle of an explosion, you can't think, and you feel you're going crazy.' This is certainly something familiar to child psychotherapists who recognise that the taxing and demanding therapeutic task is to receive these projections, detoxify them, return them in a more-digested form, work through the negative transference, help the child tolerate ambivalence and loss, and establish a more integrated object (Klein, 1946). It is never as neat as this, but the participant's vivid account makes very plain the burden the therapist carries, compounded by the quite isolated circumstances the work takes place in. Although peers, supervisors and most likely loved-ones who are intimate with the therapist's daily life are probably aware of the impact, within a clinic setting one often finds that even familiar colleagues report a sense of mystery about what happens in a session; what goes on behind closed doors can seem an unfathomable process.

Often colleagues display a healthy curiosity, but one wonders how curious they would be if they knew of the violent attacks therapists must withstand. The participant's comment likening her experience to being in the middle of an explosion and unable

to think invokes Bion's 'thinking under fire' (Bion, 1984). The feeling of losing her mind, of her head 'splitting' and 'bursting', demonstrates the power of these projections aimed at the therapist which impact on a concrete, physical, level. The interference in the participant's capacity to think, instigated by the patient, may have been intended by the patient since in a paranoid-schizoid state of mind the thought processes are being destroyed rather than advanced (Bion, 1957).

Participants described these projections spanning from ordinary development to the deeply pathological. The account given suggests more likely the latter, but another participant gave an example of a more ordinary situation when a young child was frightened of her as somebody whose biting impulses had been projected into. This child touched a toy lion in passing and, on arriving for his next session 'he screamed his head off and refused to come into the room'. In this situation, the child was quite easily contained by the therapist's interpretation of his anxiety that she might be about to eat him up like a lion, which she and I both feel suggests he had enough symbolic capacity to cope with her interpretation. Her simile of him coming into the room like an angel appropriately hints at the elements of idealisation associated with the good/bad split inherent to early emotional development (Alvarez, 1992a), as well as in evidence at the more pathological end of psychotic functioning.

Some of the more disturbed children were described as utterly uncontrollable, one participant conveyed a sense of chaos with the child running rings around her, running up the stairs, along the corridor, smiling and 'charming sweetness' to other people he came across. She recounted feeling 'desperate', stressing the extreme split of which she was on the bad end. This was galling, her tone of voice communicating a countertransference of indignant bitterness, her struggle compounded by her

colleagues not failing to understand her experience but being gifted an entirely different – more likeable – aspect of the child.

As against this, the most disturbed children who split and project on a monumental scale are not always the least likeable. One participant felt that seeing her patient was 'unbearable', describing a dreadful ordeal that pervaded her ordinary world and daily life, and yet she 'loved him as well as hating him'.

5.3.5 Sadism, blood and gore

The participant's account of the child running amok clearly evidences his profound lack of containment; she described being pushed to her limit, and whenever she reached the point of needing to end the session he would immediately stop, suggesting he could respond to a boundary and required a firm container. Thinking about this child solely in terms of his lack of containment would be erroneous because there was something more tyrannical in his behaviour which the therapist had to respond to, possibly this could be thought of as a sadomasochistic exchange since she said the child loved to taunt her (Smith, 2008). She also used the words 'torment' and 'torture' to describe his treatment of her, and expressed his more explicitly violent treatment towards her and the room; he would climb to the top of a cupboard and throw things. Another participant described the 'murder, savagery, tearing and cutting to pieces' that she felt filled her patient's mind. Following the Kleinian conviction that the earliest sadistic attacks are directed against the mother's body, both participants described the aggressive projections as targeting the therapists themselves and the room as a transference representation of their primary object (Rustin, 2001).

Both children were described in a way that suggests a manic frenzy of activity, yet the first participant's child also conjures an image of a slow torment in some moments, suggesting these children project various emotional states; at times persecutory anxiety driving their 'kill or be killed' mentality and at others wishing to disown their suffering, perhaps with an unconscious communicative intention.

Another participant characterised the difference between autistic and psychotic children in terms of effects they may have on the therapist, with the former sometimes leaving the therapist with a 'chilling' feeling that lingered after the session, contrasted with more immediate feelings in the presence of psychotic children including horror and fear. She described one child as being on the edge of psychotic a lot of the time 'with an amputated arm, horribly amputated blood, and gore everywhere.' This recalls Tustin's observation (1986) that at some point the psychotic child must recognise the separateness of the therapist from his body, inducing in him a deep anguish which feels like the loss of a limb, and revives the original separation predating the development of autism. Tustin's (1986) observation that the 'confusional' child borders on awareness of their humanity, what she describes as their flesh, blood and wounds, possibly finds accord here.

The participant's gory image very well illustrates the primitive nature of psychotic minds, the amputated limb a graphic image of an inner world replete with part-objects, the horror that seems so shocking severed from the child's mind and expelled into the therapist who must decide what intention was behind this and how to respond. Whether the child takes narcissistic control of their suffering in this way, as the instigator of their destructive act as proposed by Rosenfeld (1971), is worth considering.

5.3.6 Psychic holes, psychosis as a defence and persecutory anxiety

James Grotstein(1990) built upon the work of Klein and Bion and endorsed the 'black hole' concept popularised by Tustin (1986). She postulated that confusional and encapsulated children use the image of a hole to express traumatic primal awareness of bodily separateness precipitating their psychosis, and Grotstein claimed the aim of psychoanalysis was to reverse the direction of travel away from the hole and concurrently to relax the dominance of the psychotic alter-ego over the surviving self (Grotstein, 1990). Two participants in this study cited their patients' preoccupations with making holes in the ceiling of the clinic-room, though they had little to say about it; possibly they felt its position as a concept within the psychotic mind is taken for granted, or perhaps it is easier to identify it than grasp it in a multidimensional way for the non-psychotic therapist.

Haag (2005) described an autistic patient whose progress in treatment could be seen in one respect through his relationship with holes; Rocky initially used clay to cover up the eyes and mouth but was later able to look in a mirror and turn his attention to his eyes, nose and mouth. Another interesting and different concept, the 'white hole matrix', was proposed by Miller and Sweet (2017) and amounts to a construct in analysis of something akin to a bungee cord, allowing the patient a period of suspension to witness, observe and think about the fall without entering a state of annihilative anxiety. One participant alluded to something similar, albeit taking a different form, concerning the need to ensure by whatever means necessary that a patient does not fall into a black hole, citing reassurance as a kind of lifeline. This underlines the state of crisis that pervades psychotic children's inner worlds; of course the frame is essential but within that the therapist often adjusts their role to that of an emergency worker to arrest the child's slide towards psychic catastrophe.

The ‘broken universe’ (p.2) of these psychotic children were often linked by participants to dreadful events in their earliest moments – assaults, impingements, and failures. This raises the question of survival. Freud’s claim that the subjective sense of the end of the world underlies psychosis seems plausible, but rather than being a single moment, what must it mean for children – like those many participants discussed - who suffered complex developmental trauma and find themselves repeatedly impoverished or attacked? Freud’s (1911/14) view that the psychotic symptom is an attempt at recovery rather than constituting damage itself implies a degree of hopefulness, however mad the psychotic’s mind may seem. Meltzer’s ‘aesthetic conflict’ perhaps also explains the intense emotionality these children stirred in the participants, and Meltzer’s belief that somewhere, deep inside, there is a trace of ‘the dazzle of the sunrise’ originating in a pre-paranoid-schizoid state that cannot be extinguished carries some hopefulness (Meltzer & Williams 1988). Meltzer’s more artistic dimension perhaps captures something about the limits of language especially pertinent to the inner worlds of children often damaged by pre-verbal trauma. The participants’ discussion made clear how difficult it often was to observe or intuit in the children’s minds the essence of anything beautiful at all but there were exceptions, such as the moment in which the most intensely and persistently destructive child recognised the truth of his experience and risked allowing a new and caring experience in the transference.

One participant cited her patient’s visual hallucination of a clock with its insides falling out; this evokes the debate about fragmentation, unintegration and disintegration informed by psychoanalytic ideas from Bick, Bion, Klein and Winnicott, which Alvarez has discussed extensively and supplemented with ideas from developmentalist researchers (2006). Her paper summarises various ideas

potentially relating to the broken clock: perhaps it expresses a faulty skin function (Bick, 1968) or conveys an interruption in the 'going-on-being' propounded by Winnicott (1960). Moreover, the alternation of the child's auditory hallucination of a ticking clock with a visual hallucination of a broken clock perhaps reflects Klein's conviction of the pull towards integration and its alternation with falling to bits. Alvarez highlights the divergences of opinion regarding the degree of ego-integration at birth, and cites Bick's belief in the introjection of an object with a skin function as a precondition for primal splitting. Splitting and projection underlie hallucinatory phenomena, so despite the child having been removed from his psychotic mother's care at eighteen months, perhaps something of a skin function was internalised despite his mother's significant psychopathology.

This therapist interpreted the child's anxiety that he had 'bunged up his mother's works and mine', and early in treatment the child expressed feeling frightened by his conscience. Waska (2002) emphasises the paranoia and primal guilt which arise from the damage inflicted on the object in phantasy and the concomitant anxiety of the object's retaliation.

This question of unintegration and disintegration and whether they are mutually exclusive feeds into to Durban's autisto-psychotic spectrum (2019) whereby the child vacillates between 'anxieties of being' and defences associated with the paranoid-schizoid state of mind (p.293). The patient who hallucinated the insides of the clock falling out may approximate the 'leaking out' anxieties which Durban connects to the deep autistic level of some patients (p.296).

All participants described intense feelings of anxiety about the child's potential to harm himself or others, and frequently experienced persecutory states where they had powerful phantasies of incurring judgement from others, often colleagues. One

recounted a state of total panic in the presence of an out-of-control child who was shouting out of the window, feeling terrified that he would harm himself and that a surge of disturbance would crash through the building, blanketing colleagues and passers-by, and she would find herself on the receiving end of their fury. Although obviously unpleasant, participants communicated this as a more tolerable aspect of the difficulties working with these children, most likely because it is an easily understandable countertransference which they have had a lot of experience of.

5.3.7 Depressive elements

Depressive elements were also present in some of these children. A participant described her patient's nightmare or delusion that Mother Goose had died of grief because she produced a rotten egg. The participant emphasised that in this case the child was not paranoid; sadly, it was likely that the mother had indeed made the child feel responsible for having driven her mad.

Guilt featured in the study in different ways; a participant recalled extreme feelings of guilt upon realising how many damaging mistakes she made in her technical approach to the child. Another participant described a summer holiday when she suffered with powerful feelings of guilt, to the extent of needing her husband to hear and understand how she felt, crying in the mornings about what she perceived to be 'awful things' she repeatedly told the child which made him worse. This demonstrates intense emotional involvement; the fact that these children seep into the daily lives and inner worlds of their therapists, and that there is a human need to feel personally supported during such emotionally demanding work.

Guilt and sorrowful sadness are inherent features of the depressive position (Klein, 1937), and these children were capable in some moments of contact with this state of mind. Some participants discussed the meaningful moments that occur with these children in the transference in this more integrated realm. A powerful moment of understanding and reparation with a child was recounted; this was a child whom she had worked with at the deepest and most traumatic level, enduring innumerable violent attacks and seemingly-unbearable projections. Suddenly there was a very profound silence and an uncharacteristic stillness to the child, who in that moment was in touch with the terrible reality that nobody had looked after him as a baby. I imagine this remarkable moment was one the participant thought would never come. There's something special about these poignant moments that seem to come out of the blue, though of course weeks, months, years of mental and emotional availability silently work away under the surface; somehow, though, they feel like an unbidden moment that makes the transferential suffering worthwhile.

Despite these profoundly touching and more hopeful moments, participants also described the enormous difficulty of facing the severity of some of these children's conditions, expressing pessimism about the likely outcome, allowing their minds to go to places that perhaps others sometimes cannot bear to contemplate; residential placements, suicide, homicide.

5.4 Rival Babies

One of the most interesting findings in this study concerns the phantasy of 'rival babies' and their interaction with the participants' actual babies or children, and the effect this has had on the child patients.

Klein agreed with Freud that the Oedipus complex was centrally important, but was convinced that the infant's psychic life was shaped by an earlier situation than he proposed. Klein's Oedipal situation begins with a phantasy of a terrifying and exciting parental couple engaged in an exclusionary intercourse; the infant overwhelmed by a phantasy of rival babies (1928).

Three participants discussed their patients' painful struggle to tolerate the fact of rival babies. One linked the increase in her patient's violence with her own pregnancy, and described her guilt when her supervisor pointed out that her interpretations intensified his sadism and were damaging. This was because his sadism was linked to betrayal, the responsibility being on the object not the child's jealousy. But two participants described surprisingly positive developments. For one, a chance encounter where the patient saw the therapist with her own children on their way home from school prompted a dramatic shift whereby his aggression and rivalry with other children became explicit and the child's projections became communications as he moved into a three-dimensional state of mind. Very movingly, another participant described a severely unwell training-patient who had been totally unable to acknowledge the impending arrival of the therapist's baby; up until the birth she referred to the baby by her own name. The therapist was stunned when she spoke to the patient on the phone shortly after the birth and the child asked: 'what's the baby's name?' The participant noted the profound significance that the patient recognised there was another baby, that she was still the patient baby, and that the therapist would be back.

Conventional psychoanalytic principles of neutrality and abstinence originated with Freud (1915). Shill (2004) suggests that these principles function so as to sustain a container for the analyst's countertransference, and rejects some recent arguments

that suggest these principles create an artificial relationship; these counterarguments propose that self-disclosure can positively 'undo' the game-playing nature of the transference. Freud's conventional principles seem intuitively right to me, but the apparent rival baby phenomenon I have stumbled upon casts at least a degree of doubt about a too-simplistic assumption; perhaps these sacrosanct principles require a more nuanced defence.

Houzel (2001) acknowledged the relative lack of attention to sibling rivalry within psychoanalytic literature, especially within Freud's work, and in this paper discussed Klein and Lacan's perspectives on the subject and revisited Tustin's 'nest of babies' phantasy as it pertains to autistic children. He concludes that sibling rivalry originates when the infant recognises the maternal as 'other', bringing with it a feeling of needing to jealously guard the object to prevent a third-party making a claim.

5.5 What's Required?

In this area, participants tended to share many views. Participants often felt unable to manage this work at the deepest and most disturbed level without significant support from others. Two recounted needing to seek help from colleagues in an immediate way; for one this was a regular occurrence at the end of the patient's session because she felt in such a distressed state. What she needed was for someone to help her 'recover'; the emphasis here is on something rather different from containment, not necessarily drawing on an alpha-function to make sense of experience. Alvarez's (2006) citation of Brazelton's (1974) developmental finding that infants need both digestion *and* recovery from interpersonal experience, may be

relevant. One element of this is the need to forget, as Alvarez says 'empty the mind'; perhaps this applies as much to therapists in the countertransference as the young children they are helping. A participant who frequently awoke feeling unwell and bearing a feeling of dread about the impending session later that day may be one such example.

The mindset of the participants was discussed in terms of participants' managing their own expectations, which one imagines is quite complicated when these children are so unwell. Developing realistic expectations is bound up with the acquisition of clinical experience; for one participant who described her naivety, her very-experienced supervisor helped her understand that she could help the child but 'she will always remain mad, you know.' One might add that personal analysis likely also supports the necessary emotional tolerance and growth to appraise the prognosis reasonably accurately.

For parents who love their children and feel genuine concern, the capacity to face the bleakness of their child's prospects, or at least conceive of the struggle ahead, is even more difficult. Psychotherapists must be alert and sensitive to these issues, and creative in their engagement and partnership with these parents. The need to be truthful and avoid over-promising was cited by a participant who described parents often pressing for answers. She emphasised taking great care not to make predictions.

As well as cultivating a realistic and compassionate mindset, participants had plenty to say about aspects of technique. Verbal interpretations alone were considered often insufficient, since they assume a level of sophistication often beyond the reach of children, and participants were all explicit that many of these children had missed out on basic containment from infancy; accordingly, therapists might need to allow

for a great deal of physical acting-out, and containment may concretely take the form of clearing-up.

Many of the findings regarding 'what's required' are captured within the concept of 'concentric rings' (attributed to Rustin in McLoughlin, 2010) consisting of a robust physical space, a resilient therapist surrounded by supportive colleagues and supervisors, support also for the parents, flexibility of technique, and enough time. The move away from hospitals and towards integrated community care is an outer layer that must be fit for purpose; the closure of therapeutic communities and depletion of resources across CAMHS and adult services is detrimental in this respect.

Supervision was seen as indispensable to the work for numerous reasons. Sometimes this related to powerful projective identifications (Klein, 1946), and the requirement for a reflective space in which to think more about what occurs, confronting our motivations and recognising when we are drawn into retaliatory acts. One participant recalled mistiming interpretations and justifying them to disguise from herself the wish to return something to the patient. Supervision also represented a means of clarifying the aim of treatment; a participant described her supervisor giving her a clear aim, 'what you need to do is try to unblock him.' These bewilderingly complex children naturally require participants to call on all their faculties to survive and understand the meaning of the work, but naturally experience and creative thinking can help the therapist remain alive to the meaning of the patient's communications.

The capacity to cope with the work was explicitly linked to collegial support; the therapist needs a team around them, for example, one participant recalled a 'well-held' case which made her feel she could just about survive the work. The child, of course, also needs committed support and active involvement from a wider network.

One participant mentioned this conviction being central to the Tavistock approach in the 1980s, and learning a great deal from colleagues including the fact that family and network liaison is an essential part of the work for ill children.

Parents play an integral role in their children's treatment, and the findings here suggest they often exhibit their own varying degrees of psychopathology, but careful consideration of the type of help given to parents was emphasised. One participant maintained very strongly that one must not make interpretations to parents who are seen on a once-weekly basis; it absolutely must not be done until and unless there is a very solid foundation and a lot of work in the background to hold it.

The personal qualities therapists bring to the work are perhaps sometimes overlooked; participants discussed these as well as the acquisition and development of skills. One described 'enduring all this racket' for the best part of a term, waiting for the right moment to intervene or speak to avoid premature interpretations, in the way proposed by Alvarez (2010). Another explained the need to wait, and the potential for much more informative countertransference if the therapist can give extra time to this. She called it the difference between a general and more specific interpretation; it is in this depth of work that the clinical benefit lies.

One participant boldly announced with force, 'it does take stamina!'; she described being prepared to stay with the patient for a long time, she felt she had this resource in abundance. Another spoke more about perseverance, 'sticking' with her line and trying to take up what she felt the patient needed to hear. Presumably this links to the therapist's intuition about the underlying conflict she is attempting to help the child become more aware of and cope with. One can imagine a therapist sometimes wrongly persevering with a misjudged interpretation, but in this case the participant

meant understanding her patient and trusting that he needed to hear and would – at some stage – be able to take that in.

There are few links in the literature – as far as I am aware – between the therapist's personal qualities and the work with psychotic children. Occasional references may be made in passing but there is not a great deal, which contrasts with the findings here; participants spoke about these more personal aspects of the work in myriad ways. Indeed, it was striking that the interviews generally yielded a great deal of data referring explicitly to their personalities and personal lives. This was in sharp contrast to the academic and theoretical papers, that had very little to say about the more subjective elements of the work with these children.

The wisdom of previous analysts has been integrated into participants' learning and teaching, and these encompass the personal qualities, values and technical rationale for developing and refining a whole repertoire of emotional states. One participant cited Meltzer's 'values of the battlefield' including courage, bravery, strength; the clinical accounts described by participants clearly demonstrate why. Working with some these children is, as one participant said, 'like being in the middle of an explosion'.

There was unequivocal agreement about the critical importance of resilience as a means of surviving the relentless acts of violence and aggression, and coping with the discomfiting feelings these children arouse. One participant emphasises the commitment to the child and the regularity of sessions, perhaps three-times weekly for several years, feeling it was vital to have an inner resilience to survive.

Sometimes participants recognise that grave circumstances dictate stepping outside what might be considered classical technique; one advocated going straight for

reassurance with psychotic children. For similar reasons Durban (2019) highlights the need to flexibly shift between the spheres of symbolic and non-symbolic interventions dictated by the patient's type and level of anxiety.

Despite an extensive range of skills, the challenges these children pose probably test the confidence and capacities of all psychotherapists, who in some moments wonder whether they are up to the task. One participant remembers having felt her husband [non-analyst] would know how to handle her patient much better; 'Why don't I just hand him over to him?' Perhaps all therapists have experienced wanting to hand over their unmanageable patients to someone else, but what's interesting about this comment is that it underlines again, in a different way, how these children cross over into more personal aspects of the therapist's inner world.

Earlier in the discussion, these children's propensity to act-out (Freud, 1914b), and the impossibility of skipping over missing phases of early development requiring physical containment, was noted. Participants all mentioned the enormous importance of the physical setting for these children, including giving the child clear direction, taking measures to ensure physical safety, and using heavy furniture.

The dreadful state of these children's inner world, described by one participant as a 'broken universe', makes it more crucial than ever that the environment does not reflect the damage back to them. A participant recalled a damaged room where lots of very unwell children had smashed holes in the ceiling and defaced the walls; she felt every child who went in there got worse straight away. This raises many questions about how to manage in such resource-deprived public services.

The participants are profoundly affected by the experience of their time with these children and remember them throughout their career. One participant put it

especially well when she compared the work with psychotic children to her other cases, stating that she remembers the children she has seen but they did not cost her so much (repeated with emphasis), that these psychotic children stirred so much for her analytically that the work with them had a unique impact on her life. Another participant agreed, saying the work with these children changed her, clarifying for emphasis that she meant they had changed her as a person.

In the face of such a 'broken universe', some participants discussed having low expectations regarding treatment outcomes, but one stressed the importance of retaining an underlying hopefulness. Both positions tap into the principles of neutrality and abstinence (Freud, 1914b), and bring Bion's 'without memory and desire' to mind (1988). The results show that these children get under therapists' skin in an unusually intense way, which perhaps opens a possible future discussion about the interface between the phenomenology of this work and conventional analytic ideals.

For those who felt some degree of hopefulness, despite the layers of evident bleakness in these children's inner worlds, it would be interesting to hear more about its meaning; whether faith in Meltzer's idea of the 'dazzle of the sunrise' buried in the psyche resonates, or whether a different ideology sustains them. Sometimes there are positive outcomes, producing feelings of enormous satisfaction; one participant described seeing a child come to life, and experienced his transformation as extraordinary.

These children live on in the minds of the participants for decades. One discussed the pain of not knowing what happens to her patients after treatment has ended. The deep involvement she felt and still feels with this child was clear, and she ended on a

note that brought us back to the uncertainty; 'it is very painful to put years into the life path of these children and to not know.'

5.6 Strengths and Limitations of the Study

Adhering to the method felt like a process of deconstruction, and it was a struggle in the later stages to reconstruct something that satisfied the need for a degree of coherence while respecting the inherent disorder of inchoate psychotic phenomena. Upon reviewing the draft of the findings, I felt dissatisfied by the 'fragments' of findings which due to word count stipulations were isolated from sufficient context.

The undrawn universe of the 'under-integrated' children discussed by participants implies that there is nothing in their minds to orbit around, whereas as a researcher I did have some navigational points because there was structure of a kind owing to these pieces of data; but the requirement to keep an eye on findings across the dataset interfered with the desired depth of analysis.

Participants were much freer than I was to speak spontaneously without concerning themselves with 'jeopardising' the research and indeed this naturally led to familiar - feeling, open exchanges that felt not dissimilar in some ways to those that took place in seminars. These were also inevitably inflected with a student/teacher dynamic, as participants were all seniors to me. There were perhaps opportunities for me to push for further clarification or to ask participants to expand on certain things, in some moments during the interviews my attempt to sustain a more distanced researcher position lapsed. There was a degree of inhibition associated with my trainee status with these established and senior psychotherapists and it did in subtle ways inhibit me from raising challenging questions. This was also an issue when it came to

analysing the data: it is not an easy thing to 'analyse' the material of experienced psychotherapists who have themselves already analysed their own experience. Who am I to speculate and associate to their material?

The generational and cultural difference between myself and the participants; as such, my capacity to understand their experience is inevitably limited. Their discourse seamlessly spanned the ideas of Freud, Klein, Winnicott, Tustin, Bick, Alvarez and more, all participants lived through a lively professional era when the limitations of earlier psychoanalytic theorists spurred change and the incorporation of developmental research.

This study offered an interesting and, as far as I know, unprecedented insight into the clinical experiences of senior figures in psychoanalytic child psychotherapy in Britain. The flip-side of the data's fragmented nature is that it illustrated the breadth and diversity of experience acquired by these therapists over the course of their careers.

It also represents all-too-rare attention paid to the treatment of a group that is distinctly under-theorised in the literature and illustrates the need for renewed theoretical focus on these patients.

5.7 Professional and Clinical Implications

Participants spoke a common language where psychoanalytic understanding of psychosis is concerned, but there was a lower degree of confidence when it came to pinning down a definition and there were mixed views about the value of this. Of course, independent thinking is something to be appreciated and it is helpful to question why definition is important and the extent to which it is; these questions are

likely to enrich the debate and need not aim at reaching a premature or restricted consensus. I think, however, there is a need for a more concentrated discussion with a clear sense of purpose about how we are going to represent the needs of this population. Their current neglect may be overdetermined, perhaps it is not only our turning away from the most painful of presentations, possibly these young people are also caught up in a wider issue regarding the identity of child psychotherapists and the contexts in which they are working. It seems here that for as long as we are speaking to our psychotherapy colleagues there is accordance, but when we consider outward communication with colleagues working within a medical model it becomes more difficult to find a consensus about defining psychosis. In some ways this is also a confidence issue: should we collectively decide this as a profession and then communicate this to other multidisciplinary colleagues or is our hesitancy because we feel caught between incongruous worlds and we're not ready to so? I suggest that it would be enormously beneficial to this population of children and to developing our professional confidence and wider integration if we could attempt to resolve this diagnostic question and make this clearer for ourselves and others. Of course, it's important to respect the complexity of all the factors previously described when it comes to diagnosing children and young people and this highlights why it is vital that there is protected time in services for complex case discussions. We all know the level of demands on the service and the effect this has on the quantity and quality of clinical discussions but with especially unwell and complicated presentations it is crucial that this is prioritised. In terms of our engagement with managerial structures, it needs to be recognised that care pathways are the currency of CAMHS today; to be able to make a case for funding there needs to be a service specifically

developed to the needs of these children and young people underpinned by evidence. We need to gather and present our evidence for this.

Participants underlined the spectrum of normal to pathological psychotic functioning and it is this nuance that I think could be very helpful to CAMHS clinics, early intervention services and put to use through liaison with social care and parenting programmes. There were many initiatives in my own clinic during training tailored to neurodevelopmental support but there seems to be an absence of shared thinking about ordinary development (including psychotic functioning) and the ways in which this might – at times – look like anything but that. Although psychotherapists work with the chronic and acutely unwell children and young people, there is much to be shared about the nature of early development with other clinicians, parents, and school staff. Perhaps we can also inform early intervention pathways that we very often have an underutilised role in developing.

Participants felt they could best help these children with a combined psychoanalytic and developmentally-informed approach. The findings suggest that psychotherapists working with these children need to be thoughtful and flexible regarding altering clinical technique. Participants were broadly supportive of the central aim of child psychotherapy with its focus on illuminating and understanding the inner world of the child and by extension working in the transference is as fundamental as ever. However, it was very interesting to note the caution expressed around 'awakening the mind' and attempting to project in advance as far as possible whether the level of need can be met. The question this poses, however, is what is the alternative? These children may require a different type of intervention or a different approach, which child psychotherapists may be well placed to develop owing to the strength of their assessment skills and depth understanding. It was also very interesting to note that

even with less 'risky' cases there were views expressed about both the importance of adapting classical technique, in a developmentally informed way; and statements from participants highlighting the clinical benefit to the children of increased knowledge about the external world, especially the discovery of 'real' rival babies. Taken together, these suggest that perhaps this is an evolving area of clinical work which may, in time, lead us to make further technical adaptations. How to do so while preserving the intense focus on the internal world and remaining scrupulously attentive to the minute shifts in the transference is presently unclear.

The results also suggest there is a need for adequate resources in terms of length of individual therapeutic work and parallel parent work with a sensitive clinician. Children and young people are rarely now offered intensive psychotherapy; one fifty minute session per week is meagre when one considers that three or four sessions used to be the norm for these cases. It makes sense to increase the provision for parent support, parents who are with the child throughout the week and are both desperately in need of containment themselves but also need help to understand the violent and disorganising forces at play.

Participants indicated that therapeutic work with these children requires a supportive network around the child, family and psychotherapist. In view of the demanding nature of the work, child psychotherapists may benefit from pursuing informal avenues of professional support alongside clinical supervision, perhaps in the form of peer supervision groups. It is also abundantly clear that there is much to learn from each other across professions and sectors and the intense needs of these children can only be met by frequent and detailed communication and shared understanding among all the professionals who populate their strange daily worlds.

This would also reduce the burden that child psychotherapists seem to feel while working with these young people. The sense of themselves as 'heroic' sufferers engaging in battles of attrition that wear them down and push them to their limit could perhaps be ameliorated by much better support and more joined-up working. It is also something for training supervisors and training schools to be more aware of, undoubtedly psychotherapists' analysts are constantly thinking about and working through omnipotent attitudes and themes of manic reparation but remaining alert to the sensitivities that this population exploit in their therapists seems critical.

The findings suggest that elevating the profile of some of these overlooked children is essential. This could take place through psychotherapists' academic work and research interests but also by locally representing the needs of these children within their workplace, especially within the multidisciplinary team of CAMHS clinics.

5.8 Further Research

Further research could replicate the study with a younger generation of child psychotherapists. Further attention to the 'rival babies' finding could prove to be informative since it is a relatively neglected area (Houzel, 2001) and perhaps further exploration of the phenomenological aspects of child psychotherapy and its interactions with psychoanalytic ideals would be of interest.

CHAPTER 6

CONCLUSION

6.1 Conclusions of the Study

This study's findings elude a neat conclusion, bearing out the fact that the inner worlds of psychotic children pose more questions than answers and linger in an ambiguous area, presenting their therapists with a range of conundrums as they consider linguistic, semantic, theoretical, and clinical issues. The participants in this study believe a differentiation between autistic and psychotic children is crucial because of its implications for technique; but there is no clearly-unified view regarding the usefulness of a distinction between psychosis and psychotic states of mind, and those who do make this demarcation do not all do so in the same way.

A shared theoretical framework underpinned their formulations and discussion of their clinical work's technical aspects, but some participants gave surprisingly candid personal accounts which added an unexpected and valuable dimension to the study.

Participants described severely unwell children who presented in different ways; some chose to discuss the strange, otherworldly, mechanical and mindless aspects of their patients, others described the children's dramatic, frenzied, and disintegrated minds suffused with violent aspects. The 'too-much-ness' (Butler, 2005, p.55) of these patients is reflected in the participants' enormous range of countertransference experiences including disbelief, confusion, disorientation, sometimes quite debilitating and intense physical effects, as well as poignant sadness and awe. It is abundantly clear that knowledge about the extent and nature of the professional suffering endured has been largely confined to supervision and analysis and that much more widespread awareness and help is vital. This might take the form of

discussions between training schools and training analysts to highlight the burdensome nature of this population and find new avenues of support, perhaps it could be taken account of where clinical training requirements are concerned, such as considering how many of these cases it is safe and appropriate to work with. Training analysts and supervisors can help analysands and supervisees to recognise realistic expectations. There was a clear sense of heroism presented in the findings and although it is commonplace to discuss and understand the defensive role of omnipotence and the colonising nature of projections, it is important to recognise the particular danger with this group of children and young people, who evoke such powerful despair and helplessness because of their profound disturbance. We have not adequately shone a light on the pathology of this group and their limited visibility to the consciousness of our professional community potentially renders child psychotherapists vulnerable to such enactments.

Participants were totally united in their passionate views that these children require a whole-team approach; therapists must be supported by colleagues, supervisors, and other professionals in the network, while parents must be seen as an integral part of the treatment, requiring thoughtfulness, sensitivity, and support. Treatment must be of sufficient length. It was clear that participants were describing having worked in a world unrecognisable to the present climate. We must not passively accept this. Educating and persuading of the need for these linked-up networks is a task of utmost importance for this generation of psychotherapists.

Rival babies were a source of intense anxiety and distress for some of these children, but in two cases the therapists' own children and newborn baby prompted a dramatic change in their patients' inner worlds, stimulating a more alive and 3-dimensional state of mind for one child, and for another, shockingly, ushering in a sane state of

mind. This is an unexpected finding; perhaps more research will be done to build upon Tustin's 'nest of babies' phantasy and the more recent work of Houzel (2018). Might it become clear, in time, that we need to consider whether there is room for psychotherapists to adopt a slightly different emphasis and more actively (in a paced way) introduce external reality to these young people?

The findings were vast, deep, and resisted integration, seeming rather more like kaleidoscopic fragments of intense and vivid thoughts, feelings, and bodily-states. I found it personally and professionally generative and growth-promoting, but also vexing and perplexing. Bollas (2015) describes the work with psychotic patients as involving a degree of mystery and incomprehension, believing the analyst will never possess a full understanding of what they experienced and learned; he links this to the core fact of the psychotic patient's absence of direction. This resonates strongly with the experience of undertaking this research.

The study was undoubtedly affected by the dynamic between participants and researcher; my trainee status and their wealth of experience inevitably introduced a dynamic in the Tavistock tradition of generational transmission of knowledge. Participants were all close-to or above retirement age, with extensive clinical experience; a future study might introduce greater variation in the sample. It was notable that no mention was made of racial or cultural factors in their accounts of their work with these children; this may be a future consideration.

The commitment of these therapists, and the costs to themselves and their ordinary lives, are significant; but so is the astonishing experiential learning and personal growth that arises from these therapeutic encounters. The nature of the children's disturbance and the intensity of their encounters burned the memories of these children into their minds.

There is a striking contrast between the therapists' intense emotional involvement with these psychotic children and their overlooked status in the literature. To some extent these are forgotten children.

Occasionally the children were transformed by their treatment, more often they were helped to live with their madness and to feel less alone with it. There is a risk of a 'perfect storm' in which their very great disturbance and extreme need combines with a drastically-decreasing mental health provision, leaving them neglected or inadequately treated. Further attention to these non-autistic presentations may help ensure this does not happen by raising the profile of these disturbed and disturbing children. Some ways in which this could happen include the development of an ACP specialist network, much like many of the others currently in existence; perhaps a specialist edition in the Child Psychotherapy Journal; or requests for clinical papers on this topic for essay prize competitions through various UK training schools.

A participant highlighted the work of Francesco Bisagni and while it may not be possible right now to work in the way that he does, intensively, sometimes for decades, it is indisputably better to aim high than to push for a little bit more resource. The need is so great.

Participants gave thoughtful and detailed accounts of their experience of these children and cast light on the phenomenology of the young people's inner worlds. It is a very small study, and perhaps more ambitious questioning could strengthen its findings in future, since it is clear participants had a lot to say about these complex children, leaving me wondering what else could be learned about their inner worlds and how we can work with them to best effect.

6.2 Final Reflective Thoughts

In terms of my experiential learning, as a student entering the lineage of a long established body of knowledge I felt well positioned to explore this topic, bridging the gap between gathering together historical insights and approaching an important clinical presentation in a novel way. The project was shaped by my personal interest in psychosis and the desire I felt to mine for useful information was certainly for my benefit as well as that of others. The project was also driven by a wish to find solace within our community of psychotherapists in a way that might help me to continue this work. It was impossible to divorce myself from some degree of hope about what I might discover and undoubtedly my familiarity with the participants and their work set my expectations high. All these undoubtedly had implications for the way I approached aspects of the design process, as discussed previously, for example in the conducting of interviews and interpreting the data. I was impressed by the immense accumulation of lived experience and knowledge across the participant set as a whole and I felt inspired and humbled by this. The project also made it possible for me to see the limitations in our professional knowledge and understanding of psychosis rather than focusing on the all-too-maddening limitations imposed by our working environments and political context. I regret not having been more ambitious about pursuing more forcefully deeper discussion of the 'psychotic' cases that I set out to research but I believe this project has the potential to start up a new debate, in a small way, about this important and neglected topic.

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APPENDIX A

The Tavistock and Portman NHS
NHS Foundation Trust

Amended interview prompts

- Supervision
- Technique
- Interpretation
- The outside world
- Recovery
- The setting

APPENDIX B

The Tavistock and Portman NHS
NHS Foundation Trust

Semi-structured interview schedule for Child and Adolescent Psychotherapists

Research Title:

What is it like working with Children and Adolescents in non-autistic psychotic states of mind?

A study of Child and Adolescent Psychotherapists' experience.

Interview question: Can you tell me about your experience(s) of working with children and adolescents in psychotic states of mind of a non-autistic kind? I am interested in hearing from you about a single case or a number of cases that you feel fall within this group. It would be helpful if you could let me know what you define as a psychotic state of mind that is non-autistic. You are free to say anything you feel is relevant, either about the case, or your own thoughts and feelings evoked in the presence of the patient or at the time of your work with them. You may wish to describe your struggles, difficulties, highlights or particularly poignant or alarming moments, for instance, or any other significant feelings or absence of emotion. You may describe bodily, mental or emotional experiences. You may also choose to describe the impact or effect of the patient upon you during the course of the work or any subsequent encounters or memories that arose.

Interview prompts

- Supervision
- Technique
- Interpretation
- The outside world
- Recovery
- The setting

APPENDIX C

The Tavistock and Portman NHS
NHS Foundation Trust

Participant information sheet

Version number 1.0 - date 25/11/2019

What is it like working with children and Adolescent in non-autistic psychotic states of mind? A study of Child and Adolescent Psychotherapists' experience.

You have been given this information sheet because you are being invited to take part in a doctoral research study. This information sheet describes the study and explains what will be involved if you decide to take part.

What is the purpose of this study?

In this study I want to explore the experience of working with children and adolescents in psychotic states of mind. In particular I want to explore the clinical experience of working with cases which the clinician defines as psychotic and which exclude the clinician's formulation of cases which are psychotic in the context of autism. The purpose of this study is to shed light on the phenomenology (what it is like) of clinical work with this patient group from the clinician's perspective.

Who is conducting the study?

My name is Hannah Galvin and I'm the principal investigator of this study. I'm a doctoral student on the Child and Adolescent Psychoanalytic Psychotherapy Training at The Tavistock and Portman NHS Trust affiliated with the University of Essex.

What will participating in this study involve?

If you agree to participate in this study, you will be invited to take part in a small number of interviews (likely to be one or two) with myself as the researcher. During these interviews you will be given space and time to consider your experience in this area of work and to tell me what comes to mind. There may be some areas in which I offer a prompt but this is generally intended to be an interview that is guided by the participant clinician. Interviews will be tape recorded and transcribed before the data is analysed.

Do I have to take part?

No, it is completely up to you whether or not you take part in the study. If you agree to take part, you are free to change your mind at any time without giving me a reason. Should you choose to withdraw from the research you may withdraw any unprocessed data previously supplied.

What will happen to any information I give?

Any information I have about you and everything you say during the discussion will be kept confidential. Your name and contact details will be kept separately from the transcript and any details that could be used to identify you will be removed from the transcript. Any extracts from what you say that are quoted in written work will be entirely anonymous. Because the group is a small number of people it is possible that you may be recognised from your direct quotes although every effort will be made to prevent this through anonymisation such as changing names and any particularly identifying details.

All electronic data will be stored on a password protected computer. Any paper copies will be kept in a locked filing cabinet in my office. All digital recordings will be destroyed after completion of the project. Other data from the study will be retained, in a secure location, for five years.

Data will be kept for no more than 5 years after the end of the study and eventually destroyed, in line with University's Data Protection Policy.

What will happen to the results of the project?

The results of the study will be written up as a doctoral research project. It is possible that the results will be used in academic papers for publication and in presentations. I would be happy to send you a summary of the results if you wish.

What are the benefits of taking part?

It may be helpful to you to reflect on and discuss your experiences of working with these kinds of cases and the benefits may extend to your colleagues and wider professional community by contributing to a specialist area of research.

Are there any risks?

There is no identified risk to taking part in this study.

General Data Protection Regulation (2018) arrangements

The Tavistock and Portman NHS Foundation Trust is the sponsor for this study based in the United Kingdom. I will be using information from you in order to undertake this study and will act as the data controller for this study. This means that I am responsible for looking after your information and using it properly. I will keep identifiable information about you from this study for not more than 3 years after the study has finished.

Your rights to access, change or move your information are limited, as I need to manage your information in specific ways in order for the research to be reliable and accurate. To safeguard your rights, I will use the minimum personally identifiable information possible. I will use your name and the contact details you provide only to contact you about the research study. My supervisor and I will be the only people who will have access to information that identifies you. I may be assisted in the analysis of this information by senior colleagues, but they will not be able to identify you and will not be able to find out your name or contact details.

You can find out more about the legal framework within which your information will be processed by contacting the sponsoring Trust's Clinical Governance and Quality Manager, Irene Henderson: IHenderson@tavi-port.nhs.uk

Contact details:

I am the main contact for the study. If you have any questions about the project, please don't hesitate to ask. My contact details are:

Hannah Galvin

Email: Hannah.galvin@nhs.net

Tel: 07767615148

Tavistock and Portman NHS Foundation Trust

Cornwall Foundation Trust

You can also contact my research supervisor Lucia Genesoni (luciagenesoni@gmail.com).

If you have any concerns about how the study is run, please contact Paru Jeram, the Trust Quality Assurance Officer pjeram@tavi-port.nhs.uk.

Project Team:

Principal investigator: Hannah Galvin,

Research supervisor: Dr Lucia Genesoni

Thank you for considering taking part in this study and taking the time to read this information. If you are willing to take part in an interview(s) for this research project, please complete the consent form on the next page.

This research project has been formally approved by the Tavistock Research Ethics Committee.

APPENDIX D

The Tavistock and Portman NHS
NHS Foundation Trust

Consent form

Version number 2.0 – 23.01.2020

What is it like working with children and Adolescent in non-autistic psychotic states of mind? A study of Child and Adolescent Psychotherapists' experience.

	Please Initialise box
I confirm that I have read and I understand the information sheet version number 1, date 25/11/2019, provided for this study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. I understand what is being proposed and the procedures in which I will be involved have been explained to me.	
I understand that this is research that will lead to as professional doctorate and may be published.	
I understand that my participation in this study is voluntary and that I am free to withdraw at any time, without giving a reason. Should I choose to withdraw from the research I may withdraw any unprocessed data previously supplied.	
I understand that the interview(s) will be digitally recorded and then transcribed.	
I understand that information given in this/these interview(s) may be used by the research team 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. However, I understand that although all efforts will be made to ensure confidentiality, due to the small sample size of this study I may be identifiable to others.	
I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researchers involved in the study will have access to the data. It has been explained to	

me what will happen to the research data once the research programme has been completed.	
I hereby freely and fully consent to participate in the study.	
I hereby freely and fully consent to participate in the study	

Participant's Name (Printed):

Participant's signature: **Date:**

Researcher's signature: **Date:**

This research project has been formally approved by the Tavistock Research Ethics Committee.

APPENDIX E

Emergent Themes

Exploratory Comments

Transcript 1 interview

Interesting that participant defines through clinical example rather than (also) with theory

Okay, I think, I think what I want to do is define what I mean by psychotic states of mind by thinking about clinical cases and giving and giving umm, some observations, clinical observations from that work in terms in terms of how it informs me that I'm in the presence of quite significant psychotic phenomena and I think I want to start by actually just talking about a child, that, and I certainly won't focus on her entirely but one child I worked with actually for quite a long time and I'll call her Poppy and that's not her real name but I'll call her Poppy and um, you know, it was very clear to me that I was in the presence of something that you would think of as more psychotic when after the Christmas break mum came back to me with the child and said Poppy wouldn't open her presents on Christmas day. Umm, and she wouldn't open them because Christmas day fell on a Friday and Friday was the day I saw her for therapy and that all through Christmas day she had asked about going to therapy umm and I think for me that highlights a really important and kind of first aspect of psychotic phenomena in my mind which is that those ordinary facts of life, days of the week, special events in the year seem to have little meaning and no relevance and

Psychosis as presence / atmosphere

Therapeutic break problem

Ordinary life has little meaning

they're certainly not faced and engaged with. So umm you know, it wasn't something I felt flattered by that my patient wanted to come and see me on Christmas day, ummm, quite the opposite, it massively concerned me and made me reflect upon whether or not I had prepared her enough for that Christmas break umm and it wasn't the first Christmas break, I'd been seeing her for some time, all told I worked with her for about four years but it highlighted to me just how hard it is and what a struggle it is for parents with children who are in a psychotic state of mind. How hard it is to kind of maintain that kind of framework of life umm and how disappointed that mother and they were actually adoptive parents how disappointed those adoptive parents were umm in relation to Poppy and her rejection of what they felt was were quite important symbols to her of, their love for her and her membership of the family and those presents went untouched for many days as that umm protest deepened and as her protest deepened their sense of despair deepened too. The presents were opened just after the New Year umm just shortly before she came back into therapy but for those parents that was actually quite devastating and it made them think what is this therapy? In terms of our daughter wanting to be driven to a clinic to see a psychotherapist which which umm

Therapist's doubt about what she had done. I feel anxious about the child's dependency.

Therapist questions her technique

Parents' struggle/ empathy

Patient's protest

Parents' despair

Parents' bewilderment & doubts about treatment.

kind of brings me to another of the work, of working with children who are sort of expressing such sort of strong psychotic phenomena so together with this sort of everyday aspects of life umm umm they don't seem to kind of engage with alongside that is this umm is this kind of idea that oh gosh it is hard to talk about really something to do with about how incoherent umm what these children, you know the thoughts the phantasies that these children have how incoherent that is at times and how difficult it is to engage with it and how therapy can become a place where you defensively don't have to face those facts of life as I was talking about earlier so that in a sense that regular coming to therapy is both a place of healing and one would hope integration but also how it can also become a place of enactment of defensiveness so that is you know as further evidence of the withdrawal from real life you know for example I prefer to go to therapy than engage in Christmas day with my parents, ummm so that's yeah another aspect there about this balancing act that I think you have as a therapist in terms of trying to engage with the young people with whom you're working in such a way that real life starts to become tolerated a little and that you've got an eye to the defensive structure of the retreat into therapy as an alternative to being in the world with one's friends or one's family.

'Hard to talk about' resonates. I hope participants will be able to!

Incoherence

Therapist finds it hard to engage

A lot of discussion about the external world and family. Is this linked to dual task of keeping an eye on inner & outer world? Or perhaps because it is hard to talk (think?) about...

APPENDIX F

Participant one cluster themes

Ordinary life

Not faced; not engaged with;

Phenomenology (disturbed and disturbing?) terror, surrounded by madness

Psychosis as presence; incoherence; unspeakable; hard to articulate; patient sleepwalks; psychosis as presence/atmosphere; fragments surrounding; danger of awakening the mind; dangerous for whom? Total destruction; forceful violence; burdened therapist; wish to retaliate; patient's rage/distress; patient trapped/stuck; echoes, screams; intolerability; engulfing terror; patient highly sensitive; intrusion; therapist suffers; raw emotion at the time; lack of reciprocity; persecuted and persecuting**;** terror; rigid; still; intense fixed stare; fixed/pinpointed to place; meeting place in mind; centre of time; time stands still; imperceptible movement; mesmerising; unnerving; patient getting into therapist's head and taking over; patient guarding self; outside presentation opposite to inside; chaos, frenzy, unleashing; presence; no storyline; fragments; no orientation; boundlessness; madness everywhere; oral fangs; words as knives/cutting; surprise recollection; body reaction; endless falling; vertigo; unbelievable disorientation; primitive anxieties; presence; eyes fail to hold; patient as protrusion; not relational; lack of reciprocity; presence; anatomical cold gaze; cranium not mind; patient's wish to occupy; violent eye contact; patient not allowed own mind; patient communicated savagery; patient wanted them to have the same mind; desperate for therapist to experience disturbance; urge to retaliate; violent reciprocity emerges; patient draws therapist to retaliate; giving persecution back

Assessment

Gather information over time; patient assessment; missing links get filled in; intuition/prophecy;

Communication

Highly communicative non-verbally; drawings as communication; archive of drawings;

Reflexivity

Self-justifying mistakes; whose distress is it? Recognise own distress; ongoing reflexivity; reflexivity as a means of understanding the patient, technique re breaks

Aetiology

Questioning; no obvious cause

Reflections

sadness; lost opportunities; times have changed; reflects personally and professionally; children need community;

Qualities of therapist

Importance of hope; resilience; the need for imagination

Hierarchy of need

What is the primary need? Meeting the need in the moment; extremely rare event;

Even worse than psychosis

Is there something even worse underneath? Psychosis as a defence;

Technique

Eye on Internal and external; balancing act of the therapist; preparing for breaks; questioning technique; how to help patient see reality; linking clinic and home; questioning theory/technique; preparation, thoughtful organisation; holding patient in mind and showing it; sensitivity and timing; technique; wrong timing; mistake; resisting fight or flight; timing of interpretation

Infant life and patient's early life

Babies and early life lessons; infant abuse; Early neglect and trauma; lack of emotional care; baby who never thought comfort would come

Weighing things up

Treatment offers risk and benefit; conundrums; danger of awakening the mind;

Parents

Parental struggle; empathy for parents; parental despair; bewilderment; parents' doubts about treatment;

Miscellaneous

Patient protest; patient and therapist similarities; support and validation from colleagues

APPENDIX G

The Tavistock and Portman NHS
NHS Foundation Trust

Quality Assurance & Enhancement
Directorate of Education & Training
Tavistock Centre
120 Belsize Lane
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Tel: 020 8938 2699
https://tavistockandportman.nhs.uk/

Hannah Galvin
By Email
30 January 2020

Dear Hannah,

Re: Trust Research Ethics Application

Title: What is it like working with children and Adolescent in non-autistic psychotic states of mind? A study of Child and Adolescent Psychotherapists' experience.

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.

Please be advised that any changes to the project design including changes to methodology/data collection etc, must be referred to TREC as failure to do so, may result in a report of academic and/or research misconduct.

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, Research Lead

APPENDIX H

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