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### BOOK CHAPTER

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frequent bouts of violent acting-out and his refusal of intimacy. Peter himself would sit with a cushion over his face, protecting himself, we thought, from any possibility that we would be asking something of him, or showing him our own vulnerability, or anything that might be frightening about our relationship to one another. We discussed, among other things, how frightened he might feel about being suddenly presented with a mum who was drunk, or drugged, or having sex. As Peter began to feel safer, he was able to speak from behind his cushion and tell us about other boys being "silly" at school. He would let us think together—while he listened behind his cushion—about his difficulty in not joining in with them, how hard he found it to protect himself from being whatever they wanted him to be. His foster carer soon reported that he was now able to sit with the family for dinner. His growing affection for her was expressed in terms of praise for her wonderful cooking: he loved her Yorkshire puddings, he explained, but not toad-in-the-hole. He preferred the sausages when they weren't "all mixed in". He was eventually able both to emerge from behind his cushion and ask whether, if he had stayed with his mother, she might not have needed to be placed in a psychiatric hospital, and also to explore his worry that he might be mad or might drive his foster carers mad.

### *Conclusion*

In this chapter I have tried to continue along the lines of thought explored by Canham in his work with *Looked After Children*, looking especially at issues related to early experiences with which such children are still unconsciously preoccupied. Like Oedipus, they may have had good-enough later experiences, but these have occurred in the aftermath of early trauma that is not remembered and has not been sufficiently acknowledged or processed. I suggest here that the problematic and violent behaviours that such children display may have their roots in a struggle against the death instinct: the pull towards compliance and total projective identification with an internalized tyrannically needy mother. I have related this struggle to the story of Oedipus and the Sphinx, and to a universal phantasy, born out of projection, that has implications for infantile ideas about gender. I have tried to illustrate how, for many *Looked After Children*, this universal phantasy has been embodied in a real-life experience, which leaves them terrified of intimacy and of the intensity of one-to-one encounters.

## CHAPTER ELEVEN

### Neglect and its effects: understandings from developmental science and the therapist's countertransference

*Graham Music*

In this chapter, I consider the effects of early neglect on the developing mind of a child and how this, in turn, has a profound effect on the adults in that child's life. I draw on some classical psychoanalytic ideas, in particular the work of Hamish Canham with such client groups, and I interweave this with learning from attachment theory, neuroscience, and developmental psychology. I depict children who have been neglected, who have lacked good early input and experiences, and whose development has been stymied. I describe some of the challenges that working with them present to clinicians, as well as some of the ways in which contemporary therapeutic technique has had to be refined and developed to work with them successfully. I will build on the work of thinkers such as Canham (1998) who particularly pointed us to the central importance of the countertransference in work with such children. I have built on such understandings with recent research findings from neuroscience, attachment theory, and developmental psychology that can aid our understanding and interventions with neglected children.

I allow the term "neglect" to cover a broad spectrum, from relatively mild neglect to more extreme examples such as children brought up in deprived institutional care. Such children can be experienced as empty, deadened, inhibited, passive, apparently self-contained, with little ability to reflect on emotions (their own and others). Often their

narrative capacity is limited, they have little faculty to experience pleasure, and they do not easily inspire hope, affection, or enjoyment in those around them. I will argue that the most important tool we use with these children is our countertransference, and that we need to be profoundly aware of the effect of being in a room with such children as it is this that gives us the clearest clue about what they need therapeutically. Canham's (1998) sensitive work in residential settings for children in the care system, many of whom were neglected, has helped a generation of therapists to take seriously the grave effect of poor early care on the psychic lives of children but also, as importantly, on the professionals and other adults who try to care for them. Just as Winnicott (1994) helped both mothers and therapists give themselves permission to "own" their hatred, Canham (2004) was particularly helpful in helping child psychotherapists be aware of a range of other powerful feelings that can be evoked in us by such patients—communications that we have to work hard to bear and process but which, when we do, generally lend profound meaning to the work.

Neglected children receive little attention from parents and carers, and they also further "doubly-deprive" (Henry, 1974) themselves of care they do not know is available to use. In addition, they also tend to get ignored or neglected by adults and other professionals, including mental health professionals, leading to a triple deprivation (Emanuel, 2002). I differentiate overt abuse from neglect. Both can be traumatic, albeit in different ways, and whereas abuse often means bad things being done to a child, neglect can be described as a child not receiving good input necessary for psychological growth. Thus neglect is "omission" and abuse is "commission", and, of course, they both often come together. Yet I think that in comparison with children who suffer overt abuse or violence, whose acting out one can barely ignore, neglected children often seem flat and lifeless, with minds that can function in a more pedestrian way. They tend not to ask for help and appear not to need it. The developmental trajectory following emotional neglect is often quite different from overt trauma, and the prognosis can in fact be much worse, but they can too easily slip "out of sight and out of mind".

I am aware of the danger of confusing symptomatology and aetiology. Similar presentations and symptoms can be seen in children with very different experiences and histories, and by the same token similar histories do not necessarily lead to the same symptoms. Nonetheless, I believe that there are sufficient commonalities to describe a common clinical experience.

### *Some psychoanalytic thinking*

There is much helpful psychoanalytic thinking about "cut-off" and un-psychologically minded patients we can draw on to make sense of work with this group. In child psychotherapy, much of the writing about autistic spectrum patients is directly relevant. In particular, the need to adapt a more "active" technique is central, the use of "reclamation" (Alvarez, 1992), as well as the importance of not colluding with deadly ritualistic and empty behaviour (Alvarez & Reid, 1999; Rhode & Klauber, 2004).

In adult psychoanalysis, Bollas (1987) uses the concept "normotic" to describe patients he sees as psychologically "unborn", who he found were often raised in families where their "real selves" were not mirrored or facilitated, with parents not alive to their children's inner reality. Importantly, he describes the normotic patient as having little ability to take in an object, to identify with another, or to empathize. Bollas says that such patients can be "strangely objectless". They rarely introject in the usual way, nor do they project much into others, which is partly why they are so often ignored. This is different to the extreme projective processes and "highly disturbed object relations [that] . . . enter the room" (Canham, 2004; p. 119, this vol.) in therapy with children who have been actively abused. With neglect as opposed to abuse, one often experiences a more quiet, sometimes numbing countertransference. Very neglected children, rather than projecting deadness, can seem psychologically deadened, so that our words, spoken with meaning, life, and energy, can quickly become denuded of significance. Such patients are not so much attacking links (Bion, 1959), or the oedipal parental couple (Canham, 2003b), but rather often have not yet developed sufficient psychological links. Neuroscientists such as Siegel (1999) are corroborating Bion's initial theses and finding that literally neglectful experiences can lead to fewer links in our brains, such as between the left and right hemispheres (Siegel, 1999), and very severely neglected orphans have, for example, been found to have a smaller brain circumference and less activity in brain areas that specialize in emotional functioning (Music, 2010).

McDougall (1992) describes a similar kind of patient, whom she called normopaths, who lack a genuine affective life. Her writing is full of metaphors often used about this kind of patient, such as them having "armour plated shells", and she too is describing patients who seem to never have become fully psychologically alive.

In clinical writings about such patients by psychoanalysts such as McDougall, there is often an almost despairing thread about how the therapist is affected. Countertransference is the central tool, something that Ogden (1999) has clearly described. He writes that one's sense of aliveness or deadness is a crucial measure of the state of the therapy, and he argues that the analyst has to work hard to be honest about the countertransference in order to generate ways of relating meaningfully. He writes with candour about, for example, fantasies of feigning illness "to escape the stagnant deadness of the sessions". I think that the primary clinical challenge is often to stay psychologically alive and hopeful enough to be able to breathe life back into their deadened internal objects. Even if these patients are not projecting deadliness, we inevitably experience deadness in their presence, a countertransference very different from but as meaningful as that evoked by Canham's kicking and spitting patients (Canham, 2004). There are also similar risks of enactment, although the enactment in this case is less retaliating and more of falling into a semi-comatose stupor where there is little aliveness and few thoughts.

*Marsha: the difference between neglect and abuse*

Marsha was a 5-year-old African-Caribbean girl profoundly affected by a lack of early input. She was born into dire neglect, was left in her cot, had little predictable care, was rarely cuddled or even held when fed, and spent much of her time staring into space. She had developed tics and self-soothing mannerisms. At the age of 1 year she had been taken into care and placed with an experienced foster carer who had several other children. She was described as "a good girl", and as she was no trouble she was left very much to her own devices.

She was placed for adoption at age 4 years with parents who had already adopted Hayley, a lively and much more demanding 5-year-old. Hayley had had a different kind of tough start. She had witnessed violence and had spent two years with an unpredictable drug-using mother. In contrast to Marsha, Hayley was rather hyperaroused, demanding and clingy—what is now often called "hyperactivated". She was also furiously jealous of Marsha, and the parents felt guilty, saying they should not have brought Marsha into their home, as it was not fair on her sister. Hayley was high maintenance, demanding all their attention, but the parents at least were in no doubt that Hayley needed them. With Marsha, it was hard to tell if she cared about her parents at all. She did not cry when they left her, did not smile when

she was reunited with them, did not point things out to them nor want to interact very much. She seemed as happy to approach strangers as to go to her parents, and she acted as if she had no need of them.

In school, she had few friends and did not seek out other children, and her learning was very limited. Again she became lost, and there were plenty of more active children demanding teachers' attention. Staff had surprisingly little to say about her, and she slipped out of their minds too.

The intervention used was influenced by both infant observation and the very early work of Fraiberg (1974) with blind babies. The sighted but dispirited mothers of Fraiberg's sample of blind infants needed help to spot that their babies needed them. Their babies did not smile or have a twinkle in their eyes when their mothers interacted with them, but Fraiberg pointed out subtle signs, such as how a baby's toe wiggled when their mother spoke to them. Such understanding broke a terrible cycle for the mothers, who otherwise felt rejected and inadequate, leading both mothers and babies to give up and withdraw from each other. Similarly, in Marsha's case much of the work was in helping the adoptive parents spot faint signs that Marsha needed them (foot tapping when anxious, looking around the room a bit when they left). I also videoed sessions, realizing that the adoptive mother might feel criticized if I pointed out what she was or was not doing but would find it less persecuting to spot meaningful moments on tape. This proved to be the case, and we watched for easily missed and subtle cues and tried to amplify them, watching how easy it was to not notice Marsha, realizing how she did not protest when Hayley demanded all the attention. I advised both parents to spend time separately with each child, giving Marsha one-to-one time, so that her sister did not receive all their attention. I was struck as I talked to mother by how easy it was for me to forget Marsha while she did her self-sufficient thing.

We easily ignore children like Marsha, but this has serious consequences. They can fall further behind at school, have little social life, and their over-all prognosis is bad. We worked hard to keep Marsha more alive in her school's mind, asking her teachers how she was getting on, inviting them to regular reviews of the therapy. We tried to help staff spot potential signs of interest and aliveness. This can be hard. School staff value their quiet children and do not always want them to become more lively. She was put into a small "nurture" group, where she was noticed and thrived a bit. She was no longer slipping under the radar so easily. When we received the referral, the parents

were at the point of not proceeding with the adoption, but a year later they were fully committed. Mother noticed real signs of change. Marsha began to point things out to mother that she was excited about. Marsha fell over in a session and cried, and only her mother could comfort her, and this made a huge difference as mother at last knew she was wanted. Marsha was accepting cuddles, and cuddling her teddies, was smiling and talking more, and protesting occasionally. Everyone was pleased, except maybe her sister Hayley, and her adoption went ahead. Hayley and Marsha had different pasts that certainly affected the trajectories they were on, and one has to assume that they also had different temperaments. I think this case describes ways in which the effect of neglect is different to that of abuse, how it can impact differently not only on children but also on those around them, and how it requires a very different therapeutic technique.

*Undrawn unenjoyed children and neglect:  
trying to make sense of the group*

The group of children I am trying to delineate are best described in terms of what they lacked rather than what they received. Developmental psychologists such as Trevarthen, Kokkinaki, and Fiamenghi (1999) have shown how infants have an inborn wish for contact with other humans, and in psychoanalytic terms such children have, as Canham (1998) stated, been left on their own to manage unprocessable psychic and bodily states and to develop huge defences to get by. Such defences are erected at huge cost to the personality.

I think there is a spectrum of neglect, from the most deprived children abandoned to poor orphanages, to more mild forms. Maybe the most shocking examples were seen in Romanian orphans during the Ceausescu regime. Brain scans of such children showed graphically how deprivation induces profound alterations in the physical architecture of the brain. Rutter et al. (1999) found that a disproportionate number showed serious emotional deficits, and about one in eight showed what he called autistic-like symptoms, such as perseverative movement and lack of empathy. They did not seek proximity to caregivers, or seek interactions with others, and had basically "given up" on human contact. Many adopted Romanian orphans did not release normal levels of oxytocin—the "love hormone"—when cuddled by their new parents, even after several years (Kosfeld, Heinrichs, Zak, Fischbacher, & Fehr, 2005), suggesting a neurobiological concomitant to the coldness and deadness that psychotherapists report in their

countertransference. The more recent research about deprivation (e.g., Garvin, Tarullo, Van Ryzin, & Gunnar, 2012) corroborates earlier studies on the effects of institutional care (Tizard & Hodges, 1978), which found persisting and profound deficits in capacities to form intimate relationships, even in children who had later been adopted into well-functioning families.

There are less extreme examples of neglect than those described by the likes of Tizard and Hodges, or in Canham's descriptions. Those classified as "avoidant" or "deactivating" in attachment terms show similar but milder symptoms. In the Strange Situation test (Ainsworth, 1978), they act as if they do not care when their mothers leave them, but their physiology gives them away. When they are separated, their heart rates and cortisol levels shoot up. We do not see their distress, and they too do not seem to know that they are distressed. They lack (or have lost) the ability to read their own emotional-bodily signals. In other words, their emotional worlds have been neglected and have then become further neglected by themselves. By school age, avoidant children have less capacity for empathy, do not comfort other children in distress, initiate less contact, and are less popular.

A similar deficit in affect processing, sense of agency, and liveliness can often be seen in the children of post-natally depressed mothers. Murray, Kempton, Woolgar, and Hooper (1993) reported that such children showed a flatter and more passive sense of themselves as they grow up. Research by Field (2002) using Tronik's (2007) "still-face" experiment showed that the infants of depressed mothers barely reacted when their mothers began to hold a still-face. The expectations of infants of depressed mothers are of flat and less alive mothers. As Howe (2005, p. 137) states, with "out-of-touch" parent-infant relationships "the psychological traffic between minds has all but stopped", and children often spend more time in a world of their own.

*Paul*

In the hope that being clinically with such patients is recognizable to others, I describe the opening moments of a typical individual session with 10-year-old Paul, eighteen months into his weekly therapy.

I notice a reluctance on my part to answer the call from the receptionist and a stiffness of manner as I walk along the corridor, as if my body were more rigid than usual. A slight feeling of impending deadness gnaws at me as I enter the waiting room, where I predict correctly that Paul will be sitting in his usual place, will glance up at me and

then down to his comic, and will not move until prompted. He politely comes shuffling along, having given a compliant smile, which seems to lead my mind to go blank. Once in the room, he sits down and looks at me, paradoxically partly expectantly and partly with a total lack of expectation. By now I am already feeling rather despondent, plummeted back to the feeling of other weeks, that the burden of anything "alive" happening is down to me. I feel a less than proper therapist if I stay silent, but when I try to make interpretations these seem to go right through him and disappear into a chilling silence. I have learnt that if I am to have any impact, then what I say and do must come from a genuine "feeling-fullness" inside myself, and words need to be spoken with emotional honesty. I can console myself with the knowledge that I have "comrades in feeling" in most of the adults who have contact with Paul, most notably his parents and his teachers.

Paul's story is hard to describe because, typically I think, he and children like him have few stories about them. He is the oldest of three children, and the younger two seem to have developed relatively normally. He was born a few weeks prematurely, with some birth complications but apparently no organic damage, and he remained in hospital for two weeks, alone for much of the time. At the time of his birth, his maternal grandmother was terminally ill, and she died soon afterwards. His mother was physically absent, but she was also depressed and preoccupied with needing to look after her bereaved father and was also adjusting to being newly married. She could not offer what Paul needed in terms of an attuned mind able to be aware of his emotional state, and in this respect he reminded me of many children who have been in residential care for too long, from too young, so accurately and painfully described by child psychotherapists such as Hodges (Tizard & Hodges, 1978) and Canham (1998). Paul was described as "good" and "quiet" as a baby—presumably "too good" for his own good—and was frequently left with family and neighbours. Physically, he reached all the usual milestones, but he demanded and received less input than one would hope. As he grew up, he showed little interest in other children, did not play in an imaginary or "make-believe" way, and was described as being a loner and "deep", which seemed to mean inaccessible and faraway. His parents experienced little pleasure from him; he spent hours in his room in aimless activities and had little fellow feeling. Time takes on a different complexion for children like Paul, and as Canham suggested (1999), they have not been given a sense of themselves as continuing over time in anyone else's mind; they have not introjected an object

that is attentive to them; and they have been given little sense of themselves as having a past or future. In attachment and developmental psychology terms, such children lack a narrative sense of themselves and a developed autobiographical self, and they can seem to live in an eerily timeless realm.

I have found that many patients engender similar feelings in myself and others. These include some children adopted after neglect, many of whom in schools sit at the back of classes unnoticed while their acting-out peers gain adult attention and access to services. My hunch is that cases like this, even when they get referred to services, tend to get closed quicker than others. We can justify this to ourselves and say that they seem "just fine", and they seem not to care if they get help and certainly do not ask for it. They often can be experienced as rejecting, and too often the carers are not very bothered. It is difficult to admit to, but we can sometimes be relieved at the idea of not working with them, which thus perpetuates their neglect.

Psychoanalytic writers like Canham (2004) have been clear that we must be prepared in our countertransference to bear something of what these deprived patients feel themselves. Yet to really take on those feelings with such patients can give rise to many "heart-sink" moments, and it is easy to feel that we are not very successful with these "hard-to-reach" patients. Flat inner worlds, lack of fantasy and imaginary play, and little empathy all make for unrewarding sessions. Paul did not understand ordinary social cues, and, for example, he looked very "uncool". He had been bullied at school, but he had no words to describe any feelings about this. He would say, "I am one of those fidgety sorts of people", as his legs twitched and he tapped his hands, his body working at a speed that belied the apparent slowness of his mind. I understood his leg-bobbing and fidgeting as his way of holding himself together, a form of self-soothing that compensated for the lack of a containing internal object or recognition of good external ones.

He had no friends, although he mentioned a boy who was obsessed with trains and timetables. He was also obsessed with money and selling fishing rods on eBay. Cozolino (2006) suggests that in such patients their right-hemisphere emotional functions might not be very connected to left-brain, more rational and logical thinking. These children can sometimes be logical but have little emotional depth. When I tried to speak in my usual way—imagining his feelings, for example—my comments were generally brushed aside or ignored, and I soon felt myself becoming enveloped in a cotton-wool like deadness. At times,

I spoke just to feel that I was alive. I think that often such patients do not so much ignore what we say as not really notice it, irrespective of how empathic or accurate it is, and they lack the very idea of a mind that could be interested in them. Neglected children, and perhaps particularly those classified as avoidant, have a "dampened-down" system, the opposite of the hyperactive and acting-out children with heightened "sympathetic" nervous systems. As opposed to children who have suffered trauma or intrusion, they do not have to bother overly much with "others", of whom they have few expectations, and they concentrate on maintaining their own bodily homeostasis—for example, as in Paul's fidgeting.

*Sustaining thinking, empathy, and internal freedom*

I often draw on the writings of Coltart (1992), and Symington (1983) concerning the importance of "inner acts of freedom" and how the internal work we mentally undertake during sessions is the most crucial aspect of maintaining aliveness. One has to be constantly on guard to avoid the trap of doing work that can feel like psychotherapy but in fact is a form of pseudo-therapy. It is hard to sustain an empathic stance and manage the feelings that get stirred up in us, such as a sense of uselessness and boredom. As Morgan (2005), who is a mindfulness-based psychotherapist, wrote about working with hard-to-bear affects,

... the task is first and foremost not to be killed off. I am not implicating the patient's aggression. We are killed off when we are not present in the moment. [p. 141]

We too easily end up in a dead world like theirs, which I think is not a result of them projecting such feelings into us but, rather, a form of role responsiveness, a non-conscious mirroring of a patient's experiences and gestures—what also has been called "emotional contagion" (Hatfield, Cacioppo, & Rapson, 1993)—in which our mirror neurons (Rizzolatti, Fogassi, & Gallese, 2006) play a central role. Often our seemingly well-intentioned therapeutic interventions are ways of escaping the emotional contagion of living in a patient's cut-off world, a defensive retreat from the grim reality of a patient's internal world. As Canham clearly showed in his work and writing, therapeutic work must always be a "mixture of emotional and intellectual activity" (Canham, 2004; p. 132, this vol.), and sometimes our pseudo-statements, made by rote, are not emotionally alive to our patients.

This is a paradox, as we need to be sufficiently empathic to bear the patients' psychic states in our countertransference, but without being drawn too far into their deadliness. Empathy is often the last thing one feels with these patients, and so it is a huge challenge to use the countertransference in the interests of helping them.

Paul is typical in this respect. He had been reluctantly dragged to therapy by parents who were frightened by how they felt about their oldest son. He evoked frustration and hopelessness in them, feelings I soon understood too. At school, too, he was seen as a little odd and something of a loner. He was described, sometimes to his face, as "lazy" and "stubborn". Sessions were dull, and he would sit, stare, look compliantly, and then hesitantly tell me what he was going to do that day. Each session was neatly divided up: he might start by saying that "I will talk about my dreams for 3 minutes, things at home for 4 minutes, play a game of hangman for 5 minutes, talk about worries for 4 minutes".

A huge lesson for me was realizing what an entirely different world he inhabited to the one that I took for granted. One week, he came in speaking and acting exactly the same as other weeks and made his list of "things that happened this week"—which included at the end of the list that his grandfather had died. I was shocked and disturbed, and I tried to show what I believed was empathy. However, he looked at me blankly and told me some factual details about the funeral, but he was far from any of the feelings that I had wrongly assumed he would have at such a time. I was not facilitating any kind of mourning; rather, my expectations of what he should feel were pushing him where he could not go.

What made a difference was when my attitude changed and I concentrated on what it really felt like to be in a room with him, watching my countertransference, carefully, of boredom, irritation, wanting to shake him up, or drifting away. As Canham (2004, p. 120, this vol.) states "we have to experience them in the counter-transference and in this way temporarily inhabit their world", but we also have to find a way out of enactments or acting-in (Aron, 2001). On one occasion, when I was in a kind of half-alive torpor, I managed to concentrate hard on what he seemed to be experiencing, and surprisingly I found myself feeling some sympathy. I am fairly sure that in response to a change in my feeling tone, he looked up and smiled—a small moment to cherish, one from which some genuine relating followed. For once, there was a smile that seemed real, not compliant. At such moments when I spoke, I know my voice had more urgency but also

genuineness: I was "calling him back", "reclaiming" (Alvarez, 1992) him, and he could respond. I wonder what an MRI scan might have shown up in his or my prefrontal cortex at such moments, or what measurements a skin-conductivity test would have revealed, but I feel fairly sure that something would have registered in a way that was unusual in our therapy.

Slowly he seemed to slightly loosen up, as I found a way to empathize and feel my way into his world, and as a result I realized I could find myself liking him. Then I could be more actively challenging of him in a way that he would not feel as critical and judgemental. Sometimes my attempts to engage him were all too clearly expressions of my frustration, and then a less than sympathetic tone precluded real contact. When my attempts to reach him had urgency but not frustration and challenged him warmly, then real contact was made. When, as I leaned forward slightly, I said "Oh wow, this bouncing leg keeps Paul from feeling nervy, but it keeps him from noticing that Mr Music is really interested in him", he looked up and his tone changed. These small changes nearly always seemed to result from immersing myself in an aspect of his being that I found almost unbearable, but that it helped to know. As he bounced his leg, I bounced mine in response, and he looked up at me and awkwardly smiled. There was the beginning of "reciprocity" (Brazelton & Cramer, 1991): as he stopped jiggling his leg, and I did too, he then looked up again, jiggled, and waited for me to respond. There developed an ordinary rhythmic to-and-fro that most babies engage in with their parents, but which Paul had lacked. He was developing the beginnings of a capacity for conversation in which eventually slightly more difficult feelings could be processed. It made no sense to him when I talked—as I did too much—of breaks between sessions, or of holidays. However, when in a game (of leg-bouncing) I enacted being suddenly stopped in my tracks and expressed frustration, he seemed to enjoy this. He looked awkward, then laughed, and in the next session he did a slightly wooden version of the same thing, showing a capacity for both introjections and "deferred imitation" (Meltzoff, 1988). He had also become slightly humorous, which, as Canham (1999; p. 68, this vol.) states, means that a patient "has a benign observing function on another part". He had also become interested in what I was up to, and what I was making of him, knowing that I had a story in my mind about him.

There are also less easy feelings that it is necessary to bear if we are to help neglected children develop. I have found that when such deadened patients start to "thaw out" or come alive, we often witness

both aggression and sadism. This can be hard to stay with, yet I think expressing such unsavoury aspects of their personalities can ironically be part of their salvation, their very lifeblood. Eigen (1995) has been helpful about this, arguing for a therapeutic approach in which we aim to allow whatever is in the patient in as "capacious" a way as possible. He argues that some psychopathic patients need actually to act psychopathically while "on the road" to achieving a more moral and "depressive" outlook. If we too quickly interpret their actions and impulses as destructive or aggressive in a way that smacks of being judgemental, then a developmental opportunity is lost. This idea is not so far away from Freud's view that we need to accept "id" impulses that can then be used in the service of the life instinct. Sometimes, disquiet at destructive and cruel aspects of the personality can lead to pseudo-interpretations that, in fact, stymie the development of something more "feelingful" and "alive".

As Paul began to seem more lively in his play, I sometimes saw rather disturbing and sickly scenes being enacted, such as horrible deaths and torture. Animal and human toys were lined up, hurt, and killed. If I interpreted this in a way that revealed any hint of disapproval, his play ground to a halt. When I realized what was happening, I could stay with the play more, and at times it did turn into a sickening frenzy of death and destruction, although still expressed in his rather wooden and slightly deadened way. Again, I needed actively to speak to, or even for, the sadistic aggressive part of him, strongly and empathically saying things like, "Yes, he really wants to beat him up as hard as he can, that's what you want". As horrible as it could seem, there was some "wanting", some "desire", in his play which needed encouraging. Sometimes, when something frozen begins to thaw out, what replaces it might be traits that we find abhorrent. In the cases I have seen, tolerating this has been a stepping stone in development, rather than the unleashing of psychopathic monsters. A big part of such work is encouraging "aliveness", and, as psychoanalysis has always shown, life is not always nice or pleasant.

#### *Pleasure and enjoyment*

Paul's leg-bouncing led to interactions that I can only describe as playful. He would sit behind a chair, put his leg out, wave it around, and wait for me to respond by doing something similar. He began to show some initiative and a sense of agency, but perhaps more importantly it seemed like the beginnings of fun. I generally felt guilty



about such interactions, hearing a psychoanalytic superego telling me that if it was enjoyable, it was not psychoanalytic, and was probably a defensive retreat. However, I have begun to think that a range of emotions are neglected in the psychoanalytic literature (Music, 2009). These include enjoyment, pleasure, excitement, liveliness, and joy. Neglected children generally experience few of these, and they also lack a sense of agency (Broucek, 1991) and a belief that they can be active partners in social interactions. Infancy research describes how babies love making things happen, whether making a noise by pulling a cord or making mother come to them through a cry or laugh. Infant imitation (Meltzoff, 2007) is a typical example, as are the active attempts to regulate the other described by Tronik (2007) or the playfulness that Reddy (2008) writes about. When all goes well, babies are active participants in social life from the start. This is an outgoing, often joyful, experience and is not simply emotional regulation or containment of psychic pain. Neglected children rarely seem to have this capacity for pleasure and enjoyment.

Alvarez (1992) in particular has cautioned that we can see manic defences where in fact there are developmental opportunities. She suggested that, with certain deprived children, if we interpret what we see as defences too quickly then we simply deflate patients. The child who jumps on the chair and shouts "I am king of the castle" might be being defensive; however, for some children this can be the first experience of feeling strong and confident, and they might revert to a more hopeless state if we interpret something like "you want to be strong but really inside you feel little and hopeless". In recent years, there has been some research that suggests that it is helpful for a child to have a slightly overconfident view of him/herself (Bjorklund, 2007). When asked to rate how well they understood how mechanical devices such as a toaster worked, kindergarten children give themselves the highest ratings of all. After they had heard an adult's "proper" explanation of how these contraptions worked, older children lowered their belief in their own understanding, but the confidence levels of self-belief of the little ones was undiminished (Mills & Keil, 2005). Generally, we become more realistic as we get older, but children when young tend to think they can climb higher mountains, balance more balls, score more goals, and generally perform excellently, and they are adept at ignoring any evidence that contradicts such beliefs (Stipek & Gralinski, 1996).

Such confidence, in fact, increases resilience, but it does not appear in severely neglected children who have had no one really believing

in them or believing that they are special. Such "protective optimism" is not just a defensive process used to deny a painful reality, and Bjorklund (2007) suggests that such optimism is necessary for children to experiment with hope and confidence and to persist at tasks that currently feel too difficult. It seems that over-optimism, even if it can seem almost delusional, does in fact give children the confidence to persevere with tasks. Genuine confidence is not what most neglected or abused children have in much abundance, and hence they often need help developing a sense of agency and belief in themselves.

In therapy with children, such capacities can start to form. It was noticeable how Canham's patient Toby, "built up . . . some sense of hope that I will return and be there on time. . . . What struck me most was Toby's different use of his session. He seemed to feel that it was time for him, it would not be gone in an instant, but that he had gotten some time to play with" (Canham, 1999; p. 67, this vol.). He was gaining some of the confidence that Bjorklund's resilient children are given much earlier on and more consistently. My patient, Paul, also developed hope and began to try harder, to not give up so easily, and he developed confidence that he could make things happen. Often when he tried to do something, like build a tower, and he seemed to be failing, he would quickly give up. I would then begin to actively encourage him ("yes you can do it, no need to give up, wow, you are doing well"). He was rather like the children of depressed mothers that Murray (1992) or Field, Diego, and Hernandez-Reif (2006) studied, who tend to be more passive, and with less sense of self-belief. Obviously there can be dangers in overestimating one's ability, but children like Paul run the opposite risk, of becoming hopeless, with little trust that they can make an impact on the world. Although reality must be faced, too much facing painful reality too early might not always be in a child's best interests.

Many neglected children have simply not been enjoyed very much and do not easily experience pleasure. Psychoanalysis and attachment theory has tended to privilege our defensive systems, the need to seek out attachment figures when fearful and to manage difficult experiences. As the neuroscientists have found, as well as a defensive system we also have an "appetitive" or "seeking" system (Panksepp, 2005), which uses different brain regions and stimulates different hormonal reactions, which is working when we are exploratory, experiencing pleasure, and are outgoing and confident. Playful, mutually enjoyable interactions are needed for this to flourish. Deprived humans, and indeed primates generally, such as those reared in isolation, often

never learn to play, and generally nor do chronically traumatized, abused, or neglected children.

This is a challenge to our technique, as it requires us to make a space to facilitate the positive as well as working with the negative. We have to proceed delicately around potentially positive feeling states, maybe "tip-toe up to pleasure" as well as pain; pleasurable experience can for some such children be very dysregulating. When Paul smiled slightly, or seemed mildly excited, I could occasionally meet that feeling and respond with, maybe, a "Oh, yes, that is exciting", or "wow, you really want to do that such a lot". The trick, as Fraiberg (1974) found, was in ensuring a tolerable level of excitement, being alive to signs of life that were faint and hard to detect, even harder if one had been lulled already into a rather cut-off state of mind. I hate to think about the signs that have just bypassed me over the years. When we learn to notice signs of life, and amplify or "mark" them (Fonagy, 2002), this can be responded to, and so we can then find courage, even enthusiasm, to continue to build potentially lively and mutual interactions. With Paul, by the end there were certainly moments when I enjoyed being with him, and he with me, and something was built. It is not easy to find a language to describe this in psychoanalytic terms. The danger is that we are seen as being seductive, or manic, or refusing to stay with difficulty, but I cannot help feeling that the opposite danger—sinking into a feeling-less world with no narratives and no pleasure—is more dangerous.

Neglected children often do not receive the kind of enjoyable and conversational partnership that leads to a sense of playfulness, of agency, to a sophisticated communicative dance. They struggle to be "live company" (Alvarez, 1992), or to receive it. Recent research, including that about resilience (Maddi, 2005), shows the importance of positive affect for healthy emotional development. Much other research makes it clear that the ability to manage unhappy feelings is quite different from the ability to manage happy ones (Zautra, 2003). It suggests that working with negative feelings and the negative transference helps manage one aspect of psychological functioning but does not help develop more positive traits. Learning to be outgoing, to be positive, and to have a sense of agency are all capacities that use different parts of our brain (Davidson, 2004). Negative affect is mostly processed in prefrontal right sides of the brain, while positive feelings are associated with higher left-brain activation. Toddlers who are introverted and anxious show more right-side activation, while confident ones have left-side dominance. New experiences can change these

patterns. As an example, Davidson's research with mindfulness meditation has demonstrated that brain changes can follow interventions. We need to help patients manage difficult feelings, and this is perhaps our main skill, but what we have possibly under-theorized is how we can also increase a patient's sense of agency, enjoyment, and aliveness through a way of being that is not merely helping them process difficulty nor being a blank screen. For patients like Paul, blank screens can breed more blankness, which is certainly not what they need.

#### *Conclusions:*

#### *neglect can be more pernicious than trauma*

In this chapter, I have described how neglect is different from trauma and requires a different kind of therapeutic technique. With such children, an awareness of core psychoanalytic principles is vital, such as being attuned to pain and subtle defences, using one's countertransference as a primary tool to frame how we intervene, and being in touch with the excruciating experiences of many of these children. As Canham movingly stated, "unless young people . . . have people around them who are able to face up to and tolerate their experiences, they do not stand a chance of making sense of their lives by themselves" (Canham, 1998; p. 55, this vol.). To do this, though, I have argued that we need to adapt our technique. We need to be able to bear and not be taken over by the numbing atmosphere they can evoke. We also need an increased focus on positive as well as negative emotional states; we must also ensure that our interpretive technique is such that our words are infused with emotional aliveness, moving away from more cognitively based comments to the different levels described by Alvarez (2010a), such as lending meaning via description or amplification, and, even more basically, helping patients to begin to access feeling.

I have suggested that there are a number of common factors that make neglected children into a loosely defined group. They can leave carers and professionals with feelings that are hard to admit to—being de-skilled, dehumanized, bored—and also feeling dislike and coldness. The main factors that give rise to this are, I think, these children's lack of awareness of minds and mental states, lack of stories and imagination, deficit in emotional expression and language, lack of a sense of agency, and, perhaps more than anything, lack of much capacity for ordinary enjoyment. Canham talked about how many children from deprived backgrounds missed out on the early care that gives rise to a sense of time (Canham, 1999). Having a sense of

time, as Canham showed clinically, requires the knowledge that one is held in mind over time, that one exists as author of one's own stories, with a claim to a past and a future—what developmental psychologists term having autobiographical memory. We now know that this is more likely to occur if one's mental states have been acknowledged and reflected upon from early on, giving rise to increased understanding of one's own and other people's minds (Meins et al., 2002). Many neglected children, as Canham states, have had "limited opportunity for the sorting out of feelings and impulses associated with particular stages" (Canham, 1999; pp. 62–63, this vol.), which is why so many neglected children "cope by obliterating time" (p. 64, this vol.). Canham's description of time often passing "excruciatingly slowly" for such children is also one that will find echoes in many therapists' experiences of working with them.

Neglect does not affect all children the same way, and some children can, it seems, make do with less, as recent genetic research has discovered (Bakermans-Kranenburg & van IJzendoorn, 2008). Yet whatever our genetic inheritance, all humans need a degree of good early interactive care, and what we have learnt from studies of the Romanian orphans and others is the "deadly" effect of a lack of sufficient early interpersonal input. We have different potentials that can give rise to different sets of behaviours and different brain patterns, and thus are our brains are "experience-dependent". We are also born with "pre-conceptions", as Bion (1962a) stated; or, in another language, we start life experience "expectant", and if such an "evolutionarily-expectable environment" (Cicchetti & Valentino, 2006) is absent, then certain basic capacities simply do not develop. For example, children not exposed to language in the first few years never fully develop the capacity to use words in their richest forms, and the same can be said of children who suffer a lack of interpersonal growth-inducing relationships. Their pre-conceptions—to use Bion's language—did not meet with a realization, and so they can suffer from a stymieing of development.

The impact of neglect may well be more pernicious in the long term than that of overt abuse and trauma, as Field's research shows (Field, Diego, & Hernandez-Reif, 2006). Neglected infants who are not interacted with much by withdrawn, depressed mothers, compared to infants who suffered intrusive parenting, were less exploratory at 1 year, and by 3 years were not showing empathy, were passive and withdrawn, and were doing worse cognitively. Intrusion is at least stimulating, whereas neglect is deadening.

I have attempted to delineate a group of children who have worried me and to describe a clinical group who pose particular challenges for psychoanalytic work. I have alluded to a few areas of technique that I find particularly challenging, including tolerating and not over-interpreting sadistic states of mind, finding a way to encourage agency and positive affect, and the paradoxical task of stepping back from a lifeless encounter in order empathically to be in touch with the patient. These only brush the surface of developing an effective therapeutic technique with very neglected children. We walk a delicate tightrope between being there to amplify aliveness and being too intrusive. Similarly, we need to find a way to foster a sense of agency and enjoyment, while being neither too manic nor seductive. The neglected children I have known, like Paul, have not undergone personality transformations through therapy. They often slowly "warm up", get livelier and slightly more real. Parallel work with parents is crucial in learning to identify and amplify any slight developmental signs, which in turn can lead to more rewarding experiences for both parties. Sometimes, parents, teachers, and therapists might not be pleased that our technique leads to children moving from being dull and cut off to becoming more lively, aggressive, and challenging, but at least some life is forming. Such children are at least moving towards life, which is the hallmark of people who are confident and outgoing, with more prefrontal left-brain activity. Neglected children do not generally inspire passion and therapeutic zeal, and sadly they have not only been neglected emotionally in their early lives, but are often further neglected by other adults and professionals. If we do not provide them with the help they need, then their prognosis is particularly bad.