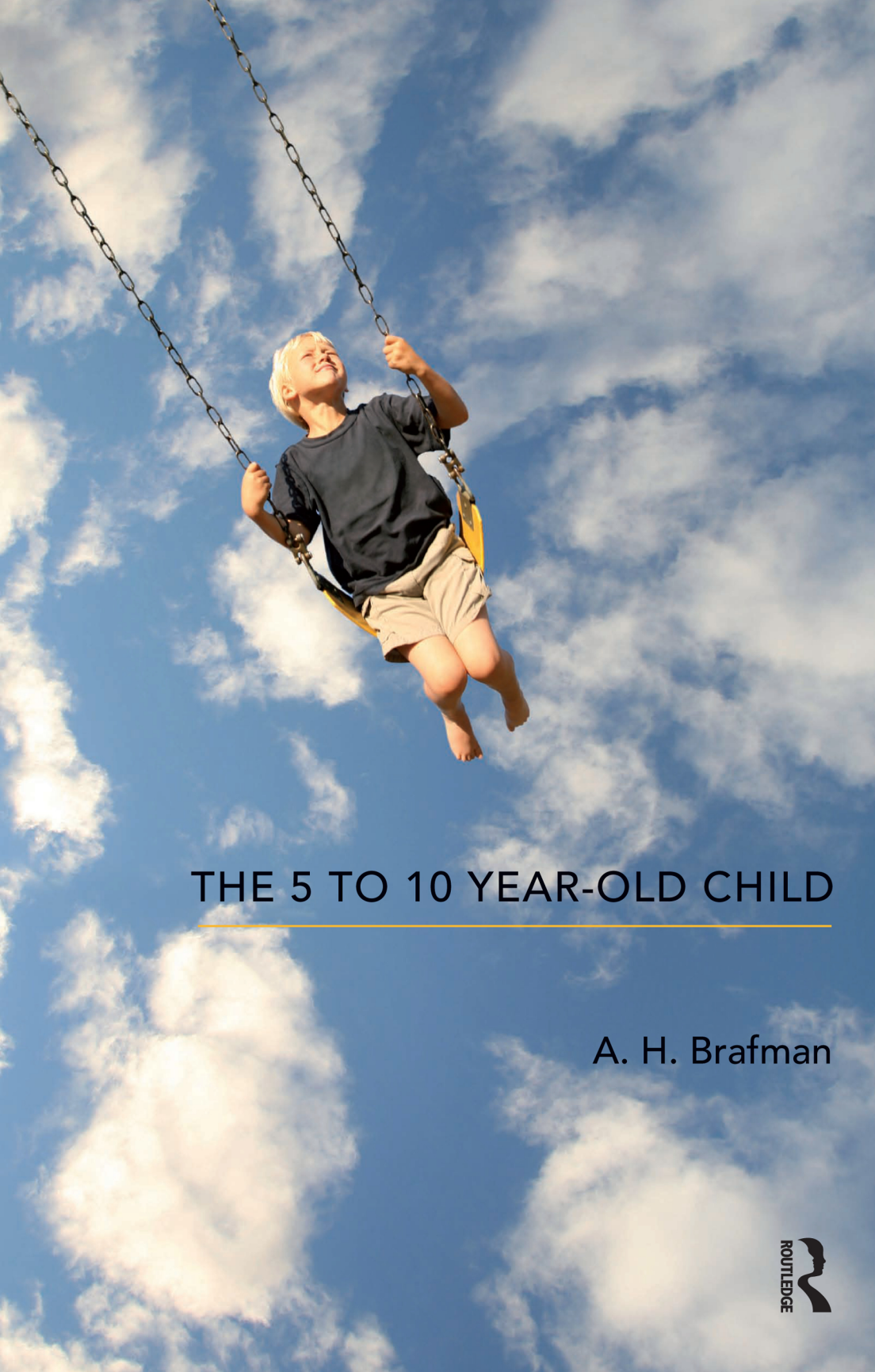

THE 5 TO 10 YEAR-OLD CHILD

A. H. Brafman

ROUTLEDGE

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Dr Abrahão H. Brafman worked as a Consultant Child and Adolescent Psychiatrist in the NHS until his retirement. He is a qualified psychoanalyst of adults and children, and gave seminars on infant observation for trainees of the British Psychoanalytic Society and other training institutions. For many years he ran a weekly meeting for under-fives and their parents at Queen Mary's Hospital, Roehampton, London. He has published two books based on his work with children and parents: *Untying the Knot* (Karnac, 2001) and *Can You Help Me?* (Karnac, 2004), as well as a series of papers on various clinical topics. For several years, under the sponsorship of the Winnicott Trust, he ran weekly clinical seminars for medical students at the University Hospital Medical School, Department of Psychotherapy.

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SERIES EDITOR'S FOREWORD

Full-time schooling in Britain starts after the child is five years old. This is the point where parents have to accept that their child is out of their sight for most of the day. Some parents will feel free to devote their time to work or other favoured pursuits, but others may feel quite lost, as if deprived of a valued *raison d'être.* The period from five up to ten years of age also represents a time when most children are more difficult to reach. Some children find difficulty in adjusting to the ethos of a primary school, but at the same time they appear to lose their ability to confide in the parents. The "open", spontaneous under-five becomes a reserved, elusive child and, even if they know that this is not a sign of pathology, some parents do struggle to rediscover their younger child.

Puberty signals further changes, both physical and emotional, but this book focuses on that period that psychoanalysts call "latency years", a colourful description of years when the child's impulses and feelings appear to become dormant, as if he wanted to isolate himself from the world.

The literature describing the developmental stages that lead the infant to adulthood contains two aspects that deserve to be made explicit and discussed. One is the difference between references to

the *actual* infant, as distinct from those focusing on the *reconstructed* infant (Stern, 1995); the other follows from this one and involves the degree of experience that the authors have of direct, close involvement with infants and children. It is very easy to ignore these features, but, once aware of them, one realizes how important they are and the degree to which they affect the views put forward by the authors.

Over the years, I have met many analysts and psychotherapists to discuss the observation of infants or actual clinical work with children. I came to recognize that some of these students or qualified professionals spoke about the infant or child they were involved with in a manner that suggested a sense of distance and coldness; they seemed to be reporting the finding of something they had read or heard about. I could not pick up the tone of delight and warmth that one experiences when discovering something new in an object that one feels close to, the sense of excitement and discovery that an individual object engenders when approached with a background of recognition and familiarity. In other words, having been close to other infants or children, the gratifying discovery that this is not "just another infant", but a new, different, special infant, with his own unique characteristics.

Eventually, it occurred to me to ask these students what previous experience they had had with young children and I was surprised to find that the infant they observed or the child they were treating was the first child they had ever come so close to. These were professionals who had trained to work with adults, and it became clear that the images they had of "an infant" or "a child" had been gained from their studies. I later found that most people who decided to train in the analytic approach to children opted for the child psychotherapy training, while those who chose the psychoanalytic training were aiming to work with adults. This may well be the explanation for the failure of all the efforts made by so many analysts to persuade their trainees to get involved with children or, at least, with the study of children.

Anna Freud (1972) saw the child as a live field of research and she believed that "child analysis . . . opened up the possibility to check up on the correctness of reconstructions in adult analysis" (p. 153). And yet,

> analysts of adults remained more or less aloof from child analysis, almost as if it were an inferior type of professional occupation . . . It was difficult not to suspect that most analysts vastly preferred the childhood images which emerged from their interpretations to the real children in whom they remained uninterested. [*ibid*.]

Hannah Segal (1972) shared Anna Freud's views:

> In our institute in Great Britain we had for years lectures on child analysis and clinical seminars, which were compulsory for all students. Unfortunately, we are going through one of our periodic great upheavals and reorganization, and I find to my horror that the child has been thrown out with the bath water: the course of child analysis for the ordinary candidate has disappeared, I hope only very temporarily. [p. 160]

To help a professional to obtain true, thorough familiarity with the growing child, she listed what she saw as her

> minimal requirements: first, full integration of theory of psychoanalytic knowledge derived from the analysis of children in teaching; secondly, baby and child observation; and thirdly, attendances at lectures and clinical seminars on child analysis irrespective of whether the candidate is treating children himself. [*ibid*.]

In fact, infant observation has been the only one of these disciplines that has been (virtually) universally adopted as part of the training in adult analysis and psychotherapy. However, analysing the reports of students and reading the available literature, we can recognize the effect of the preconceptions with which the observers approach infant and parent(s). We can only *see* what *we make* of that which our eyes show us. This is not pathological; it is an inevitable fact. Whichever one of our senses is stimulated, some perception is formed and immediately interpreted in line with previous experiences. Presumably, each and every one of us is able to spot a sensorial stimulus not previously met, but if some stop and try to make sense of it, others quickly ignore it, choosing to concentrate on more familiar perceptions and interpretations. Of course, nobody reaches adulthood without having been involved with children of all ages, but there is a major difference between taking an interest, developing a relationship, and warming up to children and, instead, approaching children as no more than an object of study.

Friends, colleagues, acquaintances, relatives of all ages arouse feelings and images of various degrees of clarity in our minds and we are usually able to describe their qualities and attributes as individuals. But, on becoming a student, there is a powerful qualitative change in our frame of mind and we move on to learn about and search for group characteristics; indeed, this is a response to what most teachers expect from their trainees. In zoology, we learn of species, races, genders, etc., much as in psychology we discover all kinds of classifications of appearance, behaviours, etc. Since medicine has "diagnosis" as the primary goal in the process of investigation of the individual patient, the student has to work hard to learn the relevant data to consider when making his "differential diagnosis", i.e., having considered all *possible* illnesses that *might* be affecting that particular individual, deciding which one is, in fact, producing the clinical phenomena found in that particular patient.

And here lies the problem I wanted to define and focus on. Meeting an infant or a child, we are flooded with images and possible interpretations of what *that child*'s appearance, behaviour, utterances, etc., are supposed to indicate. But, having examined each and every one of these *impressions*, we still have to admit that these are no more than interpretations based on our previous life experiences. Only a closer interaction with the particular child will help us to clarify which of our hypotheses are in fact correct, and, at last, recognize and define the specific cluster of conscious and unconscious thoughts and emotions experienced by the child that lead to its expressed, manifest behaviour and utterances.

The reports of students on their observations of infants demonstrate very clearly the degree to which their descriptions reflect the theoretical framework they are being trained in. Indeed, their personal opinions also influence what they perceive, and only when they give a detailed enough description of their observations will other students be able to recognize other possible ways of interpreting what has been observed. Two examples may illustrate this point:

> A seven-month-old baby was described as particularly unresponsive to the mother's ministrations. The student, in fact, at times considered the mother's behaviour as a possible cause of the baby's responses. Taking a broader view of the three visits under discussion, the other students