SECOND EDITION

THE HANDBOOK OF

# Child & Adolescent Psychotherapy

## PSYCHOANALYTIC APPROACHES

Edited by
Monica Lanyado
and Ann Horne

# The Handbook of Child and Adolescent Psychotherapy

## Second edition

This updated edition of *The Handbook of Child and Adolescent Psychotherapy: Psychoanalytic Approaches* reflects the many changes in the profession. It includes:

- additional chapters on neuroscience, work with 'looked after children' and with foster parents, working in schools
- enlarged chapters on research, attachment theory, work with parents, and developments in child and adolescent psychotherapy around the world
- chapters on areas of specialist interest including violence, sexual abuse and abusing, trauma, parent–infant psychotherapy, autism, victims of political violence, delinquency, gender dysphoria.

The handbook remains accessible and jargon-free. It will be a valuable resource for all who work in allied professions where the emotional well-being of children is of concern – health, education, social services – as well as trainee psychotherapists and experienced practitioners.

**Monica Lanyado** is a training supervisor at the British Association of Psychotherapists (BAP). She is co-editor with Ann Horne of the first edition of *The Handbook of Child and Adolescent Psychotherapy*, *A Question of Technique* and *Through Assessment to Consultation* and author of *The Presence of the Therapist*.

**Ann Horne** trained in the Independent tradition at the BAP. She has discovered that retirement (after 10 years latterly at the Portman Clinic, London) can become very crowded and makes occasional sorties from behind the keyboard to speak and teach in the UK and abroad.

# The Handbook of Child and Adolescent Psychotherapy

## Psychoanalytic Approaches

Second edition

**Edited by Monica Lanyado and Ann Horne**

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**Ann Horne** is a member of the British Association of Psychotherapists (where she trained), the Scottish Institute of Human Relations and an Honorary member of ČSPAP, the Czech Society for Psychoanalytic Psychotherapy. She served terms of office at the BAP as head of training and later of post-graduate development. A previous joint editor of the *Journal of Child Psychotherapy*, she is co-editor with Monica Lanyado of *The Handbook of Child and Adolescent Psychotherapy* (1999) and *A Question of Technique* (2006). Now retired from the Portman Clinic, London, she talks, writes and teaches.

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# Acknowledgements

The first edition of *The Handbook* was received with an enthusiasm that has more than rewarded us for the work involved. So we were delighted, if somewhat daunted, when our publisher suggested – 'suggested' is something of a euphemism as the 'suggestions' demonstrated a remarkable persistence over a year or two's duration – that in view of continued good sales around the world, plus translation into Italian and Czech, we update the handbook with a second edition. We were assured that it need not involve too much work but in the event the number of new contributions is far greater than chapters that have remained largely unchanged.

We thank Routledge and our editor the suggestive Joanne Forshaw for the stimulus she gave us, and also vow to be extremely cautious next time we are told that 'not too much work will be involved'. So much has changed in the profession in the last ten years that this became inevitable – but it has also been very gratifying to track development and change in this way.

Our thanks to the contributors who patiently worked on their chapters until we arrived at what is once more a very readable and accessible volume. In addition gratitude must be expressed to Domenico Di Ceglie and the Gender team at the Tavistock; to a large number of colleagues abroad who responded to Lydia Tischler's call for an update on the international scene; and to Rachel Brake, Natalie Barnes, Tammy Fransman and Cain Snipp.

Monica Lanyado and Ann Horne

# 1 Introduction

*Ann Horne and Monica Lanyado*

The second edition of this handbook continues the tradition established in the first of offering an overview and explication of the profession of Child and Adolescent Psychoanalytic Psychotherapy. It is not, in any common sense, actually a handbook – there is no intent to train the reader who will not, in turn, emerge as a child psychotherapist from the reading. Rather, we would hope to broaden knowledge about the profession and the range of work with children and young people that this adaptation of psychoanalysis encourages; we would wish in addition to explore what a psychoanalytic understanding – in terms of theory, research and the implications for practice – offers in work with distressed and 'stuck' children and young people today.

It is thus designed for several types of reader. For those who are already training or working as child psychotherapists the value may well lie mainly in the chapters on work of specialist interest, although many of the other contributions will offer creative ideas and sparks to further thinking. For those contemplating a career in child psychotherapy – perhaps undertaking pre-clinical Masters courses – this is the volume that hopefully helps your friends and family understand what you want to be about. For the reader in allied professions, we offer an overview of the profession, its context and settings, and hope to clarify some of the assumptions about and insights of the psychoanalytic approach. Most chapters are therefore deliberately written to be accessible to a general audience and the authors have responded to that brief. Those seeking greater depth may find the suggestions for further reading helpful.

Our hope would be that the more generalised introduction will make accessible some of the excitement and potential in recent thinking about practice and research, and that the general reader will also find much in the more specialised chapters to enhance practice in other professions as well as to facilitate understanding of why and how the child psychotherapist is working in a specific field.

We have also included writers from a variety of theoretical backgrounds: Contemporary Freudian, Independent, Jungian and Kleinian. In general, these are experienced writers with proven interest and expertise in specific

areas. This multi-authored approach should give the reader a sense of the diversity within the profession, and of a vibrant profession able to discuss, differ and develop, while sharing clear underlying principles.

## Structure

The book is structured in four main parts but each chapter stands in its own right. The first part introduces the theoretical foundations of the work. While the first two chapters reprise the themes of the first edition, they have been updated – and the chapter on attachment theory has been rewritten and expanded to incorporate current knowledge and research. Neuroscience represents an important addition to the theoretical base and we welcome the clarity of Graham Music's contribution. Finally, in the ten years since the first edition appeared, research has moved on considerably: we are most grateful to Nick Midgley for an erudite and measured exposition of the field. Throughout, authors have used straightforward language to introduce important ideas and concepts. These introductory chapters also provide plentiful references for those readers who wish to have more detailed knowledge.

The theoretical section is followed by three chapters about the child and adolescent psychotherapist in context – the cultural and racial context today; the most usual setting for the UK therapist working in the public sector (the multi-professional team); and as good an international overview of child psychotherapy as we could manage from colleagues abroad, encouraged by Lydia Tischler who was in 2005 celebrated for her work as co-ordinator of Central and Eastern European Networks for the European Federation for Psychoanalytic Psychotherapy in the Public Sector (EFPP). We are, of course, delighted that the first edition has already been translated into Czech and Italian; and that this second edition will appear in Japanese.

The third part of the book describes the diversity of treatment models offered by child and adolescent psychotherapists, beginning with the therapeutic setting and process. The tradition of intensive psychoanalysis (of four- or five-times weekly frequency) with which the profession began retains its rightful place; the principles, however, have become applied and developed in once-weekly work, probably the norm for most individual treatments. It is important that Part III then goes on to demonstrate the extent of work undertaken by the profession as many would assume individual psychotherapy to comprise the bulk of the child psychotherapist's day. Not so. Brief interventions are explored, as is consultative work which applies psychoanalytic principles to enable colleagues in a variety of settings to make sense not only of the young people with whom they work but also of their own responses and feelings. Expanded chapters appear on work with parents and parent–infant psychotherapy. Both have generated a great increase in interest and engage child psychotherapists in most work settings. We are fortunate to have a child psychotherapist, also a group

analyst, co-write the chapter on group work and have added a new chapter on working in educational settings, another growth area. The chapters on in-patient work and therapy and consultation in residential care remain as before.

The final section of the book describes areas of special clinical interest: autism, trauma, work with looked after children and foster carers, delinquency, violence, sexual abuse and sexually abusive behaviour, gender dysphoria, eating disorders, work with young people exposed to political violence. These chapters provide a mixture of an overview of ways of working with these specific problems as well as giving access to the theoretical thinking behind the interventions. They are rich in case illustrations and provide an intimate and impressive view of how far the profession has come in adapting classical psychoanalytic practice, originally developed for the treatment needs of mainly neurotic patients, to the more complex nature of a child and adolescent psychotherapist's work today. Six chapters are new – or almost totally revised; four have been reviewed and updated.

## A note on history

A full history of developments in psychoanalytic work with children and young people, leading to the establishment of training schools, is contained in the Introduction to the first edition of this handbook, to which the curious reader is directed.

Although the lasting impetus to the establishment of the profession of Child and Adolescent Psychotherapy comes from the theoretical interest and practice of both Anna Freud and Melanie Klein (Daws 1987), other influences helped found the structure for psychoanalytic work with children and young people. In Vienna, Hermine Hug-Hellmuth (or Hug von Hugenstein) combined her experience as a teacher with her growing interest in psychoanalysis, publishing her first monograph in 1912 and a paper on child analysis in 1921 (MacLean and Rappen 1991). Geissman and Geissman conclude: 'Her work, buried for sixty years, is being unearthed at last: and that work was the invention of child psychoanalysis' (Geissman and Geissman 1998: 71).

In the 1920s the child guidance movement, begun in the USA, reached the UK. The first specially trained psychodynamic workers with children in the child guidance multi-professional teams were the psychiatric social workers (PSWs). Following the establishment of the first child guidance clinics in the UK (by Emanuel Miller and Noel Burke in London and the Notre Dame Clinic in Glasgow) the 'Mayflower ladies' – the first PSWs – went out to the USA to be trained by colleagues there. This interest in gaining particular expertise in work with children and young people grew amongst the early professions in the new clinics – psychologists, psychiatrists (originally specialists in Psychological Medicine) and social workers. Although there was a stimulating ethos of interest in applying

psychoanalytic and child development understanding to children, many clinics remained voluntary, reliant until the advent of the National Health Service in 1948 upon jumble sales and donations to keep going. This picture of committed enthusiasm by professionals, yet a backcloth of it being difficult for society to take seriously child mental health issues, remains with us.

At University College, London, the 1920s saw the first courses in child development and observation, run for social workers and teachers. It was during this period of early enthusiasm that Dr Margaret Lowenfeld established in 1928 the Children's Clinic for the Treatment and Study of Nervous and Delicate Children:

> Here Lowenfeld's wartime experience and research observations had already led her into the belief that, in addition to environmental considerations, there were processes inherent in children themselves which would enable them to find more adaptive solutions. For Lowenfeld the key to these possibilities was play.
>
> (Urwin and Hood-Williams 1988: 42–3)

This developed in 1931 into a one-year training course and, in 1935, into a three-year 'training in psychopathology and psychotherapy with children and leading to a diploma' (ibid.: 89). The first child psychotherapy training was thus established at Lowenfeld's Institute of Child Psychology.

Melanie Klein's move to England in 1926 greatly influenced the British psychoanalytic world not only through her theoretical exploration of the internal world of the infant and the very early mother–infant relationship but through her practice of child psychoanalysis and her belief in the availability of very young children to psychoanalysis through the analytic play technique that she developed (Klein 1955). Klein's influence led the Psychoanalytic Society to develop its own criteria for training in child analysis, beginning with the supervised analysis of two adult patients, and followed by supervised work with a pre-latency, a latency and an adolescent, all while the candidate was in full analysis.

Notable at this time was the work in applied psychoanalysis undertaken in Vienna by Anna Freud, Sigmund Freud's daughter, and colleagues: the establishment of the Jackson Day Nursery (forerunner of the Hampstead War Nurseries) and the use of systematic, detailed observation of children; two child guidance clinics in Vienna for children and for adolescents; work with Aichhorn on juvenile delinquency; the establishment of a school, run by Eva Rosenfeld, to give disturbed children an appropriate learning environment; lectures for teachers and the development of a growing relationship between teaching and psychoanalysis.

The final scene in the pre-war setting for post-war developments in child psychotherapy, therefore, was that of the Freud family's arrival in London in 1938. Daws gives a singular insight: 'It is characteristic of Anna Freud's

directness and the practicality of her interest in children that her luggage included 10 little stretcher beds – a foreshadow of the War Nursery she later helped create' (Daws 1987).

Anna Freud and Melanie Klein, as psychoanalysts, provided a rare combination of the close observation of children with psychoanalytic theory. Despite important theoretical differences, harshly disputed in the Psychoanalytic Society's 'Controversial Discussions' (King and Steiner 1991), these two principles remained central in the development of that application of psychoanalysis which was child psychotherapy.

Multiple influences arose from the experiences of the Second World War: evacuation of children which, for the first time, probably alerted the middle classes to the conditions of the poor and especially of the inner-city child; loss of parents in war; the work of John Bowlby on maternal deprivation and on separation, foreshadowing his thesis on attachment (Bowlby 1969); an Army Medical Corps, influenced by leadership from the Tavistock Clinic, taking seriously issues of war neurosis, mental health and trauma; and the influence of the child guidance movement on the establishment of the National Association for Mental Health. Together with the climate of change heralded by the Beveridge Report and the advent of the Welfare State, it seemed an atmosphere in which development could be nurtured.

In 1947 Anna Freud established at the Hampstead Clinic (now the Anna Freud Centre) a child psychoanalytic training based on her approach and accepting lay and analyst candidates. The following year the Tavistock, where John Bowlby was Director of the Children's Department, instituted a psychotherapy training under the joint auspices of Bowlby and Esther Bick (who developed the Infant-Observation model that was to become a central part of all analytic trainings (Bick 1964)). Doris Wills has described the processes leading up to the establishment of the Association of Child Psychotherapists (Wills 1954, 1978) – initially the Provisional Association of Child Psychotherapists (non-medical) – and the essential involvement and support of John Bowlby, Ethel Dukes (a colleague of Lowenfeld), Margaret Lowenfeld, Kenneth Soddy and Donald Winnicott who helped draft standards and engaged in successful negotiation. In 1949 the Association of Child Psychotherapists (ACP) was born.

Although many graduates of the ICP (Institute of Child Psychology) had Jungian analyses, it was not until the late 1950s that the first moves towards a Jungian child training began at the Society of Analytical Psychology (SAP) in London, under the guidance of Michael Fordham. Davidson (1996) gives a personal insight into this process, which culminated in the arrival of the first trainees in 1974, and: 'In 1979 the training was finally granted accreditation and our members were entitled to membership of the ACP' (Davidson 1996: 45).

The contribution of Michael Fordham to work with children is, for a profession where theoretical differences can sometimes assume large dimensions, both an immense and an integrative one. Astor writes:

> His innovative researches into childhood gave a genetic basis to Jung's ideas about the importance of the self as both an organizing centre and the thing being organized within the personality. He connected it both to Jung's work on the self in the second half of life and to emotional development as described by psychoanalysts (the depressive position), while making clear what was distinctive about his 'Jungian model'.
>
> (Astor 1996)

In the 1980s and 1990s three further training schools were established and gained accreditation from the ACP. The London-based British Association of Psychotherapists, established in 1951 and training psychoanalytic psychotherapists and Jungian analysts in work with adults, set up a child and adolescent training in 1982. The theoretical emphasis is that of the Independent Group in psychoanalysis (Kohon 1986), an object-relations-based training. The Scottish Institute of Human Relations runs a training in Edinburgh and Glasgow, although trainees come from all over Scotland and the north of England. The Birmingham Trust for Psychoanalytic Psychotherapy training marked a further welcome development in the establishment of training courses beyond the London nucleus, and in the new century, the arrival of the Northern School, Yorkshire based, provided a most welcome northerly extension of training and provision of child psychotherapy.

All schools run introductory courses in observational studies at Masters level for a range of participants from a wide variety of professional backgrounds; and many are involved in trainings abroad. The clinical doctorate is becoming established as the baseline qualification for the clinician and all training schools are linked to university departments for research and accreditation. Moreover, there has been an explosion of Psychoanalytic Studies – university level courses at undergraduate and post-graduate level – indicative of increased interest amongst the general public and often with child psychotherapists on the academic staff.

The role of the ACP today, in setting standards for the profession, in accrediting and reviewing trainings, in appointing assessors for interviews for Child Psychotherapy posts, in acting on behalf of the Department of Health in assessing the qualifications, for work in the UK, of EU nationals, has expanded greatly since the inception in 1949 of the Provisional Association of Child Psychotherapists (non-medical). In addition, its committees have been greatly involved in educating service commissioners and funders as to the reality of the role and impact of psychotherapists within the public sector. Robust participation in forums responding to governmental initiatives – ways of working, training escalators, protocols and standards for CAMHS work – takes up a great deal of time and has necessarily made many members into political as well as clinical animals. Some of the current pressures of work in a changing NHS are outlined by Gabrielle Crockatt in Chapter 7.

The demise of the ICP as a training school in 1978 followed the closure for economic reasons of its clinic, and the decision of the ICP in 1948 not to become part of the then fledgling NHS must have played a role in this. (One recalls John Bowlby's prescience in insisting that the Tavistock training be from its inception within the new National Health Service.) Other UK schools are similarly vulnerable: recently two London trainings have suffered – the SAP and the Anna Freud Centre, although the latter has recently announced that its future focus will be on purely analytic rather than psychotherapy training. It is also part of the ACP's brief to balance and promote claims for access to NHS monies (where there be any) by schools not in the NHS network, a role that is essential if diversity of theoretical perspective is to be sustained.

## Training

The content of present-day training has built on the base of the original trainings but there now is a growing and wider body of theory and research information, tremendous expansion in child development, attachment and neuroscience theory, greater variety in individual children helped, and a broader experience of different ways of working within the multi-professional team and beyond the clinic.

The core of training remains fourfold:

- personal psychoanalysis (preferably four- to five-times weekly)
- psychoanalytic theory, research and practice
- training in Child Development and Parent–Infant Observation
- clinical work under supervision.

All trainees are required to be in four- or five-times weekly personal psychoanalysis, although this may exceptionally be three-times weekly where there are access/geographical pressures. The ACP regulates strictly the qualifications required of those who become training analysts. 'This is an essential and central requirement of training' (ACP 1998). Such a requirement is not, simplistically, to give an experience of analysis and 'being a patient': it is vital that the child psychotherapist explores his or her own unconscious motivations, defences and anxieties and is as 'grounded' as possible before engaging with the inner world of children. The trainee is in analysis throughout training and most continue after qualification. Such requirement was first agreed at the Budapest Congress of the International Psychoanalytical Association in 1918 (King and Steiner 1991: 14).

For trainees who enter training without adult mental health experience, a supervised placement is required. Trainees should be aware of adult psychopathology, of the roots of that in childhood, and of the particular predicament of the child with a mentally ill parent.

All trainees have undertaken a Parent–Infant Observation, usually during the pre-clinical Masters course. A newborn infant and carer are visited for an hour a week for a two-year period. The trainee records these observations, bringing the recordings to a weekly seminar group (no more than five members, to allow frequent discussion and presentation) where an experienced seminar leader enables the group exploration of the material. A pass in the final written paper is essential. The importance of this cannot be stressed too highly: it marks the development of skills in close, detailed observation that will be necessary professionally, and begins the integration of child development theory and psychoanalytic theory into a framework combining what is observed, what one knows and what one thinks. Bick, who established the approach, describes the development of this part of training (Bick 1964) and it is now a feature of all child psychoanalytic trainings in this country. For a fuller view, the reader is directed to Miller *et al*. (1989) and Sternberg (2005). In addition, the sustained observation of young children is also a requirement.

Throughout training, trainees attend both theoretical and clinical seminars. Areas to be covered include:

- human growth and development (including non-psychoanalytic perspectives and particularly including developmental psychology and attachment theory)
- developmental disturbance and psychopathology
- psychodynamic theories (each school will differ in emphasis, according to its theoretical stance, but 'this should be set in the context of other theories' (ACP 1998))
- psychotherapeutic techniques
- the range of treatment techniques is taught and trainees are encouraged to explore other approaches
- research methodology and practice.

In their clinical settings, trainees must see at least three intensive (*at least* three-times weekly) cases under weekly supervision by an approved supervisor. These are an under-five-year-old, a latency (primary school age) child and an adolescent, and the group must include both boys and girls. At least one must be in therapy for not less than two years and the others for a minimum of one year. Additionally, at least six children and young people must be seen once or twice weekly on a long-term basis for which the trainee is offered regular supervision. These should include a range of presenting clinical problems, levels of disturbance, ages and both sexes. Instead of a non-intensive case a trainee may substitute running a children's group, treat a mother and young child on a long-term basis, participate in longer-term family therapy or undertake some time-limited treatments.

Trainees also undertake weekly work with the parent(s)/carer of a child in therapy with another psychotherapist: this is not adult psychotherapy but

aims to hold the child in mind and address the parents as carers of the child. An assessed report is written on this work. Assessments are also undertaken, both with the trainee as colleague contributing to a multi-professional diagnostic and assessment process and with the aim of making appropriate recommendations to the team, parents or outside agencies. Joint working as a member of the multi-disciplinary team is of course a prerequisite in the training. In their work settings, trainees are expected to learn the structure and management of the NHS (especially as it operates in that workplace), current legislation and child protection procedures, and to keep appropriate records and write appropriate reports. These structures are taught by the training schools but local systems differ.

Towards the end of their training, trainees will explore aspects of brief and time-limited work, family work, group work and parent–infant counselling. 'Trainees need to have knowledge of the variety of settings across health, education, social service and forensic provision within which children and young people are at higher risk of mental ill health. These include paediatric wards, child development centres, residential children's homes, special schools and off site educational units and young offender units. Training Schools and work placements should liaise together to ensure that such knowledge is provided' (ACP 2007). Consultation to other institutions and other professionals working with children and young people is also required experience. Such applications of psychoanalytic understanding are essential.

Such an intensive training requires four years to complete. It is also expensive, the main cost being the personal psychoanalysis. A major achievement since the appearance of the first edition of this volume has been the establishment in many clinics of trainee posts where training fees are paid and a significant contribution is made towards the cost of analysis and the three intensive case supervisions. Although not every candidate can succeed in gaining such a post, their numbers have grown significantly. Some posts are directly linked to training schools jointly with clinics; others are open to competition from trainees of any school.

Post qualification expectations are also high. The ACP recommends further training in:

- the dynamics of groups and institutions
- teaching courses to other professionals and caregivers
- understanding other forms of treatment, e.g. cognitive and behavioural methods, family therapy, medication
- experience of consultation to other professionals
  (ACP 2007 paragraph 3.54).

The ACP has established a Code of Ethics. Concerns about the practice of any child psychotherapist are referred to the Ethics Committee of the ACP.

## A note on confidentiality

At the very heart of any therapeutic contact is the need to protect the privacy of the client – adult or child. When working with an adult, the boundaries of privacy are usually fairly straightforward as contact between the therapist and other people in the patient's life is likely to be minimal. However, with children, there is often an equally important need for the therapist to be in regular contact with the key adults in the child's life – parents and foster parents in particular, but also teachers, social workers, residential workers and medical staff. In practice, issues of confidentiality are worked out within the guidelines of the Code of Ethics of the profession for each child who is seen, as appropriate. The complexity of therapeutic work with children means that a flexible balance has to be found between the child's need for confidentiality and the need to communicate helpfully with the child's parents, carers, family, and the multi-professional team.

The experience of a private and protected therapeutic space is so central to the child and adolescent psychotherapist's work that the question of how to write publicly without compromising this privacy raises many issues. As with any other profession that needs an ever-evolving theoretical and experiential base, we have to share our clinical experience with each other and outside the profession if we are not to become moribund. The problem is how best to achieve this without sacrificing our relationship with our patients.

Some case illustrations will have been disguised. It is always tricky to know how much one can do this before it begins to sound unconvincing. Some of the children and families discussed in this handbook will have been directly approached by their therapists asking for permission to write about their treatment; some therapists ask for permission to use disguised material for teaching or publication at the outset of treatment. This request is made in the spirit of advancing knowledge, training and practice, so that, should it be helpful to share what has been learned from a particular treatment, permission has been given.

The way in which the rich variety of clinical examples throughout this handbook brings the work alive is perhaps the best testimony to the value of grappling with such issues. As editors, we have found it a pleasure and a privilege to collate this overview of the profession of child and adolescent psychotherapy.

## Concluding introductory thoughts

The following chapters will speak eloquently for themselves. We are grateful to the colleagues who took time to elaborate their work and its meaning. The wider benefit is best described below:

> We do not need only specialist services. We need a framework for understanding extreme emotions – love, hate, jealousy, envy, destructiveness. This is something that psychoanalysis can provide. It also helps us understand how these emotions come to be violently evoked and enacted and how they can be modified and channelled more constructively. We believe that psychoanalysis can function as a shared framework of understanding between professionals from a variety of disciplines, even if they are not using it as a therapeutic tool.
>
> (Trowell and Bower 1995: 4)

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# Part I

# Theoretical foundations

# 2 The roots of child and adolescent psychotherapy in psychoanalysis

*Meira Likierman and Elizabeth Urban*

This chapter provides a brief historical overview of psychoanalysis, the body of thought that underpins the practice of child psychotherapy and that equally informs a wide range of therapies that are practised today.

Psychoanalysis is a clinical and theoretical discipline that is only a century old and yet has accumulated a body of knowledge that is substantial and complex. Having started as a single theory, it has branched out into several substantial schools of thought around the world, each with its distinctive culture, training institutions, favoured techniques and theoretical contributions. Whilst traditionally these schools have competed for a monopoly on the 'truth' about mental life, many contemporary psychoanalysts are able to sustain a pluralist position whereby they accommodate a theoretical diversity in their clinical approach.

Psychoanalysis began with the efforts of Sigmund Freud shortly after he completed his medical training in Vienna in 1885. Before deciding on the area in which he should specialise, Freud obtained work experience in Paris under the tutoring of Jean Martin Charcot who was making groundbreaking discoveries in the treatment of hysteria.

Hysteria was a major public health concern throughout the nineteenth century, afflicting women with symptoms such as paralysis of the limbs or loss of vital functions such as sight or speech. The symptoms would strike suddenly and would typically baffle medical experts, which even led some to dismiss it as no more than a female excuse for opting out of responsibilities.

Charcot was among the progressive medical scientists who viewed the condition as a genuine neurological disorder and, while he assumed that it indicated a degeneration of the nervous system, he also hypothesised a possible traumatic trigger for it in the patient's life circumstance. In order to substantiate this, Charcot began to hypnotise hysterical patients, managing to demonstrate that in an altered state of mind some of their symptoms could vanish.

Freud was impressed by witnessing these experiments at first hand and, furthermore, had an immediate intuition of the implications of what he saw. If indeed ideas had agency and could affect the body to such a degree, then

there was a whole region of human experience, which was as yet undiscovered, as were the scientific principles that governed it.

Freud returned to Vienna to set up his own practice for nervous disorders. He continued to hypnotise his patients, trying to use this as a means of uncovering the possible traumatic triggers of their condition. Hypnosis, however, proved too clumsy a method for eliciting the detailed information that Freud soon found he required. He gave it up for a new method of introspection that he taught his patients – free-association. He asked his patients to follow their natural train of thought using as guidance their spontaneous associations. They were to relinquish the normal self-critical standard of their speech and to narrate to him in full what their minds led them to, whether this seemed trivial, irrational, rude, embarrassing or otherwise.

His patients had some success with this method. Furthermore, the narratives that emerged from their attempts to disclose thoughts without self-censorship uncovered a hidden world of human mental activity. This was governed by secret desires and urges that often conflicted with the patient's self-approval. The method of free-association revealed that one's everyday mind, far from being occupied mainly with intellectual content, was close to the life of the body with its primitive pleasures and urges. Patients often felt at odds with their intimate bodily states and found the force of their raw sexuality obtrusive and threatening. The result was a distressing psychological conflict which patients tried to end by fending off unacceptable ideation.

Their unease led Freud to what he thought was his first clinical discovery, for he assumed that it pointed to the traumatic trigger of hysteria hypothesised by Charcot. Thus in his first theoretical model Freud suggested that the trauma at the root of hysteria was a sexual one and that his patients had all been the victims of childhood sexual abuse. The reason that his patients could not tell him this directly was that their minds had never been able to assimilate the traumatic event and store it as an ordinary memory. The patient 'forgot' or repressed the event without dealing with its forceful impact. Unbearable traumatic tension thus remained trapped within the patient, and this now found an outlet via neural pathways into the body – hence extreme physical symptoms.

It did not occur to Freud at this early stage that human subjective experience was, in itself, a worthwhile object of study. He regarded his work as essentially medical, hoping to demonstrate the organic processes at the root of nervous illness. He believed that neurological psychic energy, though still not fully understood, justified attempts at a scientific quantification and investigation.

However, psychoanalysis was to take a different turn from a purely neurophysiological direction, and this coincided with a change of mind in Freud about his 'seduction theory' that attributed all neurotic illness to childhood sexual abuse. This theoretical revision resulted from his new and

hitherto most ambitious project of research. Freud decided to put his method of free-associations to a rigorous test via an analysis of his own mental life, specifically an area of it that seemed the most free of his conscious control – his dreams. Since he did not suffer from a major nervous disorder he was not expecting to discover a trauma in his own background, but what he did discover surprised him.

His dream material revealed to him the almost equally powerful impact of apparently ordinary life frustrations. Each night his dreams resurrected fragments of the previous day, which were connected with areas of failures, anxieties, disappointments and hurts. His frustrated professional ambitions, his envy of successful colleagues, his anxiety about promotion, his small jealousies of his wife and his pain when he thought she was slighting him, all surfaced again at night, but not as he had actually experienced them. Rather, his dreaming mind transformed the reality of his daily lacks, made good his frustrations and presented to him his wishes as fulfilled.

Freud was struck by how insistently his mind wished to compensate him for the frustrations of living. Further exploration led him to realise that ordinary daily disappointments had accrued a traumatic-like force because they were underpinned by hurts that had accumulated over an extended period, dating all the way to childhood. The sorrows and resentments of childhood lived on in his unconscious, infusing each new disappointment in his life and influencing his mental well-being.

In this new understanding, the helplessness of the human child with its unfulfilled needs itself seemed traumatic, and this led Freud to realise that the needs and wishes of the child were far more acute than had been suspected. The childhood memories that linked with his dreams revealed that, far from desiring a simple care regime, the child has powerful cravings for love and physical pleasure, as well as an intense primitive sexuality. Freud thus realised that it was not necessarily actual sexual abuse that had been at the root of his patients' disturbances. Nervous illness was not a sudden phenomenon with a single traumatic cause, but a condition that developed over time and was intimately bound up with the life history of the human individual. It seemed to Freud that the most delicate and formative area in this history was childhood, dominated as it was by the unruly forces of infantile sexuality.

It was thus that Freud reached one of his theoretical milestones, which was his theory of infantile sexuality. Along with this achievement, Freud's exploration of his dream life had a further crucial outcome, and this was an updated and newly understood version of the unconscious mind. Freud had made use of the term 'unconscious' from the very beginning of his psychological researches, but did so initially in a purely descriptive sense. In other words, he used the term as an all-purpose label for a range of mental states in which the individual was not aware of certain ideation. This now seemed too superficial to Freud. His dream life had just provided a 'royal road to the unconscious', suggesting to him that it was far more

useful to view the unconscious as a separate mental system which was subject to its own, distinct patterns of logic, and which had a complex relationship with the very different system of consciousness.

Freud noted that the dreaming mind offered a first-hand knowledge of unconscious processes because its activity was not restricted to a mere gathering and reproducing of portions of reality from the preceding 'dream day'. Rather, the dreaming mind subjected such portions to alterations which followed typical patterns; unconscious activity either condensed disparate fragments of reality so as to create multiply determined symbols, or else it did the opposite, breaking apart what should have remained together, for example, by shifting the appropriate feeling stirred by an event to a trivial substitute. It is thus that an individual can dream of the death of a loved one without feeling appropriate grief, or that the person who appears to us in a dream is often a condensed creation which combines features drawn variously from family members, friends, colleagues, each selected because it contributes to the symbolic meaning of the dream.

Freud reasoned that such manipulations of the truth had a function, which was to enable the nightly processing of those of the day's thoughts which had been too unbearable to own during waking hours. The sleeping mind used stratagems to conceal the full impact of the meaning which it was addressing so as not to raise levels of anxiety and awaken the individual. The very intricacy of the mind's stratagems led Freud to realise that unconscious content causes anxiety precisely because, once repressed, it refuses to lie still and continues to press for discharge. Unconscious wishes continually press to reach the conscious mind, which alone commands the body's movements and thus the route to need-fulfilling action.

These insights led Freud to further realisations. Whilst awake, the mind was surely equally under a continual pressure from unconscious impulses. And even when this does not result in neurotic symptoms, repressed unconscious impulses keep returning to hound consciousness in various large and small ways. Freud was to explore how this happens in our everyday life, manifesting as slips of the tongue or built into the comic moment in jokes. These explorations highlighted for Freud the need to discover why the human mind needs to repress wishes to such an extent, and he found the answer in his conception of infantile sexuality.

Childhood sexuality was not a new idea in the late nineteenth century, but Freud's originality consisted in his ability to draw on pre-existing theories and integrate them in a unique way with his own findings. This culminated in a groundbreaking theory of psychosexual development that accounted both for normal development and for neurotic illness.

In this vision, childhood psychosexual development was posited as the biological underpinning of human mental development. Freud described the infant as bringing with it into the world elemental aspects of its sexuality which infuse every facet of its existence. Sensations, sights, smells, tastes and sounds all carry some sexual charge with a potential for

excitation and arousal. Of particular intensity are sensations in the body orifices of mouth and anus where the internal membranes are sensitive, hence becoming focal sexual centres.

As the infant develops and its experiences cohere, the still immature components of its sexuality find a more intensified expression. Since the small child is not self-conscious or ashamed, it expresses its developing sexual trends uninhibitedly in its family circle, much like an adult afflicted with perversions. For example, in its normal daily routine the child derives sexual pleasure from activities that variously enable elements of voyeuristic, exhibitionistic, fetishistic, sadistic or masochistic excitement. Its oral and anal experiences mingle with these to create particular 'pre-genital' configurations of sexuality.

In this thinking Freud's interest shifted to an 'instinct theory' in which sexual instincts underpinned human urges and were the prime motivational energies in mental life. Freud felt that normal development requires a gradual subsuming of infantile sexuality with its 'perversions' in a normal reproductive adult sexuality, leaving only symbolic traces in the sexual activities of fore-pleasure. But if this process is disrupted for some reason, the child becomes fixated to a particular primitive sexual urge in a damaging way. This results in later pathology, with the individual taking the path either of perversion or else of neurosis, depending on whether the fixated sexual activity is retained in its explicit, primitive form, or whether it is repressed at the cost of developing symptoms.

Tying the theory of mental development to biological sexuality seemed promising, as it appeared to ground psychoanalysis in an established branch of science. However, one aspect of Freud's thinking on infantile sexuality intruded on this purely scientific aspiration, inserting the perplexing topic of human subjectivity into an otherwise watertight biological theory. This aspect was Freud's (now widely familiar) concept of the Oedipus complex. It was this concept that obliged Freud to recognise that biology, along with the mental life, which it underpins, does not take place in a vacuum. Human sexuality and its instincts are inseparable through their very aims from interactions with others, initially caregivers and eventually sexual partners. The social behaviours of seeking, and interacting with, love objects are inherent in psychosexual development.

Taking the male child as an example (but suggesting an analogous female experience), Freud delineated an intimate psychosexual bond with the mother from the time of conception. The mother not only carries the foetus in her body and feeds the newborn from her body, but also continues, through her physical proximity, to cater to basic infantile needs. She is thus the natural recipient of her infant's nascent sexuality. By the time the boy develops into a small child, his primitive component instincts give way to a new focus of pleasure, which is his penis. But the boy is not mature enough to understand the significance of this event. Since his mother has always looked after all his bodily and emotional needs, and

apparently regards herself as responsible for satisfying these, he assumes that she will similarly continue to be responsible for satisfying his growing genital desires.

Normally the boy's open expression of desire meets with disapproval in the family. Not only are his attempts to induce his mother to witness or touch his genitalia rebuffed, but he is now cognitively mature enough to make sense of her disapproval. His growing awareness has bred in him self-consciousness, enabling him to experience shame, disgust and guilt for the first time in his life. As well as this, the boy is much more perceptive in registering obstacles to his desires. He realises that the genital pleasure refused to him by his mother is nonetheless awarded to his father. In referring to this stage in life Freud did not use the term 'complex' lightly. He realised that it raised emotional storms of desire, pain and rage that lead to extreme conflicts between love and hate in the boy. It thus amounts to the first life crisis or infantile neurosis.

Freud suggested that, as with earlier stages of infantile sexuality, the Oedipus complex needs to be outgrown. However, this event is a developmentally complex task. It is not enough for the boy to surrender his desires uncomprehendingly, as this only leaves him feeling defeated and 'castrated'. A genuine resolution requires a fundamental psychical change which expands the boy's mental horizons, enabling an altered and developmentally broadened perspective on his situation.

Freud visualised this psychical change in structural terms. The mind acquires a new and qualitatively distinct extension, and this happens when the child absorbs into itself aspects of parental authority. These are internalised to create an intra-psychic agency of a 'super-ego', enabling the boy to find a more mature perspective on the procreative sexual roles of his parents. The boy identifies with this newly understood family structure, internalises parental values and instates his father in his mind as a role model which points the way to his own future sexual aspirations.

In his last 'structural model' Freud put much more emphasis on mental life as the product of subjective human experience – that is, of the child's mode of interacting with its caregivers and family. However, Freud also wanted his structural model to absorb his lifelong scientific interest in instinctual energies that propel the human organism. He thus hypothesised a tripartite structural model which accommodated a 'super-ego' internalised from the external world, an 'id' which consists of raw instinctual activity, and an 'ego' – the mind's central organising agency which mediates between the id and the super-ego (instincts and the world), thus negotiating an optimal developmental route for a growing 'self'.

## From Freud to ego psychology and object relations

Freud's final theory attempted to bring into dialogue two aspects of his own thinking – his scientific concern with the organic, biological energies that

propel the individual from within, and his humanistic concern with subjective, narrative meaning that emerges from the individual's relationship with his human environment.

This synthesis was not straightforward, at least not in the sense of bequeathing to the psychoanalytic movement a single theory that could be agreed upon. Freud's followers found it easier to focus on partial aspects of his structural model, giving prominence either to its interpersonal aspect as exemplified in the relationship of ego and super-ego, or else to its biological-instinctual aspect as exemplified in the relationship of ego and id. One crucial result for psychoanalysis was a cleavage between an 'object relations' school favoured in Britain and an 'ego-psychology' school favoured in North America.

Two thinkers who were instrumental in influencing this division were the pioneers of child psychoanalysis, Anna Freud and Melanie Klein. It is important to stress that neither saw herself as dispensing with Freud's tripartite structural model. Their differences emerge from subtle but crucial shifts in emphasis onto different aspects of it.

### *Anna Freud*

Anna Freud focused on the id–ego aspect of the model, exploring the effects of instinctual pressures on the ego's development. She realised that the ego is unlikely to fend off id impulses in simple, easily distinguishable ways. Rather, defences infuse the ego's entire mode of functioning and are integrated into its very life. Whilst the ego's healthy survival does indeed depend on its ability to master turbulent id functioning, if defences are too entrenched in the ego's habits, instinctual impulses are stifled rather than processed and mastered, hence continuing to overwhelm the individual with pathological manifestations.

Anna Freud's thinking led to emphasis on the ego's complex tasks in its move towards an adaptation to reality, and this theme was taken much further by an 'ego-psychology' school which included among its thinkers Ernest Kris, Edith Jacobson and Heinz Hartmann. A further dimension of Anna Freud's influence was evident in the work of Margaret Mahler, who demonstrated how the complex task of separating from the mother and loosening the most primitive psychical ties with her paved the way to ego autonomy and a coherent sense of self.

### *Melanie Klein*

Unlike Anna Freud, Melanie Klein explored the interpersonal aspect of the structural model. She believed that it was not helpful to view the super-ego as a mere conceptual abstraction because its internalisation is experienced subjectively in a highly anthropomorphic manner. Contradicting Freud,

Klein suggested that the infant could relate to its mother from birth, even though it possesses only a rudimentary capacity to apprehend aspects of her nurturing. However, these are qualitatively distinguished as 'good' or 'bad' and internalised as archaic 'part-objects'. An archaic phantasy life thus emerges in the infant, infusing its perceptions of, and interactions with, caregivers. Growth and cognitive development enable the child to internalise increasingly understood, realistic objects which complete and refine its formerly internalised primitive ones.

Klein felt that the internal world created through these processes is the key to mental health, provided that it isn't populated with disturbing, persecuting objects but is, rather, a domain in which objects emit benevolence and continually infuse the personality with warmth and security.

### *Divergences between Anna Freud and Melanie Klein*

Anna Freud and Melanie Klein proceeded from the same significant starting point, which was their study and treatment of children. And since this was a new field of enquiry, its principles needed to be established even as it was being used as a research tool. It was thus that they both became engaged in pioneering a psychoanalysis for children, and at the same time utilised this process to investigate and discover the nature of earliest mental life. Yet theirs was not a joint venture; quite the contrary, they did not perceive any complementarity in their respective findings and conclusions, and in fact engaged in a lifelong professional debate.

Melanie Klein's belief that the infant relates to others from the beginning of life required her to assert that an ego exists from birth. Although she felt that the infantile ego was not unified or coherent, she nonetheless assumed that it could carry out a few essential operations such as a limited registering of reality, an ability to welcome or fear its impact and also an ability to defend against this. Such thinking led her to conceive of an array of archaic defence mechanisms and, in a further controversial step, to link these to the kinds of defences employed in adult schizophrenic and manic-depressive disorders. This threw light on the infantile origin of adult mental illness, but it also portrayed early ego activity as strangely destructive to the very process of growth which it was supposed to promote.

Anna Freud felt that such thinking was negative and also that it attributed too much complexity to the early psyche. Like her father, she continued to believe that the infant is unlikely to arrive in the world with a psyche that is sufficiently formed to possess a clearly differentiated entity such as the ego. The infant's post-natal existence amounted to an undifferentiated, foetal-like state of 'primary narcissism', and he only emerged from this gradually and in response to environmental impingements. In this view, identity and mental structure were shaped during the process of early acculturation, and were thus constructs which did not exist outside of this process. Anna Freud suggested that in keeping with this, defence mechanisms develop

later and express a broader and more diverse relational repertoire than that expressed by the limited archaic defences which Klein envisaged.

Anna Freud and Melanie Klein might have continued to develop their views separately and to have their thinking go by unchallenged were it not for circumstances which brought them into the same professional organisation. The war in Europe obliged them to settle in London and join the British Psychoanalytic Society, where it was difficult to find a mode of professional co-existence. This was to lead, in 1941, to a theoretical confrontation between the two of them which was popularly referred to as the 'controversial discussions', and which also drew the entire British Society into a debate on early mental life and the origins of the psyche. In spite of the discussions being careful and lengthy, no consensus was reached and members of the British Society were obliged to accommodate a greater diversity. This gave rise to three schools of thought, since to the classical Freudian group were now added a Kleinian and a further 'Independent' group. It was this last which provided the foundation for a distinct British object relations school, the members of which chose to draw on the thinking of both Anna Freud and Melanie Klein, and to add further original discoveries to this mixture.

### *Object relations theorists*

Klein's theories gave rise to an 'object relations' school, which included among its thinkers Donald Winnicott, Michael Balint, Ronald Fairbairn and Wilfred Bion. However, while these thinkers agreed with Klein on the activities of the early ego, they also, unlike Klein, and with an awareness of Anna Freud's insights, emphasised the utter helplessness of this ego in the absence of external support from the mother. Winnicott noted that, viewed philosophically, the newborn's ego exists only in a potential sense, since it is activated and brought into being only in the context, and through the agency, of maternal handling.

In spite of areas of disagreement, the object relations group which Klein inspired were at one with her on a crucially significant issue. They underscored the fragility of the newborn psyche at moments of distress, and outlined a range of archaic defensive manoeuvres which it employs to break down and disperse portions of disturbing reality that impinge on it. Bion, for example, pointed out that repeated and excessive deflections of reality can damage an individual's capacity to absorb and process experiences and hence to mature mentally. Anna Freud and her followers were sceptical about the suggestion of a very early onset of defence mechanisms, but they did agree that defensive functioning begins in childhood and should be explored with the child where appropriate.

With this thinking Melanie Klein, Anna Freud, and the schools which they inspired, made a unique mark not only on psychoanalysis, but also on the broader canvas of twentieth-century thinking. Their legacy is evident in

the degree of sensitivity which our culture, to this day, considers as appropriate for infants.

While Anna Freud and Melanie Klein exemplify some of the ways in which creative thinking extended and refined the foundation provided by Freud, it is important to remember that psychoanalysis had other important strands which enriched it and which therefore need to be taken into account.

## Fordham and the influence of Jung

Another major contributor to child analysis was Michael Fordham. Although he drew upon Freud and Klein, his central concepts were derived from Carl Jung.

Jung was a young Swiss psychiatrist when his studies at the Burghölzli Hospital led him into an intense collaboration with Freud lasting six years. From the outset there were theoretical differences between them. Jung had held that the energy of libido was neutral, rather than exclusively sexual. Added to this, Jung thought that psychic contents included not only repressed sexual wishes, but also an innate psychic endowment, which he called 'archetypes'. Archetypes are organising structures, expressed in typical and universal themes across time and cultures, such as those found in rituals, myths and religions. He studied archetypal themes in the material of his patients, expanding his investigations by examining analogies between various cultures and religions throughout history.

When the split with Freud came in 1913, Jung was deeply affected. He gradually recovered and each morning sketched formalised circular patterns, or mandalas, which he found containing. He came to see this series of drawings as a reflection of psychic changes from day to day within the conscious and unconscious whole of himself; changing over time yet having continuity within an overall totality. He considered the mandala to be an archetypal symbol of the totality of the personality, which he conceptualised as the 'self'. For Jung the self had a centralising, organising and integrating function, thus making the self similar to Freud's notion of the ego. However, Jung's concept goes beyond this. For Jung the self is the organisational centre of the whole personality, of which the ego, the perceptual centre, is only a part; a secondary, although important, organiser.

Jung's ideas arose from experiences with adults, and it was Fordham, a London child psychiatrist, who was the first to extend Jungian thinking to childhood by integrating archetypal theory with clinical and observational experiences of children. Fordham entered child psychiatry a year after Klein published *The Psychoanalysis of Children* (1932), and just as he was coming to appreciate Jung's ideas. Fordham soon began to discern archetypal elements in children's clinical material. Recognising that unconscious phantasies were conceptually identical to primitive archetypal images, he

readily linked Jung's theory of the psyche with Klein's description of the infant's inner world. Fordham borrowed Klein's technical handling of material, which enabled him to enter more fully into the psychic lives of children.

Through work with some very young children, Fordham noted that their circular scribbles (mandalas) accompanied episodes of ego growth. He sensed that a more fundamental organiser lay behind these developments, which drew his attention to Jung's concept of the self. Out of this Fordham postulated a primary self, conceived as a psychosomatic integrate evident from before birth. Hence, in contrast to Winnicott, Fordham concluded that the infant's first state is one of integration rather than unintegration.

Conceptually the primary self represents the psychosomatic whole of the organism and its potential. The potential unfolds through the complementary processes of deintegration and reintegration, lifelong processes that involve coming into relation with the environment and then assimilating these experiences. These processes are structured by the self, which organises them in distinctively human, archetypal ways, such as the universal, over-arching patterning and timing of the unfolding of infancy, Oedipal development and adolescence. The mental contents that are built up do not simply represent external experiences that are internalised. They also are influenced by the self, which organises reintegrated contents, for instance, into good and bad objects.

The purpose of Fordham's postulate was to account for the global organisation of the infant, conveying his view that even a very young infant, or, as later became clear, a foetus, is not in an overall sense disorganised, unintegrated or disintegrated, but functions as a whole. His model formulates a self that is not constructed by the infant, but is, rather, the starting point of development. This notion of the self is more comprehensive and extensive than that in psychoanalysis, which tends to refer to the sense of self. Despite this difference, Fordham's work brought archetypal theory much closer to the instinctual phenomena as understood by psychoanalysts, especially Klein and her followers. Fordham also turned to Klein for a more precise understanding of the primitive processes, like projective and introjective identification, which are elements of early de- and reintegration. For instance, autistic children have serious impairments to deintegration and those with 'no-entry defences' have impairments to reintegration.

What Anna Freud, Klein, Fordham, and the schools which they inspired, all had in common was a strong belief in the importance of the child's imaginative life as developed in the matrix of family relationships and as expressed symbolically through play. Understanding how play could be used clinically took time to develop. Freud had indirectly treated a five-year-old, 'Little Hans', through the boy's father, and Jung wrote a paper concerning observations of his daughter. Other early psychoanalytic practitioners had attempted some direct work with children, but it was Klein

who worked out a technique that combined the rigorous technical tools in work with adults with the child's natural expression in play. This technical development proved an effective way of reaching the child's unconscious, and others, like Winnicott and Fordham, drew upon this. Thus play, as the crucial idiom of childhood, remains the medium through which child analytic therapy is conducted.

## Conclusions

To conclude, divergences between the psychoanalytic schools described in this chapter have produced conflicts but have also been advantageous, as they have led to the development of psychoanalytic theory through the collective effort of gifted practitioners.

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# 3 Normal emotional development

*Ann Horne*

## Introduction and context

Child and adolescent psychotherapists are constantly aware of the developmental processes at work – or obscured and obstructed – in the children and young people whom they see. In simple terms, the normal capacity of the child to adapt to and embrace growth and change, both physically and emotionally, is an ally of the therapist. Given that our caseloads today, however, tend towards children who have experienced severe and often very early trauma, where the survival of any sense of self seems an amazing achievement, it has become even more vital that we retain as part of our repertoire a clear sense of the normal developmental tasks and processes which lead to 'good enough' emotional health and functioning.

Each psychotherapist, in considering emotional development, will tend to use the constructs and vocabulary of his or her own theoretical orientation. In practice, one integrates this with what is found to be clinically useful and valid. This chapter will inevitably present the author's view of key developments but attempt to incorporate major theoretical positions. A workable brief overview is the aim.

The reader should also keep in mind Stern's dictum that developmental progress does not take place at a smooth, even pace. Rather, the infant and child is subject to quantum leaps in physical, emotional and cognitive achievement (Stern 1985). One would add that it is also important for the therapist to keep in mind that, although each sign of progress represents a gain for the child, it also contains a loss: the infant who achieves walking has made a step (or several!) which leaves behind the perhaps comfortable dependency of the pre-mobile nursing state. The child's world, moreover, has suddenly become a very different place. It is not unusual for sleep problems to be associated with such developmental gains as mobility, as separation anxiety sets in (Daws 1989). Developmental achievement thus incorporates loss and the child can feel a regressive pull to earlier states at times of anxiety and uncertainty. Anna Freud gave probably the clearest early model of normal development from which pathological diversion could be assessed, with the emphasis on normality (Freud 1965).

## Early infancy

The development of the infant's psychological sense of self paradoxically begins, for the psychotherapist, with the development of the 'body ego' or sense of physical boundariedness in the baby. The first defensive manoeuvres – ways of protecting and enabling the growing 'self' (see Chapter 10) – are physical: crying, kicking, using the body and the musculature to cope with internal anxiety or external intrusion. An experience of the body as potent, to be enjoyed, therefore, is important for the developing baby, as is the mother/carer's capacity to meet, understand and enjoy the communication involved. Where the communication is one of distress, the infant needs the mother to make sense of this and respond in a way which both alleviates the distress and does not leave the baby with an overwhelming feeling of uncontainment and 'falling to pieces'. A colleague who observed Sikh friends with a new baby boy noted that part of his care involved his mother oiling his body and lovingly massaging his limbs and torso – an interaction clearly delighting both. While this example may be culture-specific, the need for the baby to feel that his body, and therefore his person, is wanted, understood and valued is an important one. The quality of touch in containing and confirming body boundaries can be seen in this vignette, as can the mother as *active* participant with her infant, calling forth and 'meeting' his capacities and ventures.

This sense of omnipotent functioning, of expecting and receiving a caring experience in line with one's needs, is described in different ways by various commentators: the caregiving mother of attachment theory, the 'dance' of the mother–infant dyad outlined by Daniel Stern (Stern 1977), and probably most famously the in-tune 'good-enough' mother of Winnicott's writings (Winnicott 1965). The critical experience for the infant is of being protected, kept safe, of maternal containment (Bion 1962). The corollary is to leave the infant with overwhelming anxieties that have to be coped with by pathological means: avoidance/denial/a recourse and retreat to the bodily self as the only available resource.

Freud termed the first stage of infant psychosexual development the 'oral stage': the infant uses the mouth to test objects, to gain pleasure, and a major focus of that pleasure is in the feeding relationship with the mother. Although the concept of infantile sexuality is one of Freud's most important legacies, it is important to keep in mind that this sexuality or 'proto-sexuality' of the infant is *not* the adult sexuality of equals. Thus total physical and emotional satisfaction can be engendered by a good experience, such as a good feeding relationship where the infant's sensuality is met and encouraged by the touch and holding of the mother as the infant feeds. Winnicott describes the gradual move into reality made by the baby as the mother, in careful accordance with what the baby can manage, allows gentle frustration and 'an experience of disillusionment' (Winnicott 1953). Should the lessening availability of the mother occur at a pace with

which the infant cannot cope, the immature sense of self is overwhelmed and a range of early defence mechanisms is called into play to deal with the primitive anxieties of annihilation, disintegration and abandonment. These, if they persist into childhood and adolescence, augur badly for peer relations and the capacity for independent functioning.

Although the focus of most commentators on the first months of childhood has been on the mother–child relationship, the work of attachment researchers has made us very aware of the infant's capacity and drive to engage and communicate with others in his environment. The role of fathers thus becomes important early on, not simply as the 'facilitating environment' described by Winnicott (1979), but also as an alternative to the intensity of the mother–infant dyad with its potential fears of merging and over-closeness. Wright (1997) has developed an elegant thesis about the father's place in the development of creativity: that the receptive, good-enough Winnicottian mother meets the infant's primary creativity and encourages it, while the father's role is to help the infant direct that creativity towards the outside world and to take advantage of what that world offers. The different nature of the father's relationship with his child is also outlined by Colarusso (1992), who finds that task-achievement, setting limits and looking outwards to being a socialised person in the world are part of the paternal function.

## Toddlers

With mobility and further development of sensorimotor functions, the infant takes a major leap forward. In Chapter 24 the author describes the growing independence and assertiveness of the toddler. Ambivalence in the relationship with the mother who has to refuse his demands, the place of magical thinking ('I hate her therefore she has been made to go or been killed off by me'), and the growing capacity to integrate love and hate in the same person are features of this stage (Klein 1937). The child by two has a primary sense of gender and a sense of agency that is constantly exercised and tested. The anal stage of Freudian theory contains this sense of wilfulness, taking control for oneself, and the ability to enjoy saying 'No!' In the temper tantrum of the toddler can be seen a real sense of disbelief and acutely-felt insult to the omnipotent self that is now being challenged. The toddler begins to explore leaving mother, making sorties with her in sight, but returning to the secure base for reassurance and congratulations. This develops into the capacity to make the adults pursue the child, another significant sensation for the toddler. Games of escape and capture create high excitement but are not always tactfully located: the queue at the supermarket is an all too frequent venue. Language is developing and with it, the capacity to symbolise rather than to enact – to use words rather than the body of earliest childhood. Crucial progress lies in the affirmation of identity, now internalised, demonstrated in the appropriate use of 'I'. Play

at this stage is still very much interactive with mother, but an ability to be 'alone in the presence of the object', engaged in his own fantasy, has developed (Winnicott 1958). Play with objects has not yet acquired symbolic content but seems to focus on tactile exploration of basic concepts – shape, sensation, hardness, softness – and on motor competencies of stacking and knocking over, pulling and pushing, as 'What can I do with this?' is investigated.

Finally, progress towards the use of 'transitional objects' (toys or materials like a comfort blanket, which can contain aspects of the mother–child relationship and so help in the tolerance of independence and absence) should be mentioned (Winnicott 1953). Such objects, often from very early infancy and treated with both attachment and contempt, provide a space that is transitional between infant-and-mother and infant-alone, an 'intermediate area of experience' (ibid.: 2). They can remain important to the child for many years.

The child's preoccupation with his anatomy is a feature of genital stage development: theories of difference between boys and girls emerge along with fears of castration in boys and reactions to male potency in girls. The sense of an internal space for babies in girls can be paralleled by an envy of this child-bearing capacity by boys. A more narcissistic, self-centred child appears, almost in preparation for the integrated identity that is consolidated after the Oedipal resolution.

## Play

The ability to play is important for the growing child. Early creativity and curiosity depend greatly on the mother's attunement to her infant. Responsive playfulness and the potential to initiate play appear even before the infant is mobile, although mobility adds to the possibilities. The capacity for symbolisation is linked, psychoanalytically, to the perception of separateness from the mother and the need to bridge that gap. Although this differs from the inborn drive for engagement and communication seen by the attachment researchers, both approaches contain the inherent element of the need to attract and engage the primary person in the infant's life.

As the toddler grows, so does his ability to endow toys and play materials with genuinely symbolic meaning and his competence in using others in this play: the child who begins nursery may at first 'play alongside' others, but develop the ability to 'play with' as he advances. Earlier experiences of 'good-enough' attachments and separation of a non-overwhelming kind will obviously play a role in allowing the growing toddler the internal security that enables him to explore how he can interact with others safely and with curiosity (Furman 1992).

The purpose of play is diverse: a rehearsal for future life; dealing with anxiety and conflict; exploring the space between fantasy and reality; and cognitive and social experimentation. As one three-year-old reportedly said

to Winnicott, 'Play is work, of course!' All toddlers at some time engage in play which copies the roles and tasks they have observed their parents undertake. This is not necessarily gender-specific and can be very fluid in the possibilities thus entertained. One may see precursors here to the use of day-dreaming in the adult, trying out possibilities and exploring dreams and hopes (Freud 1908; Rycroft 1974). Perhaps less obvious is the play which helps the child make sense of things which cause anxiety – the visit to the dentist repeated with a teddy bear as the patient or using dolls to re-enact a family quarrel or trauma. This ability to symbolise what has been feared and to place it outside, for perusal and hence to acquire control, is important for later adolescent and adult capacities to think, to gain mastery and not be overwhelmed, and helps in the process of not having to act out what might otherwise feel uncontainable. This is patently of importance in child psychotherapy where the child's capacity to symbolise anxiety through play is a route to unconscious conflicts (Klein 1955). When a child cannot play, it is the task of the therapist, through work on the immature ego and early attachments, to help the child's abilities develop safely.

## Oedipal resolution and parental sexuality

In classical theory the importance of the Oedipal phase and its successful resolution cannot be overstressed. This involves the renouncing of the intense emotional relationship with the mother (most parents of boys will recall the stage where their child was certain that 'When I grow up I am going to marry Mummy'). Winnicott's description of the Oedipal child as 'all dressed up and nowhere to go' gives a succinct picture of infantile sexuality and passion (Winnicott 1964). For the boy, ambivalence in the relationship with the father, admired and feared as possessor of the mother and a potentially castrating rival for her, becomes gradually replaced by a developing closeness to an available father-figure, allowing identification with him and the outward-looking described earlier. For girls, the intensity of the maternal relationship is replaced with passion for the father who, equally unavailable as a sexual object, has to be renounced as partner. As the girl turns away from parental partners, identification with the mother becomes possible.

Most modern commentators would now view the significant parts of the Oedipal resolution as those centring on the realisation of parental sexuality and partnership, three-person relationships, and on the boundaries between adults and children, parents and offspring. For the child in a single-parent family, as for the child with two parents available, the *idea* of a parental relationship matters – that the parent living with the child does not decry adult partnership but can keep the possibility benignly in mind for the child. The child, therefore, turns from the parents and infantile amnesia sets in ('Did I used to do that? No I didn't!') and embarrassment at family myths and stories is common. The normally developing child will

focus with relief on external peer relations and the continuing acquisition of skills and competencies as his cognitive development grows.

Hamilton (1993) in her eloquent reassessment of narcissism and the Oedipus complex offers an important and wider reinterpretation:

> The resolution of the Oedipus complex entails a renunciation; not only must the child give up the fantasy that he can have an exclusive relationship with the parent of the opposite sex, he must also accept that there is an objective order of things which he will never completely understand or control. In *some* cases this realisation is experienced as a castration or narcissistic blow. The blow is to the child's budding feelings of power and curiosity and to the satisfactions gained by learning.
>
> (Hamilton 1993: 273)

It is useful here to think a little further about the role of the parents immediately post-Oedipally. For the girl, identification with the mother and engaging in play as a rehearsal for her future as a woman is a feature. It is also vital, however, in the consolidation of her sense of femininity to have a sense of being valued as a girl by her father. For many of the girls who present with gender dysphoria, the emotional or physical absence of the father seems to play a part. The opposite process, with the mother, is important for boys. For parents it is vital that this affirmation of the opposite-sex child does not become sexualised and confusing.

At this point, one finds the presence of the capacity for guilt and shame: the child has an 'ego ideal', a sense of who he is and who he would like to be, based on internalisations of his parents and the 'self' they reflect back to him, and is aware when he falls short of achieving this internal ideal.

Psychoanalytic theoreticians differ as to the age at which such developments occur. Perhaps one could say that, while seeing development in absolute stages to be achieved by a particular age may not be helpful, to see a continuum of development on which the child takes up a changing position, according to nature, environment, growth and internalisation, is useful. Indeed 'most of the processes that start up in early infancy are never fully established, and continue to be strengthened by the growth that continues in later childhood, and indeed in adult life, even in old age' (Winnicott 1963).

## The primary-school-aged child

With the move into school, other identifications not only become more available to the child but can also be useful in separating from and challenging the parents. 'But my teacher said . . .' is not unheard in families with latency children, as 'greater' external authority becomes internalised into what is initially a fairly rigid conscience or super-ego. 'Latency' (in psychosexual terms) or primary-school age is par excellence the time of rules,

fairness and the acquisition of self-control, as the child struggles to leave behind the conflicts and embarrassing desires of the Oedipal stage and focuses on internalising mechanisms of competence and control. As the years go by, the severity of this conscience eases and an autonomous, non-persecuting super-ego should be established before the child has to deal with the changes and regressive pull of the pre-pubertal period.

This is the time of the 'family romance', the sense that one has been taken home by the wrong parents from the hospital or that there has been a dreadful mistake and really there are a princess and a pop star somewhere waiting sadly to find their real child. Such fantasies aid the necessary distancing of the child from the passion of earlier inter-familial feelings.

Children at this time tend mostly to play with their own sex. Clubs, groups and games with clear rules are important; new rules will be created but must be adhered to. A clear and rigid perception of right and wrong is at work. Nevertheless, there is also a delightful sense of subversion at this time – a glance at children's literature will show children defeating or being cleverer than the adults, and a gentle mocking of adult roles, hypocrisies and pretensions (Lurie 1991; Allen 1993). Indeed, few would now agree with the idea that sexuality has disappeared in a 'latency' phase. Although the intensity of parentally directed passion has lessened, children of this age are still developing theories about sex and explore these with peers, away from adult view. 'Doctors and nurses', with all its variations, is an early latency game, after all. Curiosity about the sexuality of others (outsiders, not family members who are simply embarrassing when they make children aware of sexuality and towards whom a certain prudishness can often be found) is ongoing and a rehearsal for adult wishes and possibilities. Identifications with heroes and idols are a feature of this age range – it is always interesting to note which pop stars appeal to pre-pubertal girls with a glossy but safely packaged sexuality and which become the heroes of the adolescent, when individuality of choice and discrimination are coming to the fore.

The rhythmic games of girls in the playground have long been seen as a sublimation of sexual feelings, enacted safely and physically. It is also possible to see the rough and tumble of boys' play, and the intrepid rush towards contact sports, as an affirming rehearsal for their adult sexuality as they establish a sense of boundary to their bodies in preparation for an adult penetrative role.

## Puberty and adolescence

> Adolescence begins with biology and ends with psychology. It is kick started by puberty and cruises slowly to a halt at adult identity, the point at which the petrol is getting low and we need to think about saving it for the long, straight road ahead.
>
> (Van Heeswyk 1997)

This wry comment comes as the author notes the tendency of our profession to list developmental tasks as absolutes. For the child approaching puberty, comparison in any kind of straight-line physiological way with his peers may be the source more of anxiety than consolation. There is a gulf between the girl who reaches her menarche at nine and the one who desperately hopes that menstruation will start now that she is sixteen. Indeed, a rapidly changing body with its overture to adult sexual roles can be more difficult for the younger girl to encounter without the parallel experiences of her peers to support and confirm her feelings (Orford 1993). Similarly, the boy whose growth spurt comes later than his peers can find the idea of ever coping as an adult a terrifying and bizarre prospect. Shifts in the body self in pre-puberty (Tyson and Tyson 1990) can often be accompanied by regression in relationships with key adults: a swing back to the safety of previous experience in the face of the inevitability of adolescence.

Although puberty can often be presented as '*Sturm und Drang*', most young people make their way successfully through adolescence despite the projections of adult envy and adult fears that accompany every step. That said, there *are* important psychological negotiations to be made. 'Who will I be?' is the sub-text as the adolescent faces external, physiological and internal pressures about future role and identity.

Intimacy once more becomes an issue, but intimacy of *mind* as well as of the body. This can be perceived as finally taking over from the parents responsibility for and ownership of one's body at a time when the earliest sexual feelings of infancy are revived, but with the addition of a sexually functioning body: no longer 'all dressed up and nowhere to go' but potent. Adapting emotionally involves somehow making the parental intimacies less intense – a reworking of the oedipal experience. This occurs in the realm of ideas and opinions, too, where separation from parental assumptions and family values can feel shocking to suddenly disparaged parents. The silent adolescent is not a myth: keeping quiet keeps fantasy, thought and internal life private (the use of a personal diary is not uncommon), and helps with finding the optimal safe intimate distance as the adolescent seeks to accommodate change. The reluctance to care for the body – often a contentious issue in families in early puberty and perhaps an attempt to ignore the imperative of physiological and sexual changes – gives way to great attention and concern in later adolescence. Family pressures refocus on ownership of the bathroom. Acting via the body – discos, flirtation with drugs, alcohol and nicotine, sports, body piercing, sexual exploration – takes the teenager back to early mechanisms for dealing with what might feel unmanageable and rehearses possible futures. The capacity to tolerate this new, fluid body-self is crucial: adolescence is not surprisingly the risk time for eating disorders and suicide in those who find the move towards establishing an adult, sexual self too impossible a task.

The availability of peers and alternative adults takes on even greater priority in early and mid-adolescence than at earlier ages. This can be the