The presented case study aims to demonstrate the efficacy of psychotherapy with a child previously treated with medication.

C. CHEESMAN

...an understanding of the child's inner life, and indeed of that of his parents too, must precede the choice of treatment method and that a psychotherapeutic attitude is essential for all treatment endeavours.

S. Wolff, Children Under Stress.

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C O N T E N T S

ABSTRACT

The impetus for using the therapy with J.B. for this study was primarily the challenge inherent in the situation from the moment the parents and J.B. arrived for their family interview and assesment. They had been through many professionals by then, and much medication. They were sceptical of our intervention, since nothing to date had relieved the situation, and J.B. still had outbursts of rage towards his mother, he was still expressing suicidal ideation and anxiety.

The challenge was particularly in relation to the mother, who had great difficulty conceptualising J.B's problems as being emotional and relational in nature - she was infinitely more comfortable with physiological interpretations of everything. This had the effect on the therapist and the supervisor of frequently reasuring their belief in psychotherapy as the treatment of choice in this case, or if in fact there was a lurking 'disease' or organic cause to the child's behaviour. The pressure was thus considerable in this respect, despite the fact that the child had been examined physically and nothing found.

This study aims to demonstrate the efficacy of psychotherapy, and the changes that took place, with this patient who was previously treated with medication.

CHAPTER 1: METHODOLOGY

WHAT IS THE CASE STUDY METHOD?

The case study is not a new method nor is it confined to any one discipline. In this chapter the focus is specifically on the case study method within psychology. Thus, reference will be made to psychological case studies, bearing in mind that there is no established blueprint for how one should be done - only recommendations are made by authors. While some realise the potential value for psychology of this method and aim to formulate it with this in mind, others have responded largely to the reservations that the natural scientific method has made regarding the case study.

In a psychological case study the focus is on a person in a situation (Bromley)(1986). There is usually something problematic about this situation and the relationship between person and situation. The case study usually deals with a segment of the person's life, and this period tends to be critical in some way in that person's life. This account tends to take the form not only of narrative concerning the person's actions, experiences and circumstances, but also an attempt is made to explain the facts and events described. There is also the aim of finding the solutions / resolutions to presenting problems. The case study thus aims to add to our understanding of an area of inquiry, through description and analysis.

They are selective pieces of work in that they focus on some issues and ignore others: obviously some life-history is included, particularly those facts that illuminate or place in context the present situation and issue. The boundaries of a case study are arbitrary, and it is up to the investigator to define the issues and terms of reference and to make sure that the material pertains to the aims of the study, and that

the aims are effectively dealt with in the work.

With particular reference to single case studies - these are termed idiographic - which does not however mean that they are concerned solely with the individual, as they may be described and interpreted in terms of a general conceptual framework within which others can be described and interpreted.

Bromley conceptualises the case study method in psychology in terms of a 'quasi-judicial' non-experimental method: what this means is that one arrives at conclusions, solutions, decisions and recommendations on the basis of rational argument about the relevant evidence. A danger, he cautions, is that facts may be badly constructed and misinterpreted.

Kazdin (1981), in keeping with Bromley's description of the case study method, says it refers to the intensive investigation of the individual client. Reports thus include detailed description of the clients. These tend to be anecdotal accounts of the therapist, from which inferences are drawn about factors that contributed to the client's plight and changes the course of treatment. However, Kazdin fails to mention that therapists do have recourse to the other sources that inform them about the patient: including psychological theories which may be used to make sense of the client's history, present situation and presenting problems; collateral may also be obtained from the others in the client's life. This is not to ignore the fact that theories also have different interpretations of events and that a therapist will be biased in a particular direction.

In an attempt to reconcile case studies with the experiment and heal the rift between them, Kazdin places them both on a continuum, and believes that from each, different scientifically adequate inferences may be drawn. He does however, note that case studies are so organised that they do not allow for conclusions that are as unambiguous as those reached through experiments.

The various authors agree on the point that there is no established form of the case study in psychology, possibly due to the fact that in the last 30 years there has been an emphasis of psychometric assesment in psychology, as well as an upsurge of experimental research. Psychology has tried to contribute to the latter via cognitive / behavioural experimentation. In describing the present state of the case study and what it involves, particular reference is made to psychanalytic therapy, and how it has been used, albeit minimally, for research. The points and assumptions made, do however apply also to psychodynamically-orientated psychotherapy generally.

Kvale (1986) notes that psychoanalysis has had an impact and influence on culture generally, and that it has been the generator of research in psychology. And yet, there is no established research form.

It is useful at this point to look at the nature of the therapeutic situation - that is psychodynamically orientated - since this constitutes the bulk of the material used in the single case study under discussion: Kvale describes the situation as follows - therapy takes place in both a free and non-directive context as well as a highly standardized situation: that is, there are no presuppositions about

what can transpire and yet it is guided by theory. It is both descriptive and interpretive. By standardized he refers to the set time and place and role of the therapist, while the content is unplanned and free. The historical dimension is central to the therapeutic relationship, and an attempt is made to see the human phenomena in a meaningful historical perspective. Thus, the long-term nature of intensive psychotherapy means that not only is a quantative body of knowledge gathered but also the focus is on the internal logic of the individual's development: how things have come to be as they are for this particular individual.

An important point is that the primary aim of therapy is change in the patient and alleviation of troublesome symptoms. The research aim is in effect secondary. Freud was in favour of research not impinging on treatment - saying that research should only be done once treatment was completed.

PROBLEMS WITH THE CASE STUDY METHOD:

Central here is the ways in which the case study method described above, differs from the experimental design of natural scientific research: from the perspective of natural science the case study both violates neutrality, since the relationship involves both patient and therapist and in fact they are involved in a deep emotional relationship. Transference and countertransference thus emerge as central to the process and are evidence of the mutual involvement of the therapist and patient.

Further problems include, the fact that the subjects are generally suffering and evince some sort of pathology, which raises the possibility that

there will be a pathologising of people's behaviour; also, since freeing the patient from symptoms is the primary aim, the validation of interventions (interpretations) about the meaning of symptoms is subordinate.

In addition, there are no large samples, and no formalised procedures of observation and no quantifiable facts.

These reservations concerning the case study method are expressed by Janis (1958), quoted in Wallerstein (1971):

> "An obvious weakness of the single case study...is that it can provide no indication as to whether the relationship applies to all other, many other, a few other, or no other human beings. Thus, even when a casual sequence is repeatedly found in a given person, the investigator cannot be sure that his findings can be generalised to any broad class of persons because the relationship may occur only in unspecifiable, restricted class of persons sharing a unique constellation of complex predispositional attributes..."

To continue with this tirade against the case study, Shakow (1960) says about therapists:

> (they are) "handicapped sensorially, memorically and expressively...Put simply, they are limited in how much they can remember of what they do grasp, and in how much and how well they can report even the slight amount they have grasped and remembered".

More specifically, Wallerstein says basic observations made by therapists are not available to independent concurrent observers, and the clinical retrospective method in which causes are inferred after the fact from the study of consequences, involves circularity of reasoning.

Kvale is also aware of the reservations held regarding the case study: observations are not objectively reproducible; interpretation is also not an unarbitrary matter, as it is open to multiple meanings - that is the patient's

behaviour is open to different interpretations. He also cautions that psychoanalysis particularly, tends to move too quickly away from the descriptive stage of the observable symptoms and on to the deeper levels of unconscious meanings.

Discussing the merits and downfalls of the case study Laskov (1987) acknowledges that for the specific purpose of testing general causal relationships the case study is, compared to the experiement, a relatively ineffective method.

ADVANTAGES OF THE CASE STUDY METHOD:

Laskov goes on to say that this method may be the most effective if the purpose is to describe the experience of a single person, to develop interpretations or explanations of that experience, or to develop courses of action and to make decisions appropriate for this person.

It is important to rember that the single case experiment and naturalistic case studies have traditionally had different emphases: that is, the former assess mainly the effects of treatment, or control for threats to internal validity in the treatment process on selected outcome variables, while the latter places greater emphases on identifying origins and meanings of a person's problems in the context of his/her life-history.

In support of the case study method Bromley describes it as offering a more comprehensive form of understanding than other methods of inquiry and that it can reveal social structures and processes. Contextual elements are

revealed by the case study which are not revealed by more closely controlled studies. It is useful as an explorative method even where is is not the definitive method. However, he cautions that the case study needs to be restricted in scope and sharply focussed to be useful. He adds that they have value in communicating scientific knowledge, especially to those outside the particular branch of knowledge. One should not, this writer believes, discount the importance of such communication within the particular area of work either.

In support of the method Wallerstein quotes numerous authors who claim that the psychoanalytic situation does essentially fulfill the requirements of a quasi-experimental research model. By this they mean it is a relatively stabilised, recurring experimental situation in which the analyst introduces independent variables and can predict and ascertain their impact on all the dependent variables within the situation. However, it should be pointed out in the above, that the assumption seems to be that the goal is to claim that particular interpretations or comments on the therapist: while this may be the aim of some research, it certainly does not encompass that which aims to explicate process rather than isolated variables and interventions.

Wallerstein makes a valid point when he discusses the faculties of empathy and introspection as being faculties that have been utilised as reasoning through history and such should not be written off as invalid ways of knowing and understanding, when used in the case study method. Furthermore, to show that even in natural scientific research inferences that are

specific can often not be made - he cites an example of research in pharmacotherapy where the group averaging model of research design was used, and only general results were obtained. That is, on average the group on the test medication fared significantly better than the group on the placebo; however, it cannot be said how many patients or which patients fared better.

Kvale makes the following supportive points regarding the case study method: he maintains it may be an advantage that the therapist relies on attention as he / she then does not get lost in endless tapes and content analyses. Instead, the deeper meanings unfolding during the process are focussed on. As regards different theories leading to various interpretations, Kvale says that this is certainly not limited to psychology, but also occurs in physics: he mentions Kuhn who has said that depending on the perspective of the scientist, different theories emerge. He also gives examples of cases that have proved to be milestones, and therefore bode well for the case study method: for example, Ebbinghaus's work on memory and Piaget's work which utilised an open mode of observation with children.

In defence of the case study method Kazdin says it occupies an important role in clinical work and serves to develop hypotheses about clinical problems and explore treatment methods. He also agrees that it is not optimal to utilise the experimental design within psychotherapy based on research since the method may require for example that the treatment be withheld. This is clearly not in keeping with therapeutic aims, as mentioned above, the primary aim pf therapy is to relieve the patient of suffering not to test the hypotheses. Wallerstein on the same issue points out that

our scientific interests are not anchored in the case but in the processes involved.

Dukes (1965) quoted by Wallerstein, gives the following conditions for when a single case study is justified:

1) When uniqueness is involved - that is the sample of one exhausts the population
2) If the nature of the findings is dissonant
3) When there is limited opportunity to observe
4) Problem-centred research on one subject may be valid when it makes substantial contributions to the study of behaviour by clarifying questions, defining variables and indicating approaches.

AIMS OF THE CASE STUDY IN PSYCHOLOGY AND HOW THESE MAY BE ACHIEVED:

> "It is not the aim of the case study to find the 'correct' or 'true' interpretations of the facts but rather to eliminate erroneous conclusions so that one is left with the best possible, the most compelling interpretations."
> Bromley (1986)

In order to arrive at these 'compelling interpretations' Bromley suggests that the following rules be adhered to when utilising the case study method: central to the study should be the description and analysis of the central problem/s that the study has been set up to deal with, together with recommendations based on the analysis.

1) Report truthfully on the person. Rational argument should support the inclusion of particular facts.
2) Aims and objectives should be explicitly stated.
3) An assessment of the extent to which these aims and objectives have been achieved should be included.

4) Someone trained appropriately should carry out the study - if it deals with emotionally significant issues, and this is best done in the context of a close, long personal relationship.

5) A full account must be given of the objects, persons and events in the subject's physical, social and symbolic environment. Hence the focus is on a person in a situation.

6) Direct, plain english should be used - without the study losing its human interest as a story. Length depends on the purpose of the study and the complexity of the problem and resources available to the researcher.

Kazdin tends to make his suggestions from a position that is trying to be acceptable to the demands of the natural scientific approach when he says that the more immediate the change appears after onset of therapy the stronger the chances that the treatment was responsible. This does not accord with many experiences of therapy that have been documented: while there may be a 'honeymoon' period during which symptoms disappear, there is usually a resumption of the pathology, and enduring change (depending obviously on the nature of issues) only occurs later on in the process.

This is not, however, to deny the role of external influences on the treatment of one's patient, and this must be taken into account and considered when research is done. For exapmle, in treating children, the potential influence of normal maturation has to be considered, as well as changes in the child's environment.

This writer nonetheless believes that it is realistic to have such influences in the therapeutic process, since the latter is at base a relationship, and not an experimental endeavour isolated from the respective contexts of therapist and client/patient. Thus the aim is to explicate as much as possible of the process, without in any way assuming omnipotence in terms of effecting change or in thinking one can include every possible 'variable' that effects the process. The ambiguity and complexity is to be acknowledged and not denied.

Wallerstein's contribution to how the case study may by improved is first of all to ensure that full process notes are made and that as much attention as possible is given to the role of countertransference. As regards the notes, this means that a clinically experienced reader will be able to gain an overall picture of the course of events and the clear turning points. Patterns may then be identified and checked against observations made. Similarities and differences between groups of sessions may be evident.

Tapes are not necessarily an improvement, he says, since they are not as manageable as notes, as visible, and they are more difficult to extract data from. The argument that all takes place in the space between the therapist and patient and as such in their verbal exchanges - is not entirely true, since it ignores what is going on at least within the therapist's mind. By attending to the latter, in accordance with Casement's 'internal supervisor' (1986), the therapist makes explicit a vast dimension of the therapy process.

Bearing in mind the above suggestions and rules for the execution of the case study, and assuming they have been achieved as far as possible, then the case study should leave the reader with the following:

1) It provides insight into the person, making the meaningless comprehensible
2) Providing a feel for the person, conveying the experience of having met him/her
3) Helping to understand the inner or subjective world of the person, how they think about their own experience and problems
4) Deepening our sympathy or empathy for the subject
5) Portraying the social and historical world of that person effectively
6) Illuminating causes and meaning of relevant events, experiences and conditions
7) Being vivid, evocative and emotionally compelling to read

Laskov (1986)

The case study, according to Laskov should be evaluated in terms of the following: how well the problem has been delineated; whether the need for collecting additional types of information has been identified; whether suggestions for possible goals and course of action have been made and finally whether the case study has sensitized us to the likely consequences of alternative courses of action.

In conclusion, Wallerstein provides an encouraging word for those utilising the case study method when he says that sharability and agreement are the crucial test of reality; that is, if one can perceive and compare one's own and other's awareness then the essence of objectivity is achieved.

REASONS FOR USING THE CASE STUDY METHOD IN THIS CASE:

The therapy with this particular patient (J.B) was chosen as it illustrates the usefulness of psychotherapy as a treatment method with a child who presented with various symptoms indicating a problematic relationship with his mother.

The case study method is considered appropriate with the above material since the researcher / therapist intended to describe the experience of this individual child, as well as the process of treatment: through doing this, the aim is to interpret his behaviour in terms of his context as well as according to particular psychological theory.

The case study method serves as an effective medium to explicate as fully as possible the relationship between therapist and patient and the process of therapy, in an attempt to understand the dynamics of the situation, and to communicate this to the reader. In explicating the therapy in this way the intention is also to try and ascertain where change took place during the therapy, and make this clear to the reader.

An assumption is thus that some change did take place during the course of therapy: this is however not being fully attributed to the psychotherapy, as other factors are taken into account - namely - maturation and the mother's own therapy.

THE PROCEDURE INVOLVED IN USING THIS CASE:

Primarily, the aim of therapy was to relieve the patient of his problems and to improve the family situation - via the mother's own therapy. Thus, the research aim was secondary. Thus, the therapist was dictated to by the perceived needs of the patient and not her own research needs: for instance, the therapist (in consultation with her supervisor), decided to change the therapy venue from the playroom to the therapist's office, in response to the patients persistent negative attitude towards 'playing', which he associated with the playroom. Wheras if research were the primary aim - this would probably not be done - in keeping with the attempt to keep as much constant as possible, and there would also have been a stricter adherence to a particular therapeutic technique.

Instead, the shift in venue and the adoption of a less interpretive style by the therapist was used as much as possible to illuminate the relationship between the patient and therapist in the light of the patient's dynamics, and the countertransference. It was treated as one of many unpredictable happenings inherent in any human encounter.

Dynamically speaking, the initial focus was on the patient's rage towards his mother - what the meaning of this rage was for him, and how it could be dynamically understood.

However, the therapist went into the process open to the possibility of other themes emerging: thus, further themes are described and discussed which hopefully give a greater understanding of the complexity and richness of the patient's experience.

This receptive attitude contrasts with that of the Natural Scientific approach which requires that the scientist conducts the experiment within as tightly controlled an environment as possible - controlling the variables and only looking for evidence that supports / refutes a particular hypothesis.

The emerging themes and subsequent dynamic understanding of the therapy are used to illustrate the importance of psychotherapy as a useful form of intervention as it attempted to address fundamental issues pertaining to the patient's relationship with his mother (interpersonal dimension) as well as taking cognizance of his own internal world (intrapsychic dimension). These dimensions were not addressed by the patient's previous treatment - medication - which primarily aimed at controlling behaviour in this case.

The dynamic understanding of the case is achieved via particular authors within the object relations framework and self psychology. This in turn throws light on salient issues within the therapy process itself: the relationship between theory, dynamics and the therapy process are dealt with in the Conclusion to the study.

Finally, it is intended through use of a specific case study, to alert clinicians to the importance when assessing patients, of considering the available treatments, and not rely on one method when it is proving of dubious benefit.

The intention has been to adhere to the guidelines described in this chapter, particularly in terms of the following:

1) Using as full process notes as possible which are included in the Appendix.
2) Taking into account the role of countertransference and the therapist's 'internal supervision', in order that the reader gains as full a sense of therapy as possible.
3) In addition to the process notes, other information is used: including the mother's reports on the patient, and the feedback from the mother's therapist; psychological testing was used initially to illuminate the patient's problems, and after treatment was completed, for clinical purposes, to establish what can be expected from the patient as regards ego strengths and coping mechanisms. Relevant material is included in the Appendix.

ETHICAL CONSIDERATIONS:

On admission to the Children's Clinic the parents of the patient signed release forms, which permit the professionals involved in the case to discuss the material arising from assessments and therapy, and to utilize it in clinical settings deemed appropriate, with due consideration for preserving the anonymity of the patient and his family.

CHAPTER 2: LITERATURE REVIEW

> "In the case of any individual at the start of the process emotional development there are three things: At one extreme there is heredity; at the other extreme there is the environment which supports or fails and traumatizes; and in the middle is the individual living and defending and growing."
>
> Winnicott (1964)

In this review Klein's contribution to theory - particularly in terms of the libidinal positions - Paranoid - Schizoid and Depressive - and her notion of the internal world - is acknowledged, while the focus will be primarily on Winnicott and Kohut. The reason for this is because they facilitate consideration of the interpersonal dimensions more fully, as well as the intrapsychic. Furthermore, they also provide a continuity between theory and the process of therapy in this case study, in which the therapist found herself dealing more with the interpersonal space than overtly with the inner world of the patient: the therapist was however, informed by object relations theory in her thinking about the patient.

In the object relations view the infant does not distinguish clearly between inner and outer reality, internal objects merge with outer. The task thus becomes to distinguish inner from outer reality. The baby has a sense of omnipotence in that he/she creates the world from his/her experience of it: for example, in feeding situation the mother places her breast at the child's mouth and to the child s/he has created this source of nourishment and comfort. (Davis and Wallbridge, 1981) This omnipotence dominates the first year of life, particularly.

Feelings at this stage are potentially overwhelming: rage and hate can be experienced as able to destroy the world. The opposite applies when the infant is contented - then the whole world seems filled with goodness. This process

described, involves a splitting process - into good and bad experiences.

Winnicott speaks of early childhood as a gradual process of the building up of belief - in people and things through good experiences. The latter are weighed against the bad experiences - those that arise when anger, fear, doubt and hate are prevalent.

The concept 'good enough' is central to Winnicott's approach to emotional development in the individual. It is used in relation to both the mother and the infant's early development: the good enough mother is such that she intuitively responds to the infant's needs for food and comfort, and she faciliates the infant's movement and growth through the stages from Absolute Dependency through Relative Dependency towards Independence. The mother can thwart this growth through 'doing' too much as opposed to simply responding to the child. By doing the mother invokes a 'reaction' in the child which is compliance. The latter, says Winnicott, is evidence of the development of a false self in the child. (To be discussed in Section ii of this chapter).

The good enough mother's function encompasses holding, handling and object presenting in the early stages of the child's growth and development. These functions will be elaborated on in the following pages.

It is evident that to Winnicott:

> "There are no such things as an infant, meaning, of course, that whenever one finds an infant one finds maternal care, and without maternal care there would be no infant."
>
> Winnicott (1964)

The good enough environment is that which is a holding environment, which is needed if the line of life is not to be broken. Crucial to holding is the

mother's identification with her baby: this involves protecting the baby from psychological insult, and attending to the baby's routine care, which includes handling. She is also attuned to the changes which are part of the infant's growth, boith physical and psychological. In terms of the latter, holding functions to provide ego-support for the infant, particularly at the stage of Absolute Dependence, before the integration of the ego is established.

On the journey from Absolute Dependence to Independence a number of concepts need to be noted: central is Winnicott's notion of self and ego. The self is perceived as the basis for mental health, as it is the source of energy and spontaneity. The self is related to the individual's inherited tendency for psychological growth - which is the capacity to become what one is. The ego functions to link neuropsychological development with the outsife world, and it organizes the individual's psychic reality.

In healthy development three achievements are made on the abovementioned journey: 1) Integration 2) Personalisation 3) Start of Object Relating. These three achievements are interrelated and overlap. They may be achieved momentarily and then lost and regained. They do not necessarily take place consecutively. They tend to be consolidated by the end of the first six months of life. By the end of the first year of the infant's life s/he has achieved the status of an individual - that is - the personality has become integrated.

1) Integration (and unintegration):

The baby feels no difference between 'me' and 'not me' (environment). The mother is fused with the infant, and thus there is a continuation of the prebirth state. This is the state of unintegration in which there are spatial and temporal non-associations. The nascent self of the infant is not felt as the same at all times. The baby does not perceive a single self - this is - the baby is not aware of being the same in two different situations. For example: the baby may be aware of skin

sensations while bathing, which is not experienced as the same body that is later screaming for satisfaction. Also the child asleep and awake is not experienced as the same.

Integration means uniting these aspects of the child's experience of his/herself. The personal psyche has to be organized and this leads to individual relations with the environment and the environment is then felt to be external and finally permanent. This is where the good enough mother is important, in that integration and even continuity of the line of life are dependent on her care. Through the holding environment thus should be engendered in the child for the environment.

This state of integration is not permanent for the infant as he/she should be allowed to return to an unintegrated state in the form of 'rest', without a threat to 'going-on-being'. This can only happen if the care-giver/mother provides the ego-support for the infant. This return to the unintegrated state is the precursor to the adult ability to relax and enjoy solitude. This ability to be alone is a sign of emotional maturity, says Winnicott. (1981).

Thus the capacity to be alone in adult life depends on the experience the infant has of being alone in the presence of mother. Referring to Klein, Winnicott describes this capacity to be alone in terms of the existence of a good object in the psychic reality of the individual. The relationship of the individual to his or her internal objects along with confidence in relation to internal relationships, enables the individual temporarily to rest contented even in the absence of external objects and stimuli.

Maturity and the capacity to be alone implies that the individual through good enough mothering has had the chance to build up belief in a benign environment.

There must be relative freedom from persecutory anxiety for this state to be possible. When the infant and mother are able to be together in this way - ego-relatedness is said to be operative: that is, both are alone yet the presence of each is important to the other. Thus it follows that when an infant is alone in the presence of someone in this way, s/he can then safely contact his/her own personal impulses. It follows also that the infant in this situation will then not feel ocerwholmed by impulses - which may happen if ego support from the mother is not experienced.

The individual who is able to be alone is constantly able to rediscover the personal impulse in a contained way. The state of being alone is thus paradoxically always implying that someone else is there.

2) Personalization:

This is an aspect of integration and involves the acquisition of body scheme: this means that the psyche is placed in the body, so that gradually the body becomes the dwelling place of the self. Again this process relies on the good enough mothering environment. Particularly important here is the handling of the infant: this involves the mother's management of the baby as a unit, which facilitates the acceptence on the infant's part of the body as part of the self. This implies a joining up of uncoordinated movement of the infant to the expressing of significant actions. In time movement is harnessed in the service of specific goals and purposes. Before personalisation takes place it is evident that babies seem purposeful, at times, in play. Yet, they spend much time simply fascinated by the movements in their fingers and toes. Winnicott gives an example of a woman (patient) which had not achieved personalization in that her personality was not felt to be localised in her body:

> "She could only see out of her eyes as out of windows and so was not aware of what her feet were doing, and in consequence she tended to fall into pits and trip over things. She had no eyes in her feet!"
>
> Winnicott (1981)

Even after the establishment of this psychosomatic collusion in the infant, the psyche may lose touch with the body: for instance, when an infant wakes from deep sleep and screams, the infant is having trouble locating his/herself back in the body.

We now turn to the third achievement on the path to Independence:

3) Object Relating:

This means a relationship with a person or part of a person: in the stage of Absolute Dependence the child does not distinguish between 'me' and 'not me' - the distinction between the object and the self is not made. The object is experienced as a 'subjective object' as opposed to an 'object objectively perceived'. The child has to 'find and come to terms with the object'. Winnicott (1981).

Thus the stress is on the initiation of action on the part of the infant, child or patient in therapy, and not on the environment. The implication is that if the mother is 'doing' too much and not responding to the infant then she will impinge on the infant and force his?her to react. The latter being the opposite of 'being' and as such amounting to annihilation of being, in the infant's experience.

In relation to the primitive object (usually the mother), the infant experiences omnipotence: the infant combines fantasy and reality into one, by means of transforming the meeting of his/her needs into a creative process. That is, the infant sees him/herself as the creator of his/her world and s/he feels in control.

The importance of this primitive object relating between mother and infant is that the mother is involved in object presenting, which is one of her functions, and it facilitates the first object relationship and this experience of omnipotence

described above. Object presenging embraces not only the initiation of relationships but also the introduction of the whole world of shared reality to the baby and the growing child. Initially it refers to the mother's presentations of herself. The most primitive of all relationships takes place in the weeks before and after the birth of the baby. The infant experiences a sence of 'being' through this relationship. This sense relies on the capacity of the mother to be someone 'who is' and not 'who does'.

According to Winnicott, the mother is the holding environment in that she manages the events that take place: for example, the feeding situation during which the breast is presented and the infact is allowed to imagine it has omnipotently created the breast. In the same vein the infant is allowed to turn away from the breast when s/he wants to.

The world needs to be presented in small doses to the infant - so that shared reality appears visible to the infant. In this process of presenting the world to the infant it is important to preserve a certain amount of illusion; that is, the child exists in two worlds at once: the child's imaginative world is that which we share when we play the child's games; however, it is also important that the adults keep a clear distinction between the fact and fantasy in themselves.

> "In all sorts of ways your clear knowledge of what is real and what is not real helps the child, because the child is only gradually getting to the understanding that the world is not as imagined, and that imagination is not exactly like the world. Each needs the other".
>
> Winnicott (1981).

It is relevant to look at Winnicott's notions of impingement and trauma, when considering the importance of 'being' as opposed to the destructiveness of 'reacting': Winnicott mentions three forms of impingement: 1) and 2) describe situations where impingement takes place in the context of <u>ego support</u>:

1) When the baby is in creative contact with the world and expresses hunger and the mother responds to this by feeding for example.
2) When the environment acts on the baby in the way that is positive: the mother considers the child as a person - when bathing the infant, she is considerate of her physical handling of the infant.

The third situation forces the infant to 'react' to the environment which is impinging on it: for example when there is a loud noise, or the baby's head is not supported. Then continuity of being is interrupted and the baby only recovers when the environment again becomes adaptive - when holding characterises the mother's relationship with the infant.

As regards the mother's adaptation to the infant, she is allowed to fail the infant when thinking emerges in the infant: good enough mothering is thus converted into the perfect adapted environment by means of the child's thinking. Thinking involves the deliberate directing of the mind onto a specific task, which only comes about after the stage of Absolute Dependence. Thinking arises out of the child's creative imagination, which is the result of a line of growth moving from body functioning to fantasy and finally to being able to categorise and remember. The mother is allowed to fail at this point because the infant's mind is allied to hers and so takes over part of her function. For example, when the child is hungry, instead of screaming and demanding instant satisfaction, the child utilizes thinking, and on hearing the sound of food being prepared in the kitchen is able to wait satisfation. However, the child can be forced to understand too much if there is a failure in maternal adaption at the initial stage of Absolute Dependence. A false sense of self develops. (Discussed under section ii of this chapter).

Development of the sense of self:

The child starts talking of the individual self with the start of self-consciousness. The latter corresponds with the ego organising the child's personal psychic reality. This inner reality is the personal organisation of the infant's fantasy which consists of instincts combined with the mental representations of the human environment. It is the source of much of what constitutes the personality: being largely unconscious, it is the source of dreams, fantasy, as well as the source of a social sense which the child develops. As regards the latter, guilt springs from this inner reality. It is the seat of struggle between benign and persecutory elements and between impulse and control.

With the assertion of self in the form of 'I am', there is also the expectation of persecution from the 'other than me' which is now felt as separate. At this stage the child relies on the holding environment for safety. A breakdown of this support will mean a breakdown of integration.

Much has been said on the preceding pages concerning the development of the infant in terms of the mother/child relationship and how this effect and facilitates the internalisation of a strong ego and the development of a stable sense of self. Furthermore, the interplay of inner and outer reality is central to the development process - and what needs to now be considered is the area where fantasy and reality meet: the area of illusion: to the infant what he/she discovers as being in the outer world - 'not me' - s/he creates. The transition from functioning in accord with the Pleasure Principle to the Reality Principle takes place in this area of illusion.

Transitional phenomena are located in this area of illusion: here the object is neither 'me' nor 'not me' and this paradox should be retained not resolved, says Winnicott. Transitional objects are usually evident in the child's life from 4

to 12 months and they have the inbetween status - 'me' and 'not me'. They are concrete examples in a specific period of development of the transition from being merged with the environment to being separate from it. Transitional object include the corner of a blanket, or a word which becomes important to the child and functions as a defence against anxiety. The infant assumes rights over this object, although there is some abrogation of omnipotence from the start; the object is treated affectionately, excitedly and also mutilated'n it must not change unless at the hands of the infant'n it must survive instinctual loving and hating; it must be seen by the infant to give warmth, or move with a reality of its own. From the infant's point of view is comes neither from within or without.

Also located within the area of illusion if playing: playing takes place, according to Winnicott, in the potential space, originally between mother and infant, and is neither part of the inner world nor external reality. While playing, creativity takes over from omnipotence and the infant is then on the final stretch towards Independence. Through communication in shared play the infant moves towards mature participation in a cultural world, and the self is discovered in the activity.

The mother-figure is vital as one who participates and hands back to the child what is handed out. Mother is thus in a to and from between being that which the baby has a capacity to find and being herself waiting to be found. Confidence in the mother in this respect makes an intermediate playground (potential space) where the baby experiences some omnipotence. The child then moves on to be alone, while in the presence of mother. (discussed above).

Towards Independence:

The capacity for concern is another achievement of the mature child: this concern

is Winnicott's version of Klein's guilt. It is a more positive notion since it implies more integration on the individual's part in that it is connected with a sense of responsibility in relation to others. The individual is then able to care and feels and accepts responsibility. Mutuality is now possible, as the individual can share his/her life productively with others.

In this final move towards independence, the infant needs to establish a sense of object permanence and see the object as separate from him/herself. This is achieved by the increased number of 'I am' moments, which foster integration in the infant. The infant also starts having a sense of time and of complete experiences. There is a change from object relating to object usage: the latter involves placing the object outside the area of omnipotent control. The object is thus seen as an entity in its own right.

Aggression and destruction play important roles in the establishment of object permanence: first there are erotic impulses, then the infant expresses destructiveness towards the object, which is seen to survive and so it takes on permanence in the eyes of the infant. The first is the mother (usually) who according to this process is then placed outside the child and then acquires permanence. There is thus a progression from:

me.... me/not me..... not me

in the change from relating to usage.

The mirror-role of the mother in the development of the child:

In the individual's development the mother's face is the precursor of the mirror: the infant sees itself in her face - that is - her expression gives back to the infant what she sees in him/her. For Winnicott, the mother's functions of holding, handling and object presenting are included in mirroring .

If the mother's face is unresponsive, the child will look at it, but not into it. Some babies, says Winnicott, don't give up and they study the mother's face (object) to see in it some meaning that ought to be there, if only it could be felt. They may try and predict the mother's mood from her visage and so act accordingly. This becomes pathological, since the baby's spontaneity is gone and s/he ends up reacting to the mother. The false self develops.

Mirroring for the child involves not just being seen, but also being acknowledged, and being made to feel that s/he exists, and has a right to look and see the world for him/herself in safety.

Winnicott's views on mirroring of the infant by the mother accord with Kohut's, and this is a good point at which to turn to Kohut's theory of emotional development: there is evidence in Kohut's ideas of a shift to the importance of the ego's response to the real object in its development. There is thus a deemphasis on the role of internal representations of external reality. This contrasts with the focus of the Kleinians, whose primary thrust is on the internal world and how cycles of projection and introjection develop the psyche.

For Kohut, the focus is on the self and the importance of the self object. Winnicott also acknowledged the role of the self when he notes that narcisistic individuals experienced trauma as children when their sense of self was still developing. He adds that deficient maternal empathy during childhood necessitated the establishment of a precocious and vulnerable sense of autonomy supported by fantasies of omnipotence, around which the grandiose self develops. Both Winnicott and Kohut stress the development of the self and the central role of the mother figure as regards having empathy for the child and serving to reflect the nascent and emerging self in the child.

What is the self in Kohut's terms? -

Kohut is speaking about the person's subjective sense of self. This develops out of relations with others, starting with the infant's relation to the nurturing mother. Depending on the quality of the experience, either a self that is relatively cohesive develops or one that is tending towards fragmentation. He shifted from viewing the self in more abstract terms to a notion of the self as the centre of our being 'from which all initiative springs and where all experiences end'. (1978). This means that no longer are the drives the force behind this, but something else is operative, either in addition or instead of the drives. (Chessick, 1985).

Kohut maintains that through developing a cohesive self individuals are able to establish an empathic matrix with other people. In saying this his links with his precursor, Fairbairn, are evident: the latter postulates a move from dependency through to a mature dependence among equal adults.

The self as the centre of our being is also in keeping with Winnicott's description of the self as a centre of energy and the life force. This develops over time and may be healthy due to good enough mothering, or it may not develop itself, and instead a false self appears.

For Kohut, the self emerges in the 2nd year of life and is a bipolar self: the two poles are self esteem and guiding ideals. The former is derived from the grandiose self and its strivings for acclaim and mirroring; thelatter is derived from internalisation of the idealised parent imago. They are connected by the executive functions and skills.

A thread of narcissism runs through the development of the self: Kohut perceives this as both normal and important to mature human personality functioning -

provided it has been properly transformed along the way.

How does this take place?

Kohut perceives a normal, intermediate phase of powerful narcissistic cathexis of 'the grandiose self' and the idealised parent imago for children of 8 months to 3 years. The psychic formation are gradually internalised and integrated within the psychic structure. The grandiosity is consolidated around 2 to 4 years. This forms the nuclear ambitions pole of the self, driving the individual forward. It derives most from the relationship with the mother. At age 4 to 6 years - the height of the oedipal phase - the idealised parent imago (derived from both parents) is internalised and integrated. These consolidations of the idealised parent forms the other pole of the self - the nuclear ideals pole.

Kohut adds a third line of selfobject development involving twinship (alter ego) experiences from about age 4 to 10 years of age. At this stage what takes place is, for example: the little girl kneading dough in the kitchen next to grandmother. This selfobject need, says Kohut, corresponds and confirms the intermediate area of skills and telents which, with the two poles described, forms the nuclear self.

When these three consolidations have to some extent taken place a cohesive sense of self is formed, and the person is ready to continue by resolving the oedipal phase. For Kohut, even after adolescence still further transformations of narcissism occur, resulting eventually in mature wisdom, a sense of humour, acceptance of the transience of life, empathy and creativity. These transformations involve an increased firming of the sense of self, making mature love possible. What permits these internalisations to occur smoothly is the response of the parents to the child's libidinal and aggressive and exhibitionistic strivings - their pride and mirroring confirmation are important. For

example, Kohut says that it is not only the boy's fear of castration by the father that causes him to identify with the aggressor and internalise the values of the father, but also the father's pride in the boy's emerging assertiveness as it presents in the oedipal strivings and imitative efforts, that softens the boy's disappointment in not possessing the mother. And this enables a firm internalisation of the idealised parent imago as a nuclear pole of the self.

If, however, the parents withdraw from the child as a response to their horror of the child's oedipal strivings, this internalisation cannot take place, and the result is that the child remains fixed in development on finding some individual to which the child can attach the idealised parent imago. In such a case the child's self-esteem is very low and both self-esteem and sense of self require continual enending bolstering from the external object which had been invested with the idealised parent imago. When this bolstering is not forthcoming, profound disappointment, narcissistic rage and even a sense of impending fragmentation of the self occurs. This echos Winnicott's view of impingement from the environment resulting the the infant experiencing the 'unthinkable anxieties' which threaten to destroy the developing sense of self.

The crucial role of mirroring in human experience is expressed by Kohut:

> "We need maternal and paternal responsiveness to know we are in the world. We need it from our first breath to our last".
>
> Chessick (1985)

The selfobject:

Selfobject was used by Kohut to distinguish between object relation and object love: the small child has object relations not object love. The child relates to others as selfobjects in which the object is experienced as part of the self and having no life of its own. There are two kinds of selfobjects:

1) Selfobjects who respond to, confirm and mirror the child's sense of greatness and perfection and to whom the child can look up and with whom the child can merge.
2) Selfobjects who provide an image of calmness and omnipotence which can be borrowed to provide narcissistic equilibrium.

Mirroring and its part in transmuting internalisation:

A reasonable empathic ambience between mother and child will enable the child when realising mother's not perfect, to learn in little ways to do things for him/herself. Things once done by the mother. This is the notion of transmuting internalization: this involves the ego being built up slowly by the child taking into itself the mirroring function and the object for idealization, in the formation of internalized goals and values.

Through these transmuting internalizations, in an appropriate environment (empathic mirroring mother), the grandiose self becomes incorporated into the self as ambition (mentioned under discussion of the self) which can be realistically sublimated.

To reiterate, for Kohut, there are no built-up primary conflicts in the phyche from birth, but be concedes that traumatic disruptions lead to defects or deficits in structure building, which in turn, lead to secondary conflicts that can be studied by psychoanalysis as drive psychology and not aimed at replacing it.

ii) SPECIFIC ISSUES DISCUSSED IN THE THEORY OF WINNICOTT AND KOHUT THAT ARE PERTINENT TO THIS CASE STUDY:

Love, rage and destruction:

Winnicott describes infants as 'getting excited' at various times - during which the infant has impelling needs, some of which the mother can satisfy:
for example if the infant is hungry and wants this need met, the mother can feed;

the infant may also feel excited in connection with acutely felt love for the mother, father or significant others in his/her environment. He adds that the ideas that go with the primitive love impulse are predominantly destructive, and are associated with those of anger. There is much frustration in the infant at such times and this can lead - in a healthy child - to anger and even to rage. A risk is involved in feeling emotions fully in this way, since these experiences of rage and excitement must be quite painful for the infant - says Winnicott. Thus the infant will find ways of avoiding these intense feelings. One way of doing this is to clamp down on instinct and the infant then becomes unable to let the full extent of excitement of feeding take place; or the infant accepts only certain kinds of food and not others. There are many more ways in which the infant attempts to manage feelings which become too intense and being about painful conflicts. Excitement is also felt in relation to sexual feelings and in relation to the infant's own excretions which are felt to be good, until such point at which the infant turns away from these with disgust. When some difficulty has blocked the child's progress we see a return to such excitement in older children.

Winnicott maintains that the most primitive and early impulses are felt <u>ruthlessly</u>. Initially the child may experience a destructive element in the early feeding impulse - and be unconcerned (this is at the level of ideas). At first s/he is carried away by the impulse, the only gradually comes the realisation that the thing attacked in an excited feeding experience is in fact a vulnerable part of the mother, and the other human being who is much valued as a person between these excited periods. The excited infant violently attacks the mother's body in fantasy. Although the physical expresssions of this appear quite feeble, to the infant they are powerful. Satisfaction then comes with the feeding experience and the attack stops. In fantasy the mother's body was torn open so that good things could be got at, and taken in. Thus, it is crucial that the mother is seen to survive these attacks and be there to be the object of tender feelings

again. Finally, the infant experiences a guilt feeling and a sense of concern for her welfare.

The normal child enjoys a ruthless relation to the mother, mostly showing it in play. The infant needs the mother because only she can be expected to tolerate the ruthless relation to her - as it hurts and wears her out, says Winnicott. If the infant cannot indulge in this play, then s/he can only hide the ruthless self and give it life in a state of dissociation. In the latter state the infant is threatened by disintergration, that is being abandoned to his/her impulses, that are uncontrolled because they are acting on their own. They are thus not being contained by the mother's ego support and presence.

Speaking on aggression, guilt and reparation, Winnicott (1971) says that a sense of guilt (which for him is closer to conern) arises from toleration of one's own destructive impulses in primitive loving. This toleration results in the capacity to enjoy ideas, even the destruction of them, and the bodily excitements that belong to them. This facilitates the experience of concern: for Winnicott this is the basis of everything constructive. He emphasizes that he does not refer to the crippling and burdensome guilt that is found clinically in disturbed patients.

Having spoken much about the 'normal' child, Winnicott comments on the difficult child, when he says that at the base of the antisocial tendency (including stealing, aggressive outbursts, destructive acts, bedwetting) is deprivation. What he means is that the good enough environment was known and then lost. He perceives these antisocial acts as an SOS on the part of the child. Particularly referring to outbursts of rage, he notes that they are senseless in that the child will not be able to account logically for his/her actions. These

outbursts become for the child, a means of rediscovering his/her own aggressiveness, in the hope of a return of some sort of security from the environment. He adds that it is vital that the child's environment survives, in order for the loving and aggressive impulses to become integrated. Still on the topic of aggression and rage, which is particularly pertinent to this case study, Kohut's viewpoint is in violation of the traditional drive psychology in that he maintains that aggression is not a fundamental characteristic of personality and inevitable; instead the rage of the subject is secondary to frustration. Fairbairn stands as precursor to Kohut on this issue as he maintained that aggression is not an instinct, but is a reaction to the frustration of libidinal drive. Guntrip (1973).

Aggression and narcissistic rage for Kohut, is thus the result of self-pathology, arising from a deficiency in early mirroring and parental empathy. This narcissistic rage is a disintegration due to profound disappointment in selfobjects. Such rage,adds Kohut, may be directed at the self, in the form of depression, or at the body-self in psychosomatic disorders. The healthy version of this rage is adult assertiveness.

This view differs from the Kleinians who view rage as due to imborn infantile aggression and a subsequent fear and guilt.

The False Self (Winnicott):

Winnicott states that the denial of need accounts for, in infants,

> "an organisation towards invulnerability... What is common is this, that the baby, child or adolescent or adult - must never again experience the unthinkable anxiety that is the root of schizoid illness - the autistic child who has travelled almost all the way to mental defect is not suffering any longer. Invulnerability has almost been reached".
>
> Winnicott (1981)

Winnicott cautions, that in extreme situations, accumulated traumatic impingements at the stage of Absolute Dependence place the infant at the risk of insanity, because a pattern of fragmentation occurs which breaks the line of continuity of being. After an impingement from the environment the child fantasezes about the 'unthinkable anxieties' which Winnicott describes as being: going to pieces, falling forever, having no relation to the body, having no orientation, and complete isolation because of no communication. He says:

> "The primitive agony which results in the face of the possible threat to being, brings about <u>disintegration</u> - which is the reversal of the maturation process."
>
> Winnicott (1986)

The infant reacts to the trauma of impingements by bringing into play defences, which function against the unthinkable anxieties and are an attempt to protect the developing self. These defences take the form of distortions of ego-organisation, and this lays the basis for disturbance in the form of a schizoid character. In extreme cases the dissociation results in the development of the <u>False Self</u>.

The latter comes about specifically when the child is in a position which calls for <u>compliance</u>, thst is, if the mother does not implement the child's omnipotence but instead substitutes her own gestures and does not let the child create the world initially. False sets of relationships develop on the basis of the False Self. The pathological extreme is when the split off compliant self is taken as being the whole child, thus leaving the true self hidden and not relating to reality.

<u>The Grandiose Self (Kohut):</u>

In Kohut's description of the development of the infant to emotional maturity, he states that if the grandiose self is not integrated into the realistic

purposes of the ego, derivatives of it are split off or it is repressed. The individual will then oscillate between irrational overestimation of him/herself and feelings of inferiority. Also, if the idealized parent imago is not integrated into the ego-ideal, it is then repressed as an archaic structure, and the infant (or patient in therapy) becomes unconsciously fixed on a yearning, for an external, idealized selfobject with whom to merge and gain strength and protection.

iii) PSYCHOTHERAPY WITH CHILDREN:

The foundation for treating neurotic children was laid by Anna Freud and Melanie Klein, particularly. The latter conceptualised and defined Play Therapy as such. This discussion will look at therapy with children from within the psychodynamic framework generally, and will not include other approaches such as the Cognitive - Behavioural approach.

An important starting point in describing therapy with children is to look at the differences and similarities between adult and child psychotherapy: Similarities include:

1) Acceptance of the patient and his/her communication and actions
2) Empathic understanding of the patient's feelings, which then need to be conveyed to the patient: in the case of child therapy the child's language must be used - verbal or non-verbal.
3) The task of treatment is to help the patient give up defences and allow forbidden impulses to surface and for the patient to come to terms with them. The assumption is thus that symptoms

are an expression of repressed impulses in conflict with how the patient (adult / child) thinks s/he ought to be.

Major differencesbetween adult and child psychotherapy are:

1) Children are generally not willing to come to therapy - adults choose to come.
2) The therapist is perceived by the child as another adult - on a par with the parents - and so not equal to the child - which is an issue as regards trust.
3) The child's parents are in the present and this must be taken into account in the therapy. This differs with adults, for whom usually, parents are part of their past, and there is not an ongoing real dependence on the parents.
4) As regards actual communication in the therapy - adults depend mostly on verbal exchange, while the children are doers and the play activity is the main means of communication.

For the therapist, the main task of psychotherapy with children is to understand and interpret the symbolic content of the child's play. At any given moment we are confronted with a dominant trend of anxieties, emotions and onject relations. Furthermore, the therapist's task is to be a receptacle for the child's feelings, and to transform them and give them back to the child in a manageable and less frightening form.

The 'work' of psychotherapy thus involves a process whereby the child is helped to act out in play or go over verbally those feelings and thoughts that make him / her most anxious. The hidden meaning of the communications of the child are interpreted repeatedly until it is evident that he / she has mastered the anxieties - evident in the child's play or behaviour

generally.

Wolff (1981) describes the aims of therapy as follows:

1) To allow free expression of feelings.
2) To help the child correct any misperception of the environment.
3) To provide insight - in order to help the child understand why he/she feels as he/she does. In so doing the intention is to increase the child's mastery over emotion.

The kind of therapy described above is intended on average for children aged 4 to 11: although Klein treated children of 2 years of age, as did Winnicott. The difficulty with older children is that they tend to find 'play' childish and yet are not in a position to fully utilize the 'talking cure'.

WHAT IS INVOLVED IN PLAYING?

Winnicott (1971) says that it is a creative experience, taking up space and time. However, to be more pragmatic, what would one see if one were to observe a session through a mirror? Nothing significant would strike one - an adult and child in a room surrounded by various toys, with some verbal exchanges at times; usually there would be more activity on the part of the child. How this differs from a scene at home is that the therapist is maintaining a largely observer role - only taking part when directed by the child, and not sharing his/her own experience and feelings with the child. The therapist does not initiate activity, and reflects the child's feelings and interprets the activity where appropriate. The therapist is also informed by theory regarding the child's symptoms and behaviour.

Winnicott makes constructive comments about playing and psychotherapy, which serve to alert the therapist to the danger of narrowly viewing 'play' in terms only of play content, at the expense of the playing child and playing as a thing in itself. Play is universal, says Winnicott, and it belongs to health; it facilitates growth and therefore health. It leads to group relations and can be a form of communication in psychotherapy. The latter indicates Winnicott's attitude, in that he does not focus solely on content in therapy with a child, but has a wholistic view of the relationship between patient and therapist. He adds that psychoanalysis has been developed as a highly specialised form of playing in the service of communication with oneself and others. He also stresses that the therapist also needs to be able to 'play' in the therapy. In describing the psychotherapeutic task, Winnicott says:

> "Psychotherapy is not making clever and apt interpretations; by and large it is a long-term giving the patient back what the patient brings. It is a complex derivative of the face that reflects what is there to be seen...if I do this well enough the patient will find his or her own self and will be able to exist and to feel real. Feeling real is more than existing; it is finding a way to exist as oneself, and to relate to objects as oneself, and to have a self into which to retreat for relaxation."
>
> Winnicott (1971)

Playing as a means of communication between a therapist and child is thus seen as meaningful and symbolic of the child's underlying fantasies, feelings and anxieties. Playing is also considered a safe means of expressing the above: it thus serves as a mediator between the child's internal world and direct expression of it. To facilitate this expression of the child's particular internal world and experiences of it, toys used are generally such that they can be used as the child wishes - human figures, animal figures, trains,sand-pit; not toomany to overstimulate the child and not too structured, which do not allow for idiosyncratic use.

Before looking at specific aspects of the therapy process, some preliminaries are important:

1) The average length of time in clinics and hospitals dealing with neurotic problems is about 6 months. More severe pathology requires longer.

2) Adequate assessment of the family: a history of the presenting problem as well as the individual history of the parents and the index patient must be taken. This is important to come to some understanding and possibly diagnosis of the problem as well as the most appropriate treatment method. For example, is there a medical problem that needs attention, or is psychotherapy indicated, or should academic problems be addressed first; family or parental counselling may also be indicated.

3) Relationship of therapist to parents: This is crucial, in that parents can potentially sabotage the therapy or contribute to its being effective. A good relationship is thus imperative. The child needs a supportive environment for therapy to be optimally effective and to have a sustaining effect. It is usually recommended that the mother (having most contact with the child - unless there is a particular problem between the index patient and father) - come for counseling in order to deal with issues in relation to the child or the family generally. The aim is also to include her in the therapeutic process so that she does not feel ousted as parent and not good enough. It is advisable that two therapists are involved - one for the child and one for the mother.

THE PROCESS OF THERAPY:

Children may have to be forced into the therapy room initially - as they generally do not choose to come to therapy. Hopefully this changes as they gain trust in the therapist and process. Limit setting is an important part of the process and the therapist must have a clear idea of what s/he is prepared to take in the room as regards destructive and aggressive behaviour: while there is room here for personal capacity, it must be remembered that it is destructive for the child to experience him/herself as omnipotent to the extent of leaving therapist and room in an apparently devastated state. Limits can be a containing aspect of the process if dealt with densitively by the therapist. This can be done by using the passive tense when instituting a rule - so that the child does not feel singled out and punished. Make it clear in other words, that the rules are part of the playroom. If the rules are transgressed the therapist must have a strategy for dealing with the child: for example physically holding the child until the child is able to 'hold him/herself'. This can be done for a specified number of minutes which is communicated to the child.

Some initial meeting between therapist and child may often deal with the child's fantasies about coming to therapy - what he/she has been told or hopes or fears about coming. The aim is to allow these feelings, as opposed to generating anxiety in the child - who may have no realistic sense of what the therapy is about. Thus, it is usually added that therapy is a place where children can bring their worries.

It is important not to lose sight of the fact that the relationship between therapist and child is central to the process - and that trust had to be built up between the two people in order that therapy takes place. Sometimes a longer period (more than the mentioned 6 months) is needed for real change to take

place, particularly if the child happens to be, for example , withdrawn or difficult to make contact with.

Within such a trusting relationship the recurrent aspects of both adult and child therapy can effectively be dealt with - namely transference and the process of interpretation. While reflections form a large part of the process, interpreting implies that underlying meanings are brought into the open for the child, in order to diffuse the potency of the child's anxieties. Winnicott (1971) is wary of jumping in with interpretations and asserts that psychotherapy (depth) can be done without interpretations: his concern is that if an interpretation is applied from outside the material presented, the child is effectively being indoctrinated and becomes compliant. The latter being indicative of the development of false self, and pathology. Interpretations can, however, further the therapeutic work if given within the area of overlap between therapist's and patient's potential space. He reminds the reader that playing implies trust, starting between infant and mother - and if this was not established , then the child will have difficulty in the subsequent moves to Independence: s/he will have difficulty playing in the therapist's presence; difficulty in being alone in the presence of another; and difficulty playing with another.

Finally, the importance of termination cannot be stressed enough: the set date of ending therapy must be established initially, even though the child won't register it properly. This must be reiterated in the final phase - roughly the last 6 sessions of a five month therapy. The assumption is that the child does have various feelings about ending - even if s/he has difficulty expressing them. It is the therapist'ns task to make these explicit, and thus allow them to be. These feelings include feeling sad, angry with the therapist,

or pleased to leave. All of hese may leave the child feeling uncomfortable and anxious, hence the need to bring them into the open, and so to diffuse them of their destructive potential - in the child's perception.

It is appropriate to terminate at this point with Kohut's comments on empathy. He says that through empathy:

> "one recognizes the self in the other, it is an indispensable tool of observation; by the expansion of self to include the other it constitutes a powerful psychological bond between individuals; and the accepting, confirming and understanding human echo evoked by the self".
>
> (Chessik, 1985)

Kohut sees this as psychological nutriment throughout human life. He cautions that empathy too can be misused, and that only when it is effectively and sensitively used can it diminish rage and desrtuctiveness by increasing the empathic bridge between separate peoples.

CHAPTER 3: CASE PRESENTATION

IDENTIFYING DATA:

J.B. is a 10 year old boy, living in Johannesburg with his parents and one brother. He attends school in Johannesburg.

REFERRAL:

J.B. was referred by a neurologist who had been treating J.B. for two years with medication for behaviour problems.

PRESENTING PROBLEMS:

J.B. was having recurrent outbursts of rage towards his mother, he also appeared depressed and anxious to his parents and he had suicidal ideation.

HIGHLIGHTS OF PERSONAL HISTORY:

1) Pregnancy was normal. Following the birth J.B. was in an incubator for a few days.
2) J.B. had one convulsion when he was 1 year old, as a result of pyrexia.
3) He was put on a gluten free diet at the age of 2, as it was thought that he had ceoliac disease. This proved incorrect after a biopsy 7/8 years later.
4) J.B. was late speaking, and he received speech therapy, at age 3.
5) He was sent to a new school age age 3 to help with speech.
6) J.B.'s brother was born when J.B. was 3 years old.
7) Behavioural problems started when J.B. was 6 years old in 1983: his mother noticed 'tics' at this time, and she sent him to a neurologist and he was assessed at Forest Town. Petit Mal, a chemical imbalance and Gilles de la Tourette were considered as diagnoses. As a result of this investigation

J.B. was put on the following medication: Tofranol and Anatensol.

8) J.B. received remedial help at school in Grade 2.

9) In 1986 he was given educational assessment by a psychologist who found that he was of average intellectual ability with uneven cognitive development. His spelling and written language were found to be below age level.

10) In 1987 J.B. started getting aggressive towards his mother. An EEG was done, and a mild irritation was shown on the right side: he was consequently put on Epilim. The mother reported slight improvement, regarding the aggresive outbursts.

11) J.B. was put on Ritolin twice for this same aggresive behaviour, but is was stopped as it apparently hyped him up.

12) At the beginning of 1988 J.B. appeared depressed on return to school and was suicidal. He appetite was also down. He was then referred to Tara Children's Clinic.

13) There were no notable problems at school during this time - other than that he apparently did not have many friends.

14) His parents describe his aggressive outbursts as verbal and physical, and he only attacks his mother, with rulers and ropes. Mother holds his hands now, to stop him and he seems to get soothed when held by her, and goes to sleep. She has tried all forms of punishment including locking him in his room, which have not helped.

15) On the whole, he is described as an affectionate child.

HIGHLIGHTS OF FAMILY HISTORY:

FATHER'S HISTORY:

1) Mr B was born and lived in London before coming to S.A. after his marriage.

2) He has one brother and he described his family as being close.

3) He was a slow learner at school, and had problems reading.

4) He was placed in a technical school, where he blossomed and went on to college.

5) At 16 years of age he had a motor vehicle accident and he was not concussed.

6) He has periods of withdrawal during which he stays in bed and does not want to communicate with anyone. He only wants to eat. This was apparently diagnosed as Klyne Leven Syndrome.

7) Mr B today works as a Contracts Manager in engineering.

MOTHER'S HISTORY:

1) Mrs B. was born in England, and came to S.A. after her marriage to Mr B.

2) She is the elder of two siblings. She has a brother three years younger than herself.

3) She describes her parents as having been strict with the children.

4) Her parents were divorced when she was 10 years old: her mother left the family for another man and remarried. She saw her mother during holidays but lived with her father.

5) Mrs B was placed in charge of the family - in the mother role and the only person she received affection from was a maternal grandmother.

6) After completing school she went to Technical School and then Private Grammar School.

7) She became a caterer after doing an Hotel Management course.

8) At present she is a housewife.

MARITAL HISTORY:

1) Mr and Mrs B met and married in England and came to settle in S.A. They lived initially in Botswana, where J.B. was born.

2) Mrs B was at home throughout this pregnancy as well as the second.

3) The family moved to Johannesburg after J.B. was born.

4) They report their marriage as being good.

5) Recently, Mrs B has had difficulty coping with J.B.'s aggression towards her: she now handles it better. Father would generally arrive home to an unhappy atmosphere, as a result of J.B.'s outbursts. The family's weekends together seem to be better - especially as J.B. enjoys doing practical things - such as working on bikes with his father.

5) The younger brother does well at school and they have no problems with him.

ASSESSMENT FINDINGS:

Prior to recommending psychotherapy for J.B. psychological assessment was done: this included the DAP (Draw a Person); KFD (Kinetic Family Drawing); TAT (Thematic Apperception Test). (See Appendix).

Findings of this assessment include that J.B. experiences the environment as potentially punitive, and unnurturant, and not meeting his needs. He fears impulses will be overwhelming and this also elicits guilt in him. He copes by withdrawing from the environment and tries to keep distress and bad feelings to himself.

Play therapy was recommended in the light of the above as well as the assessment interview and the history: it was felt that psychotherapy could facilitate managing feelings for J.B., particularly the aggressive. Also, it was felt that an improved sense of self would be beneficial for J.B., and that this was something that could be encouraged in psychotherapy.

It was also recommended that J.B.'s mother be seen for counselling, in order that she be helped to acknowledge the strength of her son's emotional life,

as opposed to conceptualising everything that happens in physiological terms.

With the agreement of the neurologist who had been treating J.B. the medication was stopped.

INTRODUCTION TO THE ANALYSIS OF THE THERAPY PROCESS:

J.B.'s particular problems need to be approached with an open mind, since they do remain ill-defined: this therapist in no way presumes to discount the possible presence of a biological substrate to his behaviour: he certainly does appear to have a highly reactive temperament, evident in various problems from infancy: he was in an incubator after birth; had speech problems; had remedial help at school; tics; and has more recently reacted to his mother in a problematic way.

The actual cause of these remains debatable. However, what is at issue here, is how the mother has dealt with the givens of her son's nature. That is, she has tended, it seems, to disaffirm him, and has been intent on finding physical illness where none has been clearly diagnosed. Hence, it is reasonable to confront the problem at the level of relatedness, since no manifest organic or physical cause has been found to account for the presenting problems.

While the therapist adopted an object relations approach to understanding this case, there was not a strict adherence to interpretive work particularly in the later part of the therapy, when innovation took place (Session 10), and J.B. and the therapist met in her office, and a more reflective approach was adopted. Furthermore, it is believed that a longer therapy would have been desirable in J.B.'s case. This was not possible due to constraints of the particular rotation of staff.

This therapy with J.B. proved to be a challenge on many fronts: not only was J.B. one of the first children seen in therapy by myself, but also because of the staunch physiological orientation of the mother which meant the therapists

involved were constantly re-eveluating their psycho-therapeutic intervention; and also because J.B. posed a problem as he was resistant to the setting and therapy, and had apparent difficulty with an interpretive approach on the therapist's part. The therapy took place over 14 sessions. A month's break followed, after which the mother asked for a follow-up. The latter consisted of 5 sessions.

THE THERAPY WITH J.B.:

My initial impression of J.B. in the first session was that he appeared more at ease and more competent than I expected in the light of the initial assessment and the mother's descriptions of him. I was, however, from the beginning aware of his use of adventurous stories about himself and others, as being a means of building himself up in my eyes and of telling me that he is not merely an anxious and out of control child.

Even if some of these instances of adventure were fantasy, which they may be, they still served an important role in the therapy process: they informed me of his need to be seen in that way. Furthermore, points can be made about J.B's use of bravado and adventurous activities in the sessions: firstly, there is an element of defence against intimacy with the therapist and it effectively directs my attention away from his vulnerability and feelings generally; and finally, it is evidence that despite J.B's problems and difficulties, he is competent in some respects and better able to deal with his world than his mother gives him credit for.

My attempt in therapy was largely to facilitate a greater self-esteem in J.B largely through mirroring, which involved acknowledging his experience as he related it to me, and reflecting feelings when they emerged or were implied.

At the start of therapy, however, feelings were quite hidden and action (talking about) was predominant.

It seemed important to J.B to present the 'good' parts of himself to me, at first, and this persisted on and off during therapy. It was very difficult for him to deal with bad feelings that he kept inside himself.

I discovered in Session 2 that direct statements and questions to J.B concerning emotional / feeling states were not welcome, and were ineffective in any positive sense at that stage. I myself experienced my comments and interpretations at the initial stage of therapy (first few sessions) as impingements on him, rather than freeing him to express himself or in any way relieving his anxiety.

My response involved a trial and error approach, with a fair amount of guesswork as to how J.B was feeling in the therapy, as it seemed that he was holding it all in and out of my reach. What seemed a more positive approach for J.B was indirect: In Session 2 when he was burying his hand and unburying it, he referred to his hand as a monster's hand. I was able to take this up and make references to what made it hard for this hand to emerge etc, and what would make it easier...he accepted this probably because there were no direct reference to J.B himself.

I have grouped the first four sessions together as they involved the 'good' and competent J.B, who has many skills in the outdoors and also can speak Sotho. In addition, and in contrast to this competence, there is evidence of his shyness and reserve about therapy - evident in the recurrent burying theme, and the resultant reluctance to deal with (inability probably at this stage) interpretations and references to his emotional state.

I aligned myself with J.B's bravado at this stage, whenever it came up later in therapy, and did not focus on the underlying vulnerability. I perceived a fragile sense of self, and I felt as time went on that to undercut the bravado would have been experienced as an undermining to J.B . Furthermore, as Ritov (1977) has said, the child patient can easily feel overwhelmed by his/her instinctual drives and as such can usually only tolerate indirect recognition of wishes, fears and defences.

Session 5 and Session 6 herald a change in that J.B brings in his own 'toys'- not that J.B. would probably have approved of them being 'toys' - as the playroom smacked too much of the childish for him in the first place. He brought yo-yo's to Session 5 and Garbage Kid cards to Session 6. What first came to mind was that this was again a means of defence - against my interpretations, and that he perhaps hoped this would give his own structure to the time and space with me; thus also, intimacy may be averted. However, I believe he also used these toys to communicate about himself, in that I was given glimpses of him at school with peers and at home. For instance, I glimpsed his sexual awareness and his anxiety about that. I intended to utilize what was also a defence as an attempt to introduce some mirroring into the sessions, by simply acknowledging the importance and enjoyment for him of these items.

I did not interpret his reasons persistently, for bringing toys in, other than mentioning that he perhaps did not find anything in the room that could be used, as I did not think that J.B. was ready for interpretations about the defence, or for that matter about his sexual anxieties. Hopefully he experienced my response as accepting and non-punitive.

The cards appeared again in Session 7, and with them a much more overt reluctance to be in the session: he was no longer performing and explaining how things worked with the cards, but was using them to absorb himself and shut me out of his space. His reluctance was also evident in his having kept his mother looking for him while he played cards, before this session - with the result that they were fifteen minutes late. His mother was scolding him in front of me when they arrived, and appeared to place herself in the role of the good child who was wanting to be there for her therapy on time, and it was thus all J.B.'s fault. It seemed to me when J.B. and I went into the therapy room that he fully expected me to scole and cajole as his mother had done - hence his rather dark and furtive expression. I reflected that he might not have wanted to come, but this agained seemed too direct for J.B. and he could not really acknowledge this. I should have added that it seemed to me that he expected punishment and that it may surprise him that I would not give this to him. He thus proceeded to try and shut me out of his space as the therapy session proceeded. My feeling was that he was also shutting out his own frustration (at coming and at his mother's scolding, which no doubt left him feeling again infantilised) and his anger at me in the room.

Session 7 was significant since it was the first clear sense I had of J.B.'s anger, in contrast with the earlier talk about adventure and skill and prowess. As regards the countertransference: this session was the first in which I felt that I was in a mother-transference with J.B. I mentioned to J.B. on the session that perhaps he tries to shut his mother out when he is cross..... etc. My belief is that this shutting out which is also a withdrawal on his part from me and the situation, is bound up with a fear also of his own anger and bad feelings which he may perceive as wildly destructive. It was as if J.B. did not trust himself to let out what he was experiencing at the time; as he may feel he has no control in how it emerges.

In the light of the supervision I received after Session 7, it may have relieved some pressure off J.B. if I had acknowledged ambivalence in J.B., early on in the therapy. That is, while allowing him to be angry, also allowing him to sometimes want me to listen/be there etc. I think it may have been frightening for him to only acknowledge the negative and bad feelings, particularly if they seemed overwhelming to him. Possibly my intention to facilitate the latter may have not enabled him to be ambivalent and gradually to get used to acknowledging the negative side of his feelings. He may have felt that my interpretations would end up unleashing chaos.

The more vulnerable side of J.B. did however, emerge to some extent in the follow-up sessions during which he spoke openly about being afraid in relation to experiences in the outdoors as well as being anxious about going to boarding school next year; despite also being excited and wanting to go. Feelings were definitely not ignored in some of these sessions. He was also able to tell me that his mother was bugging him - with her over-concern and treating him like a baby. At this point it seemed to me that although J.B did not want to be infantilized and treated as a baby he also was aprehensive about having to be completely adult and independent. The latter concerned him particularly as regards going to boarding school.

When we moved to my office in Session 10, following the decision made in supervision to do this, a shift took place in the therapy: J.B started speaking more freely, and physically his demeanour changed - in that he sat erect in the chair, was apparently alert and the dark sullen expression cleared, on the whole. The intention with this move was to acknowledge J.B's growing discomfort in the playroom and his frustration at being to him, again infantilised. I had been aware of a growing sullenness and resistance to this playroom setting.

I realise that a more strict adherence to psychodynamic theory would probably have sat out this resistance, but since J.B and I had limited time together this did not seem a practical thing to do. I was, however, at the time, questioning whether I was simply colluding with J.B's defences and his difficulty in dealing with feelings and the therapeutic relationship. However, while some of this does apply, I felt that in view of the time factor there were some issues that could be dealt with by changing venue, and that the therapeutic value of the process would not necessarily be lost. By accepting and acting on J.B's experience and feelings I intended to mirror him, and so facilitate a development of the self that was perceived as lacking.

Certainly the change seemed to relieve J.B. of some pressure as he started talking quite freely: again, the adventure and bravado was present, as well as things that he enjoyed about camping, riding bikes etc. My worry was when this change took place that the session would degenerate into chat shows. Hence, I attempted to use these sessions to mirror whatever he brought into the sessions and to let him know I saw what was important to him and how he felt about them. I was still wary of interpreting, and this was tricky, as overtly the situation was one of adult therapy where interpretations based on largely verbal communication is called for, and yet here was a child who was not in a position to deal solely on that level.

I engaged largely thus in reflective work, occasionally initiating a topic, that had emerged earlier for example. My reason for this was that again, the adult therapy experience of silence I did not feel was appropriate here. However, we did have a partly silent session in Session 2 of the follow-up, when he seemed to not want to talk and was again keen to end therapy. I acknowledged this and said we could keep quiet and sit silently till the session ended. He appeared

reasonably comfortable with this. Again I intended to mirror him and not force a discussion about his feelings or interpret them.

Termination: While termination is always an important part of any therapy, it had particular nuances with J.B.: first of all, it felt decidedly premature as I believed he needed a longer therapy to truly benefit from the process, which could become more interpretive over time; and secondly, I was not sure of J.B.'s feelings towards the therapy and myself, other than his overt statement about being pleased to leave. I suppose it also devolves onto the issue of wondering whether he had gleaned anything which he coulc take away with him after termination. Feeling pretty much in the dark about his feelings, I attempted to allow the whole range of possibilities, since he seemed still defended against intimacy in the therapy, and against a sharing of his experience. He did however, seem to acknowledge some mixed feelings when I raised the possibility. This termination took place over Sessions 12, 13 and 14 which was the last session.

FOLLOW-UP SESSIONS:

J.B.'s mother was concerned a month after termination, that J.B. was being 'difficult' and that he was anxious - for example sometimes wanting to sleep in her bed. I was arare again of the mother's tendency to find something wrong with J.B, while acknowledging that he did need more therapy, ideally, and that this should therefore be looked into. What was however, also significant, was that at this time the mother's therapist was away for a holiday, and it seemed to me that she did need some formal contact with the Clinic, to fulfill her own needs.

It was possible to arrange a couple more sessions with the same therapist, hence

the 5 follow-up sessions took place in September and October.

On the whole J.B. was more in touch with feelings and able to express some of these to me: regarding the mother as well as his own anxieties about camps, and going to boarding school. Important is that at this time J.B. appeared to be indulging in slightly 'anti-social' behaviour - I use this with Winnicott's description in mind, which is less categorical than anti-social in the personality sense: on the positive side, J.B. seemed more active and involved in his world - at school etc, and was expressing feelings out there - for example teasing the teacher, and on one occasion breaking a window when he was angry at home. An important shift here is that he did not vent anger and rage on his mother. His mother apparently burst into tears at this event and sent J.B. to his room - telling me that he thus knew how much this had upset her because when she cries she is truly upset. I questioned to myself whether this was ideally what J.B. needed in response to breaking a window, as it may have again reinforced the destructive potential of his feelings. Again, the result is as if J.B.'s action has directly hurt her, even though it is difference from attacking her bodily. He was also not allowed to ride his bike for a set time as punishment.

Obviously, a tendency to act out in this way is not something one wants to encourage as adequate coping behaviour, but in the short term it is a distinct shift from the withdrawal J.B. indulged in previously, and the rages towards his mother. I think this tendency to now act out in this way can be understood as J.B. still not being able to experience himself as unthreatened by the environment, as the possibility is still lurking in him that he could be annihilated (fantasy) and undermined, in more real terms, by the environment.

During the follow-up sessions, I attempted again to support that in J.B. which was coping, and acknowledged all that he brought simply by passing no comment as to whether the acting out was good or bad, but trying to see what he felt about it himself. Again, if therapy were longer, a point would be reached where his expression of feeling would be channeled in a more acceptable direction, while also aiming at building up his sense of self so that the environment is not perceived as at base persecutory, and requiring an aggressive retaliation.

On the last follow-up session, termination was talked about as well as administering a Rorschach during the last half of the session: this was to get a sense of what could be expected from J.B. after he leaves therapy. The tendency to withdraw was still present in J.B.'s responses, and a tendency to deal with 'bad' feelings by himself. On the positive side, there is evidence that he can cope with stress in his life. The indication on the whole is that further therapy is recommended, as self-esteem is not yet well-developed in J.B, and as mentioned above, could well have a role in acting out that emerged in the follow-up sessions. As regards the future (immediate), J.B. is going to boarding school in 1989, about which he is on the whole very happy.

Change over the course of therapy:

J.B.'s mother reported that J.B. stopped his outbursts of rage towards her and gradually she and he engaged on more levels: she said that he began telling her that he felt she was babying him and that he did not like this. She in turn was able to respond differently following her own councelling: this helped her to acknowledge his feelings and to realise that there was a relationship between herself and J.B, and that this involves emotional responses.

She acknowledged that all could not be explained in terms of medical health/ill-health. (See Appendix for report on mother's therapy). Mother's therapy is considered important in facilitating change and improvement in J.B.'s behaviour.

In the therapy with J.B. he seemed to grow up somewhat: while some maturation is obviously acknowledged, there was more: he was able to deal with the therapist as someone who was not out to persecute him, and he was then able to share some of his feelings.

As regards J.B.'s performance at school, there were no complaints about his work or behaviour on the whole, and he was participating well in sport and other group activities - camps etc. He also took pride in doing well and was eager to report that he was now working hard because of a previous failure in a subject in the past.

DISCUSSION OF THE THERAPY IN RELATION TO THE LITERATURE REVIEWED:

At the outset of therapy with J.B. rage and its manifestations was the focus. However, what emerged stronly through the sessions was J.B.'s need not to be intruded upon as he was struggling to assert himself and to be seen as competent and able, and not as an infant. Hence he seemed to experience direct comments about his emotional state and interpretations as intrusive,as impinging, in Winnicott's terms. In such instances J.B. withdrew and closed up.

It seemed to me that J.B. was needing to protect himself - protect what he could - which was the feelings he kept inside of himself - from being tampered with. It was as if he had no real sense that he would be acknowledged by the other and given credit for who he is at this point in time. We get back to Kohut's mirroring process, and that it seems to have been lacking in J.B.'s experience. It felt as if J.B. did not have an established sense of himself, and that he was trying to present in the therapy, especially in the beginning, was quite grandiose at times. In Kohut's terms one could say that he was unable to integrate the grandiosity and the idealised parent. This is further understood if one recalls that he had suicidal ideation and a sense of worthlessness at the start of therapy, and this ties in with a process of self-denigration alternating with grandiosity: the bipolar self has thus not been established successfully.

He was also expressing guilt with the suicidal ideation in response to his feared destructive actions towards his mother, who was probably not perceived as able to withstand these attacks.

The reason for the grandiosity and idealised parent imago not coming together is, according to Kohut, due to the lack of maternal mirroring and empathy. The infant thus develops a precocious and vulnerable sense of autonomy.

In Winnicott's terms, the mother's mirroring role (holding, handling and object presenting) is crucial if the child is to establish an adequate sense of self with which to negotiate the world. If the child is placed in a position by the mother that necessitates reacting, then the false self starts to develop. When the child is not left to be, spontaneity is prevented, and so is the development of an individual response to the environment and an expression of needs.

In Kohut's terms, rages such as that expressed by J.B. is seen as a result of frustration, not the expression of an innate impulse. Rather the role of the early environment is acknowledged as having failed the infant in some way. As Winnicott would say, there was maternal deprivation, which leaves the child frustrated and hence the rage.

J.B. can thus be seen to be frustrated at the lack of mirroring and he developed a way of coping with them: he withdrew when threatened (in his perception) by the environment because he had no experience that informed him that he could cope with it. There had been insufficient containing of his feeling for him to feel that they were manageable and not ultimately destructive.

During the therapy itself, some of J.B.'s frustration was evident in relation to the therapy situation and the therapist (Session 7), when he got visibly more frustrated and then angry and withdrew from contact, by attempting to shut the therapist out. Interpreting was then seen to be a source of impingement for J.B. and reflection was used instead, hence no unearthing underlying anxieties.

Kohut makes the point that the parents are crucial in their response to the child's libidinal and aggresive and exhibitionistic strivings: if they withdraw from these needs in the child then the internalisation of grandiosity and the idealised parent imago cannot take place effectively. Hence the bipolar self cannot develop properly.

In J.B.'s case, it appears that his mother is not experienced as surviving his attacked - his rage - and hence his feelings are not being effectively contained. Winnicott mentions the importance of the mother surviving the infant's fantasy attacks. Mrs B appeared to be daunted by J.B.'s rage and was not initially able to comprehend that there were feelings involved in her attempts to find a physiological reason for the rage.

In the therapeutic relationship with J.B, it felt as if he did feel threatened by Winnicott's 'unthinkable anxieties': as if he feared that his feeling if shared would be destructive and overwhelming and leave him fragmented and dis-integrated and probably alone, without a holding mother, and so uncontained.

It seems, in terms of Winnicott's conceptualisation of rage as an attempt to rediscover one's aggressiveness in the hope of getting some security from the environment, that J.B. was in fact trying to get his mother to contain him. Winnicott understands anti-social acts in this way: hence J.B.'s later actions - breaking a window, and his naughtiness at school, can be seen in this way.

By the end of therapy, J.B. did show a measure of <u>concern</u> about his own actions - in that he wanted to control his anger - and would try and stop himself. The problem being that he had not fully developed the meahanisms to do so, and did not yet trust himself enough to control himself.

It was apparent in the therapy, that J.B. could not play: partly this may be due to the fact that he is bordering on adolescence and that the playroom was geared towards younger children: however, this is not the entire explanation: there was something constructive about his being in therapy. As Winnicott says there is something both 'exciting and precarious...' about playing, because it involves an interplay between that which is subjective in the child's mind and that which is objectively perceived - actual or shared reality.

J.B. may well have found it very threatening in indulging in play for these reasons. It would also have been exposing and he may have feared vulnerability as a result. Possibly his concern that his feelings would be overwhelming was also a deterrent. In view of his postulated lack of mirroring and containment it is understandable that he did not expect the therapist to contain his feelings and survive.

CONCLUSIONS:

This case study attempted to show the usefullness of psychotherapy with a child treated previously with medication. This was done by analysing the process of therapy with this child and including testing results and the mother's therapy, to evaluate what positive change took place. Changes were enumerated as well as the limitations of the therapy: it was stated that further therapy is considered advisable for this patient in view of the state of the patient at termination , as well as the Rorschach results obtained at termination (See Appendix).

It is felt that his case study did provide the reader with insight into the patient's problems and the context in which he was struggling. Attempts were made through analysing the therapy process, as well as though use of theory, to understand J.B. and his difficulties, and as far as possible to find causes for the present situation.

The case study also illuminated the reality of the therapeutic endeavour, which involves being open to what emerges from the other person involved. The therapist thus attempted to be led by the patient, not imposing her research aims on the patient and therapy.

While it is sincerely felt on the basis of the thereapist's experience of the process and of J.B., that some positive change took place, no claims are made that he is in sound mental health. There is still work to be done, including improving his self-esteem, improving his relational ability - developing empathy, and further facilitating mastery over his own feelings.

Medication which J.B. had been taking was stopped (with the agreement of the neurologist) at the beginning of therapy, and there were no negative repercussions. His mother was able to get used to this lack of medical support and J.B. himself was very pleased.

APPENDIX

1) Assessment.

2) Report from mother's therapist.

3) Therapy Process Notes.

1) Initial Assessment prior to therapy:

TAT, DAP, KFD.

INITIAL PSYCHOLOGICAL ASSESSMENT: REPORT ON J.B.

Name: J.B.

Age: 10 years, 9 months

Date Tested: January 25, 1988

Tested by: C Cheesman, Intern Psychologist

Tests Used: DAP, KFD, TAT.

Clinical Impressions:

J.B. was anxious and withdrawn, initially making little eye contact with the tester. However, he willingly did the drawings and TAT. As the session progressed his anxiety abated and he engaged in conversation with the tester.

Interpersonal Functioning:

J.B. portrays anxiety and conflict in relation to his sexual and aggressive impulses, as is evident in both his DAT and TAT stories.

There are signs that he feels both inadequate as a person, and insecure in the world. There is also emotional immaturity and signs of regression.

While his DAP is developmentally acceptable, the figures in the KFD were less differentiated: in contrast mechanical objects were clearly drawn and detailed appearing more substantial than the figure of J.B. himself - which was transparent, seated on his bike. His mother dominates the family drawing - by virtue of her size and her central position. The father was represented by a small, undifferentiated figure working under a car.

Despite his lack of substance compared with his bike, J.B. represents himself as quite an active figure in the world.

J.B. showed his efforts to control the stimuli of the TAT cards by a silence of a few minutes prior to presenting a rapidly-told story. He would not allow any spontaneous response to the cards, which could have exposed his anxieties to himself and the tester.

He tended to distance himself from the cards and his stories by focussing on events and actions rather than on relationships between people. He ignored some figures and introduced elements of his own - again trying to control the stimuli. Some of the details in his stories were conflicting / did not logically tie up, and showed signs of confusion in the face of trying to keep anxiety at bay.

Most of his TAT responses indicated that he perceives the world in terms of absolutes: for example - if one does something punishable, the penalties are extreme - such as death. Similarly, if one follows one's instincts / impulses, the results tend to be negative for oneself / others.

The environment is perceived as uncompromising, where one's needs are not met, and where in one's frustration, one may resort to extreme actions when they are not met. Guilt is also a result of expressing needs.

J.B. tended to deny what was anxiety - provoking, and he had difficulty describing or staying with feelings. 'Therapy-endings' were often tagged onto other stories without conflicts having been resolved / dealt with.

Summary and recommendations: J.B. does not experience his environment as meeting his needs and impulses - which are then left uncontained. It seems that he thus perceives extreme actions as a way of being 'heard'. This, however, is not comfortable for him, as he experiences guilt at expressing needs.

His anxious withdrawal and attempts at keeping his distress to himself is comprehensible when one considers that he is experiencing the environment as unnurturant and potentially punitive.

J.B's feelings need to be contained as they threaten to overwhelm him. Play therapy may facilitate expression for example of aggressive feelings without resulting in destruction. A punitive some of self would then be developed. However, J.B's mother is an important focus in attempting to help J.B. She needs to be helped to acknowledge the strength of his emotional life - including the negative, and to de-emphasize his physical health / ill-health.

J.B. - TAT RESPONSES

CARD 1:

He's looking at a picture - he wants to become that when he's older. He asks his mother and father's advice - what he must do - they agree. He goes to college a few years later - then he wants to be what he wants to be (What's that?) A game ranger.

Before this... he's thinking whether he must or must not do that. (Feels?) His friends say that he won't earn enough money doing that.

CARD 13B:

He's in a log cabin and looks out in a veld and wants to explore and take a tent and his pellet gun and sleep in the veld for a few days. He asks his mom and dad and they say yes.

He gets lost in the veld - he forgot his compass at home.

(Then?) He comes across a farmhouse and asks the people where he is and they tell him and he goes home.

(Feels?) It was quite exciting.

CARD 2:

They were busy ploughing in the field and a plane flew past and dropped a bomb - the horse got loose and ran. The man in the plane wanted the horse - so he landed and followed the horse. The people followed it and caught it. Going back to the fields they found the man, and he wanted to exchange it for a few shillings. They said no, and he carried on

following them. They went into the house and locked the door, he banged on it. They got tomato sauce and pretended they were shot. He saw them and went away.

CARD 4:

The man was going to Angola to fight and she says no - he went and she followed him in a car. He got there and so did she. He got captured by the opposite people there, both of them got captured. They escaped and went back home.

(Feel?) They were scared.

CARD 7BM:

The boy (right) did not want to go to college, he wanted to go straight to work. His father said he must go 'cause he would not earn enough money. He argued about this and he went to live with a friend who was on drugs. He forced him to take them and so he ran away to his father and said he was right that he should go to college.

(Felt?) He felt he'd done the right thing. (What?) To go to college.

CARD 5:

There was a cat in there, busy sharpening his claws on the furniture. The lady was in the kitchen washing dishes and she heard him and came to the lounge and smacked him - said don't do it again. Then she felt something - the cat was sharpening his claws on her dress, and she smacked him. Then the cat was sharpening his claws on the bed, and then she went to bed, and felt something in the bed, and it was the cat sharpening its claws. Then she went to have a cup of tea in the lounge in the morning -

the setee was wrecked.

(Felt?) Bad - so she sold the cat.

CARD 6 BM:

Man was going to leave home -'cause he was there for a holiday - the lady did not want him to - talking about this - he said okay, he'd stay another night. He went and when he arrived home the person he was staying with was there and she stayed the night and went back the next morning.

(Feel?) Don't know.

CARD 3 BM:

The man had R1 million in his car - so the robber knocked him out and took the keys. He drove to his lane - he wrecked the whole car - and could not find the money. He went back to the man and asked him where is it? He said he did not have it - meanwhile - he'd brought the car with it - so he (robber) killed the man.

CARD 8 BM:

It's in the olden days - the man had to have an operation during the war. The doctor did not have the right thing, and the man was going to die. So another person who had a motor-car accident - they put his heart in the person - it was the first heart operation.

CARD 17 BM:

The fire brigade alarm went off - so they slid down the rope and went to the fire, took five days to put it out, it was so big. They had to nightwatch over the fire, every fireman was there. Another house was on

fire, she phoned that fire brigade, they were not there - so she went to them and half of the brigade came to her house. She felt terrible 'cause it was on T.V. that the house was on fire (other house).

CARD 14:

It was the middle of the night and the robber broke into the house - people who owned it were watching T.V. He crept up to the bedroom and poured things out of the window to his teammate. Then someone put on the light and he jumped out of the window and he died.

CARD 11:

It was on a mountain - a volcano struck - rocks started falling - people were walking on the mountain, looking for a cave - it had a golden dummy in it. They got to the cave and took the dummy. The lava came and hit them. Other people came to get the dummy and lava hit them too - the dummy was so hot that it hurt their hands.

BLANK: CARD 11:

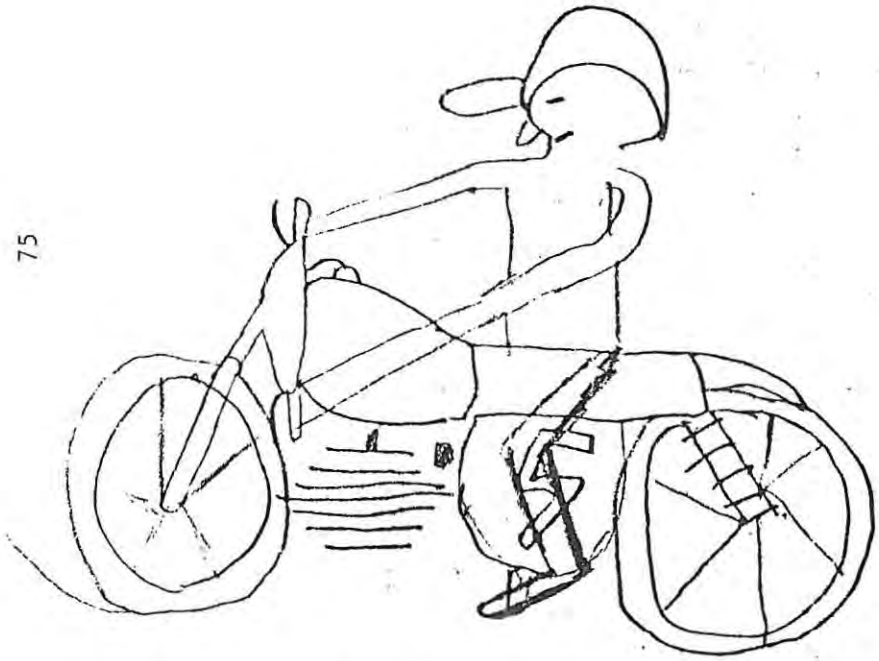
There was only one whale in the ocean - the man wanted to kill it 'cause it chopped his leg off. He sailed to the mysterious lands to find it. One stormy night - the ship wrecked - they blew onto an island - they collected wood and tools and made a boat. They set off to their own land.

10yrs

P. 13

- Likes fixing things with father
- Not like washing dishes.

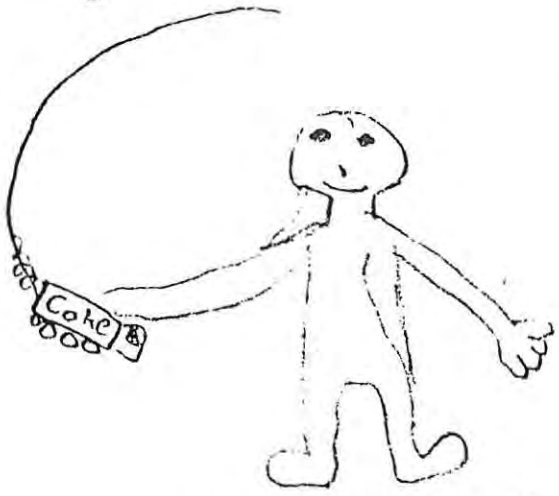
10 yrs



9 riding his bike.

- mother cooking

- Father working under the car.



Brother playing

Final assessment: Rorschach.

J.B. RORSCHACH REPORT:

It is important to note that J.B. only gave 13 responses to the cards, which is low for his age-group, and thus the test is interpreted with caution. The low number of responses indicated some constriction in J.B., and a reluctance to share his feelings. He was given the standardised instruction to encourage more responses, but this did not elicit more; "Most people see more than one thing..."

However, what can be gleaned from J.B's responses is that his response style is introversive, meaning that he deals with decisions, problems, at an ideational level, rather than react spontaneously to the environment. Furthermore, he tends to withdraw from the complexity of emotional stimuli, and prefers not to engage with others if such complexity is a possibility: this is evident in the following ratios: Lambda = 0,54 which is low, as is the Affective ratio = 0,30; the low number if human responses, H = 2, is also supportive of this point.

It appears that J.B's attempt to withdraw and /or hold himself back is his way at present, of exerting self-control. He possible fears that he might get out of control and be overwhelmed by impulses and bad feelings. This attempt at organising and controlling the environment is evident in the Zd score =-1.

However, despite the attempts at rigid organisation and control, he does not deal accurately with the detail and complexity of situations; thus his perception is not as accurate as it might be, when situations are ambiguous and require attention to detail: this is evident in the ratio X+% = 53% which ideally should be higher.

He does not seem to have as much self-esteem as one would wish, and this may account for, partly, his withdrawal and his response style which as mentioned above, is introversive. It seems that he distances himself emotionally in order not to get overinvolved, with feelings that are difficult for him.

On the positive side, J.B. does have inner resources and is able to cope to an extent with stress. This differs from his initial assessment prior to therapy where he appeared more stressed, anxious and helpless in his environment.

In summary, it appears that J.B. is still somewhat constricted in his dealing with his environment, particularly when it comes to emotionally complex and ambiguous stimuli. His way of dealing with the latter is to withdraw, rather than react spontaneously or on impulse. It is evident that further psychotherapy would be beneficial, as his self-esteem is still not as good as it could be; also, an empathic quality is lacking in J.B at present, and this needs to be developed to avert acting out.

J'S RORSCHACH RESPONSES

	INQUIRY:
CARD 1: A butterfly.	(whole) There is the head, wings and feelers.
CARD 2: A moth bleeding. (upside down) The top looks like plants that grow in the sea - the shape.	Where...? The black part - moth - bleeding head and blood at bottom. What...? Cause of that part of the wing...(outlined). If there would be a spine. Plants? The red part - ..What...? Usually flat on the bottom - and then every now and then the spikes shoot up. Spikes? The jagged lines.
CARD 3: Black part looks like a robot - that's all...	Where...? Feet and arms (side), sensors, and mouth and eyes are black. What...? The arms - usually...are scary... Scary...? not to me - to others...

NB: "What...?" - What made it look like that to you?
"Where..?" - Where on the blot did you see that?

Questions and brackets are the tester's comments.

CARD 4: A gorrilla needing a support stand...

Where? there is the support - (middle)
Gorrilla? The feet and arms - a bit small for a gorrilla - the head - like a moth's head...
What...? The gorrilla - I don't know...
Support? it's like he's extinct - and they have to keep him standing in a museum. Moth's head? They are usually quite chubby...
Chubby? the cheeks - (outlined).

CARD 5: A bat, and a moth (upside down).

Where...? Legs and wings and ears, mouth, (whole) - What? usually the wings they flap - and then they face down - Bat-type feet -...
Bat...? Like these - usually more detail - I've seen a bat before...
Moth? The talons, and eyes and feet and wings...What...? Those feelers...

CARD 6: A cat's skin - that's flat...

Where? Whiskers and mouth and fur on the cheek, and arms and legs -
Flat? The way it's drawn...Like no shadows straight on the paper...

CARD 6 cont...

Fur? fluffy - the light grey...
Cat skin? I'Ve got a lion skin
at home, it looks like that...

CARD 7: If you put them together - it makes a rabbit... take the arms away and turn it...there is a fold there like paper -
Or it is some children - baby bunnies running away from each other

Where...? (pointed out parts - whole) Ears and mouth and body and legs -
What...? If you take away the arms - put them together ... the big ears - a bit furry... Furry? The dark shade - and the light shade...
Children/Bunnies? If you take one away (one half of blot) - it is running away and looking back. What...? The ears...

CARD 8: (upside down) - (sideways) - A ghost and a ferret (red) - that way - a tree (sideways) - so it could be used as a badge - like for nature conservation...

Ghost? What...? Looks like it has got arms and a scary straight face - and squinted eyes. Ferret ...? The shape - the line - nose and eye and ear and feet...Tree? The grey and green - it goes up and down like a palm tree (outlined) - Badge...? Like nature for trees - the ghost could be the destruction of trees...

CARD 9: Looks like a space-fight - one of those elephants... Where...? The elephant - (pink) - and arms and hands in pockets where gun is - and feet - (orange) - What...? The big ears and usually elephant in the space fight - he always wears - they comment on the colour - sometimes he wears odd clothes...

CARD 10: Looks like a lot of animals put together - here is a seahorse (red) and it's a made up drawn picture - Lions are jumping - (bottom) - here are two rhino beetles (top) - fighting over a stick - and two rabbits jumping (blue) - rabbits head with worms coming out (bottom middle). Seahorse? The nose and tail... Lions? Front paws and back part - the dark shade where the mane is - the rest is lighter...Jumping? It's at a slant - front paw is straight Rhino beetles...What? Usually a rhino horn and front talons and back thing...Beetles fighting...? Looks like a thing in between there - and mouths are open and fierce - Stick? Straight. Rabbits jumping? Front and back paws - and it is big...Rabbits head and worms...? Take this away - then it looks like the head - Worms? It has bad habits - lets things crawl in and out.

EXNER SYSTEM USED

J.B. Age 11 Sex M Date 17/10/88

SEQUENCE OF SCORES
(Blend det.'s parentheses)

pT	R	Loc	DQ	FQ	Move	F/FD	Col	C',Y	TorV	Ref	Blend seque (FQ)	(2)	Zsc	Po	Cont's	Specl.
1	I	W	o	o		F							I	Po	A	
2	I	W	o	u			CF-						4,5		A,Bl	DR
	2	D	v	u		F									B+	
3	I	D	o	u				FC'						Po	(H)	
4	I	W	+	o	MP								2		A	MOR/INCOM
5	I	W	o	o		F							I	Bl	A	
	2	W	o	o		F							I		A	(PSV)
6	I	W	o	o				FT					2,5	Po	Ad	
7	I	W	o	-				FT					2,5		A	
	2	Dd	o	o	Mq							(2)			H/A	
8	I	W	+	u			FC						4,5	Po	Ant	
9	I	W	o	-	MP								5,5		(A)	INCOM
10	I	W	+	o	(FMq)			(FY)			FMqFY	(2)	5,5		A	FABCOM

R = 13 Zf = 10 ZSum = 30 P = 5 (Z) = 2

Location Features

W = 10
D = 2
Dd = I
S =

Determinants (Blends First)

FM.CF.Y = I

Contents

H	= I	Bl	=
(H)	= I	Bt	= I
Hd	=	Cg	=
(Hd)	=	Cl	=
A	= 10	Ex	=
(A)	=	Fi	=
Ad	=	Fd	=
(Ad)	=	Ge	=
Ab	=	Hh	=
Al	=	Ls	=
An	=	Na	=
Art	= I	Sc	=
Ay	=	Sx	=
		Xy	=

Contents (Idiographic)

_____ =
_____ =
_____ =
_____ =
_____ =
_____ =

Single Determinants

	S	(Bl)
M =	3	
FM =		I
m =		
C =		
Cn =		
CF =	I	
FC =	I	
C' =		
C'F =		
FC' =	I	
T =		
TF =		
FT =	2	
V =		
VF =		
FV =		
Y =		
YF =		
FY =		I
rF =		
Fr =		
FD =		
F =		

DQ

+ = 2
o = 11
v+ =
v =

M Quality

+ =
o = 3
u =
— =
NO FORM =

Form Quality

FQx

+ =
o = 7
u = 4
— = 2
NO FORM =

FQf

+ =
o = 3
u = 2
— = I

S-CONSTELLATION (Adult)

___ FV+VF+V+FD > 2
___ Col-Shd B1 > 0
___ 3r+(2)/R ≤ .30 or ≥ .45
___ MOR > 3
___ Zd > ±3.5
___ ep > EA
___ CF+C > FC
___ X+% < .70
___ S > 3
___ P < 3 or > 8
___ H < 2
___ R < 17
_____ TOTAL

Special Scorings

DV (1)	=
DR (3)	= I = 3
INCOM (2)	= 2 = 4
FABCOM (4)	= I = 4
ALOG (5)	=
CONTAM (7)	=
____ WSUM6	= 17
AG	=
CONFAB	=
CP	=
MOR	=
PER	=
PSV	=

RATIOS, PERCENTAGES, AND DERIVATIONS

ZSum-Zest = 30 - 31
Zd = -1
EB = 3 : 1,5 EA = 4,5
eb = 0 : 3 ep = 5
Adj = I : 4 Adj =
(FM= I m= T= 2 C= I V= Y= I)

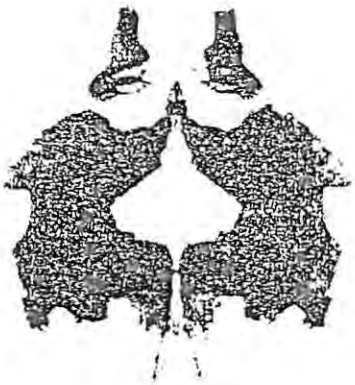
D = 0

a:p = 2 : 2 Adj D =
Ma:Mp = I : 2 Depi = 0
S-Con = Sczi = I

FC:CF+C = I : 1
Pure C = 0
Afr = 0,30
3r+(2)/R = 0,16
L = 0,54
Blends:R = I : 13
X+% = 0,53
X-% = 0,15
F+% = 0,25

W:M = 10 : 3
W:D = 10 : 2
A% = 76%
Cont:R = 4 : 13
Ab+Art = 0 : I
Isolate:R = I : 13
H+Hd:A+Ad = I : 10
(H)+(Hd):(A)+(Ad) = I : 0
H+A:Hd+Ad = 1 : 0

I



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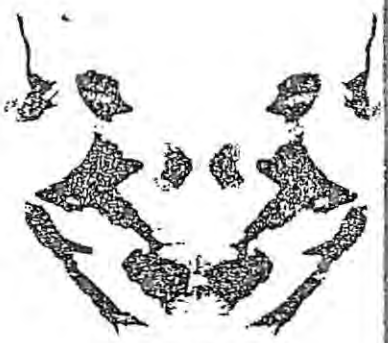

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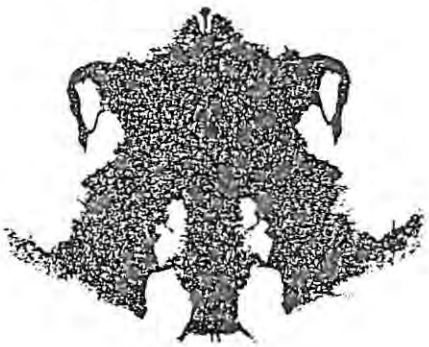

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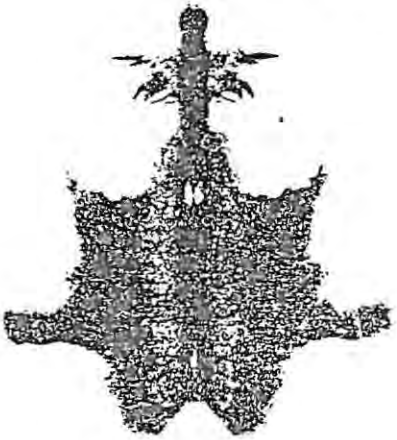

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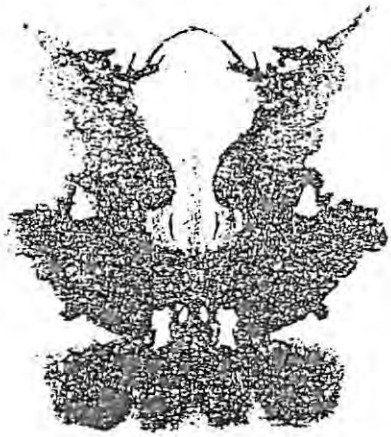
VII

VIII



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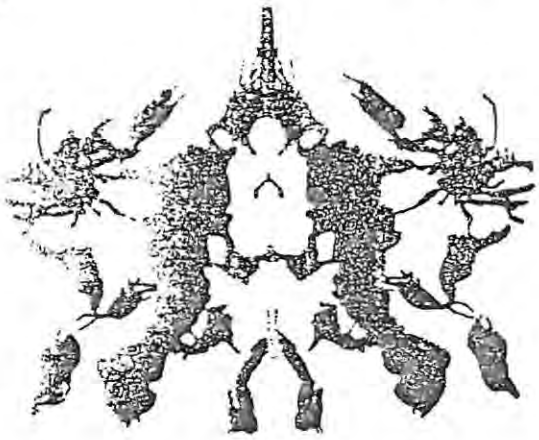

X

2) Report from mother's therapist

COMMENTS BY THE MOTHER'S THERAPIST

In his opinion, the mother has difficulty resonating with her son's fundamental goodness - despite her visible love and concern for him. There is a quality of anxiety in her attitude towards him in that she wants him to be in a certain way - specifically that he should be behaved and correct. She has difficulty appreciating the fact that he is a child, and that spontaneity is 'normal' and healthy. In this regard she has lost touch with her own 'child' in herself and as such appears quite restrained and unspontaneous. She is uncomfortable with what is impulsive, robust and unintellectual.

Thus, she is unable to endorse the latter qualities in her son's behaviour, and places a dampener on him, possibly based on a fear of that way of being, and she may be worried that this way of being would reflect on her: she wants her son to reflect her a good and charming mother. Wheras if he behaves in these unconstrained and spontaneous ways she may become tainted.

She effectively negates his own uniqueness: he has not been confirmed and reaffirmed for himself. His rages towards her can then be understood as reactive to her response to him. She appears unable to transmute or contain his feelings. Her way of dealing with his behaviour and experience, is to rebel and interpret it in physiological terms, and thus invalidate the reality of his feelings, the intensity of his needs and his ambivallences.

Her attitude and view of her husband: She describes him as moody, and dissatisfied with his achievements. He apparently has difficulty communicating his thoughts. The therapist is of the opinion that she perceives him as a child in the family, as if he is dependent and reliant on her.

Her background: She is the eldest child in her family and had the responsibility from age 12 of looking after her siblings as her mother ran away with another man. It appears that she never dealt with her own rage and dissapointment and says that she and her mother eventually 'got on well.' She was thus the supportive one, and has taken it upon herself since then to pragmatise life and avoid emotionality, not only in her own experience but that of her family.

Did the therapist perceive any changes in mother during the course of therapy; She certainly appears 'lighter' in manner, less constrained, and has come to a point where she acknowledges a psychic and emotional life. She has come to accept that we do not know absolutely about things, and that something unknown remains in relationships. She is more humorous and some spontaneity has emerged.

Countertransference: The therapist, particularly initially, felt subtly watched, judged and scrutinized in a controlled manner. At the same time she appreciated the relationship and certainly wanted reassurance of the contact with respect to issues to do with her son. She left the therapist often anxious to convice her and to be adequate in her presence. She had the effect of rendering the therapist unheard, particularly on the emotions versus physiology issue.

She frequently persisted with finding physical fault with her son, and would then leave the therapist having to reassess his interpretation of the situation, and wanting to convince her. She would accept his interpretations of her son's situation and behaviour towards her as being concerned with the relationship between them and feelings - but this had to be reiterated frequently.

3) Therapy Process Notes

INTRODUCTION TO THERAPY PROCESS NOTES

An attempt was made to make notes from memory - as fully as possible: however, they are not word-for-word what took place, as no tape recorder/ video was able to be used.

Supervision comments are made where it is considered to be particularly necessary: on the whole, supervision dealt with the therapist's attempts at mirroring J.B's actions and feelings, in an attempt to build up self-confidence and at base - a more solid sense of self, with which to act on the world. Some time was spent trying to gain an understanding of J.B's lived-sense of his mother, in order to be aware of how he was experiencing the therapist in the transference - and what could be expected of him in the therapy.

SESSION 1: FEBRUARY 5, 1988

Comments:

(Countertransference and supervision)

I knew J.B. was not keen on the playroom as his mother had told us (myself and her therapist). I anticipated resistance as a result and so jumped in with this. I think I was too quick to defend the playroom and thus therapy - he may have felt exposed too soon.

I changed the subject too soon.

Therapy process;

J.B came in looking a bit reserved and anxious....

Therapist: You have not been into the playroom before have you?

J.B: No.

Therapist: I wondered if you were thinking that coming to a playroom is for younger children and not for someone as old as you.

J.B: Mmmm (smiling)

Therapist: There are things here for younger children and for older children - you can choose what to do...

J.B: (nodded)

Therapist: Did you have any thoughts about coming here today?

J.B: (shrugged) ... No

Therapist: Do you think you know why you are coming?

J.B: (nodded affirmative)

Therapist: Sometimes children come here because they have things that are worrying them...

J.B: (nodded)

Therapist: Okay, we will meet here once

a week for 45 minutes, okay?

J.B: Yes.

Therapist and child were sitting on edge of sandpit both filtering sand through their fingers. J.B. started making patterns in the sand - indentations.

I thought J.B. was possibly speaking of what it might feel like for him coming to therapy, but it seemed too soon to interpret...

J.B: These are like beetle traps -... in the sand... a type of ant runs and falls down the side here into the middle and they bury themselves...

Therapist: Yes?

J.B: I've seen them in the Drakensberg, they are little holes as big as this (showed finger) and ants fall down the side - there were lots...

This was unnecessary - I suggest an extreme possibility without containment.

Therapist: When they are buried...do they die?

J.B: No.

SILENCE...

Therapist: It sounds like you've been to the Drakensberg on holoday?

J.B: Yes, we go once a year... my dad is part of a Vintage club. We camp and make huge big fires at night, we also go

for 24 km walks... my brother and I ride our bikes there, we go on the trails. Once my friend and I ran a lot of the way... over streams and rocks...

Therapist: Sounds like you really enjoyed the holidays?

During these stories I felt that he was becoming more at ease - and that he achieved this by placing me in a peer-position - someone to regale 'macho-stories' and with 'action'.

J.B: Yes... I want to be a game ranger... we used to live on a game farm, where we used to shoot game for the blacks. They would pay for the bullets... the man who owns the farm now had to shoot the donkeys belonging to the blacks, cause they would eat and stand on all the fruit. He told them he would if they did not keep them away. He fired one shot in the air and then shot the donkey. I've learnt a lot about Sotho there. When a man dies a woman sells everything and has a big party with the money from what she's sold. And then... I don't know... And when people retire... what do you call what they get...?

Therapist: Pension?

J.B: Yes, they don't have that, they say their children are their pension and they will look after them when they die... the blacks do things much better than we do...

Therapist: You like the way they do things ... they seem to care for each other and help each other...

He started playing in the sand: using moulds and making piles of sand with them.

J.B: These are elephant footprints. (smiling)

He had some difficulty as some of the mounds of sand would not turn out in the shape of the mould - sand was loose

J.B: It is easier with the wetter sand underneath the dry sand...

He clearly tells me that he is competant and able to look after himself. It is important for him to feel that I see him like that - not as a baby.

Therapist: Mmm. Do you want some water?

J.B: No. Like elephants they know where to find water.

He dug and found damp sand.

Therapist: You are making patterns...

J.B: Yes, a triangle shape.

He got into the sandpit and started testing the sand shapes to see if they would stay in shape - sprinkled sand on them and them blew it off and shapes stayed.

Therapist: They are still there...

It crossed my mind that J.B. may be wondering what the effects of therapy are - how safe it is: I could not find a way of saying this without it being too involved - so I left it.

He then tried putting them back in the mould and turning them out again.

J.B: To see if they stay whole.

They did and he looked pleased - and tried lifting them carefully - some broke - did not seem to enjoy.

Therapist: It really looks like a tricky thing to do.

J.B. was smiling, brushed over some of them and got out of the pit and sat down next to me.

He appears comfortable enough to release some feeling (in physical activity) - and he tells me of his outburst with another boy.

J.B: Can I punch on the punch bag?

Therapist: If you want to yes...

Punched hard and controlled the bag well. He sweated and his mouth pulled down at the sides as if angry.

J.B: I gave a friend a black eye at school...

Therapist: Mmm. Maybe you were cross...

J.B: Yes...

He punched and then stopped.

I'm allowing his anger - facilitating 'acting-out' in the room rather than outside.

Therapist: That bag's nice cause you can pretend it's anyone you want it to be...
J.B: Yes, it would be nice to paint his face on it and put his name under it...
Therapist: Ja...

Both the therapist and child are sitting on side of pit.

Therapist: We have got a few minutes left today...

J.B. climbed into pit and made a sweeping path in the sand.

Therapist: It looks like a winding road...
J.B: Yes, a wide winding road...

He picked up moulds and used them to race each other round the road.

'Burying' has come up repeatedly - (note session 2)

J.B: They are burying each other...(both got to end of road) They tied.
Therapist: No-one won...they got together. We are stopping now till next week.

By the end of the session, it seems that J.B. is prepared to come back.

J.B: Here is another track for next week.

Session ended.

On the whole I was left with a sense of a much more competent little boy than the anxious, tearful creature whom I had assessed: there are two interpretations of my impressions - I think he was needing to put up defences around feelings (vulnerability, dependence) and secondly - he probably is more able than his mother puts across, and I was partly influenced by her reports of his difficulties.

SESSION 2: FEBRUARY 12

J.B. came in and we both sat on the edge of the sandpit.

J.B: How are you?

Therapist: Fine thanks...How are you...

J.B: Okay...

He was quiet for a number of minutes - fiddling in sand. He made patterns, looked like faces.

The therapist reflected what she saw - faces - and he acknowledged that's what they were. He added it was a cross face.

This was too direct for J.B, I should have developed the feelings around the 'cross face' in the sand - and not immediately drawn J.B. in.

Therapist: Maybe you are feeling cross?

He shook his head - for no.

He then made a drawing of a shark and told me that when they were on holiday at the sea he was body boarding and he saw a shark's fin. He caught the next wave back and told the guards and all the people came out of the water.

J.B. then again turns to the 'macho' and bravado stories, steering away from feelings and exposure of himself.

Therapist: Gosh, I wonder how that was for you?

J.B: All the people said I saved their lives...

Therapist: Ja, it seems like you did...
He then told another story about a friend of his sighting a dead killer whale.
Therapist: I imagine it could be really scary seeing sharks and killer whales...

He did not respond but carried on drawing in the sand.

He drew letters in Sotho - 'Hello Tani'. The therapist commented on that he could speak different languages. He agreed and said it was Northern Sotho.
He then made roads in the sand and put handprints on the roads and wiped them out. The therapist commented that they did not seem to stay in the sand. Later the therapist commented that perhaps he'd like his prints to remain - in response to him making deeper imprints. He then showed the therapist the animal tracks that the Sotho had shown him - antelope and cattle tracks in the sand. The therapist said that he knows those and so can track the animals. He nodded and looked pleased...
He was burying a little stick and he counted how many flicks of sand it took to cover the stick. The therapist reflected what she saw him doing - and how

He is again being a peer - even educating me. He enjoys my praising him and abilities.

Burying theme emerges more fully: this time J.B. seems to accept my interpretation.

much sand it took him to bury the stick. He was also burying other things - which the therapist mentioned. Initially J.B. said 'Pardon' to my reflection of the burying, but then he went on to burying his own hands.

Therapist: Perhaps you feel that you are buried like that with lots of stuff pressing down on you...
We had been pressing lots of sand down upon his hand, and every now and then the hand threatened to pop out. He nodded and seemed to agree.

We seemed to be on the same wavelength here - with him acknowledging the shyness and need to be hidden with me, and fear that I may be intrusive with him (Possibly as his mother has been). This made me wary of direct interpretations, which may be experienced as impingements rather than a relief.

Therapist: Maybe it's hard to come out...
He said it is like a monster hand - as he made it come out slowly and them quickly put it back. The therapist reflected these to and fro actions.

J.B: It's shy (smiling).
Therapist: I wonder what would make it better for it to come out?
J.B: I don't know... an eye for it to see out of...
He made an eye in the sand.
Therapist: Now it can see what's going on.. Maybe it will come out later...

He finally buried a paper windmill he'd been using to write with some of the time. The therapist reflected that it was completely hidden, and looked just like a mountain or sand dune - and one would not know anything was there. He seemed to acknowledge this - nodded. The therapist reflected that perhaps it was safer for now to be hidden and buried.

J.B: Ja... He left this and drew noughts and crosses on the side of the pit. The therapist wondered if he was letting himself win. He did. He did not make any sign of hearing the therapist when she said it was the last few minutes... he carried on drawing...

Session ended.

SESSION 3: FEBRUARY 19

J.B. came in looking angry and scowling... He sat down and drew circles over and over again in the sand... The therapist reflected what he was doing and wondered to him whether he was feeling like he was going round and round in circles?

A guess on my part.

J.B: Ja.

He then fiddled in the sand and made vicious and angry actions in the sand. The therapist postulated that he might be feeling cross...perhaps even with the therapist...

Again, the direct reference seems to irritate him and he appears more angry. I felt that I had 'struck' him in some way - he almost recoiled.

He shook his head for no - vehemently... The therapist amended this and suggested that he might be cross with someone...

He continued to sit and mouth words silently - eyes downcast...

Therapist: You may have lots of thoughts about may things - but perhaps people don't listen or hear you...

SILENCE....minutes...

Maybe you think that I may not hear you or understand you - like some other adults around you...?

He then made spoors in the sand...

I felt as if J.B. decided to take control in some way and communicate with me quite clearly.

A more indirect approach seems more effective and also satisfying to J.B.

I attempt to allow him to get irritated with me - acknowledging some 'ego' in him and some judgement of his own situation.
I was not sure whether he felt better / not about my admission of not always knowing what's right etc. In retrospect I was concerned this may leave him feeling I'm not in control/ able to contain what happens / his anger etc.

The therapist commented that these were like the ones he had shown her before... He continued to draw in the sand -

Therapist: I wonder what that is?

J.B: A stop sign.

Therapist: Perhaps you are telling me to stop?

J.B: Pardon? (Therapist repeated) No.

Therapist: People have to obey stop signs otherwise they have accidents...?

J.B: Yes. (definitive nods)

Therapist: But, then when it's safe one can go again.

J.B: Yes (nods)

He then continued to fiddle in the sand and made some angry swishes in the sand. He again made burying actions. The therapist reflected these actions - to which J.B. cast furtive, angry glances at the therapist...

SILENCE...minutes

Therapist: Perhaps I say stupid things in your opinion, sometimes... things that are not right for you...

SILENCE...few minutes...session ended.

SESSION 4: FEBRUARY 26

J.B. came in silent and fiddled in the sand ... both therapist and child sat on the sandpit edge.

J.B. made spoors in the sand - not any particular animal.

Therapist: It looks like you are making your own this time? I wonder if this animal is being followed?

J.B: No.

Therapist: Perhaps it's too clever?

J.B: Yes (smiling)

He appreciated this - I thought he identified with this animal: am I losing him?

Burying actions again, perhaps he's feeling better about being 'seen' here and communicating...

He got very involved here - determined actions.

SILENCE...minutes...

He then buried his hand and arm continuously...

Therapist: It looks like you'd like to use all the sand in the pit and cover your hand?

J.B: (he nodded affirmatively)

He made his hand break out of the sand very slowly. He then got into the pit and made sweeping tracks.

Therapist: It looks like a track?

J.B: It's a rally road...

He took lots of care in constructing this and used three objects and buried them making humps in the road.

The therapist commented that it took a lot of work to make.

J.B: Yes (smiling)

He then dusted himself off and covered the road with dust. The therapist commented that he was covering it up cause he was not using it... He did not reply.

Possibly he's reforming to therapy - I was not sure - I may have been looking for significant actions here!

Therapist: You don't seem to know what you want to do with the road you have made? J.B. nodded and smiled. You took a lot of care making it but you're not sure you want to use it at the moment. J.B. looked at the therapist (which he did not do often in the session) and nodded. The session ended.

SESSION 5: MARCH 4

J.B. appeared quite comfortable with the yo-yo's: I felt this was something to place between us - to direct my attention to this - away from his feelings etc.
However, he does also use the playing to me more about his school and his sexual interest: it seemed that he furtively wondered how I'd react to the boys trying to lift the girl's dresses.

J.B. came in with his yo-yo in hand... and started to tell me about a competition and all the different tricks that can be done with a yo-yo.
The therapist listened and acknowledged the tricks. He meanwhile carried on playing and performing the different tricks...

Therapist: You have brought your own things to do here today - something you enjoy doing...
No particular response from J.B.

SILENCE...while he played...

Therapist: You really wanted to bring something you like today because I think it's been difficult for you here with me the last few weeks...?
J.B: Mmm. I just had them in my pocket.
(not sounding particularly phased or concerned by the therapist's interpretation)
Therapist: Yes, and you enjoy playing with them...

Playing continued...
He went on to tell the therapist that at school they use the yo-yo's to lift up the girl's dresses...

Therapist: I wonder what the girls think about that?

J.B: It does not always work, sometimes we put press-stick on the end to lift them up...

Once my yo-yo got stuck between a girl's legs and she did not realise it...

(seemed to enjoy telling the therapist this story - quite cheerful at this point)

Therapist: Seems you did not expect that?

J.B: No I did not.

Possibly he's anxious about his own 'potency' being dangerous - or simply his sexual awareness being dangerous.

He then told the therapist that yo-yo's were also used by the Portuguese in the 2nd World War to knock people out with...

The therapist reflected that they have lots of uses and can be dangerous too it seems...

Continued playing...

I stuck to what was more overt and non-threatening for him.

Therapist: You've shown me lots of tricks today... and you have brought something here that you enjoy...cause perhaps you could not find anything here that you could use...

J.B: He did not respond, only looked up at me...

I could not make out some of the last minutes - he seemed as if 'off-balance', lost his at ease showing off demeanour - possibly evidence that it was presented to me and covering up other feelings.

Therapist: And you really enjoyed playing with the yo-yo...We have only a few minutes left of today's session... J.B looked around the room, and seemed slightly disorganised in comparison with how competent and performance-orientated he had been during the rest of the session.

Therapist: It's hard for you to keep up your concentration for so long...

J.B just smiled at the therapist...

Session ended.

SESSION 6: MARCH 11

A range of possible meanings to bringing in the cards occurred to me at the time: it could be a defence (as I implied in the previous section) against exposure and intimacy with the therapist, who tries to talk about feelings. Or he may be telling the therapist she is not able to give / do anything for him, and that there are competent and varied aspects to him that he is able to bring into therapy and show the therapist.

J.B. brought in his collection of Garbage Kid cards. He was quiet and sat down, absorbed in reading the cards. The therapist commented that he had brought something else in today, and that he was reading the cards.

J.B. acknowledged the therapist's comment and proceeded to tell the therapist about the cards: how at school they play with them, gamble etc. He added that his mother does not want him to spend R10 on them.

The therapist responded to this, wondering whether he was cross at not being allowed to buy more cards.

J.B. did not directly take this up, and proceeded to tell the therapist how many cards people have in their collections and the desire he has to win more.

Therapist: I bet you'd really like to have many more cards than anyone else...

J.B: Yes, I would.

J.B. proceeded to tell the therapist that if teachers find the cards they are confiscated.

Therapist: I bet you'd hate that - be awful.

J.B: Ja

Therapist: So I bet you keep them well hidden...

J.B: Ja, in my top pocket, but sometimes they are too thick to fit...

J.B. then told the therapist that his brother wrote 'J.B.' on the card named 'Bully'. J.B. appeared a bit concerned by this.

I have stayed with J.B's defence here against feelings of hurt and vulnerability.

Therapist: You may not have liked that...

J.B: Ja, I nearly killed him.

J.B. related how he had written his mother's name on the 'Barber' card 'cause she cuts their hair and his father's name on the 'Mechanic' card.

I realize that in keeping with a 'bully' front he tries to keep up bravado - which I support in this session, to the detriment of explaining his vulnerability and feelings about himself - other than anger - which functions as a form of defence.

Therapist: So everyone got a card, except your brother.

J.B: Mmm.

Therapist: Maybe you'd like to find an awful one for him...?

J.B: Ja, I looked for one...

Session ended in a few minutes.

SESSION 7: MARCH 18

J.B. and his mother arrived 15 minutes late. Mother flustered, saying she could not find him at school. She wanted him to apologize to me. J.B. looked sheepish, embarrased, as if expecting punishment from me. Brought in his cards.

Mother appears to present herself as the good child and J.B. as the naughty - she makes him feel small and uncomfortable here.

Therapist: Maybe you did not want to come here today...

He tries to deflect my comment.

J.B: No, I was just busy with a card game..

J.B. then sat down and assumed an absorbed attitude with his cards.

SILENCE...numerous minutes.

Therapist: It looks like you've won more cards...?

J.B: Mmm.

At this point, I felt J.B. was vehemently trying to shut me out of his space.
A heavier, more intense atmosphere was developing.

SILENCE...numerous minutes.
J.B. in the therapist's perception looked progressively more 'black', he seemed more angry.

Therapist: I bet you'd rather be outside playing with your cards with someone else...

and not here with me...

J.B. nodded agreement.

I was trying to allow him to be cross - as opposed to me being punitive, which he seemed to expect.

Therapist: It's hard to have to come here when you don't want to, and that could make you really cross and angry.

SILENCE...during which J.B. stole one look at me.

This direct comment seemed not to work.
Unnecessary comment.

Therapist: You may be cross with your mom and with me for you having to come here... I can understand that.

On reflection, my interpretation may be demanding too much reflective capacity from J.B. at his developmental stage.

It seems to me that you are trying to pretend that I'm not here with you...cause you don't want to be here...perhaps this is what happens when you're cross at home... you may pretend that people (maybe your mom) is not really there cause you're angry.

During this session, I felt for the first time that I was in a mother-transference-countertransference-hence the above interpretation.

SILENCE...

Therapist: I bet if you could, you'd make the time go so fast - so that you could go home...

J.B. was looking at his watch at this point.

Last few minutes of session.

Therapist: I understand that it's difficult for you to come here, when you really don't want to...

J.B. nodded in agreement...

We are stopping here today...

Session ended.

J.B. was away for two weeks on holiday.

Supervision:

The supervisor suggested that it could be helpful to facilitate ambivalence on J.B's part by: saying that sometimes he'd like me to leave him alone, other times he'd like me to listen - Ie: "I make you feel confused..."

SESSION 8: APRIL 14

J.B. came in and told me it is his birthday tomorrow - and that he is going to their family's farm...

It seemed as if he spoke spontaneuosly and then realized what he'd done and clammed up.

He then clammed up and sat silently on the edge of the sandpit. The therapist picked up on the fact that it was holiday time. However, J.B. only acknowledged this.

SILENCE...minutes...

I did feel that he was angry - but again the direct focus on this does not draw us together...

The therapist suggested that he might prefer to be doing something else / playing rather than being here.

J.B: nodded and smiled slightly

SILENCE...minutes...

Therapist: I bet it makes you cross with me cause you have to come here and cross with your mom for bringing you here...

SILENCE...while J.B. fiddled - in the sand..

Perhaps you'd rather be out there - you might be thinking about your birthday and the holiday...

SILENCE...minutes

The therapist commented on the sand that J.B. was pouring repetitively from hand to hand and through his fingers...it reminded the therapist of an hourglass motion, which she told him...adding that he might be measuring the time passing... J.B. looked irritated at the therapist's comment...

Despite his silence, his face was quite expressive - I felt slightly as I had done back in Session 2, when he got visibly irritated at my comments - I felt pushy / a bit intrusive.

Therapist: Perhaps it's not like an hourglass to you at all, you may think that was a silly thing to say...

SILENCE...minutes...longer than previous...

Therapist: Maybe you are cross, or maybe you are not - I'm guessing about this...

In this session I should have allowed him some of the ambivallence mentioned in the Supervision to Session 7.

SILENCE...

Session ended after the silence... the therapist wished J.B. a good holiday...

SESSION 9: APRIL 20

It struck me as they arrived, that the mother presented herself as the good child arriving for her therapy session while J.B. was put forward as the bad child - to be severely scolded...she appeared quite smug, in fact...

In retrospect, I should have mentioned to J.B. that he seemed to expect me to punish / moan at him like his mother did, when she nudged him towards me before the session.

Supervision:

It was decided to change venues with J.B. - the intention being to thus acknowledge his feelings about being there, as opposed to just crushing him.

J.B. came in angry and silent...having arrived with his mother 15 minutes late for the session...he appeared to expect some chastisement from me - a furtive look was on his face - and he blinked nervously. The therapist reflected again that she thought he did not really want to be here today. The therapist did not address directly the fact of lateness.
The therapist added that he may be angry that he has to come, and that he may feel he has no choice about this, about coming to see the therapist...

SILENCE...seconds...

Therapist: You probably have a lot of thoughts sbout coming here - but they are difficult to talk about...

SILENCE...minutes...

At this stage J.B. appeared tearful... sniffing...he refused an offer of tissues...

The therapist simply repeated that he really did not seem to want to talk about coming here...
SILENCE...until the end of the session...

SESSION 10: APRIL 27

Following the therapist's supervision, it was decided to give J.B. a change of venue, from playroom to the therapist's office.

J.B. arrived still looking sullen and with a 'dark' expression

I wanted him to know there were limits around therapy - ie. we would not stop before the agreed time, but I would consider his feelings.

It struck me that he started talking with relative ease - as if I'd released dome pressure. The sullen look lifted considerably.

The session started off in the playroom: The therapist told J.B. that she really thought he did not like being in the playroom which seemed to him to be for small children, and that we were going to continue meeting for the agreed period of time (till end June) but that we could change venues.

J.B. nodded in vehement agreement and seemed to lighten up visibly at this possibility of a change...

We moved to the office where the therapist made coffee for them both. J.B. started talking almost immediately...He told the therapist about an impending school camp which he was looking forward to, but that he was also a bit scared, cause he did not know what would happen on the camp...he said he is excited cause of the animals he would see there, and they would sit around the fires...

He added that it is tricky at school now because they have to behave if they want to go on the camp...

The therapist acknowledged that it is hard to be good all the time...

The therapist also mentioned that going on a camp that he described was a bit like boarding school... (this had come up before as a possibility for him). He agreed and said he liked the idea of boarding school as well...

We then talked about how many sessions till the end and therapist reiterated that we would meet in the office...and set the final date.

Session ended.

SESSION 11: MAY 9

J.B. arrived this week having been on the school camp... he told me about the aminals they had seen, and that it was scary at night with all the animal sounds... they were told about berries that they coul eat and how to spot snakes lurking around... and generally how to survive in the bush...

He seemed more able to acknowledge the scary and worrying, as well as being competent and able with me.

At this point J.B. enjoyed relating this to me, some of a sense of 'bravado' was apparent as well as a genuine interest in what had been experienced.

My feeling was that J.B. felt very in control and important telling me things about the outdoors and survival - he put himself in a sort of educational position vis a vis the therapist.

He went on to tell me that some animals are dangerous, for instance the black and white rhinos...

I got a bit edgy here, as I did not want my office to become a place of informal antitherapeutic chats!

The therapist attempted to bring the conversation round to people and feelings by commenting that like some animals are dangerous, some people may seem a bit dangerous and not nice...
However, J.B. did not take this up.

He went on to talk again about the holidays organised by the school every year...and how they had to behave well to be allowed to go...and that it was difficult...

Supervision:

It was decided to let J.B. speculate about how his mother would respond to dangerous animals - scary situations (If the issue came again).

The session was almost over and J.B. asked how many till we stop and I told him.

Session ended.

J.B. was away for one week after this session.

SESSION 12: MAY 16

Initially J.B. seemed to be waiting for some structure and did not launch straight-away into talking as he had done before... Holidays were mentioned again, and he said that the teachers do not like them although the children do. This is because it means work gets behind and they have to catch up a lot...

Essentially he appears at ease, and no overt anger...perhaps the anger is now being avoided?...Am I colluding?

He talked about the recent camp again, telling me how a snake got into their tent and he hit it with his pillow. The therapist simply acknowledged that this might be scary, etc. This was a chance to let J.B. wonder how his mother would react to the snake for example? He seemed to enjoy this, and clearly felt himself quite able in dealing with such things, whereas perhaps his mother would be scared, he was not sure...

As discussed in the previous super-vision.

Told me they are going to the Berg for the long weekend. He started talking about bikes, and told me his father was good at fixing them. His father has 4 bikes, he said, and J.B. also has some to ride in the nearby park. He irritates an old man who lives near there. He related how a friend

I am supporting his sense of competance - and am responding to what I perceive as a tacit appeal for mirroring and positive feedback. I think this is important for J.B. and justifies the change of venue and apparent 'collusion'

of his fell off J.B's bike...cause he did not know how to ride bikes... where the throttle was and that (told me parts, indicating that he knows motorbikes). The therapist reflected that it certainly requires skill to handle bikes...

Therapist mentioned 2 sessions left...

Session ended soon afterwards.

SESSION 13: MAY 23

He was not forthcoming - I did not feel I should sit in prolonged silence in this setting, which is more adult and may become too stressful for him (and perhaps for the therapist - who did not want to feel punitive!)

The therapist started the session after a few moments silence by asking J.B. how the Berg trip went...

J.B: It was nice, but very cold, at night we made big fires, so big that we could not even get right up to the fires...
We also went to the Holiday Inn this weekend cause my brother played soccer there for the team...it was the first time the team won...

SILENCE...seconds...

The therapist mentioned that it seemed there were no more holidays to talk about, and that he had to do school work again...
J.B. agreed but added that they were going to Durban in July.
The therapist said that she could see that he was looking forward to that...

SILENCE...minutes...

Some vulnerability is shown through the bravado.

The therapist initiated at this point by bringing up school again, saying that she wondered if there were exams coming up soon?
J.B. said there were.

Therapist: I bet you'll be pleased when that's over... J.B agreed to this and then told me that his best subject was science, and that last year he said to his mother that he knew it all, but when he got his marks he did not do well... so now he is working...

Therapist acknowledged that he was determined to do well this time...

The therapist then brought up the termination - that there was one session left.. and she wondered if he's had any thoughts about that...? She suggested that he might feel many things, and he might be pleased that he does not have to come much longer, or he may even feel a bit sad about it...

J.B: Ja, sometimes...

At this point I was confused and did not have an immediate reply and did not ask him to explain...mainly as I was trying to figure it out...

Therapist: Ja, it's like that sometimes when one stops or ends things...one feels lots of different things...

J.B: Ja, like when one goes away on holiday, you think it's ended and then it has not...

Therapist: Mmm.

The therapist then continued with termination issues: looking back over the therapy, enumerating how many sessions they had had together...J.B. responded quickly, saying he's been coming here since March... The therapist said that it probably would be quite different for him not to come there...

J.B: Yes

J.B. was given the option of coming back to join a therapy group with some other therapist, but this was not enforced as it was felt by supervisor and therapist that he should feel he had a choice at this stage. He chose not to come. He knew his mother would still be coming to see her therapist.

SILENCE...minutes...

Therapist: It's hard to know what to talk about when we are near the end of meeting here, is it not...?

J.B: Yes...

Session ended.

SESSION 14: JUNE 6

J.B came in a lot quieter than previous session in my office...there had been a minor skirmish in the corridor between J.B. and his mother as she was trying to get him to give me a slice of her birthday cake. He appeared rather embarrassed by this process.

The therapist reflected that he did not really want his mother to tell him to do this...
Therapist asked him what the cake was for...
J.B. told me it was his mom's birthday the other day...

The therapist then said that this was the last meeting... J.B. acknowledged this...

Therapist: I know you've been pleased to stop coming here... But it will probably take some getting used to not coming...
J.B: Ja...
Therapist: I wonder what you will do at this time every week?
J.B: Don't know...probably do my homework or play with a friend...

SILENCE...minutes...

I was not acting totally on my own sense of sadness at what was likely to be a premature ending with this child - but also he was struggling a little to be in control and adult about this impending change of situation ...there was a sadness in the room - although not overwhelming...

It can be sad to say goodbye to people... but the happy part is that you don't have to come here anymore...

J.B: Ja

Therapist: There might also have been some good things about coming here...like not having to take your medicine anymore...

J.B: Ja

The therapist asked if there was anything he wanted to know from the therapist or wanted to ask...he did not have any questions.

Therapist mentioned that his mom would continue to come to talk about her own problems with her therapist.

The session ended with J.B. mentioning exams, that were approaching and the holidays...

Session ended...

FOLLOW-UP SESSIONS IN AUGUST AND SEPTEMBER

SESSION 1

J.B'S concern of his mother's understanding at present is that she says to him that he is bolshy, and cheeky to her...J.B is peeved by this, and if he can't understand her reaction, as he thinks things are okay with himself.

J.B. was remarkably articulate in this session about his mother, telling the therapist that she interferes with his homework, and does not leave him alone, she gets upset when he wants to go to the cafe to play video games; she notices every scratch he gets; and generally J.B. complains that she worries too much. J.B also had a few gripes about his father, who he says at this time is quite grumpy and wants to sell J.B's bike which J.B does not approve of.

The therapist then wondered aloud what happens when J.B. gets cross,...? I suggested that he did not always know what to do with his cross feelings, and that he might then try to keep it all inside himself...which might be frustrating.

Therapist: Maybe at such times you'd like to scream and shout and you'd like not to have your mother around...for her not to be there...but the thing about mothers is that they are around and do stay...and we need to find out how we can help you when you are cross and she needs to be helped not to worry so much...

The therapist mentioned that she would soon have her therapist again to talk to about her worrying... The therapist near the end of the session suggested that J.B. try and remember over the week the times he gets cross and what happens then...J.B. agreed (in an advertly adult fashion) to comply, but we did not deal with this 'homework' in later sessions.

I intended that he should feel that there was something practical he could do, and also that his anger was okay to talk about.

We contracted to meet 3 times and then we would decide if we'd have any more sessions -depending on what happened over the weeks.

FOLLOW-UP SESSION 2:

J.B came in looking cloudy and angry... I suggested this may be due to coming here...J.B agreed that this was the reason.. J.B's face then visibly cleared...and he told me that he had hit out a boy's tooth today...

J.B. was also smiling slightly at this point, although he was looking a bit wary as if wondering and not quite sure how I would react to this...

Therapist: You don't look too worried about this now?

J.B: Ja, it's okay, there were no heavy punishments or anything...I just went to the headmaster...

Therapist: Mmm...I wonder how your mother handled this...

J.B: Mother?...She's getting used to it... J.B was smiling at this point...looking more comfortable...

J.B's tone was one of concern, however, it was then not directed at the other boy's possible pain, but at the cost to his parents...at first I thought this bit of fighting was not unusual or necessarily a problem, but I realised

He went on to tell me that they were both cross and he did not realize how hard he hit...he first thought it was a broken jaw...but then it was the tooth...Lucky, he said, that it was not a second tooth, cause it would have cost his parents a lot

it could become problematic if this remained a means of releasing his anger and also if he did not manage to empathise with others...an antisocial tendency could develop...

I knew from the mother that Treverton was a possibility now as a boarding school and I felt this may be an issue and should be explored, and since we had a limited number of sessions I decided to bring this issue up...

In retrospect boarding school at this point could be experienced as a punishment for the fight.

Again J.B appears more worried about 'things' and not about the people involved, it appears as a defence here against acknowledging his own angst and fear about being strange

of money...

Therapist: I wonder if you are worried about seeing this boy again? J.B. did not think he would take revenge because he could have done it today...

He also mentioned that his brother went to the office as well, today, but for nothing...

SILENCE...

The therapist mentioned the possibility of boarding school, in the future...?
J.B. then said that he was looking forward to going and started telling me about the various activities he would be able to take part in...he was thinking of taking his bike down there, and that he will probably be the only one with a bike there.. and that he could charge people for rides.. (said with a smile - quite playfully).
But he was worried that someone might damage his bike...

Therapist: Your bike is important to you, and you would not like it to be damaged...

J.B: Ja.

and new and alone when he goes to boarding school...this emerges slightly in the following comments...

He then went on to talk about his feelings of slight apprehension about going to boarding school...that he was the only one going there, of his friends, but he will probably make friends...although his mom did not when she first went to boarding school...The therapist acknowledged that it would be new and that this could be scary - new place and new people...but that it could also be exciting referring again to what he wanted to get involved in when he was there...

He spoke again about the sports he'd do there, and that he'd try horseriding... which he could not do at home...

The therapist wondered about holidays...? J.B. said he thought he'd go home every eight weeks and also for the long holidays.. He mentioned his younger brother, who he was telling about this new school as well...

The therapist was aware that the brother was seen as a success by the parents and was overtly successful - and that J.B. may feel he could not compete or had nothing that his brother did not have.

The therapist responded by saying that J.B would be doing something different to his brother, and would be able to tell him about this...

J.B acknowledged this.

Nothing else emerged...the therapist again reiterated the agreed number of meetings and session ended.

FOLLOW UP SESSION 3:

The mother had contacted the therapist during the week to say it had been a difficult week with J.B. as he had broken a window when cross...She had responded by crying...and he was prohibited trom riding his bike as punishment.

J.B. came in looking decidedly eager hoping that this third session would be the last...I reflected that I thought he was hoping this...J.B. agreed with a smile...I said I thought it was important that we meet a few more times...

I was (during these follow-up sessions) constantly juggling whether J.B's having therapy at this point was his need or that of his mother. The latter certainly is part of it - but - J.B. could clearly have originally had a long therapy as opposed to a few months. In view of the fact that I had limited time with him, I felt his strengths and positive points should be encouraged.

J.B. was dissapointed, but not in the way he had been in the past (black looks and scowls) he was quite playful, and smiling about it this time...He went on quite articulately to tell me that he thinks he is okay, and that he is doing better at school...gor 80% for something, and is the best in science...

The therapist acknowledged that he was doing well in things at school, but there were other things that we should deal with here, possible things to do with him and his mom...

J.B. went on to say that it's okay with her...she really tries...but still says

he's cheeky and that she makes him feel embarrassed.

The therapist wondered aloud whether other mothers make their sons feel that? J.B. did not know...The therapist went on to say that most mothers sometimes make boys feel embarrassed etc...

He then went on to say that he gets angry... and does try and stop himself...

but it does not always work ...

The therapist asked how he tried to do this.

J.B: I said stop it James!

Therapist: I think we should look at what's difficult for you when you get angry with your mom...It seems that your mom is worried...? She will be able to talk to her therapist when he gets back...

J.B: Ja, it was okay when she came as well and talked to Charles, but now, she is always going at me, she's fussy, and treats me like a fairy...

The session ended with J.B. mentioning boarding school and that he was keen, but worried cause it did mean being independent...but it was okay...

The therapist reflected his ambivalence - that he was both looking forward to it and pleased but also anxious about being alone

At this point I should have stayed with his attempts to stop himself, and not gone on to justify why I thought he should come...

I was not sure whether J.B actually of his own accord realised his mother eased up on him when she was talking to her therapist...or whether I had influenced him by mentioning that his mother would have her therapist back soon to deal with her concerns...

there, away from the family and independent...

He also mentioned a holiday in October... going to relative's farm...going hunting... and they would ride bikes there...looking forward to it...but does not always enjoy the trip cause it seems quite far...

The contract is to meet for 2 more sessions in 2 weeks time after his holidays.

Session ended.

I felt it was important and positive that J.B. had spoken about his mother directly.

His mother subsequently told me that he would tell her that he was feeling this or that in relation to her.

FOLLOW UP SESSION 4:

J.B. came in quite talkative today...he spoke about a teacher he does not like, and that he put a cracker on her chair... she then punishes the class; he says all the boys don't like her, but the girls do... and they always tell tales...

I am implying this is a way of getting attention and that he needs the latter.

He says he is the naughtiest in the class - The therapist wondered what this was like for him? J.B. likes it but he says the teachers don't...The therapist said that as the naughtiest it means everyone knows who he is, and he stands out...J.B. agreed.. and went on to say that he won't do homework for the teachers he does not like...and that all the boys cheat when they call out their marks...

Again it is evident that J.B. is not directing any empathy towards other people, but shows care and concern and responsibility in relation to his material goods - bike in last session and the new cricket bat in this session...

He then told me that he got a cricket bat... with money that his grandparents left him in England...he described this bat, wooden, and that it was important to polish it properly.

The therapist acknowledged that it seems really important to him...and added that he played cricked and his brother played soccer...(therapist knew this from the history and past sessions)...

J.B. however, said no, they both play cricket ...and added that he (J.B.) used to play tennis and will start again...

SILENCE...seconds...

I felt the need to come back to the anti-social tendencies, as he was putting across this overt lack of concern. I was however, of the opinion that underneath that was anxiety about his actions, and possible fear of consequences underneath the bravado...but I did not want to quell what also seemed to be a better state of affairs than when the therapy began, when he was withdrawn and suicidal...

Therapist: It is difficult having teachers you don't like ...

J.B: Ja...

Therapist: And sometimes you may wish they would dissappear and then you would not have to go back to their classes...

J.B: Ja...(vehemently agreed)

Therapist: But that's what school's like... we have to stick it out...

FOLLOW UP SESSION 5: LAST SESSION

The therapist opened the session mentioning it was the last session...and added that he may be pleased cause he's been looking forward to this...

J.B. was smiling and agreed he was pleased..

Therapist: So this is the last session and you wont have to come anymore...

J.B: Yes...

Therapist: Charles is also back, so your mom will be able to talk to him again...

J.B: Yes...

SILENCE...seconds...

Therapist: We have not met for the past two weeks, there were holidays...?

J.B: Yes...we went to Secunda...

He proceeded to tell me what he did there...

He always feels comfortable when telling me about outdoor holidays and what he did.

He also told me he was definitely going to Treverton, and that his grandfather will pay for him...very pleased about it all...

Therapist: I wonder what your brother thinks about you going?

J.B: He is also pleased...they do fight

sometimes..

Therapist: Probably you'll be pleased to see each other on holidays...cause brothers do fight...

J.B: Ja...two days and then we hate each other...(smiling)...

Therapist: Ja, that's the way it is with brothers...

I felt that J.B. was not going to express much about ending, and so I decided to make the transition from the therapy to the new year and new school, thus emphasising beginnings as well as endings.

The therapist then mentioned again this was the last session...and that he had exams coming up and the move to Treverton in the new year...and suggested that he must have had lots of thoughts about the new year and the school...exciting but also new and so this can make one a bit anxious..

J.B agreed and added that someone he knows is probably also going there...the therapist agreed that this makes it nicer - a new place etc...

The therapist went on to say that they'd spend some time today doing something different - did the Rorschach and I described what it involved and what I wanted him to do. He did the Rorschach willingly although he kept control of his feelings and did not reveal too much in direct responses.

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