Clinical Commentary

This commentary is slightly different from previous ones in that the clinical work presented took place some 20 years ago. This gave an opportunity, for those commentators who wished to, to take up how they think the work of a child psychotherapist might have changed in the intervening years.

Graham Music, Clinical Commentary Editor

Clinical Material

Background

Jeremy was referred at two and a quarter year old with his mother Mrs. O, by his Health Visitor. His mother was uncertain about how much was her difficulty and how much his. His presenting problem was that he was ‘extremely violent and unable to accept the least restriction’. The final straw was when he hit his father on the head with a hammer. His parents had a very different approach to him but both agreed he was impossible to control and could not set limits for him. His father showed a real fear of hurting him, so he never dealt with discipline at all, stating ‘I might knock something off!’ Mrs. O was deeply depressed, exhausted and was frightened of Jeremy, fearing that he might damage her. She told us he was ‘very strong and enjoyed inflicting pain’. She felt he could be ‘sadistic and ruthless’ and at times she hated him. She felt very guilty about her feelings towards him. They had wanted to have another child but would not even consider it now. Both parents were at their wits’ end and felt at the mercy of Jeremy’s violent outbursts. In spite of the bleak picture painted of him, Mrs. O was always generous in her support of his therapy and wanted what was best for him. As the work progressed with Mrs. O, it became clear that Mr. O was quite a disturbed man, with Asperger’s features. He was unable to work with others and quite egocentric and arrogant. Family life was at the mercy of his moods, and they were financially insecure as they never knew how long he would be able to sustain a job.

I saw Jeremy from the age of two and a half until he was five and a quarter. He attended once then twice a week in the first term, increasing to three times a week for the bulk of the work and reducing to once a week for the final term, due to his starting school. His treatment ended prematurely as I became pregnant and left the service. His mother was seen weekly by a social worker in the service.

Jeremy was a small, wiry, blond boy with a rather spiky look, especially when his hair was short. He was very articulate and precocious in his manner. He took to therapy like
a duck to water. At the beginning, when I was seeing him once a week, in the countertransference even I experienced the gap between sessions as an eternity. He would talk of being here, then away, then back again and play games of opening and closing doors saying ‘who needs to come in?’ He would leap around the room and roar and bang and crash and I felt he had a desperate need for someone to receive his projections and hold them. He would often throw toys at me and shout ‘don’t throw them back!’ or ‘why can’t you take it?’ He often showed a fear that I would just leave. His play was dominated by a cycle of attack and despair. Overall he was dominated by a strong possessive jealousy, exacerbated at the end of sessions and holidays. He vented his fury at ‘those damn calendars again’ (calendars I made for him to explain and prepare for holidays). He would attack me, calling me a ‘silly old dirty, smelly rag,’ threatening ‘I’ll break your head off with a pickaxe, you blasted woman.’ However, quite early on there was a shift to a more ambivalent position, wanting to possess me totally but worried at the damage he may inflict on me. This was particularly marked around holiday times.

Many of the sessions were a whirlwind with occasional pauses. I would mostly be ducking missiles and trying to follow what was happening in the room. His anger and aggression made it very difficult for me to think and talk and for him to listen. The play consisted mainly of him being a powerful, rather violent, often sexual Daddy or what he called an ‘ah-ah baby’ (a pooh baby) dropped uncaringly by me. He would often try to push himself into me, either in my lap, ‘diving in’ or my bottom. Scenarios also involved him being a variety of men who ‘service’; plumbers, garage men, repair and maintenance workers with specialist tools. But this usually deteriorated into using their tools to damage.

**Themes in the therapy**

*The therapist’s body and building an internal object*

He related to the room very concretely as the inside of my body, particularly the sink and taps. He was fascinated by what I came to think of as my ‘internal plumbing’, by how his messes were cleared up, how the room was clean after his very destructive sessions. He had the fantasy that there was a Daddy P or Dr. C the psychiatrist he had met initially, who helped me clear up.

Sometimes he would be frightened of what he might find inside me. After asking if I had a Daddy at home he climbs onto the table and says he can leap deep, deep. He repeated this many times looking excited and flushed saying ‘deep down the deeps’. I say he sometimes wants to leap deep down in the deeps inside me. He says ‘to see in’. I ask what he thinks he’ll see. He says he thinks ‘it’s a giant, a lion Daddy,’ who will eat him up.

Eventually he did get some idea of my being inside him in a positive way. In one session when it was time to leave he took great dives into my lap. I spoke of his wish to get right inside. He then asks me ‘where do you work, Mrs. X?’ I ask where he thinks and he taps himself on the chest and says ‘you work in here’.

With time he also had glimpses of a helpful daddy rather than a competitor.

As his omnipotence and violence in the sessions decreased, his ambivalence became clearer and more conscious. ‘I don’t like you and I do. And I get cross and I can’t control it. I’m getting cross now.’ This of course allowed us to think about his
feelings rather than having him act them out wildly. He had also become less violent at home.

*Ambivalence, fear of exclusion, loss and separation*

At this point his mother became pregnant and his concern about her welfare and that of the baby increased, as well as his worry about me in the transference.

In the seventh term, we still had a lot of intrusiveness and ‘secret doors into you so you’ll never see me and can’t fetch me home’ or a ‘trap for being in charge when it’s time to go home’. However there was more of an idea that he needed to be in charge, not in an omnipotent and possessive way, but in control for fear of falling. He felt he needed to be really ‘fit’ to deal with the pain of separation. ‘Why do five minutes (before the end of the session) always come so fast?’ He became very preoccupied with dinosaurs and why they became extinct, stating that they had very small brains. I linked this to his very powerful and primitive feelings and how he felt that not being able to think about these feelings, having a small brain, was dangerous. The struggle between the ‘good and bad’ sides of him became depicted more frequently. He also began to see the possibility of a sibling as more than a rival.

He talked about his mother being fat because she had a baby inside. He tells me ‘the pony is in the boat and is very lonely because he can’t have a baby, nobody will let him’. I link this to his feelings of sadness and loneliness about not being able to have a baby like Mummies can. He says ‘but the duck comes on the boat with the pony to be his friend’. I talk of him realising that although he cannot be the Mummy and have a baby he sees that the baby could be a friend to him. This was a very calm and peaceful moment.

*The final phase*

After the birth of his baby sister, he soon started school and as he was so much more manageable, his parents were keen for him to reduce his sessions, with a view to ending therapy soon. At this point I too was pregnant and by the 8th term we reduced to once a week for the final term. Although we probably would have ended treatment soon, my pregnancy accelerated the process and obviously brought a new dynamic into what would have been a more ordinary ending.

At first there was a regression to the earlier play I had seen at the beginning of the therapy. There was a lot of anger, to feeling pushed out and cheated, making him want to be a ‘burglar’ and to hoard. He then seemed to want to harden and then he felt despair. However towards the end of the treatment he went beyond this to an awareness of the relentless march of time, and to reviewing our work together.

*Fourth week before the last session*

He talks about robots and tells me there’s a mechanic in me and if only he could get rid of it then it’d be great. I say that he knows what is inside of me, a baby . . . He interrupts me and complains that ‘Nobody in this place will tell me when I first came here.’ I say
he’s been wondering about it, how long ago was it, how old was he then, do I remember and can I remind him? He says ‘Yes, how big was I? Like this? Like this?’ I talk of how he came at two and a half and how he was smaller then and is bigger now and going to school and how he will get bigger and older still. I also talk about perhaps he wonders if I only like very little children, like he was then? He talks of his robots with buttons on. I ask where the buttons are and he points to his ‘chest-belly’ and asks ‘Do you like it?’ I ask if he does. He replies ‘Yes it’s good, do you?’ I say he’s also asking me do I like him. He says ‘Yes, do you?’ I ask what he thinks. He says ‘Yes, you do. What do you think?’ I say I’m sure he knows that I do care for him a lot, but perhaps feels I don’t because I’m leaving soon, is that because I don’t like him anymore? He draws robots and says one fits inside the other. I talk of the baby inside me which he’d earlier called a mechanic, as if I was a robot Mummy with a robot baby inside me, no feelings for him, just a machine with control buttons. He draws a robot around himself and I say when he loses me as a loving Mummy and feels I am a robot, this makes him feel like a robot too. He gets a drink and climbs into the sink. He sings and dances a very touching song and I feel quite choked and tearful, ‘The water, the water, it only goes one way, one way. It goes in pipes, in the taps, in the river and sometimes in flower pots.’ He sings it again stressing the ‘one way’. I talk of this water after his drink having to do with me here as a feeding water-Mummy and his thinking of the water going only one way and this way at the moment being away from him.

**Third week before the last session**

Jeremy is laughing in the waiting room, talking about hair and calling either his mother or his sister ’silly’. On the way to the room he carries on saying ‘silly’ and ‘banana’.

In the room he tells me he has a man, called Peter A.B. and shows me a small plastic figure. He runs around the room throwing this little toy around, all over, especially high, to the ceiling or the light. I ask about P.A.B and he tells me he got him in a chocolate. He says ‘A man goes high’ while he climbs up and down the table. I talk of him going high, off the ground and losing touch with the firm ground and me and getting high in his mood too. P.A.B. crashes to the floor. I talk of the drop for Jeremy as well from this height. He says ‘Yes, it’s great!’ P.A.B. falls to bits and I say there is a danger of Jeremy getting so high that he then falls apart like the toy. I say that Jeremy may also feel this way, dropped by me and wondering if he’ll fall apart. He says P.A.B. can be put together again and proceeds to do so. At first the toy is quite loose but Jeremy manages to fix it.

He carries on like this throwing and crashing the little figure and climbing on the table. I get quite worried that Jeremy will fall and hurt himself. I talk of the danger to him now and how I am the one to feel it, not him. I am to worry that he will lose touch with me, get high and hurt himself. He stops for a bit, comes over to me and looks at the picture of a rabbit he did in the last session. I talk of this rather mysterious rabbit – how we didn’t really get to know much about it. He says ‘He’s not a wild one, I have one at home that isn’t wild.’ He looks at me very seriously and asks ‘How do you get them not wild?’ I talk of how he has wild feelings at times and friendly feelings at others.
and he is asking me how can he be ‘not wild’, how can he hold onto his friendly feelings and not go wild like when he’s running up and down the table.

He remains quiet for a bit and then returns to running up and down off the table and I talk of how now he feels out of touch with his friendliness and taken over by wildness again. ‘I’m not wild’ he tells me. I say at times he gets wild and far away from friendly feelings as if they too had been crashed and dropped. I talk of when he’s running on and off the table in a high mood and how today he’s rushing away from the misery and missing what we had talked about last time.

He’s on the table again, swinging the string of the heater switch. He swings it away and catches it and cheers every time he gets it. When it slips away I talk of his feeling that I and his feelings are slipping through his hands, they are hard to hold onto. He swings and jumps off quickly to see if it is still swinging and moving. If it is, he cheers ‘yeah’. It all feels frenetic. I worry and feel awful about leaving him before I would have done had it not been for personal reasons, before I feel confident that he has a strong internal good object to hold onto. I take up the feeling that with only two more sessions to go he is racing against time here. This seems to settle him and he moves near me. He shows me P.A.B. again and looks up at the light. There are dead insects in the glass cover. He asks ‘What are those? Are they flies? Butterflies? How did they get there?’ I ask what he thinks, he says ‘they made a hole and got in and then got stuck’. He then asks ‘How did they get in really?’ I explain what I think happened but also his feeling that they made a hole and got in where they shouldn’t have and so got stuck. He says ‘Yes, dead, the wings got stuck and the juice was sucked out and then they got away and left a pattern.’ He tells me another version of this where in the end they died.

He looks in his box and chucks toys about a bit and gets P.A.B into a car. He drives it all over the floor and says he’s ‘going to Australia, a long way away. It’s hot there.’ I say he has always thought that I came from a hot country and may be wondering if that is where I will go when I stop working, will I go far? He goes back to the table and tells me his friend Paul went to Australia and is back now. He tells me a long and complicated story which I cannot catch about Paul and poohs. He then returns to talking about the flies. He draws a fly and then a hole in the light where the fly got in. I talk of his seeing the light as me, a hot place where he wants to dig a hole and get in but then he’s scared he’ll get burned and stuck and die. I try to clarify his story about Paul and the poohs. He says Paul should do a pooh, cut it up and then throw it in people’s faces so they can’t drive, they’ll get stuck in traffic jams. I say that’s what I think he’d like to do to me, and stop me from leaving and driving away. He changes the picture of the light into an aeroplane. I say he may think I’ll fly far away on an aeroplane. He draws ‘a train with a heavy black lump of coal’. I take this up as me loaded with a pooh baby, like the lump of coal, also his wanting my baby to be a pooh and flushed away or stuck but not a real baby. He says ‘Yeah! pooh pooh!’ in a triumphant tone. He asks do I like the picture. I ask if he does. ‘Yes, do you?’ he asks again. I tell the story of the picture as I see it, of his feelings about my leaving and my baby and how I think he wants to know do I like him. When I know how he feels about all this, do I still like him? He says ‘Paul missed me.’ I say he wonders if I will miss him and will he miss me and how he’s afraid that if I see the wild angry part
of him I won’t miss him. He says he’ll add the sun and grass to his drawing and does so. I say when he knows I like him in spite of his anger, he feels his own friendly and warm feelings come to life, not just the dead stuck poohs.

He colours green for a while and then returns to black. He says a bit defensively ‘Trains are black.’ He adds coaches, some for one and some for two people. He talks of poohs. He adds an eagle in the sky. He says ‘Orange Mrs. X.’ I ask more, he says ‘Oou are an orange – no arms, no legs.’ I say he sees me as a ball, no arms to hold him, just a juicy fruit belly to feed the baby inside. He says ‘Yes a big fat belly.’ I say all for the baby and none for him. He says ‘No, just for him and he doesn’t need to look around for an orange, he’ll just eat me up and then he’ll pooh and flush me in the graveyard.’ I talk of how I then turn dead in his mind, as orange turned to pooh, not an orange/breast he can feed from to get strength.

He again adds green to the train and says ‘Some trains are green.’ He has a blue one at home. He then returns to colouring black and to talking about poohs and me being dead. I say he worries I’ll just die in his mind, that he won’t be able to hold onto me inside him. He says very seriously ‘What I want to know is this: will we ever meet again after we stop?’ He says he knows we stop work, then we have a visit (a review) but after that ‘will we ever meet again?’ I explain again about how we would see how he was getting on. If he was well he could carry on the work by himself, if he really needed help and I am not here then someone else could see him. I take up about how he wonders will I disappear forever and say that I won’t and am always happy to hear from him. At this point I am feeling very sad at ending with this little boy I have grown so attached to and know that the likelihood is that I will miss him terribly and always wonder how he has got on.

He colours more black. I talk again of his fear that I’ll just turn dead in his mind. He talks of the flies and graveyards and flushing me out. I talk of his fear of getting inside me with his anger and killing me and the baby in this hot light place and so dying a little himself. He says he’s ‘Not that hot, just sweaty!’ He goes to get a drink of water and returns. He says very seriously ‘I expect you’ll be getting married now.’ I ask if he thinks I’m not married. He states that I’m not. I say it’s really difficult for him to accept the idea of a Mr. X. I ask how he thought the baby got made, who made it with me? He says ‘Me!’ I talk of how painful it is to him that he is not the Daddy X. He goes to the water and lets it run hot and steamy. I say that thinking of the Daddy X makes him feel steamy. It is time to stop.

Clinical commentary by Eileen Orford, a child and adolescent psychotherapist, retired from the NHS

The sessional material presented is from very near the end of what has been a relatively long therapy. Regression and re-presentation of all the referring symptoms is often characteristic of sessions in the termination phase, usually followed by a calmer and more measured ending. I wonder if, in these final sessions, there are glimpses into the regressive tendency together with what had been achieved in the course of nearly three years. The situation is complicated in this case by the therapist’s pregnancy which follows closely on the birth of a sister.
It seems to me that this is a child who, these days would probably find himself ‘diagnosed’ with ADHD and who might not therefore find his way to psychotherapy. To my understanding ADHD is to do with a failure in the child’s early holding environment. Sorensen [1997] identifies three components of the containing process.

- Observation, which implies attention to and interest in the baby, such as his cries and his physical state in the first instance.
- Clarification, which involves sorting the world out for him, helping to differentiate one thing from another, identifying and naming things and learning from the observation process.
- Emotional resonance, which means being in touch with how the infant is feeling in the booming, buzzing confusion of the world he has recently entered.

It is clear that none of these categories is discrete and Sorensen describes the task the carer has of integrating these three containing functions. If it is achieved more or less successfully then the infant can gradually get to know his formerly unknown world and feel relatively safe within it. Failure may be traumatic and the infant can be thrown back on what defences he can assemble to keep at bay terror of the unknown, of nameless dread.

I was struck by the links between Sorenson’s categories and the three categories of symptom that define ADHD in most of the Diagnostic categorisations. These are, firstly, a deficit in capacity to attend, secondly, hyperactivity and thirdly, poor impulse control. Whilst in no way co-terminus with Sorensen’s categories, it might seem plausible that failure in the capacity to observe (attend) to the infant’s needs might result in his having no ‘attending object’ to introject and thus he himself will be more likely to be deficient in the capacity to attend. Without this the infant must need to fend for himself and, in having to look out for himself, might become hyper-aware and hyperactive. Without adequate emotional responsiveness to what he experiences, the infant may become out of touch with his feelings and thus unable to control them and therefore impulsive.

Perry (Perry et al., 1995) draws attention to the similarity of ADHD symptoms to reactions to traumatic events and suggests that ADHD is a response to trauma in infancy. He states that the ‘hard-wiring’ of the brain is established by use in the first year or so of life and thus the traumatised infant lives in constant expectation of trauma. All the diagnostic categories for ADHD indicate that the symptoms are in place by two years of age.

It seems from such history as is available for this case, that Jeremy may well have been a child for whom containment in his early years was a problem. He may well have fallen between a father who feared ‘knocking something off’ his son in disciplining him and a mother who was ‘depressed, exhausted and frightened’. The mother’s fear was attributed in the write-up to have been on account of Jeremy, but it is also possible that she may well have felt frightened of her husband who was said to have Asperger’s features.

Thinking about the possible aetiology of ADHD and the functions of containment that may have been absent early on in the child’s life, has influenced my understanding of how best to help such children in therapy. I have found myself policing the
boundaries much more firmly than in work with other children, emphasising the need to keep not only the child but myself safe and trying to make sense of issues such as these. I might, for example, say ‘Please do not do that to me, if I can’t look after myself, how can I expect you to trust me to keep you safe?’ These issues do not arise in the sessions presented, but I do not think that twenty years ago they were as easily verbalised.

In the write-up, the possibility of damage to the therapist is only alluded to when describing the preceding sessions. It is hardly surprising that Jeremy is ‘desperate to get inside’, to be contained, but that he is also frightened of the damage he might inflict by so doing. Thus he takes to therapy ‘like a duck to water’, relishing the containment of his projections in the room and showing acute sensitivity to the comings and goings that once-weekly therapy entails. The therapist also experiences the gaps between sessions as an eternity. This projection into the therapist was acted upon and the frequency of the therapy was increased to three times a week.

The therapy proceeds in the way that would be expected from such a child, as ‘a whirlwind with occasional pauses’. The therapist struggles to contain the patient’s fantasised intrusions into her body, though these intrusions seen to have something of a reparative flavour as Jeremy becomes a plumber, if a somewhat untutored one prone to doing damage. However, her attempts to make sense of Jeremy’s constant strategies to keep terror at bay, to remain intact and to keep thinking were eventually rewarded and he ‘did get some idea of my being inside him in a positive way’. He began to be able to introject a less damaged and more containing object and to allow some ambivalence. Clearly much good containing work went on, though Jeremy seemed to suspect that the holding was not secure enough. Secret trap doors were felt to threaten him, linked undoubtedly with pregnancies but also perhaps with intimations of the end. He also began to make some sense of what was happening. Despite his doubts he was able not only to ‘bring good and bad together’, but also to imagine that ‘another’ could be useful like The duck in The boat.

Given the nature of his difficulties the pregnancies both of his mother and of the therapist were bound to present problems. The frequency of sessions was reduced and the ending brought forward. He seems to have weathered the birth of his sister on the basis of this growing capacity to think, but the pregnancy of the therapist and the premature ending of therapy seems to have set them both back.

Jeremy’s on-going need to feel held is seen in the session that is fourth from the end. In this he is preoccupied by robots held by other robots. This need to be held is undoubtedly overdetermined by all the pregnancies he was having to contend with. The container is hard and mechanical, presumably to express his feelings about an uncaring deserting therapist and to withstand the repercussions arising from his angry feelings about being displaced. Once feeling symbolically held, albeit by a hard object, Jeremy is free to think a bit and wonder about the therapy that is about to end. The therapist answers but, understandably in the circumstances, sees the questions about buttons as a reference to breasts and babies. I wondered whether the buttons were not also to do with the previous question. How does the containing process/therapy work? And has he got buttons of his own to contain himself? The therapist maintains a
different sort of containment by remaining in touch with his feelings, and is eventually rewarded by the sad song that moves her and expressed a different strand in what Jeremy is feeling.

However, he starts the next session, two before the last one, again expressing his need to be held, as the Lego figure, Peter A.B. falls to pieces and is put together again, as must have happened over and over again in the course of the therapy. The therapist makes sense of this and Jeremy becomes more thoughtful, wondering how to tame his wild feelings. The therapist replies to this in terms of friendliness, and I wonder if he is not wondering more about how the ‘taming’ goes on in the room. This understanding comes and goes rather in the way in which the string from the heater switch comes and goes from his grasp. I wonder if the therapist’s own reasons for ending the therapy come into play and she talks of feelings and not of his struggles to think. He becomes ‘frenetic’, but communication about the ‘race against time’, settles him and he becomes interested in what has happened to the once living creatures inside the light in the room. If I am right, the driving force at this time is his struggle to understand what happens in this room. Is what has happened dead and gone, or will it leave a pattern in his mind? All this is very frightening and he falls to pieces again, thinking of endings, people going away, poos and he becomes very confused and manic. The therapist sticks with the feelings of missing and whether she cares and is rewarded with a sun and grass. He is very preoccupied with what happens when the therapy ends. Is it because he is full of poo? Can things be remembered? However he cannot quite stick with it: thought comes and goes like the light switch string, and the therapist talks rightly of his fear of damaging. Again something thoughtful follows ‘I expect you will be getting married.’ Did this not carry something more thoughtful with it, some concern for the therapist and his wish to know that she will have someone, like the duck and the pony? Her response ‘how do you think the baby got inside?’ while addressing the Oedipal issues, seemed a bit hard and did not quite acknowledge his wish to know that she would survive.

When I first read this session I thought it was much the same as any one might hear today. It was only when I began to seriously to think about it that I realised how much the work has broadened in the past twenty years or so. Then, it was felt that focussing on the feelings in the transference was the proper work of the child psychotherapist. These days there are other modes of interaction, such as maintaining boundaries, naming what is going on, binding with words and making sense of the child’s experience, to mention just a few.

I think we can conclude that Jeremy was a lucky boy, for even without the benefit of developments in the understanding of ADHD and of the nature of the containing process, it was a successful treatment due to the sensitivity and staunchness of the therapist. These days despite the advances in our awareness of the child’s experience he might not even get near a child psychotherapist.

30 Regent’s Park Road
London NW1 7TR
e-mail: eorford@freeuk.com
Clinical commentary by Christopher Reeves, retired child and adolescent psychotherapist

The bulk of the clinical material provided for commentary comes from the final sessions of a treatment lasting half of Jeremy’s life up to then. Through her choice of focus, the therapist evidently wants us to consider this ending phase in particular, and perhaps its timeliness. How endings in therapy are negotiated, and how they can often be differently experienced by therapist and child, is an important topic, so taking my cue from her I shall concentrate on this end phase. However I don’t propose to confine myself to it, since my commentary will only make sense in the context of my understanding of the state and stage Jeremy was at when therapy began, and where he had reached by the time the issue of its ending arose.

At 2, Jeremy is seemingly not only beyond his parents control, but also beyond their capacity to feel spontaneous parental love and concern for him, as distinct from anger, anxiety and guilt about him. Whatever the antecedents of this sad state of affairs, the parents seemed to regard their two-year old as something between an enigma and an outrage. He had also become an effective contraceptive device. Notwithstanding this unpromising initial scenario, within a relatively short time a remarkable transformation occurs. Jeremy is reported as becoming more manageable, and the parents more at ease in their dealings with him. And, despite their previous determination not to have another child after their experience of Jeremy, a second one is born, a baby girl.

To what factors should we attribute these changes? The therapist uses a revealing phrase in saying of Jeremy that ‘he took to therapy like a duck to water’. The setting and the provision made for a natural environment in which he was able to thrive. As a therapist one likes to believe that such change is largely due to the special skills, commitment and attunement that one brings to the task. Yet one can deploy these in other cases without feeling that the child ‘laps up’ therapy in the way Jeremy did. The beneficial reason here, I believe, is that psychotherapy for Jeremy was peculiarly opportune from a developmental perspective. At its start he is in what I would call a crisis of ‘unownment’ (not ‘disownment’, which is something different). That is to say, he does not truly feel he belongs to his parents, in particular to his mother because he cannot be controlled and made sense of. Lacking this sense of belonging, he is reduced to feeling alive only through the (negative) effects of his actions upon them: I disrupt; therefore I am. In short, he is stuck in developmental terms at what I have elsewhere (Reeves, 1993) called the stage of ‘the ablative case’ – of being a child who only feels real through registering the aversive effects of his actions on others. The opportuneness of therapy at this juncture is that it provides the possibility of his making the vital

References

PERRY, B.D., POLLARD, R.A., BLAKLEY, T.L., BAKER, W.L. and VIGILANTE, D. (1995) ‘Childhood trauma, the neurobiology of adaptation, and use-dependent development of the brain: How “states” become “traits”’. Infant Mental Health Journal, 16: 271–91.

SORENSEN, P. (1997) ‘Thoughts on the containing process, from the perspective of infant/mother relations’. In REID, S. (ed.) Developments in Infant Observation. London: Routledge.
transition from being ‘ablative’ to being ‘genitive’, that is to say, of moving away from feeling real through registering the negative effects on others, to feeling real through an incipient sense of belonging to someone. Where previously Jeremy had lacked containment in the mother’s mind, now he finds himself in the presence of a ‘not-mother’ therapist, who has one aim, not to confront, cajole or control him, but just to make sense of what goes on in his mind and his actions, if she can, and, if she can’t, not to blame him for the failure. As a result Jeremy begins to change from sterile action and reaction to communicative action and response, and in the process moves from relating through aversiveness to possessiveness instead.

Of course, the process is not without its travails, as the therapist’s frequent references to the periodic bouts of violence, mess and destruction testify. Yet throughout there is method in Jeremy’s mayhem. Often this type of behaviour in the early phase of therapy is wrongly described as one of ‘testing out’ the therapist. Jeremy, I suggest, isn’t trying to discover whether his therapist will endure him and survive. Rather, he treats her at this stage as a ‘subjective object’ in Winnicott’s sense (Winnicott, 1969), relating to her in terms of inner need rather than external reality. He assumes that she and the therapy will survive, because, in default of an experience of satisfactory early mothering, he needs its continuance here in his therapist. His ‘going-on-being’ becomes tied up with the going-on-being of the therapy. Due to the ‘ablative stage’ he is at when therapy begins, the ‘going-on-being’ of the therapist has to be experienced against a background of destructiveness. In this connection, I am struck by Jeremy’s explicit injunction that the therapist should not throw back at him the toys he has hurled as missiles, and his accompanying panicky plea: ‘why can’t you take it?’ Perhaps this reaction has less to do with his fear of retaliation in kind than the prospect of verbal interpretations of his behaviour emanating from the therapist in response. One should be aware that these can often be experienced, even by a verbally agile small child like Jeremy, as his own words and actions being turned into boomerangs flying back at him. At this delicate stage, where the therapist’s capacity to tolerate the disordered expressions of his own existence is paramount, attempting to verbalise the supposed symbolic content of his attacks is not the main requirement. More useful is for the therapist to communicate what his aggressive behaviour makes her feel – her countertransference registration of it – so that Jeremy can feel that his aggressive behaviour towards her and the setting has an effect (is ‘real’); that it is meaningful (namely that it feels hostile and unloving, just as it would be felt by him should the therapist behave in a similarly hostile fashion); and that it has a dual underlying purpose: to both make her want to reject him, and to discover that she won’t in fact do so.

From her general remarks about this early phase of treatment I felt that the therapist was perhaps over-ready to interpret back to the child the imputed phantasy motives underlying his aggression and intrusiveness. I also feel that her attempts to assuage his panic over the inevitable interruptions to his treatment through producing charts and calendars to mark the breaks in treatment, may have been experienced by Jeremy as a seeming denial of his overwhelming need to have her as a ‘subjective object’ rather than as ‘an object objectively perceived’ at this stage. If one is able to tolerate being ‘used’ by the child in this ultra-possessive way for a time, two things happen. He begins more easily to tolerate gaps (because he has you ‘inside’ as it were – you are ‘his’); and the
move from the oppositionality associated with the ablative stage towards the more positive, but stifling possessiveness of the genitive stage, can be negotiated more smoothly.

Despite these caveats, Jeremy was clearly responsive to the huge emotional investment the therapist was making towards him. I am pleased also that in reporting on this phase the therapist is not over-defensive about revealing the extent of her own attachment towards her young client, admitting that at this time the gap between sessions often felt like ‘an eternity’. In this, I believe, she is responding appropriately to the need for ‘primary maternal preoccupation’ that the infant Jeremy seems so conspicuously to have lacked at the beginning of life. Indeed, it would not surprise me if at this stage Jeremy had harboured a near-to-conscious fantasy that the therapist was his ‘true’ mother, but in disguise. It can sometimes be helpful to allow such fantasies to be elicited, especially if the child seems to have become stuck in a possessive dependency of the genitive type (often expressed in false compliance or an ingratiating attitude), thereby impeding the child’s healthy progress from a sense of being ‘owned’, to the beginnings of ‘self-ownership’ – a ‘me’, if not yet quite an ‘I’.

Fortunately, Jeremy doesn’t seem to suffer unduly from compliance. He both wants and needs to make the forward move towards becoming a ‘somebody’.

In the final stages we observe him struggling with the hard reality that ‘belonging to’ someone is not the same as ‘owning’; that sharing a person (a mother in particular) is a necessary part of developing a more autonomous relationship with her. In his case, the surrender of his self-blighting yet effective control over his parents is a fraught business. First he has to trust this stranger-therapist over whom he has no real purchase to see him through to a different form of dependency relationship; then to confront the realisation that his parents are going to have another baby after all. Is this going to be a displacement or a replacement of him in their concerns? Lastly, he must contend with the news that his therapist is having a baby too, a new arrival that will indeed replace him, since with its coming he will cease being her patient.

These are the principal issues Jeremy is grappling with in the concluding sessions. We join the first of these where the recurring subject matter concerns robots, and where Jeremy is complaining about his therapist having a ‘mechanic’ inside her, which he would like to get rid of. It’s impossible to unthread the multiple strands of this remark. The therapist initially equates the ‘mechanic’ with the baby inside her. Is this interpretation confirmed by Jeremy’s subsequent complaint that no one will ever tell him when he first came here, as the therapist seems to think? I am not so sure. My impression is that her baby, where it comes from, and who its father is, aren’t Jeremy’s primary concerns here, and that perhaps the therapist’s response to his initial slightly plaintive comment about the mechanic in her is unduly, if understandably, influenced by her regret at having to abandon him at this juncture. As for Jeremy, I sense that he is more concerned about self-survival once the therapy has ended than directly about rivalry with, or displacement by, the prospective baby. I see this overwhelming need to survive as a task or a fact of life underlying his preoccupation with robots. Robots are survivors par excellence. Only, they survive by being completely indifferent to their surroundings, doing just as they like and never what
they are told. Jeremy knows all about that sort of robotic activity, his own, and that of others in response to him. Being robotic, hence ‘out of reach,’ is an attractive option for him, but also dangerous, and he toys with the idea rather than indulges it. At the same time, I suspect, he is sensitised to anything redolent of a comparable pre-programmed reactivity towards him on the part of grown-ups, for instance, questions or responses to him based on assumptions about the sort of child he is believed to be. This makes adults feel equally out of reach to him – ‘mechanical’. Jeremy’s stance towards the therapist seems to be: you are having a baby, therefore you must believe I’m a baby no longer; that I can manage. So why play on my regrets or doubts about my future? I’m going to grow up. The moving scene towards the end of this session, where he talks about water only being able to flow in one direction sums this up. It also constitutes an important moment of communication of loss and gain and a shared affective ‘realisation’ (in Winnicott’s sense) about the healthy child’s need ‘to grow up’ due to the impossibility of ‘growing down’.

What exactly does ‘growing up’ mean for Jeremy at this juncture? I see him as having moved, partly through internal growth, and partly from environmental necessity, from being a possessive and possessed ‘genitive child’ in the course of the therapy, towards becoming at its end a rudimentary ‘me-in-the-eye-of the beholder’. As yet this development is precarious and heavily dependent on the continuing positive regard of his therapist. The immediate danger is that this incipient self will collapse once she disappears. However, there is a converse, and more subtle danger lurking too, namely that a lingering attachment will subsist once the active association is broken to this would-be mother therapist, one that could stifle his growing up, by confining that ‘me-self’ to being a ‘me-in-her-eyes’ (as imagined), rather than a ‘me which is mine’. Thus it’s a matter now of taking possession of himself, which for a little boy of Jeremy’s age is a primary ingredient of the sense of ‘growing up’. I am not suggesting that such considerations are consciously articulated by Jeremy here, just that bubbling just below the surface they are responsible for much of the motivatedly mindless behaviour that dominates the final reported session.

This must have been an extremely uncomfortable one for the therapist. Once more there is the theme of robots, but now it is their self-determination rather than their ability to survive that is to the fore. Jeremy, like his alter ego, the chocolate doll man P.A.B., is on a manic high. The therapist sees him as becoming helplessly wild, like the uncontrolled and uncontained Jeremy she first knew. He declares (correctly, it seems to me – at least from an internal point of view) ‘I’m not wild,’ not, that is, in the way he once was. What Jeremy seems to be doing here is taking possession of himself at a certain level, rather like the would-be toddler does when (s)he takes the first faltering steps. Symbolically we have an over-anxious therapist mother, fearful of Jeremy’s actual and metaphorical collapse, with him urging her to ‘leave me alone, - I can manage by myself!’ This is only half the story of course, because Jeremy too is well aware of the possibility of his not being able to stay upright unaided. If I refer here to an over-anxious therapist in the face of his provocative behaviour, it is as one created to be such out of Jeremy’s own need to reverse roles, and to experience her in the guise of the helpless bystander. She is required to endure the feeling of impotence, yet all the while retaining a sense of self intact. This serves as a useful template for
Jeremy in his journey towards the internalisation of an enduring sense of ‘being me’, someone with a secure and distinct family identity now that another newcomer, his baby sister, occupies the salient ground in parental concern and maybe in their affections too.

Several motifs about continuity through change are interwoven in this session: about coming and going (Australia and back), of being upside down and downside up (Australia as ‘Down Under’), of being inside yet able to get outside, like the train that travels into a tunnel and comes out unscathed. These emphasise the idea of ‘going on being’ in spite of change, like the dropped, yet reconstituted doll figure. But there is also the fact of change in and through apparent continuity. Foremost here is the question of what makes something (such as a baby) come out of nothing? Is it evacuated, like a pooh that grows inside you, only to be discharged? What makes it a baby and not a pooh? And how can a mother be the same before and after having a baby – still be my mother, when she’s now the baby’s mother as well? These are just a few of the myriad issues occupying Jeremy’s mind in this session, all configured around the theme of survival through change.

I don’t see Jeremy as angrily aggressive or out to make his therapist despairing. Rather, I see him playing out his puzzlement about how things and relationships can continue yet alter. Inevitably, it strikes us differently, particularly as therapists with our developed sense of personal integrity subsisting through change. For Jeremy, however, surviving involves extrication from a past state in the process of becoming new. I don’t think his overriding wish is to climb inside the therapist, to become, still less to displace, her prospective baby. Consequently I sense more of a duologue than a dialogue taking place between them here, due to a difference of perspective, one fixed on survival, the other on loss. Such a transient ‘confusion of tongues’ (Ferenczi 1932) between adult and child often accompanies the necessary yet painful riddance process marking the final stage of a successful treatment with a child like Jeremy: the need now for him not to be understood by someone whom he feels has hitherto been uniquely understanding of him.

Gorseacre
West Polberro
St. Agnes
Cornwall
TR5 0ST

e-mail: reeves.gorseacre@btinternet.com

References

FERENCZI, S. (1932) ‘Confusion of tongues between adult and the child’. In Final Contributions to the Problems and Methods of Psycho-Analysis. London: Hogarth Press, 1955.
REEVES, C. (1993) ‘Unintegrated states and the process of integration: a new formulation’. British Journal of Psychotherapy, 9 (4): 414–27.
WINNICOTT, D.W. (1969) ‘The use of an object and relating through identifications’. In Playing and Reality. London: Tavistock.
Commentary by Alan Shuttleworth, a child and adolescent psychotherapist working in CAMHS in East London

Jeremy, with his gift for language and his passionate nature, indeed ‘took to therapy like a duck to water’ and so, I think it’s fair to say, did his therapist. There is a wonderful vitality in the detailed accounts of them thinking together. The style of the work shows something of the influence Dr. Meltzer had on child psychotherapy at the Tavistock Clinic. The therapist’s fundamental line of thought about Jeremy derives from Freud and Klein on mourning and depression, amplified by Bick on early infantile separation anxiety and defences against it. To this is added some of Meltzer’s particular zest for interpretations in the transference of the child’s relationship to the inside of mother’s body. And there is certainly Meltzer’s particular sense of the deeply passionate nature of the psychoanalytic relationship and process.

After asking if I had a Daddy at home he climbs onto the table and says he can leap deep, deep. He repeated this many times looking excited and flushed saying ‘deep down the deeps’. I say he sometimes wants to leap deep down in the deeps inside me. He says ‘to see in’. I ask what he thinks he’ll see. He says he thinks it’s a giant, a lion Daddy who’ll eat him up.

I understand that this clinical work took place twenty years ago. I don’t think my own clinical work then was quite like this or, to be honest, as good, but, in some respects it was more like this than my work is now. To get at this difference, I will focus mainly on the few parts of the paper that aren’t directly presenting clinical work, particularly the first two paragraphs and some later comments. It is here that what might be called the case management context or framing of the work is outlined. This includes, first of all, the reasons for referral; that Jeremy was ‘extremely violent and unable to accept the least restriction’; and that his parents, each in rather different ways, were ‘at their wits end’ with him. This is linked to some important aspects of Jeremy’s family that are briefly sketched in. The framing consists secondly of the arrangements for the therapy; intensity increasing to three times a week for an extended period, with ‘traditional’ social work and psychiatric support, with a child who ‘takes to’ the process with a passion and, as we will see, gains substantial benefit from it. These arrangements approximate to what many child psychotherapists feel is ideal. I do not need to spell out that they can no longer be taken for granted in most NHS child psychotherapy today.

This has led me, over the last twenty years, to be greatly preoccupied with just these ‘framing’ questions, beginning with the question of what practical arrangements make best sense in most CAMHS clinics as they now in fact are. Trying to address that question has led me on into questions of the reasons for treatment and its aims.

Given those preoccupations, at the crux of what I want to focus on is a statement of what I take to be the therapist’s view of the core of what it was she was engaging with in Jeremy. ‘Overall he was dominated by a strong possessive jealousy’ leading to ‘a cycle of attack and despair’. Then, at different places in the paper, there are statements that
together outline her view of the basic evolution that took place over the three years of therapy.

In the beginning,

He would leap around the room and roar and bang and crash... Many of the sessions were a whirlwind with occasional pauses. I would mostly be ducking missiles and trying to follow what was happening in the room. His anger and aggression made it difficult for me to think and talk and for him to listen.

As the psychoanalytic process got underway, ‘... quite early on there was a shift to a more ambivalent position, wanting to possess me totally but worried at the damage he may inflict on me’.

Later, ‘The struggle between the “good and bad” sides of him became depicted more frequently. He also began to see the possibility of a sibling as more than a rival.’

And by the end, after the birth of his sister, starting school and ‘becoming more manageable... he went beyond this to an awareness of the relentless march of time, and to reviewing our work together’.

It is this series of assessments that I want to focus on. The view I will take is both that, on the evidence presented, these assessments are warranted and that I think they can be significantly added to, giving us an extended picture of Jeremy in the midst of, and actively responding to, a complex mixture of forces.

That Jeremy should feel some possessive jealousy, particularly at two and a quarter when he began psychotherapy, is not, in itself, pathological: it is to be expected. The issue is its strength in Jeremy, the extent to which he was dominated by it, and the disinhibition with which he expressed it. Where did these qualities come from? We are pointed towards what is likely to be part of the answer when the parents’ difficulties are described. It seems clear that, when therapy begins, Jeremy and his parents are locked together in a dangerous, progressive, downward spiral of interaction with each other, in which both parents are feeling themselves to be severely negatively affected by Jeremy and unable to contain him. They are also unable to contain each other and are both further negatively affected by this. Furthermore, Jeremy is negatively affected by their inability to contain him (and each other) and by the extent to which they are both now persecuted by him (and each other). Why was this?

It is implied in the opening paragraphs of the paper that at least one reason may have been father’s pre-existing mental health disorder. Though we don’t know if he had any psychiatric assessment or treatment,

Mr. O was quite a disturbed man, with Asperger’s features. He was unable to work with others and quite egocentric and arrogant. Family life was at the mercy of his moods and they were financially insecure as they never knew how long he would be able to sustain a job.

Jeremy’s mother was ‘deeply depressed’. It is not clear how severe this was, whether she needed or received psychiatric care, and whether the depression was entirely a reactive consequence of the ‘downward spiral’ or partly of independent origin and therefore
possibly a separate contributory factor. We know that Mrs. O was seen weekly by a Social Worker and that by the end of both Jeremy’s and Mrs O’s treatment something significant had shifted in the marriage so that the couple felt able to have another baby. That is, by the end of Jeremy’s and his mother’s treatment, the marked three-way downward spiral had been replaced by at least some upward features. Jeremy’s therapist was quite rightly concerned, at the point of ending, about how he might cope in the future and whether she could ‘feel confident that he has a strong internal object to hold onto’. Of something like equal concern might be how well-established the turn towards an upward spiral in the family is and therefore how much help with coping Jeremy will have at home. A fuller presentation of what was known within the psychiatrist, social worker, child psychotherapist team might give us a fuller sense of these things.

I am not suggesting that these are easy questions to resolve. I am suggesting that, in cases like Jeremy’s, where a child’s own negative states and the negative states of their parent(s) might be amplifying each other, it is important to address these questions as far as we can. For one thing, in such cases, arriving at clinically realistic overall case management arrangements is pivotal if treatment is to stand the best chance of success: determining what is realistic, in turn, pivots on detailed, psycho-social causal judgements of just this kind. It has become increasingly rare over the last twenty years to find Social Workers seeing the parents of children in therapy weekly for three years, as one did here. How much would that have mattered in Jeremy’s case? To what extent today, and in actual, not ideal circumstances, might some currently available form of work, whether family therapy or behavioural work or psychiatric treatment or whatever, either in combination with psychotherapy or instead of it, meet the needs of Jeremy and his family as well as the team described here did? These are questions I was already concerned about twenty years ago. But I did not feel their force as pressingly, or see the absolute need to forge radically new kinds of working agreements within the multi-disciplinary team in order to complement the practice of child psychotherapy, as I do now.

There are indications in the paper that a very different kind of causal factor might also have been contributing to Jeremy’s state at the beginning of therapy, to do with his natural endowment. This would not have been such an explicit object of attention for me twenty years ago as it often is now and I would not have been able to give names to or gather evidence about it then as I do now. Two aspects of his natural endowment are particularly striking. ‘He was very articulate and precocious in his manner.’ Indeed he was. Part of the reason for this is that he seems to be highly intelligent. There are many times where he is very quick to take in the real substance of his therapist’s thinking and quick to respond, directly as well as associatively, with genuine thinking of his own.

The paper’s evidence suggests that something else was also a feature of his endowment. Especially at the beginning of therapy, not only was he angry and aggressive, he was also overwhelmingly hyperactive and impulsive. This was true in a physical sense, ‘Many of the sessions were a whirlwind with occasional pauses.’ He ‘would leap around the room and roar and bang and crash’. But a similar hyperactivity/impulsivity could also be seen in his speech, as outrageous expressions of his anger came disinhibitedly straight out of him: ‘I’ll break your head off with a pickaxe you blasted woman.’ It is, I think, evidence that this hyperactivity/impulsivity was part of Jeremy’s natural endowment, just as much as his intelligence, that this aspect of him hadn’t really
changed in its essence by the end of therapy, despite his psychodynamics having changed significantly. In the impressively psychoanalytic session three weeks before the end of therapy, we can still clearly see it. (In the detailed recording, I think we can also see signs of limited attention span.)

He carries on like this throwing and crashing the little figure and climbing on the table... He remains quiet for a bit and then returns to running up and down off the table... He's on the table again, swinging the string of the heater switch... He swings and jumps off quickly to see if it is still swinging and moving... It all feels frenetic.

In my own clinic, a Strengths and Difficulties questionnaire would now be routinely completed for Jeremy on referral. I think it likely that Jeremy would have scored very highly for hyperactivity on this. In which case, a Conner's questionnaire would be completed and I think it likely that the same result would have been confirmed. A psychiatric assessment would then be recommended. Because of his age at referral and during treatment, it is very unlikely that medication would be recommended.

What has changed by the end of treatment is that Jeremy is now able to think with his therapist about this quality in himself and to recognise and respond fully to the substance of what she is saying. I think the use Jeremy makes of his intelligence has also changed. At the beginning, we see it being used to add precision to his impulsive forcefulness, as when he says 'those damn calendars' and to use that precision to triumph over his therapist, as when he is throwing toys at her and shouts 'Don't throw them back!' or 'Why can't you take it!' My own experience has been that this way of using intelligence can add a quite disabling rapier-like speed and precision to the penetration of provocations. As the therapeutic process develops, we see this same intelligence being put to a different use, in which what was aggressive impulsivity of speech and action has been transformed into a helpful forceful directness,

In one session when it was time to leave he took great dives into my lap. I spoke of his wish to get right inside. He then asks me, 'Where do you work...?' I ask where he thinks and he taps himself on the chest and says you work in here.

His hyperactivity/impulsivity has also changed significantly in the form of its expression. There are many examples but for instance,

He stops for a bit and comes over to me and looks at the picture he did in the last session of a rabbit. I talk of this rather mysterious rabbit – how we didn’t really get to know much about it. He says 'he's not a wild one, I have one at home that isn’t wild.’ He looks at me very seriously and asks 'how do you get them not wild?’ I talk of how he has wild feelings at times and friendly feelings at others and how he is asking me how can he be 'not wild’, how can he hold onto his friendly feelings and not go wild like when he’s running up and down the table. He remains quiet for a bit...

At this point, with the help of the word ‘wild’, Jeremy’s therapist is interpreting not only aggression but also manic defence. I think it is clear he is now being greatly helped
by this kind of thinking, recognises its truth and value and feels genuine depressive concern. He now has some sense of how to come back into contact. We see him coming into this kind of contact for a time and then going away into the separateness that allows him to be absorbed in free (sometimes excited, at times dangerous, but not now nearly as aggressive, and sometimes none of these) hyperactivity/impulsivity and then coming back. That is, on Conner’s, which might now be used for an assessment of progress on closure, I think it likely that, while Jeremy would have had a really high score for oppositionality on referral (a score that would capture something of his aggression and manic defence), he would not have done so on closure. I think it likely that he would still have significant scores for hyperactivity but I think it possible that, without having any medication, its degree has lessened. If these conjectures are true and, of course, there is no way of knowing now, we would have a finding of some importance.

In my own clinic, partly in view of some aspects of Jeremy’s presentation, adding to the reference to Mr. O having Asperger’s features, it would be asked whether Jeremy had Social and Communication Difficulties. Investigation of this would again now include questionnaire based enquiry. My guess is that this might indicate that Jeremy has some autistic features but not a diagnosable ASD. But whatever its outcome, I think the enquiry, and the psychotherapist’s cross-checking of all the ‘external’ measures I have referred to with those from therapeutic contact, is likely to be illuminating both for the diagnostic assessment and for psychotherapy.

In conclusion, today (but not twenty years ago) I would want to explore, using available psychiatric and clinical psychology resources in the ways I have outlined, what I think are signs in the clinical material that Jeremy may have real neurodevelopmental difficulties as well as strengths. If these conjectures turned out to be right I think the neurodevelopmental understanding we had would add to, rather than compete with, the understanding of his psycho-social situation outlined earlier. For instance, it is known that the combination of hyperactivity/impulsivity with high emotional arousal is very combustible. This can add exceptional explosive force to negative psycho-social spirals of the kind discussed earlier, making them fiercely bio-psycho-social. I have suggested that one use of his intelligence was to give added charge to that. I think this would help us understand in a different way what we see in Jeremy’s therapy; that is, as an evolution in the way he actively responds psychodynamically to what, psycho-socially and neurodevelopmentally, he is faced with. At the beginning of psychotherapy, I think his response took the form of trying to consolidate himself internally around a persecuting bad object, exploding his own way deeper into the family’s downward spirals. I don’t see major signs of that sort of internal organisation when therapy ends.

69 Collingwood Avenue
London N10 3EE
e-mail: shuttleworthalan@hotmail.com

Note

1 I think what we now know about the causation of depression means it is more likely, but not certain, that it was the latter.