A Discourse Analysis of Lacanian Psychoanalysts Conceptualisation of Child Psychopathology

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Declaration

I hereby certify that this material which I now submit for assessment on the programme of study leading to the award of Doctor of Psychotherapy is entirely my own work and that I have exercised reasonable care to ensure the work is original, and does not to the best of my knowledge breach any law of copyright, and has not been taken from the work of others save to the extent that such work has been quoted and acknowledged within the text of the study.

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Abstract

This study explores how Lacanian Psychoanalysts understand child psychopathology. Addressing this question in line with the principles of the methodological approach that was adopted for the study meant conducting a review of the literature pertaining to the dominant discourses that construct the concepts 'child' and 'psychopathology'. The discourses found to be most influentially to the construction of childhood, historically and contemporaneously, were those of religion, philosophy, and developmental psychology. A review of the literature concerning psychopathology revealed how developmental psychopathology and psychiatry remain the dominant models in research and the clinical treatment of children experiencing mental health problems. The most prominent methods of clinical treatment are also addressed as part of the literature review. This served as the backdrop against which the subject of Lacanian psychoanalysis with children is being explored. Lacanian psychoanalysis provides a coherent theory, with an emphasis on subjectivity, the unconscious, discourse and early childhood as factors that structure the individual. It is these elements that enable practitioners to conduct a form of treatment that is described as 'one-by-one', always unique and original to each case. Six semi-structured interviews were carried out with the participants and the interview data was transcribed and analysed using Foucauldian Discourse Analysis (FDA). FDA was used to explore how the participants constructed their understanding of child psychopathology by paying attention to the discourses they used in discussing this subject. The study outlines the role of contemporary culture in the conceptualisation of childhood and psychopathology according to the participants and reveals a radically different way of conducting treatment to the dominant models, those that are addressed in the literature review. These findings from the study advocate for a more nuanced approach to treating children with mental health difficulties that recognises the unique individual qualities of each child and takes account of their social and cultural experience in devising and delivering programmes of treatment.

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Acronyms

ADHD	Attention Deficit Hyperactivity Disorder
APA	American Psychiatric Association
ASD	Autistic Spectrum Disorder
CAMHS	Child and Adolescent Mental Health Services.
CD	Conduct Disorder
DSM	Diagnostics and Statistics Manual
ICD	International Classification of Disease
NICE	National Institute for Health and Care Excellence
ODD	Oppositional Defiant Disorder

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Description of terms

Social constructionism refers to a theory of knowledge which holds that our experience of the world is largely determined by the shared ways in which we think about and represent things. Despite the interchangeable use of the term's constructionism and constructivism within therapy literature Georgaca (1995) points out that constructivist approaches are concerned with the way individuals construct the world and their problems while constructionists tend to focus on the way culture and social structures form realities that people live within. This study follows with the use of constructionism to highlight the role of culture (discourse and language) in the shared conceptualisation of concepts discussed within.

Mental disorder. The current guidance for assigning diagnoses in ICD and DSM is based upon symptoms as signs of psychopathology. This represents a descriptive approach to classification. There is however no definition provided by the DSM for mental disorder. Psychiatry, employing a medical model based on observation and testing in conjunction with the reports provided by patients, attempt to reach a consensus vis a vis clinical judgement in accordance with an existing nosological system. Mental disorders are common in the general population (Nuevo, 2012) and exist along dimensions that are continuous with normal variation (Clarke et al., 2017) which in part "complicates the determination of where the threshold lies between healthy and psychopathological ranges of specific symptom presentations" (ibid, p. 112).

Discourse. The term discourse is complex and nuanced. Discourse theory is being applied for the purposes of analysing data by employing several Foucauldian concepts in the process. Discourse is also the term used to identify how language organises our common understanding of concepts such as the child, childhood, mental illness, psychopathology and so on. Lacanian psychoanalysis proposes a unique theory of discourse which pertains to how language organises human inter-relations (Lacan, 1971). The significance of this theory is in how it can be applied to clinical and psychotherapeutic settings. The use of the term discourse will be fully explained within the sections of the study that deal with it in the forms mentioned here.

Structure. Lacanian psychoanalysis is often regarded as a structuralist's rereading of Freudian theory. Structuralism is a branch of linguistics that holds language to be a self-contained system whose elements (signifiers) are defined by their relationship with each

other within the system. Lacan introduces the work of Ferdinand de Sassure to denote the linguistic quality of the unconscious in human life. The principles of structuralist linguistics can be found at the heart of the entire corpus of Lacan's psychoanalytic theory. The term structure is often taken up to imply an opposition between surface and depth, symptoms are surface phenomena while structure remains a static yet less discernible entity. Lacanian nosography makes use of three distinct structural categories: Neurosis, Psychosis and Perversion, each of which are defined by how the subject functions within discourse (the social bond).

Other. Lacan draws the distinction between the (o)ther and the (O)ther that is central to his theory of psychoanalysis. The other is the specular image in the mirror or the counterpart, peers. Lacan locates this other within the imaginary register. The Other designates that which is radically ulterior to the person and that which cannot be identified with. Lacan designates the Other with the order of language and the law, the symbolic order that mediates the relationship between people. The Other is also the locus in which speech can become constituted. Lacan ascribes the unconscious to the discourse of the Other and desire as the desire of the Other. The individual (subject) is divided by language, split ($ the split subject) and alienated from himself.

Jouissance. Lacan introduces the term *jouissance* to denote the paradoxical satisfaction the subject derives from his own suffering. Jouissance represents a tension that the subject experiences at the limit of his own enjoyment. Freud's pleasure principle (1920) sets a restriction on satisfaction that jouissance attempts to go beyond, the result of which is pain or suffering, a painful pleasure.

The Symbolic. The symbolic order is the order of language and culture, the synchronic structure in which the child is inscribed, unknowingly through the prohibition of incest (paternal metaphor). This concept of the symbolic was proposed by Levi-Strauss who demonstrated how the permutations of kinship not only establish the prohibition of incest as the law that transforms nature into culture but also reveal that language and culture are both shaped by a symbolic system operating on an unconscious level (Dor, 1994, p.21). Lacan's application of Levi-Strauss concept allowed a clinical insight into the functioning of language on the human psyche. Drawing on Freud's (1920) example of the game of fort-da and Jackobson's (1956) theory on phonology, Lacan concluded that language acquisition goes hand in hand with primal repression. Lacan, discussing the fort da game explains how the child's ability to symbolise the mother's presence and absence with just two syllables

(fort/da) and in his joyful expression of this experience and observation simultaneously repressed the sadness of its materiality thus inaugurating the unconscious. From this point on the unconscious becomes the reservoir of all phonematic traces related to every subsequent experience of loss. The symbolic is comprised of signifiers that enable endless forms of representation. The process of castration brings about the substitution of two metaphors: the desire of the mother for the name of the father. All human interaction and even the formation of subjectivity is founded upon a symbolic order without the conscious awareness of the individual.

The Imaginary. The basis of the imaginary order is the constitution of the ego. It represents an encounter between the world and oneself where cognition and identification are grounded within the visual field, in particular, images. It is in this preverbal stage that Lacan locates the Mirror Stage (Lacan, 1936), the establishment of the ego based on an identification with an other, ***I** am an other*. The register of the imaginary is correlative to the two other registers (Symbolic & Real). The Borromean knot is concerned with the implications each of these registers have for the structure of the subject. Central to the register of the imaginary is the ego, narcissism and aggression. The mirror stage involves an integration of the specular and idealised other (the mirror image) that possesses the quality of unity and integration which belies the real state of the infant at a physiological level. This integration of the specular other as oneself is carried through to adulthood. The alienating effect of this *meconnaissance* or misrecognition produces knowledge within the subject that is based on an illusion, leading Lacan to declare that one of the preconditions of knowledge is paranoia (Lacan, 1953).

The Real. The Real is the order of existence that exists outside of symbolic representation. The symbolic introduces a "cut in the real" through the process of signification, (Evans, 1996). "It is a that which resists symbolisation absolutely" (Lacan, 1966). Lacan links the concept of the real with impossibility as it lies within the fault lines of perception and beyond articulation. Freud's 'das ding', the unimaginable, is frequently evoked in reference to the real, a sense of what is uncanny and often traumatic. Lacan in reference to Freud's case of Little Hans identifies two distinct eruptions in the early life of the child, the breakdown in the pre-Oedipul harmonious relations with his mother through the arousal of his genitals (the penis as a real organ) and the birth of the boy's little sister (the intrusion of the real other). Lacan uses the concept of the real to elucidate several key clinical phenomena. In anxiety neurosis the Real is "the object of the anxiety, not a material object but an object with which all words cease, and all categories fail" (Lacan, 1966). In psychosis what fails to be

integrated in the symbolic (*the name of the father*) returns in the Real often in the form of hallucinations.

Lacan's use of topology can be seen in his construction of the Borromean knot listed below. This topological construction illustrates how the Symbolic, Imaginary and Real become knotted together. At the centre of the knot is the object *a*, 'cause of desire' in Lacanian discourse theory. The subject, in psychoanalysis, is a consequence of the unique way in which the knot is bound.

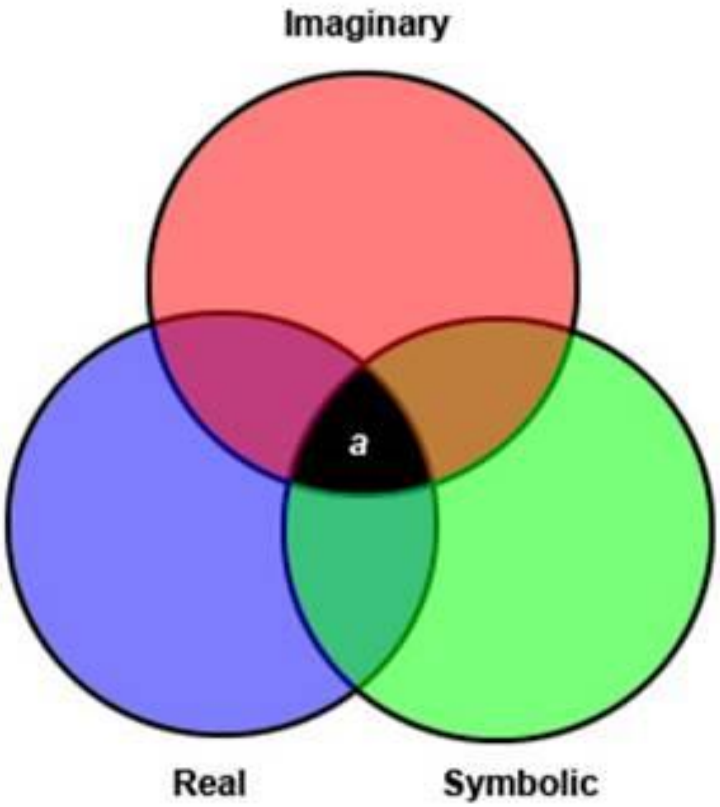

Figure 1. The Borromean Knot

Chapter 1: Introduction

1.1 Introduction

This chapter introduces the psychoanalytic theory and treatment of children and presents an outline of the structure of the thesis alongside the aim, objectives, rationale and background to the study. Psychoanalysis with children has been practiced since the beginning of the twentieth century. It has been very successful therapeutically and has been a central component to psychoanalytic theory both in the wealth of material supplied and in the therapeutic potential that it offers (Geissmann,1992). The inaugural case of psychoanalysis entitled 'Analysis of a Phobia in a Five-Year-Old-Boy (1905) served as a template for understanding both psychopathology in childhood and psychosexual development. This present study**,** a Discourse Analysis of Lacanian Psychoanalysts' Conceptualisation of Child Psychopathology aims to illuminate how Lacanian psychoanalysts speak about their understanding of child psychopathology[1] in a contemporary context. The study examines the key theoretical concepts that underpin the Lacanian tradition and outlines how these concepts provide the participants with a means of conceptualising psychopathology.

1.2 Background to the study

Freud's theory on human development challenged many of the idyllic notions of childhood that existed in the early 20th century and remain controversial today (Cunningham, 2006). Despite this the field of psychoanalysis with children has grown significantly over the past twelve decades. Pioneers such as Melanie Klein (1882-1960), Anna Freud (1895-1982), and Donald Winnicott (1896-1971) developed theories and concepts that enabled different understandings of children and provided a structure for the psychoanalytic treatment of young subjects. Jacques Lacan's influence on psychoanalytic theory and clinical practice with children has grown considerably in the past forty years (Rodriguez, 1994) and includes contributions from Francois Dolto (1908-1988), Maud Mannoni (1923-1998) and Rosine Lefort (1920-2007). While Lacan was not a child-analyst he treated few children (Laurant, 1990). Nevertheless, internationally there are now many analysts, as well as institutions, devoted to psychoanalysis with children that follow the Lacanian orientation (Rodriguez,

[1] Psychopathology is a termed frequently used to denote mental illness, suffering, abnormality and deviations from expected forms of behaviour, conduct and development. The term is also understood to refer to mental functions that cannot be justified by an explanation of the goal toward which they are directed according to Freud (1905).

1999) which in turn has had a significant impact to the broader practice of psychotherapy with children.

What makes Lacanian psychoanalysis with children of interest to this researcher and differentiates it from other approaches is its conviction that psychopathological phenomena are considered productions of a structure that follow an order, as Verhaeghe (2004) argues, with its flaws, inconsistencies, and destructive effects but an order nonetheless and not as mere disorders, that is, 'negative' phenomena or deficits. For Lacan, 'the unconscious is structured like language' (Laplanche and Pontalis, 1988, p.293) and as such operates in accordance with the same fundamental laws and principles. It was only with the inception of psychoanalysis at the beginning of the 20th century that a revolution in terms of treating children suffering from problems considered 'psychological'[2] began.

According to Verhaeghe (2004) the dominant discourse in the treatment of psychological problems is medicine (psychiatry) which is aligned to a positivist paradigm in research and supported by classical empiricism. This model of treatment for psychological problems in both children and adults is such that symptoms are gathered into an objectively generalized syndrome which, in accordance with an established knowledge of aetiology, distinguishes health and illness. In this sense symptoms are read as signs pertaining to an underlying disorder, a diagnosis and prognosis is reached by way of an instrumentally assisted procedures (psychometrics). The aim, thereafter, is to return the patient to a previous state of health. Psychoanalytic diagnostics focuses on symptoms as signifiers that remain open to the patient's interpretation rather than the clinicians. In medical terms symptoms read as signs pertain to an illness scenario. However, symptoms in psychoanalytic terms are read as signifiers which derive their meaning and function from a specific relation to the Other (language and the Symbolic order). This indicates a subject-other or relational factor in the aetiology of psychopathology. This remains unknown to the patient. For the psychoanalyst there can be no universal meaning in a symptom. Furthermore, by employing general diagnostic terminology the individual is put at a further remove or alienated from others. As Szasz (1972) argues "every rule or norm of psychological health generates a new category of mental illness", (p. 26), to which, Michel Foucault ((1926-1984) adds his idea of 'regimes of truth'. The use of psychiatric terminology carries significant power. This power to pathologise children has infiltrated the educational social life of children profoundly

[2] It must be added to that 'emotional' and 'behavioural' disturbances in childhood are also broached under the term 'psychological'.

influencing ones sense of identity (Harwood, 2006). Foucault (1960) holds that terms like disorder operate as 'truths' due to the power of the discourse from which they emanate.

More recently, changes to the Diagnostics and Statistics Manual of Mental Disorder Vol. 5 (DSM V, 2013) have demonstrated a further movement towards a neurobiological view of mental life 'further enforcing the idea that mental and emotional problems are situated entirely within the person' (Mash & Barkley, 2014 p.18). Harwood's (2006) study of behaviour related disorders concluded that children are stigmatised and adversely effected by the diagnostic procedures of psychiatry where their social and educational lives were concerned. A significant critique of the DSM and of psychiatry is that is has moved from being a knowledge base concerning human experience to a model that classifies behaviour. Verhaeghe (2004) also notes the tendency to have the patient fit the within the theory. Psychoanalysis by contrast, aims to draw attention to what is subjective or unique to the individual. Lacanian psychoanalysis more than any other school of psychoanalysis emphasises the notion of singularity and supports the desire of the individual in ones radically subjective constitution. This represents a departure from more mainstream models with their focus on adaptation: social and familial, through the utilisation of cognitive, behavioural and systemic theories.

1.2.1 Psychoanalysis and research

Psychoanalysis represents a particular type of discourse or 'social bond' that is primarily concerned with human experience. It is also a unique form of dialogue that takes place between two people, analyst and analysand[3]. It has based its theory and clinical application on the unique lived experience and unconscious elements in the subject's world, this is evidenced by its dependence on single case studies (*Analysis of Phobia in a Five-Year-Old Boy* (1909), *Fragment of an Analysis of a case of Hysteria* (1905), *The Importance of Symbol Formation in the Development of the Ego* (1930), *The Piggle: An Account of the Psychoanalytic Treatment of a Little Girl* (1977), as empirical sources of data. Unfortunately, the publication of individual single case studies is relatively uncommon. There are multiple reasons for this, not least being the complexity of protecting the integrity and right to privacy of the individual. Here lies a conundrum for any student or researcher

[3] Lacan introduces the term 'analysand' to distinguish psychoanalysis from a medical approach in which the patient – doctor relationship operates under a master discourse. The analysand is the one who is "at work". The term is to denote the active rather than passive position that is taken up by one who, in other domains may be referred to as patient or client.

of psychoanalysis. Psychoanalysis is a practice that does not lend itself to the forms of empirical evaluation applied in other psychological therapies. It is, by design, an approach that treats every patient or analysand as a unique and singular subject. Attempting to draw general assumptions from cases is antithetical to the ethics of psychoanalysis. However, this does not alienate the discipline from research outright. While case studies provide insight into the principles o f its practice this cannot be mistaken for a set of instructions, hence the absence of a psychoanalytic clinical manual. Qualitative inquiry has proved very useful as a method for exploring the theory and practice of psychoanalysis in recent decades, Parker (2008).

1.2.2 Psychodiagnostics

The changes that took place within the most recent edition of the Diagnostics and Statistics Manual 5 (DSM V, 2013) included alterations to the section previously entitled 'disorders usually diagnosed in infancy, childhood and adolescence' (DSM IV-R, 1994). The disorders considered to be most frequently diagnosed in childhood are Autistic Spectrum Disorder (ASD), Anxiety disorders, Disruptive, Impulse Control and Conduct Disorders and Attention Deficit and Hyperactivity Disorder (ADHD) which, along with ASD has recently been subsumed into the category entitled 'Neurodevelopmental Disorders' reflecting and supporting at least in name the shift towards a neurobiological perspective. Accurate prevalence rates for many disorders can prove difficult to identify due to the methods for conducting systematic population-based surveys. However, Ford (2020) found the proportion of under-16's experiencing any mental disorder had risen from 11.4% to 13.6% between 1999 and 2017 while a study by The National Health Service (NHS) estimated that approximately one in six children were currently experiencing a mental health disorder in 2020, a figure that had increased from one in nine in 2017[4]. Despite slight variations to the proportions of children experiencing and presenting with mental health difficulties, which is largely the result of variable measurement methods, there is a consistency in the upward trend that is also being recognised by clinicians and researchers.

The practice of diagnosing children or adults is often a much less explicit affair in psychotherapy and psychoanalysis. In psychoanalytic terms diagnosis remains structural rather descriptive, the patient rarely if ever being informed by the psychoanalyst of the diagnosis. A slower process of diagnostic formulation aids the analyst in directing the work

[4] https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2020-wave-1-follow-up.

whereby the analyst relies on the language and signifiers the analysand[5] uses to develop insights into their psychical life, this is unique to ever individual. For psychoanalysts symptoms are a representation of the psychical life of the individual, a psychical life that is comprised of conscious and unconscious forces, a psychical life that is ordered or structured on the principle of singularity and marked out by language (Fink, 1995, p.37). With the emphasis placed squarely on singularity - psychoanalysis represents a movement away from the generalist approach of psychiatry and a culture of uniformity in how we engage with one another.

1.3 Rationale for the Study

Dirks *et al.* (2012) argues that there is a growing recognition that children's behaviour varies 'meaningfully' across different situations, which demonstrates that the situations in question are at least partly responsible for inter-rater discrepancies in reports of symptomatology. Clarke *et al.* (2017) note 'contextual factors' remains one of the greatest challenges that psychiatry faces in producing accurate and effective diagnoses. Dirks *et al*. (2012) study concludes by stating that the most prudent step in conceptualising and treating mental health difficulties requires moving away from models of psychopathology as generalized traits that manifest uniformly across situations and settings, and towards theoretical conceptualizations that explicitly incorporate contextual features. Such a recommendation would advocate a departure from the diagnostic criteria of psychiatric/medical discourse[6] towards a more interpretive model of symptomatology. In such a situation the attention would shift from diagnosing based on a quantification of symptoms to a more interpretive approach in conceptualising meaning and representation. However, meaning and representation also require explanation. A certain 'taken for granted' quality exists for many of the concepts, including childhood, that organise how we understand aspects of everyday life. Making meaning out of experience must begin by addressing the way terms such as childhood and psychopathology have come into being. Foucault's genealogical approach to discourse serves as a useful guide for examining concepts such as psychopathology that operate on how we make sense of fundamental aspects of our lives.

[6] Verhaeghe argues that the fundamental premise of the *DSM* system is classification based on empirical observation alone. It is a tautology that discards the subject.

Fonagy *et al.* (2015) indicate that psychoanalytic psychotherapy can be an effective form of intervention for children experiencing a range of mental health problems, however, it remains one of the lesser prescribed, non-medical, treatment modalities as recommended in the National Institute for Health and Care Excellence (NICE) guidelines; Pathways to care[7], (2019). Those more commonly recommended employ a cognitive and/or systemic approach. In a systematic review of behaviour related disorders in children, Waddel *et al.* (2018) suggested that much of the research has tended to focus on the prevention and treatment of these conditions. The authors outlined how studies which focus on prevention and treatment frequently employ quantitative methodologies based on positivist paradigms, thus appealing to the medical discourse. Consequently, this approach further enforced a model of standardisation and the promotion of manualised approaches to treatment resulting, overall, in a narrower view of a complex issue. Of the qualitative studies seeking to explore the experiences of clinical specialists and children, Hersen & Thomas (2007) note a general tendency to employ phenomenological methodologies which shed light on the lived experience (personal and professional) of individuals experiencing mental health problems but exclude a focus on how such concepts emerge and in what context they continue to exist. Urwin (2009) states 'child psychotherapists have long appreciated that psychoanalytic work with children cannot simply be about analysing conflicts, removing repressions or reconstructing the past. More often it involves enabling processes and structures to develop to allow for the possibility of thought, reflection and sustained emotional experience in the first place' (p. 147).

Psychoanalysis with children, which has an interpretive approach at its core, is based on the pioneering work of key theorists and offers a range of approaches to understanding and treating children experiencing mental health difficulties. Within the related field of psychodynamic psychotherapy several attempts have been made to manualise and standardise models of practice for children presenting with specific emotional and behavioural problems (Hoffman, 2014, Prout & Rice, 2015). Manualised approaches to treatment are antithetical to Lacanian psychoanalytic practice. The Lacanian Psychoanalyst focuses on the single subject with a lens informed by a rich theoretical body of knowledge, which is used to guide the direction of the treatment and the interpretations and interventions that occur. As such it does not offer a roadmap for practice. This championing of singularity

[7] Pathways to care is the term used by several health organisations including NICE and WHO. This phrase comes from the field of Health Operations Management and is designed to address planning, analysis and control as the steps necessary in the provision of a service, including mental health, to a client according to Vissers and Beech (2007).

makes a study of how the Lacanian analyst conducts treatment problematic and at the same time heightens this researcher's curiosity regarding how to illuminate and share knowledge about the way this clinical work is informed and conducted. By making Lacanian child psychoanalysis visible, practitioners in the field may gain a greater understanding of its underpinnings and application while avoiding any attempt to create a manualised approach. Lacanian psychoanalysis, as a distinct method of clinical treatment, can best be explored by examining the concepts that make up this theoretical framework in conjunction with the ethical positions adopted by the psychoanalyst in relation to the child as subject.

The study sets out to highlight the specialised and creative form of dialogue that is psychoanalysis. This would seem important considering the increasing degrees to which evidenced based approaches continue to produce manuals for clinical practice thus reducing the counsellor, therapist or analyst to the mechanical application of clinical or pedagogical steps and processes. The psychoanalyst, in paying attention to the ontological status of the unconscious, actualises hidden dimensions of discourse that are excluded from most forms of conversation. The question of how the Lacanian psychoanalyst conceptualises mental health problems in children is of relevance to clinicians, their patients and those who share the social world of the child.

Burman (1994) highlights the range of discourses that have come to inform how the child and childhood is conceptualised for the purposes of education, welfare, development, and clinical treatment. In broader political terms the place of the child in western societies has only more recently become recognised at the highest levels of public life. In 1992, the United Nations Convention on The Rights of the Child introduced into international law article 12 which recognised the autonomy and individuality of the child – '*children as people and not just objects of concern'*. In 2015, the Irish government introduced changes to the constitution regarding the rights of the child in Ireland. While children had previously enjoyed many of the same rights as adults, Article 42.5 sought to address the rights of children, *as children*, introducing the following into law; '*The State recognises and affirms the natural and imprescriptible rights of all children and shall, as far as practicable, by its laws protect and vindicate those rights'*. Prior to this the presumption was that the rights of the child were best vindicated through their family, by their parents (Smith, 2014). This bill further served to acknowledge the autonomy of the child and to have their voices heard where their own welfare is concerned. The changes within legal discourse reflect the changes occurring at a social and cultural level to the extent that a child is now considered as a member of society

in his or her own right. Other, and sometimes competing discourses, contribute to this understanding and influence how child health, in particular child mental health, is conceptualised.

The term child is not a psychoanalytic concept, rather it is a socially constructed concept (Jenks, 1996, Prout and James, 1997, Kehily 2013). The extent of how social, cultural, and political discourses inform psychoanalysts understanding of their young patients, and the influence of this on their approach to treatment, warrants exploration. A basic assumption within social theory is that our ideas concerning mental health and childhood do not develop in a vacuum, rather, they are constructed out of a particular context and within a specific social milieu. Social constructionism holds that all knowledge is culturally and historically specific and structures the social world (Burr, 1995). Michel Foucault (1926-1984) has been hugely influential in the area. Foucault (1972) draws attention to how knowledge and power are structures of discourse. Drawing on the principles of social constructionism and Foucauldian discourse analysis, the current study seeks to explore how Lacanian child psychoanalysts speak to their understanding of child psychopathology. As psychoanalysis is a theory and praxis intimately bound up with discourse and culture a socio-constructionist approach to childhood and psychopathology has been adopted in reviewing these concepts within the literature. A fundamental aspect of Foucauldian informed research involves exploring discursive practices that give rise to specific objects. In the current study the formation of childhood and psychopathology have been drawn to specific discourses that may be regarded as dominating how these concepts have come to be understood. These discourses can be set against the accounts provided by the participants in how they discursively construct versions of childhood and psychopathology to reveal the distinctive features of Lacanian psychoanalysis. Examining the subjective accounts of these experienced practitioners may provide valuable resources in the wider understanding and practice of psychotherapy with children. Furthermore, as each of these practitioners have conducted their work over a long period of time, it is also argued that this experience enables a unique and valuable perspective on the changing patterns of child related psychopathology.

1.4 Research Aim and Objectives

The research aims to explore how Lacanian psychoanalysts conceptualise child psychopathology.

Objectives

- To make visible the specific components of the discourse of Lacanian psychoanalysis used to address the subject of child psychopathology.
- To analyse the participant's discourse and identify the knowledge that structures their model of practice.
- To explore the features of the Lacanian model of psychoanalysis that the participants deemed to be distinctive from other models of practice in the treatment of children.

1.5 Research Outline.

The study is divided into seven chapters. Chapter one introduced the study along with the background and rationale. Chapter two explores the discourses that have played a significant role in the construction of childhood and psychopathology. This chapter also addresses the methods most prescribed in the treatment of children experiencing mental health difficulties. Chapter three explores the theory and concepts within Lacanian psychoanalysis as it applies to childhood and psychopathology. Chapter four describes the outline to the methodology and provides a detailed account of the philosophical underpinnings of discourse analysis along with methods applied in gathering and analysing the data. Chapter five contains the findings which identifies the categories of discourse that the participants draw upon in addressing the research question. Chapter six provides a discussion of the findings and draws out how the participants position themselves in the undertaking of their work as child psychoanalysts along with the strengths and weaknesses of the study. Chapter seven highlights the main findings and conclusions from the study, implications for the practice of psychoanalysis with children and future areas of study. Some personal reflections and discussion of my personal motivation for undertaking the study are also included here.

Chapter Two: Literature Review

2.1 Introduction

The following chapter will address the literature informing the reader of how discourse has organised the broader conceptualisation of childhood and psychopathology. A corpus of statements[8] needed to be developed as part of the literature review. This included examples of how the construction of childhood and psychopathology took place over time. This temporal variability provides some perspective for how knowledge and power relations operate within different historical epochs and how the different ways of describing children and psychopathology has led to different forms of treatment available today. While it is possible to include a corpus of statements as part of the data set the current study sought to include this component as part of the literature review in order provide a background to how child psychopathology has come to be conceptualised in contemporary discourse. Applying this approach meant covering a broad and diverse set of literature that is used to elucidate the key features of Lacanian psychoanalysis as outlined in chapter 3.

This chapter is organised into three sections addressing Childhood, Psychopathology and Psychoanalysis. Section one provides a brief historical review of how childhood has come to be recognised as a distinct period in life. This section addresses how the discourse of religion, with its knowledge of 'the child' exerted influence over how children were raised and treated in previous historical epochs. A brief review of the philosophical influence on the conceptualisation of childhood is considered to provide a context for how a developing 'sentiment of childhood' altered the relationship between the child, the family and society. These cultural shifts coincide with the introduction of legislation protecting the child and the family, as discussed in 2.4. This section of the review concludes by examining how developmental psychology, employing conventional scientific methods, has constructed a version of the child we are more familiar with today. Section 2.7.5 concludes by outlining how psychology has become the dominant discourse in constructing the version of the child in the 21st century.

[8] A corpus of statements is a selection of discourse samples about an object relevant to one's inquiry (Willig and Stanton-Rogers 2017). A corpus of statements should also highlight discontinuity where objects undergo an historical transformation i.e. how the change in what they are called determined how they are understood.

The next section of the literature review addresses the concept of psychopathology and offers a critique of how psychiatry and psychology, as the dominant discourses in this area, construct a particular version of human experience as it applies to children. While data for the prevalence of mental health conditions in children along with contemporary approaches to the treatment is also provided, a predominantly theoretical as opposed to empirical approach has been adopted in this chapter to provide a context for understanding the concepts of childhood and psychopathology. This is in keeping with the social constructionist framework of the study. Foucault (1969) highlights the importance of genealogy[9] in rendering aspects of life, including childhood and psychopathology, knowable. The centrality of discourse is considered throughout this chapter as it is the keystone that enables people to construct and imbue meaning into talk about mental health and therapeutic treatments, Speed (2011). The overall aim of the chapter is to provide the reader with a context for how these concepts have evolved over time and to situate psychoanalysis as an alternative to the dominant discourses.

2.2 Literature Search Strategy

The overarching aim of the literature review was to develop a foundation for how the concepts of the child and psychopathology have become organised by discourse. A genealogical approach to exploring these concepts was adopted which inevitably led to a broad and diverse range of literature being covered. A social constructionist framework for understanding childhood and psychopathology was developed using literature retrieved from a library search. Articles drawn from research databases including Pubmed, PsychINFO, Psycharticles and Google Scholar made up much of the literature for the study. Accessing statistics for national and international prevalence rates in the diagnoses of childhood disorders came from surveys and systematic reviews published online, NICE Guidelines, CAMHS annual reports. In addition to online journals, material was sourced from printed books. To review relevant literature on the subject of psychoanalysis with children various national and international journals (Lacunae, The Letter, The Symptom, Hurley Burley) were accessed. While the literature review was restricted to those articles published in English it must be acknowledged that much of the literature which exists regarding Lacanian Psychoanalysis with children is written in French, Spanish and other continental languages.

[9] Foucault develops a method for the analysis of thought that extends beyond the structures of archaeology and history and aims at revealing how contingent turns in history results in the outcome of how something can be known or thought about. To do this Foucault turns to discourse.

There were no systematic reviews of Lacanian psychoanalysis conducted with children discovered during this search.

2.3 Childhood as a Social Construct

Perusing the literature on childhood it appears that this phase in life is configured as a generative mixture of past influences, philosophical positions, religious beliefs, the romantic era and scientific discourses. These are the systems which create a set of parameters that we adopt, like the image in the mirror, to generate a sense of who we are. Lacan (1994) points out that any concrete psychology must be augmented by a reference to ethnology, history and law, and that psychoanalysis itself must adapt to the complex theoretical structures that will result from this development. Foucault (1960) informs us of how divergent discourses create tensions, continuities and discontinuities regarding all concepts including the child. The salient features of these discourses have been addressed in terms of how they have contributed to the contemporary western version of the child.

Contemporary notions of the child and childhood are situated entirely in culture and history (Kennedy, 2015). Prout and James (1997) argue that 'childhood' is a social construction that provides an interpretive framework for contextualising the early years of life. The French historian Phillipe Aries (1960) argued that childhood only began sometime in the late 17th century. Prior to this, little appreciation existed for what is known of childhood today. While the accuracy of Aries' claim has been debated (De Mauss, 1974; Stone, 1977; Wilson, 1980) the thrust of his conclusions were simple in that the object of his enquiry 'childhood' was something that could only be understood if one was sensitive to the social, cultural and political forces that, over time, produce childhood, and by extension it's object, the child. Contemporary approaches appear committed to the view that childhood is not a natural phenomenon but is, according to Jenks (2005), a social construct. 'Our knowledge of children is shaped not by understandings inherent to the state of childhood but by much wider forces influencing our thinking' (Pattison, 2017, p.101). Moreover, the concept of childhood is one produced by adults through a multitude of discourses. From the early 20th century medicine and psychology, under the discourse of science, usurped the role of defining what can be understood about the child and about childhood. Prior to this the discourses of religion and philosophy held a powerful influence over the way society understood and treated children, (Kennedy, 2015). The following section provides a brief account of the influence of Christian discourse on the conceptualisation of the child in previous eras.

2.4 Religious Discourse and Childhood

The Church and religion were, for many centuries, a dominant factor in the lives of western societies. The power of the church was evident in all facets of life leading Foucault (1969) to contest that religion can be distinguished by how it inscribes language on bodies, in other words how precisely it shapes what it is we see in ourselves. The status of the child within Christian theology changes considerably over the centuries. McNeil (2005) notes the influence of St Augustine on religious doctrine and the teleological changes that occurred as a result of this. The child, as a subject and moral agent, within Christian thought is seen first in terms of the moment of a fall from Paradise. The child is stained by Original Sin. However, the child as an object in the discourse of religion oscillates from a sinful being to that of a pure and innocent being. Costello and Angold (2010) remark on how Original Sin marked children as being morally unclean. The authors point out how St Augustine's (AD 354-430) teachings gave rise to the notion that the child is born in need of moral reform. Disobedience and defiance, even poor adaptation were indications of a lack in moral fibre. An adherence to church rules generally brought about physical punishment where disobedience occurred. This idea was most strongly held amongst puritans, particularly English and American Protestants of the later 16th & 17th centuries who believed in a strict moral code adopted following the reformation. This interpretation of religious doctrine led to notions of the child as being wilful and as such requiring a strong hand in his upbringing, "to spare the rod was to spoil the child" (Brocliss and Montgomery, 2003, p.81). Just as 'Man' had fallen and had to submit to God to be redeemed, so children needed to submit to the will of their father. However, Bunge (2001) observes how a social move towards liberalism in the late 18th century was also impacted the theology of the day. The theological conservativism of Calvinism, Lutherans and early Protestantism were declining as liberalism grew. Notions of how children should be treated changed in accordance with these movements, as Kehily (2013) notes, through Jesus God chose to convey not only the adult but also the child, the infant and the various stages of the life cycle. This, according to alternative interpretations of St Augustine's teaching, was in recognition of the importance of early life of man. "Give me the boy until he is seven and I will show you the man", a maxim often attributed to Aristotle and echoed by St Ignatius of Layola, such maxims also allow for the child to be recognised more as an 'asset of the state', according to Kehily (2013, p.13). The discourse of religion was implicated in the changes that took place around the 'sentiment of childhood' (Aries, 1962) in the latter part of the 17th century. Depictions of the Christ child in the arms of the Virgin Mary have been described as being replete with notions of purity and innocence

conjuring up versions of the child as ‘the perpetual Messiah’ according to Emerson (1965). Several other passages from the New Testament can also be read in a way that celebrates childhood, bestowing a grace and favour upon the child that is wholly absent in the adult; “Whoever does not receive the kingdom of God as a little child will never enter it” (Mark 10:15). Religious discourse has provided a mixed and sometimes contradictory view of the child throughout the centuries in which it exercised significant power and influence over generations of people. Foucault (1969) notes how such regimes change with time and with that the objects of which they speak also undergo changes. The shaping of childhood via religious discourse is evident in how depictions of children in 1200-1700AD changed from being miniature adults to something more closely resembling their natural physical form.

Figure 2. Duccio di Buoninsegna. Madonna & Child (1300)

Figure 3. Bouguereau. 'Vierge, Jésus, Saint Jean Baptiste' (1875)

The early Christian influence on the conceptualisation of childhood would later be overwritten by the Enlightenment and Romantic eras wherein philosophical thought further informed how childhood and the child were conceptualised.

2.5 Philosophy and Childhood

In a pre-Christian era, philosophical thought brought about changes to how governance and teaching, including that concerned with childhood, took place within early Western society. The few accounts of how children and childhood were depicted within written documents from that period convey a version of the child that diverged considerably with later philosophical ideas. Turning to Plato (428 – 348BC) children were like slaves and women and the inferior multitude who possessed a poorer constitution to their adult male counterparts: "*the boy…just because he, more than any other has a font of intelligence in him which has not yet 'run clear', …is the craftiest, most mischievous and unruliest of brutes. So, the creature must be held in check…*" (p.1379). Similarly, Aristotle's ideas on childhood found in the Nicomachean Ethics and Politics, (as cited by Burnett, 1962) implies a view of the child as being uncultivated, their desires in need of training for the sake of developing

the intellect. The spread of Christianity in the early centuries insured the domination of religious discourse throughout the middle centuries leading up to the Enlightenment era of the 16th and 17th century. An example of the how Christianity built on earlier philosophical ideas before usurping them into their own discourse to enable a form of discipline over Christian followers can also be seen in the way medicine and psychology emerge as dominant discourses that exercise power over the population while retaining a moral perspective in how they conceptualise deviance. Early applications of psychiatry include moral connotations to how disorders are understood and what type of treatment is prescribed. This is witnessed in the Retreat in York,[10] one of the first psychiatric institutions in Britain and one that advocated for religious observance as part of the recovery process.

Smith (2014) contests that the two major strands of philosophical thought that have informed our contemporary notions of childhood are Romanticism (Jean Jacques Rousseau, 1712-1778) and the concept of the *Tabula Rasa* or blank slate (John Locke 1632-1704). Locke's rejection of innateness of character and his denial of the religious ideology gave rise to the concept of the child as being in a "state of becoming", where the goal was to attain rationality. Locke's Tabula Rasa would later be taken up by Freud as means to understanding the unconscious. However, Freud would instead consider the unconscious as the slate upon which an echo of what was erased remains. Jean-Jacques Rousseau (1712-1778) would later become an influential exponent in the central conception of modern childhood. A particular sentiment of childhood, according to Aries (1969), is attributable to Rousseau who championed the idea of children as special beings with a particular cherished nature that harkened back to the virtue of purity as mentioned previously; "God makes all things good; man meddles with them and they become evil" (Brocliss and Montgomery, 2003, p.83). Rousseau's contention that children were born pure but were corrupted by the outside world became accepted amongst the aristocracy and middle classes as a more favourable notion to that of sinfulness held in the previous era according to Mathews (2009). As the child became imbued with notions of innocence and preciousness the cultural attitude towards childhood moved in the direction of safeguarding the child from the corruptive influences of the world around them. The attempts at the preservation of these qualities changed how children were cared for and educated. Pollock (1983) points out how these changes remained mostly

[10] The York County Asylum was opened in 1777 following a public appeal. Patients' attempts to control themselves were encouraged; individuals were treated as rational beings as far as possible; patients were not urged to reject their feelings and delusions; and a good diet, exercise, occupation, and social activities were provided. Religious observance and reading were recommended but excessive stimulation was to be avoided.

ideological, the reality of life for most children in Western society remained perilous throughout the 18th and 19th century, it was no doubt these same sentiments that were significant to how the Child Guidance movement of the early 20th century altered the lives of the child, the family and the wider social world, Kennedy (2015).

Psychoanalysis shares a long and ambiguous relationship with philosophy. Freud notes how the unconscious was discovered by the poets and philosophers before him. He did however develop a method for investigating the unconscious. Lacan (1953) while opposing what he considered a totalising view held by most forms of philosophy makes references to Plato, Socrates, Kant, Hegel, Aristotle and Heidegger are littered throughout his work (Evans, 1996).

2.6 The Political Child

In the previous sections the concept of childhood was explored through the discourses of religion and philosophy. As such the child was organised by moral principles and philosophical ideals. During this long period in history the most common form of governance was that of the monarchy. Foucault (1972) notes that during the late eighteenth century we have left behind the juridical models of power, a model that favours coercion, where power was exercised in the name of the king and parliamentary body. The beginning of the 19th century the expansion of discourses of sociology, medicine and psychology began to alter how power functioned. Power now was disseminating into fields of research. The exercise of this power is found in how these fields of research shaped how childhood and psychopathology, amongst other things, is understood. These fields of research also had profound effects for how children were treated and educated. In this section childhood is explored from a political perspective revealing how neoliberalism style goverance changed the path of childhood towards familiar to us today.

Lloyd deMause remarked, ‘the history of childhood is a nightmare from which we have only recently begun to awaken’, the further back in history one goes, the lower the level of childcare, and the more likely children are to be killed, abandoned, beaten, terrorised, and sexually abused’ (ibid, 1974, p.1). A growing concern for the welfare of children in the last two centuries brought about changes to how the child and the family are conceptualised in society. Cunningham (2006) noted that within a relatively short period of time the place of the child in working class families shifted from being one of active contributor to the family finances to one of docile beneficiary. Prior to this many children between the ages of seven

and nine years were routinely sent away to relatives or neighbours for the purposes of labour (Brockliss and Mountgommery 2013). Passivity and dependency became characteristics more associated with this period of life. The centrality of the family within the community gained greater prominence in the 19th and 20th century with legislation and social policy beginning to play a more significant role in how children and their families were recognised during this period. The introduction of The Factories Act (1867) in Britain made it illegal for any child under the age of 8yrs to be employed by a factory of any kind. Further amendments to child labour laws throughout the 20th century[11] reflected the 'sentiment of childhood' previously mentioned and altered the way children were managed and treated by society. Other legislative changes including The Prevention of Cruelty towards Children Act, or 'Children's Charter' (1889) gave the state the right, for the first time to intervene in the relationship between parents and their children, the National Society for the Prevention of Cruelty to Children (NSPCC) was established in Britain in the same year. These policies served as the foundation for child welfare. The 1908 Children's Act established a juvenile justice system under which a different application of the law would apply to children that committed crimes. While the various acts in legislation have sought to address the nightmare of childhood, as described by DeMause, many children remain exposed to dangers in contemporary family life. Safe Ireland, the national social change agency working to end domestic violence presented its latest national annual statistics recently which showed that 10,572 children received support from domestic violence support services in 2018. While these figures are clearly concerning Tusla's 2019 report[12] regarding the availability and comparability of child protection services across eight countries (England, Wales, Scotland, Norway, Australia and the USA) found that Ireland overall had less children in state care, had fewer reported cases of abuse and had fewer follow up investigations to alleged cases of abuse. The authors suggest that much of this is owing to the emphasis that is placed on family support and a less interventionist system culture compared with those other states.

In addition to the various acts in legislation and the accompanying social policies to safeguard children and enhance their educational resources the Irish state is also moving considerably in how it enables the voice of the child to be heard. In its commissioned report (2016) following up on the report on the application of the UN Convention's Rights of the Child in Ireland several important changes are currently being addressed at governmental

[11] Children's Act (1908, 1948, 1991), Education Act (1973, 2013), The Child Support Act (1991), Every Child Matters (2003), The UN Convention on the Rights of the Child (1992), Children First Act (2015).

[12] https://www.tusla .ie/upload/content/COMPWELFINALREPORTMARCH29_-_Final.pdf

level. These include how the state ensures equality of identity for all children, including those born through reproductive technologies, how it goes about protection for the 'freedom of thought' by allowing children to opt out of religion classes and providing suitable alternatives, by enacting legislation that explicitly and comprehensively provides for children's consent to and refusal of medical treatment in line with the Convention, and by enhancing the quality and availability of mental health services to children and adolescents. It also recommends that the government consider establishing a mental health advocacy and information service that is specifically for children.

The Irish Government reacted to the changes in discourse concerning childhood and children by introducing new legislation and altering the constitution[13] in a way that reflected these changes. The most recent report to the United Nations (UN) Convention on The Rights of the Child (2013), defined childhood as referring to 'every human being under the age of eighteen, unless under the law applicable to the child, majority is attained earlier'. This legal definition implies a clear distinction between 'childhood' which is organised in accordance with chronology, and 'the child', 'a term Plastow (2015) suggests 'cannot be separated from the societal, political, ideological and even clinical discourses that prevail' (ibid, p.7).

In charting the various pieces of legislation introduced throughout the 19th and 20th century it becomes apparent that the political child has grown from being one in need of care to one who possesses agency and whose voice deserves to be heard. The Irish state for its part would appear to be adopting a less paternalistic approach, evidenced by the falling number of children taken into state care and the shift towards family support-based interventions. Overall, a greater emphasis has unquestionably been placed on educating the child which is evidenced by the various acts brought into legislation that aim to keep children in school longer and the raft of supports designed to address early school drop-out. Psychoanalytic concepts developed by Klein and Anna Freud play a significant role in the early education of children during the middle 20th century. This later became the domain of developmental psychology.

From a societal perspective one could argue the changes to education policy reflect an effort to produce a more expert workforce which is in keeping with the market-based philosophy of productivity and a growing culture of performance and human capital. The impact of the political discourse of readiness on young children both in terms of education and

[13] Child Care Act, 1991, Children Act 2001, Children First Act 2015.

development can be seen as overlapping with the establishment of child psychology and the industrial revolution (Kessen, 1979). The scientific study of childhood has grown considerably in the past two centuries producing a field of research broadly referred to as developmental psychology. In turn, this academic discipline has had a significant baring on how children are educated and the provision of mental health support. The following section explores how the role of developmental psychology has constructed a version of the child that, as Foucault (1960) describes it, renders him knowable, measurable, governable, and in line with the current research question; "treatable".

2.7 Developmental Psychology

Developmental psychology, more than any other variety of psychology, has had the most powerful impact on our everyday lives and the ways in which we think about ourselves (Burman, 2008). It has come to shape our lives in almost imperceptible ways structuring relations between parents and children, educators, clinicians and social policy makers. As an academic field of research developmental psychology has brought childhood within the domain of scientific enquiry whereby a positivist approach, based on measurement and observation, produces a standardised model of assessment in almost every aspect of the child's life. Walkerdine (1984) highlights the enthusiasm for this field of research at the beginning of the 20th century,

> 'Children's bodies were weighed and measured. The effects of fatigue were studied. As were children's interests, imaginings, religious ideas, fetishes, attitudes to weather, to adults, drawings, dolls. Lies and most importantly for us, their stages of growth. What is important is that children as a category were being singled out for scientific study for the first time' (p.171).

The main focus of this section will be on the manner in which developmental psychology has contributed to a version of the child made knowable through behaviour, emotion and cognition and it is generally this area of childhood considered most pertinent in the study of child psychopathology. A brief account of the main approaches to understanding development (Emotional, Psychosocial and Cognitive) within this field of research is provided before a more critical appraisal of this discourse is offered as a summation.

2.7.1 Emotional Development

Emotional development (ED) refers to the emergence of the experience, expression, understanding and regulation of emotions. ED occurs in conjunction with neurological, social, physiological, cognitive and behavioural development and emerges within a particular social and cultural context (Schultz, 2004). The theoretical perspective taken towards ED in childhood includes functionalist theory and dynamic systems theory (Saarni, 2011). The child's encounter with an environment involved the dynamic interaction of multiple emotion related components (appraisals, behaviour, feelings) that change in conjunction with physical maturation. The study of ED attempts to incorporate an understanding of bio-ecology (human beings are dynamic systems embedded within a community context) and social and cultural experience. The recognition of emotional development can be observed in early behaviour, a corollary of which being attachment theory (Bowlby 1969, Ainsworth 1974). Behaviours are indicative of normal adaptive development and regarded as signs of wellbeing as outlined in table 1 below.

Table 1. Development: Behaviour and Emotion chart

Age Period	Regulation/Coping	Expressive Behaviour	Relationship Building
Infant **0-12 Months**	Self-soothing and learning to modulate reactivity. Regulation of attention in service of coordinated action. Reliance on caregivers for supportive "scaffolding" during stressful circumstances.	Behaviour synchrony with others in some expressive channels. Increasing discrimination of other's expressions. Increasing responsiveness to stimuli under contingent control.	Social games and turn taking ("peek-a-boo") Social referencing. Socially instrumental signal use ("fake" crying to get attention).
Toddler **12mts – 2.5yrs**	Emergence of self-awareness and consciousness of own emotional response. Irritability due to constraints and limits imposed on expanding autonomy and exploration.	Self-evaluation and self-consciousness evident in expressive behaviour accompanying shame pride and coyness. Increasing verbal comprehension and production of words for expressive behaviour and affective states.	Anticipation of different feelings towards different people. Increasing discrimination of other's emotions and their meaningfulness. Early forms of empathy and prosocial action
Preschool	Symbolic access facilitates emotion regulation, but symbols can also provoke distress.	Adoption of pretend expressive behaviour in play and teasing.	Sympathetic and prosocial behaviour towards peers.

Age Period	Regulation/Coping	Expressive Behaviour	Relationship Building
2-5yrs	Communication with others extends child's evaluation of awareness of own feelings and of emotion-eliciting events.	Pragmatic awareness that false facial expressions can mislead another about one's feelings.	Increasing insight into other's emotions.
Elementary school **5-7 years**	Self-conscious emotions (embarrassment) are targeted for regulation. Seeking support from caregivers still prominent coping strategy but increasing reliance on situational problem solving evident.	Adoption of "cool emotional front" with peers.	Increasing coordination of social skills with one's own and others' emotions. Early understanding of consensually agreed upon emotion "scripts".
Middle Childhood **7-10yrs.**	Problem solving preferred coping strategy if control is at least moderate. Distancing strategies used if control is appraised as minimal.	Appreciation of norms for expressive behaviour, whether genuine or dissembled. Use of expressive behaviour to modulate relationship dynamics (Smiling while approaching friends)	Awareness of multiple emotions toward the same person. Use of multiple time frames and unique personal information about another as aids in the development of close friendships.

Much of the research on emotional development has been fuelled by a growing awareness that childhood social experiences, within and outside the family, are linked with a host of short- and long-term adjustment outcomes including behavioural problems, school adaptation and psychopathology, (Buhs & Ladd, 2001). Children's social behaviours with peers show remarkable stability from early childhood to school age (McCartney and Phillips 2008). Barish (2013) notes how emotional expression becomes linked with social and cultural expectations as the child develops. Parents, as demonstrated by Freud in his case history of Little Hans (1905), frequently seek some clinical expertise where the socialisation of emotional expression in their children has failed to take place. While Freud sought to address the unconscious knowledge of the child which gave rise to the symptom, contemporary developmental approaches are, instead, designed to promote positive socioemotional relations between children and family members and tend to focus on the prevention of negative behaviour and the improvement of interpersonal skills. Programmes such as Parent Child Interactive Training (PCIT), Eyeberg (1970) and The Incredible Years Programme, Webster-Stratton (2013) draw heavily upon developmental theory in their effort to promote age-appropriate environmental adaptation. These programmes apply direct training involving explicit instruction, practice and reinforcement of relevant social skills such as problem solving, emotional recognition, reflective practice in play and a range of socio-cognitive processes utilising role play techniques, modelling and coaching. They have shown some success in improving pre-schoolers and toddlers observed social behaviour and reducing aggression and behaviour problems (Denham and Burton, 1996, Webster-Stratton, Reid & Hammond, 2001). Unlike individual or family-based therapy these programmes attempt to alter aspects of the child's social environment and to generate a specific desired effect in behaviour.

2.7.2 Psychosocial Development

Psychosocial development refers to the process by which the individual formulates a concept of oneself relative to the world around them. Cooley (1964) suggested that the concept of self is formed based on how others respond to us, implying a relational component to identity. Erikson's (1950) psychosocial theory offered a "crisis model" of development. Each of the stages within Erikson's model involved a central conflict to be resolved involving the social world, setting the ground for the subsequent stage.. This model proposes that a failure in over-coming the challenges encountered at particular stages in development resulted in common forms of psychopathology, e.g., impulsivity and compulsion as occurrences of the failure to achieve autonomy in the in the second stage of development.

Lowe (1998) points out that there is little empirical evidence for Erikson's theory, however, it is of interest to the current study that the increasing emphasis on chronology in development determines what can be known about the child and what is to be expected of the child. Mead (1967) posited a version of the identity formation based on how one sees oneself through the eyes of others. There are similarities between Mead's anthropological account of identity formation and Lacan's concept of the mirror phase (1936) discussed further on. Bowlby's (1969) attachment theory posits the infant/child's relationship with the primary caregiver as being the fundamental element to all subsequent relations. Lacan (1966) contests that it is only through a process separation and alienation that the child can begin to take up a position as subject in his or her own right. In many cases this occurs without any apparent disturbance to the child. However, where this process becomes problematic disturbances manifest in symptoms that reveal the underlying pathology.

Bandura's Social Learning Theory (SLT) (1977) attempted to understand development based on modelling and imitation of others. The principles of SLT are to be found in many approaches to treating children presenting with emotional and behavioural disturbances, Morris *et al* (2008). Bandura's theory could be regarded as a bridge between the cognitive and behavioural approach to understanding psychosocial development.

2.7.3 Cognitive development

From a child development perspective many of the concepts of contemporary cognitive psychology can be traced to the work of Jean Piaget (1896 – 1980) and Lev Vygotsky (1896-1934). Levine (2013, p.19) describes cognitive development as 'the study of changes that occur in how we think and learn as we grow'. These changes refer primarily to neurological and psychological development. Piaget's theory was rooted in biology and philosophy resulting in what he liked to call a "genetic epistemology". Amongst his contributions to the study of child development was the idea that children's minds are qualitatively different to their adult counterparts. Piaget's stages of development gave credence to the idea that different ages correspond with progressively more sophisticated forms of knowledge integration. With an emphasis on adaptation Piaget's theories were applied to child education during second half of the 20th century (Plowden report, 1967). This approach also became favourable among researchers dissatisfied with the environmental determinism of behaviourism as well as the rationalism and innatism of genetic determinism during the mid-20th century. Vygotsky's interest in the social origin of individual behaviour stressed the importance of language and culture as vehicles of cognitive development mirroring Freud's

(1921) argument that culture, and society could only be formed once we had developed language. Programmes like Aistear, the early childhood (0-6 years) curriculum for learning and development in Ireland, evidence the growing appreciation for cognitive development as it applies to the environment surrounding the child.

Cognitive structures enable the connection between emotion and experience resulting in what Izard (1991) refers to as "affective-cognitive structures", the fundamental building blocks of mind memory and the self. Terms such as 'emotional competence', (Saarni, 1997) and 'emotional intelligence' (Meyer and Salovey, 1997), rooted as they are in cognitive processes, operate as signifiers of healthy development in children (Barish, 2009). This field of research has reshaped the child's world in terms of education and performance producing a version of the child that is subject to certain normative expectations.

2.7.4 Deconstructing the developmental approach

The following section attempts to deconstruct aspects of developmental psychology and to identify the type of child that is constructed and, in accordance with the methodology behind the study 'governed', by this discipline.

Burman (2008) notes how the developmental model became popularised through the creation of the notion of 'mental life' and the medicalisation of mental life via the subsuming of the mental into the physical (ibid, p.21). Standardisation could be achieved through the newly emerging field of psychometric testing. From conception the medical and scientific gaze becomes prominent in the life of the child. IQ tests became acceptable indicators of mental ability linked to chronology. Defining the stages in children's normal development became even more salient with the establishment of mass education.The attention of this newly emerging discipline was directed towards intellectual, moral and physical development in children. In more recent years these categories have been altered somewhat to delineate development based on cognitive, social, emotional, and biological/neurological development, (Woodhead, 2013). Within this framework, childhood is often seen as an apprenticeship for adulthood in the sense that stages relating to age, physical development, and cognitive ability maybe categorised. The progression from child to adult posits the child as being in a process of embarking upon a path to rational subjectivity. A movement from simplicity to complexity of thought characterised by rationality and behaviour was, in Jenks (2005) view, the developmentalist model for understanding childhood. This he argued is akin to an apprenticeship whereby rationality, the hallmark of adulthood, is in an evolving

state. Woodhead (2013, p.144) proposed "from a social constructionist perspective, developmentalism is a discourse in which children are constructed as not yet adult, as in a process of becoming rather than a person in their own right".

The task of turning children into adults fell in no small part to schools. Foucault (1979) included both schools and asylums amongst the institutions at the heart of the "great confinement" designed for the purposes of "moral reform and constraint" (ibid, p.138). 'Just as the new "disciplinary technology" developed for the criminal and the insane involved confinement in institutions, harsh and systematic punishment, constant surveillance, and "treatment" in the form of rigid, objectifying psychologies and pedagogies; so the same regime of description and classification for purposes of control and manipulation was applied to the child' (Kennedy, 2017 p. 19). Like the insane and the criminal, the child was understood to be in need of being forged, as Foucault described into a 'docile body that may be subjected, used, transformed, and improved' (Foucault, 1979, p.198). Porter (1990) argued that the growth of science in the 19th century, which came to replace the predominant religious discourse of previous centuries, had significant ramifications for the place of the child in medical, legal and educational discourses in the centuries that followed. Childhood, in becoming the object of scientific enquiry, was subjected to forms of measurement that served the purpose of delineating normal from abnormal development (Rose, 1990). Normal and abnormal are not terms commonly used in psychoanalytic theory where the emphasis is on subjectivity which allows for an understanding that the symptoms of the subject are an adaptation to their individual experience as opposed to a set of universal standards.

Rose (1999) cites social context factors such as liberal governance as being instrumental in the reconstruction of childhood which supports the values of 'competence', 'responsibility' and 'self-reliance'. The rise of neoliberalism in the 21st century played a significant role for how childhood became reconceptualised in accordance with economic forces. While developmental psychology historically considered childhood as referring to a state of an emerging self, contemporary neoliberal conceptions, as referred to by Smith (2014), depict a vision of the child as a competent social agent. Despite this radical social revision of childhood, medical and legal discourses tend to characterize young children as generally ''innocent'' and as having limited moral agency due to their cognitive immaturity (Burman 2008; James and Prout 1997; Stephens 1995). Social construction, with its postmodern ontology holds that there isn't one unequivocal truth, rather it is the very tension that exists between discourses that produce changes in how we conceptualise and make meaning out of

such things. These tensions can be observed in how children are treated psychotherapeutically. Recent regulations regarding the practice of counselling and psychotherapy, particularly in cases involving children now dictate what must be done with knowledge e.g., the mandatory reporting of suspected cases abuse.

2.7.5 Summary

The changes in developmental, cognitive, emotional and psychosocial aspects of understanding childhood indicate increased the visibility of the child in society. This visibility has brought welcomed changes to child welfare with children now having access to more resources than previously. Increased visibility may also be a burden. Being under the gaze of the observing Other has consequences that inevitably restrict freedom according to Foucault (1960). Childhood is becoming increasingly regulated by the growing number of discourses that shape it, Aubury *et al* (2017). Increased regulation leads to specific expectations on the part of the child. A growing cultural tendency to measure all aspects of contemporary life encourages a performance-based economy and society in which the child, through the discourses of psychology and science can be more 'accurately' measured.

While developmental psychology informed much of the political and governmental policy making regarding children in the 20th and 21st centuries, Smith (2011) contended that policies regarding the governance of childhood in the 21st century were adapting to a changing social construction of the 'child' which was moving away from the traditional developmentalist framework of process and apprenticeship. The changes occurring in government policy regarding childhood inferred greater degrees of autonomy and self-determination on the part of the child, as noted by Smith (2012, p29) 'the rise of the 'participative child' as a product of neo-liberalism is facilitated by the right to participate in decision-making accorded by Article 12 of the Convention on the Rights of the Child'. The Greta Thunburg UN Speech[14] offers us an example par excellence of this shift. The dichotomy of dependence versus autonomy that characterises much of the more recent discourse on childhood could be considered a reworking of the tensions that existed between religious and philosophical discourses in a previous epoch. Starting with Freud, looking at the continuities and discontinuities between these early 'epistemes' enabled a perspective on how the 'psy' sciences have more recently usurped the role of defining and dictating what a child is and how he or she is managed, governed, and treated. Foucault (1972) notes how knowledge is

[14] (https://www.un.org/development/desa/youth/news/2019/09/greta-thunberg/ downloaded 01.10.21)

inextricably connected to power such that they are often written as power/knowledge. In the next section the application of 'psy' knowledge/power will be explored through the phenomenon of child psychopathology.

2.8 The Discourse of Child Psychopathology

"Diagnoses have become part of how we make sense of ourselves, each other and the world" (McGann, as cited in Brinkmann 2017). The language of psychiatry has become ubiquitous according to Timini (2002) as people make use of diagnostic categories such as ADHD, OCD, and Bipolar, to the extent that we have become a "diagnostic culture", in which "diagnoses are no longer just medical, biological and psychological concepts but also bureaucratic, social, and administrative entities" (Rosenberg, 2007, p.5). Furedi (2004) argues that a more recent phenomenon of a "therapeutic culture" has altered how mental health is understood. Despite a lack of consensus and the absence of any definition on what constitutes mental health and wellbeing in children, the wellness machine of the 21st century continues to gather pace, with public health campaigns (Stephan *et al.*, 2007) rolling out mental health literacy programmes that, according to Francis *et al.*, (2007) lack consistent theoretical articulation. Instead, children's mental health discourse, and the practices that follow from it, seem to have developed in piecemeal fashion through media efforts and diverse programmatic interventions to target individuals and social practices within schools and families (Lester and O'Reilly, 2015). Strong and Sesma-Vasquez (2015) highlight how an increasingly nuanced discourse of children's mental health has been developing, accounting for a need to prevent childhood psychopathologies (Harari, 2013), mental disorders (Francis, 2013), traumas (Quosh and Gergen 2008), as well as disorderly behaviour (Graham, 2005, 2010). Children as young as five years of age are now being taught mindfulness as part of an overall attempt to improve cognitive, social, emotional and behavioural wellbeing (Klingbeil *et al.*, 2017). This amounts to what Rose (1990) describes as the "good life" by inculcating non-professionals in the practice of its philosophy both in their own lives and in the lives of the children. The trend continues by promoting mental health in a consumerist model of health care in which, those formerly referred to as patients are now clients and service users (Plastow, 2015).

A notable consequence of the growth in attention to children's mental health led researchers to speak of an epidemic in childhood disorders (Francis, 2013 p.37) which coincided with the widespread availability of psychopharmaceutic medication such as Ritalin (Whitaker, 2010). However, as Strong & Sesma-Vazquez (2015) argue, despite a proliferation in the

diagnoses of disorders more commonly seen in children neither the DSM V or ICD 11 provides a coherent description of what constitutes a mental disorder or indeed mental health in children or adults. A consensus on what constitutes mental health remains allusive. This is perhaps a reason for the expansion in the discourses that surround mental health where terms such as mental health, psychopathology and mental illness are used interchangeably although they refer to different aspects of human experience. Rose (1990) argues that vocabularies of the professionals allied to the psy-complex are languages of government which do not merely reflect or legitimate power, they make new sectors of reality thinkable and practicable. Parker (1995) notes how deconstructing psychopathological categories may be useful to consider the categories as a discursive complex, a form of discourse where a system of statements constructs an object.

2.8.1 Developmental Psychopathology

Feldman (as cited in Ollendick 2004 p. 28) describes developmental levels as being a "snap shot at one point in time of the accumulation of predictable age-related changes that occur in an individual's biological, cognitive, emotional and social functioning". Researchers in the area of clinical treatment have focussed on the cognitive and emotional domains since many treatments designed to address behavioural, social and emotional problems hold that altering thinking is an important precursor to adaptive functioning. Developmental approaches to psychopathology highlight the importance of considering how normal and abnormal behaviour are related in development by applying what Masten *et al.*, (2006) terms 'the normative principle'. Normative expectations are sometimes described as developmental tasks or milestones or simply as "normal behaviour". The normative principle aims to take into consideration judgements about adaptation, good or poor functioning are set against what is typical or expected for children of a specific age, gender situation and culture. While certain expectations are universal (walking) others may be more cultural (obeying rules and customs, toilet training) developmental psychopathology attempts to account for contextual features in the evaluation of psychopathology. A question remains as to who may decide what is normal and what is not, as noted by Drabick and Kendall (2010). The DSMV has moved increasingly towards a developmental and biological model in its attempt to address this difficult question, Burt *et al*., (2016). It has been clear for several decades that patterns of competence (e.g. school or work success) are often linked to psychopathology, concurrently and sequentially according to the APA Handbook of Psychopathology (2018).

Developmental psychopathology provides a recourse to measurement generating observable data regarding behaviours which are set against perceived norms and chronological markers. Abnormalities can be measured and categorised through the application of psychometrics and psychological observation and psychiatric terminology became mainstream leading to what Foucault (1981) termed as "regimes of truth". Now the modification of behaviour could be achieved via psychology (Burman, 1994 p.8) consequently the better management and treatment of children with emotional and psychological needs in educational and social settings is made possible with this new knowledge (Plowden Report, 1967, Head Start Project, 1969). Hinshaw & Cicchetti (2000) note how a developmental model in conjunction with a neurological based approach to understanding psychopathology further enforces the idea that problems, "disorders", are located within children. Cushman (1995) points to the mental hygiene movement of the early 20th century as being the force that ushered in a more medical approach to understanding mental life which in turn posits the locus of pathology within the patient.

A developmental model stipulates that child psychopathology is indicative of a failure in the normal developmental process whereby "normal development has gone awry" (Wenar, 1994, p.2). However, a reliance on a developmental approach to understanding mental health offers little insight into the subjective component to psychopathology. The logical positivist approach that underpins developmental psychology assumes the aetiology to be found increasingly in biological factors (Francis, 2013). This recourse to biological models is to be found in both the understanding of childhood and psychopathology according to Burman (2017). Breggin (1994) contests that the biological view of the most prevalent psychiatric disorders in childhood has become the most persuasive. Psychoanalysis, from Freud to Lacan, takes careful consideration of biological factors to both development and psychopathology. However, there is a concerted effort to promote diversity by avoiding the temptation to alter the child in accordance with perceived norms or social and environmental expectations.

2.8.2 Diagnostic Overload

Pointing to the pop psychology shelf of every large bookstore, Harwood (2006) argues that compared with the literature advancing the practice of psychodiagnostics in children there is limited available literature that is critical of these practices. Moreover, researchers have increasingly recognised the over diagnosis of mental disorders in children and a rapid recourse to psychopharmacology treatment (Abrahamson, 2008; Angell 2005, Whitaker

2003, 2010; Fisher &Over, 2011). The DSM V lists several neurobiological markers such as abnormalities in the prefrontal cortex as risk and prognostic features in the development of psychiatric disorders. However, the APA have thus far stopped short of positing biological factors as diagnostic markers for disorders in childhood. This medicalized construct of children's mental illness is contested by scholars and practitioners (Timimi, 2002) who argue that despite there being no biological or behavioural marker that definitively indicates the presence of clinically impairing psychological syndromes in children the recourse to pharmacological treatments continues to grow (Dirks *et al.,* 2012). Increased amounts of content regarding the genetic and physiological factors in psychopathology compared with previous editions of the manual has led to a reduction in data regarding the role of context in the development of mental health problems in children (Verhaeghe, 2016). This in turn leads to a poorer integration of contextual factors into the measurement tools designed to identify psychopathology in childhood. Despite a long-standing recognition of the subjective factors as offering informative data regarding the aetiology of a disorder, Vanheule (2014) observes "that in the DSM, the context of the individual (i.e. the personal life history, social circumstances, cultural background) is thought to play a minor role in relation to symptom formation and expression" (ibid p.54).

From a clinical perspective, psychiatrists have become much more comfortable with writing prescriptions than interpreting patients' psychical crises according to O'Neill *et al* (2010) as the proliferation of pharmaceuticals has driven the research into the biological processes of the brain. The individual case studies of children and their families that Freud (1905, 1907, 1919) and later psychoanalysts Klein (1930), Winnicott (1977), Lefort (1990) and Mathelin, (1999) used to promote a particular form of practice has by and large been relegated as unscientific due to a lack of generalisability while the disease model is reinforced by the exponential growth in pharmacological medication. The Randomised Controlled Trial (RCT) dramatically altered what counted as scientific fact dethroning the importance of the unique doctor-patient relationship, the scientific importance of clinical case studies and the previously dominant psychoanalytic approach thus altering clinical approaches to treatment in favour of generalisation over tailored or individualised interventions, (Braslow, 2019). Braslow's contention is taken up in the next section which explores the most commonly prescribed methods of treatment for children experiencing mental health difficulties.

2.9 Contextualising Treatment

As outlined above the discourses that have organised a collective understanding of childhood and psychopathology have also played a significant role in influencing how parenting, education and wider approaches to mental health care have come about in the 21st century. Parry-Jones (1995) notes how the development of mental health care in general has always depended, not only on 'the prevalence and severity of cases, but on economic, social, political and cultural factors' (p.7). Freud open the door for us to consider childhood mental health by publishing his 'Three Essays on the Theory of Sexuality' in 1905, for which he received much criticism from the established medical community, along with his 'Analysis of a Phobia in a Five Year Old Boy' in 1909. Child psychiatry was not established as a separate field until 1956. The term child psychiatry itself came into formal use once the Swiss psychiatrist Moritz Tramer established the first journal of child psychiatry in 1934. Child and adolescent psychiatry was not recognised as a specific psychiatric discipline by the APA until 1973 when the first Chair of Child Psychiatry was created. Similarly, the widely used DSM did not initially refer specifically to childhood mental health disorders. It was not until the third edition, published in 1990, that a comprehensive list of child psychiatric disorders was included. The establishment of CAMHS services in Ireland and the UK has come about as a result of changes to policies regarding adult mental health care along with changes in social attitudes towards children consequent to emerging understandings of childhood development. Prior to the foundation of the Health Service Executive (HSE) in Ireland in 2005 children experiencing mental health problems were under the jurisdiction of one of ten regional health authorities. This system was first established in 1948. Throughout the 19th and early 20th centuries the asylums of Ireland were home to children as well as adults. There was no minimum age for admittance to these asylums according to Barrett (2019) and although many of the asylums were reluctant to admit children there are records of children as young as six being admitted and kept on wards alongside adults. These young people were most likely to be suffering either from 'idiocy' or from 'moral insanity', although Maudsley's influential 1867 textbook stated that children could also suffer from monomania, choleric delirium, insanity, mania and melancholia and while there were no specific treatments for child patients this was less problematic than it might seem since the general consensus at the time was that lunatics were exhibiting child-like behaviour and should be treated as children. Less disturbed children however were often treated in accordance with the recommendations of the child guidance clinics, one of the earliest being the Luceana clinic established in Dublin in 1954. The clinic consisted of a

team which included a general trained psychiatrist, a clinical psychologist and a social worker. The prevailing medical consensus regarding the aetiology of children's psychopathology at this time was that it pertained to parental and familial deficiencies, a lack of psychological and emotional care underpinned by medical terminology that resulted in children being described as maladjusted or abnormal. However, the belief that parents were primarily responsible for their children's mental health was being challenged by the work of Melanie Klein and Anna Freud who argued that all children have an internal psychical life of their own which could be treated largely independent of their parents through the newly emerging theories of child psychoanalysis and psychotherapy. The attribution of psychical agency to the child revolutionised the way in which children with emotional and behavioural disturbances were cared for. Unfortunately, then as now, access to this form of clinical intervention was often only open to children from wealthier families who did not need to rely entirely on state funded mental health care. Evans (2008) points out how, in previous eras, children from working-class families who were diagnosed by doctors as *"*difficult*"* were often sent away to residential schools in an attempt to prevent them from becoming delinquents. John Bowlby's studies (1969) on attachment stability between child and primary carer laid what became the ground for family therapy, a specific branch of psychotherapy frequently recommended for cases involving children according to Carr (1990). Rutter's Isle of Wight Studies (1964-1974) demonstrated how the combination of familial and socio-economic conditions proved the most likely factors to the aetiology of children's emotional and behavioural problems. Moreover, the studies also contested that specialised 'child appropriate' interventions were needed to meet the specific requirements of this population.

The percentage of children suffering from mental health problems has risen consistently since records began and although child psychiatry is now a fully-established medical specialty and there are specific training programmes for child and adolescent psychotherapists there is no ring-fenced budget for CAMHS, additionally working conditions for CAMHS clinicians are becoming increasingly difficult due to insufficient resources, Barrett (2021). This leaves a significant number of patients dependent on a restricted amount of private professionals and/or charitable organisations. In Ireland, the Irish Association for Counsellors and Psychotherapists (IACP) along with the Irish Council of Psychotherapy (ICP) currently register approximately 6000 members. However, only a small proportion, 482 (ICP), of these members are identified as family therapists and/or recognised child and adolescent psychotherapists. It is evident that child and adolescent mental health care has, over the course of less than 100 years, developed as a specialist practice that requires input from trained skilled professionals. In this emerging field there are competing paradigms between the professions as to the etiology of childhood mental health problems ranging between psychical, social and physiological which influence the type of treatment that can be delivered. However, it is reasonable to argue that childhood mental health interventions are, in general, driven by a bio/psycho/social model of care mirroring the approach offered in adult services. There is no conclusive evidence from an Irish or indeed international perspective that one particular form of psychotherapy intervention is preferable over another.

2.9.1 Contemporary Approaches to treatment

The following section explores the recommended approaches to treatment for children diagnosed with disorders that have the highest rates of prevalence nationally and internationally. While the criteria for diagnosis have been mentioned in some cases it is the objective within this section to highlight how child psychopathology is addressed according to the standards of practice outlined by National Institute for Health Care Excellence (2013, 2018), Child and Adolescent Mental Health Services (CAHMS) and recent empirical studies on the efficacy of particular 'care pathways'. A good deal of overlap was discovered within the modalities discussed under the heading psychological and psychosocial. These overlaps included family-based interventions that combined CBT interventions with systemic theory. In cases where children were prescribed medication in conjunction with a psychological intervention the literature was lacking details for several conditions including childhood anxiety and depression. An effort has been made to highlight the underlying epistemological

differences in these approaches along with the intended goal of treatment. This is set against the psychoanalytic episteme and method discussed in the following chapter.

A) Psychopharmacology

The Centre for Disease Control (CDC) recognised children diagnosed with ADHD as a cohort of paediatric patients most likely to receive medication for the treatment and management of this disorder. 62% of those surveyed during 2016 had been prescribed medication with 42% receiving additional behavioural supports. NICE (2013) recommends the limited use of pharmacological medicines for children and adolescents experiencing mental health difficulties including ADHD but the guidelines suggest the use of Methylphenidate (Ritalin, Concerta) or Atomoxetine (Strattera) in cases of ADHD where children above the age of 6yrs are not responding to psychological interventions, Risperidone is also recommended for the short -term management of aggressive behaviour in children and adolescents. ADHD is listed under the category of neurodevelopmental disorders by the DSMV. The peak age for diagnosis of this condition is between 7 and 9 years of age with symptoms becoming apparent from the age of 3. Slight variations to symptoms exist between genders with boys demonstrating higher levels of externalising behaviours including aggression making the likelihood of referral greater (Kendall, 2000). Diagnosis frequently involves the use of psychometrics such as the Child Behaviour Checklist (Achenback, 1991) along with general medical evaluation. The prevalence of the disorder varies according to diagnostic systems and criteria. The APA estimates a prevalence rate of between 3-5% in school age children (APA, 2008) while NICE (2008) estimate the UK prevalence rate to be between 4.2-12% in the same population. Woods, Keane and Keane (2018) report a prevalence rate of between 5.1- 7.9%.

Lejdstrom *et al* (2017) report a 34-fold increase in the prescription of pharmaceutical medication for the treatment of ADHD between the years 1992 and 2008 in the UK. The authors note a rate of 1 in 20 children or 5% of under 16's being prescribed ADHD medicines Methylphenidate is believed to work by blocking the reuptake of dopamine and norepinephrine. The National Institute of Mental Health (NIMH, 2009) UK conducted an 8-year Multimodal Treatment Study of ADHD and found that there were no differences in the outcome of participants using medication with those engaging in behavioural interventions. Moreira-Maia *et al*, (2018) note that children diagnosed with ADHD are more frequently treated with medication compared to all other diagnosed disorders.

Other conditions, including Anxiety Disorders (General Anxiety Disorder GAD, Separation Anxiety, Social Anxiety) and Depression, are often treated with a combination of medication and psychological treatments. NICE (2019) recommends pharmacological treatment for children presenting with Anxiety and Depression only in more severe cases. Selective serotonin reuptake inhibitors (SSRI's); Fluoxetine, is the most commonly prescribed to paediatric patients in accordance with the guidelines (Phillips, 2015). Vitello (2016) contests that despite the large number of studies there remains debate as to whether antidepressants have a favourable benefit/risk balance in depressed young patients. Rodzinka (2018) highlights the concerns many patients have with the relationship between the pharmaceutical industry and prescribing physicians. A lack of transparency has led to a call for changes in how drugs are marketed to physicians (Moynihan, 2019). In a systematic review of patients and parents' preference in relation to ADHD treatments options and processes of care, Schatz et al (2018) found that parents had a greater tendency to seek psychosocial approaches over pharmacological therapy for their children. Pharmacological interventions are not considered as cures by the APA or WHO, rather it is recognised that they are designed for the sole purpose of managing symptoms associated with an underlying neurological disorder.

B) Psychological Approaches to Treatment

The following section explores the literature concerning the psychological methods of treatment for children experiencing mental health problems according to NICE (2013, 2018, 2019) guidelines. While it is not possible to compile a comprehensive list of all psychological treatments this section attends to the models most frequently applied for conditions with the highest rates of prevalence. Wampold (2008) estimates there are over 250 different models of psychotherapy in existence today. Kazdin (2000) contends that the number of child centred psychosocial models of treatment for children experiencing mental, emotional and behavioural problems is in excess of 500. While some of these approaches may not be considered classically psychotherapeutic in nature, they do integrate many of the fundamental principles of traditional "talk therapies" into their practice models (Eyeberg, 1988, Parent Child Interactive Therapy & Webster-Stratton, 2013, The Incredible Years). Psychological treatments aim to produce changes in "cognition, feelings and behaviour" (Holmes and Lindley, 1989). The NICE guidelines (2013, 2019) are weighted in favour psychological interventions for children in all but the most severe cases of psychopathology.

The following lists and describes psychological treatments most frequently recommended for children with commonly occurring mental health difficulties.

C) Systemic/Family Therapy

Systemic and family therapy (FT) is a broad term for a range of methods for working with families and children experiencing mental health problems. Systemic and Family Therapy explores the dynamics and relations between the members of a family whereby "pathology" is viewed as the product of these inter-relations (Carr, 2003). Carr (2012) notes the epistemological differences between several of the major schools of family therapy based on positivism and social constructionism. For example, positivists argue that our perceptions are a true reflections of the world as it is (Gergen, as cited in Carr, 2012, p.121). Family therapy conducted from this point of view assumes a single true definition of the problem. Behavioural and psychoeducational approaches to family therapy are explicitly rooted in positivism (ibid, p.121). Family-Based CBT has been developed by Barrett and colleagues (FRIENDS programme, 2000, 2004, 2007) for the treatment of children experiencing anxiety disorders. This approach explores the reciprocal patterns between family members. Interventions are designed to identify the skills of each family members that can be used to foster bravery and competence in the child. Liber et al (2010) found family-based CBT for child related anxiety to be linked with improved outcomes to internalising symptoms such as worry, withdrawal and fatigue. Alternative forms of FT underpinned by a post-modern and social constructionist epistemology include MRI brief therapy, Narrative Therapy and Family based Interpersonal Therapy. NICE (2018) recommends the use of family based Interpersonal Therapy (IPT), for children (5-11yrs old) experiencing moderate to severe depression. FT is also recommended in cases of eating disorders. Lock et al (2010) reported family based treatments as being superior to individualised treatments in cases of Anorexia and Bulimia in children aged between 12 – 18yrs. Carr (2012) highlights how family therapy aims to restore to the family a form of homeostasis that allows the needs of each of its members to be met through the functional dynamics within the family unit.

D) Cognitive and Behavioural

Cognitive Behavioural Therapy has been widely publicised as being the most empirically validated, evidence-based form of psychosocial intervention for individuals experiencing psychological and emotional difficulties (Ollendick, 2002). Cognitive and behavioural

approaches aim to alter thinking and behaviour for the purposes of the reduction or eradication of symptoms that are considered undesirable, either by the child or the parent.

CBT holds the following assumptions: cognitive mediational processes are involved in human learning, thoughts feelings and behaviours are causally interrelated, cognitive activities such as self-statements or attributions are important in understanding and predicting psychopathology and effecting change through psychotherapy. The task of the CBT practitioner is to collaborate with the client to assess distorted thinking and dysfunctional behaviour and to design new learning experiences that enable adaptive functioning (Morris et al, 2008 p.39). NICE (2019) recommends CBT for the treatment of five to eleven years old experiencing mild to moderate anxiety and depression. Pharmacological interventions are recommended only in cases where there is no response to psychological treatment. Epidemiological studies suggest that anxiety disorders are among the most frequently diagnosed class of disorders in children and adolescents (Seligman and Ollendick, 2012, p.217). CBT follows a methodological approach to treatment which has been manualised for the purposes of treating anxiety and depression in children; (Biedel, Turner and Morris 2000). CBT aims to understand the problem only to the degree that this sheds light upon the current state of dysfunction which in turn allows for an intervention in the "here and now". The approach centres on addressing only the factors that maintain the child's symptoms rather than understanding what gave rise to the disorder (James *et al.*,2015). Seligman and Ollendick (2011) identify several principles that underpin the numerous manualised approaches to treating children for anxiety with the use of CBT. These include establishing a rapport, providing psycho-education to parents, exposure techniques, behavioural rehearsal and cognitive restructuring. In a systematic review James *et al., (*2020) found that manualised CBT for child and adolescent anxiety is probably more effective in the short-term than waiting lists/no treatment but found little to no evidence across outcomes that CBT is superior to usual care or alternative treatments. Alternative pathways to care for children with anxiety disorders and mood disorders include interpersonal therapy and psychodynamic therapy (NICE, 2019).

E) Parent Child Interaction Therapy (PCIT) & Parent Management Training (PMT)

Parent management training (PMT), also known as behavioural parent training (BPT), and Parent Child Interaction Therapy are treatment programs that aim to change parenting behaviours, teaching parents positive reinforcement methods for improving pre-school and

school-age children's behaviour problems such as aggression, hyperactivity, temper tantrums, and difficulty following direction, (Maliken, 2013). Parent Child Interaction Therapy (Eyeberg et al 2010) is a model developed to teach parents to build positive relations with their children and to teach the child appropriate behaviour. Parent and child are brought through phases in which nondirective play skills, 'similar to those used by play therapists' (Fonagy, 2016, p.133), are taught to parents to enhance the quality of the parent-child relationship and attachment style. Positive reinforcement through praise for the child's more desirable behaviours is used and parents are provided with a form of psychoeducation regarding child development. Chase & Eyeberg (2008), Cicetti (2002) and Chaffin (2017) report improvements in internalising and externalising behaviour problems in children who completed PCIT programmes. Such parenting programmes aim to modify aspects of parenting which are known to contribute to behavioural problems in children. These approaches to stemming behavioural problems in children draw on the principles of mental functioning which include behaviourism and attachment along with systemic concepts used within systemic models of psychotherapy. PMT is the treatment of choice for ODD and CD in pre-adolescent children according to NICE (2013). Disruptive behaviour disorders are characterised by emotional and behavioural problems are among those most resistant to psychosocial intervention if left untreated (Kazdin, 2002). Boylan, Vaillancourt, Boyle and Szatmari (as cited in Fonagy et al 2015, p.122) reported a prevalence rate of between 2.6% and 15.6% of ODD in a community sample which rose to 28%-65% in clinical samples. The study did not report rates of comorbidity with ADHD or mood related disorders (anxiety and depression). In a meta-analysis of 30 behavioural parenting programmes and 41 child-focussed skills training programmes, McCart et al (2006) found that for children under 12 parent training programmes were significantly more effective than child focussed programmes. Carr (2009) points out that PMT programmes have been shown to have higher efficacy rates in reducing externalising behavioural problems with pre-adolescent children. The support for these models is countered by the position that many of the behaviours and symptoms are understood as indicators of maladaptation and as such the objective is to train or recondition the child and parent rather than interpret the meaning of these behaviours and symptoms such that the child and parent rely less on these patterns of communication and circuits of interaction.

2.10 Conclusion

The section began by pointing out the ubiquity of psychiatric diagnostics today which has fuelled a wellness and therapeutic culture (Ferudi, 2009). Foucault's term 'regimes of truth'

proves particularly helpful in unpacking what such terms mean and how they determine much of our social existence. When children begin to experience distress, or when some feature of the child's behaviour or thinking becomes distressing to those around the child the recourse to managing and treating the child is usually the same. However, the proliferation of discourse that organise how we understand child mental health and wellbeing has significantly altered how the child is managed and treated within society. Foucault's concept of 'regimes of truth' is helpful in allowing a perspective here. The literature regarding the treatment of child psychopathology demonstrates a movement towards a manualised approach in the provision of treatment that, as can be seen by the changes in discourse, is influenced by an economic and consumerist ethos where 'pathways to care' or 'service delivery' conforms to best practice for 'service users', the evidence for which drawn from 'key performance indicators' that are in line with evidence-based practice. This universal and approach, informed by economic rationalism risks losing sight of the subjective component to symptoms which constitute psychopathology that psychoanalysis holds as the true currency of mental health treatment.

The following chapter outlines key concepts that are central to psychoanalytic practice with children. The chapter will also highlight the epistemological differences that exist between psychoanalysis and the approaches to understanding the child and psychopathology that have been outlined above.

Chapter 3: Lacanian Psychoanalysis with Children

3.1 Introduction

Lacanian Psychoanalysis constitutes a powerful theory and a socially significant practice (Fink, 1998, p.29). However, this does not make it a totalising world view, rather the success of psychoanalysis has in large part come because of its theoretical flexibility amongst the waxing and waning discourses that have thus far shaped a collective understanding of and approach to childhood and psychopathology. Lacan's structuralist reading of Freud does not fail to take into account ancillary disciplines in the field of art, science, philosophy and anthropology. Psychoanalysis makes use of developmental psychology insofar as it attempts to inscribe it in its own discourse, a discourse that favours singularity and the unique history of each subject. Psychoanalysis is a discourse less concerned by development than by history and structure (Miller, 1990). The concordance or deviation from standardised or objective norms is not the concern of the psychoanalyst, moreover the subject may well be represented by a rejection of such norms or ideals insofar as they may objectify him/her in a reductive and categorical fashion. Psychoanalysis is concerned with the singularity of the subject or, as Lacan writes, "Psychanalyse, c'est la science du particulier"[15]. One of the reasons why Freud was so innovative, according to Verhaeghe (1995, p93) was "that instead of making a categorical system in which every patient had to find his proper place and trying to convince the world that his system was the only useful one, he chose a completely different approach. Every patient is listened to, and every case study results in a category into which one and only one fits". Consequently, the frame of an analysis must be set around each individual patient. Where children are concerned the structure of this frame is informed by additional features such as the place of the parents in the work and the child's consent to or demand for treatment. Swales (2017) highlights how neither Freud nor Lacan left specific recommendations for conducting the practice of analysis with children and, with the exception of a few minor contributions to the subject of child psychoanalysis, left no particular recommendations regarding the conceptualisation of psychopathology in childhood. Instead, this has been left to subsequent researchers and child psychoanalysts who have contributed to the theory. In their *Dictionary of Psychoanalysis,* Roudinesco and Plon (1997) assert that no special field of "psychoanalysis of the child" even exists. The

[15] Psychoanalysis is a science of the particular (as cited in Verhaeghe, 1995, p.93)

requirements to become a psychoanalyst of children do not differ from those for becoming an analyst of adults (as cited in Plastow, 2015, p.66). In the absence of any formal recommendations to practicing child psychoanalysts[16] and the "anti-manualised" approach to conducting this specialised treatment the literature concerning this topic invites further contributions to illuminate how this work is to be understood. This chapter addresses the theoretical sources in the literature of Lacanian psychoanalysis as it is practiced with children who experience various forms of psychopathology.

3.2 Psychoanalysis and Development

Mannoni (1967) points out how subsequent schools of psychoanalysis[17] endeavoured to make a developmental framework out of Freud's stages, which has led, incorrectly to assume a linear path in psychosexual maturation. Rather, these phases of development centre around the organisation of the drive[18]; its aim and object (Dolto, 2013). This idea of organisation conveys the concept of a structure that does not limit itself to a particular moment in time Plastow (2015), rather "it is an organisation that persists over time, even if it might be more prominent at particular moments in the life of each subject" (p.8). A linking of stages and ages further enforces a normal-abnormal dichotomy. Applying such a logic in clinical diagnostics leads to false or misguided understandings of psychopathology. However, developmental considerations are not irrelevant in psychoanalysis. Rather it is insofar as they relate to historical events that inscribe the subject in a history and structure. Stages are not observable biological phenomena as may be recognised within Piaget's model of development. Rather they constitute evolving complex structures that persist over time. Lacan's formulation of the various complexes as outlined in *The Family Complexes in the*

[16] Institutes such as the Tavistock Clinic in London provide formal training programmes in undergraduate and post graduate "Child and Adolescent Psychoanalytic Psychotherapy" that have a primarily Object Relations focus. Lacanian psychoanalysts however refer to a "formation" which is testament to the relationship one has with psychoanalysis. This is often comprised of one's own clinical practice, supervision and personal analysis. Some psychoanalysts seek to undergo a formal recognition of their experiences and psychoanalysts and as analysands in a practice established by the Ecole Freudienne de Paris known as the Pass.

[17] The School of Ego psychology

[18] Freud (1905) introduces the term "trieb" (trans: drive) to refer to the "dynamic processes consisting in a pressure (charge of energy, motricity factor) which directs the organism towards an aim" (Laplanche and Pontalis 1973). The concept lies at the heart of his theory on sexuality. A distinction between a drive and an instinct comes by way of comparison between human beings and their animal counterparts. The human drive, unlike instinct, is extremely variable and develops in ways that are contingent upon the life history of the subject Evans (1996).

Formation of the Individual (1938) 'remains a highly relevant article to the practice of psychoanalysis with children' (Rodriguez, 1994, p.107).

3.2.1 A 'complex' view of development

Lacan's 1938 paper 'The Family Complexes in the formation of the Individual' is an examination on the role of the nuclear family in the development of the child. It draws attention to the cultural function of the family and its role in the aetiology of psychopathology. Central is Lacan's contention that the family is a 'psychical object and occurrence' in the life of the individual' (Gallagher, p.9). Imagos[19] and Complexes[20] shape the reality as it is experienced by the young child. These complexes designate crucial moments in the subject's history and exert a decisive structuring effect from which, as Rodriguez (1994) points out, pathogenic influences may derive. The three complexes or "organisers" of psychical development, outlined by Lacan in the paper include the *Weaning* complex, the *Intrusion* complex and the *Oedipus* complex.

The first of these, the Weaning complex, involves a trauma of separation; 'it leaves in the human psyche the permanent trace of the biological relationship it interrupts' (Lacan, 1938, p.13). Dolto (2013) discusses how weaning dialectical structure in the sense that the biological function becomes overwritten by socially regulating practices that are particular to different cultures. "Pathogenic influences deriving from weaning may include some of the more serious effects disorders such as anorexia or addiction" (Hinshelwood, 2005, p1188).

The complex of Intrusion concerns the relationship with the sibling but coincides with Lacan's earlier concept of the mirror stage and the establishment of the ego. The mental identification that takes place in relation to the sibling or the *o*ther gives rise to a jealousy that Lacan argues is 'the archetype of all social sentiments' (Lacan, 1938, p.19). Rodriguez (1994) draws a theoretical connection between the concept of intrusion and

[19] The term denotes the subjective determination of the image. An imago is an unconscious representation relating to other people. Lacan refers to 3 distinct imagos; the mother or breast, the counterpart or sibling as rival and the imago of the father.

[20] A complex involves multiple identifications with all the interacting imagos and thus provides a script according to which the subject is led 'to play out, as sole actor, the drama of their [family] conflicts. Whereas imago designates an imaginary stereotype relating to one person,...the complex is a whole *constellation* of interacting imagos. A complex is the internalisation of the subject's earliest social structures, social structures meaning the relationships between the various actors in his family (Evans, 1996, p.27).

psychopathologies in which paranoic psychoses reveal themes of filiation, usurpation and spoliation that dominate the delusional production.

Often referred to as the cornerstone of psychoanalytic theory, the Oedipus complex was originally referred to as the nuclear complex of neurosis by Freud (1909). Lacan ties the function of the father to the Oedipus complex. This function refers to the father as a signifier, a representative of the law. The Oedipus complex is concerned with the substitution of two signifiers, the desire of the mother and the *nom du pere* (the name or the *no* of the father) otherwise referred to as the paternal metaphor. Thus, the father for Lacan is 'a symbolic function to which all group members are subjected. It provides human beings with an internalised compass of culturally and socially viable principles' (Vanheule, 2011, p.61). It serves a protective function according to Bailly (2009). It sets a limit to the mother-child relation and as such regulates jouissance. A failure in the function of the father can be witnessed in Freud's case history of Little Hans (1909) whereby the child's anxiety is a consequence of a 'too much of the mother'. The mothers desire saturates the child resulting in anxiety. The advantage to accepting the paternal metaphor is that the child is freed up from supplementing the mothers lack, from being in a position of the phallus for her (Lacan, 1956). These complexes support Lacan's concept of subjectivity.

3.3 Subjectivity and Psychoanalytic Practice

The Lacanian subject is a split subject, divided by language and cut off or separated from the self as it is represented by the ego. Verhaeghe (1995) provides a definition for Lacan's subject, "the signifier is that which represents the subject for another signifier', so that the subject itself is nothing but the effects of the chain of signifiers', (p.103). 'Inaugurations' of subjectivity occur during those moments in psychical development when the processes of separation and alienation become part of the infant's real experience. Consequently, there is no quantifiable difference in the subjectivity of a child compared to an adult, one is neither more nor less a subject. While the adult may have a greater store of unconscious material, subjectivity itself is not measurable in any manner akin to how developmental psychology attempts to chart biological, psychological and emotional maturity as discussed above. The ego, which is closely connected to the Imaginary register, is the place from which one can speak of as 'I' or a 'me' but in doing so the unconscious is given the possibility of expression, in other words it is only through the act of speaking that the subject (of the unconscious) can emerge. Lacan's subject speaks in ways that often defy the conscious intentions of the individual i.e. through slips of the tongue where the subject is represented by a signifier or

word that the speaker had no conscious intention of speaking. The $ubject, in its Lacanian constitution, is a product of language and as such *is* a speaking being, *parletre*, it emerges as a nuisance or non-sense (Melman, 1995). The subject is not only represented by language he is produced as an effect, a real effect, of language which transforms the organism into a subject according to Soler (2015).

Lacanian psychoanalysis goes further than any other branch in 'psy' sciences in its attempt to engage with this phenomena of being ($).

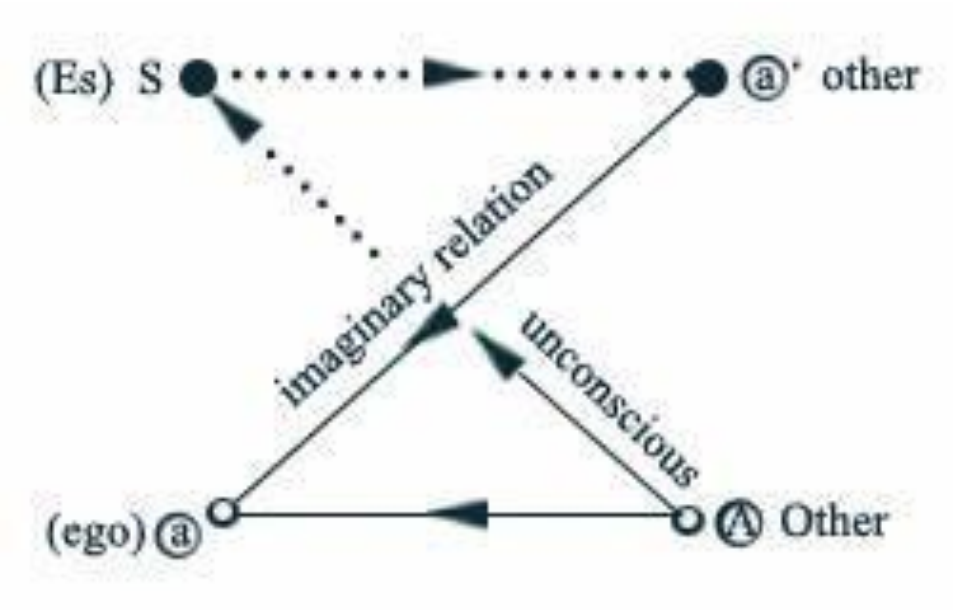

Figure 4. Lacan: Schema L. (Source: The Ecrits (1966)

Speech, as an act of discourse, entails the condition of assigning positions to both the speaker and the addressee. Schema L illustrates the difference between full and empty speech. Empty speech is conducted along the axis of the imaginary relation between the speaker (as, ego **a**) and another (**a'**) which entails identification. Full speech articulates the symbolic dimension of language. The psychoanalyst attempts to take up the position **A** in which the unconscious, in its fleeting appearance within the discourse of the patient, may be captured for the purposes of revealing the truth of his desire. The schema demonstrates how difficult a process this can be as the imaginary relation between ego (**a**) and ego (**a**') interrupts or bars the unconscious enunciations between **$** (Es) and the Other (**A**). The child may often communicate in ways that are less verbal than their adult counterpart, but this does not mean that they are any less symbolic. The drawings and play the child engages in during an analysis serves the same purpose as Freud's technique of free association whereby unconscious material finds expression along the **S-A** axis. Considering the relative lack of

separation between child and parent it may be argued that the child remains more within the imaginary than the symbolic and from here it may be asked, if the unconscious is emerging then whose unconscious is it and what position does the child, as object, occupy within that unconscious? In 'The Child his illness and the Others' (1970, p.53), Maud Mannoni describes how the child is born into a pre-existing discourse to which he must submit. 'It depends on the nature of the unconscious parental discourse as to whether the child will have access to his own speech. Psychoanalysis she writes:

> 'for us analysis is not a dual relationship in which the analyst offers himself as the object of transference. The most important factor is not the inter-personal relationship but what is going on in the process of communicating; that is the locus from which the subject is speaking; whom is he addressing and for whom'.

3.4. Psychoanalytic Diagnosis

As mentioned in chapter one, psychoanalytic diagnosis is a much less explicit affair when contrasted with diagnostic procedures in psychiatry and psychology, therapists and analysts rarely provide the client with a diagnosis despite often being asked to do so. The utility of a psychoanalytic diagnosis is in its potential to direct the treatment as opposed to offering the patient or analysand some categorical description for their malaise. Freud realised the difficulty surrounding diagnosis, he noted how on the one hand it can be difficult to have a clear idea about causes of neurosis without having analysed them in depth while at the same time in order to direct the treatment one needs to establish a diagnosis (Freud and Breuer 1895). This paradox is what makes psychoanalytic diagnosis unique according to Dor (1997). In his seminar on psychosis Lacan (1954-55) insisted on the need to arrive at an adequate diagnosis of structure to make sense of the phenomenological manifestations of any given case. This may be challenging where younger children are concerned.

Verhaeghe (2004) notes how the DSM makes use of symptoms as signs where the proper identification of certain symptom(s) inevitably leads to the underlying psychopathological disorder. By contrast, symptoms in psychoanalytic terms operate as signifiers, they do not possess any universal meaning. Rather they are actions or productions owing entirely to the subject's unique history and structure. Diagnostics, in Lacanian terms, involves the mapping out of the subject whose psychical structure refers to a mode of desiring that constitutes the subject in his relationship to the Other[21]. Dor (1997) points out that from the beginning one

[21] It is the mother who first occupies the place of the Other because it is she who receives the infants' earliest appeals and puts a meaning on experience through language and gesture. Fir further explanation see compendium of terms.

must recognise that no predetermined and general relationship exists between symptoms and psychic causes where structural diagnostics is concerned. The correlations between symptoms and a given diagnosis presupposes the movement within a chain of signifiers in the unconscious[22]. Structural diagnosis must go beyond symptoms and into the intersubjective space that is ordered by speech. Dor (1997) contends that 'it is in the unfolding of the utterance that structural landmarks make their appearance as breakthroughs signifying the desire of the one who is speaking' (ibid p14). The landmarks are clues to the structure, indices coded by structural traits or stereotypes to the functioning of desire. Lacan makes note of three distinct clinical structures which remain central to his theory of subjectivity and psychopathology: Neurosis, Psychosis and Perversion.

3.5 The Child, his symptoms and The Others

Psychoanalysis is not family therapy but that does not mean that the family does not have a stake in the work of analysis or its therapeutic outcome. Carbonell (2015) argues that there are at least two components to the symptom, one that implicates the body of the child and one that implicates the Other. In the latter case there is a symbolic dimension to the symptom and the family. Drawing on Lacan's 'Note on the Child, 1969' it can be seen just how implicated the Other is in the child's symptom.

> "*The symptom, which is the fundamental fact of the analytic experience, is in this context defined as the representative of truth. The symptom may represent the truth of the family couple. This is the most complex case, but also the one most open to our intervention. The articulation is much reduced when the symptom that comes to dominate stems from the subjectivity of the mother. In this case the child is concerned directly as a correlative of a fantasy. The distance between identification with the ego ideal and the portion taken from the mother's desire, should it lack the mediation which is normally provided by the function of the father leaves the child open to every kind of fantasmatic capture, he becomes the mother's object. The child realises the presence of what Lacan calls the object* a[23]".
>
> (1969, trans; Russell Grigg)

[22] The unconscious is the discourse of the Other (Lacan 1966). This implies that the unconscious is organised in accordance with the principles of language and the functioning of the signifier, and that desire is predicated on the others desire.

[23] The acceptance of the paternal metaphor enables identification with another who lacks, the child enters into the pact with the other whereby the phallus cannot be occupied by anyone person. The phallus from this point on becomes an imaginary object, something whose experienced loss is the only proof that it ever existed, it is the lost object which is later represented by *'a'* that Lacan (1957) refers to as the object cause of desire. Lacan later describes the concept of the object *a* in terms of a surplus (1970), echoing Marx concept of surplus value. For Lacan the surplus involves enjoyment or *jouissance.* Where the child finds himself in the position of *a* for the mother, jouissance becomes overwhelming and a pathological response occurs in the form of a symptom.

The attempts by clinicians operating other modalities, as discussed in section 2.8, to trace the aetiology of the child's symptoms to specific events in the life of the child frequently end in failure. What Lacan's note on the child indicates is how the symptom does not originate so much from a traumatic encounter with the Other as with the Real[24]. Freud's case of Little Hans (1905) illustrates how the child of 4yrs of age is confronted with the dilemmas of his own origin, his sexuality and the desire of the m(O)ther. These issues lay outside his ability to symbolise or to even make sense of. Little Hans, left in the lurch by the failure of his father to function as an ideal, resorted to a symptom (phobia) as a solution to the enigmas he faced. As a child he found himself in the place of his mother's object of enjoyment (jouissance). The traumatising factor in the neurosis was not a specific event, as a behaviourist[25] would try to argue, but what remained unspoken about the events that were occurring in conjunction with his development. His position as an object of jouissance barred him from putting into words the very experiences which were shaping his reality. The symptom in the case of Little Hans and in the case of every symptom owes its origins to the transmission of desire within the unique constellation of Han's family as a psychical object and occurrence.

3.6 Lacanian discourse theory

Lacan posits discourse as a social bond that is established through language (1972). He outlines four distinct forms of this social bond each of which is comprised of the same four elements: *agent*, *other*, *product* and *truth*. Corresponding with these elements are four terms: the master signifier (S1), the other (S2), jouissance as product (*a*) and the divided subject ($) as purveyor of truth or the symptom[26]. The agent is the giver of the discourse, the other is the one to whom discourse is addressed. The discourse of the master places the agent (S1) in the position of purveyor who addresses the other (S2) on the basis of knowledge or in terms of the others function. The other in working for the master must produce something

[24] Lacan uses the term Real to denote all that stands outside of the individual's capacity to put into words. 'It is that which resists symbolisation absolutely' (Lacan, Seminar I, 1953-54). The Real is characterised by impossibility and frequently associated with trauma. See compendium of terms.

[25] Behavioural explanations for the phobia in the case of little Hans have included ideas such as the child was traumatised by the sight of horses being whipped and horses falling down.

[26] Tomsic (2015) discussed the influence of Marx and Hegel on Lacan's theory of discourse. Tomsic, in writing about the capitalist discourse, explains how the social symptom assumes the position of truth within Lacan's theory; 'this nomination openly addresses Marx's correction of the labour theory of value and the invention of the social symptom, the proletarian, which assumes the position of truth, the same place where Lacan situates the subject of the unconscious $ (p.205).

(*a)*. Taking the capitalist[27] as master here and the other as slave what is produced is a surplus, which is appropriated by the master. Its production also brings about some form of enjoyment or jouissance for the other (S2). Lacan points out that for the master to remain in this position there must be no outward signs of lack, instead this fundamental fact of existence is hidden, barred from view, and put in the place of truth. This hidden dimension is what brings about the divided subject, something remains repressed. The master is unconcerned by what this truth entails as long as it remains hidden and the other continues to produce (a*)*. The matheme of the master can be written as follows:

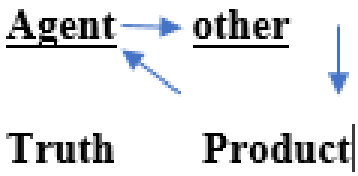

Figure 5. Discourse Graph

Lacan equates the discourse of the master with many of the practices observed in the health care. Moore (2012) points out how the medical doctor functions as a master in relation to the patient who must produce a given set of symptoms. This dynamic completes the circuit in which each of the agents are assured of their position. A rotation of the four elements produces a different form of discourse or social relation. These four terms and the corresponding elements enable the analyst to map out and describe clinical phenomena, and it is solely on the basis of the discourse of the analyst that the treatment can be conducted. In this discourse the analyst is positioned as agent which is occupied by the (*a)* this is to illustrate the fact that the analyst must become the 'semblance' of the cause of desire for the analysand. The analyst, operating in the position of agent and cause of desire puts the analysand to work in pursuit of the truth that remains hidden S2 which remain repressed. The product of this bond between the analyst and analysand is the master signifiers S1 which mobilise the subject.

[27] Capitalism can be described, in short, as a theory of relations of production based on a materialist ontology. Its object is called the commodity. Marx (1867) defines commodity in the following way, 'a commodity is first of all an external object. Initially the commodity appeared to us as an object with a dual character, possessing both use-value and exchange-value…a commodity appears at first sight an extremely obvious trivial thing. But analysis brings out that it is a very strange thing, abounding in metaphysical subtleties and theological niceties.

Figure 6. Analyst Discourse

Transference operates as a catalyst to the analytic discourse. Transference encapsulates love, repetition, and resistance according to Freud (1915). It is the regression of libido that revives the features of those family complexes outlined above only to play them out again in the encounter with the analyst. In children these unconscious complexes are less inclined by the forces of repression, they are in fact often still within the course of construction. Therefore, the possibility of intervention may bring with it the greatest opportunity to rewrite history in the making. A psychoanalytic intervention offers the child a chance to reposition him or herself in language (through the signifier) and as such experience life in a less symptomatic and painful way.

This chapter has sought to address the fundamental features of Lacanian psychoanalysis that enable a conceptualisation of the child and psychopathology. It has outlined the differences at an epistemological level between the discourse of psychoanalysis and those discussed in chapter 2. The following chapter provides a detailed account of the methodology that informed the study.

Chapter 4: Methodology

4.1 Introduction

The following chapter outlines the methodology underpinning the study and gives an account of how the research was conducted. It provides the reader with the ontological and epistemological foundations of the chosen methodology, Discourse Analysis (DA), and demonstrates why the chosen methodology was considered most suitable to address the research question: How do Lacanian Psychoanalysts conceptualise Child Psychopathology? Choosing expert practitioners who have extensive experience and knowledge that have been peer reviewed by presentation to international audiences via conference papers, journal and book publications provides a unique and valuable perspective on the changing patterns of child related psychopathology. An outline of the research method employed to collect data and analyse the findings along with the steps taken to maximise validity and reliability is provided. Reflexivity and ethics are discussed.

This study aims to explore how Lacanian psychoanalysts conceptualise child psychopathology.

The objectives of the study were:

- To make visible the specific components of the discourse of Lacanian psychoanalysis used to address the subject of child psychopathology.
- To analyse the participant discourse and identify the knowledge that structures their model of practice.
- To explore the features of the Lacanian model of psychoanalysis that the participants deemed to be distinctive from other models of practice in the treatment of children.

As outlined in Chapter 1, a manualised approach to Lacanian child psychoanalysis is agonistic to the belief system underpinning practice. Additionally, published accounts of case studies, while traditionally favoured in this field are rare as they create significant ethical dilemmas for researchers, clinicians, and their patients. Therefore, first-hand accounts from practitioners regarding practice were deemed to be a rich source of data for the research aim and objectives and explore how they relate Lacanian theory to clinical practice.

4.2 Methodology Overview

As the study is designed to explore how meaning is constructed the methodology required was one that provides an epistemological framework for understanding the process of meaning making. Amongst the methodologies that utilise such an epistemological position within qualitative research is Discourse Analysis (DA). DA aims at exploring how we use language and are used by language (Parker, 1992) which is broadly regarded as having a social constructionist ontology. DA is predominantly qualitative as it is inherently interpretive, "it sets out to make sense of or interpret phenomena in terms of the meanings people bring to them" (Denzin and Lincoln, 2000, p.3) making it a suitable model for exploring specialised areas of enquiry such as the current study. DA allows one to actively inquire into how meaning is generated through human relations, how subject positions are formed within language and how power is produced and effected, in short, how social bonds are organised (Willig, 2008). This model also enables researchers to explore specific aspects of participants' verbal accounts of their own work.

Lupton (1992) suggests that discourse analysis has the potential to reveal valuable insights into the social and political discourses regarding how health care takes place. The main aim of DA is to understand how talk and text construct particular versions of things such as psychopathology. DA is widely used within qualitative research on childhood to explore topics including single parenthood (Carabine, 2001), ADHD (McHoul and Rapely, 2005; Clarke, 2011) and the diagnosing of children with behavioural disorders (Harwood, 2006). DA is considered a useful methodology for exploring how the things we speak of, concepts such as children's mental health problems, are discursively produced and acquire a 'sense' of their own within discourse. DA can also be used to reveal how common discursive practices engaged in by mental health professionals; rhetoric, categorisation uncover the dynamics of power through the application of certain knowledge bases and the consequences for those concerned (Foucault, 1972). As the current study seeks to explore how child psychopathology is conceptualised by Lacanian psychoanalysts, who operate with a theory and practice which emphasis that the person is constructed in and by language, DA is considered the most appropriate method for conducting the study and is further explored and justified below.

4.3 Philosophical Underpinnings

DA is a postmodernist epistemology unconcerned with truth or falsity, rather discourse analysts endeavour to reveal the very processes by which the construction of truths may

emerge and how social realities and identities come into existence via language (Denzin and Lincoln, 2005). According to Wittgenstein (1889-1951), our realitie(s) are inseparable from the language we use to describe it. Hagstrom (2013) citing Wittgenstein contests that the meaning of words is constituted by the very function they perform*;* "instead of believing there was some kind of omnipotent and separate logic to the world independent of what we observe, Wittgenstein took a step back and argued instead that the world we see is defined and given meaning by the words we choose. In short, the world is what we make of it" (ibid. p.64). Wittgenstein focussed attention on the ways in which discourse is constitutive – building worlds. Such an approach to language highlights the shape and nature of discursive practices and the relation between order in talk and its context, as such, 'knowledge' itself is the product of social relations. This philosophical position can be found to underpin many constructionist approaches to qualitative research.

4.3.1 Constructionism

Schwandt (2007) describes constructionism as a particularly elusive term with different meanings depending on the discourse in which it is used. However, "the common usage of the term provides an alternative perspective to empiricism and rationalism by asserting that knowledge is neither discoverable from an external reality 'out there' nor produced through a process of reasoning divorced from such a reality" (ibid, p37). Burr (1995) outlines two basic tenants to social constructionism. Firstly, knowledge is sustained by social processes, e.g. what we understand as dyslexia is a phenomenon that has come into being through the exchanges between those who have difficulties reading and writing and others who teach literacy or diagnose perceived deficits. Secondly, knowledge and social action go together. The negotiated understanding of phenomena such as delinquency determines a certain course of action as Conrad and Schneider (1992) point out. Descriptions and constructions of the world sustain certain patterns of social interaction while excluding others. These constructions are bound up with power relations as Burr (1995) notes which have implications for what is permissible and determines how others are categorised and treated.

The ontological position associated with constructionism is relativism and the idea of local and specific constructed and co-constructed realities (Denzin and Lincoln, 2005). Theories about the nature of reality are often reduced to two competing categories in the literature: 'realist' and 'idealist', both of which have a long history in the philosophy of science (Schwandt, 2007). Following the work of Bhaskar (1978), a broader range of categories is generally now employed. Constructionism can be delineated into two broad strands; radical

constructivism (Von Glasersfeld, 2013) and social constructivism (Gergen, 1985; Berger and Luckmann, 1966; Shutz, 1962). Radical constructivism or psychological constructivism focuses on the individual knower and acts of cognition. The current study is aligned with social constructionism as it focuses on the processes of social interchange or what Parker (2005) refers to as a *social bond* in the production of meaning and subject-other relations. The roots of constructionism can be found in the work of structuralism which informed much of the philosophical thinking of the 20th century. Kearney (1994) points out how Saussure' linguistic methodology demonstrated in precise terms just what the 'study of the life of signs within society' could achieve (ibid, p.250). Cultural meanings have a direct but hidden relation to power as identified by Foucault (1970) and to the unconscious as recognised by Freud (1900) and Lacan (1953). Foucault refers to 'epistemic epochs' to account for how a society organises its thinking in relation to a given subject at a given period in history.

The significance of such an ontological approach is acknowledged by Harwood (2006) who contests that labelling children as disordered is a further effect of the way in which such terminology provides a version of a reality that is all too frequently accepted as being true. The author notes the importance of the interrogation of both the language and the discourses that make such terms meaningful. The power of discourse in the construction of meaning suggests that in the current epoch, it is difficult if not impossible to speak of a child with mental health problems without invoking terms such as ADHD or Conduct Disorder and so on, so ubiquitous is the discourse of psychiatry with its emphasis on observation and categorisation in contemporary culture. This social constructionist approach involves the study of the language that organises how children's mental health can be problematized and rendered 'knowable', 'teachable', and 'treatable'.

The epistemological framework for most forms of DA is social constructionism (Parker 1992, Willig 2008) which holds that knowledge is something that arises out of social practices i.e. the fact of speech and language itself. The constructionist approach in qualitative research is also referred to as "interpretive" (Schwandt, 1994) or "naturalistic" (Lincoln and Guba, 1985; Guba and Lincoln, 1994). To claim that discourse is social action is to reject the idea that language merely reflects realities, moreover *"texts such as a transcribed interview are not part of some natural process like a chemical reaction but are in fact complex cultural and psychological products, constructed in ways which make things happen and which bring social worlds into being"* (Wiggins and Riley, 2010, p.16). Discourse constructs a version of social reality. A question for discourse analysts is why put

things this way or that way? Why this version or this utterance? The literature reviewed showed how the discourses of psychiatry and developmental psychology produced terms that enabled clinicians and researchers a certain vantage point on the child and this conditions the way in which the child and professional engaged with one another. Lupton (2003) points out how discourse analysis is more commonly being used to analyse concepts of health and illness and the ways in which they are produced in social relations and the social influences on the production of knowledge in health care.

4.4 Discourse Analysis

Potter and Wetherell (1984) point out that providing a strict definition of DA is difficult to achieve given the breath of its application in the social sciences. However, DA can be understood as a term that refers to the study of the ways in which language is used between people and, in a broad sense, it is concerned with the function of speech and language. A fundamental aim within DA is to understand how talk and text construct particular versions of reality. The idea that words do not simply reflect a reality but actively shape it is generally shared by most DA theorists. Leech and Short (2001) describe discourse as the linguistic communication seen as transaction between speaker and hearer, as an interpersonal activity whose form is determined by its "social purpose". The current study draws upon Hall's (1992) definition [for the purpose of data analysis]:

> '*a group of statements which provides a language for talking about - a way of representing the knowledge about a particular topic at a particular historical moment. Discourse is about the production of knowledge through language and since all social practices entail meaning, and meanings shape and influence what we do – our conduct – all practices have a discursive aspec*t' (ibid, p.291).

It should be noted here that the term discourse, as mentioned at the beginning, can and is being used in different contexts throughout the study. In the current chapter it is being used to incorporate DA as a methodology and method for research and later in chapter five and six to include the Lacanian understanding of discourse as a particular type of "social bond".

4.4.1 Theoretical principles of DA

Potter and Wetherell (1987) outline three core observations regarding discourse that serve as the theoretical principles for DA. Firstly, discourse is regarded as being construct*ed* and constructi*ve*. Words, categories, repertoires, and other linguistic building blocks can be organised in a variety of ways to construct versions of the world according to the speaker. The second principle concerns action, discourse is action oriented. Talking and writing are

the primary means for achieving goals e.g. effecting change in how matters such as psychopathology can be understood. The third principle concerns how discourse is situated. This relates not only to how words are understood according to what precedes and follows them but to the context or situation in which the speech act takes place. Interviews for example represent a more formal approach to dialogue which will implicitly influence the two parties engaging in discussion. In such a situation the researcher must remain conscious of how these dynamics impact upon the interview and the analysis of data. This a matter of reflexivity.

DA is a methodology that focuses on how language is used and how versions of the world are constructed through language. While certain concepts referred to by the participants may be common across the different interviews DA explores how such concepts place the speaker/participant in relation to a particular topic. For example, Lacan's concept of 'The Name of the Father'[28] represents aspects of the symbolic function of the Other. However, what is of interest to the current study is how any Lacanian term may be put to use by the participant. Parker (1992) highlights how master signifiers can be identified in every form of discourse. These master signifiers operate as 'anchoring points for representation'. These elements underpin meaning within discourse. Uncovering these master signifiers allows the analyst to determine what is driving the subject in their use of discourse, 'anchoring allows the researcher to situate a fixed point around which a text may revolve, locating a text in broader patterns of discourse and examining the temporal logic of the text' (Parker, 2014, p52). DA allows the researcher to identify the coordinates that a participant is using to navigate or construct a version of the world which they convey in language. The current study is asking what participants have to say about child psychopathology within a contemporary context. As such, the relationship between their understanding of psychopathology and the object 'child' which, through the inferences drawn from contemporary culture, a conceptualisation of child psychopathology comes to be formed. Psychoanalysis is one discourse amongst many. The manner in which discourses emerge and are transformed is not fixed to any set of rules, rather to the complex interplay between connected and competing discourses. The current study is interested in illuminating the relationship between psychoanalysis and the discourses that are inferred by the participants in their description of the child and psychopathology.

[28] See compendium of terms

Discourse, according to Parker (1992), is a symbolic environment of human beings marked by a quality of difference. DA explores the inter-relationship between differences in how signifiers produce meaning that build repertoires which can, when examined in an historical context, be understood in terms of power. Discourses differ not only from each other but also within themselves which, as Parker (1992) points out, makes analysis difficult. Looking at discourses in their historical context, it becomes clear that they are quite coherent, and that as they are elaborated by academics and in everyday life, they become more carefully systematised. This suggests that by deliberately systematising different ways of talking about a subject, it can be better understood and that once discourses are so articulated the dynamics of tensions between them and their effects on the world can be made visible. Extending this point further Parker states that "discourses allow us to see things that are not 'really' there, and that once an object has been elaborated in a discourse it is difficult not to refer to it as if it were real" (ibid, p.6). An important feature of the current study is to examine how 'grids of specification[29]' legitimises the authority of the participant and also to explore the potential value of one way of talking about child psychopathology over another.

4.5 Foucault and Discourse

The discourse pertaining to health, specifically mental health, was of particular interest to Foucault. His interest focused on what regulated discourse via the rules and practices within a given period in history. This represented an attempt to encompass historical and political aspects of power dynamics as evidenced by language use. Discourse, for Foucault, can be understood to refer to a group of statements that provided a language for talking about or a way of representing the knowledge about a particular topic at a particular time in history. In Madness and Civilisation, Foucault (1961) demonstrated how the concept of mental illness, as we refer to it today, evolved over the course of several centuries and how this conceptualisation was interwoven into the discourses that emerged as dominant during the various periods throughout that time. In the context of the current study the literature review drew attention to the discourses that occupy the master positions in the conceptualisation of psychopathology today (psychology and psychiatry). These discourses did not emerge in a vacuum but against the backdrop of earlier discourses (religion and philosophy). Similarly, Lacanian psychoanalysis also exists within the discourse of mental health while being considerate of alternative models for understanding childhood and psychopathology.

[29] In Archaeology of Knowledge (1969) Foucault outlines how different 'kinds of madness' ca be grouped or classified as objects of discourse. A tangible example of which being the Diagnostics and Statistical Manual.

Antagonism and complementarity within and between these models produce a vital tension that enables their existence, as Foucault (1982) points out, for power to function there must also be resistance. For Foucault all meaning rests on the discursive practices inherent to discourse. Discourse is about language and practice, what one says in conjunction with what one does, discourse defines and produces the objects of our knowledge, it governs the way the topic is meaningfully constructed, just as it rules in certain ways of communicating, it rules out other ways (Parker, 1994).

Central to the constructionist paradigm within discourse theory is the idea that while physical things and actions exist independent of language, they only take on meaning and become objects of knowledge within discourse. This epistemological position holds that since we can only have a knowledge of things if they have a meaning, it is discourse, not the things themselves which produces knowledge. Rose (1979) argues that the 'psy complexes' is an exercise in reorganisation of political power and governance in Western society. The premise for the argument is based on the genealogy of psychology, not as a distinct body of knowledge or method of inquiry but as a form of social regulation and segregation. Intelligence testing in the early 20th century succeeded in separating out so called mentally defective individuals within a population for the purposes of the administration of educational resources and later employment. The regulation of the subject within society is made possible in this way according to Foucault. Foucault's genealogy treats terms like 'disorder' as products of a system that shifts and changes over time simultaneously reflecting the dynamics of power and its administration. Walkerdine (2017) points out how the birth of psychology played a significant role in making the 'social' a reality that could be governed more efficiently.

Harwood's (2006) study recognises similar patterns occurring via the diagnostic practices of contemporary psychiatry. Conrad and Schneider (1992) highlight how the concept of juvenile delinquency has altered as a result of the waxing and waning influences of religion, psychiatry and the law and how this has impacted on the treatment and management of children in that time. Similarly, Cunningham (2006) sheds light upon the discourses that have contributed to what he terms 'The Invention of Childhood'. In turning to discourse new and productive ways of opening up psychology became visible through the very practices psy practitioners engage in. How the participants speak about child psychopathology reveals their way of understanding this phenomenon and the discourses that they adopt in constructing a version of it. Exploring the discursive practices of Lacanian Psychoanalysts

may offer greater exposure to a discourse outside of that of observation and categorisation which, as outlined above favour more prescriptive approaches to treatment. In addition, applying a Foucauldian lens may also reveal how this group of mental health practitioners are also subject to a discourse or discourses which limit their practice.

For Foucault the social purpose of discourse was in the service of power and knowledge, both concepts being inextricably linked. Foucault did not provide a precise definition of discourse, nor did he provide a method by which discourse could be analysed as this would be alien to his approach. However, drawing on Foucauldian concepts has allowed researchers to explore the machinations of power and knowledge as it is exercised in everyday speech. A central theme in Foucault's work can be observed in the following,

"*I am supposing that in every society the production of discourse is at once controlled, selected, organised and redistributed according to a certain number of procedures, whose role is to avert its powers and its dangers, to cope with chance events, to evade its ponderous, awesome materiality*" (Foucault 1971, p. 8).

For Foucault there is no external position of certainty, no universal understanding. A single discourse he argues can only become meaningful when placed alongside other discourses and that the importance of a single discursive element can only be assessed relative to others (Foucault, 1970). This, once again, indicates the importance of carrying out a review of the discourses more commonly connected to the construction of childhood and psychopathology.

4.6 Foucauldian Discourse Analysis (FDA) and qualitative research

While Foucault's philosophy cannot be understood as a prescriptive formula for the analysis of data, employing a Foucauldian lens to transcripts means the researcher can approach data with an understanding of a number of fundamental principles. FDA reflects an interest in the various ways that an issue like child psychopathology is constructed. Kendall and Wickham (2004) describe the Foucauldian framework as "an approach rather than a methodology, a predisposition to look at certain questions rather than others and assert that precise methodological tools are not on offer: rather we are given an approach and a set of phenomena to look out for" (p.143). FDA is concerned with language and its role in the constitution of social life. FDA is interested in ways that subjects and phenomena are

constructed given that society is seen as consisting of different discourses many of which compete for the power to determine how we understand and speak of things. For example, the wider discourse of science encompasses, within it, competing discourses for how psychological phenomena can be understood i.e. neurological/biological based explanations versus developmental or systemic models of human behaviour.

FDA is concerned with how an issue is constructed either within an historical epoch or within a subgroup of society. It has become an increasingly popular methodology within qualitative research designed to explore how meaning is constructed with regard to clinical concepts in psychiatry and psychology. According to Parker (1992) a Foucauldian perspective on discourse reveals how discourses facilitate and limit, enable and constrain what can be said, by whom, where and when within a culture.

Given the historical dimension of Foucault's analysis, a corpus of statements[30] needed to be developed, as part of the literature review. This included examples of how the construction of childhood and psychopathology took place over time. This temporal variability provides some perspective for how knowledge and power relations operate within different historical epochs and how the different ways of describing the problem determine how it is managed and/or treated according to Foucault (1969). While it is possible to include a corpus of statements as part of the data set (Farrelly, 2015) the current study sought to include this component as part of the literature review in order provide a background to how child psychopathology has come to be conceptualised in contemporary discourse. Willig (2013) points out that any context or setting is suitable for FDA as long as it contains historical sensitivity towards the objects and problems investigated hence the requirement for a corpus of statements. FDA is widely conducted on a variety of speech activities such as research interviews.

Hall (2004) argues that, for Foucault, discourse does not simply mean a particular instance of language use, a piece of text, an utterance or linguistic performance, but rules, divisions and systems of a particular body of knowledge. Discourse refers to the techniques and practices through which objects, concepts and ideas are formed. Discourses are not objects but rules and procedures that make objects thinkable, governable, treatable, social bonds that

[30] A corpus of statements is a selection of discourse samples about an object relevant to one's inquiry (Willig and Stanton-Rogers 2017). A corpus of statements should also highlight discontinuity where objects such as 'delinquency' undergo an abrupt historical transformation i.e. how the change in what they are called determined how they are understood.

can be explored through the acts of speech that organise them. Discourses are not what determine the objects themselves but what intervene in the relations of what can be known, said and practiced. The act of describing and discussing psychopathology draws on our understanding that the phenomena (symptoms and behaviours) have, attached to it, social and cultural implications, "markers" and, through careful analysis, can reveal otherwise invisible information about those of whom it speaks; children. FDA in such instance is interested in identifying and understanding how the object comes into being, based on the discursive practices of those who may make currency of such objects, child psychoanalysts. Applying FDA principles to the current study may provide valuable insights into how psychopathology in children is framed by the participants, thereby elucidating their ways of understanding and treating children.

While FDA encourages inquiry into how we do what we do based on the language we use to understand the things we experience in our world i.e., how we practice forms of clinical treatment, Link (1983) and Jager & Maier (2001) also draw upon Foucault's proposition that knowledge lies beyond what is spoken about or transmitted directly through language. These authors refer to 'dispositives[31]' as a knowledge that exceeds the material connection between language and objects i.e. a knowledge that exists not as a result of discursive practices or the transmission of thought through words but in something 'more' that is beyond what the sign or the word can capture. While the authors suggest that Foucault did not define exactly what this 'more' consisted of, Wittgenstein's idea of 'intransitive knowledge' or tacit knowledge (Polanyi, 1958) may best account for the type of knowledge[32] that is difficult to transfer into another person. An analogy for this type of knowledge is the steel worker at a blast furnace who can see when the steel is ready or what ingredients are still missing. Other examples may include learning to ride a bike or speak a new language or possibly even functioning as a psychoanalyst. This is knowledge that is impossible to teach through speech, one must try for oneself, it is embedded in practice. However, Jager and Maier (2001) suggest that 'dispositives' may be revealed through discourse analysis. Villadsen (2021) revealed the

[31] Foucault (1980) uses the term 'dispositif' to denote the apparatus or device that holds in place the relation between knowledge of something and the action that follows from that; a *know*ledge of vs a *know* - how. Jager and Maier refers to dispositifs (dispositives) as the constantly evolving synthesis of knowledge that is built into linguistically performed practices (i.e. speaking, writing and thinking) and non linguistically performed practices (doing things!) and materialisations (natural and produced things). In defining this implicit, non-linguistic knowledge.

[32] Lacan distinguishes between two types of knowledge; *connaissance* or 'ego knowledge' and s*avoir* or the knowledge of the subject, the latter being the type of knowledge psychoanalysis aims at. This is the type of knowledge that positions the subject in relation to the Other. It is the knowledge that relates to jouissance.

dispositives at play in a study of 'care workers experiences of change within a home care setting' through the analysis of data collected from interviews with the participants; social care workers.

As this study is enquiring about how the participants function as psychoanalysts, working with children, identifying these dispositives may reveal what is latent within the discourse[33].

4.7 Design

The study is underpinned by a Foucauldian approach to discourse analysis as discussed by Parker (1992, 2005) and Arribas-Ayllon and Walkerdine (2017). Potter and Wetherell's (1987) model for conducting qualitative research was used as a framework for designing the study and provided a foundation for the initial phases of data analysis. Arribas-Ayllon and Walkerdine (2017) and Parker (1992, 2005) provide a guide to researchers conducting FDA. Firstly, selecting a corpus of statements i.e. samples of text drawn from the discourses of religion, politics, developmental psychology and psychiatry a certain constitution of the objects 'child', childhood' and 'psychopathology' was achieved. The construction of these objects through discourse in turn determines how they are acted upon, regulated, or treated which was discussed. However, a corpus of statements can also be drawn from interview transcripts, a process akin to notation or coding as outlined by Arribas-Ayllon and Walkderine (2017). Secondly, the authors encourage FDA researchers to identify problematisations i.e. references to historical events in which objects and practices are made 'problematic' and therefore visible and knowable which is often be found at the intersection of different discourses. This aids in the exposure of power/knowledge relations. Thirdly by drawing upon Foucault's concept of technologies some inferences can be made to how governance of self and others is achieved through discourse. They note how there are two kinds of technologies appropriate for FDA inquiry: technologies of power and technologies of self. "Technologies of power seek to govern human conduct at a distance… while technologies of self are techniques by which human beings seek to regulate and improve their conduct" (Arribas-Allyon and Walkerdine, 2017, p.118). This can be achieved through an examination of the interactional activities at play during an interview and in the context of the current study may enable the identification of which discourse move and restrain the participants in their construction of 'child psychopathology'. Finally subject positions define

[33] This is akin to how the practice of 'The Pass', as discussed in chapter 3, is conducted. What the listener hears beyond what is said and what might this reveal about the speaker and their relationship to psychoanalysis for example.

the limits of what can be said, by whom and when. Identifying subject positions allows the researcher to investigate the cultural repertoire available to the speakers.

The study of discourse is the study of pattern and order but as the field develops this is not something that needs to begin fresh each time according to Taylor (2001), rather each new discourse researcher builds on or extends and transforms previous forms of identification, classification and theorisation. For this reason, DA is understood to be embryonic compared with other domains within social science. The following sections describe the method by which this current research study was conducted.

4.7.1 Sample Selection

The current study used purposive and homogenous sampling (Patton, 1990, 2015) in participant recruitment. Purposive sampling allows one to identify a specific cohort that are deemed to be the most appropriate in the context of a given study. Homogenous sampling, the practice of choosing participants on the basis of particular traits e.g. expertise in a given clinical orientation such as Lacanian psychoanalysis, allows the researcher to describe some particular sub group in detail. While psychoanalysis encompasses a vast spectrum of clinical practice and theory, the school of Lacanian psychoanalysis approaches the broader theory with specific clinical, theoretical, and conceptual nuances that span Lacan's writing from 1930's – 1980's. Furthermore, child psychoanalysis represents a unique subcategory within this area. Where smaller cohorts of samples are concerned a small participant base can be ample within a qualitative approach that favours in-depth analysis such as that of the current study. Patton (1990) proposes between five and eight participants to be an adequate number for conducting qualitative inquiries with purposive sample groups. Eight potential participants who met the criteria for the study were identified and contacted, six agreed to take part in the study. The inclusion criteria for the study were as follows:

- A minimum of 20 years clinical experience in child and adolescent psychoanalytic psychotherapy.
- A grounding in research as evidenced by peer reviewed publications and or authored books on the subject of Lacanian psychoanalysis with children.
- Membership of a national and/or internationally recognised organisation for psychotherapy and psychoanalysis.
- Membership of a national and or international organisation/school for Freudian and Lacanian Psychoanalysis.

- Currently in public and/or private practice treating children.

4.7.2 Participant recruitment

The study sought to enlist participants with extensive knowledge of the subject. However, given that only a small number of potential participants could meet the criteria recruiting participants inevitably meant contacting people who live and work outside of Ireland. These participants were known to the researcher only through their profile as leading contributors to the study of psychoanalysis with children, as evidenced by their publications and contributions to international conferences on child psychoanalysis. A total of 8 people were invited to take part in the study with 2 declining to do so. All the participants were screened to see if they met the criteria before being invited to take part. An important element in choosing the participants was their ability and willingness to conduct an interview in English. English was not the first language for half of those who took part in the study. The participants were contacted via email addresses, available online, through the professional organisations with which they are affiliated. The initial email outlined the details of the study (appendix 3) and included the plain language statement as an attachment (Appendix 4). Following an initial correspondence in which they expressed an interest in the study a follow up email or phone call was arranged and the relevant consent forms were provided (Appendix 5). This process was carried out in a manner that 'ensured that participants are fully aware of the purpose of the research and understand their rights (Bell, 2005, p.44).

4.7.3. Data Collection

DA research can involve a variety of different data sets. These may include published material, art, discussion and institutional policy. However, using only published material excludes the researcher from what Parker (2005) refers to as a fundamental component to the theory of DA namely the co-construction of information. For this reason, the use of semi structured interviews was considered the most appropriate form of data collection as it allows very particular topics to be addressed in real time where potentially relevant issues can be properly pursued and elaborated. DA rejects the idea that interviews are purely a process of retrieving information from inside the minds of interviewees. Discourse is something that is socially constructed. Addressing the aim of the current study through dialogue was considered most appropriate. In doing so the interview process made use of the following recommendations to conducting interviews in DA research. Potter and Wetherell (1987) assert that interviewers should intervene and engage with the participant on the subject matter. The semi structured interview process allows both researcher and participant to

engage in dialogue whereby initial questions are modified in the light of participants' responses and the investigator is able to probe interesting and important issues that arise (Smith & Osborn, 2008). Smith (2005) contends that semi-structured interviews are especially suitable where one is interested in complexity or process or where an issue is controversial or personal, the relevance of this point will be discussed in the reflexivity section below. Gillham (2005) suggest that when interviewing expert participants', the interview format should be "loosely structured at best", however, careful consideration was given to the structure of the questions which were open ended and designed to allow the participants the flexibility in their response and the opportunity to engage with and elaborate on the points being made (Appendix 5). This approach to data collection was thought to be more in keeping with the sentiment of the research. In addition, research with expert participants can be particularly insightful, according to Gillham (2005), as they may be willing to discuss their embryonic ideas and theories and engage critically on the extant literature. As five of the six participants were from countries outside of Ireland these interviews were conducted via Skype (video link). One interview was conducted in the participant's consulting office in Dublin. All interviews were recorded using a digital audio recorder. The participants account of their work with children and their perspective on psychopathology is a rich, untapped source of data that has not been explored in this format previously. One of the objectives during the interviews was to maintain a less 'jargonised' approach to discussing the subject. This would prove beneficial at the analysis stage as the participants inevitably drew upon wider discourses and used more colloquial language as a result.

Another important aspect of interviewing is how to establish a rapport with the interviewee. Parker (2005) suggests that the way the questions are framed will govern how far it is possible to develop a rapport with interviewees and the freedom with which they can develop their own narrative about their experiences and also the security they feel in speaking about these things to the interviewer. Kvale's (1996) use of the metaphor of the traveller who wanders alongside, in conversation with, the interviewee as they explore the subject at hand suggests a style that is convivial but not passive. It encourages flexibility in adapting to changing of direction in interviews. This is again an important issue when conducting FDA as the overt discussion of power and knowledge may be uncomfortable for some. A style of interviewing that can facilitate problematic subject matter is crucial. The interview structure was designed to be dialogical (Bakhtin, 1981) in order to explore the perspectives and positions taken on the subject matter by the participants in the very process of being

interviewed. In this way the data becomes something that does not merely emanate from the participant but instead is something that researcher and researched participate in and struggle over together. This was reflected upon during the initial stages of analysis. During the interview each participant was invited to respond to exactly the same question. However, the researcher took consideration of how each of the previous participants had responded to the same question. While anticipating similar responses was inevitable the vast experience of the participants meant that there was a good range of variance in response to all questions.

Potter and Wetherell (1987) point out how interviews in discourse analysis studies are distinct and how variation in response to questions is as important as consistency. The interview structure along with the way the questions were formulated determined the degree of manoeuvre the participants had to produce something new therefore the participants were, "seen as active participants rather than like speaking questionnaires" (Potter and Wetherell, 1987, p.165). Parker (2005) describes the interviewee as a "co-researcher in discourse analysis" (p.94). The researcher endeavoured to ensure that the participants were encouraged to approach the questions and their responses as active participants in the process of enquiry into Lacanian child psychoanalysis.

4.7.4 Data Management

The interviews were recorded on a digital audio recorded which was double locked within the researchers' home office. The transcripts to the interviews were stored in a password protected file on a laptop that was also password protected. All identifying details to the participants were removed from the transcripts and the identifying codes were stored separately in a different file. Transcripts to the interviews will be kept for five years after the submission of the thesis to DCU in accordance with data protection act (2003) and GDPR. After this time the transcripts will be permanently deleted, and the recordings will be destroyed.

4.7.5 Transcription

The process of transcription is, according to Ochs (1979), a fundamental aspect of the theory and design of a study. Transcription requires careful consideration in how to represent talk as text. Transcripts are not straight forward routes into the reality of a given interaction. A general limitation pointed out by Parker (1992) is that when we write out the interview, we do not necessarily directly reflect what was spoken, as such the earlier the transcription takes place the closer the researcher remains to the tone and sentiment of the interviews which is

often conveyed in the transcription. Many researchers contend that the transcribing and the analysis should be done by the same person. Chaffe (1995) states 'one cannot fully understand data unless one has been in on it from the beginning' (p. 61). For this reason, the interviews were transcribed by the researcher within a seven-day period following each interview. As the interviews all lasted between 70-90 minutes the transcription for each interview took approximately 12-14 hours.

Wiggins and Riley (2010) point out that for FDA 'the level of detail needed in the transcription will be a pragmatic decision based on providing enough information to give a sense of how the person spoke and to be able to address the research question' (p.143). While there is no specific format for how the process of transcription is conducted in FDA, the study utilises Parker's (2005) approach in which he outlines a number of general requirements and conventions for transcription of semi structured interviews in DA. These include: the identification of who is speaking (use of initials), what emphasis there may be in the speech (underlining words and phrases), points of interruption between the speaker (uses of square bracketing [ ]), hesitation (use of round bracketing ( )) and a note about bits of the interview you could not understand (placed in the margins outside the account of dialogue. Gibson (2010) suggests that the general approach to transcription within FDA research appears in a format like that of a play script (appendix I).

4.7.6 Data Analysis

Analysis of the data began during the interview stage itself with careful attention being paid to how the participants were positioning themselves in relation to the various points being made during the interview. However, given that the researcher was familiar with the work of many of the participants (as outlined in their publications) a minor degree of analysis could said to have begun as early as the literature review stage. This raised important points for consideration regarding reflexivity during the interviews and at the analysis stage as discussed below. Initial thoughts and impressions were noted as the interviews were being transcribed. This is a practice common to DA[34] as a way reducing subjective biases in later stages of analysis (Appendix 2). Familiarisation with data is key to conducting a

[34] Research by Theodore Adorno (as cited in Parker, 2005, p.27) indicates how every claim to objective truth is also simultaneously the reflection of the historically embedded subjective position of the researcher in what they are studying. Adorno showed how the process of remembering was compromised by the relationship of the researcher to what he was studying. As such the longer one spends away from the event the greater the likelihood of subjective bias. Transcribing interviews soon after they are conducted reduces this effect and as such is considered good practice.

comprehensive analysis. As such several readings of the text were required in which general impressions, specific subjects and objects were noted. Potter & Wetherell (1987) outline how the process of notation or coding takes place across all interviews individually. This meant reading each interview several times and noting instances of relevance to the aim and of objectives of the study e.g. the category of capitalism in the findings section was developed through the process of noting the frequency and context in use of the terms *consumer, commercial, commodity, economics, market* and so on. This procedure (appendix 1 – 5) highlights the evolution in the analytic process. Parker (1992) states, "there is no DA machine into which you can feed a piece of text; the analysis that is performed will be determined both by the kind of text and by the questions that are brought to bear on it" (ibid, p.10). While software programmes have been designed for the purposes of grouping and organising fragments of data, developing the categories remains an iterative process requiring the researcher to move back and forth between data and analysis to confirm or refute emerging the emerging patterns, Potter & Wetherell (1987).

The initial stage of the analysis involved identifying themes (Appendix 5) which could be further analysed in accordance with theoretical stand points, philosophical positions and methodological assumptions of FDA. This involved categorising the use of specific terms (see appendix III) noting general impressions, subjects and objects. This allowed the researcher to orient himself with the types of arguments, subjective positions and rhetorical practices the participants used to construct their version of things pertaining to childhood and psychopathology. Parker (1992) notes how the early stages in analysis have a pragmatic rather than analytic goal of collecting instances for examination. As such this phase of analysis begins at a basic descriptive level and works upwards in a systematic manner towards a more interpretive level. Moving in the direction of generating themes based on the identification patterns in the data was not seamless, rather it proved to be a task involving a great deal of revision. A visual map charting the evolution of themes was developed during the process allowing the researcher to add and subtract and keep a note of the process during the early stage of analysis (see appendix 4). It enabled the researcher to develop an impression of which discourses were being utilised and which ones were disregarded in formulating ideas around childhood and psychopathology, for example, the discourse of economics and consumerism featured prominently in the data and as such were recorded under the category of 'capitalism' in the findings section. Recurrences of topics such as play and behaviour, school refusal and so on were further refined into the categories of 'the family', 'symptoms', 'consent and demand' and 'child versus adult clinic'. The categories

refer to the primary discussion points in the data. The discourses identified within the analysis of the data are highlighted throughout the findings section.

Parker (2005) cautions discourse analysts against becoming absorbed by the subject matter being discussed at the expense of attending to the underlying discourses at work in the text. This proved to be an important point for discussion during supervision. Supervision was a good space in which the researcher was given a certain reset and reminded of what FDA sets out to accomplish as outlined above. The final stage in the analysis of the data involved identifying the discourses that underpinned the various themes.

4.7.7 Generating categories of discourses

While themes tend to be drawn directly from the text discourses endure over time and tend to refer to social and cultural understandings which will be recognisable during the analysis but may come from outside the text itself. Janks (1997) highlights the relationship between themes within text and discourse at a wider level. Reading meaning from text is not possible without a wider context or discourse to support the process of meaning making. Consumerism, for example, was frequently inferred by the participants as operating alongside the discourse of mental wellbeing. As discourses are about effects rather than causes it is helpful to ask what purpose the different discourses serve and how they inter-relate. In this instance mental wellbeing is bound up in consumerism vis-à-vis the products marketed as improving mental wellbeing. However, the subjective positioning of the participants revealed a certain tension to the extent that these participants found these two discourses to be antagonistic of one another in terms of the consequences it has on individuals in society. Discourses effect a form of governance over individuals as Foucault (1969) notes. Arribas-Allyon and Walkerdine (2017) point out how the borders between discourses are frequently the site of tension and the emergence of meaning. The tension found between mental health and consumerism was tied to themes such as video game play, club membership and ‘vitamin culture’ drawn from the text. In differentiating between the discourses, the authors recommend looking to how the speaker is positioned. Positioning can be descriptive of how a discourse operates i.e., subjective positioning of the speaker reveals what can and cannot be said vis-à-vis the discourse that the speaker evokes. It involves the performance of a particular vantage point offering a version of reality within spoken interaction (Bamberg, 1994). In the current study the themes mentioned above were found to be littered throughout the data but tied to different discourses at different moments during the interviews. Themes can generally be found relating directly to the research aim and

objectives as they refer to the content of the interview and are more descriptive. Discourses by contrast come from outside the text and organise how a subject is determined by the broader social and cultural issues at a given time.

4.7.8 Validity and Rigour

Some of the strategies employed to enhance the validity and rigour of the current study have been mentioned in the above section; writing up of reports as soon as is possible, note taking, transparency shown towards participants and proper representation of their voices within the findings (see chapter 5). Willig (2008) points out how DA and FDA are best evaluated by assessing the quality of the accounts they produce. The reflexivity of the researcher is a key component in maintain rigour in qualitative research. DA does not make any claims regarding objectivity. The burden of rigour lies in relation to how the researcher makes visible to the reader the process of interpretation and the analysis of data as demonstrated in the findings. This allows the reader to draw their own conclusion as to the validity of any claims being made. Findings are considered reliable 'if a reader can also see what the researcher saw, whether or not he agrees with it (Giorgi 1975, p93). Burns and Grove (2001) provide a description for rigour that the researcher used throughout the study, 'rigor is associated with openness, scrupulous adherence to a philosophical perspective, thoroughness in collecting data, and consideration of all the data in the subjective theory development phase' (p.64). The supervision process allowed the researcher in this study to address these issues openly.

4.7.9 Reflexivity

According to Potter and Wetherell (1987), unlike other experimental methods there is no uniform approach to operationalising DA. This reflects the prizing of the unique subjectivity of each patient advocated by Lacanian psychoanalysis. Both the researcher and the researched operate on the basis of a broad theoretical framework concerning discourse and its relationship to an array of practices in the social world. In this study the concern for both researcher and researched is with the discourse of Lacanian child psychoanalysts regarding the social world of clinical practice. The quality of any DA is heavily dependent upon the skills developed by each researcher as they undertake to explore the data amassed from a DA perspective. This places a responsibility on the researcher to engage in a continuous reflexive process at all stages of the study. As such the different stages of the research require different strategies for reflexivity. In the case of the current study a reflexive journal was kept throughout the process. This document reflected an evolution in the researchers thinking

regarding the study with careful attention being paid how the aim was being addressed throughout. Careful consideration went into the interviews. Here Parker (2005) refers to the 'embodied relation' between the researcher and participant whereby thoughts and feelings can become influenced by the dynamics that exist between researcher and participant. Research with expert participants can invariably become balanced in favour of the expert. As such I needed to remain conscious of whether I was finding myself in agreement or otherwise with participants both before and during the interview, whether I was influenced by their standing within the field of Lacanian psychoanalysis and whether I intended to challenge or validate what they were saying or whether I would find myself identifying with them during the interview. Consciously reflecting on this enabled me to avoid losing sight of the aim and objectives while at the same time demonstrating fairness and respect to the participants. By being reflexive and clearly identifying the participants perspective the analyst can enter discursive arguments where they may defend or modify their position. As part of the report writing reflexivity took the form of recognising and recording moments within the interviews which were more difficult, confusing or frustrating. Supervision proved to be an invaluable resource for discussing these issues and enabled clearer thinking in terms of how the data was being interpreted. The use of a reflexive journal proved beneficial in maintaining the right distance from the study at the various stages in its development.

4.8 Ethical issues

As soon as the study design was complete, I sought approval from DCU's Research Ethics Committee. The committees only concern came in relation to confidentiality and anonymity for the participants. Coffey and Atkinson (1996) highlight the difficulties associated with interviewing a small sample of elite participants with regard to anonymity and point out that guaranteeing complete confidentiality when researching niche populations is difficult. To assure the committee of this aspect of the research I provided a detailed account of how the data would be managed, stored, and analysed. Having satisfied the ethics committee of this aspect of the study permission was granted and recruitment was undertaken. The participants were all made aware of the anonymous status in the consent form (appendix IX) and no participant raised concerns in relation to this. Coffey and. King (2010) assert that researchers generally agree on the importance of ensuring the anonymity of the participants but that confidentiality in this regard can never be fully guaranteed. Every effort has been made to protect the identity of the participants in the current study including the decision not to disclose the specific organisations with which the participants were affiliated. This decision

was taken on the basis that each of the organisations have, as members, a very small number of people who could meet the criteria for the study. Having removed all identifiable characteristics of the participants in the coding section the data analysis also required special attention to remove any details of their publications as disclosed in the course of the interview. An additional consideration was that participants were asked to discuss their clinical practice therefore the data was also carefully examined to remove any details that could in any manner be traced to the participants analysands. Furthermore, all participants were allowed a substantial period to reconsider their involvement in the study before interviews were carried out. In most cases a couple of months had passed between agreeing to take part and the interview itself. Interviewees were also aware of their right to contact the researcher or his supervisors at any point following the interview should they wish to query or clarify outstanding concerns.

4.9 Chapter Summary

The aim of this chapter was to outline and justify the methodology and methods employed in the study. The study is underpinned by a postmodern approach to understanding the complexity, plurality and variety of realities and rejects any claims to irrefutable truth. By applying an FDA approach to data analysis greater insight into the regulatory effects of discourse on the participants in their relationship to power and knowledge can be acquired. The models used to structure the study (Potter and Wetherell, 1987) and provide the initials steps required for data analysis. Parker (1992, 2005) and (Arribas-Ayllon and Walkerdine, 2017) enabled the researcher to identify the various ways in which the participants positioned themselves in relation to the subject of child psychopathology and how the inherent power of discourse plays a crucial role in the construction of these issues. Finally, the reflexivity of the researcher and the ethical issues that arose in relation to the study were addressed in detail. The following chapter presents the study findings.

Chapter 5: Findings

5.1 Introduction

This chapter presents the findings generated from analysis of the participants' interviews. The study's aim, to explore how participants conceptualised child psychopathology, was subject to a Foucauldian discourse analysis. This revealed seven categories outlining how the participants drew upon specific discourses in constructing a version of the child, psychopathology and psychoanalytic treatment. The analysis demonstrates how the six participants' conceptualisations are founded in psychoanalytic discourse and are radically different from other theoretical conceptualisations of childhood and psychopathology. Participants demonstrated how the discourse of psychoanalysis is distinguished from other theoretical models by placing emphasis on subjectivity. This is a movement away from the dominant medical discourse that operates in and infuses socio-cultural versions of childhood where perspectives are drawn from medical, developmental, behavioural and educational discourses in measuring and understanding the child in contemporary society. The participants referenced the role of culture, economics, and consumerism in their understanding of children and psychopathology. Each category uses verbatim quotes from participants which is in keeping with the practice of FDA outlined above. In adherence to the ethical principles underpinning the study participants' names and any other potential identifying data has been removed from the text presented in this chapter. Table 2 gives broad background details about each participant to aid the reader in contextualising engagement with the findings.

The first section of the findings is concerned with how the data revealed the tendency of participants to draw on the discourse of capitalism, as manifested by consumerist culture and a broader cultural ethos or 'imperative' of enjoyment. The frequent appearance of terms such as "capitalism", "money", "market" and "buy" that the participants used in discussing the place of the child in contemporary culture indicated the significance of a consumerism in their reflection upon childhood in the 21st century. The participants draw a distinction between how they believe the child to be positioned by the discourse of capitalism and how they, as Lacanian psychoanalysts, conceptualise the child. The terms "object" and "subject" were used to distinguish what they considered the child to be for Other (an object) as opposed to what they, as psychoanalysts, recognised in the child (as subject). Another way to interpret this would be to posit the child as an object in the sense that he/she fulfils some function for

the Other. In this position the subjectivity of the child is negated. Four of the participants used the phrase ‘object of jouissance’ when referring to the child of the 21st century. This term applied to the child in their cultural and familial form as outlined in section 5.3. Psychodiagnostics featured throughout the data as the participants referred to the role of psychology and psychiatry in contextualising child psychopathology and how they, as clinicians differed in their approach, 5.4. The role of the symptoms in psychoanalysis is discussed in section 5.5. This is a significant component to how psychoanalysts carry out their work with children. In this section the participants draw distinctions between the discourse of Lacanian psychoanalysis and psychiatry in illuminating their understanding of the aetiology of psychopathology. Section 5.6 looks addresses what the findings reveal regarding the topic of consent in the treatment of children. It explores how consent is established and recognised and the importance it plays in the overall treatment of the child. Section 5.7 explores how the participants position themselves in their work with children. It explores how the participants discussed features of psychoanalysis that are unique to working with children. Finally in section 5.8, reveals how the participants addressed what they regarded as the aims of the treatment with children.

Table 2. Participant Profile

Participants	Clinical and Academic expertise
Participant (P1)	Child psychologist and psychoanalyst working in public health system for over 25 years. Published in several peer reviewed journals related to child psychotherapy. Book contributions translated into several languages.
Participant (P2)	Psychoanalyst in private practice for 25 years. Working in a public clinic in the area of child psychotherapy. Authored journal articles and book chapters on the subject of psychoanalysis with children.
Participant (P3)	Child and adolescent psychoanalyst in public and private practice for 45years. Founding member of an International psychoanalytic organisation. Senior Lecturer. Published in several peer reviewed journals across several languages. Book author on the subject of psychoanalysis and children.
Participant (P4)	Child & Adolescent Psychiatrist & Psychoanalyst. Convenor of seminars on Child Psychoanalysis. Author of books and articles on the subject of child psychoanalysis. 30 years clinical experience.
Participant (P5)	Child and adolescent psychoanalyst in practice for 45 years. Published extensively in books and peer reviewed journals across several languages. Founding member of an international psychoanalytic organisation. Senior researcher and lecturer.
Participant (P6)	Child and Adolescent psychotherapist and psychoanalyst in public and private practice for 20 years. Holds a senior lecturing post. Published nationally and internationally in peer reviewed journals. Contributed to books on the subject of psychoanalysis with children.

Table 3 outlines the seven categories of discourse that emerged from the analysis and under which the findings are presented.

Table 3. Categories of Discourse

Category 1	**Category 2**	**Category 3**
Capitalism	The Family	Psychodiagnostics
Category 4	**Category 5**	**Category 6**
Symptoms	Working with young subjects	Consent and Demand
Category 7		
The Aim of the Treatment		

5.2 Capitalism

The participants used the words capitalism and economics interchangeably during the interviews. The term capitalism has been chosen as a category based on its greater frequency in the data and for how it applied to contemporary subjectivity according to the participants. Consumerism is also addressed within this category. Consumerism is a behavioural consequence of the dominant capitalist discourse that drives much political activity in western society. The power of this discourse in contemporary culture was keenly observed by the participants in how they conceptualised the child and what they refer to as 'the social bond' in modern society that is organised in accordance with neoliberal ideals. The utilisation of power within the discourse of capitalism is firstly economic power. The power to acquire xyz is made possible here. The data revealed how this form of power infiltrates the lives of children and their parents and determines their relationships:

> **P5 "***the child is more than ever an object of jouissance, an object you can buy actually… Even the child of a noble tribe is possible if you buy the sperm, it's quite expensive, and also its available and also they sell you - with the price you're going to have a free test, IQ test, at 9 months, 18 months, 3 years*".
>
> **P1 "***the first thing that comes to mind is that they are objects of jouissance…and that they have it much more difficult today".*

A certain commodification of the child is occurring according to the participants. The market provides potential parents with a type of power. However, this type of power is problematic according to the participants as it fosters an illusion i.e., the perfect baby, which in turn

brings the greatest satisfaction or jouissance to the parents. However, as the term jouissance implies, this also includes some degree of suffering as witnessed by P2.

> **P2** "*the child has to bring that jouissance to the parents and if they* (the parents) *do not feel that they are happy ( ) with the symptom ( ) they are touched by the idea that the child does not bring them that jouissance so its like they are looking to a judge* (the clinician) *and saying we need that jouissance, we did everything we could to obtain that jouissance".*

The notion that the ideal child can be bought or that money can fix or even perfect something is being linked with enjoyment here. The child is both consumer and consumed within the discourse of capitalism. The child as an object of this discourse is akin to the objet *a* as Lacan (1969) writes. There is an implication that a cultural shift has occurred to bring about this situation. This shift is continuously brought back to capitalism and a culture of consumerism in the data.

> **P5 "***I don't know what's happening today everybody wants a child, when I was young everybody wanted not to have children, and arrived contraception".*

The first excerpt highlights how the power yielded by technology and money can even serve to override the experience of lack in a biological function; reproduction. For this to occur the ability to reproduce has to be sold as a right and an expectation. Moreover, there is the idea of perfecting the baby or creating a designer or bespoke baby in the process. While the overlap between the discourses of science/technology and capitalism become apparent in the data the participants focus more attention on the implicit message in the discourse capitalism i.e. happiness is an object and no one needs lack[35]

> **P5** *"of course he is majesty the baby but he is also the majesty the baby sold by the capitalist world and scientific world and so he has a rough time saying no to the mother and the father, I'm not going to be only your jouissance I'm going to try to be myself so that means…he has a lot of symptoms.''*

P5 is expressing concern here regarding the place of the child in society which is taken up by other participants who query the type of subject that is being produced within an overtly consumerist culture.The power of a capitalist culture is in how it exercises a type of governance over its subjects. The data indicates that the discourse of capitalism organises aspects of the parent child relationship that inevitably leads to discontent. Concepts from

[35] Lack is fundamental to Lacan's concept of subjectivity. The discourse of capitalism forecloses the possibility of lack thus eradicating desire according to Tomsic (2015).

within psychoanalytic theory were drawn upon in order to illustrate what P1 regarded as an ideology within contemporary culture.

> **P1** "*Right and not only that, the superego, we can go even further, because the superego is the prohibition, yes, but it is also the voice that says enjoy. The superego in Lacan changes and the superego is, enjoy, enjoy, enjoy. So eh, the em, the stronger is the voice of the superego the more the subject is compelled to enjoy …. my view, if I had to choose one characteristic I would choose that, how they (*children) *are under the surveillance and the voice of the superego, enjoy, enjoy, enjoy".*

In Freudian/Lacanian theory the unconscious is the discourse of the Other[36]. The subject of the unconscious is structured in relation to desire of the Other. Above P1 draws attention to a powerful force within culture that compels its consumerist subjects to enjoy. The super-egoic gaze or 'surveillance' as P1 puts it, renders the subject a slave to his own satisfaction and to a faith in the knowledge of the free market that "the market knows best". Enjoyment is the modus operandi of the capitalist discourse. This cultural phenomenon was not the case in previous era's as P1 goes on to say;

> **P1 "***A hundred years ago the reasons to have children were very different right, the family needed children because they needed hands to work, to build, in the mines, in the factories, em, or they needed children to continue the genealogy of the proprietors of the land or those were the reasons to have children. Nowadays, children aren't needed, ha, so eh, so eh if you ask people why they want to have children its eh(…..)"*

The participant's use of a rhetorical question "*if you ask people why they want to have children its eh*" suggests that the desire to have children is driven by commodification rather than need. The void left at the end of the extract could be interpreted as an attempt to amplify bewilderment at the status of the child in society. Similarly, P2 spoke about his perspective on the place of the child in society:

> **P2 "***But maybe there is certain characteristics today as to why it is very difficult to say yes to desire, because to accept jouissance is too much. The characteristics, right, we all know that if a subject is repressed then it is something of desire that is under repression but in our time it is not that. It is not that repression, it is being under the excess of jouissance"*

Again, the links between cultural ideals promoting enjoyment and the relationship between the parent and children are being made by the participants such that enjoyment is what is being demanded. The use of the phrase '*in our time'* implies a discontinuity in the cultural ethos of a previous era. There is no specific alternative being referenced by the participant

[36] See compendium of terms.

but it can be inferred that the systems of governance that existed in previous era's demanded a different type of citizen or subject. Governance in contemporary culture centres around a subject that enjoys, a subject of *'excess'.* This however only promotes more jouissance, the child becomes bound up with all the other commodities and objects that promise enjoyment. In previous generations children served a clearer purpose within the family, more often to work or contribute to the family in some form. However, the conceptualisation of the child today is markedly different to the child depicted in previous historical eras.

> **P5** "*sure… at the beginning of his life he is of course the object of jouissance of the mother but that's at the beginning…the consequences are that the parents are asking for too much jouissance and the child is trying desperately not to be that. He has to take a distance and that's very difficult for him"*.
>
> **SMC "***Freud spoke about this over a hundred years ago, 'his majesty the baby', so it's nothing new in this sense?*'
>
> **P5** *"Yes, yes, no, well of course it has always been, even before Freud that the child was some narcissistic possibility for the parent of course of course, but what I mean is that the way we are making children today and the place they have in capitalist system means that the system knows how to make money with children, the way they are placed in this system is quite new…children were coming one after another and not when we wanted to wait, in fact there was too many children…and so now today you can wait all your life for the wonderful child that you are going to have"*.

The undercurrent of demand being placed on the child is significant here. The child as an object within the discourse of capitalism is one that brings or should bring enjoyment to the parents, but this position is problematic.

Another feature of how the discourse of capitalism shapes the child-parent inter relation was witnessed by P4. The following excerpt brings attention to the mediation of wellbeing through a consumerist culture and its consequences for parents and their children.

> **P4 "***I caught the end of a show on TV last week, it was a humorous show about commercialism and its effects and guilty mothers and so on and the mother goes to the pharmacy and buys things that prevents colds or this and that and there's this rather bland child sitting there while this exuberant mother fills the child with pills and so on, ye know I think there is something about that, we could talk about helicopter mothers and eh and so on. I think that ye know such things are culturally determined.*

The term wellbeing featured within the data and is subsumed here within the discourse of capitalism. Capitalism has commodified wellbeing to the extent that it is hard to separate it from the products, vitamins tablets and so on, that are such a feature of wellbeing today. The participants reference to the wellbeing industry highlights the power exerted over parents in

how they raise children. The mother's exuberance for the vitamins is contrasted by the blandness of the child who passively consumes the "good object" in the vignette. While P4 uses the word guilty to describe the mother's positioning via the wellness industry it also carries a covert consumerist message of enjoyment i.e., the mother feeding the child a commercial product. A degree of irony or sarcasm can be attributed to the participants use of the word humorous here as there is clearly an allusion to something more disturbing in this scene. The comments also highlight the inherent power of commercialism in the life of parents and children.

The machinations of power through capitalism took several other forms in how it exerted influence over the behaviour of children according to the participants. The data revealed how there was a growing concern among the participants for way in which the sacred spaces of childhood were continuously being invaded:

> **P6** *"well it's a very interesting time to be thinking about this stuff because if you think about it, it's a very contradictory time, ye know kids can't do anything in the yard in case they hurt themselves or they fall, you can't run you can't play rough games and so on…*

The participants drew attention to how children have found themselves increasingly under the gaze of adults who appear preoccupied with wellbeing yet, paradoxically, introduce measures that inhibit children's natural propensity for self-regulation and wellbeing.

> **P1** "*right, because when a child could run around and fight and throw stones ha, he could do something with the drive. This is important in childhood. It is how to build a circuit for the drive and to regulate the drive…I think that in our culture we offer all kinds of enjoyment to children but we also imprison them…*"

The view here is that children inhabit a social world where, in the interests of safety, even physical activity is restricted and controlled. A market for safety emerges with the legitimate power to organise behaviour in the name of 'health and safety'. This is imposed on children by adults who themselves must 'monitor' the children during play. This was not so much a feature of previous eras according to these participants. The major concerns lay in the ramifications of this form of observation and control. P6

> **P6 "***Children are full of libido and that needs to be treated and if you're constantly being told not to move, so a child, a child is in the classroom for 2 or 3 hours and then is told to stand still ye know and then later they decide to play violent video games (laugh) because that's a way of treating something, like aggressions, it's like anxiety.***"**

> **P4 "***So maybe there is something in our society that makes it more difficult for children to grow up".*

Previous generations of children were less a target of the market and as such were less an object within capitalism. The impact of capitalism extends further and further into the lives of children in contemporary western societies according to the participants for which they express a tension and dissatisfaction. The participants note how children are major consumers of entertainment in contemporary society. Many of the products marketed towards children are devices such as game consoles which have clear implications for the way they learn and how they relate to others. Children have a quantity of psychical and physical energy that requires discharge as part of learning how to become a healthy person and that if that energy is not discharged in traditional play is pursues another route according to the participants;

> **P3 "***there is clearly a thriving market for violent video games today. This is one way children sublimate libido but is the body implicated in this* (?) and *nowadays every child has their own screen"*

> **P6** "*you can be whoever you want to be online without the consequences".*

The devices rarely enable the physical discharge of libidinal energy. Instead, the energy becomes bound up in the imaginary or virtual worlds created by the devices. Capitalism has 'technologised' the recreational lives of children according to the participants which, they argue, leads to more aggressive fantasies and as such more psychopathology. The notable absence of a real and/or symbolic Other in this virtual space reduces the ways in which the drive can be regulated or 'circuited' as P1 has termed it.

Psychoanalytic theory holds that the libidinal drive has an energy associated with it that needs to be discharged and if inhibited will seek an alternative route. Technological devices such as gaming consoles are poor substitutes for physical play in childhood which leads to more aggression because they are incapable of "treating" libidinal energy according to the P1, P3 and P6.

> **P1** *"it is always very difficult to regulate the drive but I think that in our contemporary culture, on the one hand we offer all kinds of enjoyment to children but then on the other hand we imprison them. So I think that they have to deal with that in a very different way than in the old days".*

The use of the term imprison implies a sympathy the participant has for the child that is being constructed in this way. Prisons are controlled environments designed for the purposes of

continuous observation and segregation and an exercise in dominion over the body of the subject. Viewed in this light the child rarely escapes the gaze of an omnipresent parent, a gaze as the participant points out, that monitors for enjoyment. The use of the term "in the old days" suggests a certain nostalgia for a childhood of yesteryear, uncorrupted by this omnipresent Other.

> **P5 "***Em. The second thing is that families, especially in the wealthier countries, are having less and less children. Children tend to be very lonely and very looked at"*.

The object of the parental gaze is considered here to be an idealised child where childhood is understood as being all about joy and happiness, however, as Plastow (2015) asserts childhood is always a fantasmatic construct, frequently romanticised, "your school days are the best days of your life", but is nonetheless, as Freud (1905) describes it, 'a forgotten epoch', that can only ever be re-produced in speech and language. A culture that prioritises enjoyment will inevitably require objects for that very purpose, even childhoods. This can be recognised in how the gaze functions:

> **P2 "***demand is ever present, that is the parents', teachers, all those around them, always trying to educate them, always trying to tell them what's good for them, what they should be doing, what they cannot do"*
>
> **P5** *"all the time we say to them, you must eat this, you must go here, you must not do that and so on"*

The frequent use of the term demand underscores the perspective the participants held on the way power is exercised over children, the demand to behave or comply, to eat this or that and so on is a key feature in the life of children. In this way power is operationalised through a demand, generally for a performance of some kind.

Capitalism plays a significant role in how the child is conceptualised according to the participants. Capitalism is a force that goes far beyond the organisation of political and economic (neoliberal) aspects of life according to the data, it makes an object of the child, replete with notions of enjoyment, an excess of these things according to the participants, for which the term jouissance is used, *the child is an object of jouissance*. The following section reveals how the participants position the child in relation to the family.

The findings revealed how the child, reduced to an object of jouissance is unable to desire, as enjoyment pertains to objects while desire pertains to subjects.

5.3 The Family

The previous section addressed how capitalism permeates into the lives of individuals shaping the child and in his/her relation to others. In discussing the child as an object, a discourse of the family emerged as a significant aspect within the data. The literature addressed the radical changes that have occurred in relation to the family, particularly in recent decades. The participants reflected upon the consequences of these changes for the child. The following section reveals how the participants construct a version of the contemporary family with the child positioned as its nucleus. There was a consensus among all the participants that the child occupies a precarious position owing to the alterations seen to the traditional nuclear family[37]. In the traditional nuclear family, there is a structure of Father as head of the unit, mother as primary carer and the child/children as a product of the family that the parent care for and to whom they transmit their knowledge about the world. All the members have designated roles and positions of power to fulfil. However, as the findings below indicate, even when the family is organised into a unit consisting of these characters the balance of who holds power may not fit this traditional construction in the modern age. The relationship between the knowledge the child possesses, and the power associated with the position in the family emerged as significant issues within the data.

> **P5 "***Dolto used to say that the child must not be at the centre of the family. Before we were making families and then with child, today we have child to make families, you know its eh the other move, if I have a child we have a family, first let's have a child then we'll live together or we'll get married or, but first we'll have the child and Dolto used to say a child must not be at the centre of the family, he must always be, he is always on the side, the periphery'.*

The belief being expressed here is that the child has become the nut[38] that holds the family together, but this is an unsustainable position for the child which results in him becoming ill. In discussing the place of the child in the family P3 makes the following remarks:

> **P3** "*this position is one of suppletion, 'supplier' lets say. What does not work in the sexual relation of the parents the child is used as an instrument. In most cases I've seen, very literally, the child sleeps in between the parents. He is in the position of phallus there and this is very unsatisfactory position for everyone concerned,*

[37] The term nuclear arises from the Latin, nux, meaning nut i.e. the core of something. Nuclear or conjugal families have traditionally been comprised of a mother, father and their off spring. This has been the dominant form of family structure for much of western history, Berger (2002).

[38] Nuclear arises from the general use of the noun nucleus, itself originating in the Latin nux, meaning "nut" i.e., the core of something. *Merriam-Webster* Retrieved Oct 5th 2020.

especially for the child because the child is left in a state of excitation without a proper channel".

The lack of a sexual relationship, the non-sexual rapport, results in the child occupying the position of the desired object, the phallus but this leads to a state of excitation resulting in behaviour more typically associated with Anxiety disorders and ADHD. P1 makes the following remark;

P1 "T*his is something we know since Freud since Little Hans… "Little Hans who knew about the desire that had brought him into the world and he was suffering from what he knew even though he didn't know that he knew it, right..."*

The knowledge that is attributed to the child is unconscious knowledge that has a close connection to the sexual life of the parents or what Lacan (1959) dubs 'the sexual non-rapport' of the parents.

P1 *"Little Hans is suffering because he knows that his father is not, let me be a bit rude, no, Lacanian, that his father is not fucking his mother enough, right. And little Hans knows that, and he suffers from that".*

The conjugal family is a place where certain norms of behaviour are believed to exist. However, when the sexual life of the parents is unfulfilled the family unit and the dynamics alter in such a way as to make the child the inadvertent object of libidinal energy[39]. The family unit may be changing as society changes but the participants, in referring back to the case history of Little Hans (1905) reveals the position they, as psychoanalysts hold, regarding the child's position in the family. It is this unconscious knowledge that sets the relational patterns between the child and the others in the family. The participants use the term 'unconscious truth' in reference to this type of knowledge.

P5 "*we know they know without knowing it, they could not speak about it, they know exactly what is the problem of the parents, they know when they are going to feel guilty, ha, children are devils ha".*

This knowledge is used by the child in ways that parents often find disturbing, the child's knowledge of what is repressed in the parents leads P5 to suggest that;

[39] Freud discusses libidinal energy and its relation to sublimation, a process that diverts the flow of libidinal energy from its immediate sexual aim and subordinates it to cultural endeavours, in his 1923 paper on Narcissism where he points out that sublimation takes place "through the mediation of the ego, which begins by changing object-libido into narcissistic libido, and then goes on to give it an aim" (ibid, p.30).

P5. "*Every child is in the position to be the therapist of their parents"*[40].

This further emphasises the role the participants see the child as having within the family. To be the therapist of the parent is to imply that the child possesses has knowledge about the parent that is unconscious to both and determines their relationship.

> **P6** "*well I suppose that in terms of the complaint perhaps, there would be an aspect of that, that is related to the parent, so between the child and the parent there would be a particular dynamic and there would be a particular family dynamic"*

P4 makes reference to the parent/child dynamics through a separation with a vignette;

> **P4 "***they don't get the opportunity to have an existence that is separate to family life and so the child comes home from school and the parent says 'what did you do today' and the child says 'nothing' and the parents are very puzzled and say surely you must have done something after 8hrs in school, the child insists that its nothing but I think that it's a necessary thing that the child has to fabricate in order to keep something of that a bit separate"*

> **P5** "*there is less and less separation between the child and the adult*"

This description of the child being so closely monitored implies that separation is something that the child must struggle for. The depiction of the puzzled parent that fails to recognise the child's need for keeping things separate and the attempts to resist the gaze is described by the participant in such a way as to make this scene appear very familiar, 'this is family life'. The parent is omnipresent to the child. P6 makes reference to why this situation may have come about;

> **P6** "*With children nowadays we feel that they shouldn't have fears they should be happy and safe and we should know where they are and so on so there is no cut between the child and the other, everything has to be known about the child, there's no "back of the bike shed" haha".*

An idea that children should be happy and not experience fear is one the participant resists. There is a dismissive attitude towards this notion which would again appear to be a more recent or modern phenomenon, "*no back of the bike shed*" (**P6**) indicating a space where once upon a time something could take place that was beyond the omnipresent gaze of the

[40] The participant is making a very interesting point regarding the status of the therapist as 'someone who knows something about you'. In Lacanian psychoanalysis the analyst operates in the position of 'subject supposed to know', this is a catalyst to transference. The aim of psychoanalytic treatment for Freud was to make the unconscious conscious.

adult, another scene where different experience occurs, surveillance being a more prominent feature of children's lives today.

5.4 Psychodiagnostics

The study is concerned with how the participants conceptualise child psychopathology. Diagnostics is an integral part of this process and informs the direction of the treatment. This section of the findings will illuminate the participants approach to diagnostics within a psychoanalytic framework drawing on Lacanian theory. When speaking about broader approaches to understanding psychopathology all participants discussed psychology and in particular psychiatry to distinguish what is particular in the Lacanian approach to psychodiagnostics. A significant degree of resistance to the fundamental premise of psychiatric episteme was observed in the data. The participants opposed the term disorder when referring to children and their mental life. This resistance appeared as a fundamental tenant enabling them to formulate a subjective position as 'psychoanalyst'. A very critical appraisal of contemporary approaches to understanding child psychopathology and treatment also emerged from the findings within a consistent argument that patients (children and adults) integrity, individuality (subjectivity) is compromised by dominant models of health care. The data revealed a consensus regarding the idea that children, as patients within the contemporary model of mental health care, are 'made to fit with the diagnostic categories' for the purposes of treatment. This is antithetical to the approach taken within psychoanalysis. The following excerpts are illustrative of the position held by the participants regarding the psychiatric approach to diagnostics.

> **P3** '*hyperactivity is an industry because there is a cure for it, supposedly, a cure, the psychostimulants. Once the psychostimulants show to be effective, God only knows how they could prove that, it becomes easy to diagnose hyperactivity because you have a cure for that. Here the treatment precedes the disease ha, which is an aberration in medicine but that is how it works. In the same way depression has been elevated to being an entity in its own right because there are anti-depressants, if you have a treatment, you need a patient to fit with the treatment so eh, you get depressive people everywhere'*.
>
> **P2** '*Look, I have seen children with conduct disorder and hyperactivity that are not even seen by a clinician. The clinician reports and formulates a diagnosis and prescribes Ritalin on the basis of what those parents and teachers say which is extraordinary, it doesn't happen in other areas of medicine'.*
>
> **P6 '***Two things are going on here. Firstly, there is a solution for all but if you don't fit with that then you are the outlier that's abnormal. For psychoanalysis the subject is the outlier, the thing that will not fit'*.

The path between diagnostics and treatment appears to be paved by the pharmacological industry in the first excerpt highlighting the influence of the commercial aspect of mental health i.e. the proliferation of psychopharmaceutical products. The idea that there is an industry around certain forms of psychopathology is clearly a disturbing one and P3 challenges the ethics and validity of this, '*God only knows how they can prove that'*. There is a degree of bewilderment with the practice of allowing a knowledge of a disease entity override the voice of the child in the excerpt. This underscores the belief the participants have regarding the way certain approaches to mental health function. The implication is that knowledge is put to work in such a way that renders the child (as subject) redundant in the overall diagnostic procedure. The participant is also alluding to another feature of psychodiagnostics where children are concerned. If the child is absent when the clinician is formulating a diagnosis and prescribing medication, then who is the patient here, who is being treated in this situation?

P6 comments regarding the subject being an outlier goes further to reveal how psychoanalysts engage in the process of diagnosis. The comment highlights how psychoanalysis is concerned with the various resistances, antagonisms and revolts that, despite often being the source of discontent for the child and those around the child, represent subjectivity. While psychiatry may attach the term symptom to the forms of resistance or revolt the child exhibits in his behaviour (*I have seen children diagnosed with conduct disorder…)* the symptom, according to the participants, can be understood as representing something in the psychical life of the child that is relational as opposed to organic. P2 offers the following perspective:

> P2 "*with science everything is known, this means this. The signifier*[41] *loses its evokicity (*evocativeness*). We are living more in a time of the clinic of the object than a clinic of the subject. It's the organ* (brain*) that's the problem says neuroscience. So you tell to the mother, no your boy is a good boy but he has organ failure haha, you see, so the mother says phew, it's not me eh*"

The participant contends that science, which one can assume refers to hard sciences and social sciences, implies the belief that all things can be known as long as we look closely enough. Looking at children from a scientific perspective is the domain of developmental psychology which provides a template for normality and abnormality. This is at odds with

[41] Lacan draws upon Saussaurean linguistics to illustrate how the signifier is very loosely bound to the signified. Language is full of equivocation. The unconscious, Lacan argues, possesses the structure of language. Words as signifiers can represent several different things at once. This is somewhat at odds with a positivist approach adopted within many of the psy-sciences.

the position adopted by the participants. P3 is noting how the distress of the parent and teachers appears to be the primary concern of the prescribing clinician.

> **P4 "***We know particularly with DSM, ICD that symptoms are basically behaviours. I think with psychoanalysis that we need to actually move away from that to allow the symptom to be constituted and to unfold in analysis"*.

Moving away from a behavioural approach and towards a more interpretive model requires a theoretical framework that enables different ways of conceptualising symptoms. The following excerpts reveal the direction in which the participants go when formulating a hypothesis for diagnosis.

> **P1** '*disorder is a negative category, a good rationalist approach is to try to find an order in what appears to be a very established manifestation of a subject, it's not a question of disorder which is a negative definition and doesn't tell anything'*.
>
> **P3** '*I can tell you one thing, a good phenomenological approach has to start with some kind of a hypothesis as to what is manifest ok otherwise we lose track of even what is in front of us. So, there is the whole question of what is behaviour ( ). There are behaviours for which even behaviourists have no interest. Consider dreams ( ). We have no access to these things except for what our patients tell us, but we know they have them the same way they have parapraxis. We can observe them but they mean nothing for some clinicians. The drawings of a child, we regard them as his language not just graphic representations you see'.*
>
> **P2 '***I have an idea of the diagnosis, a structural diagnosis not a phenomenal diagnosis not from observation, how do you say (inaudible) <u>behaviour</u>, no. What he has talked to me and what is his position in language ( ) in the desire, in the desire of his parents. So, I need at least three sessions and I say to the child I need to see your parents and then eh ( ) I give sometimes eh ( ) dangerous .. eh, a prognostic'..*
>
> **SMC '***prognosis*?'
>
> **P2 '***yes, how long it may take'*
>
> **SMC** '*you do that*?'
>
> **P2 '***yes, I explain. If he is a psychotic child, em, the image of the house which is built on bad foundation and then it could take a long time and I say to the parents. If not psychosis, then I say okay, I think I can do something, I hope, it will not take years and years. That is all I say, voila, that's it so I give diagnosis and prognosis'.*

The psychoanalyst attends to something different. Something that doesn't lend itself to the form of observation that psychiatry engages in. There is a different form of empiricism within the discourse of psychoanalysis, particularly where diagnostics is concerned. P3 suggests that by attending to other types of behaviour, the child's drawings or dreams, psychopathology becomes recognisable, and a diagnosis can be achieved in this way. The

child becomes subject to an entirely different type of gaze when viewed through the lens of psychoanalysis. Listening takes on a different form in the encounter, '*what he has talked to me…what he is in the desire of his parents'* P2. Attending to the speech of the child allows the psychoanalyst to identify the place the child has taken up in relation to the other which brings a unique and specific meaning to the symptoms. This is something that the participants believe differentiates it from other mental health models. The next section of the findings concerns the significance of symptoms within psychoanalytic theory and their place in informing the participants view of subjectivity and psychopathology in childhood.

5.5 Symptoms and Psychoanalysis

This category of discourse addresses the significance of the symptom in the theory and practice of child psychoanalysis according to the data.

Symptoms hold a privileged place within psychoanalytic treatment leading participants to contest that a symptom can only ever be properly constituted within psychoanalytic practice. The symptom must be something that the analysand identifies not what the clinician identifies. Symptoms hold a certain truth according to the participants which can only be articulated through the work of psychoanalysis. The data also revealed the extent to which culture was implicated in the participants conceptualisation of symptoms. The belief that symptoms were a direct response to social life and contemporary culture was held by all participants. However, there was a degree of tension evident in how the participants saw culture as playing a role in what were referred to as 'contemporary symptoms in childhood'. The following excerpts reflect the highest regard the participants have for the place of the symptom in their clinical work and how this aspect of their work situates them as mental health professionals.

> **P5 "***the symptom is eh very big deal for us because there is a lot of ways to read the symptom because it is always, how can I say that, it's always telling the truth, it's always telling something true*.
>
> **P1** *"Well em, the most important thing that psychoanalysis has thought me is the importance of taking the symptom seriously ( ) and taking it seriously as a means of living, a means of doing something with life so em, I think that in a culture that is obviously, that is em, that has as an ideal the erasing of all symptoms".*
>
> **P4** "*psychoanalysis does not promise happiness, the best society, but it does offer dignity, the dignity of the symptom and I find that overall really so ethical that I cannot think there is a better contribution to a world that is full of symptoms and the more it wants to erase them the more symptoms that are produced"*.

> **P6** [in juxtaposing her clinic with other models of care] '*so the intention is to treat the child who has an illness by removing of the symptom but what this prioritises is the clinician's agenda, the clinician decides what the symptom is, what to call it, making the illness is the main concern but the child, the subject is left unheard*'.

The first excerpt highlights the value symptoms hold within psychoanalytic practice. Truth is the concern of the participant. The attempt to lead the subject to the articulation of this truth can be considered the aim of the treatment as discussed in following category. P5 appears to be referring to the truth as something singular, a truth that is unique to each subject. Foucault holds truth to be an event in history, something that occurs or is produced by technologies[42]. P1 notes the relevance of the symptom to life itself, as a *'means of doing something with life'.* Symptoms, in a manner akin to discourse itself, enable and constrain forms of living. The participants contest that there is a collective resistance to symptoms and attempt to erase them in society. To erase them would obviously mean dismiss the truth of which they speak as truth finds some expression via the symptom. P6, in critiquing clinicians who aim to remove the symptom notes how this common practice results in effacing the subjectivity of the child. The following excerpt echoes P6's comments and reveals how symptoms unfold in psychoanalysis.

> **P4** "*I think that symptoms, in psychoanalytic terms, can really only be understood as such once it emerges through the transference and can be articulated that way, otherwise the symptom just ends up being like a psychology symptom, it has something objectifiable in it, a deviation from the norm or in psychiatry where it can be located as part of a category or criteria for a disorder".*

The position taken up by the participants concerning the status of the symptom in psychoanalytic work operates in opposition to that of psychology and provides a resistance to how psychopathology is understood by the dominant models. P3 highlights a fundamental difference between the medical and psychoanalytic conceptualisation of symptoms.

> **P4 "***A symptom cannot be a behaviour. A symptom must be ultimately something that is articulated through language, whereas a behaviour is something that someone else observes".*

The distinction being made concerns the form of observation being applied to the child. P4 contends that symptoms are bound up in language and as such they require another to listen.

[42] In Technologies of the Self, Foucault (1988) describes his own work as a critical enquiry of how humans develop knowledge about themselves (Arribas-Ayllon and Walkerdine, 2017, p.116). Knowledge is something that comes to us through particular 'truth games'. He describes technologie(s) as a matrix of practical reason. Psychoanalysis can be considered a 'technology of the self' according to Foucault.

P4 *'I think we can really only talk about a symptom, in psychoanalytic sense when a child begins to articulate it through language, otherwise we fall into the category of the symptom being something in a psychiatric sense*'.

P3 '*but the symptom is not necessarily eh, it is not an epiphenomenon, it is a phenomenon because we can speak of symptoms only if something is visible but we know very well that symptoms are not always visible or that what is visible is often deceptive…'*

P5 '*The symptom cannot be touched directly, its only when the child thinks he can talk to you about but on his terms, otherwise if you touch the symptom directly then you're gonna adopt a pedagogical approach like everyone else'.*

Rather than being features of a disorder, symptoms reveal the specific order in which the child is bound to the Other. The participants refer to psychical structure (neurosis, psychosis, perversion) in describing this underlying order or relationship with the Other.

P6 '*so in a way the symptom may be something of a message to the Other that can be deciphered, a neurotic symptom. In terms of psychosis the symptom does not possess that same kind of meaning, in this instance you are trying to treat jouissance not the subject. You are treating the body, trying to allow some knotting to occur'*.

P2 '*well yes, there is behaviours that are not like symptoms. They are not like metaphors. A psychotic child that bites is not the same meaning as the neurotic child that bites, you see there is a structure that is there and the biting must also be understood in relation to the structure'*

Deciphering the meaning of the symptom must also include taking into consideration, structure and how the child is positioned in language.

Participants were asked whether they had observed changes to the types of symptoms children presented with over the course of their career. The data revealed both the importance attached to culture in the formation of symptoms and the collective resistance to the discourses that shape contemporary versions psychopathology.

P2 "*children coming here, it's not about the symptom based on the signifier – on the place they take in the desire and jouissance of the family but it is because they suffer from being "too big intelligence" or something haha or something in their neurons gives them (inaudible) or something like that, its so stupid"*.

P1 "*contemporary symptoms mirror the subjects relation to the Other".*

P2 notes how the explanations that are being provided for the causes of psychopathology, "*too big intelligence*" (hyper brain), have become a more recent feature of psychiatric and psychological diagnostics. The participant is very dismissive of such explanations. The attempt to marry intelligence to pathology is problematic and to the participant, seems *stupid*.

The place of the symptom in psychoanalytic discourse has not changed according to P3. The changes that have occurred are at a cultural and social level, particularly in how technological advances enable new possibilities for individuals. P3 is firstly responding to the question regarding new forms of psychopathology before adding his understanding of what has changed.

> **P3** "*In our case of the unconscious we can say symptoms, there are not that many symptoms, Freud described them all. They have not changed in 100 years, this idea that there are new symptoms I think is completely false. There are no new symptoms"…*
>
> **….** *"the eating disorders, anorexia, bulimia, they may be more prevalent, it is true that culture promotes them, fine, they have always been known, since antiquity. Now all this business with gender, the transgender, sexual dysmorphia, they have always been known. What is new is how the technology assists the ( ) the hormonal technology. Now they are being promoted ( ) that's very interesting. A few more or less intelligent people in the universities have launched movements, which is fine okay, in terms of human rights, the recognition of people who want to be non-binary and not included in categories of male and female and you know Facebook has introduced 52 categories of genders so that nobody is excluded, and no one is offended. Well, its very interesting, the approach may be new, but the pathology is not modern*".

What psychiatry chooses to call psychopathology is largely dependent upon social and cultural attitudes that change over time according to the participant. Eating disorders and questions concerning sexual identity and gender have always been with us. They merely become pathologies, abnormalities depending on the cultural ideals of different historical epochs. The influence of culture may be recognised in certain pathologies such as eating disorders. Technology such as hormonal treatments may enable things that were not previously possible. This evokes the capitalist discourse that was discussed in the previous section regarding artificial insemination. The participant goes on to reveal how powerful institutions also promote gender diversity. The symptoms are nothing new but the sense we make of them are entirely owing to cultural factors. In discussing contemporary forms of psychopathology and symptoms in childhood P4 also chose to introduce gender as a means of conveying the changes that have occurred at a social and cultural level.

> **P4** "*I suppose one thing that does occur in practice is that, in a certain way, I'm not sure what you would call it, through political correctness, even the way the law is being reformulated ( ) let's just say regarding children's gender dysphoria. The law has made it easier for younger and younger adolescents to receive hormonal treatment without the supervision of a child psychiatrist…obviously when an adolescent is in their early to mid-teens it is difficult to perceive of a pathology arising without there having been some baring from the parents. There is an*

expectation that services are required and even to some degree and expectation that we will play the game".

Two things are occurring here. The participant is suggesting that providing a technologically assisted form of transition only addresses the demand for physical change to occur. However, by reducing the subject to a purely biology entity does nothing to address the psychological aspect of gender identity. For this reason the participant is dubious about "*playing along*". The participants style in addressing the issue of gender in society today also suggests a degree of caution when discussing this issue. The use of the terms "*through political correctness*" and "*lets just say*" enable a certain degree of distance form what is being discussed. However, the participant calls attention to the absence of the psychiatrist in overseeing this aspect of mental life while using a psychiatric term recently introduced into the DSM, gender dysphoria. This was introduced in place of gender identity disorder to denote the fact that gender itself cannot be an object of disorder, rather the level of distress associated with it (dysphoria) is the real object of concern to the psychiatrist. The discourse of psychiatry is being inferred here (paradoxically, as psychoanalysis is in opposition to the practice of identity regulation) as a potentially regulatory body where the vantage point of the medical gaze would appear to be required on this matter according to (P4).

Overall, the participants expressed a great deal of frustration at the cultural implications for psychopathology in a contemporary context. A paradoxical effect of how the discourse of wellbeing operates was apparent throughout the data. P6 expresses this in the following excerpt:

P6 "*because it all comes under the aegis of wellbeing and the idea is, and it's quite delusional, it comes from the idea that if we know a thing we can change it, in other words, if we tell a child you need to eat these things and then if you don't eat these things* [a shrugging of the shoulders] ( ) *and that's nothing to do with the unconscious <u>but</u> what it does <u>is</u> create eating disorders, it creates the very thing it sets out to stop".*

A paradoxical situation occurs whereby the culture imperative to enjoy a life free of suffering only results in producing more psychopathological problems.

The following category is concerned with how the participants go about conducting their work with children.

5.6 Consent and Demand

The following category of findings details how the participants discussed the issue of consent when working with children and its relationship to demand. There was a consensus among the participants that working with children entailed greater complexities where the demand for treatment is concerned. The word demand was used to describe what they regarded as consent to treatment. All participants made point of the fact that children are always accompanied by an adult, generally a parent and frequently the demand for psychological services come from the parent. If the parents demand is made the priority, then no psychoanalytic work can be done, it would remain to be purely pedagogical. Psychoanalytic work requires the analysand (child or adult) to consent to the work which is manifested in what the participants call a demand. The data also reveals how some techniques are required when working with children to bring about a demand but on the child's terms. The following excerpt reflects the initial thoughts of all the participants when asked about the differences to conducting their work with children as opposed to adults.

> **P4** "*Well I guess, first, is to say that children, by being children don't come alone. They are brought by somebody and generally that's their parents and in the first instance there's a demand regarding the child and it's a demand by a parent or by someone else other than the child, so we have to work through that demand from the parent to be able to get to the child"*

In speaking of demand the participant is clearly distinguishing the child from the parent and highlighting the idea of how in "*working through the demand of the parent"* he is able to get to work with/for the child, but this cannot occur without some involvement from the parents.

> **P6** *"there has to be a space for the parent to be heard as well, not necessarily with the child, again its one by one".*
>
> **P1** "*So, in other words the treatment is not about them* [the parents] *it is not in the parent's name but in the child's name"*.
>
> **P3** "*The child is in trouble but the adults also, as a rule they are in trouble also*".
>
> **P4** "*It difficult to say, em, ye know, something that comes to mind is that we have difficult or even impossible demands put on us by the parents that may put in jeopardy any possibility of working with a child".*

There is the recognition that the presenting problem is something that also effects the parents and that they should not be ignored. Using the term "*as a rule*" is a reminder of the understanding that he has regarding the aetiology of the symptom and its relation to the family and the importance of keeping a place open for them in the work. The lines of

separation between the parent and the child during treatment is something the participants speak about as being a crucial part of their work. The parents are implicated in the work yet must also remain removed from it, "*again, it's one by one*". A recognition that the demand the parents have and the understanding they hold regarding the problem as being very different to that of the child was a point observed throughout the data. Conducting the treatment in the child's name infers an ethical issue regarding the position the participant takes up. In the following excerpts the participants speak about the ways in which they manage demand and how relevant demand is to the work of psychoanalysis.

> **P1** *"It is important that I set aside the question of demand* (parents) *otherwise the subjectivity of the child will not appear, children are always very demanded"*.

The idea being expressed here is that demand, when emanating from anyone other than the child, becomes an obstacle to working psychoanalytic.

> **P2** "*I try to make very little demand. I hope that my demand is close to the child's demand ( ) what he sees, what he wants. It cannot be the other way around"*.

In the following excerpts the participants describe how they recognise the child's demands and when there is an absence of a demand how they go about provoking a demand.

> **P6** *"I don't have strict rules about how I meet the child. I try to take into consideration where the child is at, em, if, again, if there is consent. The consent from the child to be in the room with me and speak and to I suppose take the time and invest the time to try to understand what this all means…the fact is that it (consent) is tricky and there is something around whether there is a transition from the demand of the parent to a demand from the child for the treatment".*
>
> **P1** "*I have to get to know, I have to have the child to construct an interpretation of what is happening to him or to her. If I cannot get that to start happening it's very difficult to start working, really working"*.
>
> **P3** *"From the child, again, it's one by one, it's very difficult, to say that this means consent but you know that when a child begins to speak in a particular way, that it's in their own interests, very often you can hear that".*
>
> **SMC "***is there a way to bring about this demand?"*
>
> **P5 "***yes, yes. When you meet the child he must be surprised by you. He meets lots of people, his teacher, his doctor, he's used to seeing these people with his parents and to hear those people speak about him, eh, with the parents. So, the child says, this is something I am not going to do….they all* [family] *come to my office and sit in front of me but I direct myself to the child. 'hello I know your name is maria, your mothers says" ( ) then mother tries to speak and I say* <u>no,</u> *please. We will speak after. So the child says 'I am coming because eh, I am not doing my studies ( ) eh and they tell me I must come to meet the psychoanalyst'. Well, eh, I say no, ( ) 'well I think you must*

give me the address of your teacher and I think the teacher must come and see me' [laugh]. They are surprised, the whole family, you see. The child knows you are going to be the analyst of that child, not someone else".

P5 juxtaposes how the child, in most clinical settings is an object that is spoken about by the adults but her approach is to put the power back in the hands of the child by engaging him directly and restoring autonomy to him. Similarly, P6 is attempting to gauge the position the child is taking up in relation to the demands of the adults that surround him. In order for an analysis to begin there must be some consent from the child without which one can barely engage in some form or 'pedagogical work' according to (P1). This issue was discussed in different ways by the participants. The participants point out how part of the aim of the work is to restore to the child their autonomy as subjects of desire or 'desiring subjects', a position beyond that of passively acceding to treatment.

P1 *'its important in that first appointment that something of the truth, the demand of what they are coming, sometimes it's more difficult he* [the child]*says 'I don't know why I am coming' and you know if he's nine or ten its difficult so; "oh, you're really a good boy, your mother says you are going to come with her, you are going to meet somebody, a doctor" and - he says 'yes' - , and eh, I say "you say nothing, you just come"? Oh, I say "you are really nice eh",* [laugh].

P5 and P1 are referring to the importance of surprise, taking up a different position to other adults and trying to provoke a curiosity in the child. By provoking a curiosity, a transference may be established. The idea that he must have some knowledge of his situation and also some autonomy in his choosing to attend the consultation is relevant to how the participant positions the child in relation to the work. The child is asserting himself in the scenario, exerting power in the form of a resistance. P2 attempts are to circumvent that power. One can notice how this idea of knowledge and power becomes something that is played with in the beginning. Both child and analyst working out their position relative to one another. There is also the recognition that treatment is something that cannot be imposed upon one who does not consent. Rather, where there is a resistance, the analyst can only entice the young subject.

P1 *"yes, well em, to reduce the omnipotence of the other then sometimes it is very important to do that, there are certain manoeuvres that one can do. The first is to not place yourself as an omnipotent other, that is always important. Second of all is to make very clear to the child that you are not going to take the side of the mother or parent".*

The term transference was used to identify whether there was the possibility of working psychoanalytically with the child.

> **P4** *"One of the markers that I use is that if you have a child that is unable to develop their own symptom then they are unable to develop that transference so that if they do a drawing in a session they may insist on taking that drawing out to mum, they cannot leave it in the room. It can't constitute the work that they do with the analyst in the transference to be analysed. When I was at a catholic primary school many years ago we had to write on the top of each page, something, I can't remember precisely what it was but it was something like AMDG, but anyway what it meant was that all my work was done for God yeah, and so it was a bit like that for that child, all of that work is done for mum and can't be done in the transference and so its maybe not the time for that child to enter into treatment. The work has to be done with the parents at the preliminary stage to make that even possible".*

The marker refers to the way the child takes up a position in the discourse of the Other. With this vignette the participant argues that the child who cannot work within the transference cannot commit to the work of analysis, the child remains identified with the parental fantasy. The work must be done with the parents in such a case. There are links between the idea of demand and transference. Power and knowledge are integral components to both of these concepts in psychoanalysis. The application of knowledge and power brings about demand and facilitates the treatment.

5.7 Working with young Subjects

This category was drawn from the data which came, in large part, as a response to the question of how the participants conduct their work with children. Several participants chose to interpret the question in such a way as to allow a theory laden response in which they drew upon certain fundamental principles of psychoanalytic theory. In doing so they also demonstrated what they held to be ethical principles regarding clinical work. Other participants interpreted the question to refer more to the practice of psychoanalysis with children and provided responses that revealed features of the different methods used when working with children. These two separate approaches to the same question brought about some insight into how the participants addressed the child in both theoretical and practical terms.

> **P4** *"Well I guess eh, as an analyst, I would consider that one doesn't work with a child but with a subject. So, the child is only a provisional category or designation. The work as an analyst is with a subject and allowing the emergence of the subject. In that sense the work with a child is not particularly different. Ultimately the treatment is conducted through speech".*

There is a contention being made is that speech is the primary method for addressing the subject. There is no child in analysis only subjects. There is an avoidance of mentioning the use of toys here, instead curtailing the question to something more theoretical. P3 makes a similar remark.

> **P3** "*There is no great difference in the analysis of children than of adults, children and adults are not psychoanalytic concepts. We work with subjects, 'parletre', speaking beings. All of them are speaking beings. Even very small children are speaking beings for the very fact that we speak to them*".

Both responses are couched in theoretical and/or ethical terms. The repetition of terms *speaking beings* and *subject* represents the speaker's intention to ground their position firmly within the discourse of psychoanalysis. The return to theory as a means of describing the practice and conduct of the work is unequivocal and the use of the pronouns "*we*" and "*one*" allows the speaker to take some personal distance from the question, safeguarding the more precise details of their practice. P1, P2 and P5 considered the place of the child in analysis in different terms.

> **P1** *"I wouldn't say that I conduct child cure or treatment very different from an adult, eh, I think that the thing with the child is that the child does not allow you to sleep...in a way…I am joking of course…the child is often very active and you have to, and your presence has to be really there".*

P1 goes straight into speaking about how the children she works with effects something within her, her attention and energy levels, "*they don't allow you to sleep*". This is followed up with the idea that there is a much greater degree of activity in the work with children. The libidinal energy of the child is far more present in the work with children requiring a greater "*presence*" from the analyst. There is also a distinction being alluded to here in terms of what can or cannot be done, "*they don't let you sleep, in a way, I am joking of course*" "sleeping" is not an option for the analyst of children. P2 contests that there are differences that apply to working with children that don't apply to adults:

> **P2** '*it's a big question, a very big question. My reply is no, it's completely different. Eh, hear me well…I guess it's important because it is not only always a teaching experience for me, it is also something – I am well with them. They teach me, they are more serious'.*

P2 highlights how the experience of the work affects him, "*I am well with them".* There is clear consideration being given to the relationship between the analyst and the child. P2 also contests that the work with children is *"completely different*" to adults. This contention is followed by the comment that more can be learned from working with children. This

distinction alters how this participant positions himself with regard to his own knowledge in the process of child analysis, "*they are more serious*", may at first glance seem counter intuitive, however, P2 in describing how he allows the child to speak on his or her own behalf in the initial sessions explains;

> ***P2*** *"Sometimes the child explains, and it is alarming, it is often very different to what the parent's idea* (of the problem*) is. So, the first session I am just listening to the signifier, master signifiers of the child. What is important for him, where he is"*.

Positioning the child at the centre of the discussion and allowing the child to articulate themselves from that position can reveal uncomfortable truths for the parent, it is often more serious as P2 suggests because the knowledge of the child can disturb the adult in their understanding of the child's problem;

> **P5** "*A child I saw once, when I asked him why he came, he says I come because I just hate my little sister, she is awful, I want to kill her, then the parents say 'come on … no … not at all… it's not the reason, you know very well the reason, you're a very good little brother – big brother with your little sister, no its of course not the reason' ha ha. So it was very interesting because the parents were telling him, no, no, you know why you come, you come because you don't sleep at night and it keeps us awake and its terrible and he says no, no, no it's my little sister - ha ha. So you see, I say to the parents, maybe you don't have exactly the same idea. He's coming to the treatment because his sister, he's coming to speak about her as such. So everybody is surprised, its important in that first appointment that something of the truth, the demand of why they are coming*".

The data indicated a consistency among all participants that the knowledge of the child was of paramount importance to the overall treatment. There were variations in how the participants addressed the question of knowledge in relation to psychoanalysis with children which can be looked at in two ways: knowledge about the child versus the child's knowledge. In the following excerpts the participants speak about how their knowledge, as Lacanian psychoanalysts, inform their clinical with children. These excerpts also reveal fundamental distinctions between child and adult work.

> **P2 "***When the adult goes to see the analyst, usually it's because he is too alienated by his ideals. He thinks he must be a good man, must have to work, must be courageous for his wife and then the work in psychoanalysis is to deconstruct all these ideals…. For a child, when he's little, his identifications are still not there so he's constructing his subjective position. And then not only with the psychoanalyst will he deconstruct his identifications but with the psychoanalyst he will construct his identifications less alienated, other identifications and usually the work with the child is going… to … how you say…Its more work em, I'm ashamed to say, to tell you that, it's a kind of work of constructing, of going to a position, of a just* (morally

right) *place of his desire and then also one thing remains open for the child, the thing that is remaining open is what Lacan calls, the non rapport sexual*".

The shift from P3 & P4's suggestion that there is little or no difference between the analysis of the adult and the child is challenged in the above excerpts. Three participants highlight how a knowledge of sexuality alters the subject and how the 'non-sexual rapport'[43] is what must be met with at some point in the life of the child. The child is a child precisely because this illusion of a rapport between the sexes exists. Many examples of this can be found in children who deny or obscure themselves to their parent's marital break down or separation, often a material fact but one that can be erased by the fantasy of harmony between the couple. P2 offers a vignette to this effect:

> **P2** "*usually I see, the child has the idea of harmony between the father and the mother even if there are lots of fights, he has the idea and em, I had a child whose father was in prison because he had killed his mother, the child was 6 and it was incredible the way this child talked about this man. He said was a very good man and that he loves his mother a lot and eh, lots of things that was so incredible and so disharmony is uncharacteristic of childhood I think*".

The vignette underscores how attentive the participant is the way in which knowledge can be used in the life of the child. The child's fantasy regarding his father veils the horror of the real situation in this vignette, the child disavows the reality. A distinction can be made between knowledge of the ego, as in what is communicated by the child to the analyst here (fig 3) and what the analyst is concerned with, the unconscious knowledge that the child denies even to himself.

5.8 The Aim of the Treatment

This category distils further what the data reveals regarding the aims of the treatment with young subjects and draws particular attention to the aspects of the theory of Lacanian psychoanalysis that the participants deem most important in carrying out this work.

The following extracts come in response to the question regarding how they think about the work they do with children.

> **P2** *'Eh, hear me well. I think that it is better that a child goes to me to encounter a psychoanalyst than a psychotherapist, why? Because the psychoanalysts have no*

[43] The sexual relationship or sexual rapport is a subject Lacan takes up in seminar 20, *Encore.* In his thesis on the relationship between the sexes he argues that there is no symmetry between lovers, love is an illusion designed to make up for the absence of harmonious relations and sex, as something rooted in the Real is opposed to sense which, by definition is opposed to communication and relating. As such there can be no sexual rapport.

idea, moral idea what the child must become, because he has his own analysis then I think it's better to see the psychoanalyst because the therapist sometimes they have their own ideas'.

Psychoanalysis does not have the same ideals or even beliefs regarding normativity as those found in other models of psychotherapy, nor is it a moralising practice according to P2. This is what this distinguishes it from other discourses, educational discourses, medical discourses, and psychotherapeutic discourses. There is a contention that having gone through one's own analysis all the imaginary ideals of right or wrong, what a child should or shouldn't be, and how he should or shouldn't behave become implicated in the work, less a feature of transference. Another implication is that therapists have their own ideas regarding the child. He separates psychoanalysis from psychotherapy where therapy is about something else, something on the part of the therapist. The aim of the work can be to create a space for the child facilitates a form of separation form the parents

P1 "*it is for the child often how to make the other a little less consistent, a little less omnipotent so that he as a subject can appear".*

A separation is needed to allow the child, as subject, to appear. P2 makes indicates how this is brought about.

P2 "*The work with the child is to help him make his way from the phallic object to the signifier you see, I am important for my parents but I have to, to play with my own desire, viola.* [laugh] *, I speak too much".*

The idea that a transition takes place in analysis rather than a cure is being implied. In this sense the aim of the work is not so much about therapeutics but transitioning from one position to another. The participant depicts a version of himself in which he facilitates this movement out of a position of being a certain type of object and into a place where desire is established on one's own terms. He is taking up a position as curate to psychical development. P5 uses a similar description in terms of the aim of psychoanalysis with children.

P5 "*Well, I think the first think is to say that I am working with the signifiers, with the signifiers of the child you can see what way he is in language ( ) then you can begin to work with the symptom. I mean you can begin to see how that symptom works for the child. To make some light upon this, to let him see this. With the child you can let them choose, they have much more choice than adults"* [laugh]

The idea that the child has more choice or freedom of self determination is clearly something that the participant enjoys about working with children. To make some light upon this can

mean to shed some light upon this and also to make light of the situation. P5 infers something of the aim and the approach i.e. to be equivocal with her interpretations. This is precisely what allows for choice. A technique that represents something beyond what is spoken, a dispositive, an intransitive knowledge of the subject of child psychoanalysis. The idea that the work goes beyond what is articulated in language was something inferred by other participants.

> **P4** "*there is something that cannot be touched by language. It is present in the symptom in the form of jouissance, it is the unassimable component to the symptom*"
>
> **P6** "*Events that accompany this organise the way it is experienced, a neurotic child experiences things one way, an autistic child another way".*
>
> **P1** "*there is always something left beyond. Something in the real. Something that cannot be taken up, something 'inscrutable', unfathomable Lacan says 'the unfathomable position of being'…meaning that we cannot put all the cause of ones neurosis in the events of his life. We are not psychologists so we cannot say that A happens then we have B as a result. No. Between A and B there is something that is unscrutable that you cannot, that is on the side of being*".

The limits are the limits of language according to these two participants. That something escapes language and remain beyond signification and conscious articulation is precisely what the analyst sets out to address, the Real. However, in being scarcely capable of addressing the Real in language the analyst relies on a tacit knowledge or what Foucault referred to as "dispositifs".

> **P4 "***psychoanalysis offers the child the possibility of ye know of allowing the subject to emerge rather than reducing things to usual sorts of things. A lot of the theories that are about these days, attachment theory, affect regulation, all that sort of stuff, it's all no different to what the man in the street says, the need of a mother, a father, keeping the child under control, but I think that psychoanalysis offers something quite different and something that actually is able to, by virtue of which, the child is able to take up a place of their own singularity.''*

5.9 Summary of findings.

The findings reflected the research question and its objectives. The discourses that comprised the participants approach to addressing how child psychopathology is conceptualised were presented in accordance with how the data was analysed. It is clear from the findings that the participants take a unique and radically alternative view to how

the more dominant models of mental health care conceptualise the child and conduct treatment.

Chapter 6: Discussion

6.1 Introduction

The study sought to address the question: How Lacanian Psychoanalysts conceptualise child psychopathology? This chapter discusses and interprets the findings in line with the aim and objectives of the research. The findings drew attention to discourses drawn upon by the participants in describing their work with children. The findings made visible how the participants constructed a version of the child informed by psychoanalysis, the contemporary social world and the family unit. Psychopathology was discussed in terms of understanding symptomatology, psychical structure, and contemporary culture. The participants discussion of psychoanalytic treatment was organised around an understanding of the differences between the child and the adult clinic, the role of 'demand' when treating children and the aim of their work with young subjects.

In providing accounts of their work the participants frequently referred to a cultural shift that has occurred since the inception of psychoanalysis over a century ago. Economic globalisation and a more recent trend towards neo-liberal politics were identified by participants when discussing subjectivity, contemporary childhood, psychopathology, and their clinical work. The participants shared the view that the socially constructed version of 'the child', is one drawn predominantly from a developmental discourse but organised by neoliberalism and consumerist discourses, in other words, the creation of a linkage between ages and stages of childhood development with performance and modes of enjoyment. A consequence of this, as the findings suggest, is that the place of the child in society has been radically transformed by these political and economic shifts. The participants point out how a cultural or a 'super-egoic' imperative to enjoy shapes the social bond[44] between the child and the Other. Capitalism has, according to the participants, several consequences for people who function under its reign.

This chapter begins by revisiting the literature in light of the findings. Section 6.2 discuss the neoliberal depiction of the child and childhood, revealing what the findings indicated regarding the child as consumer and an object of enjoyment consumed by contemporary culture as outlined in section 5.2. The child's place within the family emerged as a significant issue and is discussed in the opening section along with the altered surveillance of children

[44] Where speaking of the social bond the participants frequently use the term discourse. See compendium of terms.

and the consequences of how they play and how they develop. Section 6.3 revisits what the findings reveal regarding the participants approach to, and understanding of, psychopathology. Section 6.4 addresses the participants approach to treatment and the challenges that reveal some of the unique aspects of Lacanian praxis.

An essential element to conducting research using a Foucauldian model involves careful consideration for how the historical and social circumstances create the conditions of possibility out of which objects of discourse emerge (Foucault 1971). In the case of the current study this meant covering a broad and diverse range of issues as part of the literature review. In exploring the literature on childhood and seeking to establish a foundation for how the child is conceptualised in contemporary culture a review of the historically dominant discourses was required. A social constructionist framework was used in addressing the two main areas which were childhood and psychopathology. The literature revealed how a complex tapestry interwoven with scientific, moral, and political threads all contribute to how childhood and the child are conceptualised today. This was a crucial component to enabling an exploration of how child psychopathology is understood according to the participants. The literature pertaining to child psychopathology focussed on the disciplines of psychology and psychiatry. Doing so demonstrated how psychology and psychiatry construct a version of psychopathology that renders children both treatable and governable which was largely in keeping with Foucault's assertion of how disciplinary power functions. Moreover, the practice of diagnostics has, as the literature indicates, flooded our social and cultural life. This is witnessed in how children are educated, and often segregated based on various diagnoses. The discourse of psychiatry has undoubtedly infiltrated and influences so much of how we make sense of our mental life as recognised by the participants, '*Looking at the whole cognitive approach in schools, we are teaching children about green thoughts and red thoughts, straight away you are pathologizing them'* (P1). The literature looking at developmental psychopathology revealed how children have become knowable to us based on specific sets of measurement. The literature revealed how the dominant discourses in the areas of child development and psychopathology more frequently place causation of psychopathology on biological and neurological factors inherent to the child, situating the problem within the child. The participants demonstrated a resistance to this contending instead that the role of the Other[45], in the life of the child, holds significant store in helping to understand both psychopathology and development.

[45] See compendium of terms

The exploration of childhood from a political perspective revealed how the place of the child in society has evolved considerably over the past century. These changes were found to coincide with the evolution of industry and labour law. Children were recognised more and more as dependants and in need of care for a longer period in their early lives. This extension to childhood was accompanied by a modern sentiment of childhood that the participants discussed in detail. The position taken by the participants on this aspect of the study revealed, in particular, the significance they attached to neoliberalism and capitalism. The findings suggest that the political attempts to recognise the agency of the child, as witnessed by changes to legislation and efforts to make the voice of the child more salient in society, are significantly compromised by the cultural values attached to childhood and the child in the current epoch. The participants point to what they see as the type of object that the child has become in a culture that is driven by the ideals of the market and organised around the satisfaction of the consumer.

Clinical literature was also explored with the aim of identifying how children experiencing mental health problems are treated today. It was apparent that most psychosocially based models of treatment involved behavioural approaches that apply cognitive techniques. These approaches assume general principles regarding the cognitive and emotional processes in children and are designed to be universally applicable. The guidelines for treatment (as per NICE 2013, 2018 and CAMHS annual reports, and recent literature on efficacy in child mental health care) frequently infer the importance of personal and contextual components to overall diagnostic procedure. However, given the additional time and consideration this requires, applying these principles proves challenging in the context of a contemporary mental health system that struggles to meet the demand for services.

A consistent point made throughout the findings regarded the singular approach to treating young subjects, a *'one by one'* (P6) approach that emphasises subjectivity in clinical practice with children. This could be said to function as the ethical foundation of their work. The participants in the study offered an insightful perspective that introduced a critical evaluation of several dominant political and clinical discourses which shaped an original way of understanding subjectivity in the 21st century and helped illuminate several problems associated with the practice of mental health care in children today.

6.2 Neoliberalism and the construction of the Child

The findings demonstrated how the participants constructed a version of the contemporary family organised by neoliberalism which, they argue, upturns the classical formation of the family which had the parents in a hierarchical position relative to the child. The child in the contemporary version of the family yields greater power and exercises greater influence in all aspects of domestic life. This was something that the participants considered problematic for both the child and the parent. (P5), quoting a pioneering child psychoanalyst, states how *'the child must not be at the centre of the family, he must be on the periphery'*. This contention corresponds with much of the extant literature that details how the constitution and dynamics of the modern family have altered in the past 70 years. The participants allude to how a move away from conservative values and practices have resulted in a reorganisation of the family in contemporary society. A consequence of which is that the child has become the nucleus of the family. In previous eras, the parental couple formed the base of the family and within this arrangement the parents held the power. Cultural and social changes now position the child at its centre irrespective of its particular form, '*before we were making families and then with the child, today we have child to make families'* (P5). Zelizer's (2002) 'sacralisation of childhood' denotes how the power once possessed by the parents has become refocused around the child. This, she argues, represents the turning point in history when family life began to centre around the child. Freud's reference to 'his majesty the baby' 100 years ago indicated the changing ideology regarding the infant at the beginning of the 20th century. The baby that the participants speak of in the contemporary era is one less associated with sovereignty and more closely connected to the values of the free market resulting them becoming objects of jouissance according to the participants. Technology and science have advanced considerably in the past century as has the child who now finds himself connected to all this technology.

The impact of technology on the contemporary family was also something the participants addressed. In the opening section of the findings the participants speak about the changing way in which babies are born through the intervention of technology. They point out that this also brings a change to how we see the child to the extent that technology, via the capitalist discourse, promises perfection, '*even the child of a noble child is possible if you buy the sperm'* (P2). Availing of technology also enables the production of designer babies and it is here that the participants signal their concern regarding the influx of the capitalist discourse, with its ideological compass set on consumption and enjoyment that the participants highlight their concern for children. This commodification of childhood has

been topical for several decades (Cook, 2020) leading Najles (2015) to point out how the child has become a product within the discourse of capitalism which as mentioned can begin with the act of insemination and gestation. The focus of attention is not on the technology that aids parents in their efforts towards reproduction but with the power exerted over them in the form of ideals promoted by the market around infancy and childhood. From inception to birth and beyond the child and the parents are prey to the forces of the market that infiltrates all aspects of their lives.

A key concept within Lacanian theory that the participants drew upon was that of discourse theory. The findings indicted how the participants placed the child as object in consumer discourse. Applying these concepts also enabled the participants to place the child in a particular type of relation to the Other. The commodification of childhood in a consumerist discourse positions the child in the place of the object *a*, or, product of a discourse. This objectification is a result not just of the parents' contributions but ascribed to the wider influence of culture. In this social bond the participants understood the parents to be operating as other(s)producing this object which brings about more jouissance. The child's symptoms are a representative of the truth of this culture, which is hidden, but disclosed in the findings where participants noted it's the emphasis on wellbeing which creates what it sets out to erase, psychopathology.

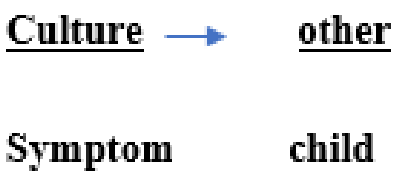

Figure 7 Child Symptoms

The findings also suggest that childhood is undermined by how children are targeted as consumers. Capitalism succeeds in manipulating the consumer into a passive subservience to the market. A consequence of which is the prolonging of childhood and adolescence through the promotion of enjoyment via consumption. Capitalism strives to bring about docile subjects (Foucault, 1969), a sort of perpetual childhood or as Lacan (1974) describes it 'the all-pervasive child of the market economy'. As the findings suggest the child is not simply a consumer it is also an object that can be consumed.

6.2.1 History and Structure versus Development

The findings revealed how the participants understood development that contrasted sharply with dominant models discussed in the literature review. Development according to the participants is not linear, rather it can be understood as series of moments, which interact and influence one another dialectically, '*Events that accompany this organise the way it is experienced, a neurotic child experiences things one way, an autistic child another way'* (P6). Despite the popular idea that Freud provided a stage-based model for development the participants argue that the stages are always rooted in intersubjectivity, in the unconscious of the parents and how they engage with the child on a conscious and unconscious level. Moreover, the contingent events that occur in the life of the child as depicted by (P1) in the example of the child's dream must be taken into consideration when considering the place the child occupies for the parent. As the findings suggest, 'development' involves extricating oneself from the unconscious of the parent, which in many instances, results in the production of a symptom. Symptoms as the findings show are vital to the subject and require deciphering rather than eradicating.

The literature review revealed how the dominant discourse of developmental psychology constructs a framework for conceptualising the social, emotional and behavioural issues in line with chronological age (see table 1 p.23) and, as the literature in section 2.7 indicates, most clinical disciplines apply this framework in conducting treatment. The findings by contrast reveal how the participants focus on the trajectory of the subject through the encounters with the riddle of sexuality and otherness, '*The work with the child is to help him make his way from the phallic object to the signifier you see'* (P2). Developmental psychology effaces this problematic issue by mapping the child in accordance with universal ages and stages. Psychoanalytic theory focuses on the relationship between the child and the Other, as outlined in chapter 3. The findings reveal how the participants conceptualise the child, as subject, on the basis of 'history and structure'. This alternative approach focusses less on milestones and more of events as they determine subjectivity. (P6), '*well obviously you have this of age but for psychoanalysis it's about working with the subject, it's not developmental'.* (P3) '*Sure there's development but you know, that's not the same as history structure'.*

The participants reluctance to adhere to a developmental model appears to be derived from a resistance to the notion that development is a linear process. Such a logic leads to the idea that development can be understood within an ever-increasing number of stages and sub-

stages wherein, fixations or regressions can be interpreted as signs of illness. This is the deductive logic of positivism in science that leads to notions cause and effect. P4 '*psychoanalysis offers the child the possibility of ye know ( ) of allowing the subject to emerge rather than reducing things to usual sorts of things. A lot of the theories that are about these days, attachment theory, affect regulation, all that sort of stuff, it's all no different to what the man in the street says'.* (P4) is suggesting that a common knowledge exists regarding child development that is in accordance with developmental psychology, but this is far removed from the psychoanalytic concept of the subject. The contention being made is that some of the more popular theories provide a description of what is expected of the various family members at different points in the life cycle but this bares no relation to the subjective position of the people that inhabit them. The *subject* cannot be reduced to these usual sorts of things. The subject is what, in developmental terms, remains outside the object of most forms of scientific observation, '*the subject* (in psychoanalysis) *is the outlier'* (P6). A subject is a subject in accordance with a structure according to (P3) who states that '*a structure determines a series of necessary relationships between a certain number of factors that produce different forms of discourse*'. An insistence upon the historization of the subject over a developmental perspective is an attempt to restore fluidity and movement within the unconscious chain of signifiers. The participants rejection of the more popular models of development, as discussed in chapter two, would appear to be based on the discontinuities between normality abnormality, grids of specification (Foucault, 1969), as they see it. The child, as subject, is in a continuous process of becoming which is threatened rather than supported by these imposed models of normativity. For psychoanalysis, history is a dimension that exists outside of development, history proceeds out of beat with development according to Lacan (1966).

This psychical structure that the participant refers to can be understood as the internal representation of interpersonal relations. What determines the subject is his relationship with the Other. The findings reveal a clear distinction in how the participants understand structure, not simply as an underlying category comprised of a collection of certain symptoms as may be found in the DSM but instead as a fundamental component that positions the child, as subject, in relation to the Other. P2's comment regarding the symptom testifies to this distinction, '*A psychotic child that bites is not the same meaning as the neurotic child that bites, you see there is a structure that is there and the biting must also be understood in relation to the structure'.* Understanding the child on the basis of history and structure

changes what can be known about the subject and also what might become possible through psychoanalytic treatment.

6.2.2 Surveillance

The findings show how the participants considered many aspects of children's lives to be overregulated by adults. The degree to which adults impose control over children in the name of safety has, according to the findings, contributed to difficulties with separation, a finding that corresponds with some of the literature addressed in chapter 3. The participants, in accordance with psychoanalytic theory, maintained that much of the anxiety found in children was a consequence of what (P1) refers to as '*omnipresent parents*', while (P4) refers to the cultural phenomenon of *'helicopter parents'*. A degree of sympathy for children was evident in how the participants spoke about this issue, '*they don't get an opportunity to have an existence that is separate to family life*' (P4), *'children nowadays are more looked at*' (P1), '*there's no back of the bike shed anymore'* (P6). Childhood in becoming a major area of study attracting the trained gaze of researchers from the widest variety of disciplines in recent decades which leads to a production rather than description of the child which arises from the technologies of psychology, psychometrics, methods of observation. Developmental psychologist Arnold Gesell (1950) famously designed detailed plans for the prototypical nursery which is structured around a hidden child observation room. The child's behaviour is recorded and becomes normalised which could later be used for the design of care plans for infants and children at all stages of their development. Jeremy Bentham's panopticon is summons to mind here.

The level of confinement imposed upon children is something the participants see as being quite new. This is supported in part by the forms of play children more commonly engage in but this according to the data has consequences for the child in terms of identity formation and emotional regulation.

> (P1) '*Its always very difficult to regulate the drive but I think that in our culture, on the one hand we offer kids all kinds of entertainment but then on the other hand we imprison, them so I think they have to deal with that in very different way than in the old days'.*

Steigler (2011) in discussing the role of technology contests in that the libidinal economy of the subject is threatened by the industrial exploitation of children through the use of psychotechnologies. Extensive amount of recreational time spent with electronic devices leads to a confinement or imprisoning of the child, 'battery reared' rather than free range

children as Palmer (2006) observes. Currently, unstructured playtime, games, and use of toys have been promoted as key elements helpful to sustaining and optimizing children's well-being (Jacobson, 2008; Milteer & Ginsburg, 2012). Strong (2015) points out that this notion contrasts with an approach to childhood wellbeing where highly structured activities and expectations are seen as good for children, as helping them to prepare for adult challenges (Chua, 2011).

Learning to regulate the drive is to learn how to inhabit one's body, a fundamental aspect of identity formation in childhood. (P6) '*children are full of libido that needs to be treated and if you're constantly being told not to move, so a child is in a classroom for 2 or 3 hours then is told to stand still, ye know and then later they decide to play violent video games (laugh) because that's a way of treating something'.* The role of technology and the marketing of entertainment products in the life of children featured throughout the findings. (P6) makes the following comment, '*you can be whoever you want to be online without the consequences'.* This observation draws attention to how identity formation occurs, particularly where children's playgrounds have been transposed into a virtual online space that is regulated by the entertainment market. Zepf (2010) asks 'to what extent buying is effectively enlarging or building identities cannot be known for sure. However, it seems to me that the identity building quality of consuming is becoming more and more dominant' (p.51). This concern was evident throughout the findings. Foucault's description of technologies of self can be recognised here to the extent that governance over the individual is achieved by observation and self-imposed regulation. The marketing of entertainment technologies can be seen to impact upon child and parent/adult relations according to the findings. Children, (P6) argues, *'are more and more left to their own devices'.* This idea of the technological babysitter can be found as far back as the 1950's when most homes in the US had a television set. However, the participants note how technology is fast becoming an extension of ourselves. Technology has enabled parents to relinquish some of the responsibility for the child in terms of the transmission of cultural and social values. A simple observation by (P3) that '*everyone has their own screen today'* illustrates not only some disturbance at the level of interaction between children and parents but additionally how the child and adult, is engaged with the market and in a unique and individualised way. Shared experiences are less common. One of consequences for those who live under the reign of capitalism is the compromise that is brought about to the social bond, the relationship between subject and other.

The findings suggest that technology increases the level of surveillance children experience. Additionally, a greater reliance upon material goods results in the child's attention being drawn to devices that operate in opposition to the Reality Principle (Freud, 1911), i.e., the deferral of gratification, the primary responsibility of adults to transmit a version of these symbolic values is further compromised by the consumerist forces.

6.3 Discourse and diagnosis

The findings revealed how the participants all utilise a structural approach in carrying out diagnoses. The conceptual foundations for this are to be found in Lacanian discourse theory as discussed in chapter 3. The attention paid to the rise in diagnoses of certain conditions called the participants to explore fundamental concepts of psychoanalytic theory. Several participants note how conditions such as ADHD, ASD, AD have become more prevalent today. This led to a consideration of the familial and social factors, along with the saturation of 'psy' discourse into contemporary culture. There were contrasting views regarding the notion of 'contemporary symptoms' in the findings. Two of the participants contested that culture plays a formal role in symptoms i.e., social structures facilitate forms of psychopathology, while three others argue that culture has a causal role in the aetiology of symptoms i.e., the social structure determines psychopathology. (P3) and (P4) argue that the proliferation of diagnostics as discussed in chapter 2 is fuelled by the commercialisation of mental health, '*hyperactivity is an industry because we have a cure for it, the psychostimulants…once the psychostimulants show to be effective it becomes easy to diagnose hyperactivity because you have a cure for it'* (P3). The industry indicates how a consumerist model is operant in health care and this aids in the discursive production of certain forms of psychopathology. (P3) *'the eating disorders, anorexia, bulimia, they may be more prevalent, it is true that culture promotes them, fine, they have always been known since antiquity', now all this business with gender, sexual dysmorphia, they have always been known*'. This was a belief shared by (P4), '*there is an expectation that services are required and even to some degree an expectation that we will play the game*'. Foucault contends that from the moment medicine became scientific it obtained a gaze that would no longer wait to observe clinical phenomena. Now its gaze knew, named and operated with power reducing the suffering subject to the accumulation of pre-established clinical criteria, "*look, I have seen children diagnosed with conduct disorder that were never even seen by a psychiatrist*" (P3). The participants critical appraisal of psychiatry upholds Foucault's contention. (P4) and (P3) are making the argument that the psychiatrist presupposes the existence of the disorder rather than even attempting to discover whether a disorder of any

kind exists. This also begs the question of who's demand is being met. The demand placed psych-services to produce solutions often results in there being less inclination to inquire and ask more questions of the patient themselves. This is an important distinction between the knowledge of the psychiatrist and that of the analyst. The latter operating within a discourse that compels the patient/analysand to engage with their own question and produce their own knowledge.

The argument that culture facilitates but does not play a causal role in contemporary symptomatology was countered by (P2), who contested that *'symptoms are no longer based on the signifier'*. Citing examples from his own clinic (P2) refers to the more common presentation of children diagnosed with 'hyper intelligence'. This is thought to explain why some children experience emotional regulation problems and social difficulties. (P2) is arguing that something in culture has shifted to the extent that what we have is a problem with performance that is linked to surveillance and measurement. (P2) finds the idea of "hyper intelligence" as an explanation to be 'stupid' as it uses paradoxical logic to explain the so-called deficit. The child is suffering because he has too much intelligence[46]. The way in which we measure and assess so much of the early phases of the lifespan is, according to the findings skewing how we understand contemporary psychopathology. Similarly (P6) observes how changes to the way children and young people interact is having consequences for the way suffering is manifested, *'now with snap chat and these apps they* (children) *can be dropped so quickly, before there had to be more human interaction, and this could be processed'.* Anxiety and panic attacks are a more common occurrence according to (P6) who argues that this is the result of a fundamental alteration to the social bond. (P1) speaks of the difficulties teens have in coping with the inconsistency of the other (P1), '*contemporary symptoms mirror the subjects lack of a relation to the other'*. The findings suggest the importance of culture in the aetiology, diagnosis, and treatment of child psychopathology.

The approach to diagnostics described by the participants demonstrated how they take into consideration several factors that are not considered by other disciplines. This finding is relevant to the overall aim of the study as it illuminates how the participants draw upon discourses beyond psychoanalysis in conceptualising child psychopathology. They say that the symptoms we see today aren't necessarily new but that culture either promotes some forms of psychopathology over others or is a critical component in the aetiology of

[46] Karpinski et al (2018) argue that high IQ is a potential predictor of psychopathology in children.

psychopathology itself. This is important considering what they speak about as the function of symptoms. Symptoms being expressions of subjectivity. This demonstrates a resistance to the mental health movement in its commercial guise as it has become a catalyst to psychopathology according to the findings.

In terms of recent psychoanalytic literature, Benvenuto (2014) suggests the importance of engaging with symptoms that entail distinctly contemporary features. The features of modern life are technological and object based according to Verhaeghe (2012) for example the identification of a new set of symptoms of psychiatric disease leading to classification of Video Game Addiction or Gaming Disorder, (ICD, 11). While the data suggests that not all participants believe childrens' symptoms were a derivative of consumerism and a capitalist discourse there is consensus that the objects of technology have become a more prominent feature in the life of children and in how they communicate. Ceaderman (2017) points out smart-phones, tablets, play station etc operate as drive-oriented devices. "The allure of the object is not based on the satisfaction of some bodily need but solely on sustaining the jouissance generated by a repetitive, mechanical and excessive circuit of behaviours" (ibid p.252). Children now share an intimate relation with these devices. The contention put forward by (P5) that technology is becoming a defining feature in every aspect of life today organising all forms of enjoyment produces its own form of malaise or discontent. This echoing Soler (2014) who contests that the symptoms of childhood suffering come from the socio-cultural sphere where today's families strive for "some sham surplus of jouissance, without any transcendence and the ineptitude of scraping a living within the balance of producer-consumer" (ibid, p.191).

The next section explores what the findings revealed regarding the way the participants position themselves against the discourses outlined in this section.

6.3.1 Capitalism and the "wellbeing" of children.

A discourse of wellbeing was drawn upon by the participants in their critique of how parents and children are manipulated into so called healthy practices. The term wellbeing is related to how family life has become socially and economically organised (Strong and Sesma-Vasquez, 2015). Section 2.3 of the literature review addressed how the growing attention on emotional expression in childhood as a measure of wellbeing changed in recent decades. Several participants point out how the expression of emotion by children was something that has become more expected by parents today. (P6) notes how children were once expected to

be seen but not heard, now they are expected to articulate how they think and feel, a phenomenon that is widely encouraged in early educational settings as outlined in The National Council for Curriculum and Assessment (NCCA) guidelines. The findings highlight how the participants, while supportive of policies that promote many aspects of wellbeing are critical of how this cultural phenomenon has infiltrated the relationship between parents and children.

The participants drew upon Lacan's theory of discourse in constructing an understanding of how scientific knowledge (University Discourse) is put to use in the service of capitalism and how this creates certain realities that organise the relationship between parents and children. The idea that wellbeing is a commodity that can be purchased is highlighted by (P4). In the following extract the participant is speaking about a TV show that reveals, through humour, the functioning of discourse in the life of the 'average family'.

> *'I caught the end of a show on TV last week, it was a humorous show about commercialism and its effects and guilty mothers and so on and the mother goes to the pharmacy and buys things that prevents colds or this and that and there's this rather bland child sitting there while this exuberant mother fills the child with pills and so on, ye know I think there is something about that, we could talk about helicopter mothers and eh and so on. I think that ye know such things are culturally determined.'* (P4).

The reference to the show serves to highlight how power is exerted on parents by industries of wellbeing. The vignette captures interdependence of power and knowledge highlighted by Foucault (1972). The pharmaceutical industry is telling the parent what is best for the child, according to science by reducing the child to its biological form. The exuberant mother feels obliged to obey the overt message that these products promote physical wellbeing and therefore must be acquired. This is power installed via ideology according to Zizek (2012). The dietary supplements being referred to in this vignette are dispensed by a pharmacist. The knowledge and power of the pharmacist lends a credibility to this product which, as we are aware, is regulated not by a medical authority but by a food safety authority. Moreover, the vignette highlights the enjoyment factor for this exuberant 'mother as consumer' which is contrasted by the description of her child as "bland" implying desireless passive subject who is 'sitting there' in a pseudo-patient like position. The argument being made by the participant is that the mother and child are subject to surveillance, subject to discipline, to the extent that they are the subjects of an unquestioned social structure and its ideology. Disciplinary society was a term first used by Foucault to describe a condition of surveillance. In a disciplinary society the subjects/people become docile bodies, who begin to internalize

surveillance, and no longer resist. This is often seen in locations such as schools or factories, (Boagrd,1991). Similar scenarios could, no doubt, be witnessed every day in most affluent societies. The description of the show as humorous can be understood in Freudian terms whereby jokes allow for socially acceptable unconscious expressions. In this instance something that is quite serious is disguised with humour. The guilty mother is drawn into a practice whereby providing her child with these 'good objects', (vitamins) confirms her position as a good mother. This is far removed from Winnicott's notion of the 'good enough mother' who was attentive to the needs and wishes of the child, in contradistinction, the mother depicted in the excerpt is attentive to the demands of the market and the perception it creates. She too, as a consumer within the contemporary wellness economy, complies with the ideology that organises so much of her position as a mother, "this is how to raise and protect your child". The excerpt brings attention to another aspect of commercialism and wellbeing in the life of parents and children when one considers the provision of nutrition as one of the primordial features of the mother infant bond." The excerpt illustrates how the commercialisation of knowledge, i.e., notion of wellbeing, exercises power over the mother's actions in relation to the child that becomes the object of the gaze. The parent has absorbed and is participating in the ideology of wellbeing and the creation of a docile child. This gaze monitors not only for signs of wellbeing but also for that of happiness according to the findings. Indications are to be found in how adjusted the child is to the world around them and how well they perform in it. This finding is interesting in light of what appears almost contradictory i.e., that the desire the parent has is for the child to be 'happy' not to be 'a doctor' 'a lawyer' or something preordained, an impossible demand and antithetical to Freud's pleasure principle (1915).

The final question in the interview schedule asked participants to discuss what they believed was unique about psychoanalysis. There was a consensus amongst the participants which was reflected in various ways throughout the study and in the findings which concerned the primacy of speech and language within Lacanian psychoanalysis. The participants juxtaposed their practice as child psychoanalysts against the commercial trend of wellbeing, instead advocating an ethics of speaking well. To the slogan 'Just Do It', the analyst replies 'Just Speak'. Just speaking is not just speaking. Children, in speaking actively construct the realities they inhabit. Speech enables the subject to unravel the knots that bind one to jouissance and reconstruct a way of being that facilitates desire.

6.4 The Aim of the Treatment

The method by which these participants carried out their work with children was of interest to the study. The findings revealed how they positioned themselves relative to their young analysands and some of the techniques and principles that enabled them to carry out their work. The following section addresses what the findings revealed regarding the practice of psychoanalysis with children according to the participants. '*I think it better that a child goes to me to encounter a psychoanalyst than a psychotherapist, why? Because the psychoanalyst has no idea, moral idea, what the child must become'* (P2). The idea that other disciplines have a preconceived idea of what is best for the child is apparent in this statement. Personal influence and suggestion are things the analyst is keen to avoid. The choice of the term 'moral idea' indicates that the participant is eager to dispense with judgement regarding what is good or bad for the child. Dor (2008) notes how psychoanalysis assumed its specific nature as a discipline as soon as Freud realised he had to keep his interventions free of suggestion. While a position of neutrality is common to most forms of psychotherapy, Bergin (2004), the findings reveal how the participants attempt to address how the child has become alienated in the desire of the Other. This is a desire that is manifested in the implicit and explicit demands that those in a position of power hold over the child; '*children are already very demanded of'* (P1). In referring to Lacan's note several participants highlight how the child's symptom is often a response to the demand of the other as such it is important to avoid becoming another demanding adult in the child's life. This is also the reason why there can be no preconceived agenda, for example, to encourage compliance in the child or foster adaptive processes, as this would become a reductive, '*pedagogical practice'* as (P1) describes it. The aim of the work with the chid is to *'make his way from the phallic object to the signifier'* (P2), and '*to make the other a little less omnipotent'* (P1) and *'it* (psychoanalysis) *offers the child the possibility of allowing the subject to emerge…the child is able to take up a place of the own singularity'* (P4). Despite a variation in the descriptions of the aim the findings reveal a consistency in terms of what the participants describe as the ethics of their practice. The intention is not necessarily to change some aspect of the child's behaviour or alter how he thinks but instead to facilitate his being as a subject. To do this the participants highlight several techniques in their clinical practice. '*When you meet the child he must be surprised by you…the child knows you are going to be the analyst of that child, not someone else*' (P5). The idea that the child must be surprised or disarmed by the analyst was something mentioned by other participants which is designed to bring about a different type of encounter than those more common between a child and an adult. To change

the rules somewhat. In doing so the participants describe how a different type of dialogue takes place. However, there is also an insistence that the fundamental principle of conducting work with children is identical to that of an adult. This is something mentioned by several participants, *'Well I guess as an analyst I would consider that one doesn't work with a child but with a subject'* (P4), *'There is no great difference in the analysis of children than adults, children and adults are not psychoanalytic concepts. We work with speaking beings'* (P3). A developmental view of childhood risks separating child psychoanalysis into a specialised field but it also separates the child into ever more categories of being human. The participants demonstrated an eagerness to avoid engaging in the practice of segregation and instead to singularise each symptomatic solution through the act of the child's speech even when, as (P3) notes *they do not speak. They are beings within language because we speak to them*. This highlights the significance of the how language structures the speaking subject and how the work with speaking beings is conducted.

The contention that the work is with the subject or the speaking being over and above the child was consistent among all participants. The aim as outlined by (P2) to allow the child to make their way to the signifier means identifying, through speech, the way the child is positioned by language. Speech possesses the specific power of the treatment. This casts new light on the family showing the alienating and separation that the child must go through in order to emerge as a subject with his or her own desire. The function of the analyst is to bring to light the way in which the child extracts himself from this object position often with the aid of his symptoms. An opening must be made for this to occur. For the knowledge of the child to emerge the other must (contrary to the discourse of education or pedagogical therapeutic practices) 'shut up' so that 'the subject can then, starting from the inventive power of language, explore in what way he is interested in the symbolic order and the Other' (Zuliani, 2014, p2).

The analytic process with the child involves a mapping of the subject in relation to desire and the construction of a fantasy that will sustain the subject when he encounters what P2 refers to as *'the non sexual rapport*' with the other. The participants speak about bringing the child to a place in which they are prepared to meet with the non-sexual rapport. This includes aiding the child with making a sense of their own sexuality and sexual identity. The participants spoke about this in terms of the construction of a fantasy that can support the encounter with the real of sexuality and the real of the body. Lacan's (1938) paper regarding the family highlights the various trauma's the young child goes through. The participants, in

speaking about separation, infer the construction of a fantasy that sustains the subject, leaving the child less alienated by the parents' desire. Many of the participants returned to Lacan's Note on the Child (1969) as a reference point here. The analyst, in being *'surprising'* (P5), attempts to be somewhat enigmatic to the child provoking a curiosity. This is key to function of the analysis, to entice the patient into seeking knowledge via speech. This knowledge, as the participants point out, is already known to the child but it remains obscured. This is the knowledge that slips out in the dream as discussed by (P1) and the symptom. 'The analysis aims to allow the subject to bring its authentic desires into the light of consciousness' (Bailly, 2009, p.185).

This positioning of oneself is what Lacan termed the discourse of the analyst, a discourse or social bond that pushes the analysand to produce a knowledge of their own in the form of master signifiers. Meanwhile the analyst is placed in the position of agent provocateur to the unconscious knowledge of the analysand. Foucault notes how all inter-relations are governed by 'disciplinary power' which regulates how we think about things, power causes action to occur between people (Wetherell, Taylor & Yates 2001). The action brought about by the engagement of the child and the analyst involves the production of new signifiers and as mentioned by (P2) the construction of new identifications. This can only be achieved if the analyst chooses a side, develops an allegiance which the participants are saying is with the child, this is not to say that they accept everything the child may do, the power to self-regulate in a manner that is acceptable to all is a feature of what is at stake here.

6.4.1 Working with Demand & Transference

The findings highlighted how the participants exercised a great deal of caution in how they handled the subject of demand in their clinical work with children noting how demand is very much a feature of the child's life, "*children are already very demanded of today*" (P1). Demand is a central concept according to the participants and must be balanced carefully within the work, '*I try to be very careful with demand*'(P2). Three of the participants provided clinical vignettes involving situations where, the understanding the parent held of the problem differed from the child's understanding. This is a common issue in the work with children indicating the many aspects of clinical work with children involve concerns of parents and not of the child. The vignettes offered by the participants underscore the importance of recognising what the problem means to the mother, father and the child. Attending to the problem as presented by the parent risks alienating the child as one participant pointed out but not attending to the problem as presented by the parent risks

alienating the parent. Satisfying some demands seem necessary. There is also an ambivalence in regard to demand. If the analyst attempts to satisfy the analysands demand to have the symptom '*put away'* (P5) they risk the loosing what may be achieved in allowing the symptom its rightful place in the work. While most interpersonal relationships involve the satisfaction of demands the discourse of the analyst is a form of interrelation that is designed to avoid conceding to demand as to do so reinforces alienation and the compulsion to repeat. Needs correspond to objects but demand, in a Lacanian sense, becomes dislodged from need and seeks fulfilment through expressions of love from the Other, demand, according to Lacan (1960-61, p.198) is situated between love and desire.

Chapter 3 provided an illustration of Lacan's L Schema. The findings reveal how the participants make particular use of this graph in handling the parental demand and the demand of the child. The relation between the analyst and the parent may remain on the imaginary axis of ego to ego throughout the course of the treatment but the work with the child is conducted along the symbolic axis of $ - *a*. Demand brings to the forefront issues of positionality. The discourses that inform a conceptualisation of childhood are those discourses that operate as forces of regulation in society as discussed in chapter 2. Children are made docile through the three specific methods of discipline according to Foucault (1975), all of which "establish rhythms, impose particular occupations, regulate the cycles of repetition", and all of which are to be found in the institutional practices of the family, education and mental health care. The findings reveal how the use of demand in the discourse of analysis is not to bring about conformity with some others desire but with the desire of the child as analysand.

Psychoanalysis is not, as the findings reveal a corrective emotional procedure or a training method in parenting. Working with parents who are, "*as a rule they are also in trouble*" (P3) involves the recognition and tolerance of a demand that is also entirely subjective. The task of the analyst working with children would appear to be in how inventive the analyst can be in the application of knowledge as it pertains to the unique structure of the family and diverse forms of "*non-rapport*" that exist between the parents. Working with parents means working with subjects, albeit subjects experiencing difficulties as parents. (P5) points out how, working with children based on addressing the symptom as it is understood by the parents or a preordained classificatory system risk bringing about a premature end to the analysis for once the symptom has been overcome there is a tendency to consider the entire pathology resolved. For this reason (P5) introduces a proviso into her work with children, '*so often at*

the beginning of the work I say to the parents you're coming for one thing, nightmares or, but, maybe the symptom is going to disappear, maybe it's going to disappear fast, it's a big eh. It is eh, please let us decide together, your child and I if we continue to work together even if there is no (…) symptom". The condition put on the work indicates the importance placed by participants on desire, the child's desire, communicated through a demand for the continuation of the work that is carried out within the transference.

Demand can be understood as a central aspect to transference. Demand actualises transference and situates desire and its articulation as the primary aim of analysis. It is based on a demand that the analyst is cast in the position 'subject supposed to know', Lacan (1977), a position of power based on knowledge. The transference is a therapeutic attachment the child makes to the analyst. It can aid in the diagnostic procedure, as alluded to by (P4) in the example of the child that must bring his drawings back to his parents. How the participants made use of the power brought about by occupying this position was revealed through the way participants spoke about the differences between the relationship they had with the parents and with the child. There was a recognition by the participants that parents generally required some form of therapeutic effect from the work. This required them to take up a different position with the parents. Several participants revealed how they are often required to offer a little psychoeducation to the parents during the interview. This is done to alleviate the anxiety of the parent and to reduce some of the pressure but a there was a consensus that there could be no collusion with the parents in how the problem was being understood.

6.5 Strengths and Limitations of the Study

One of the strengths of the research methodology was that it opened the way in which psychopathology in children can be understood in accordance with models of health care and discourses that determine the social and cultural approaches to childhood. This brought to light contrasting discourses in the literature reviewed but most importantly enabled the researcher to position the discourse of psychoanalysis in a way that reveals the ontological and epistemological differences to more frequently prescribed models of treatment in children's mental health care. Every interview produced rich and original data, the accumulation of which could form the foundation for future research. The decision to use FDA was based on its ability to show how power and knowledge operate in all human relations but this is particularly relevant where children and adults interact. Shedding light on the dynamics of power allows the psychoanalyst and psychotherapist working with

children to be more cognisant of what is occurring in the encounter beyond what was discussed, to be more questioning of what is 'taken for granted' in the work with children.

Applying FDA in the context of the current study also proved challenging. Covering a broad and varied set of literature posed significant challenges. Choosing the right material and clearly illustrating what these incredibly large disciplines had to say about childhood and psychopathology was problematic but necessary. Doing a genealogical analysis poses major challenges to most researchers but is further complicated when one is operating within the confines of a thesis with its specific requirements and limited word count. This was possibly one of the most engaging and enjoyable aspects of the study but also the most difficult. The need to avoid being absorbed and overwhelmed by the literature by keeping the aim of the study central to my reading and interpretation of the material was crucial. The challenge of avoiding being absorbed in the data generated by the interviews was also something that needed to be managed carefully. FDA was not the first methodology that was considered for the study. The use of Interpretive Phenomenological Analysis (IPA) was explored but this was not regarded as being suited to the main aim as this approach focuses on the lived experience more so than how meaning and understanding take place within language. The use of IPA in a similar study could offer a useful insight into the experiences of Lacanian psychoanalysts working with children which may prove beneficial for trainee psychotherapists embarking on career in this area**.**

Revealing tacit knowledge proved difficult. While this was not an explicit aim or objective it was hoped that something might be revealed beyond what was said. This perhaps was a fault of the questioning style or even the questions themselves. I tried to give parity to all participants in terms of their contribution. However, some participants answered the research question much more directly which may have been reflected in the findings.

The research question on first appearances seems broad. Child psychopathology is a very dense subject. However, it is believed that asking this specific group of professionals a more specific question such as 'tell me all you know about Conduct Disorder' would inevitably lead to the same outcome. This is due to the fact that introducing psychiatric terms into a discussion with psychoanalysts would be to expect them to speak about concepts that are not particular to Lacanian psychoanalysis. Inquiring into the broader issue of psychopathology the participants were free to engage more openly with the topic and as such draw upon a wider and more diverse set of discourses in their construction of childhood and psychopathology.

The sample size for the study while small, succeeded in generating sufficient data to comprehensively address the research question. The use of purposive sampling proved beneficial as those interviewed possessed expertise and were willing to engage openly about their work. Despite 3 of the participants only having English as their first language problems with communication and translation were minimal. Some participants took a little additional time to work with a more limited vocabulary but ultimately they were capable of answering all questions and providing informative accounts of their work and their knowledge of child psychopathology.

Chapter 7: Conclusion and Recommendations

7.1 Introduction

This chapter provides a summary of how the research question was addressed along with the main findings from the study. The implications of the study for the practice of psychotherapy with children is provided along with recommendations for future research. The main findings are presented under the following headings: The Child and Discourse, Psychopathology and Psychoanalytic Treatment.

7.2 Key Findings

7.2.1 The Child and Discourse.

The participants take up a position that contrasts sharply with the biomedical and developmental model of psychology emphasising instead broader social structures in the conceptualisation of the child as an object of discourse suggesting that they, like Foucault, take a postmodern perspective to exploring the impact of culture, society and power on human experience. The participants emphasised how the child was not a psychoanalytic term. As psychoanalysts they work with subjects, not children, adolescents or adults. The emphasis on subjectivity was stressed throughout the findings to distinguish psychoanalysis as separate from other discourses. However, in constructing a version of the child the participants referred to discourses beyond psychoanalysis. In particular, the discourse of capitalism was discussed in how it determined the place of the child in contemporary culture. Under capitalism the child has become an object of jouissance. Another way to interpret this would be to posit the child as an object in the sense that he/she fulfils some function in the lives of those around them. This idea was supported by reference to how children are continuously monitored by adults, surveillance being a key feature in the life of the child today. Despite changes to legislation that seeks to give voice to the child the participants argue that this voice is often difficult for adults to hear, constrained as they are by the cultural ideals that inform their perspective on children. For the child to assume a place as a subject means to step out from the shadow of these ideals and to discover a desire on their own terms. The often results in the production of symptoms on the part of the child.

7.2.2 Psychopathology

Two specific findings emerged with respect to psychopathology. Firstly, child psychopathology differs from adults in respect of how the symptom functions according to

the findings. The child's symptom is understood as a relational phenomenon. Deciphering the meaning of children's symptoms inevitably reveals the unconscious dynamics of family life. The contemporary family has become organised around the child. The family as a group is the building block for society. This cultural shift led the participants to discussed the way in which the child is placed in an order that construct psychopathology to rationalise their centrality in the family. This gives rise to the second finding. The participants contest that despite the proliferation of new diagnostic categories and alterations to terminology within the DSM and ICD, there is little evidence they argue for the idea that new forms of psychopathology exist. They argue instead that a combination of culture and the growing impact of technology in the lives of children promote forms of psychopathology that have always been known to us. This is an important point in how we come to speak about child psychopathology and by extension treat children today.

Psychopathology and subjectivity are intricately interwoven. Conditions discussed above along with the vast array of other ways of suffering, phobias, obsessive disorders, paraphilias are neither disorders nor deviations or syndromes, instead they infer specific modes of desiring that constitutes one's subjectivity. The concept of diagnosis within psychoanalysis is problematised by the fact that psychoanalysis is by its design an entirely "subjective science". This, from the study findings perspective, makes much if not all the literature on diagnostics, save for case studies, entirely synthetic. Psychoanalysis is a praxis and as such tries to avoid neatly fitting analysands' into any pre-existing frame of reference. This points back to a knowledge that has existed regarding the paradox in psychoanalysis since its inception, the need to have an overarching theory that enables a safe and effective form of treatment that also allows for each treatment to be individually sculpted to suit the needs of the subject. This is played out in practice by not moving to reduce or eradication symptoms, which is the goal of most of the models of therapy discussed at the beginning of the study, instead psychoanalysis endeavours to bring to the fore the function of the symptom in the life of the child.

7.2.3 Psychoanalytic Treatment

The findings made visible how the participants discussed what they considered to be unique to the practice of psychoanalysis with children. The position they adopt as psychoanalysts is to evoke the child's desire. It was found that Lacanian psychoanalysts who work with children possess a unique and alternative way of understanding the issue of who's desire for treatment should be addressed. This is an area that has potential interest to psychotherapists

who use different models of treatment in their work with children. Consent played a significant role in the findings. Consent involves a demand. That demand for this group of participants must come from the child. These participants addressed how they deal with the demand of the parent, frequently a significant obstacle to the work and how they use demand as a catalyst for the work with the child. Most cases of clinical work with children begin with the child being presented by an adult. The adults that surround the child dictate how the problem is understood. The child may attend willingly in accordance with the demands and expectations of the parent. However, this does not imply that there is consent according to the participants. Consent for the participants emanates from a demand. This becomes a crucial component to carrying out the work. How these participants addressed demand was a significant factor in the difference they identified in their work. The finding that the participants provoke the child's demand rather than responding to the demand of the parents, educators or psychiatrists is a significant factor in how they address psychopathology differently.

The participants made no claim to healing or curing the children of these psychopathologies they presented with. Instead, the ethics and practice of psychoanalysis involves welcoming the singularity of each child, giving them the dignity of the experience. This is arguably one of the most humanising features of psychoanalytic practice. Humanising the experience of the individual subject along with the deconstruction of the uniformity of modern life, the emancipation from slavery to the market of jouissance through the recognition of subjectivity and the restoration of the symptom as an expression of that subjectivity in the life of the child are all essential components of this approach. This enables the child as subject to emerge from the weight of the gaze imposed by contemporary society and allows the subject to begin articulating something in relation to their symptom.

7.3 Lessons learned from conducting the study

There has undoubtedly been considerable progress made in the provision of services for mentally unwell children in recent decades. However, despite the growing media interest in mental health, nationwide availability of high-quality effective care for children suffering from mental health problems looks far from certain. This is despite research indicating the benefits to providing mental health services within educational settings (McElvaney, Judge and Gordon 2017) which argue for properly funded accessible care to be made available, nationally, to those who need it. The current study has demonstrated how

psychoanalysis is successful in addressing child mental health requirements. Despite child psychoanalysis being a long standing and successful form of intervention, it is not offered as a mainstream service within any of the health care systems discussed. As highlighted, this decision is based not solely on efficacy but also on economic factors and as such many children who may benefit both nationally and internationally are poorly served by services that do not include it in the repertoire of services on offer. This may be due to the lack of knowledge about its success as a treatment; the lack of published research as outlined in chapter one; the emphasis on the subjective nature of the work over more manualised and universal methods discussed in chapter two, the misperception that it is a costly intervention and the general trend in psychotherapy education towards a one size fits all approach resulting in training therapists in other techniques such as CBT, Family Therapy and integrative approaches. Additionally, the inescapable influence and dominance of a medicalised approach to human suffering dominates any consideration of child mental health care. This study has argued that the more commonly prescribed methods of psychosocial intervention lack the same theoretical density or subjective application for understanding human development and psychopathology than what is available using a psychoanalytic approach

7.4 Implications for psychotherapy

The place of Lacanian psychoanalysis within the broader spectrum of psychological therapies is a valuable one. The strength of this model lies in the depth and sophistication of its theory. Through the proper dissemination of the knowledge developed out of the practice of psychoanalysis with children psychotherapists and other mental health professionals may appreciate a more nuanced understanding of the complex issues facing children in the early stages of their journey through life. It remains an unfortunate truth that the standing of any therapeutic model today is largely dependent on economic factors. Many of the models discussed at the beginning of this study are preoccupied by their claim to an evidenced based practice which has led towards a manualised model of therapy. It is important to bear in mind that once therapy is conducted ‘by the book’ the subject often goes out the window. Psychoanalysis keeps the subject, the unconscious, very much in focus by avoiding the temptation to look beyond the subject in pursuit of psychical truth. In the fiercely competitive market of psychological therapies the idea that a form of therapeutic practice that does not promise the eradication of symptoms or even a cure would seem implausible and bound to fail yet Lacanian psychoanalysis continues to attract the attention of more and more mental

health professionals and students and, despite being the last port of call for many patients, it demonstrates itself as a reliable model of care.

The study revealed how the social context for understanding mental and emotional "good health" in children today is closed tied to markers of social adaptation. This point was illustrated in the findings where participants referred to the way in which children are engaging in ever increasing amounts of extra-curricular activities. Their unique understanding of this phenomenon is that contemporary culture encourages more and more 'performance' from all individuals which fuels an ever-increasing number of methods by which all aspects of social and emotional life can be measured. This is in keeping with Foucualt's concept of 'dispositif's (1980) or the apparatus by which social control silently operates. Power, in this way, is serviced by the pervasive gaze that occupies the life of 'the child' in contemporary culture. The commonly heard phrase of "living your best life" captures this sentiment of someone who is doing it all, having it all and being it all. This hugely demanding form of contemporary ideology has been discussed elsewhere as a compulsion to enjoy that is linked with capitalism and consumerism. The contemporary child finds him/herself bound up in a culture that promotes performance and consumption leading to more suffering or jouissance.

7.5 Future Research

There is space in the marketplace of child psychotherapy for additional research into the methods and efficacy of a psychoanalytic approach. However due to the dominant market forces, the continued expansion of what can be measured and the caution that exists regarding single case studies psychoanalysis seems doomed to remain on the fringes as a treatment of choice. Conducting this study has made visible the absolute need for researchers and psychoanalytic practitioners to challenge the accepted truths regarding the cause and treatments of childhood psychopathology and to find ways to bring this data to a wider audience. More research into the conducting of child analysis in the form of published case studies alongside longitudinal outcome studies may provide some compelling evidence for the approach.

In conclusion, conducting this study has enabled me as the researcher to gain a unique insight into the ethic of the participants in relation to their practice and their stoic approach to enabling the child to be an active participant in treatment as opposed to having a treatment

imposed upon them that serves to uphold a system where the individual is subsumed into the culture of sameness and consumption.

References

Abrahamson, A.Y., Hyde, J. S., Mezulis, A. H. (2008). The ABCs of depression: Integrating affective, biological, and cognitive models to explain the emergence of the gender difference in depression. *Psychological Review*, *115*(2), 291–313. https://doi.org/10.1037/0033-295X.115.2.291 [accessed March 2018]

Abrehamsen, M. *et al* (2012). Parent–child interaction therapy for preschool children with disruptive behaviour problems in the Netherlands. *Child and Adolescent Psychiatry and Mental Health*. *6*(1), 24. https://doi.org/10.1186/1753-2000-6-24 [accessed February 2016]

Achenback, T. (1991). "Comorbidity" in Child and Adolescent Psychiatry: Categorical and Quantitative Perspectives. *Journal of Child and Adolescent Psychopharmacology*. 271-278.http://doi.org/10.1089/cap.1990.1.271 [accessed May 2019]

Ainsworth, M. D., Bell, S. M., & Stayton, D. F. (1974). Infant-mother attachment and social development: Socialization as a product of reciprocal responsiveness to signals. In M. P. M. Richards (Ed.), *The integration of a child into a social world* (pp. 99–135). Cambridge University Press.

Angold, A., & Costello, E.J. (2001). *Epidemiology of Depression in Children and Adolescents*. In I. Goodyer (Ed.), The depressed child and adolescent. (2nd edn. pp. 143–178). Cambridge, UK: Cambridge University Press.

Aries, P. (1960) *Centuries of Childhood. A Social History of Family Life.* Random House.

Arribas-Ayllon, M., and Walkerdine, V. (2017). Foucauldian Discourse Analysis. In C. Willig and W.S. Rogers. *The Sage Handbook of Qualitative Research in Psychology*. Sage Publications.

Aubrey, C. *et a*l (2017). The Regulated Child. In A. Owen (2017) *Childhood Today*. Sage Publications

Bailey, L. (2009). *Lacan, A Beginners Guide*. Oneworld Press

Banberg, M. (1994). Actions, events, scenes, plots and the drama. Language and the construction of part-whole relationships, *Language sciences* 16(1):39-79

Bakhtin, M. (1981). The Dialogical Imagination. University of Texas Press.

Bakke, O.M., & McNeil, B. (2005). *When Children became People*: *The Birth of Childhood in Early Christianity*. Augsburg Fortress Publishers.

Barish, K. (2009). *Emotions in Child Psychotherapy, in Integrative Framework*. Oxford University Press.

Barret, S. (2021) *From Adult Lunatic Asylums to CAMHS Community Care: The Evolution of Specialist Mental Health Care for Children and Adolescents 1948-2018.* https://doi.org/10.4000/rfcb.4138 [accessed November 2022].

Baumann, J. *et al.* (2015). Cultural Adaptation and Implementation of Evidence-Based Parent-Training: A Systematic Review and Critique of Guiding Evidence. *Child Youth Service Review.* pp113–120.

Beck, A.T. (1976) *Cognitive Therapy and Emotional Disorders*. New York International Universities Press.

Beck, U. (1992). Risk *Society towards a New Modernity*. London Sage.

Benvenuto, B. (2014). Childhood and Today's Discontent. *Child Analysis, Journal of the Centre for Freudian Analysis and Research*, (25), 62-77.

Berger, B. (2002). *The Family in the Modern Age: More than a Lifestyle Choice*. Transaction Publishers.

Bergin, A. E. & Garfield, S.L. (2004) *The Handbook of Psychotherapy and Behaviour Change*. Wiley.

Bewter, L. Matik, M. Almohamed, S *et al*. (2002). *Therapist variables*. *Handbook of Psychotherapy and Behaviour Change.* New York. Wiley.

Bhaskar, R. (1978). *A Realist Theory of Science* (2nd Ed.) Harvester Press.

Bilmes, J. (1986). *Discourse and Behaviour*. Plenium Press NY.

Bilgic *et al* (2013). Relationship between anxiety, anxiety sensitivity and conduct disorder symptoms in children and adolescents with attention-deficit/hyperactivity disorder (ADHD). *Adolescent Psychiatry* 22(9) 523-532. http://link.springer.com/journal/787" accessed 20.01.2017 [accessed June 2015]

Billig, M. (1999) *Freudian repression. Conversation creating the unconscious*. Cambridge. Cambridge University Press.

Bloomquist, M.L. & Schnell, S.V. (2002) *Helping children with aggression and conduct problems*. New York: Guilford Press.

Bogard, W. (1991). Discipline and Deterrence: Rethinking Foucault on the Question of Power in Contemporary Society. *Social Science Journal*, 28(3).

Bogner, A. Littig, B. and Menz, W. (2009). *Interviewing Experts.* Basingstoke. Palgrave Macmillan.

Bowlby, J. (1969). *Attachment and Loss*. New York. Basic Books.

Breggin, P. (1994) *Toxic Psychiatry. Why Therapy, Empathy and Love Must Replace the Drugs, Electroshock, and Biochemical Theories of the "New Psychiatry".* Macmillan Press.

Brinkmann, S., & Kvale, S. (2017). *Ethics in Qualitative Psychological Research*. SAGE Publications Ltd.

Breuer, J. and Freud, S. (1895/1995), Studies on Hysteria. In James Strachey (Ed.) *The Standard Edition of the Complete Psychological Works of Sigmund Freud.* London: Hogarth Press, Vol.2

Bronfenbrenner, U. (1977). Toward an experimental ecology of human development. *American Psychologist*, 32: 513–531

Buhs, E.S. & Ladd, G.W. (2001). Peer rejectiuon as an anticednent of young childrens school adjustment: an examination of mediating processes. *Developmental Psychology. 27*(4), pp550.

Bunge, M. (2001) *Social Science Under Debate. A Philosophical Perspective*. University of Toronto Press.

Burman, E. (2008) *Deconstructing Developmental Psychology.* Routledge.

Burr, V. (1995) *Social Constructionism* (2nd Ed). Routledge.

Burnet, J. (1967). *Aristotle on Education*. Cambridge University Press.

Burns, N. Grove, S. K. (2001). The *Practice of Nursing Research: Conduct, Critique and Utilization*. 4th Ed. Philadelphia. W.B. Saunders Company.

Carabine, J. 2001. Unmarried motherhood 1830-1990: A genealogical analysis. In: Wetherell, M., Taylor, S. & Yates, S. J. (Eds.) *Discourse as data: A guide for analysis*. London: Sage Publications

Carbonell, N. (2014). *The Knotting of Body and Language in Psychoanalysis.* ICLO Dublin.

Carr, A. (2014). The evidence-base for family therapy and systemic interventions for child-focused problems'. *Journal of Family Therapy*, 36 :pp107-157.

Carr, A (2000). *What works with children and adolescents: a critical review of psychological interventions with children, adolescents and their families*. London: Routledge

Cavanagh, M., Quinn. D., Duncan, D., Graham, T., and Balbeuna, L. (2014). Oppositional Defiant Disorder is better conceptualised as a Disorder of Emotional Regulation. *Journal of Attention Disorders*. 10, pp1-9.

Cederman, K. (2017) Left to their own devices? Child psychoanalysis and the psycho-technologies of consumer capitalism. In C. Owens & S. Farrelly-Quinn. (2017) *Lacanian Psychoanalysis with Babies, Children, and Adolescents.* Karnac.

Chafe, W. (1995). Adequacy, user friendliness and practicality in transcribing in G. Leech, G. Myers and J. Thomas (eds). *Spoken English on computer: Transcription, mark up and application.* Harlow England.

Chase, R.M., & Eyberg, S.M. (2008). Clinical presentation and treatment outcome for children with comorbid externalising and internalising symptoms. *Journal of Anxiety Disorders,* 22(2) 273-282.

Chaffin, M., Cambell, C., & Funderburk, B. (2017. Parent-child interaction theraoy in child welfare. In *Parenting and family processes in child maltreatment and intervention.* 107-125. Springer.

Clarke, L.A. *et al* (2017) Three Approaches to Understanding and Classifyig Mental Disorder: ICD-11, DSM V, and the National Institute of Mental Health's Research Domain Criteria (RDoC). *Psychological Science in the Public Interest.* 18(2)72-145.

Cook, D.T. (2004). The commodification of childhood. in *The Commodification of Childhood.* Duke University Press.

Cook, D.T. (2020). The Sage Encyclopaedia of Children and Childhood Studies. Sage.

Conrad, P., & Schneider, J.W. (1992). *Deviance and medicalization: From badness to sickness*. Philadelphia, PA: Temple University Press

Coffey, A., & Atkinson, P. (1996) *Making sense of qualitative data: Complementary research strategies.* Sage Publications.

Costello, E.J., Erkani.A., & Angold. A (2006). *Is there an epidemic of child or adolescent depression*? *Journal of Child Psychology and Psychiatry* 47:12. 1263–1271

Cottrell, D., Boston, P. (2002) Practitioner Review: *The effectiveness of systemic family therapy for children and adolescents*. *Journal of Child Psychology and Psychiatry 43:5* 573-586.

Cushman, P. (1995). *Constructing the self, constructing America: A cultural history of psychotherapy.* New York, Addison Wesley Publishing House.

De Los Reyes, A., Kazdin, AE. 2005. Informant Discrepancies in the Assessment of Childhood Psychopathology: A Critical Review, Theoretical Framework, and Recommendations for Further Study. *Psychological Bulletin, 131(4),* 483-509.

DeMause, L. (1995). *The History of Childhood*. Jason Aronson Press NY.

Denzin, N. and Lincoln, Y.S. (2005) *The Sage Handbook of Qualitative Research* (3rd Ed). London. Sage.

Department of Health and Aging. (2010). Identifying Emotional and Behavioural Problems [Online] Responseability.org [Accessed 7 June 2017] Available at http://www.responseability.org/__data/assets/pdf_file/0009/4869/Identifying-Emotional-and-Behavioural-Problems.pdf

Dirks, M.A., De Los Reyes, A., Briggs-Gowan, M., Cella, D., & Wakschlag, L.S. (2012). Annual Research Review: Embracing not erasing contextual variability in children's behaviour – theory and utility in the selection and use of methods and informants in developmental psychopathology *Journal of Child Psychology and Psychiatry 53 (5*) 558-574.

Dolto, F. (2013) *Psychoanalysis and Paediatrics: Key Psychoanalytic Concepts with Sixteen Clinical Observations of Children*. Karnac.

Dor, J. (1985) *Introduction to the reading of Lacan*. Jason Aronson Press NY.

Dor, J. (1994). *The Clinical Lacan*. Jason Aronson Press NY.

Donovan, J.E. (2005) *Problem Behaviour Theory.* Encyclopaedia of Applied Developmental Science. pp.872-877.

Drabic,D.&Kendal,C.(2010).Problems for the book of problems? Diagnosing mental health disorders among youth. *Clinical Psychology: Science and Practice,* 17, 265-271

Ellenberger, H.F. (1994). *The Discovery of the Unconscious*. London Fontana.

Evans *et.al*. (2008). "Managing the 'unmanageable': Interwar child psychiatry at the Maudsley Hospital, London", *History of Psychiatry*, *19:4.* 458-461.

Evans, D. (1996). *An Introductory dictionary of Lacanian Psychoanalysis.* Brunner-Routledge. New York

Erikson, E. (1950). *Childhood and Society.* Norton Press. New York.

Fairclough, N. (1995) *Critical Discourse Analysis: The Critical Study of Language*. London: Longman.

Farrelly, M. (2015). *The Discursive Construction of Mental Health Problems in Irish print News Media.* PhD thesis, Dublin City University.

Fink, B. (1995). *The Lacanian Subject Between Language and Jouissance*, Princeton New Jersey, Princeton University Press.

Fonagy, P. (2000). Grasping the Nettle: Or Why Psychoanalytic Research is such an irritant. *Annual Research Lecture of The British Psychoanalytic Society*.

Fonagy, P., & Kurtz, A. (2002). *The treatment of disturbance in conduct.* In P. Fonagy, M. Target, D. Cottrell, J. Phillips, & Z. Kurtz, *What works for whom? A Critical review of treatments for children and adolescents*. New York: Guilford Press.

Fonagy *et al* (2015a). The effectiveness of psychodynamic therapies: An update. *World Psychiatry, 24(14*), 137-150.

Fonagy, *et al.* (2015b) *What works for whom: A critical review of treatments for children and adolescents.* (2nd ed). The Guilford Press.

Foucault, M. (1994). *The Birth of the Clinic; An archaeology of medical perception*. New York Vintage.

Foucault, M. (1970). The *Order of Things: An Archaeology of Human Science*s. Random House.

Foucault, M. *(*1977). *Discipline and Punish.: The Birth of the Prison.* London. Penguin.

Foucault, M. (1972). *The Archaeology of Knowledge and the Discourse of Language*. London. Tavistock.

Foucault, M. (1982). Afterward: the subject of power. In Dreyfus, H.L. and Rainbow, P. *M. Foucault: Beyond Structuralism and Hermeneutics*. Brighton: Harvester.

Foucault, M. (1988). *Madness and civilization: A history of insanity in the age of reason*. New York, Vintage. Foucault, M. (1998). *Technologies of The Self*. London: Tavistock.

Francis, A. (2013). *Saving normal: An insider's revolt against out-of-control psychiatric diagnosis, DSM-5, Big Pharma, and the medicalization of ordinary life.* New York, NY: William Morrow.

Freud, S. (1926). *The Question of Lay Analysis. The Standard Edition of the Complete Works of Sigmund Freud Vol 20 pp. 179-258. ed. J. Strachey*. London: Hogart Press.

Freud, S. (1937). *Analysis Terminable and Interminable. Moses and Monotheism,* An Outline of Psychoanalysis and Other Works London: Vintage.

Freud, S. (1905). Three Essays on the Theory of Sexuality. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (SE Vol. 7). London. Hogarth Press.

Freud, S. (1915). Instincts and their Vicissitudes. . In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (SE Vol 14)

Freud, S. (1921). *Group Psychology and the Analaysis of the Ego. Beyond the Pleasure Principle Group Psychology and Other Works*. London: Vintage Hogarth Press.

Freud. S. (1905). An Analysis of a Phobia in a Five Year Old Boy. *The standard edition of the complete psychological works of Sigmund Freud* (SE Vol 7).

Frosh, S. and Barrister, L. (2008) Psychoanalysis and psychosocial studies. *Psychoanalysis, Culture & Society, 13*, 346–365.

Frosh, S. (2003). *Key concepts in Psychoanalysis*. New York University Press.

Furedi, F. (2001). *Paranoid Parenting: Abandon your Anxieties and be a Good Parent*. London. Allen Lane.

Furedi (2004). Therapy Culture: Cultivating Vulnerability in an Uncertain Age. Routledge.

Gassman, D. & Grawe, K. (2006) (General change mechanisms: The relation between problem activation and resource activation in successful and unsuccessful therapeutic interactions. *Clinical Psychology and Psychotherapy*, *13*, 1-11.

Geissmann, C. and Geissmann, *P. (1992). A History of Psychoanalysis with Children.* Routledge Press. London.

Gergen, K. J. (1973). Social psychology as history. *Journal of Personality and Social Psychology, 26*(2), 309–320. https://doi.org/10.1037/h0034436 [accessed April 2017].

Gergen, K,J. (1994). *Realities and Relationships; Soundings in Social Construction.* Cambridge, MA, Harvard University Press.

Gibson, S. (2010). Approaches to data collection and qualitative research. In M.A. Forrester (2010) *Doing Qualitative Research in Psychology.* Sage.

Gilbert, G.N., &. Mulkay, M. (1984). *Opening Pandoras Box. A Sociological Analysis of Scientists Discourse.* Cambridge University Press.

Giorgi, A. (1975). An Application of Phenomenological Method in Psychology. In: Giorgi, A., Fischer, C. and Murray, E., Eds., *Duquesne Studies in Phenomenological Psychology*, Duquesne University Press, Pittsburg, pp82-103.

Ginnot, H. (1969). *Between Parent and Teenager*. Random House USA.

Gutting, G. (2005). *A Very Short Introduction to Foucault*. Oxford Press.

Hagstrom, R. (2013). *The last liberal act*. Columbia Business School Publishing.

Hall, S. (1997). *Representation; Cultural representations and signifying practices*. London. Open University. Sage Publications.

Halliday, M.A.K. (1978). *Language as a Social Semiotic.* London. Edward Arnold.

Harwood, V. (2006). *Diagnosing 'Disorderly' Children: A Critique of Behaviour Disorder Discourses*. Routledge Press. London.

Hersen & Thomas (2007) *Handbook of Clinical Interviewing with Children.* Sage Publications.

Heward, W.L. (2010). *Emotional and Behavioural Disorders in Children: Characteristics.* Pearson Allyn Bacon Prentice Hall.

Hinshaw, S.P., & Cicchetti, D. (2000). Stigma and mental disorder: Conceptions of illness, public attitudes, personal disclosure, and social policy. *Development and Psychopathology 1*2(4) 555-598.

Hinshelwood, R.D. (2005) In Mijolla, A.D.E (Ed) *International Dictionary of Psychoanalysis Vol 2*. McMillan Reference USA.

Hodgkin D, Thomas CP, O'Brien PL, Levit K, Richardson J, *et al*. (2016). Projected spending on psychotropic medications 2013–2020. *Adm. Policy Ment. Health 43*: 497–505

Hoffman, L. Rice, T., Prout, T. (2015) Manual of Regulation-focused Psychotherapy for Children (RFP-C) with Externalising Behaviours: A psychodynamic approach (1st ed). Routledge.

Holmes, A.G.D. (2020). Researcher Positionality – A Consideration of its influence and place in qualitative research. A New Researcher Guide. *International Journal of Education 8 (4).* 1-10. https://files.eric.ed.gov/fulltext/EJ1268044.pdf [accessed May 2020]

Holmes and Lindley (1989). *The Values of Psychotherapy.* London Oxford University Press.

Jager, S., Maier, F. (2001). Theoretical and methodological aspects of Foucauldian critical discourse analysis and dispositive analysis. *In Methods of Critical Discourse Analysis*, Wodak & Meyer.

Jagim, A.R. & Kerksick, C.M. (2021). Creatine Supplementation in Children and Adolescents. *Nutrients. DOI:10.33390/nu13020664* [accessed September 2021]

Janks, H. (1997). Critical discourse analysis as a research tool. *Discourse: Studies in the Cultural Politics of Education, 18*, 329-342.

James, A. C., Reardon, J., Soler, A., James, G., & Creswell, C. (2020). Cognitive behavioural therapy for anxiety disorders in children and adolescents. *Cochrane Database of Systematic Reviews*. https://doi.org/10.1002/14651858.CD013162 [accessed September 2021]

Jenks, C. (2005) *Childhood* (2nd Ed). Routledge.

Johnson, K., & Johnson. H. (Eds) (1998). *Encyclopaedic Dictionary of Applied Linguistics*. Blackwell.

Johnston& Fruehling (2008). Psychopharmacological approaches with children and adolescents. In R. Morris & T. Kratochwill (Eds) *The Practice of Child Therapy.* Taylor and Francis.

Kazdin, A. E. (1995). Child, parent, and family dysfunction as predictors of outcome in cognitive behavioural treatment of antisocial treatment. *Behavioural Research and Therapy, 33,* 271-281.

Kazdin, A. E., & Wasser, G. (2000). Problem solving skills training and parent management training for conduct disorder. *Evidence Based Psychotherapies for Children and Adolescents.* New York, Guilford Press.

Kearney, R. (1994) *Modern Movements in European Philosophy* (2nd ed). Manchester University Press

Kehily, M.J. (Ed). (2013). *Understanding Childhood: A cross disciplinary approach.* Policy Press.

Kendall G. and Wickham G. (2004). The Foucaultian framework IN: Seale, C., Gobo, G., Gubrium, J.F. and Silverman, D. *Qualitative Research Practice*. Sage: London. 141-150.

Kennedy (2015). The Roots of Childhood Studies. Philosophy, History and Religion. https://www.academia.edu/14858806/THE_ROOTS_OF_CHILD_STUDY_PHILOSOPHY_HISTORY_AND_RELIGION [accessed June 2019]

Kessen, W. (1979). The American Child and other cultural inventions. *American Psychologist.* 34(10), 815

King, N. (2010). Research Ethics in Qualitative Research. In *Doing Qualitative Research in Psychology* M .Forrester (ed). Sage.

Karpinski, R. *et al.*, (2018). *High intelligence: A risk factor for psychological and physiological overexcitabilities. Intelligence, 66,* 8-23.

Klingbeil, D.A., Renshaw, T.L., Willenbrink, J.B. Copek, R.A., Chan, K.T., Haddock, A. & Clifton, J. (2017). Mindfulness-based interventions with youth: A comprehensive meta-analysis of group-design studies. *Journal of school psychology 63* 77-103.

Klein, M. (1930). The Importance of Symbol Formation in the Development of the Ego. *The writings of Melanie Klein Vol 4.* London. Hogarth.

Kvale, S. (1996). The 1,000-page question. *Qualitative inquiry.* 2(3), 275-284.

Lacan, J. (1953). *The function and field of speech and language in Pychoanalysis. Ecrits; A Selection.* Trans. Alan Sheridan. London: Tavistock, (1977).

Lacan, J. (1956-1957). *La relation d'objet; Le Seminaire*, livre IV (J.-A. Miller, Ed.). Paris; Seuil, (1994).

Lacan, J (1956-1957), Seminar IV Object relations, trans

Lacan, J. (1994). *The Four Fundamental Concepts of Psycho-Analysis*. London, Penguin Books.

Lacan, J. (2007). *The Other Side of Psychoanalysis*. London, W W Norton & Company.

Lacan, J. (1992*). The Ethics of Psychanalysis*. Trans Denis Porter. Routledge.

Lacan, J. (1967). *The Psychoanalytic Act*, book XV (1967-1967). The seminar of Jacques Lacan (C Gallagher Trans). Unpublished.

Lacan, J. (1973) *television; A challenge to the psychoanalytic establishment.* Ed Joan Copjec. Trans Denis Hollier. Norton Press NY (1990)

Lacan, J. (2019). *Desire and its interpretation*. Trans J.A Miller. Polity

Laclau, E. (1990) *New Reflections on the Revolution of Our Time*. London: Verso.

Laplanche, J., and Pontalis, J. B. (1988). *The Language of Psychoanalysis.* London Karnac Books.

Laurant, E. (1990). The Impact of Lacann's Teaching on Psychoanalysis with Children. *Analysis* 2. 21-37. Melbourne: Centre for Psychoanalytic Research

Lefort, R. (1990*). The first three sessions of treatment of the wolf child. analysis 2*. 9-19. Melbourne: Centre for Psychoanalytic Research.

Lejdstrom, R., Douglas, I., Evans, S.J., & Smeeth, L. (2016). Latest trends in ADHD drug prescribing patterns in children in the UK: prevalence, incidence and persistence. *British Medical Journal.* 6 http://creativecommons.org/licenses/by/4.0 [accessed June 2019].

Lewis, A. (2020). Understanding the concept of child well-being: Domains, dimensions and discourses. In *Childhood Well-Being and Resilience* (pp. 7-19). Routledge.

Libby AM, Brent DA, Morrato EH, Orton HD, Allen R, Valuck RJ.(**2007)**. Decline in treatment of pediatric depression after FDA advisory on risk of suicidality with SSRIs. *American. Journal of Psychiatry 164*: 884–91.

Liebrecht. K. (1998). The Original Sin of Psychoanalysis: On The Desire of the Analyst. In Dany Nobus. *Key Concepts in Psychoanalysis*. Rebus Press.

Lupton, D. (1992). Discourse analysis: A new methodology for understanding the ideologies of health and illness. *Australian Journal of Public Health*, 16, 145-150.

Luckmann, T. and Berger, P. (1966) The Social Construction of Reality. A Treatise in the Sociology of Knowledge. Doubleday and Company Press.

McElvaney, R., Judge, D., & Gordon, E. (2017). The Primary Schools Counselling Study (PSCS): Demand and provision of school based counselling in Ireland. *Dublin: Dublin City University*.

Mash, E.J.,& Barkely, R.A. (2014) Child psychopathology. *Child Psychopathology.* Guilford Publications.

Mcleod, J. (2002). *Qualitative Research in Counselling and Psychotherapy*, London, Sage Publications.

McCarthy, K., Phillips, D. (2008). *The Blackwell handbook of Early Childhood Development.* Wiley & Sons.

McHoul, A. & Rapley, M. (2005). A Case of attention-deficit/hyperactivity disorder diagnosis: Sir Karl and Francis B. slug it out on the consulting room floor. *Discourse & Society,16(3*), 419–449

Maliken, A.C. & Katz, L.F. (2013). Exploring the impact of parental psychology and emotion regulation on evidence based parenting programmes: A transdiagnostic approach to improving treatment effectiveness. *Clinical child and family psychology review, 16(2*), 173-186.

Mannoni, M. (1967) . *The Child, his illness and the Others*. Penguin.

Masten, A.S., Burt, K.B., & Coatsworth, J.D. (2006) Competence and psychopathology in development. In D.Cicchettii & D.J. Cohen (Eds), *Developmental psychopathology: Risk, disorder, and adaptation. (*696-738). John Wiley & Sons, Inc.

Mathelin, C. (1999). *The Broken Piano*. Other Press.

Mathews, G. (1996). *The Philosophy of Childhood*. Harvard University Press.

Mead, M. (1928) 2001. *Coming of Age in Samoa: A Psychological Study of Primitive Youth for Western Civilisation.* Harper Perennial Modern Classic.

Meuser, M. and Nagel, U. (2009). *The Expert Interview* and *Changes in Knowledge Production.* In *Interviewing Experts.* Palgrave Macmillan.

Meynard BR, Heyne D, Brendel KE, Bulanda JJ, Thompson AM, Pigott TD. Treatment for School Refusal Among Children and Adolescents: A Systematic Review and Meta-Analysis. *Research on Social Work Practice*. *28(1)* 56-67. doi:10.1177/1049731515598619 [accessed February 2022]

Midgely, N. Midgley, Jan Anderson, Eve Grainger, Tanja Nesic-Vuckovic, Cathy Urwin *Child Psychotherapy and Research*.

Miller, J.A. (2012) Contradictions to psychoanalytic treatment. *Psychoanalytic Notebooks 4.* 56-73.

Miller, J.A. (2005). *The Pathology of Democracy*. London Karnac.

Millteer & Ginsburg (2012) The Importance of Play in Development. *Pediatrics 129* (1) 204–213.

Montgomery, H. (2008). *An introduction to childhood: Anthropological perspectives on children's lives*. John Wiley & Sons.

Moore, G. (2012). *A Psychoanalytic Investigation of Transference Management in the Irish Adult Public Mental Health Services.* School of Nursing and Human Sciences, Dublin City University. Dublin.

Moreira-Maia, C.R., Massuti, R., Tessari, L. Campani, F., Akutagava-Martins, G.C, & Rohde, L.A. (2018) Are ADHD medications under or over prescribed worldwide? Protocol for a systematic review and meta-analysis. *Medicine*, 97(24). ncbi.nlm.nih.gov/pmc/articles/PMC602376. [accessed February 2019]

Morris, J. & Kratochwill, T.R. (2008). *The Practice of Child Psychotherapy* (4th ed). Taylor and Francis.

Najles. A. (2015). The child of the global market. *Lacunae.* 10 173-193.

O'Reilly, M., Lester, J. N., & Muskett, T. (2016). Children's claims to knowledge regarding their mental health experiences and practitioners' negotiation of the problem. *Patient education and counseling*, *99*(6), 905–910. https://doi.org/10.1016/j.pec.2015.10.005

Ollendick, T.H (1991). Negative affectivity in children and adolescents: relationships between anxiety and depression. *Clinical Psychology Review. 11(4)* 441-459.

Ollendick, T.H. & King, N.J. (2004). Empirically supported treatments for children and adolescents:advances towards evidenced-based practice. *Handbook for interventions that work with children and adolescents: Prevention and treatment,* 1-25.

Ollendick T.H., King N.J. Empirically supported treatments for children with phobic and anxiety disorders: current status. .*Journal of Clinical Child Psychology 27*. 156-67.

Olsen, M. (2017). Wittgenstein and Foucault: The Limits and Possibilities of Constructivism. In Peters, M.A., Stickney, J. 2017. *A Companion to Wittgenstein on Education*. 305-320.

Palmer, S. (2006). *Toxic Childhood. How the modern world is damaging our children and* what *we can do about it.* London Orion.

Parker, I. (1992). *Discourse Dynamics: Critical Analysis for Social and Individual Psychology*. London, Routledge.

Parker, I. (1996). Postmodernism and its discontents: Therapeutic discourse. *British Journal of Psychotherapy, 12*, 447-460.

Parker, I. (1999). *Deconstructing Psychotherapy*. London: Sage

Parker, I. (2005). *Qualitative Psychology: Introducing Radical Research*. Open University Press.

Parker, I., & Pavon-Cuellar, D. (2014). *Lacan, Discourse, Event: New Psychoanalytic Approaches to Textual Indeterminacy.* New York, Routledge Press.

Parker, I. (2014). *Discourse dynamics: Critical analysis for social and individual psychology*. Abingdon, Routledge.

Parry-Jones, William, "The History of Child and Adolescent Psychiatry: Its Present Day Relevance". *The Journal of Child Psychology and Psychiatry, 30:1*. 7.

Patton, M. (1990). *Qualitative evaluation and research methods*. Beverly Hills, CA: Sage.

Patton, M. Q. (2015). *Qualitative research & evaluation methods: Integrating theory and practice* (4th ed.). Thousand Oaks, CA: Sage.

Plastow, M.G. (2010). Discourse and The Clinic. *Journal of Australian Psychiatry 18.* 23-27

Polanyi, M. (1958, 1998). *Personal Knowledge. Towards a post critical philosophy.* London. Routledge.

Pollock, L. A. (1983). Forgotten Children: Parent Child relations from 1500 – 1900.

Potter, J. and Wetherell, M. (1987) *Discourse and Social Psychology: Beyond Attitudes and Behaviour*. London: Sage.

Potter, J. and Wetherell, M. (1995) 'Discourse Analysis' in J. A. Smith, R. Harre, and L. van Langenhove (eds.) *Rethinking Psychology*, London: Sage.

Plastow, M.G. (2015) *What is a Child: Childhood, Psychoanalysis, and Discourse.* Karnac.

Prout, A. (2008). Culture-nature and the construction of childhood. In S. Livingstone and K. Drotner (eds*), The International Handbook of Children, Media and Culture*. London Sage.

Prout, A., & James, A. (2003) *Constructing and Reconstructing Childhood: Contemporary Issues in the Sociological Study of Childhood*. Routledge.

Rodriguez, L.S. (1994). *Psychoanalysis with Children.* Free Association Books. London.

Rose, N. (1990) Psychology as a social science, in I. Parker and J. Shotter (eds), *Deconstructing Social Psychology.* London Routledge.

Rose, N. (1999). *Powers of freedom: Reframing political thought.* Cambridge university press.

Rosenberg, C.E. (2007) *Our present complaint: American medicine, then and now.* JHU Press.

Roudinesco, E. (1990*). Jacques Lacan and Co.: A history of psychoanalysis in France, 1925–1985*. London, UK: Free Association Books

Saarni, C. (2011). Emotional competence and effective negotiation: the integration of emotion understanding, regulation, and communication. In *Psychological and political strategies for peace negotiation* pp.55-74. Springer, New York.

Sanders, M.R. (1999). Triple P-Positive Parenting Program: Towards an Empirically Validated Parenting and Family Strategy for the Prevention of Behaviour and Emotional Problems in Children. *Clinical Child and Family Psychology Review, 2.* 71-91.

Schatz, N.K., Fabiano, G.A., Cunningham, C.E. *et al.* Systematic Review of Patients' and Parents' Preferences for ADHD Treatment Options and Processes of Care. *Patient* **8,** 483–497 (2015). https://doi.org/10.1007/s40271-015-0112-5

Schultz, D., Izard, C.E., & Bear, G. (2004). Children's emotion processing: Relations to emotionality and aggression. *Development and psychopathology.* 16(2), 371-387.

Schiffrin, D. (1996) Approaches to Discourse. In T.A Schwandt, T.A. (1996). Farewell to criteriology. *Qualitative Inquiry 2.* 58-72.

Schwandt, T. A. (1994). Constructivist, Interpretivist Approaches to Human Inquiry. In N. K. Denzin, & Y. S. Lincoln (Eds.), *Handbook of Qualitative Research*.

Schwandt, T.A. (2007). Analysing Qualitative Data. In *The Sage Dictionary of Qualitative Inquiry.* Sage Publications.

Seligman, L. D., & Ollendick, T. H. (2011). Cognitive-behavioural therapy for anxiety disorders in youth. *Child and adolescent psychiatric clinics of North America*, *20*(2), 217–238. https://doi.org/10.1016/j.chc.2011.01.003

Soler, C. (2015). *Lacanian Affects: The function of affect in Lacan's work.* Routledge

Smith, K. (2012) Producing governable subjects: Images of Childhood Old and New. *Childhood. 19(1)* 24-37.

Smith, K. (2014). *The Government of Childhood. Discourse Power and Inequality*. Palgrave and Macmillan.

Smith, J.A. and Osborn, M. (2008). Interpretative Phenemenological Analysis. In J.A. Smith. *Qualitative Psychology: A Practical Guide to Research Methods*. 53-80. Sage Press.

Strong, T. & Sesma-Vasques, M. (2015) In M. O'Reilly & J. Lester (Eds.) (2015). *The Palgrave Handbook of Child Mental Health*, 99-116. London, UK: Palgrave Macmillan

Strong, T. (2017). *Medicalising Counselling: Issues and Tensions.* Springer

Szasz, T. (1974). *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct.* Harper Row.

Taylor, S. & Smith, R. (2014). The *ethics of interviewing for discourse analysis*: *responses to Martyn Hammersley*. Qualitative Research, 14, 542-548.

Timimi, S. (2002*). Pathological Children and the Medicalisation of Childhood.* Brunner-Routledge, USA.

Tomsic, S (2015). *The Capitalist Unconscious*. *Marx and Lacan*. Verso Press.

Urwin, C. (2009). A qualitative framework for evaluating clinical effectiveness in child psychotherapy. In Ed N. Midgley *et al. Child Psychotherapy and Research: New Approaches, Emerging Findings*. (pp87-99). Routledge.

Van Haute, P. (2001) *Against Adaptation*. Other Press

Vanheule, S. (2011), *The Subject of Psychosis*. London Palgrave Macmillan.

Verhaeghe, P. (2004). *On Being Normal and Other Disorders*, New York, Other Press.

Verhaeghe, P. (1995). Lacanian Perspectives on Psychoanalysis. *The Letter*. (3) 91- 108.

Villadsen, K. (2021). The dispositive: Foucault's concept for organisational analysis? *Organisation Studies* 42(3) 473-494.

Vissers J, Beech R. (2005) *Health operations management: patient flow statistics in health care*. New York: Routledge.

Von Glaserfeld, E. (2013). *Radical constructivism*. Routledge.

Waddell, C. *et al.* (2018*).* Fifty years of preventing and treating childhood behaviour disorders*:* a systematic review to inform policy and practice. *British Medical Journal*. *21(2*) 45-52.

Wampold, B. & Brown, J (2006) Estimating variability in Outcomes attributable to therapists: A naturalistic study of outcomes in managed care. *Journal of Consulting and Clinical Psychology 73 (5)* 914-923.

Wampold, B. (2001). *The Great Psychotherapy Debate*: *Models, Methods, and Findings.* Lawrence Erlbaum Associates, New Jersey.

Watson, D. (2004). *Dictionary of Weasel Words, Contemporary Cliché s, Cant and Management Jargon* . Sydney: Vintage.

Webster-Stratton, C., & Bywater, T. (2019). The Incredible Years® series: An internationally evidenced multimodal approach to enhancing child outcomes. In B. H. Fiese, M. Celano, K. Deater-Deckard, E. N. Jouriles, & M. A. Whisman (Eds.), *APA handbook of contemporary family psychology: Family therapy and training* (pp. 343–359). American Psychological Association. https://doi.org/10.1037/0000101-021

Wetherell, R. (2011). *Forgetting Freud. Is Psychoanalysis in retreat?* Academic Press. USA

Wetherell, M., Taylor, S., & Yates, S.J. (2001). *Discourse as Data. A Guide for Analysis.* The Open University Press.

Wetherell, M., Taylor, S., & Yates, S.J. (2001). *Discourse Theory and Practice. A Reader.* The Open University Press.

Wiggins, S., Riley, S.C.E. (2010). Discourse Analysis. In C. Sullivan and M. Forrester (2010) *Doing Qualitative Research in Psychology: A Practical Guide.* Sage Publications.

Whitaker, R. (2010). *Anatomy of an Epidemic*. Crown NY.

Willig, C. (1999). *Applied Discourse Analysis: Social & Psychological Interventions*. Open University Press.

Willig, C. (2008). *Introducing qualitative research in psychology: Adventures in theory and method*. Buckingham University. (2nd Ed). Open University Press.

Willig, C. and Stainton-Rogers, W. (2013). *The Sage Handbook of Qualitative Research in Psychology*. (2nd Ed).

Wittgenstein, L. (1967) *Philosophical Investigations*. Oxford: Blackwell.

Woolfenden, SR., Williams, K., Peat, JK. (2002) Family and parenting interventions for conduct disorder and delinquency: a meta-analysis of randomised controlled trials. *Archive of Diseases of Childhood 86*, 251-256.

Wodak, R. (2005). *A New Agenda in (Critical) Discourse Analysis: Theory, Methodology and Interdisciplinarity.* Philadelphia, PA: John Benjamin's Publishing Company.

Wodak, R. & Meyer, M. (2009) 'Critical Discourse Analysis: history, agenda, theory, and methodology', in R. Wodak, and M. Meyer, (eds.) *Methods of Critical Discourse Analysis* (2nd Ed). London: Sage.

Wodak, R. and Krzyżanowski, M. (2008). *Qualitative Discourse Analysis in the Social Sciences*. London: Palgrave Macmillan.

Wolff, J. and Ollendick, T.H. (2011). Conduct Problems in Youth. Classification and Epidemiology. In Murrihy, R., Kidman, A., and Ollendick, T.H. *Clinical Handbook of Assessing and Treating Conduct Problems*. Springer Press.

Wolfing, N. (2014). The Child. *Psychoanalytic Notebooks*. (28) The London Society of The New Lacanian School.

Wright, AM. (2009). Every Child Matters: discourses of challenging behaviour. *Pastoral Care in Education, 27 (4),* 279-290.

Zelizer, V. (2002) Kids and Commerce. *Childhood, 9(4),* 375-396.

Zepf, S. (2010). The psychoanalytic process and Freud's concepts of transference and transference neurosis. *Psychoanalytic Psychology, 27*(1), 55-73. https://doi.org/10.1037/a0018640

Zizek, S. (1989). *The Sublime Object of Ideology*. Verso Press.

Zizek, S. (1992). *Looking Awry*. Other Press

Zizek, S. (2012). *The Perverts Guide to Ideology*. Other Press

Zuliani, E. (2014). The Child in discourse-land. *Psychoanalytic Notebooks.* (28) The London Society of The New Lacanian School.

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Appendices

Appendix 1: Transcript Examples

EXCERPT FROM TRANSCRITION OF INTERVIEW P1

P1. Right yes.. well em… to reduce the omnipotence of the other then (sometimes it is very important to do that) there are certain manoeuvres that one can do. The first is to not place yourself as an omnipotent other, that is always important. Second of all is to make very clear to the child that you are not going to take the side of the mother or parent….because sometimes the parents come and they do that right, they come and they talk to you in the presence of the child because you know [something inaudible] but manoeuvring with that is by letting the child know somehow that you are not aligning with the parent that it also required sometimes. Third of all is to know that the symptom cannot be touched directly… so you know if they come because, you know ( ) they have enuresis, a common symptom, how you, you let the child know that they can talk to you about it when he thinks he can talk to you about it ( )but with the terms and conditions that he thinks he can talk to you about it. Otherwise if you touch the symptom directly then your gonna adopt a pedagogical approach to it like everyone else. Sometimes it's difficult because ( ) sometimes the parents want a response to that and you know it is not possible. I can think of a child who I have seen for 4 years and the reason why he came was that he was wetting the bed. It's interesting because that symptom was related to, for him, an impossibility. Its very interesting because once he told me a dream that he was holding a [inaudible] he was flying, and he saw one of those kiosks where they sold hotdogs and he was holding a hot dog, he had stolen a hotdog and in the dream he was flying and holding the hotdog. When the owner of the kiosk sees that he has stolen the hotdog he tries to stop him, he is flying with a, not a parachute, with a balloon right ( ) when the owner tries to stop him he knows that he must let go of the hotdog but he knows that he is going to go down right so that dream is so clear… there is a certain jouissance that he must let go but he cannot let it go. We did a lot of work with that child but ha, he still wets his bed ye know so eh, because there is something he cannot let go. So… he knows that that is not the problem. He knows that is not the problem, the problem is somewhere else. Ha, I don't know if that answers the question, but yeah..

SMcC. Yes, in such a situation, if we may extend that example a little bit, there the child is in a very, is in a position of enjoyment with the mother.

P1. Of course...

SMC. So what is being demanded that he relinquish?

P1. ( ) He must consent so a certain logic of jouissance, he must consent to castration ( ) em and the point is that he can't… if he can not he may become a very very stubborn obsessive haha, he cant. Well... he is better than he was but he feels that there is something very difficult.

SMC. So () I see it as if this dual relation, this closely knit, and this is something he is incapable or unwilling to give up or relinquish.

P1. Well ( ) he must assume a certain castration, it's not that different from little Hans in a way. He has to consent to castration but he has not constructed the fantasy as well.

SMC. Is the work in that case about facilitating the child in the construction of the fantasy that allows him to deal with this desire of the other?

P1. Exactly, because he is neurotic child.

SMC. The third question then. How do you conceptualise children's symptoms? ( ) … is there a difference in the quality of these symptoms? ( ) how they are constructed and how they present and is this distinguishable from adults?

P1. ( ) Em , yes, in a way yes. Em because for the very same thing that I said at the beginning, they, the adult constructs the symptom and their transference and they come because there is something that makes them suffer, right. With the child they come because there is something that happens with the others… which the others see as a problem. But how that is transformed into a symptom is, that the child can work, its very ( ) it's the whole key of treatment right, and obviously when we get to that point for the child, it's true that the conceptualisation is never the way it is with an adult, that is that with the adult it is full of a lot more meanings and fantasies that are already constructed that already have decided a lot of things of the adult life…

Appendix 2: Notes On Initial Thoughts And Impressions

EXCERPT FROM INTERVIEW	INITIAL THOUGHTS AND IMPRESSIONS
P6 Looking at the way the whole cognitive approach in schools teaches children about their thoughts; green thoughts and red thoughts, straight away your pathologizing children. Straight away your saying to the child that there are some thoughts you can have that are okay and some that are not and if you have those thoughts you have to tell the others and the others will give you something to do…	There is an emphasis here on the rapid response to what is considered abnormal (thoughts) "straight away". This implies that she believes there is an immediacy required in the correction of this form of deviation (correct ways to think – controlling thinking – mental hygiene. Green thoughts and red thoughts, signals of pathology, there is also degree of ire being expressed in all of this.
P4 SMC The first example that you offered of the case of the 3yr old boy many years ago, his symptom, if we could call it that, was 'in answering to something subjective in the mother', would that be correct to say so far? P4 (…) Look, I'm not sure, I probably wouldn't put it in that way, but I would say that he is the object of the mothers fantasm… Whether he is answering to… did you say answering to something subjective in the mother? SMC Yes P4 I don't like this word subjective. Maybe Lacan used this word in the early days but not later on because I'm not sure that there can be something subjective ( ) that can be an attribute. You can see that the subject emergences during a particular moment or event rather than something that has an	There is a little tension in this exchange. P4 seems to wish to have things put very 'correctly'. I ask him whether I am phrasing things correctly. He corrects me several times and offers a more advanced way to understand things and by ref to the later work of Lacan indicates his advanced knowledge of the topic. There is possibly a degree of frustration with the direction of the questions and perhaps my attempt to use simpler terms to describe complex matters is an issue. I avoided reacting to this directly and instead responded by allowing his phrasing direct the answer, as such he answers his own question. Is there the adoption of a master position by the participant in this excerpt.

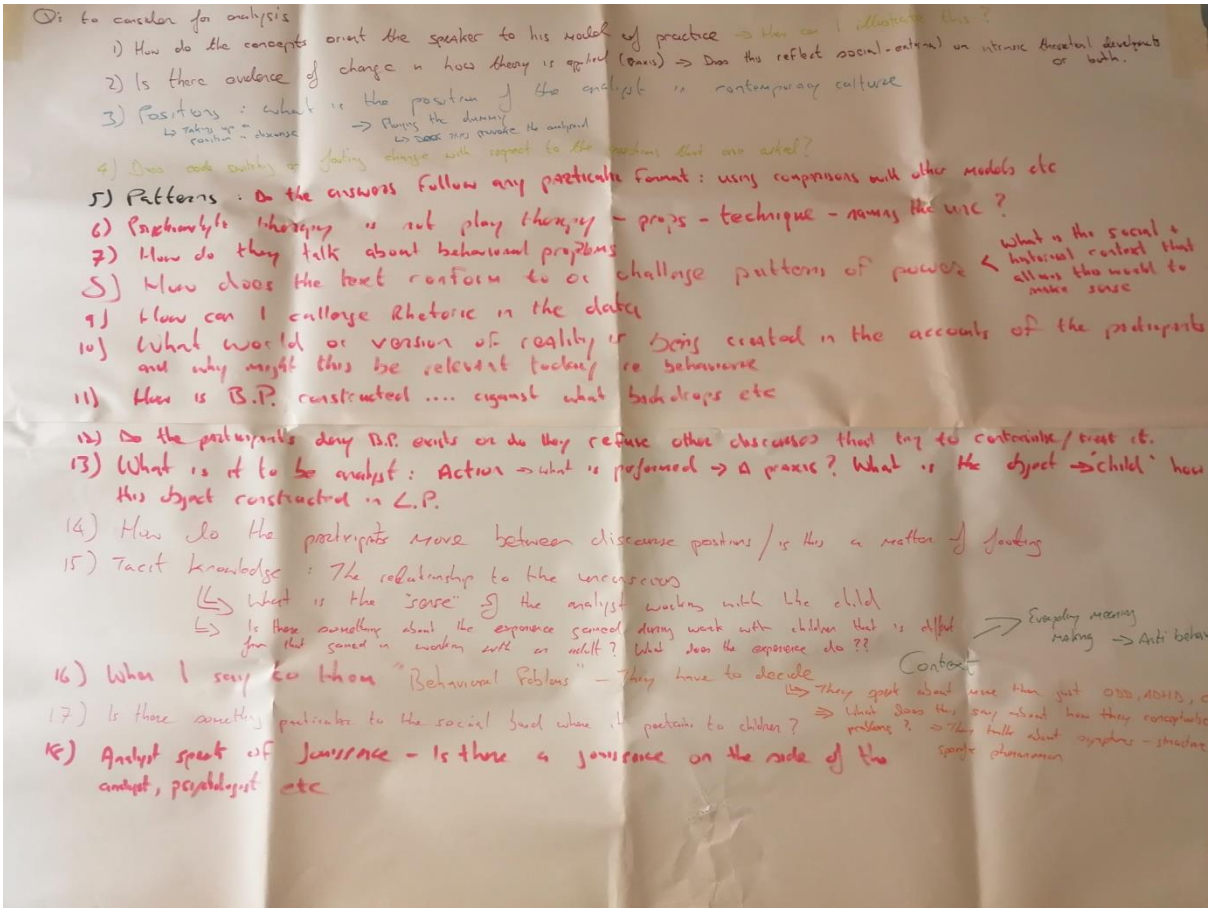
ongoing existence ( ) for which you utilize the noun subjectivity.	
P1 SMC Can you tell me more about how you engage with the child at that level.. **P1** Well… it depends very much on different children. For instance there are autistic children… I am there to give value to the work they are doing. It is very different the work I do with a autistic child or a psychotic child to the work I do with a neurotic child. It is very difficult to generalise for all children.	There is a slight degree of contradiction where she states that 'it is dependent on whether the child is psychotic or neurotic' however she also states that every child is different before going on to say that it's difficult to generalise. neurotic and psychotic could be regarded categories and therefore this is a generalisation. 'I am there to give value to the work they are doing'. Could this be interpreted as the childs work has a value that only the analyst can put on it? Could this indicate a position of power that also has a capitalist resonance to it.

Appendix 3: Categorical Analysis

QUESTION	PARTICIPANT RESPONSE	REFLECTION ON DATA	NOTE ON OBJECTS
What is unique about psychoanalysis	**P1** *psychoanalysis is very subversive. Psychoanalysis offers a dignity to the patient in a culture that over values happiness. Giving a dignity to the symptom in a world that is trying to erase symptoms is a unique contribution* *It is a unique discourse and establishes a social bond that stands apart in a cultural context. The ethics that guide the practice*	Accessing a particular knowledge. Taking symptoms seriously and taking symptoms as an interpretation (P1.p.14) Consider the different ways in which the word ethics and ethical are being used	P1 suggests that psychoanalysis is about doing something with life. It is <u>counter-cultural</u> in the sense that is values the <u>symptom</u> and doesn't aim to eradicate the symptom.
	P2 *states the signifier of the child, I have to hear it, see it, mark it, without interpretation, just I have heard it. That gives a kid of singularity to the child, and that, I think is unique you see.*	P2 references the technique of the analyst and highlights the importance of working with the signifier. There is a contradiction between P1 and P2 with regard to the signifier. P2 says that ethically there is no difference in the work with a child compared to an adult	<u>A praxis</u>? An application of concepts and theory Vs An ethical position one takes up relative to the child.

QUESTION	PARTICIPANT RESPONSE	REFLECTION ON DATA	NOTE ON OBJECTS
	P4 *that's a sort of generalist question and no doubt relates to the topic of your thesis.*	P4 offers a little resistance to the final question, (consider what this comment implies, does the participant feel that it is a move in a different direction, is he going to change tact here perhaps?)	The shift in subject position from being an interviewee to interviewer. A reversal. Who's voice will be heard on this matter.

Appendix 4: Analysis Chart



Appendix 5: Themes

Interview	**Commentary**	**Theme**
(P1) *…"<u>right away I try to put away the question of demand</u> because children are very demanded right, they are demanded to behave, to talk, they are demanded you know, they are always demanded right…*	the word demand is given emphasis even as it is repeated here. The P is constructing a version of the child as being under siege.. the expectations of the adult world are conveyed here as burdensome, the child is subjugated, the Other possesses the power that is expressed in a demand. "I put away demand", Is this not impossible? Power?	A **crisis** in contemporary childhood. "**che vuoi**" - what does the other want of me is a question but what are the possibilities and limitations in terms of a response in this case. This is dependent upon the discourse that is operating at the time.
--- (P6) …"there's a super-egoic demand on the parents, get exercise for the children etc, and I think it destabilises, the child at the centre has no power or voice"	--- Subject position: Use of psychoanalytic term applied in a broader social context. Political idea's informed by psychoanalytic concepts. Suspicious of broader social dynamics: *"I think it destabilises"* (?) allusion to parent child relation? lack of power on the	The **analyst's position** when working with children --- A **crisis** of culture.

	part of the child leading to an imbalance or unstable state of relations. **Multivoicedness** (social commentator & psychoanalyst)	
P3 *The work with the parent may involve the parent entering into analysis with myself or someone else. Treating the mother of the autistic or psychotic child is recommended because, for the mother, the child is like a symptom for them*	There is no protocol on how the other family members are involved unlike family therapy. The mother needs treatment is an assumption based on the diagnosis of the child. The participant is using psychiatric terminology to take up a clinical position relative to the mother.	The **place of the parent** in the treatment of the child. The **child is a symptom** of the parents.

Appendix 6: Interview Schedule

Q1.

Please tell me about <u>how</u> you conduct your work with children!

- Anything about your current work with children.

Q2.

How do you think about this work?

- Principles of your practice

- Nuances (differences/particularities) associated with working with children (<u>transference….</u>) compared to adults.

- The particularities of the child clinic etc.

Q3.

How do you conceptualise (understand/comprehend) symptoms in childhood?

- what (if any) are the differences in how symptoms are formed in childhood and how the function for the child and Other?

- your thoughts on the 'problem child' and his/her behaviour as 'symptom'?

Q4.

What is the role of contemporary culture in the psychopathology of childhood today?

- your thoughts on how the family-society-culture-ideology inform contemporary symptoms.

- your thoughts on the <u>discourse</u> around childhood and problematic behaviour in contemporary culture.

- your thoughts on contemporary diagnostics and treatment of children with such symptoms.

Q5.

What in your view is unique/distinctive about what psychoanalysis brings to our of childhood behavioural problems (symptoms)?

Appendix 7: Invitation To Participants

Dear Dr…

I am writing to you in relation to research which will form part of a doctoral thesis exploring psychopathology in children. The research is specifically concerned with the Lacanian understanding of and therapeutic response to this clinical phenomenon. As principal researcher I am endeavouring to interview you in relation to your thoughts and views on this issue. As a member of The World Association for Psychoanalysis (WAP) and given your extensive list of publications in the area of psychoanalysis with children your contribution to the study would be invaluable and much appreciated.

I am hoping to explore the issue of childhood behavioural problems from your perspective and using Discourse Theory as a means to investigate the key themes to this study; the role of discourse in the construction of symptoms, the efficacy or otherwise of contemporary approaches to treatment and the difference between these approaches and the Lacanian approach as a specific discourse (the Analysts Discourse).

Your participation in the study will involve an interview which will last no longer than 1.5hrs.

I would gratefully and respectfully welcome your time and contribution to this study and I am happy to furnish you with any other details by email or phone call.

Yours Sincerely,

Stephen McCoy

/

Appendix 8: Plain Language Statement

The following study has been designed by Stephen McCoy (Principal Investigator) as part of Doctorate in Psychotherapy at the School of Nursing and Human Sciences at Dublin City University under the supervision of Dr Rosaleen McElvaney and Dr Veronica Lambert. The study has been approved by Dublin City University's Research Ethics Committee

The PI intends to interview participants at their place of work or at a location that is deemed suitable and convenient for the participant. The interview will take no longer than 1.5hrs. Where interviews are to be conducted with participants living and working outside of Ireland Skype will be the preferred medium of communication. Participants will be required to engage in a semi structured interview which will be audio recorded before being transcribed and analysed. The participants names/personal details will not be included at any point in the study. Participants will be entitled to a copy of the transcribed material upon request and will also be provided with a synopsis of the study upon completion.

The PI does not believe there to be any substantial risk to any participant taking part in the study. The researcher will remain sensitive to those participants using English as a second language. In each case the participant will be provided with the opportunity to clarify or retranslate any answers provided during the interview.

As a participant you are being invited to take part in this study on the basis of your expertise in the area of Lacanian psychoanalysis with children and adolescents. The primary aim of this study is to identify the unique features of Lacanian psychoanalysis in the conceptualisation and treatment of children presenting with mental health difficulties. Lacanian psychoanalysis represents a small but significant discipline in clinical practice and boasts several original and illuminating theories on the nature of subjectivity, symptomatology and culture. It is expected that your contribution to the study can be brought to bear in how a wide variety of psychological services faced with this growing trend may better understand and respond to the difficulties affecting such children. The researcher believes that the study will be of direct relevance to you as a clinician working with children and young adolescents who present with a wide range of mental health issues.

Please be aware that data provided in the course of the study maybe subpoenaed by the Data Protection act 1998 and the Freedom of Information act 2014 which stipulate under law how data is to be stored and may be used.

In keeping with data storage legislation the researcher is obligated to store data for 5 years before shredding any hard copies and deleting the audio records. In that time the data will be securely stored and double locked within the office of the PI's private residence. If you have any concerns with how the information you have provided in the course of this study is being used you are entitled to contact the Data Protection Commissioner who may in turn request any information in this study relating to data storage, protection and use.

This project is self funded and your participation is voluntary. You are free to withdraw at any point.

Once you have agreed to take part in the study the researcher will contact you in writing to arrange a suitable time and place for conducting the interview. If you have concerns about this study and wish to contact an independent person, please contact:

Research Supervisors:

Dr. Rosaleen McElvaney. H269A. School of Nursing and Human Sciences. Dublin City University. Glasnevin, Dublin 9. rosaleen.mcelvaney@dcu.ie 017007383

Dr. Veronica Lambert. H268A. School of Nursing and Human Sciences. Dublin City University. Glasnevin, Dublin 9. veronica.lambert@dcu.ie 017007161.

DCU Research Ethics Committee. rec@dcu.ie

Appendix 9: Informed Consent Form

Why children hate the word 'NO'. A Lacanian Response.

Principal Investigator: Stephen McCoy.

Research Supervisors: Dr. Rosaleen McElvaney. School of Nursing and Human Sciences. Dublin City University. Glasnevin, Dublin 9. rosaleen.mcelvaney@dcu.ie 017007383

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Purpose of Research.

The following study is designed to explore how Lacanian psychoanalysts conceptualise behavioural problems in children. You are being invited to take part in this study on the basis of your extensive experience of working with children and adolescents in the Lacanian orientation. Your participation in this study will involve a semi structured interview that will last no longer than 1.5hrs. The study is designed to enquire into your views regarding the role of discourse in both the aetiology of behavioural problems and how these issues relate to contemporary culture. The principal investigator will draw on Lacanian Discourse Theory to provide a context for how the symptoms associated with behavioural problems are understood. The research is being self-funded by the PI. Your participation in this study will be anonymous and the researcher will omit the use of your name in the study. While the researcher will endeavour to provide you with confidentiality throughout the course of the study your inclusion may incur your identification as a consequence of the small sample size of the participant group.

Participant

Please complete the following

I have read the plain language.	Yes/No
I understand the information provided.	Yes/No
I have had an opportunity to ask questions and discuss the study.	Yes/No
I have received satisfactory answers to all of my questions.	Yes/No
I am aware that my interview will be audio taped.	Yes/No
I am aware that participation in the study is voluntary and I may withdraw at any time.	Yes/No
I am aware that I will be provided with a transcribed copy of the interview.	Yes/No

Please note: all data including transcripts of audio recordings is subject to legal limitations set out by the Data Protection Act (1998) and Freedom of Information Act (2014). The PI is responsible for the storage of the information for a period of five years and access to this information can be applied for through Freedom of Information central policy unit. All data will be transcribed before being deleted and transcripts will be shredded before disposal. As a participant to this study you will have the right to any information being used in the study that relates to you.

I have read and understood the information in this form. My questions and concerns have been answered by the researcher and I have a copy of this consent form. Therefore, I consent to take part in this research project and I am aware that I will be provided with a transcript of the interview on request.

Participants Signature: _____

Name in Block Capitals: _____

Witness: _____

Date: _____

Appendix 10: Position Statement

The process of conducting the study required me to maintain a critically engaged approach to the subject matter while acknowledging my own position as a psychotherapist working with children. As a psychotherapist who works with children my ontological and epistemological beliefs were somewhat similar to the participants in the study. As a researcher I chose to design a study that would challenge those ontological and epistemological beliefs while also proving to be a useful and informative piece of research that would address a gap in the literature on this subject. FDA was not a methodology I was familiar with prior to carrying out the study. However, one of the fundamental tenets of this approach is to expose ones assumptions. This proved enlightening from a research and practical perspective. From research stand point I was continually drawn to ask myself about how I was interpreting what was said to me in the course of the interviews. This involved a careful consideration of how I asked questions, how I engaged in discussion with the participants, what I was more attentive to and why. By closely observing my own position within the process I was endeavouring to be true to the participants in how they shaped versions of reality relative to the study. From a practical standpoint, as a psychotherapist, carrying out the study deepened my appreciation for the complexity of treating children who experience mental and emotional difficulties. Unlike the adults with whom they share their lives, their integrity and subjectivity can often be overlooked as a result of how social and psychological discourses position them within culture. For this reason I believe that the psychotherapist working with children needs to remain acutely aware of his or her ethical position at all times.