‘The Phantasy Sibling Transference’: Only-Child Adults and Finding a ‘Position’ in the Therapeutic Setting.

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Abstract

This study originated from my experience of an unusual transference with my only-child adult patients and in my own therapy. I wanted to explore the idea that only-child adults may create a transference within the therapeutic setting which mimics a sibling transference. I suggest only-child adults enact a sibling drama in which to find a 'position' for themselves in the world of peers having missed out on finding their 'position' within the sibling group in early life. Juliet Mitchell provides a valuable framework in which to understand the intersecting and yet distinct lateral and vertical dimensions of psychic life. She suggests that on the arrival of a sibling, the infant is thrown into disarray and must negotiate a new position both with the parents and within the sibling group. This propels the infant into a complex and fraught challenge around the issue of identity which, according to Jeanine Vivona, can only be resolved through the gaining of validation and recognition on the lateral dimension with siblings enabling the infant to know who they are and where they stand in the sibling group. This is later reflected in the world of peers. I suggest the only-child adult, having missed out on these psychological challenges in relation to siblings, is left without a position and without an identity in the lateral world. This research is an attempt to investigate this potential phenomenon through the interviewing of psychodynamic and psychoanalytic psychotherapists who have worked with only-child adult patients. My analysis of the data is through reflective thematic analysis and developing themes from their countertransference. The results suggest the only-child adult continues to seek validation and recognition of a unique identity through the gaining of a 'position' with peers and that this may be revealed in the transference through the enactment of a 'phantasy sibling transference'. Finally, understanding the inner world of the only-child adult can enable an attempt at resolution of this sibling conflict within the therapeutic setting with the discovery of the only-child adult's identity on the lateral dimension.

Chapter 1

Introduction and Background to the Study

1.0 Introduction

In this thesis entitled, 'The Phantasy Sibling Transference': Only-Child Adults and Finding a 'Position' in the Therapeutic Setting, I will be exploring and showing the results and discussion of my study which involves creating a conceptual framework for thinking about what I am calling the 'phantasy sibling transference'. Whilst there are references in literature to only-children and their phantasies of siblings (Klein 1932; Rustin 2007; Keiffer 2014), there is no exploration of this potential phenomenon nor any research into its presence.

There are many different ways to understand the term 'only-child', and it is important to clarify the meaning it holds for this study. There are some who may have been brought up in separate households to their siblings, half and step-siblings who live elsewhere, families where there has been miscarriage or the death of a young baby or twins separated at birth who may refer to themselves as 'only-children'. The only-child adult as referred to throughout this thesis refers to those adults who are the only offspring of each parent and where neither parent has gone on to have any more children or experienced any miscarriage either before or after the birth of the patient, as far as is known.

In the UK it is common to be brought up by one or two parents but there are many different cultural traditions for bringing up children which may include older siblings or other community members taking on care giver roles. Cousins, in some traditions, may play 'sibling like' roles with several families living together. In other cultures, people having more than 20 step brothers and sisters is considered the norm. Whilst there were a couple of participants and patients in this study who considered themselves as

coming from cultural traditions other than what is common in the UK, it would be interesting and important to consider the meaning of being an only-child and how these different experiences may influence the experience.

The concept of the 'sibling transference' (Graham 1988; Stites 1997; Coles 2003) has been discussed in relation to 'actual' siblings who have been internalised and projected onto the therapist and the therapist's other patients, re-enacting the patient's early 'position' in the sibling group. Finding a 'position', as suggested by Jessica Benjamin, is a process of establishing a place for oneself to be known through being recognised as another subject in order for the self to 'fully experience his or her subjectivity in the others' presence' (Benjamin 1990 p35). Jeanine Vivona (2013) suggests that identity is 'the psychological manifestation of position' (p68) and therefore, finding one's 'position' within the sibling group is related to the development of identity which is reflected later among peers. However, there is no research on how, or if, the only-child adult may find their 'position' among peers having missed out on this early sibling experience.

I suggest that the need to find a 'position' can lead the only-child adult to enact phantasies of being in the sibling group in the transference which I am calling the 'phantasy sibling transference'. In my research project I will describe and illustrate how this 'positioning' attempt can manifest in the transference by examining the experience and countertransference of psychoanalytic and psychodynamic psychotherapists who are working with only-child adults. Juliet Mitchell (2003) provides a valuable framework for thinking about the intersecting yet distinct lateral and vertical dimensions of psychic life which will be used as one of the three theories underpinning my conceptual framework. She suggests that every human expects a sibling and on its' arrival, the infant is thrown into disarray and must negotiate a new position both with the parents and within the sibling group in order to resolve the sibling trauma, the resolution of which, she suggests, is through the process of 'seriality' – where the infant takes its' place among others who are the same (p44). According to Vivona (2010), the arrival of the sibling propels the infant into a complex and fraught challenge around the issue of identity which she suggests can only be resolved through the gaining of validation and recognition on the lateral dimension with siblings through various psychological processes, namely identification and differentiation, the manifestations of which, must

also be recognised by the siblings. Whilst serving to mitigate interpersonal rivalry and ease internal conflict, she suggests this creates a 'textured' identity where the infant knows who they are and where they stand in the sibling group which is later reflected with peers. Vivona's theory that sibling position relates to identity on the lateral level is also one of the underpinning theories to my conceptual framework. Having missed out on these psychological challenges in relation to siblings, is the only-child adult left without a position and without an identity in the lateral world? I suggest the only-child adult is left without a position and attempts to resolve this necessary developmental conflict through continuing to seek validation and recognition of a unique identity through an attempt to find a 'position' with peers through the enacting of a 'phantasy sibling drama' and this may be revealed in the transference.

1.1 Background and rationale for the research

My own experience as an only-child adult patient in psychotherapy seemed to activate obsessive wonderings as to where I existed in relation to my therapist and her other patients with an intense fear of 'losing' whatever place I may have temporarily acquired. It also raised in me the anxiety of being thrown into a place of non-existence, with feelings of wanting to emulate my therapist, perhaps as a way of protecting myself from annihilation anxiety just as a sibling might do to protect themselves from rivalry with another sibling when competing for the favoured position with the parents.

From my clinical work with only-child adult patients I have, at times, been aware in my countertransference a feeling of the patient attempting to compete with me for what I have or who I am. One only-child adult patient in particular, on discovering I was studying for a professional doctorate, decided to undertake a PhD and later, after giving this up, decided to take up a psychotherapy training. This patient would frequently arrive in outfits that I could see myself in or had even worn on occasions. I felt like I imagine a big sister might feel whose annoying little sister was desperate to imitate, compete with and even try to succeed. Sometimes it felt uncomfortable as though my 'position' was in danger and at other times it felt flattering that she saw me in this way. Another only-child adult patient confronted the patient whose session followed after hers as she felt I may be in danger. She was convinced I was alone in

the building where I saw her for therapy. Of course, this was her fantasy, and perhaps it was her who felt alone and in danger from the rival phantasy sibling who was waiting in the waiting room to take her place. Wanting to befriend her rival, which she did, may have been an attempt to reduce the anxiety of potentially being replaced and beginning the process of finding her own 'position' within the phantasy sibling group. These experiences suggested to me that something 'sibling-like' was being enacted both in my own therapy as the patient and in my clinical work with only-child adult patients which I wanted to explore further. After several experiences of this, I was interested to see if other psychotherapists had similar experiences in their work with only-child adults or whether it was related to my own experience of being an only-child, with little or no connection to the absence of siblings. This study is borne out of these experiences.

1.2 A brief overview of the thesis chapters

Mitchell (2003) suggests that every human expects a sibling and this is 'psychically and socially crucial' – a universal expectation (pxi). This study is an attempt to understand the phantasies of the only-child adult who has not experienced this 'crucial' developmental process in early life and to discover whether there is a continued expectation of a sibling arrival throughout life and if so, how this may manifest in the transference. The psychoanalytic literature on the experience of being an only-child is scarce and whilst there have been some published clinical examples in child psychotherapy of only-children in the therapeutic encounter suggesting the unconscious 'expectation' and intense 'dread' of the phantasy sibling arrival in the transference (Klein 1932; Rustin 2009; Kieffer 2014), this has not been explored nor studied in any robust way. Most references to the only-child have appeared when discussing the experience of siblings, perhaps reinforcing the idea that only-children struggle to find a 'position' of their own. Equally absent is the study of the only-child adult in the therapeutic process which is central to this study. In my literature review, chapter 2, it was necessary to look at literature relating to the effects of the sibling experience as well as the only-child experience as understanding how siblings may serve to create a function for emotional and psychic development is necessary in

understanding how their absence may potentially have an adverse impact on the development of the only-child.

There has been much debate since the nineteen eighties as to whether having siblings was important or even necessary to psychic and emotional development and it was not until Juliet Mitchell proposed her 'Sibling Trauma Theory' (Mitchell 2000; 2003) and introduced her horizontal constellation of lateral relations that an important development in the understanding of siblings emerged. Mitchell suggests that negotiating and finding a new position within the sibling group propels the infant into the social world of 'others' who are the same but different. She suggests this is a necessary transition from babyhood to the child entering the social world. Finding a 'position' within the sibling group has been related to identity development (Jacobson 1964; Charles 1999; Vivona 2007; Parker 2020) with Marilyn Charles suggesting the sibling relationship 'becomes a forum within which the child must find and define a sense of place and of self' (Charles 1999 p898) and Vivona (2010) confirming that finding their 'position' within the sibling group is related to being 'recognised' by the sibling with 'recognition' playing a crucial role in identity. In her subjectivity theory Jessica Benjamin (1988) discusses the idea of 'mutual recognition' suggesting that each participant in this process of recognition must be experienced as the 'same' as oneself – that the 'other' is a 'like subject', another mind who can be 'felt with', yet has a 'distinct, separate centre of feeling and perception' (Benjamin 2004 p1).

In chapter 3, I will discuss my proposed conceptual framework in which to understand the relationship between the only-child adult attempting to find a position and the manifestation of my suggested theory of the 'phantasy sibling transference' within the therapeutic process. My conceptual framework will develop from, and add to, three existing theories which provide a backdrop to my proposed theory and relate to the sibling experience and how finding a position within the sibling group affects identity development and how the absence of these psychological processes may affect the only-child adult. The three theories are, 1) Juliet Mitchell's (2000; 2003) Sibling Trauma Theory; 2) Jessica Benjamin's (1988) Mutual Recognition and Intersubjectivity Theory and 3) Jeanine Vivona's (2013) Sibling Recognition and the Development of Identity. I will discuss my thoughts around what I suggest may emerge in the

transference of the only-child adult and how the therapist may detect this in their countertransference.

In chapter 4, I discuss the qualitative research method to undertake this study and the rationale which seeks to understand and interpret meanings in conversations with participants which are gathered in a context (Braun & Clarke 2013). I will discuss the recruitment and interviewing of participants who are psychoanalytic and psychodynamic psychotherapists and have worked with, or are working with, only-child adult patients. Their psychoanalytic model of understanding the human psyche, enabled the examination of their only-child adult patient's transference and unconscious processes through their own countertransferential experience. The analysis of the data is through reflexive thematic analysis which focuses on the interpretation of themes and patterns through coding but with an emphasis on the critical reflection of myself as researcher (Clarke & Braun, 2022). I will also discuss the ethical considerations, phases of analysis and any potential difficulties and issues that may need overcoming.

In chapter 5, the process of the research, the analysis of the data and a results table will be discussed along with an interpretation of the themes which have evolved from the analysis and how they relate to the research question setting the framework for chapter 6 which discusses the research participants' backgrounds and the context of the therapeutic setting as well as their own sibling experience. Also, discussed in this chapter are the research participants' countertransference reactions to their patients, as well as my own, and their relation to the themes using quotes from the interviews to support my interpretation of the data. Chapter 7 will be a general discussion of the findings. I will also discuss the experiences of the three only-child psychotherapists compared to the six with siblings to see if there is anything of interest to note. In chapter 8, the conclusion, I will look at what can be learned from the study with some thoughts about further research.

I hope this study will provide a grounding to further investigations into the internal world of the only-child adult. I will now go onto review the literature on the only-child and siblings to see if anything around the phantasy sibling transference has been considered.

Chapter 2

Literature Review

2.0 Introduction

In the first chapter, I introduced my research project and gave the background and rationale for my hypothesis. In this chapter I will review the psychoanalytic literature relating to the research question. This literature review is in six sections relating to this study; 1) 'Position' relating to siblings and identity; 2) Sibling transference and its manifestations; 3) Phantasy siblings relating to the only-child in the clinical setting; 4) The only-child; 5) Siblings and their influence on psychic development; 6) Unconscious fantasy relating to the universal expectation of a sibling. My aim is to investigate any theories which may be similar and to show that my idea of the only-child adult attempting to find their position in the clinical setting and create a 'phantasy sibling transference' has not been fully explored in the literature.

2.1 Literature on 'position' relating to siblings and identity

'Position' in relation to siblings has been used by some psychoanalytic writers to describe the individual's unique place within the sibling group which is seen to have a direct effect on the development of identity (Jacobson 1964; Vivona 2007; Charles 1999; Parker 2020). Edith Jacobson (1964) suggested that finding one's place in the family is the result of identifications brought about by sibling rivalry which achieves the development of identity – identification being an attempt to foster closeness and reduce rivalry. This was taken up by Vivona (2013) who noted that among other things, 'identity is a means to adapt to the others around whom one must fit' going on to discuss the processes used by the infant to secure a position within the sibling group,

which she also relates to the development of identity – identification and differentiation. This view was also discussed by Charles (1999) who suggested the 'sibling relationship becomes a forum within which the child must find and define a sense of place and of self' (p898) further suggesting the infant uses the siblings to work through issues relating to identity. Mitchell (2003) in her writing on siblings introduces the horizontal axis of lateral relations and sees a necessary developmental opportunity for the infant who is thrown into a sense of 'non-existence' at the arrival of the new baby – the baby loses the favoured position with the parents and temporarily has no position at all. She suggests the infant must negotiate a new position with the parents and within the sibling group suggesting this enables the infant to transition from babyhood and into the social world of the child – Mitchell's sibling trauma theory is discussed fully in chapter 3 – which is linked to Freud's (1921 p70) view that 'social' instinct could be narrowed down to originating within the family.

Social functioning has long since been recognised by group analysts as being influenced by family experience (Kieffer 2014) with group analyst Val Parker (2020) suggesting; 'When a new baby arrives, the task of the older sibling(s) finding a place for themselves is fundamental in shaping how they find their place in the world as adults' (p31). She recognised that, 'in all their games and interactions, siblings will be negotiating their positions, working out where they fit and who they are' and this will become a 'template for their emerging sense of self' (p25). In her work with groups, Parker explored how the early experience of siblings will be transferred onto later relationships with peers. Her idea of the 'sibling matrix', takes Foulkes' (1990) 'group matrix' – where all thoughts and feelings are intertwined with the internal worlds of those around, binding the group together and giving a sense of belonging. She extends this idea to the sibling group, suggesting the experiences with siblings operate in a similar way. Being part of a 'sibling matrix' offers the individual a sense of belonging (Parker 2020). The particular roles siblings take on in the sibling group and within the family will influence how they operate with others in the world (Colonna and Newman 1983) which was also noted by Sander Abend (1984) from her observation of married couples where she watched sibling dynamics being played out with partners. Vivona (2013), brings further clarity to the relationship between sibling position and the development of identity suggesting identity is the; 'psychological manifestation of position – a way to know where you are in relation to someone else.

We can and do position ourselves with respect to others with and through our identities' (p68).

While Vivona suggests that identity and position are interlinked, she sees the psychic challenge around the lateral dimension as being how to 'gain recognition for, and to validate one's unique identity with respect to one's equals' (p10). In other words she sees the child's identity developing through being validated through recognition between the siblings. The role of parents in influencing their children's interactions and abilities to recognise each other is important, as well as their own sibling experience being projected into the roles they attribute to their offspring (Bank and Kahn 1982; Kris and Ritvo 1982; Agger 1988; Akhtar and Kramer 1999). The developing relationship between the siblings will enable them to begin to establish their 'position' and identity with each other (Bank and Kahn 1982; Kieffer 2014; Parker 2020). The 'looking-glass self' function between siblings is noted by Eloise Agger (1988), as allowing the child to express themselves with others who are the 'same' and receive a more realistic response than from a parent, allowing the testing out and alteration of maladaptive behaviours within the safety of the sibling group before facing the outside world. Mitchell (2003) also refers to the mirror function served by siblings which she distinguishes from Winnicott's (1958) mirroring by the mother suggesting that the baby needs to form an image of itself through the mirroring of others who are like it – a recognition by others who have 'lateral sameness' and 'difference' (p132) in order to successfully find their place in the sibling group which represents the social world. Extending this idea, Vivona (2013) suggests parental recognition in the vertical dimension is about setting boundaries over what and how much can be desired by the child, whereas with recognition in the lateral dimension, it is the siblings who set the boundaries of the space on offer and who one is required to be to fill that space, 'An invitation to fill the position is only valid if given by one who has the authority to extend it' (p81) suggesting this negotiation of position can only take place on the lateral dimension among siblings. This need for recognition is also discussed by Benjamin (1990) in her 'intersubjectivity theory' suggesting the 'other must be recognised as another "subject" in order for the self to fully experience his or her subjectivity in the other's presence' suggesting we have a need for recognition which gives us the capacity to recognise the other (p35) which she refers to as 'mutual recognition'. Like Ogden (1994), Benjamin refers to 'intersubjectivity' as a developmental process and

a form of relating but defines her theory in terms of a relation in which each person experiences the other as a 'like subject,' another mind who can be 'felt with,' yet has a 'distinct, separate centre of feeling and perception' (Benjamin 2004 p1). Whilst this extends Mitchell's (2003) theory of 'seriality' – how the infant finds their position as one of many siblings, it does not address how the only-child can find their position, gain recognition or the implications to the only-child if they are unable to negotiate a position with siblings through the process of mutual recognition. Suzanne Haas-Lyon notes the..

> perceived absence of place or position excites annihilation anxiety, to which humans are vulnerable because of the terror of infancy's helpless dependence on the maternal object for survival. The threat to one's sense of existence makes for the most intense states of mind.
>
> (Haas-Lyon 2007 p9)

She recognises the importance of obtaining a position by suggesting the implications of the absence of a position equates to a sense of non-existence which she suggests evokes annihilation anxiety.

The theories of Mitchell, Vivona and Benjamin will be discussed further in chapter 4 when presenting my conceptual framework. I will now look at the literature around sibling transference.

2.2 Literature on sibling transference and its manifestations and phantasy siblings relating to the only-child in the clinical setting

In this section I will examine the literature on sibling transference and on phantasies relating to siblings in the transference where there have been no actual siblings.

Finding literature on sibling transference was a difficult task. A few authors recognise it as a displaced oedipal transference (Coles 2003) and others suggest the idea of a sibling transference has tended to be lost within the parent-child constellation (Szalita 1968; Lesser 1978) or that it is often avoided (Lesser 1978; Rosner 1985; Kivowitz

1995) which can reflect a ‘countertransference problem’ according to Stephen Bank and Michael Kahn (1982). They suggest that many therapists are first born and adopt a parental attitude among their siblings, carrying this over into their work. Roberta Shechter (1999) suggests that therapists are likely to experience sibling transference and countertransference as far more threatening than parental dynamics and therefore retreat into the relative safety of the power and authority of the parental transference. Coleman (1996) draws attention to the sibling transference being more prevalent in the more collaborative therapies whereas the therapist who remains silent and uninvolved is more likely to evoke authoritarian, parental transferences (p379). Agger (1988) refers to the ‘commitment to traditional theoretical concepts which inclines us to focus on parental transference figures’ as playing a crucial role in the avoidance of sibling transference (p7).

However, when it *is* observed, the sibling transference can have a unique quality of intense competitiveness, idealisation and anxiety (Neubauer 1983; Balsam 1988; Shechter 1999) and a need for a special understanding and solidarity (Rosiers 1993) which can be distinguished from their parental counterparts. In her study of sibling transference, Marcy Stites (1997) found the most predominant theme mentioned by psychoanalytic therapists was that of competitiveness. This was reiterated by Sophia Tickell in her study of psychodynamic therapists when exploring their own sibling experience on the therapeutic encounter. All her participants were aware of a sibling transference involving competitiveness and rivalry, and how their own sibling experience was evident in their countertransference (Tickell 2024). Shechter gives an example of her female patient, who had an older sister, exhibiting a competitive sibling transference where she attempted to surpass Shechter with a higher educational qualification. Shechter (1999) also described how the same patient brought her unresolved primitive annihilation anxiety into the sessions. A clinical example given by Haas-Lyon (2007) also gives an account of a sibling transference characterised by competitiveness and envy as well as annihilation anxiety. In her discussion around the sister-sister transference, Rosiers (1993) describes the transference as one which is competitive and where the ‘constant re-negotiation of territories and challenges to authority are particularly prominent’ (p281) suggesting a high level of competitiveness. In describing a brother transference, Sharpe and Rosenblatt (1994) note how it entails ‘attitudes of mingled admiration and more openly intense competition’ (p491)

compared to that of a parental transference which 'will usually embody a more ambivalent submission and rebellion' (p493).

I shall now examine the literature on unconscious phantasy relating to phantasy siblings.

2.3 Literature on unconscious phantasy relating to phantasy siblings in the therapeutic setting

The possibility that only-children and only-child adults may hold phantasies of siblings is an under-investigated area of psychoanalytic thinking. In this section, whilst the literature is sparce, I will discuss some published clinical examples illustrating the presence of phantasy siblings, although not referred to as such. These specific observations have either not been noted as relevant or have not been taken up and explored. However, the examples of only-children in child therapy which illustrate a particularly obvious phantasy transference is noted by the patient's therapist.

As discussed in section 2.5, Klein (1932) maintained her belief that all children expect a sibling to arrive. She described her 6 year old patient Erna, an only-child, who was 'occupied in her imagination with the arrival of brothers and sisters' (p73) and was prone to having attacks of rage and anxiety at the beginning and end of each session which coincided with seeing the child who was due to see Klein immediately before or after her and who, she suggests, represented the brother or sister whose arrival she was 'always awaiting' (p73). Whilst Erna related poorly to other children, she also felt a great need for them and Klein observed that her conscious wish for a sibling was a desire for reassurance that she had not destroyed them (Klein 1932). Margaret Rustin (2007), in her presentation of her young only-child patient Sophia, also captures the sibling phantasy in the transference. Sophia showed an intense curiosity as to who else used the equipment in her room and would regularly question Rustin about her other patients, suggesting names of other children. Sophia would watch up at the window as she left the sessions to see if she could spot other children taking her place with her therapist (p160). Unconsciously seeking out 'imaginary siblings' with whom to 'work out their rivalries' (Keiffer 2014 p38) was also observed by Christine Keiffer

(2014) in her work with her only-child patient, Erica, who would see other children in the waiting room and in particular a little boy for whom she felt particularly resentful. She would verbally attack him within his earshot as she feared Kieffer would prefer him to her. When the boy finished treatment, although initially delighted, Erica soon began to realise she missed seeing him and would ask about him. Kieffer suggested that as well as the fear of losing their unique position, these children were also yearning for siblings from whom they could experience mirroring and recognition (p38). As with the other authors, Kieffer does not expand on this sibling phantasy nor indicate whether these phantasies can be detected in only-child adults. Although these are child psychotherapies, Kieffer does note that sibling transferences in children and adolescents are significantly more prominent than with those in adult patients, possibly due to the symptom formation developed to protect them from anxiety by the time they reach adulthood (Arlow 1972). In other writing on sibling transference there has been limited reference to the phantasies of the only-child adult and in particular, Ian Graham (1988) in his writing about the 'Sibling Object and Its Transferences', examines the analyses of 35 of his patients where one is a female only-child. Whilst noting that there are no phantasies of dead or unborn siblings, he does observe a conflicted relationship the patient has with her mother-in-law, feeling as though she was treated by her as an unwanted rival for her son's love – a vertical interpretation and perhaps a projection of the patient's own fear of being displaced in a sibling phantasy enactment but Graham does not explore this possibility. Rosiers (1993), however, in her writing on the sister transference, refers to the 'positive expectation of a sister bond,' (p280) which she says, may not stem from an actual sister at all, but from the need to be understood by someone who is the same as them. Agger (1988) also refers to patients who were only-children and who form a positive attachment to their therapist based on the 'unconscious fantasy that he or she is their longed-for confidante and older sibling or their longed-for play mate and younger sister or brother' (p28). In her writing on sibling relationships she refers to her only-child patient whom she describes as reporting feelings of exclusion but also a competitiveness in his reactions to her interpretations and his attempts to race to beat her to the consulting room in the mornings, preferring the first or the last session of the day so 'no one could come before or after' (p17). Whilst Agger links this to his loneliness of being an only-child, she does not explore whether it could be her patient enacting a sibling drama – an attempt to find a 'position' for himself whilst experiencing a fear of being displaced by a phantasy sibling.

I will now discuss the literature relating to the only-child.

2.4 Literature on the only-child

Whilst there is limited literature on the only-child from a psychological and behavioural perspective, there is even less psychoanalytic literature with most references to only-children being when discussing siblings. Klein (1932) suggested the only-childs' anxieties are far more intense than those with siblings as they believe they have inflicted damage or even destroyed their siblings in the womb. Coles (2003) disagreed with this, maintaining that the only-child is actually protected from anxieties created by having siblings, suggesting their minds were less busy without the sibling objects populating them. Jacob Arlow (1972), in his study of the developmental conflicts in his adult patients who were only-children, refers to the widespread suggestion that the only-child struggles with, among other problems, an inability to deal with the rigors of competitive life. Kieffer (2014) also refers to the difficulties the only-child experiences in tolerating the kind of interpersonal experiences siblings have learned to deal with in early life. Winnicott (1964) noted the only-child has been deprived of the opportunity to 'play all sorts of different roles in relation to each other as all this prepares them for life in larger groups and eventually in the world' (p134) and therefore they could suffer as a result. In Arlow's (1972) study of his and his supervisees only-child adult patients he supported Klein's view and noted that the only-child experiences huge anxieties at the prospect of *any* encounters with other children as they fear them as being representatives of the siblings who had been destroyed by their powerful feelings of aggression and hostility (p529). This theory, like Klein, proposed an innate 'expectation' of siblings, but when they did not arrive, the child developed anxieties at what might have befallen them and the phantasy that they themselves had destroyed the unborn siblings (p73). Arlow, further suggested the 'surrogate' siblings, as he referred to them – who could be school peers – had to be compensated by the only-child for the damage which had been bestowed upon them. This was expressed through extreme generosity of food, money and schoolwork (p523). He observed that these fantasies manifested in various ways throughout life. Parker (2020) briefly discussed the only-child in her writing on the sibling matrix suggesting not being part

of a sibling group, can 'deeply affect their sense of belonging' (p66). She discusses two only-child patients who both reported feelings of 'not belonging' and of not mattering to anyone and she reflects on them not knowing who they were. She suggests they *may* have discovered their identity had they experienced being part of a sibling group (p67). This was also illustrated in a group analysis taken by Marit Skatun (1997) where she observed an only-child adult woman struggling with being in the analytic group; 'Being in a group was like being in a flock of siblings, and she did not know her way around, did not know how to compete with the others for my attention… impossible to share anything' (p154).

Kieffer (2014) suggests this difficulty with peers is due to the only-child experiencing a particular problem in tolerating the kinds of interpersonal experiences that siblings have had to negotiate in early childhood including tolerating a shifting focus of attention in group settings as well as the development of conflict resolution skills. She further suggests that the role of 'psychoanalytic' siblings – that is both real encounters with peers and fantasised siblings who see the same therapist, who are glimpsed at in waiting rooms – may have a significant impact on transference themes. She notes that these experiences can allow the only-child to work through anxieties and therefore contribute to normal development allowing for both the rivalries and yearnings for relationships with sibling-peers (p36). She does not expand on the transference themes which is at the base of this study. I will now discuss siblings and their influence on psychic development.

2.5 Literature on siblings and their influence on psychic development

Literature relating to the experience of siblings was neglected prior to the 1980's perhaps due to the need to prioritise the traditional oedipal constellation (Parens 1988; Agger 1988; Mitchell 2000; Coles 2003). However, there was a surge of literature from 1980 onwards and one possibility for this sudden interest in siblings may be the explosion of blended families – family units made up of different sexual partners which are increasingly changing and producing offspring within these often short lived unions

which may have evoked a nostalgia and a wish for the security of the large family with several brothers and sisters (Coles 2003 p4).

Whilst Freud clearly recognised the significance of the arrival of a new baby and the subsequent trauma bestowed on the infant, he only made scattered references to siblings throughout his work. He did not develop a defined theory relating to the sibling effect on psychic development which was highlighted as an under-theorised, yet crucial area of psychoanalysis requiring such a theory (Colonna and Newman 1983; Houzel 2001; Coles 2003; Mitchell 2003; Kieffer 2014). This has been suggested as being due to Freud's own sibling struggles which he was unable to address (Agger 1988; Bank and Khan 1988; Coles 2003). His few references to siblings were generally focussed on the rivalry and jealousy evoked and 'the threat to the bases of a child's existence offered by the discovery of the arrival of the new baby' (Freud 1905 p195-7). He also commented on the 'shock' which is repeated with each sibling's arrival and the 'magnitude of their influence on later development' (Freud 1933 p123-231). Mitchell (2000) expands Freud's view in her theory of the 'sibling trauma' discussed later in this section.

Throughout the twentieth century, siblings continued to be associated with hostility and rivalry, frequently being regarded as displacements or 'stand ins' for intense oedipal wishes and incestuous desires toward the parents (Bank and Kahn 1980; Abend 1984; Parens 1988; Balsam 2013) and whilst Klein did not deny the jealousy and rivalry, she saw the sibling as a necessary part of the child's development which helped them to tolerate powerful feelings of hate and aggression. She wrote of a 'secret complicity' between siblings (Klein 1932 p305) and of having 'phantasies of being in league with each other against their parents' often resulting in a diminution of their anxiety and sense of guilt (Klein 1928). This was followed up by Rustin (2009) who further suggested that the sibling gives the child an important ally and companion in their rebellious and mischievous encounters and a 'playmate with whom a shared imaginary world can be created' and someone with whom the burdens of parental projections and expectations can be shared (p158). Winnicott (1964) saw having a sibling as providing the opportunity for the legitimate expression of hate and aggression and saw the deprivation of this as being 'a serious thing' (p133) suggesting

the inability to express or tolerate hate and aggression could cause difficulties for the only-child.

The mid 1980's saw the idea of a separate sibling constellation beginning to emerge with Leichtman (1985) and Graham (1988) suggesting a separate developmental sibling line but neither followed this up, whilst Sharpe and Rosenblatt (1994) noted the presence of oedipal sibling triangles – where two siblings are competing with a third – which are independent of oedipal triangles. They note cases of oedipal sibling experience suggesting they may be more influential in development than oedipal parental experience because of the ability for difficult feelings to be played out without the threat of loss of the parent (Sharpe and Rosenblatt 1994). Kaës (2003) developed his theory of a 'sibling complex' where he suggests a universal, inter-linking double helix structure of the mind comprising an oedipal and sibling strand which are both central to development. Around the same time Mitchell (2000) was introducing a similar theory of the 'lateral axis' of siblings in addition to the vertical axis of the parent-child, also suggesting that this 'lateral axis' is as central in the human psyche as the vertical. Neither are reducible to the other; they are independent of each other and yet intertwined. In her 'sibling trauma' theory, the arrival of the new baby creates a 'universal trauma of displacement and replacement' describing the trauma of the sibling arrival as a 'psychically and socially crucial' event (Mitchell 2003 pxvi) expected by all humans, evoking annihilation anxiety within the infant with a loss of uniqueness. Mitchell's theory is discussed in full in chapter 3. The resolution of this trauma will see the child gradually restore the self and take it's place among others who are the same – siblings, referring to this process as 'seriality'. Mitchell uses the story of Goldilocks as a metaphor for this sibling trauma. Goldilocks' arrival represents the sudden traumatic sibling intruder to baby bear as well as being the older sister whose presence suddenly intrudes into his consciousness. 'Psychically they are the same, they represent an identical problem even if the phenomenal forms are different' (p133). She suggests that the sibling trauma occurs for the youngest child also as they too experience themselves for a time as the sole child of the parents, holding the favoured position and suddenly becoming aware of the presence of siblings as rivals for their unique position – suggesting that the sibling trauma is precipitated by a dawning of awareness, not necessarily by an actual birth (Vivona 2007). Coles (2003) disagrees with Mitchell's theory suggesting it is too destructive and negative but does

acknowledge the profound effect of siblings on psychic and emotional development. This view is echoed by self-psychologist, Claire Hart, in her study on six siblings where she explores the different developmental needs of the vertical and lateral axes. She concludes that siblings serve important lateral psychological functions in and of themselves in addition to the roles served by the vertical axis (Hart 2021). Suzanne Heenen-Wolff also discusses the importance of social ties in adult life and how they begin with siblings (Heenen-Wolff, 2021) although not all are convinced it is essential for normal development (Provence and Solnit 1983; Parens 1988; Kris and Ritvo 1983).

I will now review the literature on unconscious phantasy relating to the expectation of a sibling.

2.6 Literature on unconscious fantasy relating to the universal expectation of a sibling

Freud did not discuss the idea of sibling phantasies or a sibling complex (Kaës 2003) but did discuss the idea of primal fantasies in *Totem and Taboo* where he referred to the primal horde – the primitive group of brothers in the human psyche – as being a hypothetical model of the prehistory of human society (Freud 1912-13). He referred to the process of identification – 'the earliest expression of an emotional bond with another person' in Group Psychology and the Analysis of the Ego (Freud 1921 p115) as the process which transforms rivalry and envy into 'social instinct' which involves a wish to have the same as, and be like the other enabling the brothers to make 'the discovery that a combination can be stronger than an individual' (Freud 1930 p100). This being one of his few references to what could be seen by later authors such as Mitchell (2003), Kaës (2003), and Kancyper (2008) as a universal 'sibling complex' (Kaës 2003). Kaës (2003) suggests every human carries with them an imaginary structure of the expectation of siblings 'be it an only-child or a sibling, it is a fundamental experience of the human psyche' (p13). In his book on the Fraternal Complex, translated by Levin (2008) - 'fraternal', referring to the 'sibling lateral dimension' (Heenen-Wolff 2021) – Kaës proposes a similar concept to Mitchell (2003)

that the sibling complex has its own theoretical specifity and constellation although connected to the Oedipus complex and narcissism – all three authors saw these constellations as irreducible. 'Regardless of the presence of real siblings, every child has imaginary siblings in the figure of the double' (Kancyper 2008 p9). Mitchell, also saw the expectation of the sibling as that of 'sameness' which she related to the narcissistic self which is lost once the sibling arrives and on discovering the new baby is indeed different (Mitchell 2003). Kaës (2008) argued a similar point to Mitchell in his theory of the two axes – vertical and horizontal, describing the two in relationship like the 'two strands of a double helix rather than a causal developmental sequence' (p262).

Whilst recognising the 'sibling complex' as a concept in which to understand the effect of siblings on human development and the need for the 'actual' arrival of a sibling to activate the necessary emotional responses to enable its resolution – these authors have not extended their theory to discuss how the absence of an actual sibling and therefore the potential problematic resolution of the complex for the only-child, will manifest or even resolve. However, perhaps something of the manifestation of the sibling phantasy can be seen in the transference of the work of some of the few writers who have presented their clinical examples of working with an only-child. As discussed in section 2.3.2, Klein's (1932) 6 year old patient Erna, Kieffer's (2014) patient Erica and Rustin's (2007) patient Sophia, were all occupied with the idea of 'phantasy' siblings supporting the suggestion that the expectation of a sibling is a universal phenomena (Klein 1932; Mitchell 2000; Kaës 2003; Kancyper 2008; Britton 2009) with Klein suggesting that whilst all children have phantasies of imaginary brothers and sisters whom they are expecting to arrive and to whom they direct hostile aggressive wishes, the sibling's actual arrival confirms they have survived the murderous attacks. However, for the only-child, the non-appearance of the sibling, confirms they have destroyed them which, for Klein, explained Erna's behaviour as fearing the retaliation from the phantasy siblings. Therefore, the conscious wish for a sibling is an unconscious need for reassurance that the child has not destroyed them (Klein 1932 p74). Arlow (1972) arrived at a similar conclusion with his only-child patients and, as with Klein, suggested conflicts relating to phantasies with surrogate siblings even before they come into contact with other children at school were present and they are initially fearful at being ousted from the favoured position developing a guilt that he or

she must be responsible for their non-arrival – 'the power of his wishes has denied life to an un-specified number of potential children' (p516). Rustin (2007), whilst also emphasising the 'overly concern' an only-child shows at the absence of siblings, suggests one response to this is the development of 'imaginary' siblings which offers the child a replacement for 'missing' siblings. Arlow (1972), like Klein, describes the specific fantasy which was common in all his patients and extends her idea that while in the womb all the potential siblings were devoured or injured leaving the only-child with guilt and various symptom formations. In his only-child adult patients he observed these manifested as claustral fantasies and fears of closed spaces - the unconscious fear of being stuck in the womb and devoured by the siblings they had destroyed. He presents several clinical examples to illustrate this, but he does not discuss if or how these fantasies manifest in the transference.

Mitchell (2000), like Klein, suggests that every child is 'expecting' a sibling suggesting a universal experience. She expanded her thoughts on the 'universal' idea during a conference on *'The Development of Siblings'* in 2007, where she and Ronald Britton raised and discussed the idea of a 'pre-conception' (Bion 1962). Here Bion discusses the baby's inborn expectation of a breast – the unconscious knowledge that the breast is going to provide what is needed and when it arrives, the realisation is synchronous with the development of a conception which will be 'conjoined with the emotional experience of satisfaction' (Bion 1962 p306). However, if the breast does not arrive, depending on the infant's ability to tolerate frustration, modification may be possible temporarily. Relating this to a 'sibling pre-conception' as discussed by Mitchell and Britton, the intensity of the frustration of the non-arrival of the sibling, may be influenced somewhat by the infant's relationship with parents as well as searching for the expectation to be realised (Britton 2009 p80-81). Neither Mitchell nor Britton followed this idea up.

2.7 Conclusion

In this literature review, I have shown the current literature does not explore the only-child adult and the phantasy siblings in the therapeutic process nor how these

phantasies may play out in the clinical setting. The arrival of siblings is suggested to be a universal expectation (Klein 1932; Kaës 2003; Mitchell 2003), whose presence enables the infant to begin the process of finding their 'position' enabling the development of identity within the sibling group. For the only-child, I suggest the missing sibling may be yearned for whilst also being dreaded and their absence may deprive the infant of the potentially necessary process of finding their position to develop their identity on the lateral level. I will now go on to outline the methodology for this research.

Chapter 3

Conceptual theories to build a potential conceptual framework of 'The Phantasy Sibling Transference'

3.0 Introduction

In order to undertake this project, the first step for me was to do an in-depth conceptual analysis of the existing theory on the only-child, sibling 'position', phantasies of siblings and siblings which is examined in my literature review chapter. This is to enable me to show the platform on which I am building my own concept of 'the phantasy sibling transference' which explains the phenomenon that I have noticed in the consulting room when working with only-child adults as well as my own experience as an only-child adult patient.

As shown in the literature review, the phantasies of the only-child adult are not fully explained in current psychoanalytic literature and in particular my hypothesis that he or she attempts to enact a phantasy situation in the clinical setting which is stimulated by the psychic and emotional need to search for a 'position' among the perceived phantasy siblings – a 'phantasy sibling transference'. To enable an understanding of the complexities of the only-child adult in the clinical setting and to establish a conceptual framework in which to locate my hypothetical theory, I wish to detail the three theories which underpin, and are the backdrop, for my theoretical concept. I will then go on to discuss how I see the 'phantasy sibling transference' manifesting itself in relation to both the therapist and the therapist's other patients as well as the countertransferential feelings which may be evoked in the therapist and which may

indicate its presence. The three existing theories which my concept is built upon are; 1) Juliet Mitchell's (2000; 2003) sibling trauma theory (and the horizontal/lateral axes); 2) Jeanine Vivona's (2007; 2010; 2013) theory on finding a position and it's relation to identity development and 3) Jessica Benjamin's (1988) concept of 'mutual recognition' from her intersubjectivity theory.

3.1 The sibling trauma theory (Mitchell 2000; 2003)

Mitchell's sibling trauma theory provides an important theoretical building block in which to begin to contextualise my theoretical concept. She introduces the idea that there are two axes in the psychic life of the individual – the vertical axis of the parents and child (the Oedipal) and the horizontal axis of the lateral relations (siblings). She believes that both dimensions are present in all humans – a universal situation (Mitchell 2003). Both axes are equally important but separate, distinct but intertwined. She suggests every human expects a sibling and as with the 'expected' enactment of 'possession and murder' of the Oedipal complex, so too, she suggests, there is an 'expected' enactment of a sibling trauma, that of 'displacement and replacement' which is a 'psychically and socially crucial event' (2003, pix) allowing the infant, through a process of psychological stages, to take a new 'position' among their siblings which transitions the infant from being the baby and the only one, into the social child who is able to take it's place among others on the horizontal or lateral level – and become one among many siblings. This sets a blueprint for later relations among peers in the adult world. She proposes the arrival of the sibling or the sudden awareness of the presence of older siblings, which she suggests serves the same psychological function, is experienced as a traumatic event for the infant where he or she is thrown into a sense of nothingness – a loss of the special place or position with the parents which is felt as a threat to the infant's existence – a loss of omnipotence. She describes the trauma as a 'rite de passage' between pre-social infancy and social childhood (Mitchell 2006) – a necessary trauma which mobilises the beginning of a complex series of stages leading to the resolution of the trauma which she sees as the infant taking a new 'position' and thus a new identity begins to develop as the social child. Whilst Mitchell's theory may be relatable to many who have experienced

the arrival of a sibling as a traumatic event, it is helpful to recognise the complexities of the interconnecting axes and that for some, depending on the parental experience and family dynamics, there may be other feelings evoked on the arrival of a sibling as well as hatred, violence and annihilation anxiety as described by Mitchell. There may be some who also feel a sense of relief at its arrival and a means to lighten the parental load.

> the adored sibling who is loved with all the urgency of the child's narcissism is also loathed as it's replacement – the baby it can never be again, or the pre-existing older brother or sister that it will never be…the ecstasy of loving one who is like oneself is experienced at the same time as the trauma of being annihilated by one who stands in one's place (Mitchell 2003 p10).

According to Mitchell, the toddler experiences the new arrival as the 'same' as itself and will narcissistically love it to excess. However, it will experience it as too much of itself – the annihilating replacement and so wants to get rid of it – evoking hatred for the one who is the same (Mitchell 2021). It is this hatred for 'sameness' that is displaced – the new baby does not disappear as is desired by the infant and so has to be relegated to a new place of 'other' as a protection. The sibling who can then be imagined as utterly different can be hated or loved (Mitchell 2003 p48).

If, as Mitchell suggests, the expectation of a sibling is universal in all humans and psychically crucial then it might suggest there could be potential implications for not having experienced the arrival or presence of siblings along with the associated mechanisms of resolution relating to their transitioning from the pre-social infant to the socialised child – the consequential difficulty in not knowing one's 'position' on the horizontal level with lateral relations such as siblings and peers. The only-child adult may only feel 'known' and 'know' it's 'position' in relation to those on the vertical level such as parents and later teachers, bosses and other authority figures but flounder in relation to 'knowing' their 'position' with peers on the horizontal or lateral level. As with the Oedipal Complex, if not resolved during the individual's early life, will be expected to be re-enacted throughout life in various forms in a continual unconscious attempt at resolution. Therefore, not being displaced by the sibling could have implications on the process of transitioning from the baby to the social child and the subsequent negotiation of a new 'position' among siblings and subsequently among peers in the

social world in later life. This may mean that he or she may unconsciously attempt to enact or even actively avoid the potential sibling dilemma throughout life perhaps in various group situations where the individual unconsciously imagines there is a potential threat from the arrival of a phantasy sibling. I suggest this may be a fear of being annihilated or displaced from the 'phantasy' special 'position' with the 'phantasy' parents, as well as the only-child adult potentially feeling themselves to be in a continual 'position-less' state in relation to 'others' on the horizontal or lateral level. I also suggest the only-child adult may attempt to enact this phantasy sibling drama in an unconscious attempt to enter into, and resolve this potentially necessary and absent stage of development within the clinical setting whilst fearing it. Mitchell does not expand on how the sibling finding their 'position' within the sibling group specifically relates to identity development. Vivona (2007, 2010, 2013), however, takes Mitchell's sibling trauma theory into that direction and thinks about how the infants' attempts at finding a 'position' among the siblings creates the conditions necessary for the development of identity on the lateral level. This is important when thinking about the only-child adult's 'position' being related to identity on the lateral level and what this may mean without the contribution or influence of siblings. I will now discuss Vivona's theory.

3.2 Sibling position and the development of identity (Vivona 2007; 2010; 2013)

I have discussed in the previous section how Mitchell's sibling trauma theory provides a valuable building block for conceptualising the two axes within the psyche and the idea that the infant expects the arrival or the awareness of a sibling in order to find a new position for themselves in relation to the parents and each other. Vivona's sibling 'position' theory brings into focus the function siblings serve in assisting each other in finding that 'position' in the sibling group which she suggests relates to the development of identity on the lateral dimension. Whilst Mitchell is primarily concerned with the overcoming of annihilation anxiety evoked by the arrival of the sibling which pushes the infant into finding a new 'position' as the social child and losing the baby self, Vivona focuses on the 'positional' dilemma as being a pre-requisite to the search

for a new and unique identity among the siblings, suggesting that 'Identity is the psychological manifestation of position, a way to know who you are in relation to someone else' (p68). She notes the relationship between position and identity in the questions the sibling will ask itself; 'Who does my 'position' among my siblings allow me to be? What is the shape of my place in the family and in the world? What is the value of my place?' (p68)

The development of the child's identity among siblings according to Vivona, is marked by their attempts to resolve the sibling trauma and find a new 'position'. This will invariably involve compromises suggesting the processes in which the infant 'positions' him or herself within the family constellation will be found from unconsciously having to protect themselves from the impending competition and rivalry with their siblings for another valued and unique place with the parents. Achieving this requires the unconscious employment of mechanisms of identification – where the child emulates important others to 'fit in' and feel accepted, reducing the rivalry with significant others – and more importantly, she suggests, through the process of differentiation – an unconscious process involving developing qualities and desires in oneself that are different from the perceived qualities of a sibling whilst at the same time suppressing qualities and desires which are perceived as similar (Vivona 2013, p69). She discusses how the process of 'recognition' of difference for the sibling, is of more consequence for the development of identity than the 'recognition' of sameness and carries increased significance within the sibling relationship challenging the intersubjectivity of the siblings. Differentiation, she suggests, is an attempt to defend and protect the self against the competitiveness resulting in rivalry and create a more harmonious sibling relationship. The child needs the sibling to recognise their differences in order to feel 'known' by them. However, these differences which are amplified in order to create a separate identity – the balance between assertion and recognition – will inevitably break down but can be restored time and again and needs to remain a constant tension. It is what Benjamin refers to as 'the third' position (Benjamin 2018 p4). Vivona recognises there are many factors influencing the qualities which the child unconsciously disowns and the ones which they choose to amplify and some of these may relate to perceived or real parental comparisons as well as real differences among them (p1207). She also draws on Benjamin's (1998) mutual recognition theory to highlight the way in which these

psychological processes are recognised by each sibling which is the third of the three theories underpinning my conceptual idea and will be discussed in the next section.

According to Vivona, these mechanisms of identification and differentiation create a new identity. The sibling plays a significant part in defining the psychological boundaries of the infant – the knowing who one is through the experience of the 'other' on the lateral level. It determines the space one can take up within the sibling group through assisting and promoting the qualities the infant can champion in themselves as well as the qualities which must be repressed through the process of 'mutual recognition' (Benjamin 1988) which will be discussed in the next section. Without this forced propulsion into finding a position among the siblings and therefore forging a new identity as a social child, I suggest the only-child and subsequently the only-child adult may be left 'position-less' on the lateral dimension, in a state of 'not knowing' who they are and where they fit in relation to their peers.

3.3 Mutual recognition – Intersubjectivity theory (Benjamin 1988; 1990; 2018)

This section will examine the third theory in the building of my conceptual framework – Jessica Benjamin's theory of 'mutual recognition' from her intersubjectivity theory. As discussed in the previous section, it is crucial for the child to feel that the mechanisms they are employing in an attempt to create their own unique identity are recognised by the parents and importantly by the siblings. Benjamin describes recognition, as the validation and acceptance of another subject as existing independently of the self; 'the response from the other which makes meaningful the feelings, intentions, and actions of the self. It allows the self to realise it's agency and authorship in a tangible way' (Benjamin 1988 p12). It allows the child to feel they hold a position on the lateral level among their siblings.

'Mutual recognition' is the necessity of recognising as well as being recognised by the other (Benjamin 1990) suggesting the one *giving* the recognition 'must be recognised as another "subject" in order for the self to fully experience his or her subjectivity in the

other's presence' (p35). This suggests that being recognised by the sibling gives the child the capacity to reciprocate the 'recognising' – the necessity of recognising as well as being recognised by the other who is like him or herself and yet different and separate (Benjamin 1988 p23) allowing the child to feel they exist on the lateral level. '*Mutual recognition'* she suggests;

> confirms that I am seen, known, my intentions have been understood, reciprocally, that I see and know you, I understand your intentions, your actions affect me and you matter to me. Further, we share feelings, reflect each other's knowing, so we also have shared awareness (Benjamin 2018 p4).

Benjamin (1988) suggests that individuals grow and develop through their relationships to others, another self – a subject in his or her own right and one who is capable of sharing mental experiences and is similar to the self but at the same time distinct from the self. Her original focus was on the relationship between mother and infant and the mutual recognition of the experiences between them such as sharing states of mind, emotional in-tunement and various other mutual influences (Benjamin, 1988). Mitchell and Vivona agree that mutual recognition among siblings serves a different but equally important developmental purpose from recognition from parents on the vertical dimension and therefore leaves a different imprint on identity – that of knowing who one is among lateral relations through the recognition of similarities and in particular differences (Vivona 2007). Vivona also notes that whilst the lateral and vertical dimension challenges are interconnected, the lateral dimension in particular relates to the challenge of identity which is worked out in competition with those who are beside the child – the competition is with the siblings for the favoured position. The vertical dimension relates to the challenge of desire, which is worked out with those who are above the child – the child competes with one parent for the possession of the other through the Oedipal development (Vivona 2010 p11). The necessary recognition from siblings is from someone who is experienced simultaneously by the infant as the same but different to enable the transition from being the 'only one' and holding a potentially favoured and unique 'position' to an acceptance that there are 'others' and both can exist allowing the child to find a 'position' within the sibling group. Whilst the struggles of both desire and identity are interdependent there will, of course, be other influences from parents and siblings.

In Benjamin's view, the concept of mutual recognition is reflexive and is not just about the others' confirming response, but also how the subject finds themselves within that response – 'we recognise ourselves in the other' (Benjamin 1988 p21) and she suggests this is essential and central to human existence. Like Ogden (1994) Benjamin refers to 'intersubjectivity' as a developmental process and a form of relating but defines her theory in terms of a relation in which each person experiences the other as a 'like subject', another mind who can be 'felt with' yet has a 'distinct, separate centre of feeling and perception' (Benjamin 2004 p1). Furthermore, she suggests, being a developmental process, this experience is on a separate trajectory from the internalisation of object relations (Benjamin 1990 p33).

The only-child who lacks the sibling experience in early life, may also lack the opportunities relating to the process of mutual recognition of both the differences and similarities of a 'like' subject on the lateral level and therefore miss out on these psychological experiences. This absence may create a serious challenge in developing a sense of a unique and recognised identity on the lateral level and among peers in later life. Bringing these three theories together, I will now introduce my hypothesised conceptual idea.

3.4 Hypothesised conceptual idea – the development of the 'phantasy sibling transference'

In my proposed concept of the 'phantasy sibling transference' I will use the three theories as discussed above as a foundation and backdrop to my theory. The framework of Mitchell's sibling trauma theory provides a containing structure to think about the two dimensions of psychic life – the vertical axis of the parents and child and the horizontal axis of the siblings and lateral relations and her idea that expecting the arrival of a sibling, or the sudden awareness of the presence of older siblings is a universal expectation. The lateral 'position' and 'identity' theory as proposed by Vivona (2007) suggests that various psychological mechanisms are crucial for the infant to develop a unique, valued and recognised identity on the lateral level and that this can only develop among siblings. And Benjamin's (1988) 'mutual recognition' concept

which explains the process of how siblings enable the confirmation of the new position and unique identity. I will begin from the starting point suggested by Mitchell, that all humans having found themselves at the centre of the familial universe in early life, expect to be displaced by the arrival or sudden awareness of siblings and to be thrown into a sense of 'nothingness' which begins the process of negotiating a new position on the lateral level and developing a social identity – she says, 'everyone' 'yearns for and dreads' a sibling (Mitchell 2013 p19). Without its 'actual' arrival, I suggest the only-child continues to wait expectantly and anxiously and as the child gets older, he/she continues to feel anxious whilst at the same time is beginning to experience a sense of not holding a position with peers and feeling on the outside of social encounters finding situations in groups somewhat difficult. The intensity of this is likely to vary depending on other factors and influences from parents. As mentioned previously, I call this experience of not holding a position as feeling 'position-less' on the lateral level – the negotiating process has not started and therefore no position has been offered or found.

If this situation continues into adult life, I would agree with Arlow (1972), that defences may develop in the form of reaction formation and sublimation to protect the only-child adult from the anxieties which have emerged through the non-arrival of the sibling. Although Arlow's suggestion as to why the only-child adult experiences these anxieties, is different from mine – he says on the non-arrival of a sibling, the only-child convinces himself that he has damaged or destroyed the siblings and is terrified of a retaliation from peers who are experienced as the dead siblings returning to wreak havoc – I suggest the anxiety is due to two factors; 1) the position-less status of the only-child – the feeling of not being part of peer groups due to the lack of identity on the lateral level – not knowing who they are and where they stand, and perhaps feel on the outside looking in. Finding a 'position' among the siblings is crucial in enabling the development of a new, unique and valued identity on the lateral level (Vivona (2007; 2010; 2013) having lost the favoured place with the parents. 2) the unconscious fear and excitement of the sibling arrival – the overwhelming 'nothingness' feeling of displacement relating to the loss of the favoured and only position – the loss of the grandiose self and the loss of omnipotence (Mitchell 2003). Along with this, I suggest there is an excitement, a yearning for the sibling – a desire to enter into the

psychological stages and feel the recognition and companionship a sibling can offer – someone who is the same as oneself but different (Mitchell 2003).

Due to the non-arrival of the sibling, the only-child adult is unable to engage in the same opportunities afforded those with siblings where they are propelled into the sibling related psychological stages, having to negotiate and navigate the mechanisms of identification and differentiation and experience the process of having these recognised through 'mutual recognition' (Benjamin 1988) which may have allowed them to find a new position within the sibling group by developing a unique and (sibling) recognised identity. As already mentioned, one of the important aspects the only-child does not experience is the loss of omnipotence which allows him/her to lose their 'special' position and accept their new position as ordinary and 'one of many' (Mitchell 2003). I suggest the only-child's 'position-less' status on the lateral dimension pushes them into entering adult life without a 'position' among their peers and therefore without a unique and recognised identity which may be more of a disadvantage to identity development than has been recognised. They may still 'know' themselves in relation to parental and authority figures from their relationships on the vertical dimension but feel 'unknown' in relation to those on the lateral dimension. Whether or not this unresolved sibling dilemma is difficult to address in adult life is also unknown.

With these ideas in mind, I suggest the only-child adult may unconsciously enact a phantasy sibling drama in some form or another in the clinical setting potentially relating to the missed developmental stages of the sibling experience in an attempt to begin the process of developing a unique and recognised identity on the lateral level through finding a 'position' for themselves. I suggest it is likely this attempted enactment can be seen in all areas of the only-child adult's life where they come into contact with peers or groups but within the clinical and therapeutic environment I believe, it will manifest lin the transference and is likely to mimic a sibling transference where actual siblings have been internalised and projected onto the therapist and into the clinical setting. I will now discuss how I see this happening in the clinical setting and how the therapist may pick it up in the countertransference.

3.5 ‘Phantasy’ transference and countertransference

To fully understand the concept of the ‘phantasy sibling transference’, we must first recognise the transference can reveal, through the countertransference of the therapist, sibling relations which have not actually existed in the early life of the patient. Ackerman (1959) refers to transference phantasies in his discussion on the patient’s ‘irrational, conflict-ridden emotions, phantasies and magical expectations’ (p19) projected onto the therapist in the transference and Betty Joseph (1985) in her writing on transference also highlights that ‘everything of importance in the patient’s psychic organisation… his fantasies, impulses, defences and conflicts, will be lived out in some way in the transference’ (Joseph 1985 p453). Both suggesting that the transference is not limited to actual internalised experiences or objects.

In my own work with only-child adult patients, I have experienced what seems like a sibling transference where I have felt like an older sister without the internalised ‘actual’ siblings being present in either the patient or myself – a countertransferential feeling of competitiveness and emulation which I could not understand in any other way than a sibling transference. Aggers (1988) and Rosiers (1993) have referred to unusual transferences with only-child adults, as discussed in chapter 2, suggesting the only-child adult experiences a desire for the therapist to be their sibling, but neither have extended this thinking any further which is central to this study. The sibling transference itself can be difficult to distinguish from a parental transference even when there have been ‘actual’ siblings for various reasons not least because siblings can bring up a unique kind of countertransference which is unfamiliar to therapists who tend to work with the focus on parental dynamics (Mosner et al, 2005). A lateral countertransference may be experienced as more threatening than parental countertransference as discussed in Chapter 2. Identifying the phantasy sibling transference, therefore, I suggest can be a further challenging task particularly as therapists with actual sibling experiences are likely to have their own sibling dynamics activated at some point in the encounter making it particularly difficult to untangle the projections of a potential phantasy sibling. It may feel confusing when the countertransference of the therapist with ‘actual’ siblings may not ‘fit’ with the only-child adult’s transference. For example, if the therapist is a youngest sibling and feels

a countertransference relating to her or him being placed in a position of an eldest sibling by the patient, this may suggest the presence of a phantasy sibling transference – a projection of a phantasy older sibling coming from the only-child adult. The proposed enactment of a phantasy sibling transference in which the only-child adult can unconsciously play out the sibling trauma phantasy in an attempt at resolution may involve the recruitment of the therapist and the therapist's other patients into the phantasy drama. This I suggest will be evident in the transference of the patient and can be picked up in the countertransference of the therapist which I hope to show in the results chapter.

3.6 Potential transference and countertransferential feelings relating to the 'phantasy sibling transference'.

Although it is difficult at this stage to know exactly how the sibling drama may play out in the transference, I am suggesting some thoughts here which I have been aware of in my own work with only-child adults as they seem to mimic actual sibling-like dynamics. In the therapist's countertransference with an only-child adult patient, I suggest, there may be feelings evoked relating to various aspects of the sibling experience as the acting out of the sibling drama is attempted.

3.6.1 Feelings related to the fear and dread of the anticipated arrival of the sibling.

Feelings related to the fear and dread of the anticipated arrival of the sibling may involve the therapist and/or the therapists' other patients as the phantasy siblings who may be experienced as rivals wishing to displace the patient. The only-child may feel fearful of being displaced or thrown into non-existence by the arrival of, or the awareness of, phantasy siblings. This may be activated by the awareness of the therapist's other patients, relatives of the therapist or the therapist him/herself. Mitchell's (2003) idea of the infant's experience of annihilation when the new baby arrives is based on Freud's (1920) life and death drives theory. Acknowledging that

there is no representation of death in the unconscious of the infant, she suggests that the annihilation anxiety experienced initially by the infant at the shock of being displaced and thrown into ‘no-where’ followed by the loss of the subject’s self, is the infant’s first experience of death (p28). This psychic obliteration trauma manifests as hatred first and foremost and violence which can become envy and envious rivalry which can be sublimated into emulation or competitiveness (p41). In the transference, there may be themes of something being lost or misplaced, being killed off, being excluded or a fighting for something which feels life threatening as well as themes of anger and hatred. These themes may be related to the therapist’s other patients, other workers within the practice or the therapist’s family members if practicing from home, or the therapist him/herself. The therapist’s countertransference may include feelings of wanting to protect the patient, of feeling threatened themselves, envied, emulated or feeling intimidated. This may be intermingled with the therapist’s own sibling dynamics being activated which may or may not fit completely with their countertransference experience.

3.6.2 Curiosity and desire to know the phantasy sibling

A sense of curiosity may be present in the only-child adult patient relating to the desire for a sibling who is the same as themselves – a replica of themselves is wanted and the infant is initially excited by the idea of someone like itself and it is only when the sibling arrives that the infant discovers it is not like itself but is different and has taken its place (Mitchell 2000 p20). This curiosity may manifest in the transference as a direct enquiry towards the therapist’s other patients or the therapist themselves, or may emerge in the latent material or dreams around uncertainty, curiosity or the joyful bringing together or sharing of objects or relationships. The therapist’s countertransference may include a sense of being pulled into a friendship dynamic or be felt as an impingement on their life or work relationships.

3.6.3 Emulation, competitiveness and rivalry – the sibling drama enactment

Acting out the associated feelings of displacement, exclusion, rivalry, envy, hatred and perhaps a wish to 'join' with a sibling in league against the parent/therapist (Klein 1932; Bank & Kahn 1982) as if the sibling has arrived, may be felt. The need to emulate the therapist may be as a result of sublimation of competitiveness and envious rivalry toward the feared displacing phantasy sibling or the need to identify with the fantasy of an older sibling relating to identity development (Moser et al 2005). In the transference the patient may be attempting to behave in a similar way to the therapist, or dress similarly or even sign up to do similar activities to the therapist. In the countertransference the therapist may feel admired, idealised and it may be an enjoyable feeling or feel seductive and uncomfortable with envious rivalry and competitiveness being felt under the surface which may or may not fit with the therapist's own sibling experience and therefore may indicate the presence of a 'phantasy sibling transference'. Vivona (2010) refers to a patient who projected her need for Vivona to be her older sister who was slightly ahead of her to encourage her along, wanting Vivona to show her the possibilities life had to offer. Mitchell (2003) discusses how the older sibling is idealised as someone the infant would like to be and can be a reversal of the hatred for the rival. This sublimation of hatred and envious rivalry toward the phantasy usurping sibling who is feared will take the place of the patient, may manifest in a competitiveness toward the therapist or the therapist's other patients. The patient may seem to want to take centre stage and be the clever one or the funny one and perhaps even jump in and seem to know what the therapist was going to say – an attempt to not be usurped by the intruding phantasy sibling but to fight for the prized position with the parent, whoever the parent may be in the phantasy. Agger (1988) refers to her only-child patient who responded with competitiveness at her interpretations. The therapist's countertransference may evoke a sense of intimidation and hostility which again might not fit with the therapist's own sibling experience and may therefore feel unfamiliar and confusing. The sister-sister transference as discussed by Rosiers (1993) refers to the prominent themes of territorial conflict, identity diffusion and challenges to authority which I suggest may be mirrored in the 'phantasy sibling transference' and is in contrast to the mother-

daughter transference which is likely to manifest in themes around dependency and powerlessness. The brother transference may also be mirrored revealing more openly intense competition in contrast to a father transference which may centre around ambivalent submission and rebellion (Sharpe & Rosenblatt 1994).

3.7 Conclusion

In this chapter I have discussed the three theories underpinning my conceptual idea of the phantasy sibling transference and discussed the aspects which relate to my potential concept. I have also discussed my thoughts around how the phantasy sibling transference may manifest in the clinical setting in relation to the patient and the therapist and their other patients and how it may mimic the sibling transference. In the next two chapters I will discuss the results of my research beginning with an overview of the analysis process and overarching themes.

Chapter 4

Methodology

4.0 Introduction

The literature review chapter has brought together current writings on the relevant areas around the research question but there is no literature which specifically addresses my research question that for the only-child adult there may be a potential need and a search to find their 'position' with peers in adult life through creating a 'phantasy sibling transference'. In this chapter I will look at the methodology to enable the research of this potential phenomenon.

4.1 The research study setting and its rationale

In order to examine the unconscious phantasies of only-child adults and how they may relate to the absence of siblings, I felt, required the interviewing of psychotherapists enabling me to gain as wide a knowledge as possible about other therapists experience of their only-child adult patients and the dynamics between them as well as the dynamics between myself and them. In the following sections, I will discuss why I envisaged this as the most effective investigation into this potential phenomenon.

4.2 Rationale for the use of psychoanalytic and psychodynamic psychotherapists as participants vs a single case study

As noted in the Literature Review chapter, there is some speculation about only-children and their behaviour traits but no real investigation as to why they might

behave in such ways. To enable a fuller understanding of their internal world and phantasy life required a psychoanalytic model of understanding the human psyche using current theories as a building block to develop a relevant way of thinking and understanding this group. Examining a single case of my work with an only-child adult patient would not, I believe, assist my understanding as to whether there are potential universal themes in their internal worlds and would not therefore have advanced my hypothesis. Equally, to interview only-child adults may also not reveal the complex internal worlds and unconscious phantasies that working with an only-child adult over a period of time in a therapeutic encounter might reveal. I therefore decided to use the experiences and countertransference of practicing psychoanalytic and psychodynamic psychotherapists who have a range of personal sibling experiences including that of being an only-child themselves, to ensure the data is as valid as is possible whilst also recognising the subjective experience each therapist brings. This will also ensure the data is not contaminated by my own experience as an only-child but understand others' experiences of working with this unique group. My own only-child status will play a role in my counter-transference and for this reason, I have met with a researcher colleague regularly throughout my research to ensure my analysis of the data is as objective as possible.

4.3 Rationale for the use of the countertransference of research participants as data

The transference is central to psychoanalytic theory and is understood as being the transferring of the patient's 'being' into the relationship with the therapist. Betty Joseph (1985) in her concept of the 'Transference as a framework' suggests it is not only the patient's internalised objects which are lived out in the transference but fantasies and conflicts from early life which may only be detectable through the countertransference of the therapist. The countertransference, like the transference, is a technical instrument of significant importance in psychoanalytic thinking for researching and understanding the patient's unconscious (Heimann 1950; Racker 1968; Segal 1977; Jervis 2009). In 'Making conscious the unconscious' Racker (1968 p23) suggests it is the therapist's countertransference where the patient's psychic state can be detected

(Alexandris & Vaslamatzis 1993). This way of understanding the patient's internal world is central to psychoanalytic thinking and psychoanalytic and psychodynamic psychotherapists will have been trained in using their countertransference and experienced their own personal psychotherapies and analyses, so will be highly attuned to this way of detecting the internal conflicts, anxieties and phantasies present in their patient's unconscious mind. The level at which these phantasies may be held in the unconscious mind of only-child adults, I believe cannot be detected in any other way than through the countertransference of psychoanalytically informed psychotherapists in the clinical setting. My own countertransference to the research participants and their patients will be useful in understanding something of the unconscious processes going on between them and me. The use of psychoanalytic concepts in qualitative research interviews has recently increased significantly (Holloway & Jefferson 2000, 2008; Holmes 2013) and in particular the use of the researcher's countertransference (Ettore 2010; Harvey 2017; Holmes 2013) which Zelda Knight (2019) suggests is due to the growing acknowledgement of the power and presence of the unconscious in the research relationship (p1).

4.4 Ethical considerations

The ethical considerations relating to this study are of particular importance and relate to both the disguising of research participants and their patients' identities. My concern was that while I could keep the research participants' identities anonymous, discussing their patient's histories and comments could potentially reveal the identities of their patients. Whilst little has been written about this approach to gathering data, Gabbard, (2009) does refer to the idea of colleagues writing up case material on one's behalf, thus protecting the patient's anonymity through protecting the therapist's anonymity and therefore the patient's consent is not required, presumably due to there being no direct link to the therapist. He discusses his own experience of publishing a colleague's account of her erotic countertransference with her male patient and describes this as a useful and innovative way of writing up therapists' accounts of their experiences with patients particularly where there may be sensitive material involved requiring the patients' identities to be protected whilst at the same time enabling the psychoanalytic

community to benefit from the learning (Gabbard 2009). Whilst this made sense, I was not entirely comfortable with this approach. I was mindful that all nine participants' patients were known to be only-child adults who had been in psychodynamic therapy – hence why they were in the study – and therefore it was possible their histories could reveal who they were. With this in mind, I decided to take further practical measures in keeping the participants' patients' information anonymous by ensuring it was given to me already in disguised form. I asked each participant to change their patient's age by a few years either side and not to reveal their specific occupation or location in the country.

I was also extremely careful with the storage of data ensuring that only necessary details of the participants were kept, and these were kept separately from their audio recordings and transcripts, in-case of withdrawal. Neither the audio recordings nor the transcripts had any identifiable information but codes were used which denoted the order of interview. The information linking the codes with the participants was kept in a separate locked cupboard. The audio recordings were deleted soon after the transcripts had been produced. All data will be destroyed at the end of the study.

My ethics application was approved on this basis and the approval document is in Appendix D.

4.5 The participants

The participants of the research are nine psychodynamic and psychoanalytic psychotherapists currently working with, or worked with, an only-child adult patient within a therapeutic context. The study seeks to capture their experience of their work including how they have made sense of the transference within the clinical setting using their understanding of their countertransference. They are mostly psychotherapists working in private practice, some in agency settings using a waiting room, while others worked either from home or from premises where there was no waiting room. A waiting room may allow for the manifestation of phantasies around the therapists' other patients to emerge. There is a detailed discussion of each research participant and the patient they discuss in chapter 7.

4.6 The recruitment of participants

As qualitative research tends to be driven by the participant with the researcher searching for the meanings they attribute to their experience, a sample of nine participants has enabled meaningful discussions to fully explore the participants' experience (Morgan-Brett and Wheeler 2022) in contrast to structured quantitative methods of gathering data which is lead by the researcher to generate statistics requiring large numbers of the population (p8). Adverts were sent out to various psychotherapy journals, psychotherapy centres and social media. The adverts (see appendix A) invited suitably qualified therapists who were working with, or had worked with, an only-child adult patient to take part in research to help identify any themes which might suggest a 'phantasy sibling transference' could be present. This would involve exploring their work with their patient as well as thinking about their countertransference. It also offered an initial discussion with me to enable the therapist to gain further information to see if the research might be of interest to them.

Nine therapists responded to the adverts and each had their own reason for wanting to be involved in the research which included; having a parent who was an only-child, being an only-child themselves or recognising a struggle with their patient which they could not make sense of. There was one respondent who was initially unsure whether to proceed and wanted to discuss the confidentiality aspect in the initial zoom meeting, which we did. She was concerned whether her patient's identity could be exposed. However, after a think about it and a discussion with her supervisor, she made contact to say she did wish to go ahead.

4.7 The interviews

Following on from the advertisement for research participants, I arranged an initial zoom call lasting approximately twenty minutes where I discussed the practicalities of the research interview as well as talk through the information sheet (see Appendix B) the participant will have received on receipt of their request to be involved, answering any questions. Those who were happy to proceed met with me for the main semi-

structured interview. In this case, following on from the zoom call, I sent each participant the consent form which I asked to be signed and returned prior to the main interview (see Apendix C). This was face to face in the clinical setting of the participant where possible encouraging greater reflection as it was likely to be in the same environment as the initial work with the participant's patient. Interviews over Zoom were undertaken where it was the preference of the research participant or where this had been the format of the therapy. Semi-structured interviews are versatile giving a degree of flexibility as they encourage a freedom to explore experiences at a deeper level which may arise in the course of the discussions rather than sticking to the scripted format. Having considered the idea of both semi-structured and unstructured interviews, unstructured based on the principles of free association (Freud 1925), the 'free association narrative interview' (Holloway and Jefferson 2000), I decided that as I have already experienced an unawareness of the implications of the only-child adult patient and their 'positional' conflict through the conversations I have had with colleagues, there did need to be some direction to enable the participant to focus on particular aspects of the transference and their own countertransference whilst at the same time encouraging the reflection and exploration of those aspects.

The discussions were audio recorded as well as myself taking some notes as to my own countertransference, although also recognising this can be a distraction from the experience of the participant. The audio recordings helped in separating my role as researcher from that of clinician by enabling me to listen to them repeatedly making it less likely for me to see what might not be there, therefore, ensuring the account of the interview was as free from the 'dangers of subjective distortion' as possible (Midgley 2006 p129). Being an only-child, I may unconsciously wish to see manifestations of my own experience. These recordings were discussed with my research clinician colleague adding further to its validity.

4.8 The interview questions

The main interview discussed the questions designed to explore the participants experiences of working therapeutically with only-child adult patients. Part of this

understanding was through the transferential experiences in the therapeutic relationship gathered through the therapist's countertransference.

Prior to starting the interview, I ensured each participant had already disguised their patient information such as name, age, location and any other identifying features which may not be relevant to the study. I offered a label for each participant and their patient following the pattern of research participant 1, 2 etc and patient A, B etc, depending on their position in the interview process. The questions were wide ranging, honing into answers and probing into the feelings of the participant towards different aspects of the therapeutic relationship. The small number of questions allowed for in-depth exploration which enabled the exploration of other issues which emerged during the course of the interview.

Please see table 1 for a list of the interview questions and their rationale.

Interview questions	**Rationale**
1. What is your own sibling status?	Knowing the research participants sibling position, if any, may help to locate their experience and countertransference into a wider picture.
2. On having an only-child adult referred to you, what were your initial thoughts and feelings?	Exploring what the research participant may be bringing to the relationship may enable the exploration of their own sibling status and how it may influence their experience of their patient.
3. What was the presenting problem which brought your patient to therapy?	Exploring whether there was a link in the presenting problem and their only-child position either directly or indirectly and how they understood the presenting problem.
4. How did you make sense of your patient's early life, relationships with parents, Oedipal experience, and later relationships with peers and how did this play out in the transference? What was it I your countertransference that brought you to this understanding?	Understanding the research participants experience of these aspects and how they experienced the transference could illuminate any positional dilemma. Also, understanding how their countertransference contributed to this understanding may highlight the presence of any sibling issue of their own.
5. How did you understand your patients experience of their 'position' both as a child with their parents and peers at school and as an adult at work and in their personal and social life?	Exploring how the research participant interpreted their patients' 'position', whether or not they saw a positional theme running through their early and adult life and how their countertransference contributed to that understanding, may add to/or confirm any other positional thoughts.

6. Did you experience anything which you could interpret as a 'position' dilemma emerge I the therapy in relation to you or your other patients?	Exploring their understanding of their patients' experience relating to their patients position within the therapeutic process may add to the bigger 'positional' picture.
7. How did you feel their only-child experience was played out in the transference and what was it in your countertransference that brought you to that understanding?	Specifically exploring the research participants understanding of the transference and how they interpreted their patient's only-child 'position' through their countertransference. This may open up a longer and deeper discussion and exploration around the transference and their countertransference.
8. Were you aware of your patient showing an interest/fear or any other feelings in response to your other patients either consciously or unconsciously and if so, how did it manifest and how did you make sense of this?	This is an important discussion as to their patient's response/feelings toward their 'phantasy siblings' which may help in understanding any sibling phantasies.
9. Following our discussion, do you think there are any other aspects of your work with this patient which you feel may be related to their position as an only-child?	An attempt to gather any other information which the research participant may have picked up and understood as being related to their patient being an only-child.

Table 1: *The interview questions and their rationale.*

As discussed previously, my own counter-transference was a significant part of the research process and was noted briefly throughout the interview and was further thought about and elaborated on when listening to the audio recordings.

4.9 The Research Method for Data Analysis

I used a qualitative research method as this allows for the exploration and understanding of meanings the research participants may have attributed to their experiences within the context of the therapeutic setting. This enables a deeper understanding of a potential phenomenon than a quantitative research method where numbers are used to seek comparisons and differences between groups in a concrete way (Braun and Clarke 2013). I decided against using my own patient material as this is an area of research which has not been undertaken before and as discussed earlier, I wanted to investigate how other therapists, who will have a range of sibling

experiences, may experience their only-child adult patients to see if there were any themes or patterns which may suggest a 'phantasy sibling transference' – I was aware of my own biases as an only-child myself. I was also open to the possibility that other themes and patterns may be discovered which could also be understood to be related to the only-child adult experience which I had not considered. The data was analysed using reflexive thematic analysis developed by Braun and Clarke (2013) which is discussed next.

4.10 Thematic analysis

Thematic analysis can be described as the 'identification of recurring patterns that are presented by researchers as overarching statements or themes' (Lochmiller 2021 p2039) and over the last 10 years, has become widely recognised as a flexible and rigorous approach to coding and theme development both in psychology and the social sciences. The aim of thematic analysis is to think about how the data addresses a specific research question by either matching the patterns to a specific theoretical or conceptual framework or to develop a new concept or theory (Lochmiller 2021).

Thematic analysis itself is an accessible and robust method for developing, analysing and interpreting patterns across a qualitative dataset which involves a systematic process of coding data to develop themes (Braun and Clarke 2013 p4) – coding evolves as it progresses through the data and does not use a pre-determind coding framework. Codes can expand, contract, overlap or divide (Vossler and Moller 2015 p190). It uses a more inductive approach to data – where the analysis is shaped by existing theoretical frameworks which provide the lens through which to read and code the data's developing themes with a focus on latent meaning enabling the analysis to explore meanings at a deeper level (p10). This fits well with the research question which itself relates to a psychoanalytic understanding of psychic development. Thematic analysis can be applied where there is a broad or a narrow research question or purpose and where the research draws on the views, perceptions, and experiences of the participants regarding a particular phenomenon (Boyatzis 1998) but also allows for nuance, complexity and contradiction (Braun and Clarke 2013 p7) which can be fully explored and understood.

4.11 ‘Reflexivity’ in the Braun and Clarke Reflexivity method

Qualitative researchers tend to observe the participants in the setting where the issues have been experienced rather than bringing them to a research centre or lab, enabling the understanding and the meaning of the context of the participants’ experiences as well as the feelings evoked in the researcher which is a characteristic of this method of research (Creswell and Creswell 2018). As previously stated, the psychotherapists were interviewed in their familiar surroundings where possible. Understanding and emphasising the unconscious processes of both the interviewer and participant enriches and deepens our understanding through acknowledging the complexities and dynamics of people (Holmes 2013 p161). The term ‘reflexivity’ has become a necessary consideration in qualitative research and opens the way for researchers to examine their own thoughts, feelings and responses to the subject matter as well as the feelings evoked during the interactions with participants as a way of understanding influences and biases which may contaminate the research findings. The reflexive researcher does not simply report ‘facts or truths, but actively constructs interpretations of his or her experiences in the field and then questions how these interpretations came about’ (Hertz 1997 pvii-viii). If we do not examine ourselves, ‘we run the risk of letting our unelucidated prejudices dominate our research’ (Finlay 2003, p108). In the clinical setting the issues of transference and countertransference are central to our understanding of ourselves and our patients and cannot be limited to the two people in the therapy room. It is ethical and necessary to consider the way in which this understanding extends to feelings evoked in response to other human beings we may have any kind of connection with, from colleagues to institutions and so forth and it would seem unethical for the researcher to not engage in examining their own countertransference in relation to the participants as well as their motivations for undertaking the research. Understanding the participants’ own sibling experience is a necessary part of the research as this may have some influence on *their* countertransference with *their* patients. In view of this, I have thought carefully about the participants of this study being psychodynamic psychotherapists, as I am, and how this may play a pivotal role in the study. Participants are not just vessels carrying stories which can be extracted and presented objectively outside of any historical or social context (Dunbar et al 2002 p.131), nor too can the researcher be an objective subject unaffected by their own social and historical context (Richards, Clark & Boggis

2015). Both myself as researcher and the participants of this study are members of the psychoanalytic and psychodynamic community and this itself will influence our interactions. For example, some shared assumptions might be expected in relation to our theoretical understanding in how we make sense of the relationship between therapist and patient. This could create a positive influence as the participants may feel I have an in-depth understanding of theoretical knowledge and so freely discuss their countertransference. However, this could paradoxically lead to further assumptions as to meanings and language and therefore an awareness of this and attempts to ensure clarity was of particular importance (Morgan-Brett and Wheeler 2022).

With this in mind, analysing the data through ‘reflexive thematic analysis (Braun and Clarke 2013) is analogous with the research data being gathered using the countertransference of the research participants and the use of my own countertransference. The Braun and Clarke (2022) reflexive approach to thematic analysis involves a six-phase process with the reflexive informal notetaking and journaling of each process which will assist the final writing up. The six phases are as follows and there is a more detailed table of my adaptation of this in chapter 6.

Phase 1	**Familiarising yourself with the dataset** A process of immersion enables you to become deeply familiar with the data.
Phase 2	**Coding** Identifying segments of data which appear potentially interesting, meaningful or relevant
Phase 3	**Generating initial themes** Identifying shared patterns of meaning – clustering codes together which seem to share a core idea or concept into themes
Phase 4	**Developing and reviewing themes** Assess the initial themes to check viability and ensure they make sense and tell a convincing story
Phase 5	**Refining, defining and naming themes** Fine tune your analysis and ask yourself how the themes fit into my overall story about the data
Phase 6	**Writing up** In reflexive thematic analysis analytical writing starts from phase 3. Fine tune your writing weaving together your narrative

Table 2: *The six phases of reflexive thematic analysis (Braun and Clarke 2022 p35)*

The success of thematic analysis rests on the rigorous coding to ensure themes relating to the research question can be identified as well as identifying unexpected themes which may be equally relevant. Lochmiller 2021).

4.12 Potential difficulties and issues to be overcome

I hope I have addressed some of the potential difficulties at each stage of the research methodology process. However, from my own experience in both discussing only-child

patients with colleagues and from years of my own personal therapy with a number of psychoanalytic therapists, being an only-child adult has not played a particularly important role within the therapeutic setting due to the unawareness or resistance of many therapists to the significance and implications in being an only-child and the possible unique transference which may develop. Many of my colleagues have expressed surprise and enlightenment that missing out on sibling experiences could play such an important role in the psychic development of an individual and that this has the potential to be experienced in the transference – these colleagues are part of sibling groups and therefore may have different ways of thinking about this. My concern, therefore, was that not having considered this possibility, they may feel they have nothing to contribute and not come forward potentially creating a difficulty in recruiting and securing participants. I did, however, attempt to address this in the advertisement for participants.

4.13 Conclusion

The research methods proposed here into this only-child phenomena, I hope, will create an opportunity for insight into whether this sibling conflict continues to repeat itself in the psyche of the only-child adult throughout life with repeated attempts at resolution. In the next chapter, I will discuss my conceptual theories and potential conceptual framework in which to locate my hypothetical theory.

Chapter 5

Process of the research, thematic analysis, results table and outline of overarching themes and sub-themes

5.0 Introduction

As I have discussed in chapters one and two, the purpose of this study is to investigate the possible existence of a 'phantasy sibling transference' within the clinical setting and within which the only-child adult may search for their 'position' within a phantasy sibling group. I have also discussed in chapter 4, how the purpose for this search may be related to the establishing of an identity on the horizontal/lateral level which allows the only-child adult to know who they are and where they stand in the world of peers. I have suggested this has not had the opportunity to develop due to the non-arrival of the sibling in early life and how the absence of this may manifest in the transference and be picked up through the countertransference of the therapist.

In the following two chapters, chapter 5 and chapter 6, I will discuss the results of the data analysis and its significance and meaning to the research question. In this first chapter of the results, chapter 5, I will present the process in which the data was analysed, the thematic analysis results table which shows the relationship between the codes, the sub-themes and the overarching themes and I will give an outline of what they represent. In the next chapter, chapter 6, I will look in detail at the research participants (RPs) and their patients, discuss their backgrounds followed by a discussion of where these themes show in the data. I will now begin with a brief overview of the process of how the data was analysed.

5.1 The process of analysing the data

As discussed in the Methodology, Chapter 4, reflexive thematic analysis (Braun and Clarke 2022) is a flexible technique recognising the active role of the researcher. The activity of examining my own subjectivity and how it impinges on and transforms the research results is an important part of this study. In relation to this I am aware that my experience as an only-child adult positions me as seeing the data through the lens of my own experience. As a psychotherapist of many years experience, I have thought about this in my own analysis and in my own clinical and academic supervisions throughout this research to ensure I am as aware as I can be of my own reflexivity in the process. I have been aware of the urge to see in the data my own subjective experience and to create a narrative which is aligned with attempting to make sense of my own experience. For this reason, I recorded the interviews to ensure I can create as much objectivity as is possible whilst also recognising that in qualitative research, the researcher is part of the story and I will be drawn to and wish to explore elements of the discussion which pertain to my experience where another researcher may be drawn to something quite different. I was also fortunate to have the opportunity to discuss my ongoing data analysis on a weekly basis with a researcher colleague to further ensure my own beliefs and subjectivity are visible and not assumed (Denzin and Lincoln 2005 p22). This experience proved invaluable.

As previously mentioned, the stages of analysis followed Braun and Clarke's (2022) six stages of reflexive thematic analysis. Please see table 3: which shows Braun and Clarke's six stages with my adaptation to this study.

Phases of reflexive thematic analysis (Braun & Clarke, 2022)	Description	My adaptation to this study
Phase 1: ***Familiarisation***	Becoming familiar with the dataset through immersion into the data and note-taking.	I began by making reflexive notes of my experience of the interviews, the research participants and their patients, making notes of relevant insights. I then Immersed myself into the dataset through listening repeatedly to audio-tapes and reading and re-reading transcripts.
Phase 2: ***Coding***	Work systematically through your dataset in a fine-grained way identifying segments of data that appear potentially interesting, relevant or meaningful at the semantic level (explicit and surface meaning) and the latent level (implicit).	I coded segments of the data on the surface level and at the unconscious level – this level of coding being analogous to the psychoanalytic theoretical framework which I am using to make sense of the data.
Phase 3: ***Generating initial themes***	Start to identify shared pattern meanings across the entire dataset. Compile clusters of codes that share a core idea or concept which might provide a meaningful answer to your research question.	From the codes I began to formulate clusters of codes into themes related to the research question. Looking particularly at themes related to; • A positional difficulty • Exclusion • Annihilation anxiety • Curiosity in other patients • Relationship with research participant • Sibling-like features
Phase 4: ***Developing and reviewing themes***	Assess the initial fit of your themes and the viability of your overall analysis by checking the dataset. Check themes make sense in both the coded extracts and then the full dataset. Ensure the themes highlight the most important patterns across the dataset in relation to the research question. Themes can be collapsed together or split to produce new ones as well as some being discarded.	I checked continually whether the codes matched the dataset and themes. Changed some codes to different descriptions. Checked to see if themes describe and relate to the research question. Changed themes around and experimented with wording of themes.

Phase 5: ***Refining, defining and naming themes***	Fine tune your analysis ensuring each theme is clearly demarcated and is built around a strong core concept. Write a brief synopsis of each theme.	I reviewed themes and settled on 5 overarching themes with sub-themes feeding into them. Thought again about the names of themes to ensure they held meaning and were relevant to the research question.
Phase 6: ***Writing up***	Begin to weave together your analytic narrative and compelling vivid data extracts	Having put together the overarching themes, sub-themes and codes in an order where they related to each other. I then wrote up each individual theme and produced a meaningful story of the dataset from a psychoanalytic framework.

Table 3: *My adaptation to Braun and Clarke's (2022) six phases of reflexive thematic analysis for this study.*

5.2. The presentation of the results of the themes

To begin the presentation of the results of the themes please see table 4 below which shows the relationship between the overarching themes, the sub-themes and some examples of the codes – how the codes developed into themes. I will follow this with a discussion of the five overarching themes and how they evolved from the data.

Overarching themes	Sub-themes	Codes	Codes
Position-less on the lateral level	Feels different and on the outside of peers	*Feels separate* *Sense of loneliness* *Feels unwanted*	*Does not fit in* *RP feels on the outside of patient* *Often feels abandoned/rejected*
	Feels a lack of recognition	*Feels not good enough* *Feels unseen* *Feels invisible*	*Compares self with others* *Feels value-less* *Feels non-existent*
Search for a position	Competes for a position among the phantasy siblings (other patients/peers)	*Session times at beginning or end of day* *RP picks up a sense of entitlement* *Wants to be special*	*Never cancels sessions* *Ambitious at work* *Unable to share RP*
	Search for a sibling	*Feels a sense of longing* *RP felt a need to perform*	*Desperate for a baby* *RP felt patient needed something from them*
	Competes with RP as if a sibling	*RP feels a sense of competitiveness and rivalry* *RP feels emulated* *Takes on clinical training similar to RP*	*RP feels intimidated* *Wants to be the expert* *Wants to be 'top dog'*
The presence of peers creates anxiety	Feels unable to negotiate with peers	*Relationships with peers creates anxiety* *Can only relate on 1:1 basis* *Lack of playfulness*	*Holds senior/authoritative positions at work* *In denial of 'other' patients' existence* *Intensity*

Retreats from difficult feelings	Difficult feelings cannot be tolerated	*RP feels disconnected at times* *RP feels difficult feelings are actively avoided*	*Unable to show rage and aggression* *Shows self-reliance*
Overwhelming sense of responsibility	Feels heavy expectations	*Carries others' needs*	*Burdened by parental projections*

N.B. Themes/codes relate to the RP's patient unless stated they relate to the RP themselves.
There are two columns of codes which is merely for ease of recording and do not hold any order of importance.

Table 4: *Relationship between overarching themes, sub-themes and codes – how the codes developed into themes.*

5.3 Overarching Theme 1: Position-less on the lateral level

Feeling as though one holds a 'position' among peers can be seen as having a profound influence on identity development and is related to the need for recognition – reflected from early experience and the position taken up within the sibling group (Mitchell 2003; Vivona 2007, 2013; Parker 2020). The findings in this study show the only-child adult feels they do not hold a 'position' on the lateral level among peers and at times their actual existence on this level comes into question. This was a predominant theme among all the patients and was picked up by the RPs through the patients' narratives, how they see themselves within the world and in relation to others – particularly their peers, as well as through the RPs' countertransference. These themes were particularly observable through the discussions around the patients' work place experiences where it seemed to be more obvious to the RPs that there was a positional dilemma although it was not recognised as having a connection to being an only-child. There are two sub-themes which are encompassed in this overarching theme.

5.3.1 Sub-theme 1: Feeling different and on the outside

All the RPs reported their patients' experiencing feeling different, separate and on the outside or on the periphery in relation to groups and peers. They felt unwanted and as though they did not 'fit in' with peers and therefore felt vulnerable to feeling abandoned or rejected by peers culminating in feeling isolated. There was also a strong feeling of loneliness which was sometimes expressed but was felt in the countertransference of the RPs – more so with the only-child RPs and was difficult for the RPs to fully understand what this meant for their patients. Some understood it as relating to early experience with parents although this was also acknowledged as not always fitting with their patient's actual experience frequently leaving the RPs unable to make sense of it.

5.3.2 Sub-theme 2: Lack of recognition

The role of mutual recognition (Benjamin 1990) in relation to sibling position has been discussed in chapter 4, and plays an important role in relation to the development of identity and lateral relatedness (Vivona 2013). From the data, only-child adults showed feelings, through their narratives and through the transference, suggesting a lack of recognition from peers. This included feelings of not being seen, not feeling good enough, feeling invisible, comparing self with others, feeling valueless and feeling non-existent – all in relation to peers. This suggests a position has not been confirmed by peers on the lateral dimension resulting in feelings of vulnerability to rejection and abandonment and perhaps a need to protect themselves through being self-sufficient and self-reliant which also comes up in overarching theme 4. These aspects were also evident in the transference and through the countertransference of the RPs.

5.4. Overarching Theme 2: Search for a position

The second overarching theme is related to the only-child adult's unconscious search for a position which can be seen inside and outside the clinical setting. Searching for and hoping to find a position serves two purposes for the individual – one is to compete

with the phantasy siblings for the exclusive care and attention from the person they share, which is usually the mother, represented by the RP. The other is to find a position among the phantasy siblings which confirms their existence through the process of mutual recognition (Benjamin 1990) on the lateral level relating to identity development and the beginning of social development (Mitchell 2003; Vivona 2007; Parker 2020). The phantasy siblings are represented by peers, the RPs other patients and the RPs themselves. This overarching theme encompasses three sub-themes relating to the attempt at finding a position in relation to, and in competition with, the RPs and the RPs' other patients. These sub-themes are;

5.4.1 Sub-theme 1: Competing for a position among the 'phantasy siblings' (other patients/peers)

The data suggests patients seem to experience the RPs, their peers outside the therapeutic environment and other patients as phantasy siblings and so search for a position among them to unconsciously begin the phantasy sibling drama. The ultimate fear is about being displaced and thrown into a sense of 'nothingness' by the arrival or presence of the phantasy sibling who they fear, will replace them. Being displaced also means a loss of omnipotence. In the clinical setting this search for a position has emerged in several ways; a) through the patient requesting session times at either the beginning or the end of the day. I suggest the appointment times represent a 'special' position which is longed for. The importance of the appointment being at the beginning or end of the day feels as though it secures that special place and is not lost amongst the siblings; b) the patient never cancelling sessions. I suggest this is also an attempt to secure that 'special' position. If the appointment times represent a 'position', the patient maybe fearful of being 'replaced' if they do cancel; c) the RPs sensing their patients feeling under threat whether that be related to seeing another patient, a relative of the RP seen in the therapeutic environment or an experience with a peer from the patient's life. These situations maybe experienced as a threat of a rival which represents the arrival of the new baby and the inevitable displacement which follows; d) the RPs feeling a sense of entitlement coming from the patient. I suggest this is a defence against the threat of 'nothingness' or 'displacement'. The patient acts in a way that attempts to ensure they are the RPs' exclusive and only patient. Consciously,

the patient feels entitled to that special position. Patients seem unwilling to share the RP, or their position with the RP or with anyone else associated with the RP; e) being ambitious at work. I suggest this is also an attempt to secure a special position, one where the patient experiences themself in an elevated position in the phantasy sibling group (work colleagues) in relation to the phantasy parent (the boss).

5.4.2 Sub-theme 2: Search for a sibling

If we understand the search for a sibling as being related to the search for a position in which to enact the phantasy sibling drama, the resolution of this is to find a position within the sibling group in order to enact the process leading the only-child adult to the eventual outcome of finding a position with peers – becoming 'one of many' (Mitchell 2003) and to begin the development of identity on the lateral level. The RPs frequently experienced a sense of longing from their patients but often felt unclear as to how to make sense of this and limited their interpretations to a longing on the vertical level. The three only-child RPs reported to feeling an identification with this longing. For the other six RPs, this feeling was sometimes felt and understood as a need for them to perform for their patient, to give their patient something they desperately wanted or felt they needed but again were often unclear as to what this might be and why it might be happening. A common theme of longing and searching was the desperate need for a baby which I suggest represents the longed-for sibling.

5.4.3 Sub-theme 3: Competes with the RP as if a sibling

RPs often felt threatened or intimidated by their patient or felt a sense of competitiveness and rivalry. Wanting to be 'top dog' was particularly apparent in the work situation and this was also felt to be reflected in the clinical setting where they felt their patients vying for the position of the expert. This evoked feelings of intimidation, frustration and irritation in the RPs – similar feelings an older sibling may experience toward a younger sibling. In some cases this need to compete manifested in their patients deciding to undertake a similar clinical training as the RP whilst in therapy. This competitiveness with the RP suggests the patient is attempting to compete with them for the special place with a higher authority, as if they are a

phantasy sibling. RPs frequently felt their patient emulating them – idealising them, wanting to be like them and sometimes wanting to succeed them. The RPs' understanding of these countertransferential feelings ranged from feeling the patient wanted a friendship with them, a closeness and connection or a general sense of feeling unclear as to what was being unconsciously communicated which raised anxiety in the RPs that they may not be able to meet their patient's need. The undertaking of a clinical training could also be seen as emulating the RP although the underlying feeling felt by the RPs was of rivalry and competitiveness.

5.5 Overarching theme 3: The presence of peers creates anxiety

The third overarching theme is centred around the challenging relationships the only-child adult experiences with peers and their difficulties in negotiating and finding a position for themselves within those relationships. This was particularly observable in the work setting where the patient would use various mechanisms to cope with the anxiety this created such as excluding themselves and self-reliance. The findings show the only-child adult frequently works alone within an organisation and is reported to hold senior and authoritative roles finding it difficult to relate to peers effectively unless on a one-to-one basis. This need to be senior or 'above' peers can be related to their need to find a position where the risk of displacement or replacement from rivals is reduced and they are unconsciously searching for the favoured position with the parental representative. This is also shown in their need to gain knowledge in the work place becoming the clever, articulate senior worker, perhaps also taking on a phantasy older sibling position which perhaps feels safer.

5.5.1 Sub-theme 1: Unable to negotiate with peers

RPs reported that their patients feel anxious in the presence of peers and the potential threat of peers and seemed to find it difficult to know how to relate to them – suggesting they did not feel they held a secure position laterally. This anxiety manifested in various situations both inside and outside the clinical setting and was shown through the situations and relationships they found themselves confronted with in their work

life as well as feeling unable to consider the RPs may have other patients – this potential threat seems to be avoided by defence mechanisms with several RPs reporting a feeling that their patient is not at all bothered by their other patients but *is* bothered by peers outside the clinical setting. However, this seemed to be the case until patients were confronted with a potential rival in the clinical setting throwing them into overwhelming anxiety which some struggled to recover from.

RPs also reported a lack of playfulness in their patients and instead an intensity and seriousness in one-to-one relationships – resulting from having missed early opportunities of taking on different roles with siblings and losing themselves in play and irresponsibility (Winnicott 1964).

5.6 Overarching Theme 4: Retreats from difficult feelings

The fourth overarching theme shows the only-child adult retreats from feelings which they find difficult. These were connected to anger, aggression and sadness. The ways in which they retreated ranged from frequently physically leaving the session to emotionally disconnecting in the session and avoiding feelings, often leaving the RP feeling disconnected. Although retreating from difficult feelings is not unique to only-child adults, it was a common theme with this group of individuals. This overarching theme encompasses one sub-theme;

5.6.1 Sub-theme 1: Difficult feelings cannot be tolerated

Some RPs reported to feeling temporary disconnections from their patient which they interpreted as their patient feeling unable to connect to difficult feelings such as rage, anger and sadness. Other RPs felt the rage under the surface but felt unable to address it. When it was addressed, their patient could not think about it. This frequently seemed to result in a self-reliance reported by several RPs. A difficulty to share difficult feelings or tolerate them I suggest is due to never having experienced these feelings as tolerable through the directing of murderous rage at a new sibling who survives it

(Winnicott 1964) or themselves surviving feelings of annihilation coming from a sibling (Mitchell 2003).

5.7 Overarching theme 5: Overwhelming sense of responsibility

The fifth overarching theme is the overwhelming sense of responsibility experienced by the only-child patients in both childhood and adult life which was picked up in the patient narratives and in the RPs' countertransference. They understood their patients' carried others' needs which they saw as being connected to feeling burdened by early parental projections. There was just one sub-theme in this section;

5.7.1 Sub-theme 1: Feels heavy expectations

The RPs were aware of their patients' sense of carrying heavy expectations in their adult life. Two RPs had linked this to their patients having single handedly carried the expectations and projections of parents in early life. This may suggest only-child adults did not get the opportunity to be labelled as 'anything' in particular, but needed to be 'everything' and carried, and continue to carry, all the expectations, the hopes and insecurities of their parents. This manifested in feelings of huge responsibility for parents' wellbeing as well as other relationships often on the vertical dimension including the RPs at times.

5.8 Conclusion

In this first chapter of the results, I have outlined the process of the analysis of data, presented a table detailing the overarching themes and their relationship with the original codes and discussed the overarching themes in relation to the research question. In the second chapter of the results, chapter 6, I will be discussing the RPs' backgrounds and their patients' histories to give some context to the themes which

have evolved through their countertransference as well as discussing each RP and how the themes relate to them individually and the patient they discussed.

Chapter 6

The research participants' (RPs') backgrounds, their patients' histories, and the overarching themes and sub-themes in relation to the data

6.0 Introduction

Following on from chapter 5 and in this second results chapter, I will be discussing the RPs' backgrounds, their patients' histories and the overarching themes and sub-themes in relation to the data which will be in the form of quotes from the interview. This will include my reflections on the transference and countertransference between the interviewee (RP) and the interviewer (me). As shown in table 4 in chapter 5, the overarching themes are umbrella themes which have been developed from the original codes which were the actual behaviours and feelings, into sub-themes and finally into overarching themes.

In presenting this data, I have chosen to present the themes for each individual RP with their background, patient histories and reason for referral, rather than presenting the themes across all RPs as is common practice with thematic analysis. Presenting them individually allows the reader to fully engage with each RP, their sibling experience, their patients' histories and therefore gives a context for the themes enabling a deeper understanding of how the themes developed and their relevance.

6.1 Research participants' (RPs') data

As previously stated, the therapists are referred to as research participants (RPs) and will be named as RP1, RP2 up to and including RP9. Their patients will be A, B, C up to and including patient J – The letter 'I' has not been used. The RPs' data is their patients' narrative and their countertransference in response to their patient. My own countertransference is in response to the RPs and the patient they are discussing.

6.2 Research participant 1 (RP1) and context of his practice

RP1 is an experienced male psychodynamic psychotherapist who has been practicing for many years having qualified to masters' degree level in a psychodynamic clinical training. He holds his private practice from home and patients refer themselves directly through his advertising. He is the youngest of three boys with an age gap of ten years between himself and his next brother. He reported to feeling he was always known as his brother's little brother without a real acknowledgement of being an individual in his own right.

6.2.1 RP1's work with patient A, her background and presenting problem.

RP1's female only-child patient had referred herself because she wanted a third baby and her partner had refused. She wanted to work through ending the relationship. She is in her late-thirties. At the point of the interview with me, patient A had been in therapy with RP1 for five years. According to RP1, patient A grew up with her parents. Her mother died when she was 20. RP1 says he felt she had experienced loving parents and that there was nothing obviously unresolved from an Oedipal perspective. Patient A had worked in the same organisation for many years and was not in a senior position but felt inferior to her work colleagues.

I will go on to discuss the themes and their significance to RP1 and his work with patient A.

6.2.2 Overarching theme 1: Position-less on the lateral level

6.2.2 *(i) Sub-theme 1: Feeling different and on the outside of peer-groups*

> I think what's interesting about the work thing in particular is, you know, she doesn't kind of get pecking orders, kind of where you fit in and all that kind of stuff very well, and so she feels she's not part of things, different and doesn't belong, and I think if you have siblings, you get a bit more of a sense of all that.

RP1 refers to patient A's lack of understanding the concept of pecking orders – where one holds a place in the peer group on the lateral level which leaves her feeling different and on the outside.

He also refers to her loneliness;

> She does have the capacity to be on her own and in some ways feels ok with it but I sense this deep loneliness which is often difficult to really pin point.

Feeling 'position-less' on the lateral level can evoke a sense of loneliness as she has not found her position among her peers.

6.2.2 *(ii) Sub-theme 2: Lack of recognition*

> She's intrusive about letting me know she's paid. Unlike most patients, she wants to pay weekly. I want her to pay monthly like everyone else, but she won't, then she has to let me know she's paid – makes some big announcement at the beginning of the session. We've thought about what's going on here a kind of pushing for something from me, but it's still going on.

Patient A seems to be unconsciously asking RP1 to recognise her. Paying monthly with everyone else may mean losing herself in her phantasy sibling group in which she does not hold a position and she is therefore at risk of annihilation.

> It's like I need to be on my guard with her, that she wants me to be something or someone. I might get caught out that I'm not doing it, whatever IT is if she catches me off guard and yet on the other hand I feel she wants me to see her. She's asked me on a number of occasions whether I'm boring her, whether she's, no sorry, whether she's boring me – 'am I sending you to sleep?' and I feel I've got to be there and awake seeing her and what's going on for her.

RP1 feels a demand from patient A to 'see' her, to 'acknowledge' her and can sense her desperation to receive this from him. Patient A asked him whether she is boring him and I suspect this is her unconsciously asking him if he is seeing her and if she has a position with him. Also perhaps asking if her need of him felt overwhelming for him and destroyed him – sent him to sleep. It was interesting that he became muddled as to who was boring who, and I suggest this is about his own feelings of inadequacy linked to his own sibling status as the youngest of three boys which I will discuss in my countertransference in 6.2.7.

6.2.3 Overarching theme 2: Search for a position

6.2.3 *(i) Sub-theme 1: Competes for a position with the phantasy siblings (other patients/peers)*

> I remember she had to wait a few minutes for me, we had to start the session late. She wanted to know when we'd make those minutes up, felt quite demanding. On another occasion she couldn't make a session and I don't automatically offer another session, but again she wanted to know, demanded to know actually, when the missed session would be made up. She'd just keep on, so demanding and as though she'd missed out on something she was entitled to.

RP1 is describing an anxiety in patient A and an urgent feeling that she needed to secure a place with him – the lost minutes may have represented the lack of position, also evident in the cancellation of the session – her 'position-less' status on the lateral level being reinforced by the cancellation, even though it was her own cancellation. Perhaps an anxiety which equated with a fear of 'displacement', 'nothingness' or 'annihilation' relating to her lack of position in

relation to RP1 and his other patients – the 'phantasy siblings'. He experienced this demand as a sense of entitlement and refers to it again;

> There is also a real sense of entitlement. Like she missed out on something when she was a child, all the other kids had mums who were active and even at work – she feels like she's entitled to something and can get upset about it, anything. Feels like that with me too, she's entitled to me and the therapy.

This sense of entitlement may be a defence against the fear of 'nothingness' which she may unconsciously expect and dread at the prospect of rivals attempting to displace her. I suggest she is competing for a special and 'only' place with RP1. Her sense of entitlement attempts to secure her special place as it is too painful to acknowledge she could be 'one of many'.

6.2.3 *(ii) Sub-theme 2: Search for a sibling;*

> I am so aware of this sense of longing in her. It was difficult 'cos we couldn't really identify what it was about. We thought about the desperate longing for a child and that was there for sure, but it felt more than that, sort of intense. I suppose I understood it as a need for some connection with me. A need to be close, for me to be kind of there – never thought about it being a need for a sibling.

I suggest this desperate need for a third child is her unconscious longing and search for a sibling which continued to come up throughout the therapy. RP1 struggled to identify this longing and understood it as happening on the vertical – her longing for connection with him as a parent, perhaps transferred from her mother, which may have played a part. However, the intensity and his feeling that it went beyond this, may suggest it is a longing on the lateral level.

6.2.3 *(iii) Sub-theme 3: Competes with RP1 as if a sibling*

> She's actually decided to train to be a psychotherapist, a really kind of interesting indication of someone who is very attached, you know, she's someone who's understanding of herself has gone from nothing to a kind of real recognition that there is an unconscious and that she's driven by these things.

I believe RP1 is struggling to think about the meaning of patient A's desire to undertake a clinical training which I suggest is linked to his own sibling experience which will be discussed later. He continues to understand her motivation from the vertical perspective. I suggest RP1 represents the older phantasy sibling whom she is emulating by undertaking the clinical training which he has undertaken. She wants to be like him but also succeed him as a younger sibling will attempt with their older sibling. The idealisation and emulation of the sibling is a reversal of the hatred the infant feels for the rival, a defence against her feelings of rivalry and competitiveness (Mitchell, 2003).

The emulation of RP1 by patient A was initially an enjoyable experience for him. However, he felt irritated when she changed from being the compliant younger sibling emulating him, to competing with him by taking on a clinical training. He found it difficult;

> She's training in British Objects Relations and getting stuck right in, so it'll be interesting to see what she does with it and I suppose there's also a bit of me that thinks she's going to tell me what a shit therapist I am, and I don't know that I really want to go through that (laughs) and that's kind of interesting isn't it and I suppose we could think about does she then become a sister to me, do we then become siblings who have a kind of rivalry rather than my role with her more as a parent? (laughs). What's more interesting is that I'm going to be doing some teaching at this place which she doesn't know yet (laughs).

RP1 seemed threatened by patient A undertaking a clinical training. He was fearful that she would see him for what he felt he was, the inadequate little brother, which I suspect was a reactivation of his own sibling experience as the youngest sibling among three brothers. For patient A, she was competing with him as though he was an older sibling with whom she initially emulated as a defence against her rivalrous and competitive feelings but now those feelings were nearer the surface and she was attempting to triumph over him and succeed him.

His comment about himself doing some teaching at the same organisation which she does not know about, I suggest is his retaliation as the older sibling who feels displaced.

6.2.4 Overarching theme 3: The presence of peers creates anxiety

6.2.4 *(i) Sub-theme 1: Unable to negotiate with peers*

> I don't think she realises consciously that I have other patients, in fact I would say she is one of those people who doesn't think anyone else exists – certainly not for me, I just get that feeling. Interestingly, though, she didn't want to come back to face to face after the pandemic – said she didn't want to catch Covid. She was back at work though and she knows my set up, we talked about it, that she won't come into contact with anyone else.

Whilst RP1 felt that patient A could not consciously acknowledge the existence of his other patients, when he mentioned the likelihood of not coming into contact with other patients after the pandemic, she felt unable to confront the fear of displacement and the recognition that she is one of many patients.

6.2.5 Overarching theme 4: Retreats from difficult feelings

6.2.5 *(i) Sub-theme 1: Difficult feelings cannot be tolerated*

> Her litany of anger and resentment at her husband which she tells me about constantly, but she's avoided having any kind of conversation with him about how angry she is with him for the past three years. She's terrified of something, he might become violent, although he's never shown any tendency toward this, or something might break? She just doesn't want to face it. When I challenge her about this avoidance and suggest she might be angry with me, she can't deal with that either and 'wanders off' metaphorically speaking.

RP1 describes patient A's difficulty in thinking about her difficult feelings. Her fear of her husband becoming violent, I suggest, is her own projection of her feelings of violence which have never been mitigated through the experience of siblings (Winnicott 1962; Mitchell, 2003).

6.2.6 Overarching theme 5: Overwhelming sense of responsibility

6.2.6 *(i) Sub-theme 1: Feels heavy expectations*

This theme was not evident in the interview with RP1. Although he discussed patient A as being self-sufficient, he did not evidence a sense of overwhelming responsibility, heavy expectations or a feeling of being burdened by parental projections;

> Well, she has a need to know herself, can't ask anyone. She is self-sufficient. Again, not having anyone to share things with so has to understand it all for herself.

6.2.7 My countertransference

Meeting with RP1 was my first research interview, I was nervous and this will have played a part in my experience. I initially felt intimidated by RP1, as he was slightly older than me and he seemed to play the older, wiser therapist – this may also have been in part my projection of my older wiser therapist father. However, the more I heard about patient A, the more I felt an identification with her in what felt was his need to be the 'big brother' to us both. It made more sense when he discussed how, being the little brother, he always felt as though he had no identity of his own but was known throughout his early life as William Smith's (not his real name) little brother. It was clear to me his fantasy of being the big brother was being played out with both myself and patient A who, having no siblings, were willing participants in the phantasy sibling drama.

6.3 Research participant 2 (RP2) and context of her practice

RP2 is an experienced female psychodynamic psychotherapist who has been practicing for many years. She is qualified to masters level and held her practice in a private therapy centre where patients were offered 60 sessions. Patient B was referred

through the centre and when taking her on, RP2 had already decided to leave the centre so patient B was offered 40 sessions instead of 60. There is a waiting room. RP2 is an only-child herself and was aware of her own loneliness which she felt was as a result of this.

6.3.1 RP2's work with patient B, her background and presenting problem

RP2 described patient B as having been referred for therapy because she could not get pregnant and was exploring the possibility of IVF treatment with her husband. She had an intense relationship with her mother who had confided in her daughter throughout her teenage years. Her father died at age 18. Her Oedipal experience had been difficult as her father was emotionally and physically absent. She had few friends whom she felt did not notice her or understand her distress.

I will discuss the overarching themes and their significance to RP2 and her work with patient B.

6.3.2 Overarching theme 1: Position-less on the lateral level

6.3.2 *(i) Sub-theme 1: Feeling different and on the outside of peer-groups*

> I've always felt confused about her position at work. She spoke about work often, but I always felt that in this team she worked, she didn't quite know her place, she felt a bit rudderless and not really part of the team but separate and different. She was ambitious but she didn't talk about any of her colleagues in a way that made me think she was part of a team, even though I knew she was, so she was very singular in this group of people and maybe it's the only-child thing, she was the only-child in this group of individuals and they were all siblings with each other but she was not, maybe that's the best way to describe it.

RP2 is quite clear in her assessment of patient B's experience with her work colleagues as not feeling part of her work team but feeling quite separate from them.

6.3.2 *(ii) Sub-theme 2: Lack of recognition*

> I could feel her loneliness and sense of isolation so clearly. She felt invisible among her colleagues and friends. Frequently complained they didn't notice how she was struggling or didn't understand her. She didn't feel seen by them and I suspect by me.

RP2 describes patient B's lack of feeling recognised by others on the lateral level feeling invisible and unnoticed by friends and colleagues suggesting a lack of recognition from siblings in early life.

6.3.3 Overarching theme 2: Search for a position

6.3.3 *(i) Sub-theme 1: Competes for a position with the phantasy siblings (other patients/peers)*

> There was a week where my next patient, a female, arrived early and they saw each other as she (patient B) left. It came up in the next session which was predominantly about her feelings toward her mother who she'd visited the week before. She'd sat in her mother's sitting room and saw she'd (her mother) put up a photo on the mantel piece of her (patient B's) friend. She was so angry and upset, repeatedly asking why had her mother done this. It was excruciating for her.

Seeing RP2's other patient coming after her had caused patient B a great deal of distress. I suggest this 'other' patient was experienced as her phantasy sibling who was competing for her place with RP2 which was expressed through her feeling displaced in her position with her mother by the photo of her friend.

RP2 also refers to feeling a sense of entitlement;

> I had to explain to her that I was leaving the organisation and therefore she could have 40 sessions instead of the usual 60. She was furious, utterly furious at this. It was as though she was entitled to the full amount. We talked about this feeling, but she could not come to terms with it and I think it was underlying the entire therapy and came out in other situations.

I suggest patient B's sense of entitlement to the sessions was a defence against her fear of being replaced. The sessions represented her position with RP2 and being replaced equated to a feeling of 'nothingness' – being thrown out by the arrival of a phantasy sibling (the other patient who in phantasy will take up the sessions and throw her out).

RP2 also described how patient B was ambitious at work;

> But what she did enjoy and embrace was the opportunity to learn. The organisation she worked for offered a lot of inhouse training and she put her hand up for everything, literally anything that would better her knowledge, she would embrace it, totally embrace it.

I suggest patient B's need to sign up for all the inhouse training is her competitiveness to be top dog among her work colleagues – the favoured child. She saw having knowledge as powerful and would get her a top 'position' which would reduce the threat of displacement from her phantasy siblings (peers). She may also experience recognition from her phantasy siblings she had not experienced in early life.

6.3.3 *(ii) Sub-theme 2: Search for a sibling*

RP2 referred to patient B's desperation for a baby;

> She was desperate for a baby. She wanted this more than anything, she was so driven to make it happen. She was doing everything possible, taking her temperature, literally everything she possibly could. It had taken over her whole life and it was as though her life depended on it.

Patient B's search for a sibling is manifesting in the desperate desire for a baby. The longing associated with this search is referred to again;

> She felt a longing, I could feel it too, I identified with her longing but it was so difficult to articulate and find meaning in it as it was so deep. Thought it must be to do with the baby but it seemed too profound.

RP2 felt her patient's sense of longing and identified with it, but at the time could not articulate what this was about for her. I suggest this was related to her unconscious longing for a sibling.

6.3.3 *(iii) Sub-theme 3: Competes with RP2 as if a sibling*

RP2 expresses her feelings relating to the competitiveness she experiences with patient B.

> There was definitely competitiveness in the room and it was only when I saw your research request that it occurred to me whether it was actually about siblings – two sisters – I had never considered this. She used to use professional language in her attempts to be on a par with me so I had no authority. She didn't like the idea that I was the professional in my field – she wanted to be the professional in the room. I did bring it into the work cos my supervisor had said I needed to say that I was a professional and that I know what I'm doing. My countertransference was often that I felt disabled by her, not killed off, not as strong as that, but definitely belittled.

RP2 expressed the feelings of competitiveness she experienced and I suggest patient B felt she was in competition with a phantasy sibling in RP2. Initially she had emulated RP2 and then this changed to competing with her perhaps as the older sibling might do with a younger sibling – trying to reduce the threat of displacement. However, it seemed as though RP2 also felt a competitiveness with her patient and pulled in her supervisor who also became caught up in the rivalry and competitiveness.

6.3.4 Overarching theme 3: The presence of peers creates anxiety

6.3.4 *(i) Sub-theme 1: Unable to negotiate with peers*

> She was ok on a one-to-one basis, but being in a group was particularly difficult. She would feel anxious and really struggle to feel part of the group. So, she tended to avoid it. At work she didn't really socialise and when she went to the trainings, I got the feeling she sat on her own and was the clever one who answered all the questions.

RP2 felt patient B felt anxious in group situations. I suggest this is related to her feeling 'position-less' on the lateral level. Having not experienced siblings and negotiating her place with them, she does not know her position with peers and so is unable to take it up, but instead can feel the anxiety of feeling non-existent.

6.3.5 Overarching theme 4: Retreats from difficult feelings

6.3.5 *(i) Sub-theme 1: Difficult feelings cannot be tolerated*

> If things became painful for her, she would be absent and take herself out of it, out of the relationship – she did this with a friend whom she was angry with, just didn't make any more contact, and with me. If something painful came up, I'd feel she had disconnected – like I'd lost contact with her. Occasionally I wondered if she'd come back, but she never missed a session.

RP2 recognises that patient B found painful and angry feelings difficult to tolerate and would disconnect feeling the loss of contact from her. Although RP2 feared her leaving, patient B never missed a session – perhaps her attempt to secure her position with RP2 and not be replaced.

6.3.6 Overarching theme 5: Overwhelming sense of responsibility

6.3.6 *(i) Sub-theme 1: Patient feels heavy expectations*

> Everything her dad wanted from her, that was the academic brilliance, she gave him, and the intense relationship her mum wanted, she gave but she described feeling scrutinised and the expectations on her felt burdensome. She desperately wanted separation from them and to feel relieved of the weight.

RP2 felt patient B had given a great deal to her parents and wanted to be relieved of the heavy expectations upon her which she continued to feel.

6.3.7 My countertransference

On being contacted by my first 'only-child' psychotherapist, I felt excited that this person was like me belonging to the same exclusive club and I could not wait to meet her. When we met I initially felt as though we belonged together and I felt that she got me and I got her. I was caught up in my own fantasy world of how I imagine having a sibling might be. During the course of the interview, I alternated between feeling identified with RP2 and patient B and feeling irritated at RP2's difficulty in seeing the dynamic between herself, her supervisor and her patient. Both she and her supervisor seemed to be caught up in a sibling dynamic. I felt RP2 found it difficult to manage the competitiveness she felt from patient B, and it was clear that she felt powerfully competitive herself which is likely for the same reasons but she did not seem to be aware of this, as she was defensive with her patient and recruiting the parent, (supervisor), to take her side so she felt the special one. I suggest this clearly illustrates the sibling rivalry present in the only-child.

6.4 Research participant 3 (RP3) and context of her practice

RP3 is a psychodynamic psychotherapist with several years' experience and qualified to degree level. She works for a charity who refer patients for low-cost therapy and there is a waiting room. She is the youngest of two girls and her mother is an only-child which prompted her response to the research.

6.4.1 RP3's work with patient C, her background and presenting problem

RP3 reports to her only-child female patient referring herself for therapy as she was struggling with self-esteem issues and feeling negative toward herself. She described patient C as in her mid-thirties, with a partner and two children. She grew up with her parents experiencing an enmeshed relationship with her mother and a good relationship with her father. She held an authoritative job but did not consider herself good enough in her role as a parent.

I will discuss the significance of the overarching themes relating to RP3 and patient C.

6.4.2 Overarching theme 1: Position-less on the lateral level

6.4.2 *(i) Sub-theme 1: Feeling different and on the outside of peer-groups*

> She didn't believe she could be good enough at anything, she was always the worst one at this or that and felt like she wasn't one of the girls at work and didn't think she was one of the managers either cos she felt she couldn't do what they could do – made her feel different and second best. Sometimes I felt sad for her, there was a loneliness about her which was palpable – it felt really isolating for her. Other times, I struggled to feel much at all.

RP3 describes patient C as not feeling she fitted in with her peer group at work. She did not feel she held a position with them which felt lonely and isolating. RP3 could feel the loneliness and sadness in her countertransference at times and other times she felt on the outside of her too. RP3's struggle 'to feel much at all' is also discussed in 6.4.5 (i), *'Retreats from difficult feelings'.*

6.4.2 *(ii) Sub-theme 2: Lack of recognition*

> She would often talk about her partner not listening to her, or taking notice of her, or her work colleagues and I knew she was talking about me. It came up regularly, she would tell me how she felt ignored and invisible by everyone – "no one noticed" was her mantra.

Patient C's feelings of not being recognised by peers on the lateral level or from RP3 suggests she had not received early recognition from siblings.

6.4.3 Overarching theme 2: Search for a position

6.4.3 *(i) Sub-theme 1: Competes for a position with the phantasy siblings (other patients/peers)*

> Inadvertently, I allowed her to see something of my other life, someone important to me and we spent a lot of time talking about how she felt she wasn't good enough for me. She had this idea that she was on the shelf

> and wouldn't be picked – having someone else chosen above her. It caused a real rupture in our relationship and I'm not sure she ever really recovered from it. She felt obliterated from my life.

The important person in RP3's life represented the phantasy sibling threatening to replace her and throw her into 'nothingness'. The threat of losing her favoured position had a huge impact.

RP3 also refers to an entitlement;

> I did feel that there was an expectation for me to always be there. I felt I couldn't do anything but be there, quite a pressure, as that was expected – even to the extent that I couldn't be ill, cos she expected me to be there and ok – no option! Like a feeling she was entitled to me. It's certainly expected from her parents so I guess from me too.

RP3 describes feeling a sense of entitlement from patient C and a pressure to comply. RP3 understands this from a vertical perspective, but I suggest for patient C it is also a defence against the threat of rivals and being displaced.

6.4.3 *(ii) Sub-theme 2: Search for a sibling*

> I feel in my countertransference quite often that she comes in for a chat and that has been so strong, like with a friend although I get a sense of power, I feel powerful with her like she hangs on my every word, which is contra to my experience of being the youngest sibling. But there's a tension and a pull to be a friend – I sense this longing in her that she desperately wants me to be her friend. I am very happy to sit and chat but I do feel something else is going on and I wonder what my role actually is for her.

RP3 describes feeling pulled into what she feels is the role of a friend which is on the lateral level. I suggest patient C is trying to recruit RP3 into the role of a phantasy sibling. Perhaps experiencing her as an older sibling is illustrated by the sense of emulation RP3 feels – which also relates to 6.5.2 (iii) *'Competes with RP as if a sibling'*. RP3 also recognises it does not fit with her own sibling experience being the youngest sibling. Perhaps the 'pull' is the phantasy of being the older sibling for RP3 and the tension may be her resistance.

6.4.3 *(iii) Sub-theme 3: Competes with RP3 as if a sibling*

> I have sensed a kind of underlying resentment on occasions but don't really know what that's about. It's where she's become sort of irritated with me, but it's very brief and isn't for anything specific so I've not addressed it… I suppose it has felt a bit awkward.

RP3's brief feelings of patient C feeling irritated with her for no specific reason that she can think of, I suggest, are times when patient C has felt rivalrous with her and RP3's awkwardness may re-activate her own rivalry with her older sister – possibly why it felt difficult to address.

I also refer to the emulation quoted in 6.5.2 (ii);

> I feel in my countertransference quite often that she comes in for a chat and that has been so strong, like with a friend although I get a sense of power, I feel powerful with her like she hangs on my every word…

The emulation experienced by RP3 suggests patient C is projecting an older sibling onto her particularly as she can feel the underlying rivalry.

6.4.4 Overarching theme 3: The presence of peers creates anxiety

6.4.4 *(i) Sub-theme 1: Unable to negotiate with peers*

> What's really noticeable is that she struggles with relationships – that's massively huge. If she feels left out, she immediately feels abandoned and doesn't know what to do with that. It's when someone in her group has either left or done something different, like at work, she feels she's not worth being with and wants to know what it is about her that people don't want.

RP3 describes patient C's difficulty with peer relationships and how feeling left out relates to feeling abandoned by them. I suggest this is related to her feeling 'position-less' on the lateral level, of which she is struggling to make sense.

RP3 also made reference to her other patients;

> There's no interest in my other patients at all. Apart from the incident when she saw my relative, she doesn't really come into contact with them because of how the times work here, and she has shown no interest in my life.

RP3 says there is no interest from patient C in her other patients, although there was the 'rupture' in their relationship when patient C was confronted with a relative of RP3. I suggest patient C is in denial of any rivals until such time as she comes face to face with them and then she finds it difficult to manage the anxiety. Perhaps RP3 is identifying with this projection.

6.4.5 Overarching theme 4: Retreats from difficult feelings

6.4.5 *(i) Sub-theme 1: Difficult feelings cannot be tolerated*

> She does articulate things but struggles to really express her feelings particularly when she's angry. I've noticed she can build up and build up and then something can erupt but never in the room, she tells me about it happening outside and we think about it and that's difficult for her sometimes.

I also refer to part of the quote referencing RP3 not feeling much at all in 6.4.2 (i);

> …sometimes I felt sad for her, there was a loneliness about her which was palpable – it felt really isolating for her. Other times, I struggled to feel much at all.

Whilst RP3 describes how difficult it is for patient C to express her aggression and anger appropriately and even more difficult to think about it, she is also noting her own disconnection from patient C's feelings at times, which suggests patient 3 may be disconnected from her own feelings.

6.4.6 Overarching theme 5: Overwhelming sense of responsibility

6.4.6 *(i) Sub-theme 1: Patient feels heavy expectations*

> Her parents did put a huge responsibility on her, mother was very demanding as a child and even now will turn up and expect her to accommodate her and she does! I think this carries into other relationships too – she feels responsible for upsetting people and putting things right.

RP3 describes patient C as feeling a heavy weight of responsibility toward her parents which carries into her other relationships.

6.4.7 My countertransference

During my interview with RP3, I felt like the senior therapist rather than a researcher. I felt she was a little lost with her patient but had responded to my advert as she was keen to understand her 'only-child' mother. I found myself wanting to air my knowledge and help her out with her patient but I managed to prevent myself from doing this and physically sat back and listened. On reflection, I wonder if she was projecting her older sister onto me and I, as an only-child, was keen to accept it as it made me feel as though I held a position with her as the older sibling, which felt good.

6.5 Research participant 4 (RP4) and context of her practice

RP4 is a female psychodynamic psychotherapist who has several years of experience. She practices from home and there is no waiting room. Patients are expected to arrive on time. She is the eldest of three girls and her mother is an only-child whom she says had three children because she wanted to avoid them feeling lonely as she was. However, RP4's experience was that she felt usurped by her middle sister and says this was never resolved.

6.5.1 RP4's work with patient D, her background and presenting problem

Patient D had been referred to RP4 from an organisation. She was in her late twenties and was suffering with neurological pains which she felt were not taken seriously by

the medical profession. She felt unheard and unseen. She also wanted a baby on her own and without a father. Her parents were still together, although her mother was less emotionally available and her father was a dominant character. They seemed supportive of her therapy.

I will discuss the themes and their relation to RP4 and patient D.

6.5.2 Overarching theme 1: Position-less on the lateral level

6.5.2 *(i) Sub-theme 1: Feeling different and on the outside of peer-groups*

> She felt on the outside of groups and friendships. I remember her telling me how she felt left out at work, not really part of the friendship group going on there. She also said she was on the periphery of the friendship group she's had since her teenage years – actually used that word, periphery – even when she talked about her school experience, it came up then as well.

RP4 describes patient D as feeling on the outside and on the periphery of groups and had felt this since a child.

6.5.2 *(ii) Sub-theme 2: Lack of recognition*

> There's always some dramatic scenario which will get my attention. It feels like she has to get my attention with these dramas so that she will be important to me – it's as though she doesn't trust I'm going to give her any importance whatsoever otherwise – she turns it into that and can't believe I might be interested in her just the way she is.

RP4 feels as though patient D brings dramatic scenarios to therapy to evoke interest and acknowledgment from RP4. I suggest she is looking for recognition and looking to RP4 to provide this as the 'phantasy sibling' in those moments.

6.5.3 Overarching theme 2: Search for a position

6.5.3 *(i) Sub-theme 1: Competes for a position with the phantasy siblings (other patients/peers)*

> Her session time is at the end of the day, she chose that. I remember offering a couple of spaces at the time.

Choosing the last appointment of RP4's day, I suggest, is her unconscious attempt to find a position, feel special and important. Perhaps fearing feeling lost among the phantasy siblings.

RP4 also refers to her sense of entitlement;

> At times it felt like there was a sense of entitlement. She'd ask to change appointments at short notice and I felt under pressure to do it – as though she was entitled to it. Like I was there only for her – it felt irritating.

RP4 describes her countertransferential feeling and how she made sense of it as a sense of entitlement coming from patient D – a defence against the perceived threat of 'nothingness'.

6.5.3 *(ii) Sub-theme 2: Search for a sibling*

> She brought that she desperately wanted a child – she described wanting to have this child without a father and this had been a life-long desire. She doesn't have a partner and didn't want one, just this desperation for a child.

I suggest this desperate need for patient D to have a child represents her search for a sibling.

> She frequently brings issues where she asks for my opinion on something, not her day-to-day anxieties, but some event or activity or something that's happened – the kind of conversation you might have with a close friend.

Patient D's search for a sibling also manifests in her conversations with RP4 who feels in her countertransference a feeling that patient D wants her to be her friend. RP4 may represent an older sibling to whom she is turning for sisterly advice.

6.5.3 *(iii) Sub-theme 3: Competes with RP4 as if a sibling*

> She decided to do a clinical training and I felt a bit irritated by it, cos she was asking me what I thought and I felt like she was only doing it to wind me up. Interesting that I felt that irritation and annoyance.

Patient D's decision to do a clinical training, I suggest, is her attempt at creating a phantasy sibling drama and competing with RP4 as if an older phantasy sibling. RP4's response is that of an older sibling irritated by the younger one's attempts to emulate them. Also, I wonder if RP4 is experiencing patient D as she experienced her younger sister, as a sibling who displaced her which, she says, was never resolved.

6.5.4 Overarching theme 3: The presence of peers creates anxiety

6.5.4 *(i) Sub-theme 1: Unable to negotiate with peers*

> Peers are an issue for her, she finds them toxic and can't tolerate being with others at work. Imagines they have it in for her and don't like her. She says she doesn't trust anyone. I think they make her anxious cos she tends to keep herself to herself – very self-sufficient.

RP4 describes patient D's relationship to peers as difficult. She finds them toxic, feels anxious around them so avoids them and is self-sufficient. I suggest she experiences them as potential rivals, does not know her position with them and this creates anxiety.

6.5.5 Overarching theme 4: Retreats from difficult feelings

6.5.5 *(i) Sub-theme 1: Difficult feelings cannot be tolerated*

> It's unusual for me to feel completely cut off and disconnected and I think well, I should feel something but I sometimes don't feel anything. She finds it difficult to show how she feels when she's really angry and I've wondered if it's about her disconnection cos I've had other patients who have come with very difficult life stories and I've been deeply impacted hearing their experiences – it's quite disturbing, cos sometimes we may as well be talking about the weather.

RP4 describes how patient D becomes disconnected to her own anger and aggression which RP4 can feel in her countertransference. It may also be that

RP4's unresolved experience of displacement is influencing the intensity of her disconnection from her own aggression at her younger sibling who may be unconsciously represented by patient D.

6.5.6 Overarching theme 5: Overwhelming sense of responsibility

6.5.6 *(i) Sub-theme 1: Patient feels heavy expectations*

> She certainly feels a burden of responsibility for her parents, mother in particular. A sense of her needing to be and do what is expected of her but feeling angry about it. I think why she moved to Scotland was to distance herself from them, but of course, she still feels it. Perhaps that's where some of the tension is, she doesn't actually know what is expected of her by work colleagues, and so this causes a problem.

RP4 is aware of patient D's feelings of responsibility toward her parents and how she wishes to distance herself from them. She links these heavy expectations with parents with her not knowing the expectations of her work colleagues. I suggest the unknown work colleague expectations are also due to her lack of position on the lateral level.

6.5.7 My countertransference

I felt very aware of RP4's experience with her younger sibling whom she felt displaced her and how this was felt in her countertransference. I think it intensified her feelings toward patient D and patient D's competitiveness toward her and in particular her feelings of disconnection from patient D. At times I felt she was expecting me to make a judgement about her comments and I could feel her trying to keep me at arms length, perhaps an attempt at disconnecting from me also. I wondered if this was her expectation of her mother in response to her feelings toward her younger sister.

6.6 Research participant 5 (RP5) and context of her practice

RP5 is an experienced female psychoanalytic psychotherapist who is qualified to doctorate level. She holds her private practice from a rented room and does not have a waiting room. Her patients refer themselves through her website. She is the middle child of three with an older and a younger brother. She described her position being the middle girl as quite an anxious place for her.

6.6.1 RP5's work with patient E, her background and presenting problem

According to RP5, Patient E, an only-child male patient had referred himself as he was in a new relationship and wanted to understand his own behaviour so as not to risk breaking up the relationship. He was in his early forties and his new partner had a young son. He grew up with his mother and grandmother; his father was married to someone else and he did not see much of him. RP5 feels patient E's Oedipal experience is unresolved with feelings of ambivalence toward his father.

I will discuss the overarching themes and their relationship to RP5 and her work with patient E.

6.6.2 Overarching theme 1: Position-less on the lateral level

6.6.2 *(i) Sub-theme 1: Feeling different and on the outside*

> Being an only-child sort of fits his narrative. He grew up feeling like an illegitimate child, so it kinda makes sense for him to be the only one in his history. He doesn't feel like he fits in. He ends up standing out, yeah, a real sense of him being an outsider.

RP5 describes patient E as feeling on the outside without a position like an illegitimate child.

6.6.2 *(ii) Sub-theme 2: Lack of recognition*

> He has said that he's not very good at getting on with other people cos he expects too much from them and is not good at working in a team, better being in charge, but interestingly he denies his need to be 'seen' particularly with work colleagues. He works alone in a very senior position and gets on really well with the boss, but feels, I would say, almost non-existent to others.

RP5 describes patient E as feeling non-existent and unable to acknowledge his need to be 'seen' but works on his own avoiding contact with work colleagues. He does, however, get on well with the boss who is on the vertical parental level. Being in-charge feels safer as he feels less threatened by rivals. Part of this quote also relates to 6.7.6 (i), *'Patient feels heavy expectations'*.

6.6.3 Overarching theme 2: Search for a position

6.6.3 *(i) Sub-theme 1: Competes for a position with the phantasy siblings (other patients/peers/therapist)*

> He had his assessment in the middle of the day but he was quite insistent that he wanted the first appointment of the day ongoing. Interestingly, he leaves at 49 minutes to the hour every session and rushes off quickly. He takes control of that but he's never late.

The need for the session to be at the beginning of the day suggests his need to be first – a secure position with RP5 and to assert his existence within the phantasy sibling group where he is in fear of losing himself amongst the phantasy siblings. His need to leave at 49 minutes to the hour may ensure he does not come into contact with potential rivals and remains separate from them.

RP5 refers to patient E's sense of superiority;

> He has an air of arrogance and superiority which he is in touch with, a sense of being better than everyone else, a kind of expectation that others will perform for him and I've felt this too, that I need to be something for him otherwise he might leave.

RP5 describes a sense of ‘entitlement’ she picks up from patient E and how she feels a need to be something for him. I suggest this is his defence against the feared feelings of ‘nothingness’ related to feeling position-less on the lateral level.

6.6.3 *(ii) Sub-theme 2: Search for a sibling*

I refer to part of the quote above (6.6.3 (i)), which also relates to this sub-theme – RP5 describes feeling a need to be something for patient E and I suggest that is her picking up his need for her to be a phantasy sibling. Also;

> I have felt quite admired occasionally, as though he looks to me to show him the way, to lead and I feel important in those moments. He might ask, “what shall we talk about?”. So different from the moments when I feel confused as to why he’s here and what does he get from this, when I feel his irritation at me.

These feelings evoked in RP5 may suggest sibling-like feelings – an older sibling being admired by the younger sibling changing into a rivalrous dynamic where RP5 feels more like the younger sibling whose big brother is irritated by her. I also wonder if there is a part of RP5’s own sibling experience in her position as the middle child. She may have experienced both admiration from her younger brother and irritation from her older brother and so can feel them intensely.

> Even though he does have this arrogance and superiority thing about him, he does seem to develop these close sibling-like links with other men who are in higher positions than him.

RP5 describes patient E searching for, and developing, sibling-like relationships outside the therapy.

6.6.3 *(iii) Sub-theme 3: Competes with RP5 as if a sibling*

I refer to the second part of the quote above (6.6.3 (ii));

> So different from the moments when I feel confused as to why he's here and what does he get from this, when I feel his irritation at me.

Also,

> I do feel a sense of competitiveness, not always, but on occasions it feels like it's under the surface very briefly and then it's gone.

Both quotes suggest a sibling-like rivalry and competitiveness.

6.6.4 Overarching theme 3: The presence of peers creates anxiety

6.6.4 *(i) Sub-theme 1: Unable to negotiate with peers*

> There is no threat evident from my other patients. He would never show that level of anxiety or need at this point. He's out swiftly, doesn't hang around.

Although RP5 does not feel there is an evident threat from her other patients, she does feel he is currently unlikely to show that level of need. I suggest he is in denial of the threat of rivals and this is evident from his need to leave at 49 minutes to the hour with his swift exit from the session.

6.6.5 Overarching theme 4: Retreats from difficult feelings

6.6.5 *(i) Sub-theme 1: Difficult feelings cannot be tolerated*

> I would say that he finds talking about difficult feelings hard. He distracts himself away from them quite easily. He's self-reliance is evident in that he doesn't ask anyone for help and he won't go near feelings which might cause him to feel vulnerable.

RP5 describes patient E's difficulty with difficult feelings and self-reliance.

6.6.6 Overarching theme 5: Overwhelming sense of responsibility

6.6.6 *(i) Sub-theme 1: Patient feels heavy expectations*

I refer to an earlier quote from 6.6.2 (ii) *'Lack of recognition';*

> He has said that he's not very good at getting on with other people cos he expects too much from them and is not good at working in a team…

I suggest this shows patient E projecting his own feelings of heavy expectations onto his work colleagues and experiencing it as though he expects too much from them.

6.6.7 My countertransference

I felt an unease and anxiety in my interview with RP5 which was unusual for me, feeling I needed to be on my best behaviour as she was very professional – perhaps her defence against her insecurity. She seemed uncertain as to how to think about patient E at times and her own position with him – which felt difficult for her. On reflection I wonder if something about his position-less status re-activated feelings of her own sibling position – being the middle child sandwiched between two boys and not always knowing where she stood.

6.7 Research participant 6 (RP6) and context of her practice

RP6 is an experienced female psychodynamic psychotherapist who has been practicing for many years. She is qualified to masters degree level and is undertaking a further clinical training of which patient F was referred as a training patient. She saw him from her own practice premises where there is no waiting room. RP6 is the eldest of three girls with her next sister being 7 years younger and her second sister, 8 ½ years younger than herself. She reported to feeling on the outside of her sisters' pairing and feeling a little like an only-child herself.

6.7.1 RP6's work with patient F, his background and presenting problem

RP6's male only-child patient is described as being in his late thirties and had referred himself to therapy as he was about to become a father with his new partner expressing concern at the kind of father he would be based on his experiences with his own

parents growing up whom he described as distant. He wanted to explore this. He had been married and shared a son with his ex-wife who lives in another town.

I will discuss the themes and their significance to RP6 and her work with patient F.

6.7.2 Overarching theme 1: Position-less on the lateral level

6.7.2 *(i) Sub-theme 1: Feeling different and on the outside*

> Our early work was around whether it was ok for him to exist – there was a lot of him feeling that the world did not want him to exist that he was some sort of affront to existence.

RP6 refers to patient F's feeling that he does not exist and whilst we will see that he seems to feel more of a sense of existence with those in authority – on the vertical level – I suggest this means he feels this on the lateral level. This quote also relates to 6.8.2 (ii) *'Lack of recognition'.*

6.7.2 *(ii) Sub-theme 2: Lack of recognition*

> He doesn't know what to do with people, how he should be, or what they expect from him and we have thought about this cos it comes up with us. He doesn't know what I want from him – but I frequently feel a need to be what he wants and I believe that is to be 'seen' and acknowledged for who he is.

RP6 describes how she feels patient F needs to be 'seen and acknowledged' – recognised on the lateral level suggesting he has not experienced recognition from others on the lateral level and does not know what it feels like to be recognised. Part of this also relates to 6.7.3 (ii) *'Search for a sibling'.*

6.7.3 Overarching theme 2: Search for a position

6.7.3 *(i) Sub-theme 1: Competes for a position with the 'phantasy siblings (other patients/peers/therapist)*

> Yes, he has the last appointment…. of the day. We've met on the same day and the same time since the beginning and we've never negotiated

> anything. I wonder if that needs to happen. I have thought about asking to change the time as it would make my life easier, but I feel somehow that it is very important not to move it. It feels as though he needs to keep his position with me for the time being.

Patient F searches for a position among the phantasy siblings (RP6's other patients) in relation to RP6 through his appointment time being at the end of the day – he needs to feel he will stay in her mind. RP6 also feels a pressure not to disrupt patient F's position.

6.7.3 *(ii) Sub-theme 2: Search for a sibling*

> I feel myself being pulled into being a sibling, someone that coaches and suggests rather than somebody that listens and holds a space for exploration. That's the pull I feel and for me it's the pull of an older sibling.

It is clear to RP6 that she feels patient F projects onto her his need for a sibling relationship with her and she feels this manifests in her countertransference.

I also refer to part of 6.7.2 *'Lack of recognition'* which can also be seen as him searching for a sibling in RP6.

> …but I frequently feel a need to be what he wants and I believe that is to be 'seen' and acknowledged for who he is.

6.7.3 *(iii) Sub-theme 3: Competes with RP6 as if a sibling*

> I was pulled into something in our work and maybe it was something sibling-like. Scrapping, a strong competitiveness, they're the feelings which come to mind. Can't remember the exact situation, but I do remember it happened quite a lot at the start of our work. Now I feel much more settled and I sense that he does too – I look forward to seeing him, which I didn't back then. He was just so hard to sit with.

Although she was not specific about the situations in which she felt the strong competitiveness feelings, RP6 is aware of the presence of the feelings.

6.7.4 Overarching theme 3: The presence of peers creates anxiety

6.7.4 *(i) Sub-theme 1: Unable to negotiate with peers*

> He works on his own in a room and he does have meetings and some social things related to the projects he manages and he finds these quite anxiety provoking cos he feels there are lots of people there all at once expecting him in some way to perform and he's never sure what he's supposed to say or do.

RP6 describes patient F's anxiety at being with peers in the workplace as related to a feeling of needing to be something for them. I suggest this is related to him feeling 'position-less' on the lateral level and not knowing how to be with them.

6.7.5 Overarching theme 4: Retreats from difficult feelings

6.7.5 *(i) Sub-theme 1: Difficult feelings cannot be tolerated*

> He's felt anger and rage in the sessions but been unable to express it, and so he has physically left the session and come back and then left the session and come back – this was a long line – he was just vanishing and coming back, apologising and then going again. There was a 'can you tolerate this' feeling and I think, 'can I tolerate this?' Opening the door and slamming the door – these became some of the most important sessions.

RP6 is aware of patient F's difficulty in expressing his anger and aggression and how it becomes so unbearable for him he has to leave the room.

6.7.6 Overarching theme 5: Overwhelming sense of responsibility

6.7.6 *(i) Sub-theme 1: Feels heavy expectations*

> He feels a lot of responsibility for the things he has to do. I think he is deeply burdened. His ex-wife is a challenge for him, for which he carries a huge sense of responsibility and certainly his child and at work too. He feels it's all down to him, but even with me he felt he needed to bring a list of things to the session to 'give me' because that's what I needed – in some ways he continues to be aware of what he thinks I might need from him.

RP6 is aware of patient F's heavy sense of responsibility which may be from being 'everything' and therefore 'carrying' everything for his parents.

6.7.7 My countertransference

During the interview with RP6 I felt both a warmth toward her as she described her feelings toward patient F and a strong sense of her loneliness at feeling separate from her siblings. At times I felt on the outside looking in to this sibling-like pair and at other times, I felt like the phantasy big sister to RP7 particularly when I felt she was hanging on my words.

6.8 Research participant 7 (RP7) and context of her practice

RP7 is a female psychodynamic psychotherapist with a few years' experience. She is qualified to masters degree level. She works for a charity counselling organisation where patients are allocated to her through a referral process. There is a waiting room. She is the eldest of two with a younger brother whom she said she felt the need to protect from their chaotic mother after her father left.

6.8.1 RP7's work with patient G, his background and presenting problem

RP7's male only-child patient had been referred to her through the organisation. He is in his late thirties and had suffered an episode of depression and been prescribed antidepressants. He grew up with his parents whom she described as ambitious and harsh and for whom he feels he is a constant disappointment. She feels his Oedipal experience has been difficult and lacked an available maternal figure and as a young child he was fearful of peers.

I will discuss the overarching themes and their significance to RP7 and her work with patient G.

6.8.2 Overarching theme 1: Position-less on the lateral level

6.8.2 *(i) Sub-theme 1: Feeling different and on the outside of peer-groups*

> He went to an academic private school where he felt the poor relation – very much on the periphery of friendship groups. He was never the one who organised anything but would tag along. He never instigated an activity or pushed his needs or wants to the surface, he would just go along with whatever everyone else wanted – just didn't feel he could assert himself in these groups.

RP7 describes patient G's 'position-less' status on the lateral level through him feeling on the outside of his peer groups.

6.8.2 *(ii) Sub-theme 2: Lack of recognition*

> Sometimes he cannot bear to be looked at by me and this one-on-one relationship with me is so unbearably intense for him – it's the intenseness when he comes into the room, he sometimes can't think of anything to say.

RP7 feels in her countertransference that patient G cannot bear to be 'seen' by her suggesting a lack of recognition on the lateral level.

6.8.3 Overarching theme 2: Search for a position

6.8.3 *(i) Sub-theme 1: Competes for a position with the phantasy siblings (other patients/peers)*

> He comes later after work and it's my last session of the evening and he's never late and he's been coming for three years and doesn't cancel either, although he was ill once and we went online.

Patient G attempts to secure his position among the phantasy siblings in relation to RP7 by having the last session of the day.

Experiencing peers as the enemy from an early age affected him discussing them in his therapy;

> He was telling me about this person at work and he kept saying, 'this person at work', and I said 'why don't you give him a name and then it'll be easier' – something in me felt like this was a repetitive pattern and to explore it with him – and he said 'no I can't, I could never say his name', 'but,' I said, 'I would never know him whatever name he gave', but the reason he can't bring himself to say a name, he can't talk about anybody by name in the session, he finds it really so uncomfortable and the reason he doesn't bring them into the room basically is because he doesn't feel they signed up for this so it's a betrayal.

I suggest the phantasy siblings cannot be brought into the room by name because the competitiveness he feels is too unbearable. He needs to be the 'only one' in relation to RP7 and cannot tolerate any rivals so their names cannot be spoken as that may bring up the competitiveness which is too dangerous and life threatening.

6.8.3 *(ii) Sub-theme 2: Search for a sibling*

> I haven't really felt much with him at all except this overwhelming feeling like I'm torturing him by seeing him and on the odd occasion a sense of longing – a longing for something he hasn't had perhaps with his mum.

RP7's feeling of a sense of longing on the odd occasion which may well be contributed to by what he has been deprived maternally. I suggest she is also picking up a sense of longing for a sibling which may be related to his relationship with her.

RP7 also notes;

> I sometimes feel as though I need to rescue him from his overwhelmingly anxious feelings and I had to do that for my little brother – rescue him from my chaotic mother – and I do rescue him when he struggles to start a session, to be seen, I start it for him.

I wonder if this may suggest RP7's response to patient G in needing to rescue him is in part a response to his search for a sibling in her. Her response is likely intensified by the reactivation of her need to rescue her little brother.

6.8.3 *(iii) Sub-theme 3: Competes with RP as if a sibling*

> He's very considerate of me and at times I can feel idealised, sometimes this feels good and safe but other times I don't feel good about it and I can sense this rage under the surface – almost like he needs to catch me out. It is gone in a flash though.

Whilst I suspect there is a lot of anger at this mother, I suggest there may be a rivalry here which may be fleeting but related to competing with RP7 as a phantasy sibling. As we have seen previously in 6.8.3 (i) '*Competes for a position with the phantasy siblings (other patients/peers)'* anything to do with siblings is obliterated as soon as it emerges which is why I suspect RP7 feels it disappears in a flash.

6.8.4 Overarching theme 3: The presence of peers creates anxiety

6.8.4 *(i) Sub-theme 1: Unable to negotiate with peers*

> He does find it difficult to relate to peers, he can get quite anxious when there's a meeting at work, but seems to be better on a one-to-one – does have an issue with authority though.

RP7 does recognise patient G's anxiety evoked by peers and that he relates better on a one-to-one basis.

> I have no concern that he would ever be bothered if he sees another patient leaving the room before him or arriving after him – I just don't think it's an issue for him. Whereas I have other patients where it's such a great deal especially those with siblings.

RP7 is quite clear about patient G's potential response to seeing another patient. However, I suggest this is a denial against the 'other's' existence – particularly as it feels so dangerous to bring any 'siblings' into the session.

6.8.5 Overarching theme 4: Retreats from difficult feelings

6.8.5 *(i) Sub-theme 1: Difficult feelings cannot be tolerated*

> He sees me as important to him and is very polite and considerate of me, but I feel he has this murderous rage buried deep and he can't access it yet. It just can't be thought about in any way, but I can feel it there and it's really hard to sit with – I think there's a fear that if it does come out it will annihilate someone.

RP7 picks up the underlying rage which cannot be expressed or tolerated, in her countertransference.

6.8.6 Overarching theme 5: Overwhelming sense of responsibility

6.8.6 *(i) Sub-theme 1: Feels heavy expectations*

> I was aware quite early on that he holds a great deal of responsibility and assumes he is to blame for things that go wrong. A lot of projection from his parents – he frequently got it wrong for them and he was the only one to carry that.

RP7 recognises that patient G experienced the full force of parental expectations and how that affects him now in feeling responsible for carrying others' projections.

6.8.7 My countertransference

I felt a great deal of fear and sadness in this interview with RP7 which I felt belonged to them both. Siblings for him felt terrifying. He could not bring them into the session because they were just too frightening for him – if he names them, he would have a relationship with them and that might mean obliteration so they are kept out. He desperately wants to be the only one with RP7. At times, I could feel RP7's disconnection from him and maybe he disconnected in the moments he felt her to be the dangerous phantasy sibling. I also felt her sadness for him and her strong desire to rescue him just as she described she had spent her childhood rescuing her little brother.

6.9 Research participant 8 (RP8) and context of her practice

RP8 is an experienced female psychoanalytic psychotherapist working in private practice from a room in her home. Her patients are referrals from various sources. There is no waiting room and patients are expected to arrive on time. She is an only-child herself.

6.9.1 RP8's work with patient H, her background and presenting problem

According to RP8, her female only-child patient had referred herself to therapy because she found it difficult forming relationships and felt an irritability and anger for trivial reasons which frightened her. Her parents had split up when she was aged 6 and she saw her father regularly. Her mother could be inconsistent in her care and her father was experienced as consistent. RP8 felt she had not resolved her Oedipal conflicts.

I will discuss the overarching themes and their significance to RP8 and her work with patient G.

6.9.2 Overarching theme 1: Position-less on the lateral level

6.9.2 *(i) Sub-theme 1: Feeling different and on the outside of peer-groups*

> I think in both childhood and at school and now, I get the sense of a child and an adult who is observing all the time, not part of things, but highly attuned to 'where do I fit in?', and, 'am I wanted?'. She wasn't sure that she was and struggling with that with no one to share it with and this is mirrored in her adult life. So, there's always a bit of 'otherness' about her and where does she fit in. It feels like she can't hold her own in this grown-up world.

RP8 is describing patient H as feeling 'position-less' on the lateral level – feeling as though she does not fit in with peers.

6.9.2 *(ii) Sub-theme 2: Lack of recognition*

> She feels she's not good enough – always comparing herself to her peers in terms of what she likes and what they like or do. If her likes don't match theirs, then they won't like her. I've felt that with us too. She needs to be the same as me. If I wear something a bit different, it throws her – cos I might not accept her if she can't keep up.

Patient H's search for recognition is clear to RP8 both with her peers and with RP8. Without it, she feels unseen with a fear of being displaced and thrown into 'nothingness'.

6.9.3 Overarching theme 2: Search for a position

6.9.3 *(i) Sub-theme 1: Competes for a position with the phantasy siblings (other patients/peers)*

> She can't give me any reason to get rid of her, so she showers before she comes and she tells funny stories about work and she's very good on the narrative, stuff about her job is really interesting and she has a way of not using too many technical words – she's very good at that. It's as though she has to entertain me so I don't get rid of her in favour of my other patients and she's my favourite patient.

Patient H is attempting to find a position with RP8 in relation to her phantasy siblings – RP8's other patients – and perhaps other people in RP8's life as is referred to here;

> I remember once my husband arrived at the same time as her, he was unloading the car and she didn't know what to do – he said he was conscious of somebody pacing outside. She was so distressed and when she eventually came in, she just couldn't speak for the whole session. She couldn't just say to him, 'I've got an appointment' and just go upstairs. It just felt too overwhelming that there were other people in my life and where did she fit into that.

RP8 feels as though patient H is overwhelmed with anxiety at being confronted with a phantasy sibling who is experienced as a rival for her position with RP8. This also relates to 6.9.4 *'Presence of peers creates anxiety'*.

> She used to come at the beginning of the day and now she comes at the end, 7pm, and she asked for that – I get the sense that's quite important

> to her. It means I keep her in mind for longer and haven't got the siblings to come and take my mind away from her.

Patient H has the last session of the day to ensure she holds a special place with RP8.

6.9.3 *(ii) Sub-theme 2: Search for a sibling*

> So, if she's not like me then maybe I won't like her so I've noticed over the years that her clothing is more like mine. I don't wear much make-up and neither does she and she sees that I don't wear much jewellery and neither does she and she sees that we're the same and when I wore a pair of sandals, and I've got nail polish on my toe nails, I could see her looking – you know worried that she hasn't got that – so it's wanting to be accepted all the time and being like me means she will be.

RP8 experiences patient H as emulating her and wanting to be like her, like a younger sibling may be with an older sibling – to be accepted and recognised. This quote also relates to 6.9.3 (iii) *'Competes with RP as if a sibling'*

> It felt like a really good use of what I learned and felt in my own therapy – if I can use it well, this is exactly what she needs, somebody who 'gets it'. I've been there before and I get it, something she doesn't altogether get yet.

This quote feels 'sibling-like'. RP8 taking on the role of the older sibling who has been there before showing the way to the younger one.

6.9.3 *(iii) Sub-theme 3: Competes with RP8 as if a sibling*

> I remember feeling quite intimidated by her initially, as though I wasn't going to be able to perform for her – I didn't feel good enough for her. I felt she was clever and I wasn't as clever as her. It did feel a little competitive as I wanted to be the clever one.

RP8's feelings of competitiveness and rivalry with patient H are as though she is competing with her for a position with the parent whom they share in phantasy.

Part of the quote from 6.9.3 (ii) *'Search for a sibling'* also relates to RP8 feeling emulated by patient H as an older sibling;

> So, if she's not like me then maybe I won't like her so I've noticed over the years that her clothing is more like mine. I don't wear much make-up and neither does she and she sees that I don't wear much jewellery and neither does she…

6.9.4 Overarching theme 3: The presence of peers creates anxiety

6.9.4 *(i) Sub-theme 1: Unable to negotiate with peers*

> She doesn't have any friendships, relationships cause anxiety for her. She doesn't know how to do the banter that gets you a friend, or gets you a friendly person. She says she doesn't get on with her colleagues, although I get the impression they admire her and make overtures toward her, but she just doesn't know what to do with it and that causes her real anxiety.

I also refer to 6.9.3 (i) *'Search for a position'* (the second quote) and 6.9.3 (i) *'Competes for a position with the phantasy siblings (other patients/peers)*', which both refer to patient H seeing RP8's husband;

> …she was so distressed and when she eventually came in, she just couldn't speak for the whole session. She couldn't just say to him, 'I've got an appointment' and just go upstairs…

RP8 recognises the anxiety the presence of peers creates for her. She does not hold a position on the lateral level and therefore her identity on this level is undeveloped.

6.9.5 Overarching theme 4: Retreats from difficult feelings

6.9.5 *(i) Sub-theme 1: Difficult feelings cannot be tolerated*

> If she feels upset or angry she doesn't know what to do. She's very bright cognitively and can verbally find the words very quickly, but emotionally, she just closes down and I think this mirrors what happens at work and in other areas of her life. When this happens I want to reach out to her, to connect to her, but I just can't get there – can't reach her.

RP8 can feel in her countertransference patient H's retreat from her difficult feelings and her (RP8's) struggle to connect, suggesting she does at times feel disconnected from patient H.

6.9.6 Overarching theme 5: Overwhelming sense of responsibility

6.9.6 *(i) Sub-theme 1: Feels heavy expectations*

> She certainly tries to be what she thinks I want her to be, this someone who is the same as me, the one who would be rejected if she was different to me.

Patient H carries the perceived needs of the 'other'.

> After her parents split up, she'd see her dad weekly and would worry about him when she went back to her mums, that he was on his own. She seemed to take on her parents worries.

Patient H was burdened by parental projections – there were no siblings to share them.

6.9.7 My countertransference

At the beginning of this interview, I felt I identified with patient H and felt an irritation with RP8 for not immediately recognising the importance of her being an only-child particularly as RP8 is an only-child herself. As the interview progressed, I felt as though RP8 identified with many aspects of patient H's only-childness and I experienced a strong 'we should be sticking together and looking out for one another' feeling which, I imagine, siblings might feel in relation to parents or perhaps it's a fantasy of what I imagine I have missed.

6.10 Research participant 9 (RP9) and the context of her practice

RP9 is an experienced female psychodynamic psychotherapist who has qualified to masters degree level in a psychodynamic clinical training. Her private practice is held from rented premises and her patients are self-referrals. There is no waiting room so patients are expected to arrive on time. RP9 is an only-child herself.

6.10.1 RP9's work with patient J, her background and presenting problem

RP9's only-child patient had referred herself with feelings of anxiety. She wanted to become pregnant and was having intrusive thoughts. She had recently got married and had reported to RP9 that she had only got married in order to have a child. According to RP9, patient J grew up with her parents. Her mother was very critical and they had a difficult relationship. She was closer to her father who died suddenly when she was in her early twenties. Patient J is in her early thirties. RP9 understood her Oedipal experience as being difficult due to her un-containing mother.

I will discuss the overarching themes and their significance to RP9 and her work with patient J.

6.10.2 Overarching theme 1: Position-less on the lateral level

6.10.2 *(i) Sub-theme 1: Feeling different and on the outside of peer-groups*

> Yeah, there was a sense of her feeling like she didn't belong. At work she talked about feeling like they were all strangers and all together and she wasn't included. She found that kind of difficult and upsetting – that came up a lot – made her feel very isolated and alone.

RP9 describes how patient J felt excluded and on the outside of her work colleagues confirming her 'position-less' feeling on the lateral level.

6.10.2 *(ii) Sub-theme 2: Lack of recognition*

> I did notice sometimes I felt a need to acknowledge her for something. It was a strange thing, like at work she'd say something had happened or she'd done something, and I felt she wanted something from me – some acknowledgement perhaps. It didn't always warrant a 'oh that was great' or 'how clever you are', it didn't feel maternal in that way, it was like she needed me to 'see her'. She'd look at me almost waiting for it.

RP9 describes here patient J's need for recognition which she understands as being different from a maternal recognition.

6.10.3 Overarching theme 2: Search for a position

6.10.3 *(i) Sub-theme 1: Competes for a position with the 'phantasy siblings' (other patients/peers).*

> She had the choice of three appointments and chose the last one of the day, I remember that cos I wondered why she hadn't chosen the earlier one on that particular day, as she'd explained her commitments. I want to be the first patient my analyst sees in the morning, when she's the freshest, I think I want to be special too.

RP9 recognises and links patient J's need to have the last session of the day being about her need to hold a special place with her just as she (RP9) needs to have the first session of the day with her own analyst.

6.10.3 *(ii) Search for a sibling*

> She came with a desperate need for a baby. She'd married for the purpose of having a baby. It was an obsession and she left the therapy after she became pregnant which felt as though she didn't need me anymore.

Patient J's strong desire to have a baby, I suggest, was her search for a sibling and she left having become pregnant. This felt to RP9 as though she had rejected one phantasy sibling (RP9) in favour of the new phantasy sibling (the new baby).

> There was something about being together with her. I certainly felt we could have been friends, I could identify with so many

> aspects of her, her loneliness and her wish for a sibling – sometimes it felt like it was us against the rest of them.

RP9 identified with patient J's search for a sibling and felt as though they were 'phantasy siblings' together.

6.10.3 *(iii) Competes with RP9 as if a sibling*

> She started a clinical training before she became pregnant and was planning to complete it. That was strange because she would ask my advice – which was annoying because she idealised the profession and she idealised me. I let something slip about she'll see that therapists are not all nice and then regretted it. I really should have interpreted it at this time, but I didn't. It was always quite difficult to interpret and stay in the analytic position with her.

RP9 clearly felt the rivalry and competitiveness from patient J's decision to undertake a clinical training which she found irritating and wanted to burst her idealisation bubble, perhaps as an older sibling might do to a younger one.

6.10.4 Overarching theme 3: The presence of peers creates anxiety

6.10.4 *(i) Sub-theme 1: Unable to negotiate with peers*

> There is a theme with this patient of jealousy in relationships. She has no female friends and just one male friend who lives away. She's jealous of her husband's family, his brothers and sisters and she did say to me on one occasion that she'd never recommend me to anyone cos she wouldn't be able to share me.

Patient J finds others on the lateral level threatening and wishes to be the special one to RP9 actively rejecting any potential rivals.

6.10.5 Overarching theme 4: Retreats from difficult feelings

6.10.5 *(i) Sub-theme 1: Difficult feelings cannot be tolerated*

> She was always so sweet and I felt the idealisation but also something underlying it, something really angry or perhaps competitive. I tried to

> address it a couple of times but not very elegantly and she wasn't able to think about it at all. I think it was difficult for me too perhaps because it felt seductive and I enjoyed it even though it didn't feel real.

RP9 was aware of the underlying rivalry and competitiveness and felt neither of them could really think about it.

6.10.6 Overarching theme 5: Overwhelming sense of responsibility

6.10.6 *(i) Sub-theme 1: Patient feels heavy expectations*

This theme was not present in the data.

6.10.7 My countertransference

As the interview began, I felt I identified with RP9 and her feelings about being an only-child. She described her patient as lonely and longing for a sibling and I could sense this loneliness and longing in her also which she recognised and discussed. She was looking for a sibling in her patient as well as her patient looking for a sibling in her. Although recognising this, she felt unable to really think about it. As the interview progressed, I felt a strong feeling of being the older sibling in this phantasy sibling group and felt irritation as well as care, which is how I imagine an older sibling may feel toward her younger siblings.

Chapter 7

Discussion of Findings and Implications for Practice

7.0 Introduction

In chapter 5 and 6, I presented the results of my research which shows that only-child adults unconsciously create and enact a phantasy sibling transference in the clinical setting and attempt to find a position for themselves on the lateral dimension among phantasy siblings in an unconscious attempt to develop their lateral identity. In this chapter, I will discuss the results, the possible reasons why this is enacted and think about the implications this may have for clinical practice.

See table 5 which shows how many research participants relate to each theme as well as which ones.

Overarching themes	Sub-themes	Research participant and their patient	How it manifests	Research participant and their patient
1.Position-less on the lateral level = 9	Feeling different and on the outside of peer groups = 9	RP1/A, RP2B, RP3/C, RP4/D, RP5/E, RP6/F, RP7/G, RP8/H, RP9/J	Feeling different = 9	RP1/A, RP2B, RP3/C, RP4/D, RP5/E, RP6/F, RP7/G, RP8/H, RP9/J
			Feeling on the outside = 9	RP1/A, RP2B, RP3/C, RP4/D, RP5/E, RP6/F, RP7/G, RP8/H, RP9/J
			Does not 'fit' in = 9	RP1/A, RP2B, RP3/C, RP4/D, RP5/E, RP6/F, RP7/G, RP8/H, RP9/J

			Feels unwanted = 4	RP2/B, RP3/C, RP5/E, RP6/F
			Sense of loneliness = 9	RP1/A, RP2B, RP3/C, RP4/D, RP5/E, RP6/F, RP7/G, RP8/H, RP9/J
			Often feels abandoned/rejected = 9	RP1/A, RP2B, RP3/C, RP4/D, RP5/E, RP6/F, RP7/G, RP8/H, RP9/J
	Lack of recognition = 9	RP1/A, RP2B, RP3/C, RP4/D, RP5/E, RP6/F, RP7/G, RP8/H, RP9/J	Feels 'not good enough' = 9	RP1/A, RP2B, RP3/C, RP4/D, RP5/E, RP6/F, RP7/G, RP8/H, RP9/J
			Feels 'unseen' = 9	RP1/A, RP2B, RP3/C, RP4/D, RP5/E, RP6/F, RP7/G, RP8/H, RP9/J
			Feels invisible = 9	RP1/A, RP2B, RP3/C, RP4/D, RP5/E, RP6/F, RP7/G, RP8/H, RP9/J
			Feels non-existent with peers = 9	RP1/A, RP2B, RP3/C, RP4/D, RP5/E, RP6/F, RP7/G, RP8/H, RP9/J
2.Search for a position = 9	Competes for a position with the phantasy siblings (other patients/peers) = 9	RP1/A, RP2B, RP3/C, RP4/D, RP5/E, RP6/F, RP7/G, RP8/H, RP9/J	Session times at beginning or end of day = 6	RP4/D, RP5/E, RP6/F, RP7/G, RP8/H, RP9/J
			Never cancels sessions = 7	RP2B, RP3/C, RP5/E, RP6/F, RP7/G, RP8/H, RP9/J
			RP feels a sense of entitlement from patient = 9	RP1/A, RP2B, RP3/C, RP4/D, RP5/E, RP6/F, RP7/G, RP8/H, RP9/J
			Wants to be special = 8	RP1/A, RP2B, RP3/C, RP4/D, RP5/E, RP7/G, RP8/H, RP9/J
			Ambitious at work = 7	RP2B, RP3/C, RP5/E, RP6/F, RP7/G, RP8/H, RP9/J
			Unable to share = 7	RP1/A, RP2B, RP3/C, RP4/D, RP7/G, RP8/H, RP9/J
	Search for a sibling = 9	RP1/A, RP2B, RP3/C, RP4/D, RP5/E, RP6/F, RP7/G,	Feels a sense of longing = 9	RP1/A, RP2B, RP3/C, RP4/D, RP5/E, RP6/F, RP7/G, RP8/H, RP9/J
			Desperate for a baby = 4	RP1/A, RP2B, RP4/D, RP9/J

		RP8/H, RP9/J	RP felt patient needed something from them = 9	RP1/A, RP2B, RP3/C, RP4/D, RP5/E, RP6/F, RP7/G, RP8/H, RP9/J
			RP felt a need to perform = 9	RP1/A, RP2B, RP3/C, RP4/D, RP5/E, RP6/F, RP7/G, RP8/H, RP9/J
	Competes with RP as if a sibling = 9	RP1/A, RP2B, RP3/C, RP4/D, RP5/E, RP6/F, RP7/G, RP8/H, RP9/J	RP feels a sense of competitiveness and rivalry = 9	RP1/A, RP2B, RP3/C, RP4/D, RP5/E, RP6/F, RP7/G, RP8/H, RP9/J
			RP feels emulated = 9	RP1/A, RP2B, RP3/C, RP4/D, RP5/E, RP6/F, RP7/G, RP8/H, RP9/J
			Takes on clinical training = 3	RP1/A, RP4/D, RP9/J
			Wants to be the expert in the session = 3	RP2B, RP4/D, RP8/H
			Wants to be 'top dog' = 2	RP2/B, RP4/D
3.The presence of peers creates anxiety = 9	Unable to negotiate with peers = 9	RP1/A, RP2B, RP3/C, RP4/D, RP5/E, RP6/F, RP7/G, RP8/H, RP9/J	Relationships with peers creates anxiety = 9	RP1/A, RP2B, RP3/C, RP4/D, RP5/E, RP6/F, RP7/G, RP8/H, RP9/J
			Holds senior authoritative positions at work = 7	RP2B, RP3/C, RP5/E, RP6/F, RP7/G, RP8/H, RP9/J
			Can only relate on a 1:1 basis = 9	RP1/A, RP2B, RP3/C, RP4/D, RP5/E, RP6/F, RP7/G, RP8/H, RP9/J
			Lack of playfulness = 8	RP1/A, RP2B, RP3/C, RP5/E, RP6/F, RP7/G, RP8/H, RP9/J
			Intensity = 9	RP1/A, RP2B, RP3/C, RP4/D, RP5/E, RP6/F, RP7/G, RP8/H, RP9/J
			In denial of 'other' patients' existence = 6	RP1/A, RP3/C, RP4/D, RP5/E, RP6/F, RP7/G,
4.Retreats from difficult feelings = 9	Difficult feelings cannot be tolerated = 9	RP1/A, RP2B, RP3/C, RP4/D, RP5/E, RP6/F, RP7/G, RP8/H, RP9/J	RP feels disconnected at times = 6	RP1/A, RP3/C, RP4/D, RP6/F, RP7/G, RP8/H
			Unable to show rage and aggression = 5	RP3/C, RP6/F, RP7/G, RP8/H, RP9/J
			Shows self-reliance = 8	RP1/A, RP2B, RP4/D, RP5/E, RP6/F, RP7/G, RP8/H, RP9/J

			RP feels difficult feelings are actively avoided = 8	RP1/A, RP2B, RP3/C, RP5/E, RP6/F, RP7/G, RP8/H, RP9/J
5.Overwhelming sense of responsibility = 7	Feels heavy expectations = 7	RP2B, RP3/C, RP4/D, RP5/E, RP6/F, RP7/G, RP8/H	Burdened by parental projections = 6 Carries others' needs = 6	RP2B, RP3/C, RP4/D, RP6/F, RP7/G, RP8/H RP3/C, RP4/D, RP5/E, RP6/F, RP7/G, RP8/H

N.B. Themes/codes relate to the RPs' patients unless stated they relate to the RP themselves.

Table 5: *Overarching themes, sub-themes and their relation to each Research Participant and their patient.*

7.1 Feeling 'position-less'

The process of finding a 'position' on the lateral level according to Mitchell (2003) requires the infant to experience a painful displacement from their favoured position with parents involving a loss of omnipotence and specialness due to the arrival or sudden awareness of a sibling. Part of this process is negotiating a new position as one of the siblings which comes with the loss of the 'only one' status with the parents and the recognition of the infant's existence through the recognition of their differences and similarities by the siblings. Suzanne Haas-Lyon's (2007) observation that the perceived absence of 'position' evokes intense annihilation anxiety and 'makes for the most intense states of mind' (p9) I believe, can be seen in the data. The results show the only-child adult can unconsciously perceive they do not hold a position on the lateral level with peers creating intense anxiety when they find themselves confronted with peer group situations. At various points every RP in this study experienced their only-child adult patient as feeling 'position-less' on the lateral dimension as they had not experienced these psychological processes associated with the sibling drama. This was shown in different ways but specifically with the only-child adult feeling

different, on the outside of peer groups, as though they do not ‘fit’ in, and lonely, and this was picked up by the RPs both through their patient’s narratives and their countertransference.

Mitchell (2003) suggests that being part of a sibling group prepares the infant for adult life with peers by experiencing the loss of the favoured position with the parents enabling the negotiation of a new position within the sibling group and with the parent – the loss of omnipotence and the acceptance of being one among many. This rite of passage, she suggests, allows the infant to enter the social world fully equipped to take their place among others who are experienced as the same – those on the lateral level. This study shows that this developmental process has not occurred for only-child adults which is further illustrated by the lack of mutual recognition (Benjamin 1990) experienced between the only-child adult and a sibling in early life – the process which allows siblings to confirm each others’ existence and position. Recognising as well as being recognised by others who are the same and with whom a position must be negotiated has not been experienced by the only-child adult. Benjamin (1988) asserts that ‘he must recognise the other as like himself in order to be recognised’ (p32). The lack of recognition – the failure to be recognised by a separate being on the lateral level – is shown to be absent through their patients’ feelings of ‘invisibility’ and ‘feeling unseen’, a sense of ‘non-existence’ and a feeling of ‘not being good enough’.

Of course, this is all in relation to peers and not necessarily in relation to authority figures and those on the vertical level which is an important demarcation suggesting recognition may have taken place in some form on the vertical level between the only-child and their parents. An example of this lack of recognition can be seen with RP1’s patient A who pays her fees on a weekly basis and announces this at the beginning of each session leaving RP1 feeling that she wants something from him that she perceives is missing. He feels she wants him to ‘see’ her. Another example is where RP2 referred to patient B as feeling ‘invisible’ to her friends and she thought she felt invisible to her (RP2) also. A similar experience was reported by RP3 in relation to patient C and RP4 who felt patient D needed RP4 to ‘see’ her in the therapy. Feeling recognised by siblings means confirmation of existence in the sibling group and therefore occupying a ‘position’ with this being mirrored in the position taken up in the

peer group in adult life. Vivona (2013) in her writing on sibling identity development, suggests that ‘recognition’ is an invitation as well as an acknowledgement and that ‘an invitation is valid only if given by one who has the authority to extend it’ (p81). Recognition allows siblings to invite one another into a particular position or role.

7.2 The lateral versus the vertical and the oedipal

An interesting aspect of the data is how the only child adult can feel ‘omnipotent’ and ‘special’ as well as ‘position-less’. The ‘position-less’ feeling did not appear to be felt in relation to the vertical dimension – that is, with parents and other perceived authority figures. Infact, in many cases, the patient was shown to feel as though they held a position on the vertical dimension whatever that position may have been and often felt ‘special’ and ‘omnipotent’. This was shown through their experience of relationships with authority – for example, RP2 and RP5 both reported that patients B and E had very good relationships with their bosses but it was the presence of peers – the lateral level – which caused them anxiety and where they felt ‘position-less’. The ‘position-less’ feeling was clearly in relation to peers and those on the lateral dimension. This confirms Mitchell and Vivona’s observation that the vertical and lateral dimensions have different psychological and emotional requirements. It also suggests that the discovery that one has a sibling and is then thrown into the often unbearable state of ‘nothingness’, before having to negotiate a new position within the sibling group and in relation to the parent (Mitchell 2003), is as pivotal and significant an event to the developing infant as the discovery on the vertical level that mother has a relationship with the father, thwarting phantasies of having either parent exclusively to themselves – the Oedipal complex on the vertical level (Mander 1991). Forcing the infant to adapt to triangular and multi-personal relationships, negotiating feelings of exclusion, envy and jealousy are part and parcel of negotiating the intense anxieties created by the Oedipal phase of psychic development on the vertical level and it seems that there may be equally distressing anxieties on the lateral level performing a different function (Mitchell 2003; Haas-Lyon 2007; Vivona 2007; Kieffer 2014). As seen in the literature, in Chapter 2, the idea that the two dimensions of psychic life, the vertical and lateral, are as significant as each other, whilst also being distinct and separate but intersecting, (Kaës 2000; Michell 2003; Kancyper 2004; Jaffe 2021) seems to be born

out in the data in that by not experiencing siblings in early life there are implications for the individual's emotional and social development in adult life with those perceived as 'peers' (Winnicott 1964; Charles 1999; Mitchell 2003; Vivona 2007; Parker 2020). Additionally, two of the RPs in this study reported their patient experiencing an enmeshed relationship with the mother with the other seven reporting relationships where separation had been difficult which may confirm Fenichel's (1945) observation that the only-child has the most intense Oedipal complex. The results of the data indicates that this may be influenced by the absence of siblings. However, the absence of siblings is shown to affect the individual's experience of feeling part of peer groups in adult life and this appears to begin with not having found their position on the lateral level among siblings.

7.3 The search for a position or the search for a sibling?

This 'position-less' situation the only-child adult finds themselves in, seems to accentuate their feelings of insecurity among peers encouraging hypervigilance and anxiety to any perceived threat from rivals. The results of the data indicate these rivals are those who are experienced as residing on the lateral level and therefore represent the phantasy siblings. Arlow (1972) noted that only-children struggle with the inability to deal with the rigors of competitive life and suggested they experience huge anxieties at the prospect of any encounters with other children. The data showed this was the case with the only-child adult, who was seen to be highly anxious when a rival came onto the scene either in the clinical setting as another patient, a relative of the RP or outside the therapy in the patient's life. This was the case with RP2 when patient B saw one of her other patients arrive as she left and the following session was all about how betrayed she felt at her mother displaying a photo of her (patient B's) friend on the mantel piece and RP8 whose patient H saw her husband and could not speak for the entire session but felt paralysed with anxiety. However, the interesting aspect of this is that until the threat arrives, there is a denial of the existence of rivals to the extent that the RPs are utterly convinced that the idea of any other patients being a threat would be completely alien to their patients and unlikely to even be noticed by them. I suggest this shows the extent of the defence developed against the anxiety

evoked by the fear of such rivals. When rivals do make an actual appearance into the consciousness of the patient, which manifested in either relatives of the RP or other patients who have been seen by the patient, the reaction is overwhelming ranging from a complete inability to speak in the session, as in RP8's patient H, to an utter sense of obliteration as in patient C seeing a relative of RP3. Arlow (1972) suggests the reason for their extreme anxiety is that peers represent the siblings the only-child believe they have devoured or damaged and fear their retaliation. However, I suggest the anxiety is due to their fear at being displaced by the phantasy sibling in relation to the parent representative as this is unconsciously expected (Klein 1932; Mitchell 2003; Kaës 2003). The sudden awareness of the presence of the sibling produces the 'catastrophic awareness that one is not unique' (Mitchell 2000 p20) and that one is in danger of losing the unique position with the parent by being displaced by the phantasy sibling. This potential threat of rivals is immeasurable but so too is the desperation to secure a position among the phantasy siblings in relation to the RP. These patients have shown that they must secure a 'special' position which cannot be shared with any rivals for fear of displacement – suggesting they have not experienced the loss of omnipotence and struggle to hang onto it which could also potentially be influenced by the overly close relationship with the mother. The anxiety about being displaced or thrown into 'nothingness' is so great that defences come into play which includes an entitlement of that special position – manifesting in making demands on the RP which they feel unable to refuse. For example, when patient A cancelled a session, RP1 reported to picking up a feeling of entitlement to have another replace it and RP2 also felt a sense of entitlement from patient B for the full number of sessions that other patients had been given feeling that the rage evoked by this, could not be repaired. RP3 also experienced patient C's sense of entitlement to her being there for her and how this felt a pressure on her not being ill or absent. RP4 and RP5 also described their patients making demands leaving them feeling this sense of entitlement in their countertransference.

I suggest another defence to protect the only-child adult from being displaced and thrown into 'nothingness' is requesting sessions at the beginning and end of the day rather than experiencing the unbearable anxiety of feeling 'position-less' and therefore non-existent within the phantasy sibling group. This was evident with six RPs where five patients chose the end of the day appointments and one the beginning of the day.

The other three RPs were interviewed at the beginning of the research before appointment times had been recognised as a potential interest and therefore, those RPs were not asked the question of session times. This defence is an attempt to secure a special place with the RP rather than being lost or displaced by the phantasy siblings as they do not hold a position in relation to the phantasy siblings whether or not other patients had physically been seen in the clinical setting. This suggests unconsciously siblings were expected or their presence was assumed even though the RPs were convinced their patients would be unaware of anyone else around. Agger (1988) referred to her only-child adult patient who would race to beat her to the consulting room in the morning, preferring the first or last session of the day so no-one could come before or after which she links to his loneliness at being an only-child. She did not explore his need to secure a 'position' with her. Six RPs reported their patients never cancelling sessions, which I suggest is also for fear of losing the favoured position, and of being displaced and thrown into 'nothingness'.

Several RPs reported to their patients taking on senior and authoritative positions at work where they have a special place outside of the phantasy sibling group – attempting to re-enact the safety of being special and attempting to avoid the danger of being under threat of being displaced. This was the case with RP2 and patient B who held a senior position as well as soaking up all the training offered to ensure she was the most knowledgeable in her department and patient H who was a senior professional but could only go to lunch with the admin staff as she needed to feel 'above' or 'senior' to them.

Feelings of abandonment and rejection from peers was easily felt by all nine patients according to the RPs which Haas-Lyon (2007) suggests is how a child who is seduced into feeling special will feel as they will be particularly vulnerable to feeling rejected and abandoned when a sibling arrives. She goes on to say that such feelings exacerbate the threat of displacement and reinforce the defences against it (p24). I would also suggest that the feeling labelled as 'special' in this context is a feeling of being the 'only one' the opposite feeling of being one of many which may feel like the individual has an exclusive relationship with a parent – exclusive as in, nobody else on the same level, the lateral level, has access to the parent and therefore there is no one else vying for their attention and therefore no need to adapt oneself to show one

is better than the others through the processes of identification and differentiation (Vivona 2010). No rivals means no loss of omnipotence and no coming to terms with being 'one of the group'. The Oedipal rivalry is a very different experience and is about the child's rivalry with one parent for the other (Britton 1989 p85) with the sibling loving and hating the same person. Both the parental object of desire and the parental rivalry are above rather than beside (Vivona 2010) as with the sibling. However, as mentioned previously, it is recognised that the Oedipal situation will influence and be influenced by the sibling experience or lack of it.

Having established that all nine patients felt they did not hold a position on the lateral level, it seems that all nine patients attempted to search for a position in various ways as discussed above. The search for a position seems to be connected to a search for a sibling and it is difficult to be specific about which search overrides the other, if any does, and the influencing factors. It is important to note, though, that the ultimate resolution to the sibling drama, be that for the sibling or the only-child adult, is for one to know their 'position' in the world of peers in adult life (Mitchell 2003; Vivona 2007; Parker 2021) which is related to their sense of identity among peers. Although clearly this can also be influenced by many other factors in the case of siblings. However, there were clear themes of patients looking to secure a position with the RP as discussed in the previous section with a sense of longing picked up by several RPs in their countertransference. In many cases this was linked by the RPs to the desperate wish for a baby the patient had expressed but as RP1 discussed, it sometimes felt as though it went beyond that. Four female patients felt this longing for a baby and I suggest it is related to the search for a sibling with the baby representing the longed-for sibling which could potentially unconsciously kick start the sibling drama. The interesting aspect to this is that whilst RP1 reported patient A's desire for a third child, there was no mention as to how patient A had felt about the arrival of her other two children. It may suggest that she was as equally desperate for the other two but when the arrival of the babies did not fulfil the longing for a sibling, the search continued with the next pregnancy and the next – this is only speculation without any evidence in the data to support it. Another example of a search for a sibling could be seen with RP9 who discussed how patient J had chosen her as her therapist from her picture and profile saying she wanted to pick someone special. RP9 is a couple of years older than patient J suggesting it may have been a sibling-like choice.

Patients also attempted to recruit the RP into a sibling dynamic by playing out and projecting their phantasy of casting the RP into two sibling roles in relation to themselves, that of an older sibling and a younger sibling. The first was shown through the RPs feeling that their patient emulated them, the patient acting as though they admired them and wanted to be like them and for three RPs, RP1, RP4 and RP9, their patients decided, during the therapy, to take on a clinical psychotherapy training which was similar to the RPs' own clinical training. For some RPs this emulation felt seductive and enjoyable as it did for RP9, while for others it felt irritating and threatening as with RP1 and RP4. The second sibling role was that of enacting the older sibling and projecting the phantasy of the younger sibling onto the RP. The RP felt at the receiving end of competitive and rivalrous behaviour, where the patient wanted to be 'top dog' or the expert in the session leaving the RP feeling intimidated and, in some cases, threatened into feeling competitive themselves – feeling the need to fight their corner. This was the case with RP2 and patient B and RP4 and patient D. Agger (1988) referred to her only-child adult patient whom she reported expressed feelings of exclusion and competitiveness at her interpretations. She also refers to only-child patients who form a positive attachment to their therapist based on the 'unconscious fantasy that he or she is their longed-for confidante and older sibling or their longed-for playmate and younger sister or bother' (p28). The idealisation and emulation of the sibling according to Mitchell (2003), is a reversal of the hatred the infant feels for the rival – a defence against feelings of rivalry and competitiveness. The different responses of the RPs to these transferences seemed to be related to their own sibling experience.

7.4 The presence of peers creates anxiety

The presence of peers or the RPs' other patients – phantasy siblings – is felt by the RPs as being completely unnoticed and of no concern to their patients until they are confronted with them in the clinical setting or outside the therapy, as mentioned earlier. In the work place the only-child adult seems to take on authoritative and senior roles which I suggest is a manifestation of their anxiety at feeling 'position-less' among

peers. Just as they need to find a special place with the RP having the first or last appointment time and never cancelling sessions, equally they need to hold a place which is senior and special in the work place and which eliminates the risk of rivalry and the dread of displacement within the phantasy sibling group by being outside and above the group – this may also re-enact their vertical positioning experience by taking on the parental role. This was shown with RP2 and patient B in her senior position in the organisation but not feeling part of her peer group. This fear of displacement pushes the only-child adult to frequently work alone even within an organisational setting and struggles to make friendships of work colleagues but tends to feel separate and not part of the group as was the case with RP5 and patient E where he worked alone in a senior position and felt unable to deal with peers when he came across them. These individuals are shown to be self-reliant. There is also an intensity about them which disables them from playfulness probably having never played with siblings and taken on the many roles in games and role-play. Winnicott (1964) discusses the disadvantage of the lack of playing with siblings and suggests the only-child becomes stunted in play and misses the pleasures which belong to 'inconsequence, irresponsibility and impulsiveness' (p132) and therefore becomes precocious preferring the company of adults. This was particularly evident with RP8 who felt patient H just could not engage in social banter or light hearted chat and on coming across peers did not know how to be with them. She did not know who she was in the group.

The other interesting aspect to note here is their need to retreat from difficult feelings, aggression, anger and sadness. The struggle to tolerate difficult feelings, when they arise, by emotionally disconnecting or simply avoiding the feelings altogether was reported by eight RPs. One example was RP6 reporting how patient F would frequently physically leave the session when it felt difficult and would return after a few minutes. Winnicott (1964) discusses this difficulty in the only-child and observes how they do not know how to deal with their own hate as they have not experienced themselves violently hate the new baby's arrival which threatens their relationship with the parents and experience both themselves and their new sibling survive it. Mitchell (2003) also describes this murderous hate as being related to the feeling of having been annihilated by the new arrival and having to find a way of surviving this by finding a new 'position'. Winnicott (1964) goes on to say that children who have siblings have

plenty of opportunities to come to terms with their hate and aggression through their play with each other (p133). For only-child adults it seems to have been more of a challenge.

7.5 Overwhelming sense of responsibility

The RPs reported to their patients feeling an overwhelming sense of responsibility for parents, feeling burdened by parental projections and experiencing heavy expectations from others. These responsibilities and projections have never been shared with siblings and perhaps also due to the sometimes enmeshed relationships with the mother, can feel intense and heavy and as though there is no relief. As RP7 noted, patient G felt like he was always in the spot light with his parents, as he was the only one who could provide the answer for them. There was no sibling who was naughty yesterday or did not get the grade today who may have taken the spotlight away just temporarily. According to Vivona (2007), siblings will find their unique identity through the position they find in the sibling group and the recognition of their differences and similarities both from siblings and from parents – you are the smart one, so I will be the arty one. I suggest only-children do not get the chance to be labelled as anything – they carry 'everything' so they are the disappointing one, the clever one, the artistic one, the one the parents put all their hopes into, all their insecurities into and according to the RPs, it feels like a heavy burden. Margaret Rustin, (2007) in her work with only-children recognised how this intense burden can be lifted when one is not the only repository of the families' expectations and projections but there are siblings to share the load.

7.6 The only-child adult RPs

In this study there were three only-child adult RPs, RP2, RP8 and RP9, who all felt a strong identification with their patients' feelings of loneliness, searching and longing feeling a strong connection to them. All three were keen to talk about their own lack of siblings and how these feelings were familiar to them. RP2 had felt her position in the clinical setting strongly threatened by patient B's attempt to be the 'top dog' and had

felt pulled into competing for the ‘expert position’. She had even drawn her supervisor into the competition who had insisted she tell patient B who was boss – incidently, RP2’s supervisor was one of several siblings so it was likely playing into her own sibling experience of which she seemed unaware. RP9 felt a strong sense of emulation from patient J but was also aware of rivalrous feelings beneath it. She chose not to address this as she enjoyed playing the older sibling in the phantasy sibling drama and felt rejected when the therapy ended. RP8 also felt a strong sense of emulation from patient H and was aware of having felt the loneliness and longing herself wanting to show patient H ‘the way’ as she had been there and knew what it was all about – perhaps an older ‘sibling-like’ response to a younger one. It seems that the only-child RPs were particularly vulnerable to their only-child patients’ projections but also seemed to facilitate the phantasy sibling drama.

7.7 The role of the RP in the transference

The RPs experienced themselves as the parental objects in the transference. For most of them, the idea of a sibling transference had never really been considered and even less so with an only-child adult patient. Their patients’ difficulties had been understood from the vertical position – a parental position – even when it did not seem to fit with their countertransference as in the case of RP3 who was the youngest sibling of two sisters and felt in the transference that she was the older sibling to patient C. She was aware that it made no sense to her but could not work it out. The data showed that every only-child adult patient enacted a phantasy sibling transference of some description at some point in the therapeutic relationship as well as a parental transference where phantasy siblings were unconsciously present. The RP became the parental figure at times when the patient was looking for a position among the phantasy siblings as well as becoming both an older and younger sibling and playing out sibling-like enactments such as emulation, competitiveness and rivalry when vying for a top ‘position’ as in the case of RP1 and RP2. There is no clear predictable pattern of when and why these various sibling manifestations arise in the transference at the times they do. What is so important about the phantasy sibling transference is that it appears with no object source to transfer. It is a phantasy based on something the only-child adults never experienced to introject but only the space that at an

unconscious and developmental level they were aware was empty. Both Joseph (1985) and Ackerman (1959) discuss how fantasies as well as introjected experiences are present in the transference.

This universal phantasy of expecting the sibling arrival has been discussed by several authors (Klein 1932; Mitchell 2003; Kaës 2003; Rustin 2007; Vivona 2007; Parker 2020) as being on similar lines as the universal Oedipus complex. However, through discussing their patients, all the RPs began to see the sibling issues emerging throughout the interview and expressed surprise and curiosity.

7.8 Implications for practice

As shown in the results of this study, the only-child adult is unconsciously enacting an attempt at resolving the sibling drama in the therapeutic setting. Their starting position is being 'position-less' on the lateral level and expecting a sibling to arrive throwing them into disarray through taking their place and losing their sense of specialness. They are continually looking out for rivals becoming anxious as well as competitive and rivalrous when they perceive they are under threat. The emulation is also an attempt to mitigate the rivalry. As the results have shown, this manifests through a whole range of enactments listed in table 2 in chapter 5. None of the RPs had previously considered a phantasy sibling enactment and therefore any opportunity to create an environment enabling this to be understood and worked through was missed. Part of the issue was the difficulty in the RPs thinking about their own countertransferences – an example of this was RP4 who felt irritated by the competitiveness she felt from patient D and became defensive. She struggled to see that whilst there was an attempt to create a phantasy sibling transference, her response to this was related to her own feeling of being displaced by her younger sister which she felt had never been resolved. She discussed how she had never found another position with her mother, leaving her feeling murderously angry at her younger sister and this was being replayed in the transference. Perhaps it is too painful for therapists to consider their patients are on the lateral level with you as it evokes such difficult feelings from their own sibling experience and perhaps this explains why

RPs thought only in terms of vertical transferences and had not fully considered the idea of a sibling transference but seeing themselves as a parental figure even when this did not seem to fit with what was actually going on in the transference.

Acknowledging the existence of the lateral dimension, in the first instance, enables the phantasy sibling transference to be picked up in the therapeutic setting. The resolution of the sibling drama for the only-child adult may require the coming to terms with the loss of omnipotence and feeling special and finding a position among their phantasy siblings and peers where the shock discovery of being 'ordinary' can begin the development of identity on the lateral level. However, this research is the first step in our understanding of the internal world of the only-child adult and therefore, there are currently no definitive actions or suggestions in response to working through the phantasy sibling transference successfully. I have discussed this further in the 'Limitations of the Study' section in chapter 8.

7.9 Conclusion

As seen from the results, the only-child adult patient creates a 'phantasy sibling transference' which plays out various aspects of the sibling drama at different times during the therapeutic process. In addition to this, the only-child adult shows manifestations of other social and emotional challenges also resulting from the lack of siblings such as the ability to successfully negotiate relationships with those on the lateral level. It is clear from the results of this research that if we allow the vertical dimension to be the only lens through which we understand psychic and emotional development, we are not only likely to overlook the sibling challenge and what it means to find one's position and unique identity in the world of siblings, but we also risk overlooking the psychic and emotional needs of the only-child who is searching for a 'position' through the search for a phantasy sibling. By recognising the profound influence the absence of siblings has on the only-child throughout life, and acknowledging the existence of the two dimensions of psychic life and the different developmental demands posed by each, we enable both the vertical and lateral dimensions to be attended to in the transference. However, before we can begin to

think about the sibling and phantasy sibling transferences, psychotherapists must first lay to rest the ghosts of their own sibling battles. Otherwise, as we have seen in the RPs in this study, the therapist is in danger of retreating into the power and authority of the parental role but one which is tinged with hostility and competitiveness from their own sibling defeats.

Chapter 8

Conclusions and future research work

8.0 Introduction: Summary of thesis

This thesis originated from my working with only-child adult patients and being aware of what I considered an unusual transference which I felt was related to sibling-like aspects. This puzzled me as these patients did not have early sibling objects to transfer. I equally had not internalised an early sibling object and yet my countertransference suggested otherwise. In my own psychotherapy I was aware of a sibling-like dynamic with my therapist although this was never discussed. I was intrigued and fascinated by repeated presentations of this. This study involved investigating this phenomena and examining the experience of other psychotherapists working with only-child adults.

In the literature, there were existing theories about sibling transferences where patients had early internalised objects to transfer and there were references from child psychotherapy where only-children had developed anxiety at the presence of other patients in the waiting room, but nothing about 'phantasy sibling transferences'. I therefore developed a conceptual framework utilising three theories as a platform onto which to build my theory. To ensure, as far as possible and whilst also recognising researcher positionality, I tried to reduce the influence of my own projections and experiences by deciding to undertake this study by interviewing a mixture of only-child psychotherapists and those with siblings. I asked them a series of questions to try to establish both from their patients' narratives, as they understood them, and from their countertransference whether a phantasy sibling transference may be being enacted.

The use of thematic analysis to analyse the data, I believe, served the purpose of identifying the dominant themes relating to the research question. This early stage

exploration of the transference of only-child adults can be used as a foundation to more specific studies as discussed in the Future Research section, 8.2.

The findings of the study showed that only-child adult patients did enact a ‘phantasy sibling transference’ at many points in the therapeutic relationship relating to different stages of the sibling experience. Perhaps just as siblings arrive at different stages of the infant’s development, so it seems the enactments reflect the different stages of the process of the sibling drama; shock and fear at the prospect of a rival, annihilation anxiety, emulation and envy and competitiveness and rivalry. As previously discussed (see 7.7), it is unclear as to why these different aspects of the sibling drama manifest at different times in the course of the therapy and they do not seem to have a predictable pattern. As previously suggested, this may be the first step towards a fuller understanding of the only-child adult’s internal world.

The results of this research clearly support the view of Klein and Mitchell that every human expects a sibling and is, in effect, waiting to play out the sibling drama and all that it entails to find a ‘position’ among peers and develop their lateral identity. In the event the sibling does not arrive, the wait and expectation continues into adult life and although defences may develop to alleviate the excruciating anxiety that the threat of a sibling-like rival evokes, as suggested by Arlow (1972) it can be seen looking for an outlet in every situation where the individual encounters peers. Although rife with anxiety, the desire to enact the sibling drama and to develop one’s identity on the lateral dimension is present, enabling the effective negotiation of the challenges of the adult world of peers. I suggest it is part of the human condition.

8.1 Strengths and limitations of the study (leading onto future study)

There were strengths and limitations of this study which I will discuss in this section.

8.1.1 Strengths of the study

This study suggests the idea that every human expects a sibling (Klein 1932; Mitchell 2003; Kaës 2003) and is the first research to investigate this idea. Although there is a recognised concept of the sibling transference – when an actual sibling is internalised and projected into the transference – the results clearly show how the only-child adult projects a sibling-like phantasy object and attempts to enact a sibling drama when there is no internalised sibling. Although this has been vaguely referred to by Klein (1932), Kieffer (2014) and Rustin (2007) in their work with only children it has never been explored or theorised as I have done here. This study also suggests the idea that without a sibling, the only-child adult does not feel they hold a 'position' among peers. This has been shown through their behaviour, their feelings and the countertransference of the research participants and concurs with Vivona (2007; 2010; 2013), Parker (2020) and Mitchell (2003) that having siblings is crucial for psychic development. Without siblings it leaves the only-child adult experiencing loneliness, longing and a search for a sibling to start the process of finding a position and an identity on the lateral level. It also confirms the defences used to protect themselves from the overwhelming and excruciating anxiety of being an only-child. These findings open the way to explore how the issue of 'position' and 'identity' can be addressed in the clinical setting. I have suggested further research ideas in section 8.2.

Interviewing nine psychotherapists gave an opportunity to explore the patterns and dynamics of working with only-child adults and I hope it is the beginning of further research into the only-child phenomena using this study as a platform.

8.1.2 Limitations of the study

The small number of RPs in this study (9) could be seen as a limitation of the study. However, despite the small number, four out of the five overarching themes were apparent in all nine RPs. I suggest this makes it extremely unlikely that having more RPs would have given any more information or any additional narratives that are not included in the ones I have. Therefore, I suggest it was large enough for data saturation to have been accomplished.

It could also be argued that the countertransference is not the most adequate way to 'access' the patients' transference. However, I believe that the countertransference of the RPs reflected both the narratives of the patients, as well as their own varied sibling experiences. Again, the countertransference of the RPs showed similar themes throughout the data even with those differing sibling experiences of the RPs which I suggest justifies it's use.

The cultural diversity of the RPs and their patients was limited and it may be useful to expand the research to a wider cultural landscape to enable the exploration of additional themes relating to different cultures. This could also be thought about in terms of the age of both the RPs and the patients. In this study the age of the RPs ranged between late thirties and late fifties while the ages of their patients ranged from late twenties to mid-fifties. All patients had at least one living parent. An extended study could shed light on whether narratives changed when both parents were no longer living.

On the discovery of a 'phantasy sibling transference', one may conclude the solution to the sibling dilemma could be the need for the only-child adult to come to terms with the loss of omnipotence and feeling special and to find a position among their phantasy siblings and peers within the therapeutic setting. It is reasonable to assume this may enable the shock discovery of being 'ordinary' to begin the development of identity on the lateral level. However, as this is new research with the 'phantasy sibling transference' having never before been considered, it is difficult to speculate at this time, with any certainty, as to what might be required for the only-child to find resolution. It is also difficult to know how the transference may be handled effectively particularly as the 'phantasy sibling transference' may be associated with competitiveness and rivalry which could constitute an obstacle for successful treatment. I hope this is something that can now be thought about and worked with in light of this new discovery.

One of the fascinating aspects of this study was the recruitment of 3 research participants who themselves were only-child adults and yielded fascinating data. They experienced a more intense response to their only-child patient as shown in the discussion. Whilst the research participants with actual siblings also experienced a

pattern of feelings toward their patients, it was noted how these responses were influenced by their own sibling experience. It would have been useful to have all only-child adult research participants seeing only-child adult patients as there would have been no contamination of internalised siblings in either subject. Another useful aspect of this study would have been to examine in more detail the dynamic in the room, and this could only be undertaken by studying my own patients. The nine psychotherapists had not been aware – nor made any connection to their patients being only-children – of the meaning of the dynamics they were experiencing. Whilst using my own patients would have allowed for a far more detailed understanding and perhaps the creation of an operationalisation, I was keen not to do this at this initial stage of research so as to ensure as much objectivity as was possible in this research situation. This leads me onto my two proposals for future study.

8.2 Future research work that would further develop the line of my research

For future research work which would develop my area study, I propose two areas of further investigation.

8.2.1 Future study idea 1: The study of only-child adult patients through the interviewing of only-child adult psychotherapists

As discussed in the previous section, one of the fascinating findings of this study was the unexpected result as to how the only-child research participants felt a strong identification with many of the feelings and unconscious phantasies present in their patients with two of them engaging in sibling-like rivalry with their patients. I therefore propose a similar study specifically targeting recruiting only-child adult psychodynamic and psychoanalytic psychotherapists to investigate how these particular psychotherapists engage with, and the phantasies present in them, toward their only-child patients. I would suggest using thematic analysis to analyse the data for this study for reasons of comparison to the current study which has a mixture of both only-child RPs and RPs with siblings.

8.2.2 Future study idea 2: The development of an operationalisation (Hinshelwood, 2018)

In order to extend the understanding of the only-child adult, I propose using my own only-child adult patients to undertake what Hinshelwood (2018) describes as the 'search for moments that satisfy the conjunction of a minimum set of the selected significant features' p173). To hone in on 'moments' in the therapeutic encounter which would confirm specific aspects of a 'phantasy sibling transference' enabling a more in-depth understanding than the current study. My aim would be to operationalise the conceptual framework that I have already created to test my own material. According to Hinshelwood this involves several formal steps which will enable the identification of specific and key characteristics that will define this phenomenon.

8.3 General conclusions of the study

Through this study I have investigated a phenomenon which I believed could be present in only-child adult patients and which could be seen in the transference – the search for a 'position' through the search for a sibling among peers which was not experienced in early life. The data has produced some interesting and unexpected results which I feel is just the tip of the iceberg in the study of only-child adults, their universal phantasies and how they manifest in the transference. I hope the theory I have proposed will do justice to only-child adults and will go some way in supporting them in recognising they can have a 'position' on the lateral level. This could be just the beginning of people finally feeling able to develop their lateral identity and lateral relatedness among their peers.

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Appendix A

Advert to recruit participants

Are you a psychoanalytic or psychodynamic psychotherapist / practitioner who has worked with, or is working with, an only-child adult patient?

If so, you could contribute to some interesting and relevant research.
I am looking to discover whether the only-child adult patient enacts a 'phantasy sibling transference' in the therapeutic setting and would be pleased to hear from you with a view to asking about your work with an only-child adult patient including thinking about your counter-transference through an interview. It can be work that is complete or ongoing.
You may feel you were not aware of such a phenomenon whilst working with your patient, but this is expected and invited, as exploring your counter-transference may help to identify whether or not there are any themes which might suggest this could be present.
If you think you might be interested, I will be pleased to discuss this with you to see if it is something you would like to pursue.

Contact: Jane Langley, Psychodynamic Psychotherapist
The Department for Psychosocial and Psychoanalytic Studies,
University of Essex

Email: jl21478@essex.ac.uk

Appendix B

Information Sheet given to all potential participants

Research Participant Information Sheet

Research Project Title:

'The only-child adult and the phantasy sibling transference': Do only-child adults enact a phantasy sibling group in which to find their 'position' within the therapeutic setting?

The purpose of the study:

In this research project I will be looking at what we can understand about the only-child adult's transference in the therapeutic setting and the possibility of a 'phantasy sibling transference'. In order to understand this, I will be examining the experiences and counter-transferences of psychoanalytic and psychodynamic practitioners who have worked with, or are working with, only-child adult patients.

Invitation to the study:

You have been invited to take part in this study as you are a psychoanalytic or psychodynamic practitioner who has worked with, or are working with, an only-child adult patient. Whilst the idea of a 'phantasy sibling transference' is not one you may have considered, it does not mean we cannot explore the possibility of it's existence through thinking about the themes in the work and your counter-transference.

What will happen if I take part?

Taking part in this study means that we will have an initial meeting over zoom to ensure that you have all the information you need and any questions can be answered fully. I will also ask you a pre-interview question about your own sibling experience ie your position in your sibling group or whether you are an only-child. This meeting will take no longer than 20 minutes. At the end of this interview I will email you the Information Sheet and Consent Form.

During the meeting we will arrange a date and time for a face to face interview where I will ask you some questions about your work with your patient/s and think about your counter-transference. It will be preferable for the discussions to take place at your clinical setting as a way for you to get in touch with your thoughts and feelings. This interview will take up to an hour and a half. I will audio record this interview enabling me to listen to it again. There will be no identifiable information in the recordings.

Informed consent:

Taking part in the study is entirely voluntary and it is up to you to decide whether or not you wish to take part. If you do decide to take part, you will be asked to provide written consent.

Withdrawing from the study:

You are free to withdraw from the study at any time without giving any reason up until the analysis of the data has been written up. Withdrawing will have no impact on you and your data will be removed from the study and destroyed.
If you wish to withdraw you should contact the researcher; Jane Langley email:

jl21478@essex.ac.uk.

What are the possible risks and disadvantages to taking part?

There are no risks or disadvantages to taking part and no 'costs' involved other than your time in the interviews.

What are the possible benefits in taking part?

There are no specific benefits in taking part in the study, only that your sharing of your experience in working with an only-child adult may contribute to our understanding of the internal world of these patients.

What Information will be collected?

The information which will be collected will be information about your own sibling status as this is important when thinking about your counter-transference, your patient's gender, occupation, if relevant, their relationship with their parents, their experience with peers and your counter-transference at different points of the work and toward different aspects of the relationship. I do not need any personal information about your patient which might identify them, nor do I need any other personal information about you. I will ask you to anonymise your patient's personal details before we meet and I will also refer to them as Miss/Mrs or Mr A, B, C, D etc depending on your position in the order of the interviews.

Data access, storage and security

All information about you and your patient will be anonymised. The audio recordings will not have any names or identifiable information on them and will be held on an electronic dictaphone for the duration of the study. The recordings will not be transferred onto a CD or USB but will be transcribed and the transcript will be stored securely in a locked cabinet also with no names or identifiable information. Your name and your patient's reference ie Mrs/Miss/Mr A,B,C,D etc will be noted on a separate paper kept in a locked drawer only for the purpose of your possible withdrawal from the study enabling me to connect you to your patient for disposal. Your consent form will be kept separately in another locked drawer. All data will be destroyed at the end of this program of study on or before December 2024 and will not be used in any other research.

Ethical approval

This research study has been reviewed on behalf of the University of Essex Ethics Committee and has been given approval.

Your well-being during the interview process

As you will know, it can be distressing reflecting on feelings and experiences and we can discuss this should you become aware of feelings which are difficult during the interview as it may be in part, something connected to your counter-transference and part of the process. However, if you do feel particularly affected by the issues raised in the interview, it may be

necessary for you to contact your own personal therapist to explore in depth what has been evoked in you.

What will happen to the results of the research study?

The results of this study are for a professional doctorate thesis and will be presented at a conference and published so will be in the public domain. All material you have provided will be unidentifiable.

Concerns and complaints:

If you have any concerns about any aspect of the study or you have a complaint, in the first instance, please contact the Project Researcher. If you are still concerned and do not think your complaint has been addressed or resolved to your satisfaction, please contact the Director of Research in the researcher's department – the Centre for Psychoanalytic Studies, Raluca Soreanu (for contact details see below). If you are still unhappy and wish to complain further, you can do this by contacting the Research Governance and Planning Manager, Sarah Manning-Press, The Research Office, University of Essex, Wivenhoe Park, Colchester CO4 3SQ.

Contact details

Project Researcher

Jane Langley (Research Student), Centre for Psychosocial and Psychoanalytic Studies, University of Essex, Wivenhoe Park, CO4 3SQ. Email: jl21478@essex.ac.uk
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Director of Research, Centre for Psychoanalytic Studies

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Sarah Manning-Press, Research Office, University of Essex, Wivenhoe Park, CO4 3SQ. Email: sarahm@essex.ac.uk

0622PIS1 ERAMSref ETH2122-1106

Appendix C

The Consent Form signed by all nine participants prior to them taking part in the main interview.

Research Consent Form

20th June 2022

Title of the Study: 'The only-child adult and the phantasy sibling transference': Do only-child adults enact a phantasy sibling group in which to find their 'position' within the therapeutic setting?

Name of Researcher: Jane Langley

Please read and consider the following; Please initial box

1. I confirm I have read and understood the Information Sheet dated 20th June 2022 for the above study. I have had an opportunity to consider the information, ask questions and have had these questions answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw from the study at any time without giving any reason and without penalty. I understand that any data collected up to the point of my withdrawal will be destroyed. ☐
3. I give permission for interviews with myself to be audio recorded and transferred into anonymised transcripts which will be securely stored until destroyed at the end of the study. ☐
4. I understand that the unidentifiable data provided will be securely stored and accessible only to the researcher directly involved in the project and that confidentiality will be maintained. ☐
5. I understand that my unidentifiable data will be used for a doctoral research project and subsequent publications. ☐
6. I understand that the data collected about me will not be used to support any other research in the future but will be destroyed at the end of the study. ☐
7. I agree to take part in the study.

Participant
Name:_____Signature_____Date:_____

Researcher
Name:_____Signature_____Date:_____

0622Consentform1 ERAMSref ETH2122-1106

Appendix D

The ethics approval notification

06/06/2022

Mrs Jane Langley

Psychosocial and Psychoanalytic Studies

University of Essex

Dear Jane,

Ethics Committee Decision

Application: ETH2122-1106

I am pleased to inform you that the research proposal entitled "The only-child adult and the 'phantasy sibling transference': Do only-child adults enact a phantasy sibling group in which to find their 'position' within the therapeutic setting?" has been reviewed on behalf of the Ethics Sub Committee 2, and, based on the information provided, it has been awarded a favourable opinion.

The application was awarded a favourable opinion subject to the following **conditions**:

Extensions and Amendments:

If you propose to introduce an amendment to the research after approval or extend the duration of the study, an amendment should be submitted in ERAMS for further approval in advance of the expiry date listed in the ethics application form. Please note that it is not possible to make any amendments, including extending the duration of the study, once the expiry date has passed.

Covid-19:

Please note that the current Government guidelines in relation to Covid-19 must be adhered to and are subject to change and it is your responsibility to keep yourself informed and bear in mind the possibility of

change when planning your research. You will be kept informed if there are any changes in the University guidelines.

Yours sincerely,

Marita Vyrgioti

Ethics ETH2122-1106: Mrs Jane Langley