CHAPTER FIVE

Psychoanalysis with children, the work with the parents, and the clinical structures

Leonardo S. Rodríguez

Five-year-olds

A lady telephoned me not long ago.

> "Doctor, my son has a problem. Do you have any experience with five-year-old boys?"
>
> "Madam, most of the children with whom I work are five-year-old boys."

These children suffer from anxiety hysteria, probably the most common form of neurosis in our times among people of any age (Rodríguez, 2016). One hundred and sixteen years after the publication of his inaugural paper on Little Hans, Freud's words are still pertinent:

> Anxiety-hysterias are the most common of all psychoneurotic disorders. But, above all, they are those which make their appearance earliest in life; they are *par excellence* the neuroses of childhood. (Freud, 1909b, p. 116)

Many things have changed since the Professor offered the young Herbert Graf what might be considered as the first interpretation in

the history of psychoanalysis with children (Freud, 1909b, pp. 41–43). What has actually changed in the matters that specifically concern the psychoanalyst who works with children?—i.e., human desire, love, jouissance, the structure and functions of the unconscious, symptoms, fantasies, the composition, and functions of the family: in brief, what has changed in the phenomena, problems, and questions with which we operate, which our conceptual efforts attempt to elucidate and our praxis aims at effectively transforming? (Rodríguez, 1996).

The impressive scientific and technological advances and the significant socioeconomic and cultural changes that we have witnessed in our own lifetime should presumably have had an impact upon the ways in which subjectivity is constituted and upon both creative and morbid human productions, as well as our conceptions of childhood, the education of children and young people, and maternal and paternal functions.

In industrially advanced and in developing countries the social status of children and women has generally (but not universally) changed in the direction of an increased awareness of their human rights, and in some places (but not everywhere) there have been actual improvements in their living conditions. That the child is "a subject in his own right and in the full sense of the word" according to the very apt expression of Rosine and Robert Lefort: "*l'enfant est un sujet à part entière*" (Rosine Lefort & Robert Lefort, 1984, p. 3, my translation) does not only apply to the child in the analytic experience and to the ethics and praxis of psychoanalysis. The formula condenses a psychoanalytic contribution to the social and cultural standing of children; but it is also an effect of cultural evolution upon our own field, its ethics and its praxis.

That motherhood has become a matter of choice for a larger proportion of women and no longer an imposition upon virtually all women capable of becoming mothers has also, among other things, modified the status and subjective position of the women with whom we work, and who come to see us *qua* mothers or prospective mothers.

The position of the father has been affected in significant sections of contemporary societies quite markedly, particularly as regards the presence, responsibilities and actions of the *real* father—as distinct from the symbolic father, which is a function of the cultural law, and from the imaginary father, which corresponds to the significations of what is said about the father (both symbolic and imaginary), in particular by the mother, but not exclusively.

The institution of the family, which continues to be necessary for the constitution of the human subject, has undergone legal and ethical alterations that were simply inconceivable just a few years ago: same-sex marriage; the procreation, adoption, and raising of children by parents of the same sex; one-parent families (which have always existed, but which are now increasingly the result of a positive choice); "open" marriages in which the parents are more than two, with a variable combination of the sexes—and a few other familial arrangements. The changes in the constitution of the family are linked to the increased social acceptance of different sexual identities and orientations—something that as socially acceptable positions was—again—unthinkable not long ago (Rodríguez, 1996).

This is only a cursory reference to the changes that have affected human communities in our part of the world; a more precise account of those changes, their causes and their effects would be necessary if we were to gain an insight into their relevance for our discipline. It is reasonable to expect correlative changes in the individual speaking beings that inhabit our world. The interlocutors of these speaking beings have changed in their ways, the language that they employ has changed, and the parameters of the discourses—which are social bonds—that participate in their constitution as subjects have also changed.

I referred to "our part of the world" in the previous paragraph because the changes in question have not occurred, or have occurred only to a minimal degree, in large parts of our planet, and the same can be said of the considerable number of fellow human beings who live in "our" part of the world but who have maintained, to this day, their traditional cultural morality as regards sexuality and the composition of the family.

As for our specific conceptual and clinical categories, have the sociocultural changes that we have experienced in our lives, in the organisation of our own families and in the lives and families of our patients resulted in actual structural alterations in the clinical structures and their concrete manifestations, namely, symptoms, sexual identity, and the ways in which people deal with these manifestations?

Despite the changes in our living conditions over the last hundred years, the psychopathological organisations which human beings are capable of producing have not changed in their structure, and new types of symptoms have not appeared. It is true that some symptoms, syndromes, and clinical presentations have increased in their

statistical frequency, as social conditions and technological advances have promoted particular individual and familial disruptions. That is the case with the addictions to both illegal and medically prescribed drugs, and the addictions linked to the availability of pornography through the internet (*cf.* Rodríguez, 2007). It is also the case with the so-called "eating disorders" better described as "disorders of desire" (Rodríguez, 2009), and with the so-called "personality disorders" and "borderline personality disorders". These conditions are not new from a psychoanalytically informed diagnostic point of view, but they have been "promoted" as nosological entities by the last versions of psychiatric classifications of "mental disorders" (*cf.* Rodríguez, 2005). We can think of other clinical presentations whose diagnostic status remains problematic.

The extraordinary expansion of the use of psychopharmacological agents in psychiatry and general medical practice has contributed to the increase in the frequency, for people of all ages, of the diagnoses of depression, anxiety states, panic attacks, "bipolar" disorders, hyperactivity, and deficits of attention. These conditions have also been known for a long time, well before the advent of modern psychopharmacology, but it is not a coincidence that they began to be diagnosed more frequently in medical practice once the relevant pharma-cological agents indicated for their treatment became readily available and known to the general public.

The etiological factors behind the reported increase in the cases that fall into the category of "autism spectrum disorders" remain unclear. It is conceivable that a plurality of factors is involved in the genesis and development of cases that belong to this spectrum—and I would not disagree at this point with the prevalent psychiatric usage of the term "spectrum" (Rodríguez, 2001; 2008). At any rate, a plurality of etiological determinations (or "overdetermination", to use Freud's term) is the norm, rather than the exception, in the causal constellation of every psychopathological organisation, whether we refer to entire clinical structures or individual symptoms.

The parents' demands and the child's desire

It is usually the mother who telephones to ask for a consultation for the child or in relation to the child. These days, on occasions it is the father who takes the initiative. This represents a change, at least in my

experience, as until not so long ago it was the mother who as a rule requested the first consultation.

In all the cases with which I have dealt over forty-six years the request is fully justified: the child is suffering to a very serious degree. The child is *disturbed*, and not only disturbing. The parents are certainly disturbed in relation to the child's disturbance, but also beyond it. Beyond their distress at the perception of their child's disturbance, they do not know what *their own* disturbance is really about: it has to do with their own unconscious and its sources remain opaque to them. The disturbance in the child has unconscious determinants, but it also has to do with *the parents*' unconscious: the *transindividual* status of the unconscious is fundamentally grounded upon the primary familial bonds (Lacan, 1956, p. 214; Rodríguez, 2013). The etiology of the disturbance in each of them (the child, the mother, the father), although involving a number of fundamental signifiers and experiences common to all of them, is strictly singular and cannot be reduced to a familial or collective etiology.

Usually the parents have some idea as to the causes of the child's disturbance, particularly if this has to do with the child having become a nuisance at home, or at school, or both. This is a frequent presentation: the child has been persistently naughty, or worse; he or she has become an embarrassment and a danger to others and him or herself. No approach has been effective: punishment, leniency, conversation, silence—nothing has worked. Violence on the part of parents makes things worse, and they know that. And because they know it, they feel guilty and impotent when they exercise violence. Violence is always physical: so-called "verbal" violence is a form of physical violence. Insults, threats and other offensive verbal expressions are integral parts of discourse—albeit at the very limits of language in action. As discourse, they involve a physical materiality that literally hurts the body (and the spirit) and breaks it in various degrees.

I have worked with very intelligent, well-educated parents who behave like very dumb and ignorant people in their relation to their children and their problems. I have known parents who have adopted courageous positions in relation to the defence of human rights in the community, but who against their own better judgement use corporal punishment and verbal abuse to "educate" their children and "cure" their symptoms. They feel embarrassed when telling me what they have done to their children, because they know very well that a violent, punitive approach is not only ineffective but also unethical. They

know very well that in "our" part of the world corporal punishment and other methods of torture have been abolished and made illegal in prisons, work places, schools, and all other social settings (of course, the corresponding transgressions occur all the time); and they cannot explain why it is that they are capable of inflicting physical and mental pain to a child systematically, and not just at a moment of "losing control". Yet the horror at the recognition of the morbid, fundamentally masochistic satisfaction and consequent sense of guilt involved in the administration of corporal punishment interferes with their perception of the child's suffering and of their own tragedy, and with the transmission of a truthful account of the facts to the analyst.

On the other hand, according to my experience most of those parents who have lost their way when facing the child's suffering are the same ones who bring their child to an analyst and are prepared to sustain the narcissistic injury inflicted by the recognition that there is something fundamentally wrong with the child, that they have something to do with it, and that remaining ignorant as to the causes of the problem and impotent to find a solution only aggravates the child's suffering and their own pain. Certainly, there are also parents who are incapable of tolerating the narcissistic blow derived from what they regard as parental failure and the concomitant sense of guilt. But even these parents may be open to changing their subjective stance through the work with the analyst.

There are, of course, many parents who bring a child to analysis and who do not actively engage in any form of overt physical violence, verbal or otherwise. Nevertheless, there is always a dimension of violence in the internal and external affective struggles involved in human conflicts. From early in life the human body registers and suffers subjective conflicts in the form of anxiety, fears, conversion symptoms, psychosomatic phenomena, and the physical tension and anxious states that accompanies obsessions and compulsions—which are never purely "mental", in that the whole of the body is compromised by them (Rodríguez, 2009).

These considerations, and the simplest reflection on our daily labours, bring us to the question of the analyst's work with the parents. There is no established technique for this work. Perhaps Anna Freud and her school (at the Hampstead Clinic) have been, among all the analysts that work with children, the most committed to a systematic approach to working with the parents in parallel to the treatment of the child designated

as "the patient", broadly following the principles that Anna Freud established for working with children (A. Freud, 1946; Burlingham, Goldberger & Lussier, 1955; Hellman, Friedmann & Shepheard, 1960; Levy, 1960). A number of psychoanalytic authors, including myself, have questioned the ethical and clinical principles that guide the orientation of Anna Freud and some of her followers (Klein, 1927; Lacan, 1988, pp. 62–70; Rodríguez, 1999, pp. 36–53). There are testimonies of the work with the parents by analysts of other orientations: Kleinian, neo-Kleinian, Winnicottian, the authors of articles in *The Psychoanalytic Study of the Child*, and others. Maud Mannoni and Françoise Dolto, among the analysts with a Lacanian orientation, have provided clear accounts of their work with parents and the conceptual reference points that guided it (Mannoni, 1973a, 1973b; Dolto, 1974, 1995, 2009, 2012).

Even if we maintain differences with the psychoanalysts who have not followed the ethical and conceptual principles established by Jacques Lacan, we must recognise that there is something to learn from all the analysts who have endeavoured to work with children and their parents. Lacanian analysts do not form a monolithic group, and divergences are to be found between different Lacanian authors. In their work with the parents of children who have become analysands, all of them had to be creative in their technical approach, and inventive in the application of the psychoanalytic body of knowledge to unique familial constellations and very diverse and contingent modalities of relation between patients, parents and members of the extended family.

Psychoanalysis works with subjects

Strictly speaking, we do not treat children in psychoanalysis, but subjects. Strictly speaking, we do not treat parents either—but subjects: human subjects who come to work with us in their capacity as parents, but who are primordially and fundamentally subjects who are having difficulties in assuming the position of mother or father. It is possible to come to understand the sources of these difficulties. This requires analytic exploration and interpretation, which means the development of a transference relation. In my experience, the parents of the child brought for analysis present themselves less as parents than as children. Their own children often reproach them for being "so childish". This childish presentation is in fact a symptomatic formation—on occasions a consolidated symptom. "Child", "adult", "parent" and similar

words do not designate analytic concepts. They represent for us fields of enquiry: questions rather than explanations or conceptual reference points. Of course, we must be familiar with the developmental dimension of human history (both ontogenetically and phylogenetically), as well as with the legal and informal cultural norms that define the rights and responsibilities of children, adolescents and adults.

It is impossible to differentiate in a categorical manner the analytic work with the subjects/parents from analysis proper. In my experience, some of the interviews with the parents "progress" onto analysis proper, and the parent becomes an analysand in his or her own right. This does not mean that the interviews with the parents who do not engage in a full analysis are of a lesser analytic quality, less "deep" or less efficacious.

The analytic work with a child and his or her parents shows clearly that it is not a question of "blaming the parents". Apart from not explaining anything, such a naïve approach (extended among the general public, but also present among some analysts) has the paradoxical effect of covering up the actual contribution by the parents to the specific pathology manifest in the child, and consequently their assumption of the responsibility that genuinely belongs to them.

I work with each parent who wants to work with me individually. I do not work with parental couples. I used to do so, many years ago, until I realised that the presence of a partner interferes with the subject's capacity to engage in the psychoanalytic discourse, which is a unique, irreproducible method of speaking that discourages censorship and promotes the emergence of unexpected truths. All the parents with whom I have worked agree on this point, as they can easily recognise that the child and each one of the child's problems have a different subjective significance and resonance for each of them.

The child-analysand's desire, the parents' desires and the analyst's desire

I have maintained this ethical and technical position in consonance with what is simultaneously an ethical principle, a clinical method and a technical orientation: the concept of the analyst's desire, Lacan's original contribution that designates what is incomparable about an analyst's work—the respect for the singularity of the individual human subject in his or her capacity as a speaking being.

Lacan's "Note on the Child" remains an enlightening text on the links between familial impasses, the child's symptoms and their co-relation with the position that the child occupies in the mother's subjectivity, as well as the clinical consequences that may be extracted from those links—all this, despite its brevity: less than two pages (Lacan, 1969).

Among other cases, the analysis of children brought to the treatment because of hyperactivity and deficits of attention have illustrated in my experience the pertinence of the initial paragraph of the "Note":

> In the conception developed by Jacques Lacan the child's symptom is found to be in a position of answering to what is symptomatic in the family structure.
>
> The symptom, which is the fundamental fact of analytic experience, is in this context defined as the representative of truth.
>
> The symptom may represent the truth of the family couple. This is the most complex case, but also the one that is most open to our intervention. (Lacan, 1969, p. 7, see also Rodríguez, 1998, pp. 141–145)

Lacan then refers to subjective and familial situations in which the conditions are not so favourable:

> The articulation is much reduced when the symptom that comes to dominate stems from the subjectivity of the mother. In this case the child is concerned directly as the correlative of a fantasy.
>
> The distance between identification with the ego ideal and the portion taken from the mother's desire, should it lack the mediation which is normally provided by the function of the father, leaves the child open to every kind of fantasmatic capture. He becomes the mother's "object" and has the sole function of revealing the truth of this object.
>
> The child *realizes* the presence of what Jacques Lacan designates as the *objet a* in fantasy.
>
> […] He saturates the mode of lack in which the (mother's) desire is specified, whatever its special structure—neurotic, perverse or psychotic.
>
> In it he alienates all possible access by the mother to her own truth, through giving it body, existence and, even, the requirement of protection.

> The somatic symptom gives the greatest possible guarantee to this miscognition [*méconnaissance*]; it is the inexhaustible resource that, depending on the case, may testify to guilt, serve as a fetish, or incarnate a primordial refusal. (Lacan, 1969, p. 7)

This is a very precise definition of what is essentially at stake in the intergenerational transmission of psychopathology.

Colette Soler's remarks in her book on Lacan's contributions to the questions posed by femininity are pertinent at this point:

> We cannot fail to be aware that at the level of the organism's vital needs and the care it calls for, what occurs is what Lacan calls an "object-relation *in the real*". (Lacan, 1961, p. 548; Soler, 2006, pp. 115–116)

And she adds:

> Is motherly love thus an empty word? Certainly not, but like every other love, it is structured by fantasy. This is not to say that it is imaginary—far from it—but that in a very real way, it reduces the partner to being only the object that the subjective division calls to. Furthermore, the mother-child relation carries to a higher power the alienation inherent in love, since the newborn is not first a subject, but an object. The child is a real object, in the hands of the mother who, far beyond what is required by her care, can use him/her as a possession, an erotic doll from which she can get jouissance and to which she can give jouissance. (Soler, 2006, p. 118)

That the symptoms of the child have their genesis in the concrete experience of bodily jouissance that he or she has in the course of family life—primarily with the mother, but not only with the mother, and then not only with members of the family but also with other significant others—does not mean that the analytic experience requires necessarily the participation of the mother or the father, or of the person who takes responsibility for bringing the child to the analytic session (sometimes a grandparent, or an aunt, an uncle, a family friend or a legally appointed guardian). That the child in analysis is treated as an analysand in his or her own right and in the full sense of the term means that the word of the child is necessary, but also that it is sufficient for his or her engagement

in the analytic discourse. The aim of the work with the parents is not the gathering of information about the child and the family history. The child will expose all the unconscious history that an analysis is capable of generating. Rosine Lefort insisted that the children whom she analysed at Parents de Rosan did not have parents or any other person that could give an account of the child's history at the time of the treatment; and yet the four children whose cases she published engaged fruitfully in an incomparable analytic experience (Rosine Lefort & Robert Lefort, 1988, 1994, 1995). The aim of the work with the parents is to help them to get to know how they, *qua* subjects who speak, are engaged in the psychopathology of the child, its etiology, its evolution and its aggravation, on the basis of their own psychopathology. Since Freud "psychopathology" means differential clinical structures, or the subjective positions that human beings necessarily come to occupy in the course of their humanisation.

It is true, however, that psychoanalysis with children offers a privileged position to the analyst, which enables him or her to learn, from the testimonies of children and parents, the points of contact of the unique tragedies that each of them experiences differently—so close and so alien as they are in relation to each other in the traumatic avatars of their desires and their jouissance.

I have treated a number of children who presented with hyperactivity and deficits of attention, and for whom their symptoms made life rather miserable. I am referring to genuine cases, properly evaluated and diagnosed. I say this because I know of cases of children whose diagnosis of "ADHD" (Attention Deficit Hyperactivity Disorder) is established without due consideration of the clinical facts by practitioners who are convinced of the biochemical etiology of this condition to the exclusion of other factors.

Hyperactivity and parental malaise

The first of the cases I treated, one of the first children with whom I have worked, many years ago, when I was an apprentice of psychoanalysis working at the child psychiatry department of a teaching hospital in Buenos Aires, was that of a three-year-old boy. The boy entered the consulting room ahead of his parents, like a tornado, jumped on top of my desk, and from there onto a filing cabinet, pushing toys and small pieces of furniture in the course of his frenetic run, paying no

attention to my hopeless attempts to calm him down by verbal means, to then run away from the room before his parents had time to enter. Staff members found him some ten minutes later at a distant section of the hospital. That was hyperactivity!

"He is like that all the time, doctor", the active child's mother told me. "What can we do?"

If only I knew …

I was able to work with the child and separately with the parents, and after a few weeks the hyperactivity had gone. We worked with each of them around what was symptomatic in the family structure, as Lacan would put it. In this work I had the good guidance of our supervisor, an experienced and astute psychoanalyst who discussed difficult cases with a small group of us, young psychoanalysts-in-formation. I presented the case of the hyperactive boy the evening of the same day of my first encounter with him. The Professor said to me:

> "There you have a decent case of hyperkinesia, Rodríguez. Tell me, what are the sleeping arrangements in that family?"
>
> I did not know; they had not told me, and I had not asked.
>
> "Ah, Rodríguez, that is the first thing you have to ask in a case of hyperkinesia—and in any other case, for that matter."

In all the cases of hyperactivity (which used to be called "hyperkinesia"), with or without deficits of attention, that I have seen over the last four and a half decades, plus a good number of other cases that I have supervised or that colleagues have presented in clinical seminars, the wise clinical advice of the Professor has never failed me. When I worked in the shantytowns of Buenos Aires, I knew many families with six or more children living in one room and sharing one or two beds—without any pathogenic effect deriving directly from the absence of "private" space. It is not a question of the physical arrangements of people and furniture within the house. It is, rather, a question of the child's position *vis-à-vis* the sexuality of the parents: typically, the child is propelled to compensate for the lack of sexual satisfaction of an unhappy parental couple, by literally sleeping *between* the parents, usually under the pretext that he or she is scared in his or her own bed and wants the parents' company. In fact, as analysis uncovers, the child fears the effects of the "promotion" to a physical position of sexual excitation without resolution and with the mark of the transgression of the prohibition

of incest on top. The fear is not the cause, but the effect of the incestuous arrangement, a hopeless attempt to make up for the impossibility of the sexual co-relation.

On the whole, the clinical prospects in most cases of hyperactivity and deficits of attention are favourable, as typically the situation to which I have just referred corresponds to the prototype described by Lacan in the first paragraph of his "Note on the Child" (Lacan, 1969, p. 7). The symptoms of hyperactivity and deficits of attention are derivatives of the anxiety induced by the non-metabolised surplus-jouissance that literally, and materially, invades the child's body; and the deficits of attention may well serve a function. As a rule there is no failure of attention, but a *displacement* of attention towards the source of unhappiness: maternal and paternal dissatisfaction and impotence.

I am not claiming that this typical description is applicable to all cases of hyperactivity and deficits of attention. It is well known that neurological and other organic factors play a part in the etiology of a good number of cases. What I am describing is the testimony of an analyst who works with children and their parents and who has listened to their experiences, in the context of a discourse that offers the opportunity to hear truths that no one can say or hear elsewhere. For all the merits of the advances in pharmacology, clinicians who employ psychotropic agents as the only form of treatment should consider the human-made factors that contribute to the genesis of human conditions linked to anxiety: "the signal of the real", as Lacan defines it—the affect proper to an encounter with a real something in the face of which there is no recourse (Lacan, 2014, p. 160).

In the same connection, already sixteen years ago I wrote these lines:

> The child, depleted of his symptom (in so far as this is reduced to a pure deficit), becomes the object of medical practices and the psychopharmacological industry, thus realising in his own organism what the discontents of our civilization demands: nothing other than conformity presented as biopsychosocial stability.
>
> If the surplus-jouissance of the symptom is captured by the discourse of science and technology, and if it becomes surplus-value for the pharmaceutical industry, then the task of rescuing the truth-value of the symptom is left to the analytic discourse. (Rodríguez, 1998, p. 57)

There is a price to pay for humanisation—for becoming human by virtue of the Other's desire and the demands imposed by the Other's

jouissance. The primordial maternal discourse, whose traces get inscribed in the unconscious as the foundational *lalangue*, is oriented by the mother's fantasy and the erratic, contingent influence of her preferred modes of jouissance (Rodríguez, 2013). The best and the worst for which humans are known are first transmitted in that intimate and precious relationship. Nowadays the maternal functions tend to be shared by others: the significant others—the father, siblings, grandparents. In many societies this sharing has been the norm for centuries.

Children have something to say about what is done *with* them and *to* them, as well as about what they are capable of doing themselves. And there are analysts who are willing to listen to them, who desire to know their original stories, and who can help them to make a difference in their lives and the lives of their parents.

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