

Intensive Psychoanalytic Psychotherapy with Looked After and
Adopted Children: Exploring the experiences and perspectives of
trainee Child and Adolescent Psychotherapists

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Abstract

Objectives:

This study sought to explore the experiences and perspectives of trainee Child and Adolescent Psychotherapists (CAPTs) offering intensive psychoanalytic psychotherapy to looked after and adopted children (LAAC) within Child and Adolescent Mental Health Services (CAMHS). The study was interested in researching both clinical experiences within the consulting room, as well as work with the network supporting the therapy, consisting of adoptive parents and foster carers, the professional network, and intensive case supervisors.

Methods:

Five trainee CAPTs were interviewed, using a semi-structured interview format. Interviews were transcribed verbatim and analysed using Reflexive Thematic Analysis.

Results:

The impact of experiences of trauma and loss were considered in relation to the: LAAC, carers, adoptive family and professional network involved, and on the therapy. The propensity for splitting and re-enactments due to the disturbing impact of trauma was emphasised. Concerns regarding pressures on the CAMHS and on the individual therapist and parent worker's capacity to link-up and work collaboratively were raised. Intensive case supervision was deemed an important space where thinking and hope could develop. The prevalence of ambivalence, destructiveness and violence in the therapy was indicated. Participants emphasised the developmental focus of the therapy, and how the CAPT's reverie was considered an essential aspect of the therapeutic experience. Variations and creativity in technique were emphasised as necessary for this population.

Conclusions:

The findings emphasise how trauma can have an ongoing impact on both child and network, leading to splits, fragmentation and re-enactments; pressures on CAMHS make this more likely to occur within the treating team, and the importance of linking up between professionals is stressed. Intensive psychotherapy can be experienced as both a threat to the child's defences, but also a space where trust and understanding can grow, and where development can take place. Further larger-scale research on intensive psychotherapy is recommended.

Key words: child psychotherapy, intensive psychotherapy, looked after children, adopted children, trainee child and adolescent psychotherapist, supervision, parent work

1 Introduction

This study explores the experiences and perspectives of trainee CAPTs¹ offering intensive psychotherapy to LAAC².

During the psychoanalytic child and adolescent psychotherapy training, trainee CAPTs are placed within CAMHS, and are funded by Health Education England. It is a mandatory part of their training to have three intensive training cases, at different developmental stages: under-five, latency and adolescence.

The format of intensive psychotherapy is typically 3 sessions per week, for a minimum of one year. Adoptive parents or foster carers are typically seen either weekly or fortnightly by another clinician in the team, often by a CAPT but not exclusively. The trainee CAPT will also have weekly intensive case supervision with an experienced CAPT.

At a time when CAMHS are extremely stretched, it is rare for this intervention to be offered by qualified CAPTs. It is for this reason that this project will focus on trainees' experiences.

Whilst there is a wealth of literature on psychotherapy with LAAC, there is an absence of literature about the intensive psychotherapy model used within CAMHS. This study aims to address this paucity in the literature.

My interest in the subject of this study emerged out of my own experiences of working in a specialist fostering and adoption service throughout my training. I held intensive cases in the

¹ See Appendix A for full acronyms list.

² Whilst the subjects of this study are the trainee CAPT participants, their clinical material comes from rich and painful encounters with children who have often been hurt and neglected by adults who have struggled to keep them in mind. It can often be very difficult for the networks around these children to remain in contact with their experiences. Thus, it is important to be conscious of how even the use of acronyms, not only within this study, but also within clinical practice, can hold a dissociative function in defending the reader/professional from contact with painful experiences that can at times feel unbearable to hold in mind.

service, and these clinical experiences undoubtedly shaped my understanding and thinking about work with this population, and belief in its value. In undertaking this research project, I have sought to develop my understanding of this intervention, and to explore both the complexities surrounding it, as well as the important possibilities it can offer this population.

2 Literature Review

2.1 Introduction

This section will provide an overview of the existing literature on the subject areas of this research project and will summarise and critically evaluate the literature.

The literature review will be split into two sections:

1. Literature on the context, health and mental health of LAAC
2. Literature on child and adolescent psychoanalytic psychotherapy with LAAC

2.2 Literature Search Strategy

To research the published literature relevant to this study, several key concepts within the research question were identified:

1. LAAC: the context of LAAC in England at present; LAAC's mental health

For this topic, the literature search was conducted on the APA PsycInfo database, due to its comprehensive focus on behavioural sciences and mental health.

First single concept search:	Second single concept search:
<i>Looked after child OR Looked after children</i>	<i>Mental health</i>
<i>LAC OR LAAC</i>	<i>Mental illness</i>
<i>Foster care</i>	<i>Mental disorder</i>
<i>Foster children OR Foster youth OR Foster teenagers OR Foster adolescents</i>	<i>Psychiatric illness</i>
<i>Child in care OR Children in care OR Adolescents in care OR Youth in care OR Teenagers in care</i>	<i>Psychological need</i>
<i>CIC</i>	
<i>Adopted child OR Adopted children OR Adopted adolescents OR Adopted youth OR Adopted teenagers</i>	
<i>Adoption</i>	

Literature Search Strategy Table 1

Initially the single concept of LAAC was searched, using the Boolean operator ‘OR’ to maximise search results. Due to the extremely high result number, the second concept of mental health was included as a means of narrowing the scope of the search.

The two individual concept searches were combined to create a search equation, using the Boolean operator ‘AND’. Limiters were added. The publication date was limited, ranging from 2000 to present. In total 474 results were found and manually scanned.

Several other key papers that were not found in the literature search, but known as relevant and significant to this topic, were also included in this literature review.

2. Psychotherapy with LAAC

For this topic, several databases were searched: EBSCO Discovery through the Tavistock and Portman library, PEP web and the Journal of Child Psychotherapy.

The following concepts were searched when conducting the digital literature review:

First single concept search:	Second single concept search:
<i>Looked after child OR Looked after children</i>	<i>Psychotherapy</i>
<i>LAC OR LAAC</i>	<i>Psychoanalytic psychotherapy</i>
<i>Foster care</i>	<i>Psychoanalysis</i>
<i>Foster children OR Foster youth OR Foster teenagers OR Foster adolescents</i>	<i>Child and adolescent psychotherapist</i>
<i>Child in care OR Children in care OR Adolescents in care OR Youth in care OR Teenagers in care</i>	
<i>CIC</i>	
<i>Adopted child OR Adopted children OR Adopted adolescents OR Adopted youth OR Adopted teenagers</i>	
<i>Adoption</i>	

Literature Search Strategy Table 2

Relevant books were also included in the literature review.

3. Intensive psychotherapy
4. Intensive case supervision

Separate searches were conducted for the two topics above on: EBSCO Discovery through the Tavistock and Portman library, PEP web and the Journal of Child Psychotherapy. Relevant books were also included in the literature review.

2.3 Literature Review Results

2.4 Context, health and mental health of LAAC

2.4.1 Context of LAAC at present in England

National statistics on ‘Children looked after in England including adoptions’ (Department For Education, 2020) found that as of March 2020, there were 80,080 children looked after by local authorities in England, at a rate of 67 per 10,000 children. This was a 2% increase on the previous year and followed a trend of rising numbers of children in care each year. 56% of the children in care were male, 44% were female. 3,440 children were adopted in 2020, following a pattern of falling adoptions since 2015. The average age of adoption was 3 years, with children on average spending 2 years in care before adoption. In terms of proportion of children in care per age group: 5% were under 1 year, 14% were 1 to 4 years, 18% were 5 to 9 years, 39% were 10 to 15 years, and 24% were 16 and over. Reasons for being looked after were: abuse or neglect (65%), family disfunction (14%), family in acute distress (8%), absent parenting (7%), child disability (3%), parents’ illness or disability (3%), socially unacceptable behaviour (1%), low income (below 1%). These statistics are crucial in helping us to understand the current landscape of how many LAC (Looked After Children) there are at present in England, and the trends within this population group.

2.4.2 The impact of adverse childhood experiences and child maltreatment

There is a significant body of literature on the impact of early adverse life experiences on one's physical and psychological health trajectory.

Multiple adverse childhood experiences (ACEs) are a major risk factor for many health conditions across the life course, and Hughes, Bellis, Hardcastle et al.'s (2017) systematic review and meta-analysis found that individuals with at least four ACEs were at risk of increased health outcomes in all areas, in comparison to those with no ACEs. There were strong associations with sexual risk taking, mental ill health, and problematic alcohol use; and strongest associations with problematic drug use, interpersonal and self-directed violence. The authors highlighted how these health outcomes pose a risk of ACEs for the next generation, and form patterns of intergenerational trauma, adversity and ill health.

For the LAAC population this study is concerned with, the most common reasons for children going into care are due to experiences of abuse and neglect (Department For Education, 2020). Experiences of abuse and neglect have been shown by neuropsychobiological literature to have a significant impact on brain development and to have long-term consequences. Schore (2001), for example, wrote that:

Caregiver-induced trauma is qualitatively and quantitatively more potentially psychopathogenic than any other social or physical stressor (aside from those that directly target the developing brain). In an immature organism with undeveloped and restricted coping capacities, the primary caregiver is the source of the infant's stress regulation, and therefore, sense of safety. When not safety but danger emanates from the attachment relationship, the homeostatic assaults have significant short- and long-term consequences on the maturing psyche and soma. (Schore, 2001, p. 207)

Experiences of child maltreatment substantially contribute to child mortality and morbidity, and hold a long lasting impact on mental health, drug and alcohol misuse, risky sexual behaviour, obesity, and criminal behaviour (Gilbert et al., 2009; Norman et al., 2012).

Whilst the systematic reviews and meta-analysis carried out by Hughes et al. (ibid) and Norman et al. (ibid), as well as Gilbert et al.'s (ibid) comprehensive review of the literature (including systematic reviews, overviews, and studies, abstracts and websites), are as Norman et al. recognise, subject to potential publication bias that can lead to associations between outcomes being exaggerated; these studies are nevertheless extremely important in consolidating and synthesising data for our understanding of this topic. Their findings reflect how ACEs have lifelong consequences on both the individual and future generations. They emphasise the importance of government policies and mental health interventions in helping make meaningful improvements in outcomes.

2.4.3 Mental health of LAC

In England, research shows that LAC have higher levels of psychiatric disorders than children who live in private households, even those children who are most socioeconomically disadvantaged (Ford, Vostanis, Meltzer, & Goodman, 2007).

The most recent survey on LAC's mental health was conducted in 2002 by the Office of National Statistics (Meltzer, Gatward, Corbin, Goodman, & Ford, 2003). Although these findings are now considerably dated, they showed that 45% of LAC between the ages of 5-17 had a mental disorder, 37% had conduct disorders, 12% had emotional disorders (depression and anxiety), and 7% were hyperactive. In comparison, in the most recent survey on the general population, 'Mental Health of Children and Young People in England, 2017' (Sadler et al., 2018), it was found that around 12.8% of 5 to 19 year olds had at least one mental disorder.

LAC often have complex clinical presentations. Tarren-Sweeney's (2013) study, highlighted how out of a sample of 347 children in foster and kinship care, whilst 35% of children had classifiable mental disorders, a further 20% presented with complex attachment and trauma related symptomatology that did not fit within DSM or ICD classifications. Tarren-Sweeney's

study underlines the difficulty of ascertaining accurate clinical formulations for LAC, and the need for clinicians to continue to develop how they formulate their understanding of this population's difficulties. As this study was based on carer-report instruments, it was limited in its scope to build a fuller formulation of the children's difficulties from an objective clinical perspective. It would be of interest to compare carer and clinician scoring, to see whether this has an impact on the results found.

The literature review found that there is a paucity of data on the mental health of the under-five LAC population. Two studies (Hardy et al., 2015; Hillen, Gafson, Drage, & Conlan, 2012) that separately screened under-five LAC in an inner London borough, found significant mental health difficulties in this population. Whilst both studies arguably had relatively small sample sizes (43 in Hillen et al. and 63 in Hardy et al.), which impacted on the reliability of their findings, they had similar outcomes. In Hillen et al.'s (ibid) study, 26 (60.5%) of participants were found to have at least one mental health disorder, 11 (25.6%) to have at least one developmental disorder, and 18 (41.9%) had two or more comorbid conditions. Crucially, although 36 (83.7%) needed an intervention, only 3 were considered to have received adequate input. In Hardy et al.'s (ibid) study, only 10% of under-five's coming into care were identified as having difficulties, in comparison to 67% of the children in the screening cohort. Both studies emphasised extremely high levels of unrecognised and unmet need in this population, and the importance developing CAMHS provisions for this population. Studies such as these are extremely important for social care and CAMHS professionals to know about, as they highlight the propensity for this population to not have their complex needs met, and to be further deprived of input that could make an important impact on their developmental trajectory.

2.4.4 Traumatic early attachments

Traumatic early attachments have been shown to have a negative impact on brain development and result in maladaptive infant mental health. Such experiences impact on the “development of the capacities of maintaining interpersonal relationships, coping with stressful stimuli and regulating emotions” (Schore, 2001, p. 208), and a disorganized attachment will likely develop (ibid).

Two studies identified in this review have explored the attachment representations and reflective functioning of this population (Hillman, Cross, & Anderson, 2020; Zaccagnino, Cussino, Preziosa, Veglia, & Carassa, 2015). Both studies compared samples of children in either foster or residential care, with a sample of children living at home with birth parents. Their methods varied – adjusting to the differing ages in the sample of children, with Hillman et al. (ibid) using the Story Stem Assessment Profile interviewing 84 4-11 year olds (42 in care, and 42 at home), and Zaccagnino et al. (ibid) using the Child Attachment Interview to interview 59 9-13 year olds (24 in care, 35 at home). Both studies found that those children in foster and residential care had a higher percentage of avoidant, insecure and disorganized attachment representations. These findings offer important evidence of the long-term impact early experiences have on children’s attachment representations, and are indicative of the relational difficulties this population continue to struggle with once in care. Zaccagnino’s study also found the LAC group to have lower scores on the Child Reflective Functioning scale, which highlights the potential correlation between attachment representations and reflective functioning, and the difficulties this population encounter in understanding themselves and others.

2.4.5 Links between experiences in care and mental health

Some studies have explored the mental health of children and adolescents during long-term foster care. Tarren-Sweeney’s (2017) study on the rates of meaningful change in the mental

health of children in long-term foster or kinship care, used carer-reported mental health measures to track the development of 85 children over a 7-9 year period. The study found that mean mental health scores for the sample did not change during this time period. The study emphasised that children in care experience very different mental health trajectories, due to the varied experiences both before care and during. A limitation in Tarren-Sweeney's (2017) study was the conflation of experiences in foster care and kinship care, as there are substantial differences for children who are taken into care and put with a new family, in comparison to those who are found an alternative placement within their own extended family. Additionally, Tarren-Sweeney's study focused on carer-reported scoring, and self-reporting measures by the children and young people were not included. These could have offered an insight into their personal perceptions of their emotional wellbeing and mental health, and whether they felt that there had been significant shifts and changes.

Stanley's (2007) study is one of the few that addresses this paucity in the literature. Focus groups were held with 14 young people in care, and the damaging impact of discontinuity and change in care was highlighted by participants. The value of having control and choice when seeking and receiving support was reported, alongside the importance ascribed to carers who themselves were care-leavers and had relevant personal experiences. Studies such as this are crucial in offering a space and voice to those who experience so little control in their lives, and the findings speak to the importance that the participants (and professionals should) ascribe to the experience and knowledge those currently in, or previously a part, of the care system hold.

2.4.6 Mental health of adopted children

There is a wealth of literature on children who have been adopted. As synthesised in van Ijzendoorn et al.'s (2006) meta-analysis, studies have found that adoption as an intervention

can lead to massive catch-up and plasticity in physical, socio-emotional, and cognitive development.

Yet, evidence indicates that adopted children continue to experience mental health difficulties in childhood due to their early experiences.

Paine et al.'s (2020) important longitudinal study examined pre-risk factors [ACEs, number of moves, days with birth parents and in care] of 96 adoptive children, and their mental health over 4 years following the adoptive placement. They found that externalizing and internalizing problems remained high during this period, and that these difficulties were predicted to increase for those with more ACEs.

A further key longitudinal study, was the English Romanian Adoptees study, which was carried out by Sonuga-Barke et al. (2017). They followed 165 Romanian and 52 UK adoptees through childhood and young adulthood, and compared Romanian children who were adopted into UK families, with a control group of UK adoptees. Romanian adoptees were split into those who spent more or less than 6 months in a Romanian institution before adoption. Romanian adoptees who were exposed to less than 6 months in an institution and UK adoptees had similar outcomes. For those with greater exposure to severe adversity due to institutional deprivation, there was profound and long-lasting psychological impact, despite positive subsequent adoptive experiences. The group had higher rates of symptoms of autism spectrum disorder, disinhibited social engagement, and inattention and overactivity through to young adulthood. This group experienced low educational attainment rates, unemployment in early adulthood, and higher use of mental health services. Nevertheless, a fifth of this group who spent more than 6 months in an institution did not present with any problems in assessments. The longitudinal scope of this study is extremely helpful in distinguishing differences between early experiences in institutional care, based on the period of exposure to deprivation, and the long-

lasting impact these early experiences have on development into adulthood. The study also shows the remarkable capacity of some resilient individuals to adapt, reflecting an important cohort within this population which might be missed in research.

These longitudinal studies powerfully convey the long-term consequences of adverse early experiences, and provide important evidence that highlights the long-term difficulties many in this population encounter. These studies highlight the fundamental importance of ensuring ongoing support is available to children and families who have adopted, and how such support needs to hold a broad focus, from the social, emotional, educational and financial domains of their lives as they grow and their needs change.

2.4.7 LAAC and mental health services

Numerous studies have explored the use of mental health services by LAAC.

International studies have varied findings on the accessibility and use of mental health services by this population, due to the different health care systems and pathways to support. For example, whilst typically studies in the United States cite low access to mental health care services (Bellamy, Gopalan, & Traube, 2010), in New South Wales, Australia, there were significantly higher rates (Tarren-Sweeney, 2010). Age, gender, race, non-relative placements have also been factors that have been found to influence access to services (Leslie et al., 2000), as well as placement history, disorder characteristics, number of caseworker visits, foster carer education, and level of monthly benefits (Zima, Bussing, Yang, & Belin, 2000).

More research and evidence is needed to explore the efficacy of mental health treatments for this population. Bellamy et al.'s (2010) study used data from the United States' National Survey of Child and Adolescent Well-being, to estimate the impact of mental health services on a subsample of 439 children who had been in long-term foster care. Results indicated that

these children did not benefit from outpatient mental health care. The authors concluded that little is known about the types and quality of intervention, as well as the length of intervention, and stated the need for evidence-based treatments.

In England, there is little data on the referrals and treatment outcomes of LAAC seen in CAMHS.

Fargas-Malet and McSherry's (2018) study highlighted difficulties in accessing mental health services. Carers attributed this to waiting times, lack of information and engagement with them. Young people interviewed described how stigma, embarrassment, insecurity, guilt and fear impacted on their engagement with services.

In Rao, Ali and Vostanis (2010) study of a specialist LAAC CAMHS and their referrals, found that there was a substantial difference in the acceptance of referrals, based on whether children had indications of likely disorders. There was less consistency in accepting referrals for children with attachment and behavioural difficulties. The study noted key differences in their specialist team's work from community CAMHS, for example the flexibility to therapies and outreach work, as well as a trauma-focused approach for this particular population. The lack of information in the study on what treatments were offered to the families, carers, and children and young people, raises further questions about treatment pathways, resources, and what a national models and care pathways that the study calls for should look like – according to this specialist service.

2.4.8 Summary

In summary, this section reflects how early adverse life experiences have a significant long-term impact on the physical and mental health of individuals. For those who have experienced carer-induced trauma, psychopathogenic consequences can significantly impact a child's

capacity for growth and development, and attachment relationships are severely impeded. The literature highlights how although the LAAC population's high levels of need and disturbance are widely documented, in practice this does not necessarily lead to sufficient or satisfactory access, assessment and treatment by mental health services. The complex presentation of a substantial proportion of this population, requires further recognition and specialist input. Further research is needed to chart the current service use of this population, the treatment pathways on offer in CAMHS, and their efficacy.

2.5 Psychoanalytic psychotherapy with LAAC

Over the past 40 years, there have been substantial developments in psychoanalytic psychotherapy in the theoretical and clinical understanding of working with LAAC. For LAAC, whose traumatic experiences and mal-adaptive attachment patterns have a serious impact on their capacities to relate and form trusting relationships, entering a therapeutic relationship holds both serious challenges, as well as opportunities for new experiences and development.

Psychoanalytic psychotherapy looks into the unique individual. It does so in the context of the relationship between therapist and child, a relationship which brings into action all those unconscious processes, the difficulties in communicating and relating, which are preventing the child from getting on with life in the world. (Miller, 2008, p. 62)

The following review of the literature incorporates clinical writing on different dimensions of psychotherapeutic work with LAAC, as well as on the broader context of intensive psychotherapy and its framework.

2.5.1 *Context of psychotherapy with LAAC*

Boston and Szur's descriptive study (1983) of work with severely deprived children, as well as the follow-up study between 1988-1994, was ground-breaking in its evaluation of the outcome

of psychoanalytic CAPT with LAAC (Boston & Lush, 1994; Boston, Lush, & Grainger, 2009; Lush, Boston, & Grainger, 1991). These studies were crucial in the development and expansion of the scope of CAPT, providing evidence for the potential to work and treat this hard-to-reach population (Boston et al., 2009).

The 1988-1994 study was a controlled observational study of psychotherapy with 31 LAAC, who were contrasted with a group who had been recommended for psychotherapy but did not begin treatment within the first 2 years of the study. Of the 13 children whose therapy ended early, all but one was in once-weekly treatment, and although it was a small sample, the figures indicated that more frequent and longer-term therapy was more effective for this group. All cases where there was good support for the therapy showed improvement, and in 26 of the 31 cases, there was marked improvement in the children's progress. Changes were reported in the children's internal worlds, with increased strength and supportiveness of internal objects, and externally that there was a considerable improvement in their relationship with adults, as well as in their capacity to think and learn. Most therapists reported an increased capacity to bear mental pain, which meant that the participants were more emotionally accessible. Self-esteem was slow to improve.

These findings were extremely important in reflecting the possibility for psychotherapy to make a considerable impact on both the internal and external functioning of this population, to help these children make changes that could meaningfully impact on their personality development and consequently on their relationships and the stability of their placements.

Following these studies, CAPTs have increasingly worked with this population, and at present a substantial part of the CAPT's caseload is working with LAAC (Robinson, Luyten, & Midgley, 2017). Robinson et al.'s (ibid) survey, found that CAPTs were involved in a range of work with this population, from: assessment (83.7%), direct psychotherapy (82.3%), work with

foster carers and adoptive parents (80.9%) and consultation with the professional network (76.7%). Respondents highlighted the need for intensive and long-term work with LAAC; as well as organisational and resource constraints that impacted on the possibilities to offer such interventions.

2.5.2 Intensive psychotherapy

Intensive psychotherapy in CAMHS is typically offered to highly complex cases with co-morbidities, when other interventions have not been able to make a meaningful impact (Green, 2009). The frequency and regularity of intensive psychotherapy is a crucial aspect of building a therapeutic alliance and a sense of safety, particularly for those children who have missed out on experiences of reliable caregiving and ongoing dependable relationships.

Intensity of contact can also indicate where a child's history of inconsistent or discontinuous caregiving may leave him unable to engage safely or invest sufficiently in once a week contact in order to get to the point where separation from the therapist is meaningful. For some children, it is only where there is a great enough sense of trust and safety fostered by frequent contact that they can dare to begin to allow themselves to know what it is to miss someone, to rage against them for their absence and to experience that survival of self and other is possible. (Green, 2009, p. 186)

Evidence for the impact of intensive psychotherapy (4-5 times weekly) in comparison to weekly work (1-3 times weekly), was found in the Anna Freud Centre's retrospective study of 763 cases, between the ages of 3-17 years, seen between 1956-1996 (Fonagy & Target, 1996). There was a marked difference in outcome between non-intensive and intensive cases, with clinically significant improvements in 62% of the children treated intensively, and in 49% who were offered non-intensive treatment. However, Fonagy et al. (1996) also found that from age 12 and onwards there was a marked decline in adolescents' responsiveness to treatment.

Whilst there is a lack of studies investigating the efficacy of intensive psychotherapy in comparison with once-weekly psychotherapy with LAAC, tentative results described above by Boston et al. (1994), showed that LAAC cases seen with greater frequency of sessions and for

a longer term tended to have better outcomes. Capacity, resources, and models of working have shifted since the interventions researched in Fonagy et al.'s study (1996). However, at a time when there is a push towards cost-reducing short-term treatments within the National Health Service (NHS), findings such as these provide important evidence supporting the need for long-term intensive treatment to be available in CAMHS.

2.5.3 Supervision

Psychoanalytic supervision is a central element of a psychoanalytic training, “an indispensable medium through which psychoanalytic knowledge is passed from one generation of psychoanalysts to the next” (Ogden, 2005, p. 1265).

Ogden (ibid) linked the unconscious psychological work of dreaming (both in sleep and in waking life) to the supervisor's task in supervision, of helping the supervisee dream the elements of his clinical experience with his patient that he has either been unable to, or only partially, dreamt. According to Ogden, where the supervisee's receptive reverie state is impinged upon by disturbing communications with the therapy, the supervisor and supervisee are able to take notice and think together about where this disruption has come from.

Ogden (ibid) also referred to the unconscious aspect of the therapeutic relationship, which can preconsciously and unconsciously be brought to life within the supervisory space and requires attention. The notion of ‘parallel processes’, which has been widely referred to in the literature, is argued against in a note in the paper:

I find the latter term to be a misnomer in that the relationship between the analytic process and the supervisory process is anything but parallel: the two processes live in muscular tension with one another and are all the time recontextualizing and altering one another. The analytic relationship and the supervisory relationship constitute two facets of a single set of conscious and unconscious internal and external object relationships involving supervisor, supervisee and patient. (Ogden, 2005, p. 1268)

The dynamism of these object relationships, continually ‘recontextualizing and altering one another’ presents how intimately linked and alive both the analytic and supervisory processes are.

Ogden (2005, p. 1269) stressed the importance of the supervisory frame, how like the analytic frame, it is a space where the supervisee has “freedom to think and dream and be alive to what is occurring in both the analytic process and in the supervisory process”. Ogden emphasized the importance of security and confidentiality, so that the supervisee is free to express his private countertransference experience.

Whilst Ogden’s writing is highly relevant to the supervision of child psychotherapy cases, there is a sparse amount of literature on the clinical supervision of intensive child psychotherapy cases held by trainees. Rustin (1998, p. 433) has described how this is “surprising” considering the centrality of supervision in the child psychotherapy training, and the intensity of feelings that can be evoked in the supervisory experience.

Lanyado’s (2016) paper, written with a ‘view from the supervisor’s chair’, described the essential role supervision can play in supporting clinical work with severely traumatised and neglected children; as well as the importance of case management in these cases where the external realities are often complex. Lanyado referred to the supervisor’s role in helping the supervisee to ‘hold’ those overwhelming and disturbing feelings the patient expresses, a process which allows for those feelings to become conscious and be reflected upon, before the supervisee returns to their patient. She argued that “moments of hope” can emerge out of “moments of dark despair in the therapeutic process”, and that the supervisor, who is not part of the patient-psychotherapist couple, needs to be alert to these moments which can become an important turning point in the work (2016, p. 110).

2.5.4 Working with LAC in transition

The literature has explored questions debating the suitability of offering a psychotherapy intervention to LAC who are in either new placements, or short-term placements.

Hunter (2001) described a dilemma held by CAPTs of both responding to the emotional needs of a child in a time of transition following experiences of trauma and upheaval, as well as the need to respect the child's task at this time of adjusting and building relationships with a new family, school, and professionals.

The message to a child that their grief or distress can only be received by a psychotherapist may be unhelpful. It can be a message of rejection to a hurting child: 'I cannot bear to listen so I'll send you to a professional.' Would any of us feel comforted by such a response to our distress? But if the child is being listened to and nothing seems to help or they need something more, then therapy can be considered. (Hunter, 2001, pp. 23–24)

Hunter (ibid) stressed the need to make decisions on a case-by-case basis, and an openness in sharing this dilemma with the carers and social care professionals involved in the case. She stated the need for flexibility in assessments, short and longer term work, as a means of finding ways to offer a viable and helpful therapeutic intervention.

In contrast with Hunter, Kenrick (2000) has been more explicit in her support of offering therapeutic interventions as early as possible to LAC in transition, so as to support the child in negotiating separations and moves towards a permanent placement.

My point is that these, some of our most vulnerable children, already with unprocessed trauma, are subjected to further trauma from repeated separations while within the care system. This often reactivates early trauma and too often ensures the failure of the next placement. (Kenrick, 2000, p. 395)

Kenrick stressed how psychoanalytic psychotherapy can support these children in the process of these necessary separations within the care system. Experiences of feeling suddenly 'ripped out' can be reduced, so that the child "may become less liable to rip themselves out in order to avoid the pain of being the object of that rip" (Kenrick, 2000, p. 411), improving the security of longer-term placements.

Wakelyn (2008) has described the possibilities of offering transitional psychotherapy for children who are in short term foster care. This is a pulsed intervention, where individual sessions are interspersed with reviews. This model allows for a tempering of the closeness and distance so difficult to manage for these children, as well as a clear emphasis on close joined-up work with the network, prioritising containment and communication.

What appears to be lacking in the literature is an in-depth exploration of the differences between once-weekly and intensive interventions for children in short-term foster placements. Specialist interventions such as those described by Wakelyn (2008) respond to the difficulties closeness and intensity can bring up for this population, but perhaps more thinking is needed in how to tailor intensive interventions for this population too.

2.5.5 Working with adoptive parents, foster carers and the network – the ‘larger family’

The literature describes how the adoptive family, and “larger family” (Sprince, 2000, p. 431) of the professional network, take on an extremely complex role in providing stability, and on-going care for these traumatised and disturbed children.

Sprince (2008, p. 99) described how for a couple adopting a child, not only might this be the first parenting experience the couple has shared, but they are also parenting a child who has been subject to trauma.

In their longing to become parents, they may easily succumb to the fantasy that late adoption can be a ‘new beginning’. Their enthusiasm may sometimes lull the professional network into an equivalent optimism – a belief that an abused child can be assimilated into his or her new family without the provision of long-term ongoing social work and psychological support; or that such support need only be made available if or when things go wrong, rather than being provided as a matter of necessity from the start and over many subsequent years. (Sprince, 2008, pp. 99–100)

Sprince (ibid) recounted how adoptive parents she worked with described their experiences of not being informed of the depth and complexity of their children’s trauma and its psychological

impact, and the necessity for professional help to understand the child's disturbance and how it links to their early experiences.

Unless the professionals can support adoptive parents to fully understand and adopt their child's history as well as their child, the child's unconscious memories of their dispossessed parents will return like vengeful ghosts to haunt and attack the adoptive relationship. (Sprince, 2008, p. 113)

According to Sprince (*ibid*), adoptive parents' lack of understanding of their child's history, and acceptance of the child's traumatic history as being a part of their child too, can create huge difficulties in the adoptive-parent-child relationship. Adoptive parents can unintentionally re-enact the destructive aspects of the relationship between biological parents and child, in particular – those linked to their own early childhood experiences that were unresolved and painful.

Furthermore, when adoptive families are seen at CAMHS, often arriving at points of crisis when difficulties in the home have become unmanageable, they feel both relieved and grateful that their child is being seen for therapy, as well as a sense of lurking resentment and failure that they were unable to resolve these difficulties themselves (Miller, 2008).

CAPTs writing about their intensive work with LAAC have pointed to the importance of concurrent adoptive parent/carer work, and working with the network. The link between, and importance of, a supportive and stable placement and network for improved treatment outcomes was noted in both Boston et al. (1994) and Fonagy et al.'s (1996) studies.

The literature highlights the complex position of the child's CAPT: working with the child and attempting to build a trusting and confidential relationship with them; whilst also working collaboratively with the network and sharing important and helpful information about the child's state of mind and needs. Gibbs (2006, p. 99) has described how this can create a "tightrope situation" in which by being overly-identified with the child, the therapist might lose the co-operation of the network; or by over-sharing with the network, the therapist might lose

the child's co-operation or sense of having a boundaried and safe space to bring his disturbance and needs. Cant (2005), who wrote of her experience of working in a therapeutic community, described how working with the LAC population and children in transition, CAPTs need to reassess their ideas about confidentiality, and to become more involved in the external realities of the child's life.

We have to bring the child 'alive' in the mind and imagination of others. This requires our own passion for the work and the child's struggle, but also, sometimes, more intimate and illuminating details from the therapy that will aid understanding, and convey meaning. Thus the child 'comes to life' in the network, and can be thought about more clearly, and with a greater depth and understanding. (Cant, 2005, p. 22)

Furthermore, the task of the parent worker is to contain parental anxieties, to help them understand the nature of their child's difficulties and how these relate to the parents' own experiences and losses, and ultimately to help them move into a place where they can mourn their losses (Calvocoressi & Ludlam, 2008; Ludlam, 2008). This task is both concurrent and collaborative with that of the child's psychotherapist, and relies on the parent worker and child worker finding ways to work together, and share their understanding, so as to enrich both parallel pieces of work (Calvocoressi & Ludlam, 2008). Calvocoressi and Ludlam refer to this as "parallel collaborative therapy":

This collaboration requires not merely that the two psychotherapies run concurrently, with occasional meetings between them, but also that they should work to maintain their professional relationship so that they can monitor how the stresses experienced within and between them may be mirroring what is happening in the family. [...] We see this professional relationship acting as a lynchpin in the whole system, parallel with the position of the parental-couple relationship in the family system. (Calvocoressi & Ludlam, 2008, p. 186)

Moreover, the importance of working collaboratively with social workers has been stressed in the literature. The burden and disturbance that social workers carry and negotiate, means that at times, it can become difficult to recognise the full impact that these children's traumatic experiences have had on them, and to adequately meet their current level of need (Sprince, 2008). This has been described by Emanuel (2012) as an act of 'turning a blind eye' by

professionals, an unconscious means of avoiding unbearable pain. Such a response of paralysis in the system, becomes a replication of earlier neglect, and becomes a form of ‘organizational deprivation’ (Emanuel, 2002). The importance of social workers having an organization which can contain and tolerate their anxieties, and make space for thinking, is emphasized in the literature.

2.5.6 The compulsion to repeat

The compulsion to repeat has been a seminal theory in psychoanalysis, since Freud’s conception of it in ‘Remembering, Repeating and Working-Through’ (1914/2001). For those who have had traumatic early experiences, early situations can be repeated in the present. Fraiberg, Adelson and Shapiro’s (1975, p. 388) have conceptualised these as “ghosts in the nursery”, who “take up residence and conduct the rehearsal of the family tragedy from a tattered script [...] The baby in these families is burdened by the oppressive past of his parents from the moment he enters the world”. Building on Fraiberg et al.’s metaphor, once taken into care, and even in adoption, these ghosts continue to follow the child, spectres in each new relationship that the child attempts to build. CAPTs have explored how these “vengeful ghosts” (Sprince, 2008, p. 113) have a powerful capacity to also haunt the adults and network around the child, replicating traumatic early experiences and modes of relating.

Henry’s (1974) paper ‘Doubly Deprived’ was pivotal in showing how experiences of early deprivation, can be repeated through “the deprivation derived from internal sources: from his crippling defences and from the quality of his internal objects” (1974, p. 16). Such defences impact on the child’s capacity to form relationships, further depriving them of the containment and support they need. Henry described how for her patient, projective identification allowed him to split off and project needy aspects of himself into others, and identify instead with the unavailable, insensitive, “brickwall” object whom he idealised and allowed him to sustain an

unreachable defended position (1974, pp. 17–18). Henry explained that part of the attraction to such an insensitive internal mother is that it is available for the child at all times, whereas a live object such as the therapist is not. The therapist was instead experienced as neglectful, and maintaining this grievance was a familiar, and comfortable situation for her patient. Henry referenced Bion (1959) in describing how her patient attacked linking and contact with the therapist, noting how painful it was for the patient to repeatedly encounter his early deprivation when experiencing containment for his feelings in the present.

Emanuel (2002) extended Henry's concept of repeated deprivation, showing how organizational dynamics can lead to the 'triple deprivation' of LAC. Emanuel described how the professionals who are recipients of powerful projections, including attacks on linking, are liable to re-enact a child's original experience of neglect, by allowing a child to "fall through a hole in the 'net'-work" (2002, p. 164).

2.5.7 Attachment difficulties and forming a new attachment relationship

CAPTs have brought together attachment theory and psychoanalytic theory in their understanding of their patients' clinical presentation. The literature emphasises the importance of psychic defences as holding a protective function for an infant subjected to unsafe and frightening caregiving (Music, 2019), and how going forwards, loyalty to previous attachment representations makes forming new attachments particularly challenging (Hopkins, 2000).

Hunter-Smallbone (2009) described how whilst this population deeply desire the attention of their therapist, the possibility of a relationship is met with suspicion and cynicism.

What children of trauma and neglect show is their need for relationship and their utter confusion as to what to do with it; their anger and humiliation at the attraction of the interested other and their approach–avoidance emotions with what they are offered. (Hunter-Smallbone, 2009, p. 320)

Hopkins (2000) writing about her work with an adopted boy, linked together attachment theory's 'fright without solution' with Bion's 'nameless dread', and explained how early repeated experiences of fright for an infant, without parental recognition and containment of such states, leads to trauma, dissociation, and disorganized attachment. Hopkins described how the child's disturbance left the therapist too feeling states of "dread, alarm, anger, betrayal, humiliation, helplessness and hopelessness" within the countertransference (2000, p. 346). According to Music (2019, p. 52), much of the psychotherapist's job is understanding their countertransference, noticing how they feel and behave, when they get "drawn into the force field" of their patient, and "nudged into patterns of relating". Both Hopkins (ibid) and Music (ibid) stress how the therapist's countertransference experiences are essential in understanding their patients' attachments representations and projections, and through this experience being understood, change in the patient can occur.

The therapist's training enables her or him, as far as possible, to avoid joining the dance of attack and rejection, helplessness and humiliation. This means that the child becomes able to see beyond his attempt at enactment and to discover that alternative attachment possibilities are less threatening than he had supposed. A new attachment, that is, an attachment responsive to the therapist's actual qualities, can begin. (Hopkins, 2000, p. 345)

2.5.8 Psychic death – trauma and its impact on LAAC's sense of self and internal objects

CAPTs working with LAAC have noted how some patients experience a psychic internal deadening or death.

Alvarez (2010) described how for some children, experiences of trauma, deprivation and abuse, can lead to "defects both in self and internal object, where both are experienced as dead and empty or useless. There is often a chronic apathy about relating which goes beyond despair. Nothing is expected." (2010, p. 865). Alvarez states that in responding to this level of pathology, the psychotherapist must claim or reclaim the child, awakening and alerting the

child with an urgency to meaning. Such action on the part of the psychotherapist is a precursor for the child's own developing capacity to think.

Hart (2012) has developed Green's (1996) notion of the 'dead mother syndrome', originally formulated to describe an infant's experience of maternal depression, whereby the infant comes to perceive the mother as psychically dead. In identification with mother, the infant is left feeling as if they too are dead. Hart (2012) has described how when some children are taken into care, they are doubly bereft, both psychically from the depressed 'dead mother', and then by the actual loss of the mother when they are removed. These children are unable to use help, and instead project into the adults caring and working with them feelings of inadequacy and uselessness, which can lead to repeated foster care placement breakdowns. Awareness of this propensity for repetition is cited by Hart as a crucial to maintaining a curiosity within the therapy, and can help foster carers to remain motivated and responsive, ultimately helping the child take risks in forming new attachments both in and outside of the therapy.

Music (2009, 2019), has described how neglected children in particular can be experienced as empty and deadened.

Like plants deprived of water and nutrients, neglected children's potential to grow and flower can atrophy. They then become flat and lifeless, with less cognitive capacity and emotional aliveness than more 'hyperactivated' children. Those who experience violence or overt trauma at least have had to develop enough liveliness to become reactive, unlike many who have suffered emotional neglect. (Music, 2019, p. 88)

Music (ibid) described how their prognosis can be much more concerning, due to their capacity to slip out of mind, and difficulty in asking for help and misleading appearance of being self-contained. Music (ibid) referred to Alvarez's (1992) work on reclaiming and enlivening a child, as crucial in moving away from the deadness the child experiences and communicates. Music (2009, 2019) has also suggested the developmental importance of positive and playful interactions with neglected children, as holding a vital aspect in the development of lively and mutually enjoyable interactions.

2.5.9 Emotional regulation and safety

Music (2019) stressed a distinction between dulled-down neglected children, and those with dysregulation who were perhaps exposed to violence or overt trauma. Music stated that for those with acting out behaviours, focus in the therapy on calming and down-regulating required priority over enlivening work. Writing from both a psychoanalytic and neurobiological position, Music stressed how “the development of emotional regulation is a precursor to the development of a mind capable of thoughts” (2019, p. 68). For Music, his patient’s ‘mind-growing’ experience, arose out of greater emotional regulation, bodily awareness, and an experience of an attuned and compassionate therapist who was able to track his thoughts and facilitate the development of his own capacity to hold onto and observe his own thoughts.

Furthermore, Music (2019, p. 132) has argued that in psychotherapy we also need to focus on the “primary emotional systems”, the soothing system which is linked to attachment and security, and the appetitive or seeking system, which leads to increasing good feelings such as excitement, hope and pleasure. Music argued that the development of these primary emotional systems builds an important foundation where development and working through trauma can take place. He wrote candidly that:

Traumatised patients need help to trust in a soothing, safeness system, a prerequisite for both the pleasures of the seeking system and the ability to manage difficult experiences. Focusing prematurely on the trauma can backfire, as I and my early patients painfully learnt. (Music, 2019, p. 132)

2.5.10 Violence and psychopathy

The complexity of violence in the consulting room has been considered by CAPTs working with this population.

Canham (2004) has explored how children who have had terrifying experiences and feelings bring these into the consulting room. The psychotherapist is often placed in a position of being under attack, a state where thinking is difficult to achieve, and ‘acting-in’ is more likely to occur.

The danger of working with children when such violent projective identifications are taking place is that the risks of enactment are huge. It is not possible to sit and examine your counter-transference if a child is throwing things or attacking you; you do have to respond and the minute you begin to respond in this way there is a likelihood of ‘acting-in’. By this I mean that the therapist gets pulled into actually being some figure in the patient’s internal world or some aspect of the patient’s self. (2004, p. 145)

Canham (ibid) stated that if a child has been abused, most likely dynamics of abuser and abused will be brought into the therapy. Canham described how for the child it can feel as if the abuse is happening again within the present relationship, and so rather than the therapy being a space for development and transformation, there is a “degeneration back to the original scenario” (2004, p. 146).

According to Music (2019), it is essential for the psychotherapist to understand both aspects of the abuser and abused, victim and perpetrator, in the child. Music (2019) described how violent behaviours, although initially defensive, can take on an addictive and compulsive quality, and children can develop a pleasurable sexual excitement in inflicting pain.

The literature highlights the importance of taking the child’s threat of violence seriously, and bearing the feelings evoked with such a threat, as being an important aspect of the therapy (Henry, 1974). This can allow for violent acting out to reduce externally and be brought into the therapy where it can be more contained.

CAPTs such as Music (2019) have stressed the challenges of treating children with callous-unemotional and psychopathic traits. Alvarez (1999, pp. 179–180) describes how to work with such presentations, the psychotherapist needs to move past their own outrage and denial, and

to see the patient where they are, finding a language that is “sufficiently bleak” and a “respect for the patient’s courage in surviving in his empty world”.

2.5.11 Identity and belonging

The literature has explored the complex identifications and identities of LAAC.

LAAC are prone to use projective identification as a means of evacuating unbearable feelings, and tend to identify with a rejecting maternal object (as discussed in relation to Henry’s (1974) paper). Briggs (2015) described how these children have typically had early experiences of what Bion (1967) named ‘a projective-identification-rejecting-object’, and so:

A sense of belonging, should it exist, is more likely to be experienced in relation to the self as rejected and subject to wilful misunderstanding than to a containing adult or system of adults. (Briggs, 2015, p. 35)

Briggs (ibid) cautioned an over-optimistic view of the conventional journey of belonging that we might expect of this population, and highlighted the desperate need these children have of holding onto their internal worlds and past as a part of their sense of going-on-being.

For these children, ‘ripped’ from the biological parents, it is difficult to leave their families behind. Hunter (2001, p. 103) has described how children removed from their biological parents hold ambivalent feelings about their removal and contradictory beliefs about this event, “they could neither live with nor live without their families”. Furthermore, Hodges (1990) has observed that some LAAC hold a fantasy of having been stolen or kidnapped from their biological parents. So, rather than being the ‘unwanted’ child, the child is wanted by both sets of parents, and taken against biological parents’ will. This confusion leaves the child in a state of limbo, tied to their biological family, and suspicious of making new meaningful relationships.

Thus, for this population, a sense of belonging in permanent placements is difficult to achieve. Sprince (2015) has explored how whilst foster and adoptive parents might want to claim an ownership over the child, as in a biological family where a parent would 'own' the child born to them, for LAAC with backgrounds of neglect and abuse, the experience of being 'owned' will be mistrusted.

The literature has stressed that to develop a sense of belonging, the child must find a 'psychic home' within the foster or adoptive parents' mind. According to Cregeen (2017), part of the task of finding a 'psychic home', is finding a home that will accommodate the child's damaged internal parental objects. Cregeen described how children who are adopted, will likely have damaged/damaging internal parental objects, and understandably find it difficult imagining themselves as coming from good parental figures. These children need their CAPT/adopted parents to be able to both contain the projected negative aspects of their internal parental objects, and to embody a more integrated creative couple for the child to internalise and identify with. Cregeen described how this work is crucial in the development of the child's identity, and belief that they came from something good.

Whilst shifts and new identifications with foster and adoptive families do develop, Youell (2012) wrote that in her experience, LAAC's identification with biological parents was stronger at the time of placement, and following a period of being dormant, would re-appear during adolescence. The fostered or adopted adolescent's developing sexuality brings about significant personality changes, and adolescents might re-identify with their birth parents as a means of rebellion against their foster/adoptive parents. According to Rustin (2006) the fostered or adopted adolescent revisiting earlier oedipal psychological tasks has a huge challenge, due to having multiple parental figures and most likely disturbing phantasies about birth parents' sexual relationship. This can either inhibit sexual exploration or lead to

concerning sexual acting-out during adolescence. Canham (2003), reflected on the challenges of working through the Oedipus complex for LAAC:

For many fostered and adopted children the primitive and persecuting figures of early phantasy life may have been a reality. This makes conceiving of parents as Sphinx-like, containing good and bad qualities, so much harder. (Canham, 2003, p. 16)

Furthermore, Bartram (2003) has highlighted how the task of mourning - central to working through oedipal conflicts, is all the more difficult for this population due to the enormous losses these children have experienced. A combination of anger and guilt about whether it was their own fault that they were removed from parents, makes the task of mourning particularly difficult.

2.5.12 Time and history

Canham's (1999) exploration of the difficulties this population have with time has been an important aspect of the literature. Canham described how children who grow up in neglectful environments, miss out on essential experiences, such as the introjection of an object that cares for their development, and experiences of regularity and structure which are essential to ordinary development. Infantile needs and desires that are not met are left unresolved, and so earlier stages of development impinge on subsequent stages. Canham (1999, p. 162) stated "I believe this piling up of unresolved anxieties and preoccupations gives rise to much confusion in terms of order and sequence and, consequently, of time itself". Traumatic experiences that continue to intrude on the present, also impact on the child's sense of time and of these experiences having been left in the past. Furthermore, sudden removals and placements mean that time takes on a quality of either being painfully slow or disconcertingly quick.

The children then often feel impotent and without any sense of their own agency; that time and life happen to them or pass them by but not that time and life are there to be occupied and lived. (Canham, 1999, p. 164)

According to Canham (ibid), psychotherapy offers the child an experience of an adult who can give them time; where together there is a possibility to separate out the different aspects of the self, the infantile and more grown up parts, as well as between self and object.

Canham's thinking is supported by Kenrick (2005) who highlighted:

For fostered and adopted children, not being understood could, almost literally, have been a matter of life and death, or of a malignant misunderstanding; but being understood too well can in itself be persecuting or can put them in touch too poignantly with early deprivations. Yet when we are able, in the immediacy of the emotionality of a therapeutic session, to begin to help children to make sense of past and present, we are helping them to develop a meaningful narrative of their lives. Then there is more chance of them developing order and structure in their lives to support them with future vicissitudes. (Kenrick, 2005, pp. 37–38)

In thinking about the significance of these children's history in the work, Fagan (2011) has described how the CAPT needs to provide space for both the historical facts as well as the child's constructed internal reality within the therapy. LAAC bring their experiences of displacement and confusion, questioning whether true reality is that of their traumatic early experiences, or new present relationships. This is communicated in the transference, and so the therapist has an opportunity to help the child make sense of where they came from and where they are now.

2.5.13 Finding ways to communicate

CAPT's have explored the complexity of finding ways to communicate with children who do not hold an expectation of an interested or receptive object.

In child psychotherapy, the therapeutic encounter follows the direction and free associations of the child, and play is regarded as an essential forum through which children can communicate their internal world and phantasy life to the therapist. Both Jackson (2004) and Calvocoressi (2008) described intensive work with adopted 4 and 5 year olds, and commented on the capacity of symbolic play to not only replay and re-work internal object relationships, but to

act as a forum where the therapeutic process of transformation allows for new experiences to be incorporated as part of the child's internal reality.

Yet, for some children, developing the capacity for symbolization is more difficult to achieve, and they remain in the realm of symbolic equations and the paranoid-schizoid position (Segal, 1986). Catty's (2019) paper described her intensive psychotherapy with an adopted boy, who found meaningful symbolic links difficult, and experienced words, both the therapist's and his own at times, as concrete attacks. Catty described the need to find a method of communication that was experienced as less persecutory, and described how by listening with a 'musical ear' (Maiello, 1995, p. 32), with a focus on listening and the establishment of a shared environment of rhythm and sound, containment and moments of communication were established between child and therapist.

Such adaptations are essential, due to the deficits and difficulties this population can present with. According to Cregeen (2012, p. 168), particularly for children with despairing or gang-like states of mind, for development to occur they require a psychotherapist that is not only a steady and good object, but an object who can tolerate uncertainty and bring a "liveliness" and "courage" into the therapeutic encounter; "a new experience in relationship to an object, one that kindles fresh possibilities for psychic growth, personality development, and the generation of meaning" (Cregeen, 2012, p. 153).

2.5.14 Summary

In summary, this section highlights the complex multi-faceted work CAPTs undertake with LAAC. Psychotherapy offers the possibilities for this population to have an experience of consistency and safety with a reliable adult, who is alert to the complex unconscious communications and acting-out in motion, and who can, over time, give the child an experience of having the different aspects of themselves understood. This requires the CAPT to be attuned

to the child's difficulties, and a flexibility in technique needed to reach the individual child. The attacks on thinking and linking by the child and wider network around the child are emphasised. The developmental trajectory of the work is highlighted, and the importance of the task of mourning, for both the adoptive parents and the LAAC is highlighted as a central therapeutic goal to work towards.

2.6 Conclusion

The literature has emphasised how LAAC are one of the most vulnerable and at-risk groups in the population, who due to early adverse experiences, are likely to experience mental health and attachment difficulties throughout their lifetime. Whilst the evidence for this is clear, research on the provision and efficacy of mental health interventions, particularly in England, is lacking.

Psychoanalytic CAPTs have developed a body of literature based on clinical work with this population. These case studies provide a rich basis for the development of psychoanalytic theory that informs clinical practice. Yet, further research is needed to continue to develop the evidence base for psychotherapy, and intensive psychotherapy in particular, especially due to the context of mental health services in England being underfunded and under profound pressures.

Finally, there is a paucity in the literature on the provision of intensive psychotherapy given to LAAC by trainee CAPTs, and whether, if at all, this service is provided by qualified CAPTs at present within CAMHS. When papers on intensive work are published, it is rare for the CAPTs to describe the case as a training case, and for the broader framework of parent work and supervision underpinning the psychotherapy to be examined. This represents a gap in the literature, and emphasises the importance of this research project, and future projects, in

exploring this intervention from the perspective of an under-represented group within the literature. Intensive psychotherapy is a rare resource and an important part of the range of treatment pathways available in some CAMHS at present, and so requires further investment from additional research to better understand and evidence its contribution.

3 Methodology

3.1 Aim

The aim of the study was to explore the experiences and perspectives of trainee CAPTs on their intensive psychotherapy work with LAAC.

The project sought to further understand:

- The trainee CAPTs' understanding of working intensively with LAAC. What generally in their experience went well and what helped; as well as what didn't work well.
- The trainee CAPTs' experience of work with the intensive case parent worker and intensive case supervisor, the professional structure put in place to support the intervention.
- How do the involved professionals, wider network, parents and carers work together, and whether any links can be drawn between this population's history and trauma and the functioning of the network of adults supporting the child.

3.2 Methodology

3.2.1 Design

This study utilised a qualitative methodology in order to investigate the experiences of trainee CAPTs through semi-structured interviews that were analysed using Reflexive Thematic Analysis (TA) (Braun & Clarke, 2006, 2020).

Reflexive TA was the chosen due to its accessibility, flexibility, and compatibility to be used within most theoretical frameworks (Terry, Hayfield, Clarke, & Braun, 2016). Reflexive TA “emphasises the importance of the researcher’s subjectivity as analytic *resource*, and their reflexive engagement with theory, data and interpretation” (Braun & Clarke, 2020, p. 3). I

considered this as important, due to my own professional background as a CAPT and the psychoanalytic focus of this paper.

I adopted an essentialist/realist approach (Braun & Clarke, 2006) and experiential orientation to analysing the interview data, with an assumption that the participant's feelings, experiences, and understanding shed light on their person perspectival reality (Terry et al., 2016, p. 19). The results in the data were also coded through a deductive, interpretative psychoanalytic lens. In order not to detract from the semantic findings, some of the broader psychoanalytic findings were shared in the discussion, where they were able to be connected to the findings of the literature review.

Although there were other potential qualitative approaches to employ in this study, such as Interpretative Phenomenological Analysis (IPA), Grounded Theory, or Narrative Analysis, each of these would have had a significant impact on the focus of the analysis, and on the consequent outcomes of the research. I originally considered using IPA, and the small sample size of my project would have arguably better suited IPA. However, IPA's in-depth idiographic approach focuses on the particular, and on how participants make sense of their experiences (Larkin & Thompson, 2012; Smith, Flowers, & Larkin, 2009). Whilst participants' experiences are at the centre of this research, the idiographic focus of IPA might have led to a project that was more focused on difference, rather than on patterns of meaning across the data-set. I wanted to prioritise finding possible patterns, believing that such patterns would generate important results answering the question of this research.

3.2.2 Setting and Procedure

The study largely took place at the Tavistock and Portman NHS Foundation Trust, where four of the interviews were conducted face-to-face in a meeting room, for approximately one hour. However, due to the COVID-19 pandemic lockdown, the final interview was conducted

through a video link on Zoom. All participants were given a Debrief Form (see Appendix F) following the interview.

The interviews were semi-structured; ensuring participants answered the same questions, whilst at the same time providing the opportunity for both participants and interviewer to be flexible and open to what arose in the interview.

The interview schedule consisted of the following questions:

1. What has your experience been of working with LAAC in intensive psychotherapy?
2. In thinking about your intensive work with LAAC, what were the problems and what went well?
3. Could you tell me about how you experienced working with the professionals involved in supporting the case?
4. What is your experience of the impact of LAAC's complex history and presentations on the work and professionals involved in the work?

All the interviews were digitally audio recorded and assigned a number to identify the data. The interview audios were transcribed verbatim and anonymised during this process. The transcription notation used was influenced by the Jefferson system of transcription notation (Jefferson, 2004) (see Appendix B).

3.2.3 Participants

During the participant recruitment process, the inclusion criteria for participants required them to be undertaking the Child and Adolescent Psychoanalytic Psychotherapy training at the Tavistock and Portman NHS Foundation Trust. Participants needed to have had at least one intensive case with a looked after or adopted child.

Participants would be excluded from the study if they identified as not having a professional network to support them, as in the unlikely event that they required a debriefing process, this

was an important requirement to have in place. This was to be identified during the consent to participate process.

Potential participants were recruited by email, where they were sent a Participant Information Sheet (see Appendix D) with all the relevant information about the study. Before the interview took place they were also sent a Consent Form to sign and return to me (see Appendix E).

Although I had planned to interview approximately 8 participants, due to the impact of the COVID-19 pandemic this was not possible to achieve. Overall, a small opportunistic sample of five trainee CAPTs were recruited. The participants were from years two, three and four of the training. There was one male participant and four female participants.

Participants brought a variety of cases, as detailed in the table below.

Participant Number	Case Number	Intensive Case Developmental Stage	LAC or Adopted
Participant 1	1	Latency	Adopted
	2	Adolescent	Adopted
Participant 2	3	Under-five	LAC
	4	Latency	Adopted
Participant 3	5	Under-five	LAC
Participant 4	6	Latency	Adopted
Participant 5	7	Latency	Adopted

Participants Table

Whilst the unique importance of each child's individual lived experience was recognised, due to limitations of the scope of this study, I deliberately decided to hold the focus of the study at the level of the participants, rather than their individual patients.

3.2.4 Data analysis

I followed the recommended steps (Braun & Clarke, 2006, 2020) for data engagement, coding and theme development; adding some of my own stages into these suggested steps:

- 1) Data familiarisation and writing familiarisation notes:

The transcribed interviews were read multiple times, and initial familiarisation notes were recorded in the body of the interview transcripts.

2) Systematic data coding:

Following this, each interview was re-read again, and codes were written in the right margin of the interview transcripts.

3) Generating initial themes from coded and collated data:

For each interview that was coded, a document was compiled that contained all the codes and relevant quotes from the transcript. These codes and quotes were then grouped into initial themes.

4) Developing and reviewing themes:

A handwritten document was then compiled for each interview that had a mind map with the initial themes and codes on it. This process helped me to further develop initial themes from each interview, and provided a helpful visual prompt for the next stage.

Initial themes and codes from the separate interviews were then gathered together and reviewed. A significant consolidation process occurred, where initial themes and codes that were recurring were brought together, and those themes deemed as relevant to the research question were kept.

5) Refining, defining and naming themes:

At this stage there were still a significant number of initial themes. Therefore, initial themes were brought together, becoming the codes for the final defining themes. The final themes were re-worked several times, to be representative of the data they encompassed.

6) Writing the report:

The report was written, bringing together the quotes gathered from step 3, with the final themes and codes selected for the results.

3.3 Ethical Considerations

The study received ethical approval from the Tavistock Research Ethics Committee (TREC) (see Appendix C) and was sponsored by the Tavistock and Portman NHS Foundation Trust. The initial TREC application was amended and approved in May 2020 to incorporate the need for interviews to be conducted over video link due to the COVID-19 pandemic.

Considerations were made with regards to participants becoming emotionally distressed in or after the interview. Participants were given a debrief form, where they were signposted for further support after the interview if required.

With regards to potential safeguarding concerns, in the Participant Information Sheet, there was a disclosure statement regarding discussing safeguarding concerns with the Research Supervisor and Head of Safeguarding in the Tavistock Centre, and in following statutory reporting guidelines.

As it is a small professional community, it is therefore possible that due to the small sample size and even with pseudonyms, that the participants might be recognisable to their colleagues in the service where they work. This was explained to participants and informed consent was sought.

4 Results

This study sought to explore the experiences and perspectives of CAPTs offering intensive psychotherapy to LAAC. The research aimed to explore the experiences of trainee CAPTs, both in terms of their clinical experience and understanding of intensive psychotherapy with LAAC, as well as their experience of the professional structure and context around the work.

Reflexive TA was employed on the transcribed interviews. Four themes were generated, which encompass 16 codes.

Themes	Codes	
‘The history’: the vicissitudes of trauma and loss	4.1.1	Early and ongoing traumatic experiences
	4.1.2	Fantasy versus reality
	4.1.3	An invitation for re-enactment
The firmness of the frame	4.2.1	Parental support and resistance
	4.2.2	Conflicts relating to short-term foster care placements
	4.2.3	The service
	4.2.4	The network
	4.2.5	Intensive case supervision
The ‘bad’: feelings of ambivalence, violence and hate	4.3.1	Ambivalence to starting; keeping the therapist at bay
	4.3.2	Violence and destruction
	4.3.3	Anger and hate
	4.3.4	Splitting processes; identification with the ‘bad’
The developmental relationship	4.4.1	Claiming a space in the therapist’s mind
	4.4.2	The painful digestion process
	4.4.3	Developmental work: tending to the psychic internal baby
	4.4.4	The limitations of the parental object/therapist

Results Table 1

4.1 ‘The history’: the vicissitudes of trauma and loss

4.1.1 Early and ongoing traumatic experiences

All participants had some knowledge of their patients’ early histories. *Results Table 2* illustrates the varied early experiences of the LAAC seen for intensive psychotherapy. Whilst

the information gathered is by no means comprehensive, *Results Table 2* aims to reflect the overlap in reported early experiences that participants' cases had in common.

Range of early experiences for LAAC seen for intensive psychotherapy		Case number
Separation from biological mother and being taken into care at birth		1, 4, 5
Drug withdrawal at birth and care in neonatal intensive care unit (NICU)		4, 5, 6
Early experience of neglect, abuse and trauma with biological family		2, 6
Exposure to maternal depression and abuse during mother-baby foster placement (assessment placement)		4, 7
Foster care	Taken into care at birth	1, 5
	Spent time in foster care	1, 2, 3, 4, 5, 6, 7
	Multiple transitions within foster care	1, 3, 5
	Good experience in foster care placement	6, 7
	Foster care placement not 'good-enough'	5
Adoption	Adopted	1, 2, 4, 5, 6, 7
	Planned adoption	1
	Late adoption	2
	Not 'good enough' adoption placement	4, 5
	Adoption placement in process of breakdown, or broken down	2, 5
Kinship care placement breakdown		3
Returned to foster care		3, 5

Results Table 2

Participants varied in how they spoke about their patients' history, from discussing it in definitive terms, to more tenuous assumptions. Broad facts about early experiences of: hospitalisation, neglect or abuse, and the removal from biological parents, appeared more straightforward to communicate. Detailed knowledge of experiences with biological parents and in foster care seemed more difficult to capture. Thus, some assumptions about early experiences were, for example, described as "rumours I've heard in the network" and "my kind of hypothesis" by Participant 3.

The results suggest that all the LAAC seen by participants had significant early experiences of separation and trauma based on the known events of their early history. All children were removed from birth parents, and spent time in foster care, before being found a permanent placement. For two of the children, although they were initially found a permanent placement, due to their respective kinship and adoptive placement break downs, they had to return to foster care.

Due to the age range of the children seen, there was a striking contrast between those children whose experiences of permanency with an adoptive family meant that the trauma and losses described in their early history were distinguished as being in the past, and those children currently in care or experiencing placement breakdown. For those participants seeing patients in short-term foster care, or whilst their adoption placement was breaking down, the continuing uncertainty about the future of their patients was a concern that participants carried:

I think the one problem I often have is the thought that he has to move again. [...] Yeah, that's a constant kind of worry in my mind. (Participant 3)

Participants 1 and 3 spoke about the shifts in how they thought about and related to their patients' history over the course of the therapy. Both described how present the history was in their minds at the start of the therapy, but how over time, this reduced. This was ascribed to developments in the patient, as well as in the therapist. Participant 1 described how it was only after the end of the case, further along her training, that she was able to recognise the intrusiveness of explicitly linking to the past for the child, and the need to take these interpretations slowly at the child's pace. She also spoke about recognising the importance of keeping a space for something new to come into the therapy that was unrelated to the past, to allow for movement and development in the therapy.

For others, holding onto the history in mind seemed to remain an alive and integral aspect of the work. Participants described how these early experiences had significantly shaped their patients' ways of relating to the therapist, and how it took a lot of time and understanding for the therapist to gather this up. For example, Participant 4 described the impact of early experience drug withdrawal in particularly vivid terms:

So this is a child who was born addicted to heroin. Um and at birth was in a sort of intensive care withdrawal unit for the first month of life. [...] I mean a very, very deprived, very traumatic start. Um and I think also a real sort of. A really violent start that actually the first thing going through his veins was not sort of milk. Warm milk, like a nourishing substance. It was a drug. It was the methadone. I mean, that's - in lots of ways, I think that the - what the therapy has kind of come to - what's come out here

seems to be the real difficulty in believing that something good and nourishing actually is that, or is it just sort of something bad that traps you, makes you very addicted? Um, it's been a big feature, something quite mocking that mocks the need for something nourishing. (Participant 4)

Participant 4 reflected how alive this early experience of her patient's was in the therapy, and how it had shaped her understanding of her patient's difficulties in relating and introjecting something helpful from the therapy. Participant 4 spoke about how understanding this and translating something of this experience back to the patient within the transference, helped the patient to feel understood and less persecuted by the therapist.

4.1.2 Fantasy and reality

Participants spoke to the discord for some families between the fantasy of what it would be like to adopt a child, and the changes they would be able to make to the child, and the subsequent contrast of adopting a child with such a disturbed and traumatised start to life. Participants described how these fantasies made it difficult for some parents to accept the reality of the situation and see their child with all their complexities.

I think there was as a. You know, it's an understandable fantasy, I think to try and rescue a boy who was in dire straits. And I think that. Probably was you know a good fantasy in her, but it it made it very difficult to see the boy that was actually there. (Participant 2)

Participants 2 and 3 who were seeing children currently in care, described how as the level of involvement of professionals in the children's lives was greater, a 'rescue fantasy' also seemed to permeate and impact some of the professionals' behaviour and actions.

I think that she projects, you know, the the neediness that she projects that people want to jump in and rescue her really quickly. And they also, I think, want to be seen as the one that jumped in and rescued her. (Participant 2)

Participant 2 described how professionals felt a strong wish to repair and make amends for the lack and loss in the child's life. In one case, boundaries between adults in their different roles became blurred and competitive.

Her school teacher has acted in, in, just I mean inappropriate ways, buying her bicycles and giving her private bicycle lessons within the within the school. (...) Setting herself up in direct competition with the special guardian mother. [...] This girl particularly really triggers the kind of rainbow unicorn world of magic reparation and we can fix this. (Participant 2)

In juxtaposition with fantasies of rescue and reparation, other participants also spoke about some of the adoptive parents' profound disappointment at the realities of life with an adopted child.

I think there was also a lot of despair, a huge amount of despair. I think that mum was, um. Mum really holds herself to quite high standards and was holding him to very exacting standards as well. (Participant 4)

Professionals too seemed to also hold feelings of disappointment and despair. Participant 3 described how professionals and the wider system seemed to have given up on her patient's capacities for adoption, and held a bleak and passive outlook for his future:

And it's so sad that he's 3 1/2 and they've already decided he can't be adopted. I should say, actually, he's mixed race and that was one of the reasons they said, because of the colour of his skin and the fact he's not talking. They they don't think. He's less likely to get adopted. (Participant 3)

Participant 3 drew attention to how it was not only difficulties linked to the child's early experiences, but systemic problems in the adoption system where age, as well as a child's mixed-race heritage, impacted on his future prospects of adoption and an experience of permanency with a family.

Nevertheless, beyond these two polarised positions, other participants also drew attention to aspects of parental love and faith, as key aspects of how idealised fantasies and disappointments could be mitigated and worked through, signalling a more hopeful trajectory for some of the children and their families. Participants recognised the capacity of carers and adoptive parents

to have a substantial impact on their child's internal world, and how crucial this mutual emotional and relational work was for both the child and the family's development and relationships.

You know that he's a child who is loved and who feels loved. Um? And he's got a kindness in him. Real kindness that I I see from the parents. You know, kind of a some kind of reflection from them. Really hard and really strong love like hard work and strong love with them that they've made that he is a child who is easy to love.
(Participant 5)

4.1.3 An invitation for re-enactment

Participants 1 and 4 spoke of an unconscious invitation to, or actual re-enactment of, relational dynamics from both past and present, within the families and professional networks involved.

Participant 4 drew attention to the experience of being an object of projective identification, whereby the patient's projections evoked strong and difficult rejecting feelings in the therapist, which increasingly became difficult to ignore:

On some level this kid must sense my heavy heartedness and dread every time I walked into the waiting room to pick him up. And my relief at handing him back to his mum. And even though I thought that - even though I was not aware of it for a while. But there was something being played out in which I was so sort of almost being invited to be a really, rejecting maternal figure. [...] Who couldn't feel excitement of seeing her sort of child. Or you know, the love that I wanted to feel, or the closeness or the hopefulness or all of those things that I wanted very much wanted to feel like it was all being soured. You know something was really sort of poisoning that that wish in me. (Participant 4)

This experience illustrates the potency of a patient's projections of their internal objects, and how the recipient of these powerful projections can act out something of the patient's (not only phantasy life, but) history, and how this early relational experience can be repeated in the present. For Participant 4, the opportunity to bring her feelings to supervision, and to have the space to understand the meaning of her experience, meant that she was able to gather up something helpful for the child, and for a therapeutic alliance on both sides to be built through this.

Yet, in other situations where those caring for/working with the child/family are less able to tolerate and contain such projections, and to think about their own difficulties at the same time, substantial difficulties can arise. This was particularly acute in Participant 1's description of working with her adolescent intensive case and his family. Participant 1 described how for this patient, who had been in his adoptive placement for a substantial number of years, multiple breakdowns in the family occurred; between parents' relationship with their child, as well as within the parental relationship itself.

These parents essentially wanted to give him back to the state. They no longer wanted him. (Participant 1)

Participant 1 highlighted her understanding that this breakdown in the family was due to a combination of her patient's early trauma, as well as difficulties belonging to adoptive parents themselves.

Parents were also very unwilling to think about, the re-enactment of something that had happened before. [...] They were very on board with the idea that everything happening now in relation to things not going right were to do with his history, and they were very reluctant to think about there being anything that had happened within their family context that might have contributed to the ways that he had not been able to manage. That wasn't something that had ever really been got to, could ever be touched with them. (Participant 1)

For Participant 1's patient, his therapy became the place where he was able to bring the re-enactment of his early experiences within his present day context, and his regression towards early defences that defended him from contact with his pain and need.

I think he brought all that was happening at home, umm and just how furious he was at home, about feeling (...) I mean what seemed to be recreated in the home was an extreme instance of neglect. [...] He was holing himself up in his room, under a duvet with food and binging. And actually in sessions he would [...] bring his phone in as well and plug his phone in, and sort of be watching his phone and binging. (.) And it was just so powerful, in the room where, you know it was a kind of (.) it felt so aggressive in some ways. (Participant 1)

Furthermore, in Participant 1's account, the breakdown in relational difficulties in the family, was replicated by the extremely difficult relationship between the parents and the parent

worker, to the extent that a second parent worker had to join the case. Rather than being able to work together, relations between Participant 1 and the parent worker also deteriorated.

My relationship with the parent worker really did break down towards the end.
(Participant 1)

This breakdown in contact followed a previously good working relationship and was understood by Participant 1 as linked to the complexity and difficulties encountered in the case.

4.2 The firmness of the frame

The supporting framework around the intensive psychotherapy intervention was considered by participants. Participants reported mixed experiences about how well cases were managed within the clinic and by the wider frame of parents/carers and the network, and spoke about how important this was in supporting the development of their patients.

The kind of firmness of the frame has been a really, I think key component, to things being – for the work to happen. (Participant 1)

4.2.1 Parental support and resistance

Participants described differing attitudes held by adoptive parents and foster carers in relation to the intensive psychotherapy.

For some it seemed possible from the outset to support and recognise the importance of the intervention. Participant 3 described the “teamwork” in her relationship with the short-term foster carers of her patient, and understood this in the context of having started working with them in the role of a therapeutic observer, as well as the experience of inclusion that the foster carers had experienced throughout the work.

For others who might have initially been resistant, through an initial once-weekly intervention, a better working relationship was developed between parents and therapist. This was

understood by Participant 4 as coming from the adoptive mother's greater capacity and need to share her disappointments and difficulties of caring for her child, so that she and the therapist could "share the load" and "feel less alone with the despair [...] that he wasn't how she wanted him to be".

Participants also spoke of concerns held by professionals about parental capacity to commit to the intervention, both in terms of their willingness to support an intensive intervention for their child, as well as their own capacity to undertake a separate piece of work in the parent work sessions.

I mean his parents weren't really seen, and I felt as though, I mean they were seen, monthly, or once every six weeks. But I think that their idea of the work was that he would just be kind of be put into the system, into CAMHS, and fixed as it were. That they wouldn't have any work to do. (Participant 1)

4.2.2 Conflicts relating to short-term foster care placements

At the time of interview both Participants 2 and 3 were seeing children in short-term foster care placements and seemed to hold different attitudes to seeing a child in short-term foster care for intensive psychotherapy.

Participant 2 explained that his patient was already in intensive psychotherapy when her kinship care placement broke down, and the psychotherapy continued as a source of support for her. The complexity of her situation required the case co-ordinator to "balance a whole lot of plates", and when asked about whether such an intervention would have been offered if the child was in a short-term foster care placement from the outset, Participant 2 was hesitant and said it would have needed "very careful consideration". The potential for this child to be moved to a distant location was stated as a source of concern for the team.

In contrast to this, although Participant 3's patient was having a therapeutic observation when his adoptive placement broke down and the observation was continued to support him, once in a stable short-term foster care placement, Participant 3 moved to seeing him intensively:

Yeah, so it was my idea! I just realized that I think he could really benefit, 'cause I knew these foster carers were really supportive. [...] I just thought he could really benefit from having some intense one-to-one time I suppose. (Participant 3)

Although Participant 3 later spoke about her ongoing concerns about the child having an abrupt move at any moment, a potential conflict between the intensive psychotherapy and the child's precarious living situation was not drawn.

4.2.3 The service

Participants reflected on the capacities and limitations of their services to support the intensive work.

Some participants spoke very positively about how cases were held within the clinic by the parent workers involved, and the important therapeutic work undertaken in the parent work.

So this parent worker has known the parents, worked with the parents for many years now. And my impression, when I have reviews with them, is that they have a very good relationship with the parent worker. (Participant 1)

Participants also spoke about their good experiences with parent workers who supported both the case, as well as the trainee's professional development in their clinical work.

She's really good at, sort of like giving me a reminder about, you know, maybe something I might need to do [...] but she does it in such a way that's just really helpful. She's very respectful. Very experienced. [...] The parent work and his therapy are really linked up. (Participant 5)

However, this cohesiveness and supportive attitude was not reflective of all services, or even of two cases within the same service. There were distinct differences in services' attitudes towards parent work and its availability in different services.

For Participant 2, their patient's parent work was held in a different organisation, and there was limited collaboration between the two services. This led to split and fragmented work.

I think it was a matter of expedience. I think it was felt that OK, well, they're getting some parent work and they're already in that relationship, so we wouldn't want to disrupt that. So let's keep them over there. And I think there was a fantasy that somehow this would all hold together rather well. (Participant 2)

Furthermore, Participants 3 and 2 described contrasting approaches towards working with short-term foster carers. Whereas Participant 3 described regular and helpful parent work offered to the short-term foster carers of her patient, for Participant 2:

The clinic is treating this child at the moment as if she has no parents. So these foster carers who she has been with now for four months get almost nothing from our clinic, except what the care coordinator can offer. (Participant 2)

In other cases, it appeared that the parent work reduced in frequency or consistency during the intensive work. When participants spoke to this, it wasn't clear whether this was due to the parent worker, the parents, or a combination of the two. Nevertheless, it was seen to have a negative impact on how parents were managing and on the therapeutic work.

Participant 4 drew particular attention to what she understood to be a parental experience of deprivation and neglect that can be activated, either through difference in what the parent and child receives, or in the experience of their parent work intervention reducing in frequency or regularity.

Participants tried to be "diplomatic" (Participant 4) in the interview when describing their relationship with colleagues, and the complex politics within the teams they worked in. These tensions between professionals in the teams, impacted both on how the children came to be referred for intensive psychotherapy, as well as on the cohesiveness of the treatment itself.

Participants described their own strained or distanced professional working relationships with the parent workers, of having to 'chase' the parent worker to have some contact, and there

being not enough time. For Participant 1, these difficulties were understood as a re-enactment of the difficulties between the parent worker and the parents.

It was really difficult. [...] And I wonder if something happened between two of us that was similar to her relationship with the parents or something, because she, I think initially had been kind of, chasing or wanting them to come and they weren't coming, and then I was sort of chasing her around the clinic. [...] So I felt completely, umm. (.) On my own with it at the time. [...] I think I felt very angry with her. I think I felt really frustrated and let down. (Participant 1)

In contrast with the difficult distance between professionals described in Participant 1's account, Participant 3 described how at times both therapist and parent worker might have taken up protective roles, not speaking openly to the pain evoked in the case, so as not to overwhelm the other.

4.2.4 The network

Participants mentioned linking up with nursery and school as an aspect of their work, however it seemed that this role was typically held by the parent worker.

Participants 2 and 3 spoke in depth about their work with social workers and held differing attitudes towards working with the wider network.

For Participant 2, going to a Team Around the Child Meeting was an example of being “pulled out of position”, due to the absence of a parent worker in their service to liaise with professionals in the network on a regular basis; whereas for Participant 3, working with the network seemed like a vital aspect of the role. This difference was perhaps due to the level of additional work that was required of Participant 2, in comparison to what the parent worker of Participant 3's case was able to hold for the case.

Participant 2 was clearer about the difficulties of working with the network, where feelings of superiority and rivalry might inhibit collaborative thinking:

How difficult it is to get the network involved, how difficult it is to convey what we do in the work to a network in a way that helps them understand, doesn't feel superior or you know, arouse in us a sense of rivals as if we're the only ones that see this child. (Participant 2)

For Participant 3 this was less straightforward, and she initially described an extremely positive relationship with the network.

I wouldn't say there have been any problems actually [...] The network has been incredible. (Participant 3)

However, as Participant 3's interview developed, she spoke about how she was "shocked at how removed the social worker was".

Then she ((social worker)) had made this flippant comment about, you know, when he could just get moved to Leeds and I just was, you know? I suppose he could. That is a reality, but. Like it's like I have, I don't know. I don't think about it. I try not to think about it, 'cause I don't think it's helpful. Sometimes 'cause I worry sometimes I'm taking it to the room and he's not if you see what I mean. (Participant 3)

Participant 3 brought her shock and despair in relation to the possibility of a sudden move for her patient. This sense of removal from the realities of the child's situation was also experienced in relation to the wider network, who Participant 3 felt were pushing his capacities for adaptation and development beyond reasonable expectations:

Which seems crazy I think. Um? But there's still quite a lot of talking about him, as if he's like a normal three-and-a-half-year-old who'll just start school. Um, although they have applied for a kind of special school. (Participant 3)

Participant 3's protectiveness over her patient and wish for him to have more time to catch up and develop, spoke to the discord between what might have been the task of the therapy, and the task of the other professionals in the network.

This idea of being "removed" from the painful realities of not only the present situation, but also the emotional and traumatic content of the child's past, was also spoken to by Participant 2.

I think lots of people in networks are happy to understand the concrete facts of the history if you like, but not necessarily at all happy to engage with the emotional significance and impact of it. (Participant 2)

Participant 2 described how his patient's powerful and defensive projections, impacted on the professionals' capacity to be in contact with both the child's experiences, and a functioning and collaborative capacity within themselves in relation to others.

That the projections. Are a way of avoiding the absolute, well in this case, maybe the terror and the horror of the situation. But in the case of my under-five, uh, the pain and sort of unbearable misery of the situation. [...] The networks often do not come together. The, you know, there is something getting in the way. ((Laughs)) (Participant 2)

4.2.5 Intensive case supervision

Intensive case supervision was perceived as a central aspect of supportive frame around the intensive work. Participants largely expressed very positive and warm feelings towards their intensive case supervisors:

I love my supervision. I have a really great supervisor. (Participant 5)

If I hadn't got that supervisor, I think. Uh. You know one for her clinical understanding of the of the material, but two for her strength, and she's an extraordinarily strong supervisor, and. Yeah. You feel very well contained by her in supervision. (Participant 2)

The supervisor's experience and understanding was highlighted by all participants as a central component that had helped them develop their understanding of the case. Participants spoke about their supervision being a place where thinking could happen, as often due to the overwhelming and disturbing content of the sessions, it felt too difficult to think in the room with the child.

I felt that she had the most, understand, the clearest and most vivid understanding of the case with me through each session she heard, [...] I found it so difficult to think in the room, because I was so overpowered by how much I was being projected into I think. Umm. So I found in supervision, that was really the time that I could think about what was happening. (Participant 1)

Understanding gathered in supervision was held onto by participants and kept in mind. For Participant 5, the supervisor's voice in her mind helped her feel contained within the session.

I kind of had her voice in my head then, sitting down in the chair be like “no I continue to think” and I show him I am still thinking about him. (Participant 5)

Two participants also voiced feeling “skeptical” (Participant 2) about their supervisor’s suggested approach.

It has not been easy. Actually, I would say that when I was dreading the sessions, I think what I was also dreading was that the intensive case supervisor was really really pushing me to take different - to work in a different way that felt very unfamiliar. (Participant 4)

Yet for both participants, there was a feeling that their supervisor was often “totally right” (Participant 2). It seemed as if in both supervisions, there was an experience of being taught something new, that challenged the participant’s way of thinking and working. It was significant that both participants went into great detail about their supervision experiences in the interview, and the particular approaches adopted for working with traumatized LAAC. Participant 4 explained how the particular focus of her supervision was on the environment the therapist was creating for the child within the therapy:

The focus of the supervision was very much on the environment that I was creating in each session, and what sort of impingements that environment was creating and was causing him, and how could I think in a different way about the kind of environment that I was providing for him. (Participant 4)

As Participant 4 had been seeing her patient for once-weekly psychotherapy before moving to intensive work, starting supervision meant that Participant 4 was made aware of technical errors in how she had been working, and the supervision refocused her work towards a “developmental perspective”:

I now look back and see it was causing a sort of potentially re- at worst, a re-traumatizing and at best a sort of unhelpful um, refocusing on negative patterns that were so deeply entrenched. That actually what’s been really helpful is to see, my move into something much further away from interpreting his kind of negative feelings, his badness, and his destructiveness, uh, and towards amplifying any moments of trust or good contacts, or perceived feelings of safety in the room. Have actually uh, enabled that to take root and blossom and take up a much more, um, a much more friendly approach. (Participant 4)

Similarly, for Participant 2, an important component of the supervision was finding the correct level of analytic work through which to reach a child, whose early experiences had rendered emotional contact with others and himself unbearable. In the face of the child's destructive communications, Participant 2's description of the work pointed to the therapist and supervisor's need to hold a belief in the possibility and potential for development, in the face of the child's "avowed intent to destroy the whole world".

Participants highlighted how the supervision not only focused on the patient's experiences, but also at times the complex dynamics within the CAMHS teams themselves, and the impact this was having on both the work and the clinician.

I would point to her capacity to not only deal extremely effectively with the clinical material, but also to take up some of my experiences of being within the clinic and her capacity to take that on board as well to take that up as well. I mean, that's a rare experience, I think, and I'm not sure if it's a rare experience in supervision, but I think it's a, it's a, I don't know umm such a valuable quality. (Participant 2)

The supervisory relationship was also shown by participants to be vulnerable to splits, where the therapist and supervisor held a way of thinking that conflicted with the thinking in the clinic. For Participant 1, this split also impacted on the quality of the relationship between supervisor and supervisee.

Participants reported that the supervisor and parent worker typically had little to no direct contact between one another. Whilst participants stated that supervisors encouraged them to maintain regular contact with the parent worker, the splits in thinking could leave the participants feeling as if they were in an "infantilizing position", the "messenger boy" (Participant 2) who had to run between the two parental figures, the supervisor and parent worker. This left them feeling "trapped between the two places" (Participant 1). Nevertheless, for other participants whose relationship with the parent worker was more collaborative, there seemed to be an expressed interest by the parent worker in the supervisor's thinking, and that this curiosity was an important bridge between the two relationships.

4.3 Ambivalence, violence, and hate

4.3.1 Ambivalence to starting; keeping the therapist at bay

Participants described feelings of ambivalence at the beginning of the intensive work, from both the therapist's and child's perspectives.

Ambivalence was framed differently by the participants due to their varied experiences in how they started the intensive work. Participants 1 and 5 reflected on the anxiety of taking on an intensive case at the beginning of the training.

I remember the whole experience of feeling very pushed. (Participant 1)

For Participant 2, the lack of collaborative thinking between clinicians in the clinic, meant that he and his supervisor were not consulted before intensive work was offered to the family:

It didn't really get taken up in our team or thought about by the supervisor, before it got offered to the family. (Participant 2)

For Participant 4, the child's violence and aggression left her feeling ambivalent about starting the work:

I think in my mind I (...) wasn't enthusiastic about spending more time, uh, I found the sessions very taxing, very physically. Um, draining and sometimes quite frightening. (Participant 4)

All participants, apart from Participant 3, spoke about the ambivalence the children held to starting intensive work, and the defences employed to keep the therapist at bay.

Participants described how for those children who had not had psychotherapy beforehand, there were strong feelings of ambivalence towards forming a relationship with the therapist.

He would sit in the reception and I would walk out to get him and he would just look at me and he would just say "no". [...] So. Through the supervision really, we developed a number of strategies in order to get him to come in the room, and that took I think that took about 3 or 4 months, to even get him to come into the room. And even from the point of coming into the room, then the acting out really began. (Participant 2)

Participant 2's description of the struggle to begin work with his patient was particularly vivid and reflected the child's experience of the therapist as an adversary and the consequent battle Participant 2 had to undertake to build a therapeutic alliance with him.

He was and still is to an extent a boy who idealises power and who idealises control, so I think. In his mind I was an adversary. And I was somebody who threatened his. What I could call omnipotent narcissism. I was perceived as some. Sort of threat. But only a threat insofar as he felt perfectly able to utterly dismiss me. [...] My supervisor used to talk about, what did she call it? The values of the battlefield and that you need to, as a as a, when you are therapist seeing a child who has this particular kind of mentality, you have to develop a certain, uh ((laughs)) a certain respect and understanding of the values of the battlefield. (Participant 2)

For children who had been in once-weekly therapy with a previous therapist, there was an experience of loss at the start of the intensive work.

He really quickly took to the therapy, you could tell that he'd been in therapy for a while and he talked about a week straight away. And seemed like he was really, you know, up for this ready for this, but actually, he was very, um. And I didn't realize that he was very anxious about it, and I'm still very attached to his other therapist. Um. Which. Which I think he really tried to hide. (Participant 5)

An experience of loss also powerfully featured in the move from once-weekly to intensive work with the same therapist.

When it started, the intensive work, I felt that we went back to Ground Zero literally and had to begin a whole new contract, a whole new getting to know each other three times weekly. (Participant 4)

Participant 4 reflected on the relative lack of preparation and planning the move had, a potential reason for why the move felt so destructive to the child.

Participants also noted how for children who had moved from once-weekly to intensive work, there was less of a possibility to remain superficial and to avoid contact when being seen three-times a week. They reflected on how frightening and explosive this could feel for the children.

I think it exposed him to much more, in a way, because I think that what he was keeping me very far away from any feelings of dependence or vulnerability. And I think that when we got into the intensive work, I think it became much harder to keep that - keep me away. Um? So I think. Eh? There was quite an escalation in the kind of violence in

the beginning of the three times a week work because I think he felt quite under threat, quite exposed and quite uncertain about it. (Participant 4)

Only one participant reported having a patient who was largely silent. For Participant 1, although she felt that she had a strong countertransference experience, it was difficult to make links and build an understanding of her patient's communications.

I felt maybe at times, especially because he was so silent that I may have been looking for communications about his history. As opposed to allowing something to come more organically in the session. (Participant 1)

For Participant 1's patient, alongside a communication of deprivation, the silence appeared to be an attack on the possibility of contact and thinking. Participant 1 felt that she had made a "big mistake" in how she had responded to the patient's silence, and the potential consequences it had on the development of the case. Yet, her account shows how difficult it is to be able to think, and make links, with a patient who projects their experience of not being understood so powerfully.

4.3.2 Violence and destruction

Three out of the 7 patients discussed in the study exhibited violent and destructive behaviours within the therapy. The children were described as having "attacked the room quite intensely" (Participant 2). The scale of destruction within the therapy session was vividly portrayed by Participant 5:

And he's very destructive, so he's very violent. He has broken his box. He's broken, he's broken his box twice, so he doesn't have a box. He had a bag, cloth bag that I got from him and he ripped it. He cut it apart. He doesn't have a pillow 'cause he cut the outside of that. And he wore the stuffing. He turned it into a kind of armour. And then he ate some of that and spat it out. Until until it had to go in the bin because it was just bits of bits of the pillow stuck in the carpet, in everything. (Participant 5)

Whilst Participant 2's patient was never violent towards him, for Participants 4 and 5, this behaviour was also directed towards them.

He has tried to hurt me. He had hurt me once he left a bump on my head when he threw. What did he throw? He threw - I think it was even like it was a plastic soft softish plastic fence, plastic one that he threw and the way it hit me left a mark and a bump, and it really shocked me as well. I was furious with him. (Participant 5)

Participants reflected on the impact these behaviours had on their capacity to think in the moment with their patients.

I often used to feel that it was incredibly hard to make sense of what it was that would provoke these quite violent reactions in this patient. It was very hard to think in the sessions. (Participant 4)

Participant 5 described how her patient's states of mind "overpowers me", which left her feeling "helpless" and "paralysed":

I'm usually sitting there thinking. How do I do? What do I say? This isn't right? This is gotta, you know this is gonna get worse. But feeling a bit scared as well. Because he sort of switches off and he doesn't. He kind of. He goes off somewhere else and it's quite. It's something else to see someone kind of switched off. It's very disturbing and it can be really scary. [...] Of course it's easier now 'cause I know him better, when I'm more confident with him. (Participant 5)

In this description, Participant 5 highlighted what it feels like for a therapist when their patient is overcome by violent or sadistic feelings, and contact with a benign, or object-seeking part of them disappears.

Significantly, participants referred to a decrease in violent and aggressive behaviours as the therapy progressed. They reflected on how the establishment of a longstanding relationship where one's knowledge of the child develops, allows for a greater confidence and capacity to reach the child in these moments.

Participant 5 was the only participant to reflect on concerns of how to manage both her and her patient's safety in the therapy room. For Participant 5, the need to use a physical intervention to restrain the child, elicited concerns about health and safety.

I I don't want to have to hold this child's body still to keep him safe. But if I have to, I will, but I haven't been taught this. (Participant 5)

Participant 5 felt that there was a lack of thinking in her training about how to manage such behaviours. More generally, Participant 5 felt that there was a “culture of martyrdom” in the NHS. She described how this attitude in psychotherapy with LAAC had a serious and negative impact on the work, and on the children’s perceptions of themselves and the damage that they are able to cause.

I think that there is a really, um, perverse culture in mental health. Um, I think especially working with children, where, where, where the staff feel like. That it's normal for these children to hurt them in some ways. I think is part to do with the guilt about these children's awful backgrounds and not sort of having a proper understanding of how, how, how damaging it is for a child to be allowed to inflict pain on someone else. (Participant 5)

4.3.3 Anger and hate

Participants spoke with different levels of candidness and detail about their ambivalent personal feelings towards their patients, the most openly being Participants 4 and 5 who spoke about their feelings of anger, hate and dread towards their patients. This seemed significant, and potentially because of their patients’ intense acting out, it felt more permissible for Participants 4 and 5 to acknowledge their feelings to themselves, in supervision, and in the interview.

It's OK to be honest with yourself and say that you know, you can really hate your patients sometimes for what they put you through, and that maybe you know, maybe we just really dread seeing some of them. And they make us feel really, really bad about ourselves and bad about the work that we're trying to do. (Participant 4)

Participant 4 articulated how the task of taking ownership of her feelings within the therapy was a crucial aspect of the work, and how this was able to happen through her intensive case supervision.

We started off thinking about am I allowed to feel hate for this child who has gone through so much hell? Am I allowed to have those feelings? [...] And when we started to think about what - about how my dread is a sort of - receiving some really very primitive state of dread from from my patient. I think what then became really interesting was to focus our thinking on what part of him was it that I dreaded to

encounter and from that conversation a more creative avenue of thinking about parts of him sort of opened in my mind and there was a really quite sort of quite big turnaround in terms of where the work went. (Participant 4)

Participant 4 spoke to the dual task in supervision of understanding of the therapist's experience as an individual on the receiving end of a child's violent and destructive acting out, and also feelings understood to arise within the countertransference. In the therapy, from feelings of hate and dread, interest and creativity developed, which had a transformative impact on the work and the therapeutic alliance on both sides.

4.3.4 Splitting processes; identification with the 'bad'

Participants reflected on their patients' perceptions of themselves as being bad or having something bad inside of them.

I think when things feel like we get into something that feels about black and white, either very bad or very good. And I wonder if the very bad, kind of links to an idea that there was something that was very bad in his very early situation. Either he was such a very bad baby that his mother couldn't stay with him or that he was - that they were so very very bad that he couldn't be safe with him. (Participant 4)

Participants spoke to the 'bad' that the children carried within themselves, in terms of their early experiences, and how this shaped their conscious and unconscious perceptions of themselves. Especially for those children who were destructive and violent, these difficulties seemed to confirm an idea that they had about themselves that they were bad.

Participant 2 stressed the importance for his patient to:

... have a sense that he's being taken up for all of what he is. You know, for all of his complexity, in all the parts of him, because you know it's a. It is a pretty severe form of emotional abuse. You know, not to be seen whole. And I I, I think, I suspect anyway, that that's some part of his experience, even in adoption. Even with very good parents. Um. But you know, if they're so good. And he feels that they're these parts of him that are so bad. They can't be seen. There can't be taken up. (Participant 2)

Participants stressed the importance of integration: a process where the children could develop a whole picture of themselves, where concrete thinking of being either 'bad' and 'good', could

be developed into a more truthful and complex reality of the child's difficulties and strengths. Participant 2 stressed how being seen whole, also relies on a parental capacity to accept of the complex and nuanced reality of their child – with the 'bad' parts of the self representing an essential aspect of the child too.

4.4 The developmental relationship

4.4.1 Claiming a space in the therapist's mind

Participants reflected on the intense relationship cultivated with their patients, and the consequent need they encountered in requiring their own support to manage this.

Two of the participants described the patient as inhabiting a "space" within the therapist.

The amount of space inside me that the intensive work has demanded, has been very big. I have had dreams about this patient. I had dreams about my meeting this patient outside of work to do things together with the weekend, which I feel speaks to how hard it has been to manage um the amount of space that this patient has taken up inside me.
(Participant 4)

As Participant 4 illustrated, the intensity of the therapeutic relationship at times felt overwhelming – experienced as encroaching on her psychic life beyond the bounds of the sessions.

This space was for some participants dominated by concrete worries about their patients. These worries ranged from concerns about placement moves, to a patient's concerning states of mind and potential future risk to others.

He takes up a huge amount of space as a as a patient. And he's a concern, and he worries me. Actually for the future, because occasionally you hear something that he says that is so dark and you just. You you worry. (Participant 2)

Participants described this experience as being "emotionally draining" (Participant 5).

Participants explained how the magnitude of their patients' communications meant that they needed help from other professionals involved in the case to contain and share the feelings that arose from the case.

I've got a lot of experienced people with me that um, that I think that they're, um. That they're very in touch with the pain, so when I am in pain about it. (Participant 5)

Participant 5 drew particular attention to the intensive case supervisor's role in supporting her and sharing the pain that she was in contact with.

She's got space. And she's not in CAMHS, which is very stressed and stretched and I think that the – the – the people that work in in CAMHS probably don't. (Participant 5)

However, this was not the case for all participants. For Participant 1, the breakdown in relationships between the professionals involved in her case, meant that she felt left alone to manage the therapy breaking down and the feelings following this.

It's such a powerful experience. And, the end was so painful, I mean the case just completely broke down. I think it took me a long time to process it and I haven't spoken about it so much since. (Participant 1)

Participant 3 advocated for the importance of clinicians sharing their feelings, so as to feel less alone and better supported by their colleagues and peers.

Sometimes if you don't talk about it you can end up feeling like you're the only one who feels this much pain with a patient and I don't think that's true, at all. [...] So I think it's important to share it. (Participant 3)

4.4.2 The painful digestion process

Participants described the emotional quality of the work, and the powerful communications that they received from their patients.

I find it really intense and really sad. But I also really enjoy it 'cause I find it really. I just really enjoy that kind of work. I don't know why, but yeah, I find it really difficult. It's a really difficult experience. (Participant 3)

Participant 3's repeated "really" seemed to reinforce the difficulty and sadness involved in the work.

And often you're put through quite a lot of trauma in the room. (Participant 3)

Participants conveyed how the therapist had to experience the child's trauma for themselves, so as to be able to understand how lived experiences of trauma had been internalised, and how they had shaped the child's internal world and objects.

I felt that it took me sort of a year and a half of feeling his pain to actually really digest it and the experience of a very mocking something or somebody, who really laughs at his pain. (Participant 4)

The word "digest" was used by two of the participants to convey their understanding of the task of the therapist to digest and metabolise the patient's communications.

I think the more I spend time with him the more I'm learning is, I think one of the fundamental jobs I have is just to digest the emotional experience. (Participant 3)

For Participant 3, this process of containment was one where words were not always needed, and where her receptivity to her patient's emotional state, helped him to feel able to move into a more integrated and held state of mind.

We had this really moving moment last Thursday where he just kind of was crying a little bit. But kind of low level crying if you like. Umm and it was really unclear why. [...] I had no idea what to do. So I just started playing, he's got a jack in the box and it plays pop goes the weasel. Um so I just made that sing as it were and sang along. And he just kind of sat there slumped against the wall, and I was really moved by it and I almost started crying but I didn't. And then he managed to settle down, it was like, because I had really processed it, he then managed to come back to the room and he started playing with cars, not cars, trains, he was putting some trains together or something, and then he played peekaboo. (Participant 3)

Other participants focused on the use of interpretations as a means through which to hold and respond to their patient's communications. They described how when they had gathered up an understanding of their patient's phantasies both within the session and through supervision, they were able to make interpretations to convey that understanding back to their patient.

So the phantasy is that I go away, I abandon her. I go and look after my babies, and they get really well looked after and I'm really careful. And I almost rub her face in it seeing her just three times each week. Eh and that's how it feels so we have to give careful interpretations that parenthesize, "that's how you feel" et cetera et cetera. And they've worked surprisingly well ((laughs)) but it's bloody painful. (Participant 2)

4.4.3 Developmental work: tending to the psychic internal baby

Participants conveyed their psychoanalytic understanding of their patients' internal worlds, and specifically about the internal baby object that their patients had communicated to them through the material in the sessions.

It was also a lot at the preverbal level. I felt there was something about the communication that felt as though he was a kind of baby, an infant in the room.
(Participant 1)

Whilst the difference in ages of the patients seen meant that they were at different developmental levels, it was significant that much of the work seemed to be focused on early psychic states and emphasised a developmental trajectory to the focus of the work.

Participants described internal states of fragmentation for their patients, that had a profound impact on their sense of self as well as how they managed their emotional and social life.

A child who did not really have a very evolved sense of um, of a sort of sense of self. Or any sort of. Any umm? Any sort of internal capacities to manage any feelings. He was very very easily overwhelmed very quickly. (Participant 4)

Participants described the potency of their patients' communications of these primitive and early states of mind. For Participant 3 whose under-five patient was non-verbal, this was particularly acute.

He's so non-verbal, I talked a bit about this with my intensive case supervisor, we kind of (inhale). You're so unaware, I mean, you're so – (...) in any situation – all these projections. It's kind of – it gets right into you straight away. A bit like in an infant observation. Umm. And you come away and you're like "what was that feeling?". So it's pretty kind of - very powerful but you're not quite sure why until, well sometimes I don't even know why. (Participant 3)

Participant 3's description of her patient's projections reflected how through projective identification, the patient's own fragmentation and difficulties in forming links had an impact on the therapist's states of mind too.

When describing their patients' states of mind and internal worlds, participants brought together their understanding of their patients' early experiences, with live material in the transference.

Before lockdown, he was working through a very infantile sort of state. He was doing a lot of like paranoid schizoid things of going bad, hate, love. Um, and you know, like breaking apart the foods and food breaking apart shoving it in his mouth and like tasty food. Nasty food. And getting me to sort of hear the muffled words and try to decipher them. And. Um? You know, it's like he was shown me the good and the bad bits about coming to therapy and what's inside of him. And actually how he loves me. Um. But then also really, really sees me as someone who brings him bad things too, like his mother did. So really got, I think working through you know his early experiences with me. (Participant 5)

Kleinian psychoanalytic concepts of the paranoid schizoid position, and primitive states of mind relating to the good and bad breast/object appeared to be intrinsic to Participant 5's understanding of her patient's communications.

The role of the therapist to "decipher" (Participant 5) the patient's communications, was spoken about by all participants, and was linked by Participant 2 to missed early experiences of maternal caregiving. Participant 2 saw the intensive psychotherapy as a way in which the child could have a reparative developmental experience of being seen 'whole' by the therapist-as-early-parental-object in the transference.

These are children who need a particular particularly close attention. They need somebody to see them and to see the whole kind of picture with all the parts to it. (Participant 2)

The difficulty of this task was shared by participants, especially when aggressive and destructive impulses, meant that the relational task of meaning-making was experienced as a threat to the patient's long cultivated and necessary defenses developed in infancy. Participant 5 described how although her patient had destroyed all the toys in his box and the box itself:

The only soft thing he has left is his blanket, and this blanket actually is what it kind of encloses his toys that he knows that that's what they're kept in. And what's interesting, actually is when I am - at the end of the sessions when I'm gathering up his things and

taking them, I feel like I'm walking up the stairs with a swaddled baby in my arms. I think it really looks like it too. (Participant 5)

This act of swaddling up the broken and fragmented toys, or fragmented parts of her patient's mind, seemed to symbolize an important task for the therapist. Through containing her patient's hostile and persecuted states of mind, Participant 5 was both acknowledging the deprivation and damage the child had experienced both externally and internally, and offering a soft and containing swaddle with which to hold, make sense of, and sooth these states.

For Participant 3, techniques with which to receive and respond to her under-five patient's communications appeared more explicitly and appropriately attuned towards communicating with an infant, such as singing and babbling.

I sing things, I'm not the greatest singer ((laughs)), but it doesn't seem to matter what I sing. Um? 'cause it seems it doesn't really matter what I'm saying, it's the language and tone. [...] I mean I do a lot of imitating as well, just like you would a baby, you know, kind of babbling back. (Participant 3)

Participant 3 also spoke about the physicality the work required with her patient, and about the value their physicality had in terms of offering the child an experience of being both literally and emotionally held.

I do pick him up. I do hug him. I mean, he kind of, he climbs on things in a clear, kind of intent for me to pick him and lift him off these things. (Participant 3)

For Participant 3's patient, it seemed that the physical aspect of the relationship held an important role in helping him test and experience a safe and reliable object, of whom he could make demands and have them fulfilled.

4.4.4 The limitations of the parental object/therapist

Participants reflected on the difficult process of introjection their patients faced, when having an experience within the therapy of having good contact with a helpful 'feeding' object, who nonetheless is inevitably also at times an absent object. Participants described how when

patients had progressed within the therapy, they were able to be in contact with more depressive anxieties and preoccupations.

I think ((exhale)) that's quite a painful place to be, but I think also feels quite, um. You know developmentally, quite hopeful in terms of, you know, begin to tolerate the sadness of separating actually (Participant 4)

This focus of the work was seen as a fundamental aspect of the therapy, and for Participant 1's patient, had a tangible impact on improving her capacity to bear separateness and loss outside of the therapy.

Because there's more of me in the week, three times a week. [...] I've heard through the parent work and through our reviews, that is something, her relationship with the adoptive father is something that has significantly umm improved I guess, that's a way of saying it, and she's much more able to bear when he goes and comes. (Participant 1)

Yet, for those children seen whilst still in care, the significant and intimate relationship they built with the therapist, which also held within it the limitations of the therapist's role in their life, put them in contact with profound experiences of loss that were perhaps more acute than for those children in stable and permanent placements. Due to the children's young age, the significance of the length of time that they had worked with the therapist, and the regularity of the intervention, meant that separations and breaks became very difficult.

He is really attached to the therapy I think. [...] Although that becomes a bit of a problem I find 'cause I feel so, like so after the first break was Christmas which was three weeks. And they came back and said that he completely regressed over the break. And it was really difficult so I just felt. I end up feeling terrible, which is one of the reasons I'm working half term. (Participant 3)

In Participant 3's description, her patient's regression was a cause of concern, and indicative of the complexity of offering such an intervention to a child in such a precarious and uncertain situation, where the therapist had been a constant figure in his life. Participant 3 consequently responded to this need and changed her working patterns, so as to continue to support the child throughout the ordinary therapeutic half term breaks.

Participant 2 spoke to the dilemma of cultivating such a close relationship and the difficulty of interpreting the parental projections in the transference for a child in care.

Picking up the projections around. Um. Daddy. Around you know who is daddy? Why aren't you daddy? You see me three times a week and you seem to understand a bit of what I'm going on about. You know. So picking up fierce fierce projections in that area. And again, I'm lucky I've gotten. An an extremely good supervisor. [...] it's not at all straightforward. (Participant 2)

Participant 2 spoke to the confusion and need expressed by his patient, especially one so young for whom to gather an understanding of her situation would be extremely complex.

Participants 2 and 3 highlighted how delicate a task it is to find a way to meet their patient's needs within the scope of the therapy, without being pulled to act out the patient's phantasies for them to hold a real caregiving role in their lives.

5 Discussion

This project sought to explore the experiences and perspectives of CAPTs offering intensive psychotherapy to LAAC. To that effect, qualitative interviews were carried out and analysed using Reflexive TA to determine shared themes. The results of the qualitative analysis capture rich data from the narrative of five trainee CAPTs, and offers a new perspective highlighting the different applications of intensive work with this population. The following section will explore the salient results from the study, as well as the implications for future research.

5.1 ‘The history’: the vicissitudes of trauma and loss

The brief case history described by all five participants gave insight into the traumatic early experiences and multiple losses this patient group had endured. As the trainee CAPTs highlighted, all had experienced multiple caregivers, and for the youngest two patients seen, there were still yet more upcoming separations and losses to contend with. For the eldest of the group, as an adolescent, an ongoing breakdown in the adoptive placement left his future uncertain. These experiences of uncertainty had a profound impact on the children’s therapists, leaving them with a “constant worry” that seemed to evoke the children’s repeated experiences of torturously traumatic uncertainty.

Whilst all participants made reference to their patient’s history, participants expressed differing attitudes in relation to the prominence of the history in the therapist’s mind, and how they felt that this informed how they worked and understood their patient’s communications. One participant highlighted how it was a “big mistake” to offer interpretations too early in the therapy that linked to the child’s past; time was needed to develop a relationship with the child and to gather up an understanding of the transference communications first. This perspective

linked to Music's (2019) experience of working with traumatised patients, and how focusing on the trauma too early can backfire.

It appeared as if in the cases where there were more active concerns, acting-out, and disturbing communications, adoptive parents and the network had a greater propensity towards taking up an extreme position towards the child. A 'rescue fantasy' within some families and networks, which was described by one participant, to my mind corresponded to what Sprince (2008) referred to as the misleading fantasy of a 'new beginning' for these children, and a denial of the impact of their history and what they carried within them. The extent to which this fantasy could impact on professionals' appropriateness and boundaries, was exemplified in Participant 2's example of a teacher buying the LAC a bicycle and giving her private bicycle lessons. On the other hand, as other participants highlighted, in some cases, the system seemed overwhelmed by feelings of despair, and as exemplified in Participant 3's case, this manifested in a hopelessness in the likelihood of the LAC being adopted.

Furthermore, interestingly the case material appears to support what Henry (1974) described of how this population can become 'doubly deprived', whereby there were multiple examples of placement breakdown. 'Triple deprivation' (Emanuel, 2002) due to failures within organizations to respond and adequately meet the child's needs, were also shown in one participant's account, where the multi-layered experiences of rejection and neglect within both the biological and adoptive home, were replicated in failures between individual and parent CAPTs to work collaboratively as a unit, and for the service to adequately contain the disturbing and distressing communications coming from the family. Whilst Emanuel refers to difficulties within social care organizations, the findings of the present study stress how attacks on linking and splits are just as liable to happen between CAPTs too, who might be familiar with these processes, but still hold their own valences and susceptibility to acting-out.

The propensity for re-enactments within the therapy, was highlighted in one participant's account of the difficult and rejecting feelings contact with her patient evoked. The participant stressed the importance of supervision in helping her to digest the impact of the patient's projections, and to find a way to bring her understanding of the patient's communications back to the patient in a way that he could feel understood. It would be interesting to see whether this theme would emerge as more dominant in future research studies with a larger sample size. One might imagine that such experiences of acting-out can also provoke feelings of guilt and shame within the therapist, and so participants might be more guarded to divulge these aspects of the therapy within an interview, although they would likely emerge in their supervision. Therefore, a potential alternative source who would be able to speak to this phenomenon from a less guarded position would be the intensive case supervisor, who it would also be of interest to interview.

The findings of this section present an interesting mixture of both the range of views of the relevance of the patient's history on the work, and awareness of potential dynamics of repetition at play within the cases. While the literature stresses the importance of helping the child to create a meaningful narrative of their life (Kenrick, 2005), this aspect of the work was not pertinent for some of the participants. This was a surprising finding for me, that highlighted the difference in thinking between trainee CAPTs, and to my mind emphasised how different training placements, supervision experiences, and exposure to the relevant psychoanalytic literature, influenced each participant's position. It would have been interesting to have asked participants what literature informed their work, and to build a greater understanding of their engagement with these sources.

5.2 The firmness of the frame

The second theme that emerged was the firmness of the frame, whereby participants described different experiences of how well their cases were supported and held.

Parent work:

Whilst the literature highlights the importance of the professional relationship between individual CAPT and parent worker (Calvocoressi & Ludlam, 2008), in this study participants experienced and described differing levels of support and collaborative work practices within their services, which in some cases, to my mind, seemed to mirror the parental functioning within the family system.

In some cases, parent workers were reported as having good supportive relationships with the individual CAPT, however this wasn't always the case. Some relationships were reported as becoming strained, withholding or neglectful. These dynamics were also mirrored in the parent workers' relationships with the adoptive parents and carers seen. Concerningly, for one participant who had two LAAC intensive cases, (one case had the work held in a different organisation, and in the other the short-term foster carers were not offered regular parent work), in both cases the intensive therapy was left without a joined-up professional couple holding the work.

These findings suggest the difficulty of maintaining collaborative working relationships between professionals when working with such high levels of disturbance, which likely has an impact on the treatment outcomes of the families seen. The findings also suggest the huge strain CAMHS professionals are under; leading to important questions of whether clinicians have the capacity to protect the offer of regular parent work, and to find the necessary time to come together and think with colleagues about their collaborative work, and the complex dynamics, patient communications and identifications at play. The answers to these questions about

whether services are currently adequately equipped to offer intensive psychotherapy hold serious clinical implications.

Adoptive parents and carers:

Support for the intensive psychotherapy was not always straightforward, as in Participant 1's case, where adoptive parents wanted their child to be 'fixed' by the system, but did not want to engage with parent work themselves. This parental disengagement might be linked to what Miller (2008) referred to as adoptive parents' lurking resentment that they weren't able to 'fix' their child themselves, as well as parental resentment towards their child for the difficulties they attributed to him, and a wish to separate themselves from him. In such cases where the parent worker is unable to get to grips with parental resentment, important work with adoptive parents in helping them to understand and accept their child's history is missed. In Participant 1's adolescent case, reminiscent of Sprince's (2008) description, huge re-enactments occurred within the family, fuelled by the "vengeful ghosts" of the child's past as well as adoptive parents' own unresolved early childhood experiences and present difficulties.

It would be interesting to further explore the experiences of parent workers supporting intensive psychotherapy, so as to better develop our understanding of the work and its challenges from their position.

Short-term foster placements:

The results posed an important dilemma with regards to the intensive work with under-five children in short-term foster care: on the one hand, embarking on a time-limited intensive relationship with child who is without a permanent placement, might leave the child in contact with their deprivation, confused, and in need of more; on the other hand, intensive psychotherapy can offer the child a containing environment where their trauma can be held,

and developmental work can take place. There is a paucity in contemporary literature that engages with this dilemma, and it seems to be an important area of future research.

The network:

For the two participants with patients in care, work with the social care network was regarded with some ambivalence. One participant spoke to the complexity of holding a privileged position of understanding of the child, and the difficulty of sharing this understanding with the network without taking up a position of superiority or arousing feelings of rivalry within the network. Both participants experienced the network as being “removed” from the traumatic and emotional dimensions of the child’s early experiences and current difficulties. These findings support both Emanuel (2012) and Sprince’s (2008) descriptions of the challenges faced by social workers in remaining in contact with the child’s trauma and ongoing needs. To my mind these findings emphasise the complexity of an essential role CAPT’s play, linking to Cant’s (2005) writing about how the CAPT needs to both open themselves up to and contain their patient’s intimate, disturbing and painful communications; as well as to find a way to translate this, and bring the child to life for the network to better understand and be in touch with the child’s complex needs

Intensive case supervision:

Intensive case supervision was described as an integral aspect of the framework supporting the intensive psychotherapy and was largely described in positive and warm terms.

All participants described it being difficult to think at times in the clinical sessions, and the supervision was a time when thinking about the case could occur. These experiences corresponded with Ogden’s (2005) formulation of how supervision can facilitate the therapist to come into contact with, and dream, what he was unable to in the therapy; emphasising the

centrality of supervision in supporting the clinical work of trainees and the development of their cases.

It was of interest that the two participants who discussed their initial scepticism and subsequent agreement with their supervisor's approach, were able to speak in depth about the focus of their supervision. This suggests that they might have spent more time struggling and engaging with questions about technique, an important process of development in one's practice. Both shared their thinking on how to work with extremely deprived, disturbed and traumatised children; and the importance of aiming to create a safe environment and nurturing a developmental trajectory within the therapy (Alvarez, 2010; Music, 2019). Both participants stressed the challenge of this task and emphasised the role of the supervisor in helping to cultivate this benign and fertile therapeutic environment. This corresponds to Lanyado's (2016) description of the importance of 'moments of hope' in supervision for such cases, where 'moments of hope' might be more difficult for the therapist to individually identify. These results to my mind emphasise the extremely important role the supervisor holds for the therapist-patient couple, for the possibilities of hope and development to take place.

There appeared to be a tension in the accounts of participants between clinical thinking developed in supervision, and how this corresponded to case management. The supervisor seemed to maintain a position of an outsider for a variety of reasons; presumably wanting to privilege the privacy of the supervisory experience, as well as not to infantilize both trainee and the parent worker, who is often less well experienced than the supervisor. Although this was not mentioned, typically the supervisor is not an employed clinician within the service, and for this reason too there might be a limitation to how much they can be seen to intervene. However, this is at odds with Lanyado's (2016) emphasis on the importance of case management in her supervision, and to my mind, it is a shame that in cases where there are high levels of disturbance and fragmentation within the treating team, that the supervisor does

not consult to the service, and potentially to help bring about some triangulation and thinking about the complex dynamics at play between professionals.

5.3 Ambivalence, violence and hate

The third theme that emerged in the analysis highlighted how feelings of ambivalence, violence and hate were stirred up in the work. Participants described it both from the therapists' and patients' perspective.

For example, participants reflected on their feelings of being 'pushed' into the work and a reticence to enter into an intensive relationship, which seemed to mirror the feelings of their patients too. In some cases, concerns from the network and clinicians involved, led to a reactive atmosphere where starting the therapy felt urgent and there was a rush to begin. The urgency in these cases seems to mirror what can be activated in the social care network, where concerns and risks can often erupt and removal of the child and their placement in a new environment occurs with little preparation and time to process the change. Yet, as Kenrick (2000) has described, for these children who have experienced sudden separations, and found themselves in foreign foster and adoptive families, the traumatic shock of their loss and adaptation out of a need to survive, is a familiar but disturbing pattern. Therefore to my mind, for these children, a further expectation by adoptive parents, carers or the network for them to enter into another temporary intensive relationship with a new adult, might understandably feel daunting and persecuting, putting the child in contact with past traumas and losses and the need to protect themselves with tried and tested defences.

Therefore, accounts by participants of the beginning of therapy being a "battlefield", or the move from once-weekly to intensive leaving the therapist-child couple in "Ground Zero", offer a powerful description of the annihilatory anxieties that can be evoked for this population at

the start of therapy. The participants' description of these dangerous and deathly psychic landscapes, link to the psychoanalytic literature's description of children who have been subject to trauma, deprivation and abuse, and who have experienced unbearable internal experiences of psychic death of both the self and one's internal objects (Alvarez, 2010; Hart, 2012). For such children, contact with an alive, interested object does not correspond to their internal experiences and expectations, and so they are deeply suspicious and rejecting of the therapist's attempts to make contact – a feature of the work that has been written about widely (ibid).

Violence was also a feature of some of the therapies. It was understood as arising from the profound anxieties, evoked in the therapy due to feelings of exposure, vulnerability and dependence.

The participants described how their patients' violence made it difficult for them to think and left them feeling angry and hateful. This corresponded to the literature on the subject, and reflected how under such conditions the danger of acting-in increases (Canham, 2004), as well as the risk of becoming either the abuser and abused object in the present therapeutic relationship (Music, 2019). One participant stressed how managing violent behaviour was not sufficiently addressed in their training, and how they felt that the current culture within the profession privileged the child's need to express themselves over the need for boundaries and safety. The participant highlighted how damaging this is for the child's perception of themselves. These findings reflect how the unconscious pull to 'turning a blind eye' (Emanuel, 2012), can as Canham described lead to a "degeneration back to the original scenario" (2004, p. 146), whereby the therapist can become a neglectful or at worst abusive object. This perspective raises practical questions with regards to treating this population; should more thought and training be offered to CAPTs working with children who exhibit violent acting out behaviours, as is given to other mental health professionals? Would this training increase the

likelihood for acting-in, inviting thinking to stop and for the CAPT to become physically embroiled with the patient, or offer a possibility for containment should things get out of hand?

Whilst these questions are important to keep in mind, participants also described the critical role of supervision in managing these behaviours and finding a space and way to think about their patients' communications, so that the acting-out and violence was able to decrease in their therapies.

Furthermore, participants highlighted how for this population, the dominance of such 'bad' feelings in relation to others, was also an important communication of how their patients related to themselves. Participants' accounts underscored how early traumatic experiences, and the absence of an object to sort out and make sense of primitive early feelings of good and bad, meant that this process was now still very difficult for these children to accomplish, and that they held a split and persecuted relationship with the world. Additionally, their phantasies about their early experiences of either coming from something 'bad' or doing something 'bad' to their biological parents, alongside the difficulties the adults around them in the present had of accepting them as a whole, seemed to exacerbate these difficulties. These findings linked to Cregeen's (2017) description of how LAAC have damaged/damaging internal objects, and that these are aspects of the child that also need to be contained, and accepted by their therapists and adoptive parents/carers, so as to help the child build a more integrated sense of self and identity. The intensive psychotherapy was seen as an important space where the work of containment and the beginnings of a sense of integration could begin, where the different aspects of the child could be gathered up, and this process of thinking as modelled by the therapist could slowly be introjected by the child.

5.4 The developmental relationship

The last theme identified was the developmental relationship established within the intensive psychotherapy between CAPT and child, whereby the therapist in the transference was able to respond to parental projections and to tend to the internal baby object within the patient who desperately needed attention and space to develop. This focus corresponds to Canham's (1999) thinking about how psychotherapy is a place where unresolved early primitive needs and desires can be acknowledged and to some extent worked through, so that there is greater opportunity for growth and development.

Participants described how "one of the fundamental jobs" in the work was development of a receptive state of reverie, where the patient's communications could over time be metabolised. Bion's (1962) theory of reverie appears to be highly influential to both the psychoanalytic literature in the review, and on the participants' thinking. All the participants recognised how their role was to offer the child a developmental experience of a mind that is able to contain the fragmented pieces of the patient, and to see the child as 'whole'; helping the child to internalise a mind that can make sense of different aspects of the self and to work towards developing a capacity for integration and thinking.

Participants gave different examples of how they achieved this in their work, which included private thought, interpretation, symbolic action, singing, babbling, and physical holding. These rich descriptions of the clinical work show the adaptability of the CAPT to respond to the different needs and ages of their patients, and is reflective of the creativity and courage employed in the therapeutic encounter, which Cregeen (2012) has stressed as important in order to achieve a good outcome.

Participants also reflected on the limitations of their role as a developmental parental object in the transference and reflected on experiences of separation and loss encountered in the

transference relationship. O'Shaughnessy (1964) has described how the absent object is an integral part of the child's life, and that coming to terms with the absence of an object can be a spur for development and thinking. Whilst some participants' cases were at the stage where the importance of experiences of loss and separation within the therapy on the patient's development could be seen, an interesting finding of the present analysis was that this was more challenging for the participants whose cases were ongoing and in short-term foster care. To my mind, particularly for those children in care, the pain and sharp realities of loss and absence, without solution for these particular children, made this developmental trajectory less certain. Yet, the literature (O'Shaughnessy, 1964; Wittenberg, 1999) emphasises how experiencing the absent object has important clinical implications for all of these children who have had experiences of depressed, withdrawn or cruel parental objects, who were too abruptly and too early put in contact with separateness and unmet need – as within the therapy it is a different experience of an object who both leaves them to face the harsh realities of separateness, but who returns and can try to adequately recognise and contain their fury, loss and need, offering a hopeful possibility for reparation and growth.

5.5 Strengths, limitations and future research

The present study is a valuable qualitative study, which despite the small sample size has highlighted many findings useful for informing clinical practice and future research. This study has yielded important data not only on the clinical experiences of trainee CAPTs offering intensive psychotherapy to this population, but also on the framework around the intensive work. As the literature review has highlighted, there is a scarcity of formal qualitative research exploring intensive psychotherapy with LAAC, and no research to my knowledge that has explored intensive psychotherapy as an intervention offered by trainee CAPTs in particular, prioritising attention to the framework around the clinical work as much as the clinical work

itself. As such, this study has been the first, and has derived important clinical implications from its findings.

Significant implications from the study include evidence that the propensity for splits and re-enactments of early trauma within present constellations, as evidenced in the literature (Emanuel, 2002, 2012; Henry, 1974), can also occur within mental health services. The state of CAMHS at present, which are typically under immense pressure due to high levels of need and inadequate funding and staffing levels, make it more likely for LAAC to become further deprived by the CAMHS provision made available to them. This study found that such dynamics can be re-enacted by CAPTs, and within the psychotherapy treatment itself. Furthermore, it is likely that trainee CAPTs, at the start of their career, are particularly vulnerable to acting out, and that the provision of intensive case supervision is extremely important in supporting these cases. The possibility of the intensive case supervisor in consulting to the wider CAMHS professional network involved in a case, if difficulties do encroach on the functioning of the team, is suggested as possible adaptation of the current model of intensive psychotherapy.

This study has found that for some cases, regular, joined-up parent work is not available or offered to adoptive parents and carers. Based on evidence from previous studies about the importance of parent work on treatment outcomes with LAAC (Boston & Lush, 1994; Fonagy & Target, 1996), these findings indicate that both LAAC and their families might not be receiving what is understood to be the best practice treatment model for working with LAAC intensively. This raises significant questions about whether this intervention should be offered to a LAAC, and whether it is fair to expect a child to engage in a therapeutic process, when adoptive parents and carers do not have their own necessary space for thinking and development. It is possible that some CAMHS offer this intervention as part of their obligation to their CAPT trainee's training requirements, without having sufficient resources to fully meet

the needs of an intensive training case. This is concerning both in terms of what is being offered clinically to families, as well as to the trainee and their training needs too. Further research in different CAMHS to explore whether these findings are widely prevalent is necessary, based on the understanding that parent work plays a central role in not only supporting the intensive psychotherapy intervention, but essentially stabilising difficult family relationships and reducing risk of placement breakdown.

The entrenched difficulties, trauma and disturbance in the presentation of patients described in the study, supports the clinical writing and research on this population and their difficulties. Their fragmented and split thinking, and identification with a 'badness' within themselves, is understood as a significant feature of work with this population. Both LAAC and adoptive parents and carers need help to work towards a more integrated and complex understanding of the child's past and present.

Furthermore, the findings suggest that potential for violence in sessions can be extremely concerning for trainee CAPTs, and further thinking is needed about whether they are adequately trained and supported to manage this within the therapy.

The study has highlighted the specialist focus needed for psychotherapy with LAAC. The creation of a safe environment, with a developmental focus within the transference relationship, that has been outlined in the literature, is emphasised as being a central component of all of the participants' work. Participants linked the development of their technique to learning in supervision, and the needs for variation in technique based on the child's needs and difficulties are emphasised. The supervisor's capacity to notice 'moments of hope' (Lanyado, 2016) in the work is highlighted as important aspect of intensive work with this population, and crucial for both the trainee CAPT and patient's development.

Despite these strengths, the study has notable limitations. Whilst for Reflexive TA the recommended sample size for a professional doctorate project is between 6-15 participants (Terry et al., 2016), the sample size for this project was 5 participants. It was unfortunate that due to the impact of the COVID-19 pandemic it was not possible to conduct further interviews. Given the small sample size, there would be value in replicating this study with a larger sample size. It would be interesting to ascertain how the theme structure would emerge within a larger group of trainee CAPTs. Furthermore, whilst the participants presented a range of cases, a wider variety of cases would have provided a richer understanding of the complexities of this work with this population. As such, future research could build that into the research design, by purposefully recruiting participants who would provide a range of cases. This range could take into account not only differences in ages, short- and long-term foster placements, and adoptive placements; but could also, for example, compare clinical experiences of cases that went well, and those that broke down, as an opportunity to develop our understanding of this complex work.

A limitation of the present study was that each participant only had a single interview, which meant that important questions that arose during and after the interview were not all answered. Future research could also include a follow up interview within the structure of the project, either closely after the initial interview, or if a case is ongoing, after a certain time point, such as half a year or one year later, so as to capture developments in the work.

A further important limitation of the present study pertains to the fact that as only trainee CAPTs were interviewed, most of their cases were ongoing. This meant that it might have been more difficult for the participants to have a longer-term perspective on the impact and results of the intensive work. Wittenberg (1999) has observed how difficulties in thinking about the ending in therapy are multi-layered: patient, trainee CAPT, and the training institution itself might all struggle to manage the complex range of feelings evoked in relation to endings. Yet,

Wittenberg describes that the ending of analysis is an experience akin to that of weaning, a mourning process within the presence of the alive and receptive object, where both therapist and patient are left to feel the mutual loss of their relationship. Thus, particularly for LAAC who have had such inadequate early separations and losses, the work of ending is seen to be an important therapeutic task and phase within the work. Future research should focus on this important aspect of the work by specifically recruiting either trainees who have completed their intensive cases, or recruiting qualified CAPTs who would be able to reflect on their past cases. Furthermore, future research that not only relies on data from interviews, as this study does, but that will utilise clinical measures to quantitatively analyse the impact of psychotherapy on this population would be important. Since the ground-breaking studies in the 1980s and 1990s (Boston & Lush, 1994; Boston & Szur, 1983) that revealed the benefits of psychotherapy with LAAC, no follow up studies have been conducted. It seems imperative for larger-scale, longitudinal studies to be conducted to measure the long-term impact of psychotherapy on this population, as well as the benefits of intensive psychotherapy.

It is important to recognise that my position as both the researcher, as well as a trainee (for the most part) CAPT, training in specialist LAAC team, has meant that I have inevitably approached this work with my own assumptions, biases, experiences and motivations that have influenced both the interviews and how the data was interpreted and understood. Braun and Clarke (2019, p. 564) argue that “the researcher’s role in knowledge production is at the heart of our approach!”, and so the researcher’s subjectivity is an essential aspect of the active and creative analytic process. Therefore, whilst my position and knowledge is seen as an integral contributory element in Reflexive TA, it inevitably influences the replicability of the study.

6 Conclusion

This study has found that CAPTs seeing LAAC for intensive psychotherapy offer rich and varied therapeutic intervention to this population.

The complexity of each's child's situation, which includes both historical trauma and present-day placement, has a significant impact on the child's presentation and on the supporting frame of the intervention. Thus, challenges for the therapy come from both outside and within, and mean that CAPTs need to respond to both external and internal realities for their patients.

The high levels of disturbance and suspicion of contact with a thinking and containing object, can make the beginnings of intensive psychotherapy a battleground, where the therapist needs to learn to respect the child's position and world view, and find a way to open a channel of communication that can be tolerated by the child, which can lead to therapeutic alliances being forged.

Yet, this work can be complicated by further challenges arising beyond the battlefield, whereby fragmentation, splits and disturbance also arise in the domains of adoptive parents/carers and networks. The risk of 'turning a blind eye' and losing sight of the child's needs can occur. The essential role of the parent worker to aid the development of understanding and the process of mourning that parents and carers need to undertake, can at times be sabotaged by propensities to act-in and re-enact the child's early situation. The current pressures on the NHS seem to precipitate these difficulties. Intensive case supervision holds an important role in supporting the development of clinical work, and hope in the therapy. This study shows how especially in cases where professionals are able to find ways to support one another and work collaboratively, progress and development in the therapy can occur.

An intensive intervention, where the child has the relative security of seeing the therapist multiple times a week, makes it safer for the patient's regression and feelings of need to emerge. The work takes on a developmental trajectory, focusing on early experiences, including early trauma and losses. The child has an experience of containment within the therapy, of building a new attachment with a reliable adult, as well as manageable experiences of loss and separation, which can all hold a reparative developmental role.

These findings emphasise the importance of intensive psychotherapy with LAAC, as well as the present-day challenges and realities of this intervention within the NHS. The need for further research on this intervention is stressed, and a greater understanding of how we can continue to improve this treatment for the benefit of the population in our society who are most disadvantaged and in greatest need.

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Appendices

Appendix A - Acronym List

Adverse Childhood Experiences	ACEs
Child and Adolescent Mental Health Services	CAMHS
Child and Adolescent Psychotherapist/s	CAPT/s
Child in Care	CIC
Looked After and Adopted Child/ren	LAAC
Looked After Child/ren	LAC
National Health Service	NHS
Thematic Analysis	TA

Appendix B – Transcription Notation Glossary

Transcription notation	Meaning
<i>[word]</i>	Words are overlapped
(.)	Pause
(...)	Longer pause
=	Responded to immediately
((<i>word</i>))	Descriptive addition
?	Rising intonation
<i>Word word word</i>	Roman typography indicates emphasis
-	False start
<i>Word “word” word</i>	Speaker quoting another person
[...]	Part of the transcription has been removed from the quote

Appendix C - TREC Approval

The Tavistock and Portman 
NHS Foundation Trust

Quality Assurance & Enhancement
Directorate of Education & Training
Tavistock Centre
120 Belsize Lane
London
NW3 5BA

Tel: 020 8938 2699
<https://tavistockandportman.nhs.uk/>

Merav Hadary

By Email

28 November 2019

Dear Merav,

Re: Trust Research Ethics Application

Title: Intensive Psychoanalytic Psychotherapy with Looked After and Adopted Children:
Exploring the experiences and perspectives of Child and Adolescent Psychotherapists

Thank you for submitting your updated Research Ethics documentation. I am pleased to inform you that subject to formal ratification by the Trust Research Ethics Committee your application has been approved. The assessor had an advisory note to add– *newly and recently qualified child psychotherapists is a large range – this need to be specified more precisely given the inevitable differences there will be on the basis of experience.*

You can now proceed with your research.

Please be advised that any changes to the project design including changes to methodology/data collection etc, must be referred to TREC as failure to do so, may result in a report of academic and/or research misconduct.

If you have any further questions or require any clarification do not hesitate to contact me.

I am copying this communication to your supervisor.

May I take this opportunity of wishing you every success with your research.

Best regards,



Paru Jeram
Secretary to the Trust Research Degrees Subcommittee
T: 020 938 2699

Appendix D - Participant Information Sheet



Participant Information Sheet

Date: 23.04.2020

Intensive Psychoanalytic Psychotherapy with Looked After and Adopted Children: Exploring the experiences and perspectives of trainee Child and Adolescent Psychotherapists

What is the purpose of the study?

The purpose of this study is to investigate trainee Child and Adolescent Psychotherapists' experience of intensive psychotherapy with Looked After and Adopted Children.

This study is part of the researcher's Professional Doctorate in Psychoanalytic Child and Adolescent Psychotherapy.

What is the study about?

Intensive psychoanalytic psychotherapy is a long-term and intensive model of therapy that is a highly specialist clinical resource, offered to children and young people with the most complex and severe mental health problems. Whilst intensive psychotherapy is an established practice in CAMHS, it has not yet to the author's knowledge been systematically recorded, let alone in relation to LAAC.

I'll aim to investigate what happens in this model of psychotherapy by interviewing trainee Child and Adolescent Psychotherapists, who, in this current stretched climate in CAMHS, are most likely to be carrying out this type of work, due to their training requirements. The professional structure the trainees are working in is understood as being once-weekly intensive case supervision with an experienced Child and Adolescent Psychotherapist, alongside the weekly or fortnightly parent work offered to the family by another clinician in the team who shares the case with the trainee.

This study aims to investigate:

1. The trainees' understanding of working intensively with LAAC. What generally in their experience went well and what helped; as well as what didn't work well.
2. The trainees' experience of intensive work with LAAC in relation to the professional structure put in place to support the intensive work.
3. How do these triad of professionals work together, and whether any links be drawn between the population considered, and the functioning of the these professionals in their work around and with the LAAC.
4. Are there links between these experiences and the complex LAAC's history, trauma, past/current family and multidisciplinary professional networks that were being worked with?

Who is undertaking the study?

The lead researcher in this study is Merav Hadary, Child and Adolescent Psychotherapist in Doctoral Training. The study is supervised by Dr Felicitas Rost. Contact details for the research team can be found at the end of this information sheet.

What will happen if I choose to take part?

- If you decide to take part in the study you will need to complete a consent form. This will be completed just prior to the interview.
- These interviews will be aimed to be conducted face to face (either at the Tavistock Centre or your place of work), however, if this is not possible due to COVID-19 they will take place via telephone or video link using a platform that the Tavistock clinic is providing. I can arrange an interview time that suits you.
- At the interview appointment, you will meet with the researcher for a semi-structured interview, this is the data collection.
- It is anticipated that the appointment will take no more than 1.5 hours.

Confidentiality: how will information about me and data gathered in the study be used and stored?

If you chose to participate in the study your data will be held in confidence. You will be given a participation number by the researcher and this will be applied to all data collected from you. Your anonymity will be protected in the analysis of data and the report of findings. Data will initially be stored in a locked cupboard. It will then be transferred to an electronic file which will be password protected. Data will be kept for no more than 10 years, at which point it will be destroyed. Data generated in the course of this study will be kept in accordance with the University of Essex Data Protection Policy.

Please note: The confidentiality of the information that you provide is subject to legal limitations in data confidentiality (i.e. the data may be subject to a subpoena, a freedom of information request or mandated reporting by some professions).

What will happen to the results of the study?

The results of the study will be written up as part of the researcher's Professional Doctorate in Psychoanalytic Child and Adolescent Psychotherapy. The study's findings may also be submitted for publication in professional journals or presented as conference papers. The study's findings may also form the basis for future research or presented in workshops or seminars.

Is there a benefit to taking part in the study?

Taking part in the study will provide you with an opportunity to experience being a participant in a novel piece of Child Psychotherapy research which you may find interesting. It will provide you with the opportunity to participate in a wider professional discussion and share your experiences with someone who is interested in learning about your clinical practice and formulations.

Are there any risks or disadvantages to participating in the study?

There are no known risks or disadvantages to participating in the study. It is not anticipated that this study will be out of the boundaries of normal working experiences but in the unlikely event that you have any questions about the study please contact me.

Due to the small sample size, even with use of pseudonyms, it is important to consider that you may still be recognisable to your colleagues within the service where you work. However, I will ensure the patients you discuss in the interview will be completely unidentifiable to anyone outside the service.

Further Support and Guidance:

Further support about the conduct of the research can be sought by contacting Simon Carrington who oversees the Tavistock Centre's Academic Governance and Quality Assurance.

Further support on debriefing or advising on adverse reactions can be sought by conducting Dr Rost, the project's Research Supervisor, or through your own professional support networks (colleagues, supervisors, analysts).

In the highly unlikely event that risk to self or other be shared during the interview; statutory reporting will need to occur. I would initially need to consult with my Research Supervisor and the Head of Safeguarding at the Tavistock Centre who would guide me in managing this highly unlikely situation.

Withdrawing:

If you have a query about withdrawing your data please contact me or Dr Rost. To preserve the study's data collection time line, should you wish to withdraw your data from the study please notify the Researcher within 6 weeks of the interview, after that time the data will be included as it will be too late to recruit another participant.

Thank you for taking time to read this information sheet.

If you have any questions about the study please contact:

Researcher: Merav Hadary, Child and Adolescent Psychotherapist in Doctoral Training
Email: mhadary@tavi-port.nhs.uk

Research Supervisor: Dr Felicitas Rost
Email: FRost@tavi-port.nhs.uk

Any concerns about the conduct of the research:

Head of Academic Governance and Quality Assurance: Simon Carrington
Email: academicquality@tavi-port.nhs.uk

This project has been approved by: The Tavistock and Portman Research Ethics Committee

(TREC)

Appendix E - Consent Form

Consent Form

Date: 23.04.2020

Intensive Psychoanalytic Psychotherapy with Looked After and Adopted Children: Exploring the experiences and perspectives of Child and Adolescent Psychotherapists

	<i>Please tick</i>
I confirm that I have read and understood the information sheet provided for this study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
I understand that my participation in this study is voluntary.	
I understand that if it is not possible to conduct the interview face to face due to COVID-19, then the interview will take place via telephone or video link using a platform that the Tavistock clinic is providing, and that both I and the interviewer will conduct this interview in a confidential space.	
I can confirm that I have a professional network to support me in the unlikely event that I need further support following the interview.	
I understand that the interview will be digitally audio recorded and then transcribed.	
Should I wish for my data to be removed from the study, I understand that I can utilise the 6 week cooling off period after the interview by contacting Merav Hadary.	
I understand that the information given in this interview may be used by the researcher in future publications, reports, presentations.	
I understand that any personal data that could be used to identify me will be removed from the transcript of my interview and that I will not be identified in any publications, reports or presentations.	
I understand that due to the small sample size of the study, it is possible that colleagues will be able to recognize which data belongs to me. This is a limitation of the study that I am willing to accept.	

Participant's name:			
Participant's signature:		Date:	
Researcher's signature:		Date:	

Research Identification Number:

Thank you for agreeing to take part in this study. Your contribution is very much appreciated.

Appendix F - Debrief Form

The Tavistock and Portman 
NHS Foundation Trust

Debrief Form

Date: 24.10.2019

*Intensive Psychoanalytic Psychotherapy with Looked After and Adopted Children: Exploring the experiences
and perspectives of trainee Child and Adolescent Psychotherapists*

Thank you for agreeing to participate in this study.

If you have any questions regarding the study or your involvement in it please contact:

Researcher: Merav Hadary, Child and Adolescent Psychotherapist in Doctoral Training

Email: mhadary@tavi-port.nhs.uk

Or

Research Supervisor: Dr Felicitas Rost

Email: FRost@tavi-port.nhs.uk

Any concerns about the conduct of the research should be reported to Simon Carrington, Head of Academic
Governance and Quality Assurance

Email: academicquality@tavi-port.nhs.uk

This project has been approved by: The Tavistock and Portman Research Ethics Committee (TREC)