A qualitative exploration of psychoanalytic psychotherapists' experiences working with young people who have perverse sexual fantasies and/or engage in harmful sexual behaviour

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ABSTRACT

Objective: This study explores psychoanalytic psychotherapists' (CPTs) experiences of working with young people (aged 14-25) who have perverse sexual fantasies, and/or engage in harmful sexual behaviour.

Methods: Semi-structured interviews were conducted with five qualified CPTs working at the Portman Clinic. Interpretative Phenomenological Analysis (IPA) was employed to analyse the transcribed data.

Results: IPA revealed 5 superordinate themes: *1. CPTs view perversion as an entrenched solution to emotional pain; 2. ''…it's very, very disturbing to get hold of the aggressive, perverse part of the patient''; 3. In CPTs' views, starting psychotherapy significantly increases the risk of harm to self and others, and it cannot be contained individually; 4. CPTs' gender matters; and 5. "an antidote to the disturbance"*

Conclusions: These findings have significant implications for clinical practice, emphasising the need to structure services with an awareness of the high risk involved, and the need for supervision and team support. They also highlight the benefits of long-term, open-ended treatment for these patients. Finally, it was revealed that having expertise in how to work with the aggressive part of these patient was another major necessity for all professionals working with these patients.

Key words: Perversion, sexual offending behaviours, psychoanalysis, psychotherapy, counter-transference, adolescents.

1. INTRODUCTION

There is increasing awareness of the significant impact of sexual offending on society, whilst existing research on therapies for young people who engage in harmful sexual behaviours is scarce (Bordium et al., 1995; Lawson, 2003; Ayland and West, 2006; Letourneau, 2009; Ikomi et al. 2009; Somervell & Lambie, 2009). Some authors (e.g., Morgan and Ruszczynski, 2007; Campbell, 2013) state that when Child & Adolescent Psychotherapists (CPTs) learn more about their conscious and unconscious responses to such work, they are more able to contain the patients' anxieties, thus decreasing the risk of patients harming themselves or others.

In 1988, the Home Office also stated that about 30% of all sex offences were committed by adolescents (Campbell, 1994). In the US, adolescents were responsible for half of all child molestations, and 50% of adult offenders acted out their sexual deviancy during adolescence (Campbell, 1994). In addition to this, Keiley et al. (2015, p. 324) quotes that: 'The Office of Juvenile Justice and Delinquency Prevention (OJJDP Statistical Briefing Book, 2011) cites that on any day in 2010 nearly 80,000 youth were in custody as juvenile offenders. In that same year, over 15,000 male adolescents under the age of 17 years old were arrested for forcible rape. Adolescent delinquent behaviours (especially sexual offenses) and the resulting incarceration present a significant problem and cost to the public. According to a 2009 report from the OJJDP, adolescents constitute 36% of police-known sexual offenses against minors (Finkelhor, Ormrod, & Chaffin, 2009). This estimate is likely conservative because many sexual abuse incidents go unreported and only a small percentage of reports result in an arrest (Zaremba & Keiley, 2011)'.

I aim to throw light on this mostly unexplored territory, which could be beneficial for the development of psychotherapeutic practices as well as to the wider community of helping professions. Firstly, I will summarise the psychoanalytic literature, define the key concepts of the research question, and give a critical appraisal of the empirical research on the topic (Part I). I will then present the qualitative study I conducted, which explored the experiences of psychoanalytic psychotherapists working with young people who have perverse sexual fantasies and/or engage in harmful sexual behaviour (Part II).

2. PART I: LITERATURE REVIEW

2.1 Introduction

The aim of the literary review was to identify both theoretical psychoanalytic writings as well as qualitative and quantitative empirical studies on the subject of young people (aged 14-25) who have perverse sexual fantasies, and/or engage in harmful sexual behaviour. Firstly, I will outline the method of conducting this comprehensive literature review. Secondly, I will present the theoretical findings on the basis of which this study is constructed. Thirdly, I will present and critically evaluate the empirical findings. Lastly, I will synthesise and discuss the findings in relation to the research topic.

2.2 Literature review search strategy and methods

I have conducted a comprehensive literature search utilising a systematic approach. Aveyard (2014) distinguishes between a systematic approach to a literature review, and a systematic review that aims at to present all available evidence on the topic. The word count limitation of the present literature review has required that I adopt a systematic approach that does not aim to review all available publications.

In order to identify the existing literature, I included the following search engines: PsycINFO, PsycArticles, The Pep Archive, and PsycBOOKS. I chose the following key words to search for therapeutic input: “psychoanalysis”, “psychodynamic psychotherapy”, and “intervention”. In order to define the age, I searched for: “young adult”, “young person”, “young people”,

"youth", "juvenile", "adolescent", "teenager", "puberty", and "child". And lastly, searching for harmful behaviour, I used the following key words: "perversion", "perpetrator", "felon", "delinquency", "offence", "sexual violence", "rape", "molestation", "sexual assault", "sexual abuse", "sexual acting out", and "paedophilia". I searched for each individually, using the Boolean operator "OR" to include as many relevant synonyms as possible, and their derivatives (using the symbol ''*'' to allow for a broader search), (please see Figure 1 below. which presents a summary of the literature search). I also used inverted commas to search for whole phrases. I then combined the initial searches with the Boolean operator "AND", so that at least one of the synonyms of each concept would appear in the results.

Figure 1 *Literature search summary*

Results of combined search before limiters:**28,026**
Results of combined search after limiters:**88**

Concept	S1- 767,644 results	AND	S2- 1,287,219 results	AND	S3- 289,948 results
	Psychoanal*		**Young Adult***		**Perv***
OR	Psychodyn*		''Young person''		Perpetr*
OR	Psychother*		''Young people''		Felon*
OR	Intervention		''Youth''		Delinq*
OR			Adolesc*		Offend*
OR			Juvenile		''Sex* violen*''
OR			Youth		Paedophil*
OR			Pube*		Rap*
OR			Teenage*		Molest*
OR			Child*		Violen*
OR					''Sex* assault''
OR					''Sex abus*''
					''Sex* act* out''

This returned 28,026 results (please see Appendix 1). A decision was made for limiters to be applied to narrow the results to a manageable range. Firstly, I selected *language- English*, because another language would require a translator which was not within the available resources. This reduced the results to 25,843. I then selected all the age ranges that included the 14-25 age range specifically planned for this study*: adolescence (13-17yrs); young adulthood (18-29yrs); adulthood (18yrs or older).* This reduced the result to 2,288. I also applied a methodology limiter- *empirical study*. This returned 2,086 items. Many of the results seemed largely unrelated to the research questions. Most of them included studies on gun control; substance abuse rates; and physical symptoms. Therefore, I applied the following limiters: *classification- psychotherapy and psychotherapeutic counselling; group and family therapy,* which shaped the final selection of 88 studies.

To the 88 studies, I added 16 more empirical studies, and 25 books and articles identified via collateral suggestions and quotations. For clarity, I have divided the empirical findings (104) and the books or articles giving definitions of the theoretical concepts on which this study is based into separate sections. 3 empirical studies were excluded due to duplication, bringing the number to 101. Of these, 20 were excluded due to having an unsuitable study design, as they turned out to be narratives rather than empirical research. Another 26 were excluded based on intervention. They did not study forms of treatment, but presented statistics about number of offences. The remaining 59 studies were read through comprehensively. 46 of them only gave information about victims of abuse, and were thus excluded. 9 empirical publications shaped the final choice. Please see Figure 2 below, presenting the literature findings.

Figure 2 *Literature findings*

<table>
<tr><td colspan="5">129 LITERATURE REVIEW ENTRIES</td></tr>
<tr><td colspan="2">88 empirical studies based on the original search</td><td>+</td><td>16 empirical studies identified via collateral suggestions and quotations</td><td>+</td><td rowspan="6">25 books and articles identified via collateral suggestions and quotations Included comprising the 1st part of the literature review focusing on psychoanalytic concepts</td></tr>
<tr><td colspan="3">104 empirical studies</td></tr>
<tr><td>-3</td><td colspan="3">removed due to duplication</td></tr>
<tr><td>-20</td><td colspan="3">removed due to irrelevant study design</td></tr>
<tr><td>-26</td><td colspan="3">removed due to irrelevant interventions</td></tr>
<tr><td>-46</td><td colspan="3">removed due to studying victims of abuse, not perpetrators of abuse</td></tr>
<tr><td colspan="4">9 publications comprising the 2nd part of the literature review focusing on empirical studies</td></tr>
</table>

2.3 Literature Review: Results

2.3.1 Results: Theoretical psychoanalytic concepts

Alvarez (2010, p. 215) quotes Gabbard, stating that psychoanalytic literature has been 'remarkably silent' on the feelings evoked in CPTs regarding sexuality in general. Horne (2003) conveys how psychotherapy with children and adolescents presenting with sexual perversion could fundamentally change the course of their lives, and prevent future abusive acts.

Child and adolescent psychoanalytic psychotherapy

'The approach of Child and Adolescent Psychotherapists seeks to look beneath the surface of difficult emotions, behaviour and relationships to help children, adolescents and their families to understand themselves and their problems. They are trained to carefully observe what a

child or young person might be communicating non-verbally through their behaviour and play.

The extensive training of Child and Adolescent Psychotherapists enables them to work with these very disturbing thoughts and to develop and sustain relationships with children and young people to help them to make sense of their experience. Confused, frightened, hurt, angry or painful feelings can gradually be put into words rather than actions. As a result the child can begin to express their emotions in less disturbed ways and start to return to the normal process of child development. They are likely to feel less anxious, more able to learn and better equipped to sustain friendships.' (Association of Child Psychotherapists, 2022, "What is Child and Adolescent Psychotherapy" section)

Perversion

There is no generally agreed-upon definition of perversion, but many authors (Nathanson et al., 2021; Morgan and Ruszczynski, 2007; Campbell, 2005) focus on its nature, seeking to understand its origins and how it impacts on personality and relationships. Glasser (1979) states that the sexualisation of aggression forms the core of perversion. He differentiates between aggression as self-preservation with the aim to eliminate or avoid threat, and sadism, where the aim is to hurt and control the object. Glasser also differentiates between developing a perversion as sexual fantasies or practices which differ from what the society approves of, and a perversion as a persistent organised system of functioning which involves the whole personality.

Glasser (1979) writes that infants ordinarily seek fusion with their idealised mother, in order to avoid fears of losing all the goodness she could offer. He explains this as a universal defence against loss and separation anxieties. Glasser states that this fantasised merging with the object also serves to fend off any destructive impulses against the mother. Glasser tells us that if this defence becomes fixated, and thus pathological, no separation can be tolerated. This would then impact all future relationships. Although an ordinary stage of development, seeking fusion with the mother raises deep anxieties about the loss of self and independence in the infant. Glasser describes this anxiety as fear of being totally annihilated and engulfed by her. Often, the defence then becomes narcissistic withdrawal, which ensures a safe distance from the mother-object. Glasser explains that perversion arises as a solution to the constant tension between fear of engulfment and fear of total abandonment, as a merging of sexuality and aggression, which he terms the 'core complex'. The aim of perversion, according to Glasser, is to control the object. Through inflicting pain, patients sustain the illusion of being able to control what the object feels, emotionally and physically. The pleasure in sadism derives from being able to force or seduce the victim into participation against her/his will, by total overpowering. Glasser explains that this creates the illusion that nothing could prevent the satisfaction of the patients' needs. Glasser also explains that in order for this solution to be sustained, that mother is viewed as entirely ideal, and the bad, threatening parts are projected onto either a third party, such as the father, or onto the patient's body, which then is treated as separate from the patient's self. This might result in self-harm or suicidality. Glasser writes about the different mechanisms individuals who develop a perversion may employ later in life, such as deception, humiliation, sadistic inflicting of pain, or masochistic submission.

Chassequet-Schmirgel (1985) makes it clear that perversion seems to be the only solution that these patients find to avoid either a psychic breakdown or literally attacking or killing the other due to the unbearable pain they experience. Because of its delusional nature, however, this solution could only be sustained so long as the patient could, in fantasy, obliterate their own and others' awareness of any boundaries, limitations, and differences. Such people find themselves compelled to attack any generational or gender boundaries, and the awareness of any difference between good and bad. Any feelings of deprivation, need, or vulnerability must be destroyed in order for the illusion of omnipotence to be sustained.

Harmful sexual behaviour

Many authors (Music, 2022; Nathanson et al., 2021; Morgan and Ruszczynski, 2007; Campbell, 2005) write that harmful sexual behaviours cover a wide spectrum of actions. They could be subtle, and go unnoticed, or not cross the threshold to being an offence. Others are harrowing crimes. The literature (Music, 2022; Nathanson et al., 2021; Morgan and Ruszczynski, 2007; Campbell, 2005) says that crossing the body boundary is key to perversion. And violating the other's body can be experienced as a concrete overpowering of the other. Some authors (Danziger, 2021; Nathanson et. al, 2021) outline the ways in which such behaviour changes due to technological developments enabling infliction of unimaginable emotional and physical damage remotely, through the internet, for example by spreading photos and videos of intimate content online, and fake adverts on behalf of somebody else, inviting brutality by strangers (Danziger, 2021). Many authors (Music, 2022; Nathanson et al., 2021; Morgan and Ruszczynski, 2007; Campbell, 2005) agree that it does not make sense to typify harmful sexual behaviour, because they vary extensively. However, they state that what categorises harmful

sexual behaviour is deriving sexual pleasure by inflicting physically and/or emotionally pain on another human being.

There is a debate in psychoanalytic literature about whether or not harmful sexual behaviour is a response to the perpetrator having suffered abuse. Some authors consider what might be motivating young people, who have not themselves been abused, to engage in harmful sexual behaviour. Woods (p.138) discusses what he calls ''Street Sex Offenders'' who have not been abused, do not appear to suffer deprivation, and whose families are shocked by their offences. Horne (2003, p.351) states that 50% of perpetrators of abuse have experienced abuse themselves. Woods (2003) suggests that lack of ego capacity and excessive envy are possible reasons that people who have not suffered abuse may employ perversion. Wood (p.434, 2014) quotes Bion's ideas on harsh superegos as relevant to this patient group: 'It's an envious assertion of moral superiority without any morals…'. Wood (2014) describes how some perpetrators believe they are doing something acceptable, or even loving, whilst enacting their envy and sadism.

However, most authors (Music, 2022; Nathanson et al., 2021; Morgan and Ruszczynski, 2007; Campbell, 2005) believe that engaging in harmful sexual behaviour comes mostly as a result of having been abused, be it sexually, emotionally, and/or physically. Morgan and Ruszczynski (2007) offer such an understanding of the merging of sexuality with aggression. They state that all people gain a sense of who we are through emotional interactions with others. Knowing about oneself also includes knowing how others know us, and, by extension, how we treat others. The authors state that if we get the chance to learn that our innate aggression and envy can lead to a desire for cruelty and destruction, we would be better prepared to

contain these feelings rather than to uncontrollably act them out onto others. Added to this is the way our first objects treat us, and foster either our capacity for love to mitigate hate and destruction, or further enhance our pleasure in destruction. The authors also point out that patients who were abused or neglected often feel themselves justified to inflict this onto others.

Nathanson (p.276, 2016) points out that, in perversion, the initial attachment of sexual excitement to pain is a mechanism connected to the feeling of 'triumph over the omnipotent rage' of being helpless and little when being abused in the past. Nathanson writes that sexually abused patients usually share about a turning point marked by their initiating an act to increase the abuser's pleasure, which the abuser did not expect. This becomes highly addictive, as it gives the victim the illusion of having some power; of being in charge. Nathanson says that this turning point usually distorts the reality of the trauma, it cuts it off from thinking and feeling, cutting the link between mind and body, and the patient's awareness of being abused ceases, while they remain aware of the facts of the abuse. The good object is idealised, but never accessible or available for protection or love, while the bad object is always there, easily able to immediately bring the trauma to repeat. Nathanson (2016) points out that the sexualisation of hatred and violence becomes a highly addictive sadomasochistic mechanism. He explains that this mechanism takes over the patient in such a way that emotional pain becomes integrally connected to sexual excitement. Nathanson clarifies that the abusive experiences of these patients have shocked them out of the belief that a good object could exist. Moreover, any glimpse of hope they may get from something good stirs up an experience of humiliation of having been naïve enough, or having been seduced by the abuser, to somehow let the abuse happen. Campbell (1994) explains that,

when a child is abused, what he calls a 'shame shield' is sadistically pierced, and the disgust towards the abuser is turned inwards as disgust towards the self. How could they believe anything could be real when nobody saved them from the abuse? Nathanson (2016) states that abusing others gives a feeling of omnipotence and triumph, grounded in the illusion of being in charge. The triumph, Nathanson clarifies, is not only over the victim, but over any need for goodness, love, or kindness, and in this way it obliterates the fear of abandonment. Through these acts, they turn love into hate, abuse into love.

Many authors agree that perversion damages relationships (Meltzer, 1973; Etchegoyen, 1989; Campbell, 1994; 2005; 2013; Bergmann, 2000; Horne, 2003; Woods, 2003; Santoro, 2005; Parfitt, 2006; Morgan and Ruszczynski, 2007; Masi, 2008; Ellis, 2009; Koritar, 2013; Wood, 2014; Music, 2016; Nathanson, 2016), and that reality-obliteration fantasies are at its core, denying separateness as well as generational and other fundamental differences. Basic social capacities, such as curiosity and creativity, are impaired, as is sometimes even the ability to work. These authors also stress the link between perversion and personal experience of abuse. However, society often perceives perpetrators of perverse acts as 'evil' (Stone, 2010), and some clinicians avoid working with these individuals (Horne, 2009). Morgan and Ruszczynski (2007) suggest that society tends to fail to consider their experiences because of the unconscious wish to project one's own difficulties on perceived 'devils' (Music, 2006).

Results of the literature on CPTs' experiences

Campbell (1994) explains that children always experience abuse as their parents' failure to protect them, regardless of whether or not the parent was the abuser. The child's general belief in authority as protective thus fails. In order to survive psychically, the child idealises the cruel, sadistic, powerful image, and mocks the idea of a protective figure. Such patients often seem compliant, but this serves to exercise their power over the therapist, through the experience of trickery and deceit of authority. Campbell (2005) explains that such patients perceive the therapist as the protective authority that not only failed to protect them, but also abused them. Genuine engagement with the therapy fosters fears of being taken over by an abuser.

Morgan and Ruszczynski (2007) explain that these patients project the experiences of abuse and disturbance onto the therapist. In therapy, these patients feel forced to be in touch with what they have been deprived of when they most needed it. This stirs up envy and thus resistance and attacks on the therapists' capacities to think. Morgan and Ruszczynski (2007) also write that individuals with sexual perversion seek not only to hurt the other's body, but to violate and corrupt the other's mind by twisting and stripping reality and truth from any meaning. All boundaries become blurred and everything becomes bad. Morgan and Ruszczynski also consider Gilligan's idea of the role of shame relevant. Gilligan explains that when such patients perceive themselves to be humiliated, disrespected, or shamed, they often act out violence. This immensely complicates the work of the psychotherapist, whose role involves exploring both the victim and perpetrator part of the patient.

Yakeley's (2007) findings about the increased risk of violence during psychotherapy. She states that this patient group is usually out of touch with feelings of anger, sadness, and envy, tending to split and project such feelings onto the clinicians. However, since it is fundamental to psychotherapy to help the patient become aware of such emotions, the clinicians put themselves at risk of both emotional and physical attacks. She also says that when clinicians do not receive enough supervision and support, or they have not been adequately analysed, patients can also easily evoke anger, fear, and disgust, and thus provoke sadistic or punitive reactions in the therapists. Other patients will stir up feelings of sympathy that activate 'rescues fantasies' in the therapist, who then fails to acknowledge current risks and past offences (Yakeley, 2007, p.73). Morgan and Ruszczynski present Davies's ideas about professionals being tempted to deal with the emotional pain stirred up by the patient by finding someone to blame. This may lead to dangerous collusion with either the victim or the perpetrator part of the patient. Yakeley (2007) also stresses the need to offer staff work-experience groups and supervision to prevent emotional cut-off-ness, burn-out, cynicism, or 'us versus them' mentality.

Chassequet-Schmirgel states that there is huge pressure on the therapist to avoid insight and contact with reality in the therapy. Wood (p.430-431), 2014) suggests that, in the counter-transference, the therapist often feels 'disgusted by such a confusion of functions, tricked by sudden shifts from constructive to destructive, or cheated as if something we thought was constructive has suddenly been hijacked and distorted… an assault on the person's innocence'. She describes how, when a patient discloses abuse (either as a victim or as perpetrator), or shares their feelings, the therapist often feels confused about whether they are invited to be excited, in a voyeuristic way, or witnessing a genuine emotion. She also says

that this work sometimes makes the therapist feel special, as if they have been given the chance to learn about something so rare from a front row seat, which leaves them in doubt about whether they have colluded.

Horne (2003, 2009) explains that professionals from the support network of such patients unconsciously identify with and enact the positions of the patient's family members, which affect their perception. Some view the patient only as a traumatised victim, and do not acknowledge their dangerous behaviour. Others see the patient as evil and monstrous. She (2003, p.347) describes that the therapist's own morals are challenged, and it can feel like they are in a 'war zone'.

Woods (2003) points out that, with these patients, psychotherapeutic work is further complicated by the confidentiality principle reminding the patients of the secrecy involved in the abuse. Campbell (2013) explains that there is constant tension between the moral and legal duties a clinician needs to obey, and the effort to sustain the therapeutic connection to the patient. He writes about how doubt becomes a conscious and unconscious way for the patient to attack the benefits of the treatment, and to torment the analyst, seeking perverse gratification from overpowering the object. Campbell (2013) also writes about the difficulties of reporting an offence perpetrated by the patient, given that the clinician works with the internal world of the patient, and not the facts of the external reality.

Most of the perpetrators of harmful sexual behaviour are male. Welldon (1988, 2011, 2017) and Yakely (2007, 2014) have explored the role gender plays for these patients. Welldon's influential body of work suggests that male patients tend to fantasise about or hurt other

people, whereas female patients tend to hurt their own bodies or children. Further, Woods and Williams (2014) state that little is known about the impact that the therapist's gender has on the therapist's and the patient's experience. Yakeley (2014, p.103): 'The gender of the therapist might not definitively determine the outcome of therapy but will certainly shape our patients' therapeutic journeys in meaningful and unexpected directions. For the violent or sexually perverse male patient whose disturbed behaviour carries an unconscious communication about his early traumatic history, his experience of the female therapist will inevitably be distorted by his early experiences of his own mother that formed his internal object world, a bleak, persecutory landscape ruled by pre-oedipal modes of thinking and dominated by a terrifying pre-oedipal mother'.

Psychoanalysis provides valuable insight into the nature and function of perversion, and how young people with sexualised aggression could struggle to make use of psychotherapeutic help, to tolerate being in touch with their emotions, and to think about relationships. However, there are many unexplored aspects of psychotherapy with such patients. Most of the above-quoted authors belong to a small professional community linked to the Portman Clinic. I wonder what views therapists working in other settings could have. Further, there are no published studies that limit their scope to particular age groups, for example. Not many authors have written about the possible impact of the therapist's gender on the experience of such patients in therapy. Welldon (1988, 2011, 2017) and Yakeley (2014) have explored the CPTs observations on what role their gender could play in the interactions such patients. Yakeley's important observations on this are made in the context of leading a group, then becoming pregnant and having to hand over the group during maternity leave. She describes

how this stirs up issues with sibling rivalry in the group, which would not necessarily be a part of individual therapy with a female therapist, for example.

2.3.2 Results of the literature of empirical research

The search on available empirical research did not yield any published studies on the experience of psychoanalytic psychotherapists working with young people suffering from perverse fantasies and/or engaging in harmful sexual behaviour. A thorough search unearthed only a few empirical findings on helping interventions for young people who engage in harmful sexual behaviours (Bordium et al., 1995; Lawson, 2003; Ayland and West, 2006; Letourneau, 2009; Ikomi et al. 2009; Somervell & Lambie, 2009. Koritar, 2013). All studies identified are about adolescents with severe delinquent or violent behaviour, and aim to prove the effectiveness of particular interventions. Since the findings are scarce and largely vary in study design and population, I will present them chronologically, rather than clustering them based on study type.

Joseph et al. (1963) *The Effectiveness of a Comprehensive, Vocationally Oriented Psychotherapeutic Program for Adolescent Delinquent Boys*

This study is an RCT exploring the effectiveness of a vocationally oriented psychotherapeutic programme for 15-17-year-old teenage males. School staff had referred them following antisocial activity, or them being expelled from or dropped out of school. The program includes both practical support, such as aiding the participants to find a job, and continue their education, and intensive psychotherapy. The findings are based on pre-treatment and

10 months post-treatment data. The data-collection method consisted in presenting the youths with cards with pictures, then encouraging them to come up with a narrative.

This study opens up important questions about what such young people need in order to be able to both engage in education/work and better manage their emotions and behaviour. This research contributes to our understanding of young delinquents' need for a holistic approach, with a secure network of professionals being key for the therapeutic intervention to be effective. Choosing RCT allows for clear comparisons between the treatment and the control group. Further, collecting data pre- and post-treatment gives solid ground for conclusions that would otherwise be compromised by individual differences between the participants and those who were not offered any intervention.

However, there are significant concerns about the validity of the data. Firstly, the psychologist who collected the data relied on an unstandardized projective method, without reporting internal validity. Secondly, offered psychotherapy was not manualised, and no fidelity data was reported. The practitioner who delivered it met with the boys up to 10 times per week, both during the day and at night, without meeting times having been agreed in advance. This does not fit within common therapeutic practice. The night-time visits to the patients—without the presence of other colleagues—especially raise concerns of a lack of appropriate therapeutic settings and boundaries (Lanyado et al., 2009). Thirdly, the authors also do not mention if the participants consented. It is reported that some of the young people expressed unwillingness to participate, but were pressured to do so. The authenticity of the answers are thus put into question, which compromises the data. Significant improvement in self-image

and aggression control is reported without the researchers accounting for any of the above-mentioned limitations of their study.

Lawson, L (2003) *Becoming a Success Story: How Boys who have Molested Children Talk about Treatment*

This is a qualitative research project, using Grounded Theory to explore the impact of outpatient treatment on 14-18-year-old teenage boys who have molested other children. Over an average of 18 months, a team of nurses, psychologists, and social workers provided guidance to the boys and their families at their home and/or in the community. The data had two different sources. The participants were asked to respond in writing to open-ended questions. There were also audio-taped interviews with the young people. The authors write that the participants showed improved self-control and increased remorse for what they had done.

The use of different data sources allows the researcher to cross-reference the open-ended written answers of the young people with their interviews. Extracts illustrate the young people's answers, but give no insight into how these answers were coded. However, the findings are undermined by various unaddressed limitations. There is a discrepancy between the research question, which focuses on the participants' experiences, and the results, which are presented as evidence for relapse prevention and compliance. The research question asks how the participants talk about the treatment, but the report provides little clarity. Moreover, the authors present the treatment as entirely successful, but the 'guidance' is not manualised and lacks clear description.

There are serious ethical concerns. It is unclear if the participants gave informed consent for the audio-recordings. The young people's written answers, which contained their personal experiences, including sensitive memories of abuse, were available to parents/carers. It is unclear if the researchers explored how these boys felt about their answers being shared. There was also no discussion of how the lack of confidentiality itself may have impacted the answers of the participants. The placements of these boys were described as fragile and I wonder if they said what they thought they were expected to say in order not to lose their carers. Furthermore, the questions were phrased in a leading way. And the clinicians appeared to have significantly interfered with the data collection. One was reported to have told a participant, during the data collection, that he was a 'success story'. It looks like the people who offered this 'guidance' were telling the participants to praise the treatment.

Ikomi et al. (2009) *Treatment for Juveniles who Sexually Offend in a Southwestern State*

This research explores the available treatments for juvenile sex offenders in 23 counties in a Southwestern state of the US. It is unclear what the design of this study is. Data collection is described as: 'A 25-item questionnaire was mailed to sex offender treatment providers from counties with 60 or more reported juvenile sex offenders in a Southwestern state to determine the most effective treatment for juvenile sex offenders' (p.1). The study states that cognitive behavioural therapy (CBT) is the most common and the most effective treatment, with an average success rate of 87%. The authors also state that indecency with a child involving sexual contact is the most common sexual offence.

Although this paper broadens the awareness of the types of interventions offered to juvenile sexual offenders, there are various significant issues. It does not describe what the

questionnaire involves or how the data was analysed, quantitatively or qualitatively. The design of the study is unclear. It looks like an audit or a survey.

The authors reported CBT as most successful but there is no consideration of how this result was impacted by the fact that less than half out of 23 counties (41.88%) responded. And only 44% of the treatment providers reported they offered juvenile-specific treatment. The researchers account for the lack of random selection on the limited generalisability. However, they don't discuss the possible impact of the success rate being based on the subjective opinion of the providers, and the large variety of incomparable instruments used by the individual counties (polygraphs; plethysmographs; standardised and non-standardised measures). The authors also do not report any consideration of differences in treatment duration. Some treatments lasted 60 months, and others only 6 months.

Letourneau et al. (2009) *Multisystemic Therapy for Juvenile Sexual Offenders: 1-Year Results from a Randomized Effectiveness Trial*

This study is an RCT comparing the effectiveness of multisystemic therapy (MST) adjusted for juvenile sexual offenders and TAU-JSO, a treatment commonly offered to juvenile sexual offenders. MST is a manualised home- and community-based treatment, with team members available 24/7. MST includes expert consultation sessions, weekly supervision, and additional training. TAU-JSO is a certified treatment involving 60-minute, once-weekly, CBT-led group sessions, and includes twice-monthly supervisions and some ongoing training. The data was collected through individual assessment protocols, which the young people and their carers completed at home. There were 127 participants between the ages of 11 and 17 at the start, 2.4% of whom were female. According to the results, the group which had MST demonstrated

significant decrease in harmful sexual behaviour, delinquency, and substance misuse. They also seemed to have improved their mental health, and more of them were placed in their families.

This research demonstrates a suitable design, accurate statistics procedures, and transparent presentation of the results. The authors have considered that, due to the family contact, the researchers could not be blind to the treatment modality. They have also accounted for possible bias due to two of the authors delivering weekly MST consultations. However, the authors did not consider the differences between the two therapies regarding amount of supervision, therapy hours per week, availability of the therapists, and the training and support they received. Even though these differences were linked to the therapy model, when exploring effectiveness, the fact that SD (Standard Deviation) of MST duration tells us that the young people benefitted from this treatment for at least 4.3 months, whereas those having TAU-JSO stayed for a significantly shorter duration, for example, 2.7 for 'diverted youth', and 3.6 for 'probation'. I wonder if the difference in the results might not necessarily be due to the effect of the therapy, but to differences in amount of time the therapists spent with the participants, and the support these therapists received during the provision of the treatment.

Somervell and Lambie (2009) *Wilderness Therapy within an Adolescent Sexual Offender Treatment Programme. A Qualitative Study*

This research project uses thematic analysis to qualitatively explore the nature and impact of wilderness therapy (WT). WT is part of SAFE, a 12-24-month treatment programme. It includes four-to-six days of outdoor activities, such as hiking, rafting, or mountain biking.

Whilst taking part in the activities, the WT therapists encourage thinking about disclosure and victim empathy.

The data consists of semi-structured interviews with the young people, semi-structured interviews with the WT therapists, and the researcher's observations of the camp activities. The results consist of four themes, where WT had a positive impact on: 'enhances relationships', 'view of self', 'intensity of the experience', and 'aiding disclosure' (p. 167).

The authors admit that design issues mean that general conclusions about the effectiveness of WT cannot be drawn from the results. WT is not clearly defined, and the activities in it vary largely. However, the researchers helpfully provide data on the differences in responses from participants who were just at the beginning of the therapy, and those who had attended for longer. The authors also point out that, having no comparison group, the findings are not generalisable. However, no consideration is reported on the possible impact of researcher bias. It is unclear if and how the researcher's relationships with the participants impacted on the answers given during interviews. It is also unclear if and how the bonds between the therapists and the young people may have influenced what feedback they gave about the programme as a whole. Moreover, the young people were interviewed about the effectiveness of WT whilst they were still attending it. All participants were non-voluntary. It is unclear whether the young people tailored their answers to fit in with what they thought would be considered good progress or engagement with the program. It is also unclear whether the young people feared their answers might be fed back to the referrers.

Klietz et al. (2010) *Cost–Benefit Analysis of Multisystemic Therapy with Serious and Violent*

Juvenile Offenders

This RCT compares the cost-effectiveness of multisystemic therapy (MST) and individual therapy (IT). It relies on data from a follow-up RCT with serious juvenile offenders who have perpetrated at least one 'sexual assault', 'assault and battery with intent to kill', or 'aggravated assault'. The treatments are compared on the basis of the joint cost of resources spent on therapy, justice-system spending on rearrests, and victim compensation (for lost property, healthcare, emotional damage). The initial RCT included male and female participants, and the mean age was 14.5 years at the time of treatment. A particular strength of the study is that they did a follow-up after 13 years.

This project demonstrates a suitable design, it is well thought-out, with adequate statistical processing of data and transparent consideration of its limitations. The authors report that MST proved more cost-efficient than IT in relation to intangible benefits, such as emotional damage, but not so effective for tangible benefits, such as property and medical expenses.

MST is reported to be manualised, licensed, and providing a lot of support for the clinicians, such as supervision, staff training, weekly expert consultations, and organisational support. On the other hand, IT used for the purpose of this study is not manualised, and is described as 'eclectic'. It is unclear what this individual therapy consisted of, and it can therefore not generate the generalised conclusion that individual therapy per se would be less cost-effective than MST.

Keiley (2015) *Multiple-family Group Intervention for Incarcerated Male Adolescents who Sexually Offend and their Families: Change in Maladaptive Emotion Regulation Predicts Adaptive Change in Adolescent Behaviour*

This RCT evaluates the effectiveness of multiple-family group intervention (MFGI) with incarcerated male adolescents placed in the Department of Youth Services' (DYS) correctional facility in Alabama as part of the Accountability Based Sex Offender Program (ABSOP). The young people were between 12 and 19 years old, and had committed serious sexual offenses, such as fondling/ molestation, receiving and/or giving anal or oral sex, digital penetration, and forced vaginal intercourse.

MFGI consists of 8 twice-monthly 90-minute sessions for the adolescents with their parent(s) or carer(s), with marriage- and family-therapists, or trainees under supervision. The therapy aims to prevent future offensive behaviour, to foster a capacity for empathy, for tolerating alternative viewpoints, and for developing caring relationships based on trust and mutual dependence. The data is collected pre-intervention, post-intervention (4 months after pre-test), and a follow-up 1-year after that. Both the adolescents and their carers need to fill in a quantitative survey, and assess the adolescents' progress.

The authors justify the grounds for carrying out this research very well, quoting numerous sources that point to the high prevalence of sexual offences amongst male adolescents. There is also evidence of ethical approval, as well as formal consent from the participants.

The authors present their findings accurately and transparently, but interpret them in a highly glossed-over way, thus creating misleading impressions. The authors state that all their

hypotheses have been confirmed, maintaining that all participants have improved over the course of MFGI. However, some of the data, such as the maladaptive emotion regulation, does not significantly correlate with change as reported by fathers. It is also stated that no significant change is found in the adolescents' closeness to others. The findings show that the adolescents demonstrated no change in externalising behaviour predicted by change in maladaptive emotion regulation. Instead of accounting for the lack of significance, the authors insist that 'significant variance did exist' and that they regard this as a predictor of change (pp.330-331). The study accounts for some unexpected results, such as the positive correlation between an increased ability to depend on others and an increase in anxiety and fear of abandonment.

Some of the authors' statements are not statistically justified (p. 335): 'Because we had so little data at 1-year follow-up, we only examine change over 1 year for externalizing and internalizing behaviour and maladaptive emotion regulation'. It is unclear why the researchers assume that not having enough follow-up data would mean that some of the variables can be significant, when they have too little data to compare to the rest of the variables.

In the discussion, the authors address some of the limitations of their study, such as the impact of its lack of control group, and the fact that it is impossible to differentiate what part of the adolescents' progress is due to other interventions, such as school, educational groups, individual therapy, and carer visits. The authors rightly point to the longitudinal nature and the multiple data sources (adolescent, mother and father) as strengths of the study. However, they don't discuss the impact of MFGI not having been manualised. The paper states (p.337):

'we also rely on volunteers from the marriage and family therapy clinic at our university for assistance in the clinical work and use of the data for research'. It is unclear if and how these volunteers have been trained and supervised, which is concerning on an ethical level (in relation to the quality of the interventions offered to the young people). It also evidences a lack of consistency amongst the interventions. Possible bias is also not discussed in the context of the trainees being supervised by the researcher. The trainees could be consciously or unconsciously influencing the participants' attitudes and answers. And the participants themselves might be consciously or unconsciously impacted by a sense of loyalty towards their therapists, e.g. by wanting to demonstrate the treatment is working.

Ybarra, et al. (2016) *Lifetime Prevalence Rates and Overlap of Physical, Psychological, and Sexual Dating Abuse Perpetration and Victimization in a National Sample of Youth*

This longitudinal RCT investigates ADA (adolescence data abuse), and the overlap of victimisation and perpetration of physical, psychological, and sexual abuse (as part of the dating process). The participants were pairs of caregivers and young persons, where the young people (53% male and 47% female) were 10-15 years old at baseline, and up to 21 years old by completion. The sample was formed on the basis of random 'first come, first serve' recruitment.

The sample was a multi-million-member panel of online participants. The adults were initially sent general demographic questions without knowing this would indicate whether or not they were eligible for the current study. The ones fitting in with the recruitment criteria were then invited to participate in the larger study. The study was advertised via targeted emails sent via third parties, TV advertisements, member referrals, and telephone recruitment of

targeted populations. As much as the researchers proclaim with absolute certainty that their sample mirrors the US population almost identically, no consideration is shown to what impact the recruitment process might have had on the results, for instance that people with no internet access would be unable to take part. It is also unclear how the process of targeting was conducted, and who decided who was to be targeted. After all, only 1586 out of millions were recruited. Moreover, no consideration is shown to how the results might have been skewed by participants opting in voluntarily (who were the carers who decided to opt in, and why did they choose to do so?). Drop-out cases were reported but their data was simply removed, with no attempt being made to explain what occasioned the drop-out, and what impact this had on the findings. In addition, 18% of the eligible participants were never surveyed, as the targeted sample size/quotas had been filled in. This also remained unaccounted for in the article.

The researchers adapted items from a scale used as part of a dating-violence prevention program. Some items were combined, and a shorter scale was produced. The researchers boldly report adequate internal consistency, but one of the subscales is not at all consistent with the rest. This undermines the main measure. The researchers report that the perpetration questions were asked immediately after the victimisation questions, and that perpetration was measured as a frequency, while victimisation was measured through dichotomy. They did not address the reasoning behind this choice, nor the impact that these differences might have had on the results. What is more, the formulation of some of the questions sounds misleading and confusing, such as asking about abuse in the context of ’someone you would call a boyfriend or girlfriend’ (p. 1093). I wonder how the young people within this age-bracket would define ‘a boyfriend or a girlfriend’. Does it denote long-term

relationships only to them, or one date; two dates? The authors did not address any data that might have been missed due to the limitation of this formulations.

Ohlert et al. (2017) *Comparison of Psychopathological Symptoms in Adolescents who Experienced Sexual Violence as a Victim and/or as a Perpetrator*

This RCT compares the differences in symptoms (internalising and externalising) in young people (male and female between 15-22 years of age) who experienced sexual abuse both as victims and as perpetrators. The adolescents were recruited on a voluntarily basis, from boarding schools and residential care homes in Germany. All participants were in these institutions following harmful or delinquent behaviour. The study defines sexual violence as per the Wold Health Organisation's definition: 'any sexual act, attempts to obtain sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work' (p. 374).

All participants were invited to gather in a large hall, and were asked to fill in questionnaires in the presence of the researcher. The researchers had designed the questions addressing sexual violence, which first stated the definition of sexual violence, and then described 7 situations of violence, ranging from receiving sexual images or videos to attempted penetration. The participants were asked to respond with yes/no if they had had such an experience. Since the paper does not discuss the exact formulation of these situations, nor what impact the wording or the content might have had on the results, all of this remains unclear. The measure used for the psychopathological problems is standardised.

The authors discussed the limitations of the study thoroughly. They thought carefully about the possible impact of various uncontrollable factors, such as that the cross-sectionality of the survey does not allow for definition of direction of effect. The authors also considered that the study could not guarantee the truthfulness of the responses, due to the measure being self-reported. They also accounted for the natural bias in admitting sexual perpetration, especially in relation to possible dissociation and memory difficulties, given the sensitive nature of the topic. The limitation to the generalisability of the study, due to the sample living in residential institutions specifically for delinquent adolescents, was acknowledged. Moreover, the researchers addressed the likelihood of the participants to consciously under-report perpetration of abuse, as well as under-reporting physical perpetration, due to the explicit instruction for participants to indicate it only if they were the initiator of the attack. The authors acknowledged that not being the initiator does not necessarily mean that the attack was in self-defence, nor that it was proportionate. The researchers also thought about there being insufficient gender distribution for them to be able to investigate the possible impact of gender.

2.4 Summary

There is a significant 40-year gap between the first project (published in 1963) and the rest of the empirical findings (published after 2003). The lack of therapeutic interventions for adolescents who engaged in harmful sexual behaviour poses various questions. Why was this patient group offered so little? What impact does this gap in treatment provision have on such individuals and their possible victims? Woods (2003) suggests that people who have already acted violently need containment, and find justification for further offending in

feelings of rejection by the society. The treatment experiences with patients who engaged in harmful sexual behaviour are under-investigated, unlike the forensic aspects of the topic, and unlike the experiences and the impact of working with aggressive or physically violent patients. Horne (2009) writes about her colleagues having shared with her that they avoid working with such patients, as the emotions are too intense. It appears, from these findings, that the combination of the sexual and the aggressive aspects of the work with these patients is very challenging, or even off-putting. Morgan and Ruszczynski (2007) suggest that treatment with such patients is not simply disturbing or difficult, but that it can also be very confusing and dangerous.

What is more, many of the above-presented studies raise serious ethical concerns. Some of the studies report no ethical approval. In others, there was no consideration of the young people being forced to participate and share intimate emotions. In Lawson‘s (2003) study, in particular, the young people were taped, and consent was not even mentioned. Moreover, the participants’ answers were given to their carers without consideration for how this might impact the already fragile placements, nor how their participation in the study may impact access to jobs and educational opportunities. The way in which these participants’ rights to consent and their emotional needs were overlooked signals a tendency towards malpractice. This not only compromises the outcomes and the knowledge of the studies, but it also points to what needs to be changed regarding structure and access in relation to treatment interventions for such young people.

It becomes obvious that very few interventions are offered to such patients. Indeed, most of the above-quoted studies explore the effectiveness of new treatments, and their designs

consist of a broad range of quantitative and qualitative measures, many of which lack generalisability. There appears to be a huge gap in our knowledge about what these patients need, as well as regarding what support the professionals need in order to work effectively and safely with such patients.

There are also no empirical studies on psychoanalytic psychotherapy with these young people, and what the CPTs experiences could be. The lack of publications suggests that working with such patients is very challenging. It seems that it is also very difficult to investigate this type of sensitive phenomena through formal empirical research, since putting such sensitive data into words and making sense of it can be both confusing and challenging for the researchers. I wonder if struggling to find a suitable approach to communication and understanding of such young people is the reason for this topic being so under-investigated.

2.5 Conclusion

Overall, the literature review has yielded very scant theoretical and empirical contributions on this specific topic. The few papers identified and discussed suggest that such young people develop perverse fantasies and/or engage in harmful sexual behaviour as an addictive solution to painfully complicated relationships with their parental figures. This impacts the whole of their personality and current relationships, and thus poses significant challenges and presents high risk in psychotherapy. They are nevertheless under-investigated. In order to address the gap in the literature, I decided to carry out a small-scale qualitative study, interviewing psychotherapists working with such patients. I wanted to know what these

professionals thought and felt about their work, and to formally explore whether common themes could be identified within this patient group. In this way, I have aimed to shed much-needed light on the topic, and to broaden our understanding of the characteristics and the functioning of these young people within the setting of psychoanalytic psychotherapy.

3. Part II: EMPIRICAL STUDY

3.1 INTRODUCTION

This study explores the experiences of Child and Adolescent Psychoanalytic Psychotherapists (CPTs) at the Portman Clinic, who work with young people (aged 14-25) with perverse sexual fantasies and/or who are engaging in harmful sexual behaviour.

For the purposes of this study, perversion is defined as deriving pleasure from and aiming 'to cause the object to suffer, physically or mentally, crudely or subtly' (Glasser, 1979, p. 281).

I chose to interview CPTs because psychoanalytic psychotherapy relies on understanding patients' internal worlds, and helping them think about it in a digested form (Bion, 1984). CPTs use countertransference, where patients consciously and unconsciously communicate feelings and phantasies by the experiences they evoke in the therapist (Bion, 1984). CPTs are thus trained to make sense of patients' emotions by acknowledging and reflecting on their own feelings in response to the patients (Heimann, 1960). Therefore, interviewing CPTs will hold the potential of shedding light on the nature of the interactions between CPTs and patients.

The Portman Clinic was selected as it is the only national service offering 'specialist long-term psychoanalytically informed psychotherapeutic help to people who suffer from problems arising from: delinquent behaviour, criminal behaviour, violent behaviour, paraphilias (disturbing and damaging sexual behaviour or experiences)… provide services for people who

may be excluded or rejected by other services because of their past or present behaviour' in the UK. The Portman offers individual and couple psychotherapy, both on a once-weekly scale or as intensive therapy, as well as weekly group therapy. They also 'offer a mentalisation-based treatment programme for men with a diagnosis of antisocial personality disorder who want help for managing their aggressive behaviour.' They offer support to 'patients with a forensic history (people who have a mental health problem who have been arrested, are on remand or have been to court and found guilty of a crime) and those suffering with personality disorders…' (Tavistock and Portman website).

The 14-25 age span was identified based on the general consensus amongst UK helping professionals that this age group best outlines adolescence, as it ordinarily involves mental and physical changes, and brings sexual fantasies and risk-taking behaviour to the surface (Copley, 1993). Copley (1993, p. 83) writes: 'Early adolescence starts with the emotional responses to the bodily changes of puberty. It brings psychic energy to the surface in a sexual context, and ushers in the mental tasks and changes of the whole process. Major preoccupations at the time are likely to be around these bodily changes and concomitant confusions as to who one is in relation to this child-into-adult-body'.

The study aims to find the common characteristics the CPTs observe in this patient group, and to identify particular challenges and opportunities the CPTs face in such work.

3.2 METHODS

3.2.1 Design

This is a qualitative study, employing Interpretative Phenomenological Analysis (IPA) to analyse semi-structured interviews with the CPTs.

The choice of design is motivated by the nature of the researched phenomenon. Given that human relationships are at its core, the decision about what data to collect and what analysis to conduct was based on the conviction that understanding the lived experience of the CPTs and how they make sense of working with this particular patient group would answer the research question in as rich and truthful a way as possible.

A qualitative approach was chosen over quantitative methods, as the literature suggests that this is a complicated phenomenon involving powerful conscious and unconscious emotions (Morgan and Ruszczynski, 2007). Quantitative measures would fail to capture the complexity and the nuances in the experiences of working with these patients.

The choice to rely on a qualitative phenomenological method also stems from the fact that, as a researcher, I too am influenced by conscious and unconscious biases rooted in my personal experiences, culture, history, education, etc. This would inevitably influence how I read and analyse the answers of the CPTs, and it thus makes sense to account for this and to use my own thoughts and responses to the data as information. Cresswell (2007, pp.15-16) states: 'In the choice of qualitative research, inquirers make certain assumptions. These

philosophical assumptions consist of a stance toward the nature of reality (ontology), how the researcher knows what she or he knows (epistemology), the role of values in the research (axiology), the language of research (rhetoric), and the methods used in the process (methodology). ‘

The design choices are made in line with the postulates of social constructivism. Aiming to understand the real-life experiences of professionals in their ordinary environment, includes making sense of multiple realities, and social constructivism looks at the experiences of the participants as a consequence of their interactions with others, rather than as a fixed constant, which could befall any person in any context (Cresswell 2007). Therefore, phenomenology allows the researcher to learn about the phenomenon’s essence, ‘a grasp of the very nature of the thing’ (Mannen, quoted in Creswell, 2007, p. 58), by relying on the fundamental features that interviewees could consciously describe. Creswell outlines the development of phenomenology as taking off with Husserl’s introduction of the term ‘epoché’, or ‘bracketing’, which serves to acknowledge the subjectivity of perception.

3.2.2 Participants

The participants are five experienced, qualified CPTs working with young people (between 14-25 years of age) at the Portman Clinic. For the purposes of this study, perversion is defined to mean deriving pleasure from and aiming ‘to cause the object to suffer, physically or mentally, crudely or subtly’ (Glasser, 1979, p. 281). Three of the CPTs are male and two of them were female. This was not a deliberate choice I made, but a result of the natural process of voluntary recruitment.

3.2.3 Procedure

The participants were recruited on a voluntary basis. An email (Please see Appendix F) was sent to all psychotherapists currently working at the clinic, asking for their participation. The email contained a brief outline of the project, its aims, and how it would be conducted. The participant information sheet (Please see Appendix H) was attached to the email. It gave detailed information about the purpose of the study and how the data would be collected. It stated that their data would be retained for 3-5 years after completion of the research and stored only on encrypted devices maintained by the Tavistock and Portman Trust. A reminder email was sent after 2 weeks.

Due to the ongoing Covid-19 related measures, the interviews were conducted and audio-taped via Zoom, in a locked, password-protected meeting. All CPTs were emailed a consent form (Please see Appendix G) and were asked to fill it, sign in, and return it via email prior to the interview. At the start of the interview, participants were reminded that they will be audio-recorded.

3.2.4 Interviews

Since the interviews were semi-structured, the interview schedule was used as a guidance. This allowed for flexibility with regards to how the questions were phrased, and the sequence in which they were asked. I could also ask follow-up or clarificatory questions. The interviews lasted between 50 and 60 minutes each.

The interview included the following questions:

1. How would you describe the perverse fantasies patients typically share in therapy?

- Could you tell me about moments when patients first shared their perverse fantasies with you?
- Could you describe a typical patient experiencing perverse fantasies or harmful sexual behaviour?

2. What do you think are the challenges and benefits of working with such patients?

Possible prompts:

- What do you usually watch out for when working with such patients?
- What do you think one can learn from working with such patients?
- What place does supervision have in working with such patients?

3. How do you think such patients relate to the therapist?

Possible prompts:

- How do they communicate their experiences in therapy?
- What changes does one ordinarily see in therapy with such patients?
- What impact do you think indirect mediums of work, such as video or phone call, could have on the therapeutic contact with them?

4. What do you think about confidentiality regarding psychotherapy with young people having perverse sexual fantasies and/or engage in harmful sexual behaviour?

Possible prompts:

- Could you think of an example when you considered breaking confidentiality?
- How could you describe the risks of somebody being hurt by the patient whilst in treatment?

All interviews were digitally audio-recorded, and were assigned a number to identify the data. The interviews were transcribed verbatim and anonymised during this process.

3.2.5 Data analysis

The interview data was analysed using IPA, following the approach described by Smith et al. (2009).

I have chosen IPA as a method of making sense of the data. IPA is ordinarily applied to semi-structured interviews of a homogenous group of participants who have been subjected to the studied phenomenon, in order to address the research question, which has already been formulated in advance (Smith et al., 2009). The participants in this project shape a homogenous group, as they belong to the same professional discipline, and share the same work environment.

Smith et al. writes that 'a qualitative research interview is often described as "a conversation with a purpose"' (p. 59), and argues that IPA interviews are guided by a particular question, whilst simultaneously aiding interviewees to reflect on their own perceptions and experiences. Moreover, being semi-structured, the interviews allow the researcher to be led

by the participant's answers, which facilitates greater understanding (Clarke and Braun, 2014). According to McLeod (2001), IPA relies both on ontological (the core essence of the phenomenon), and on epistemological (what can be realistically learnt about the phenomenon) hermeneutics. As such, IPA's imbedded 'double hermeneutics' corresponds to the complexity of the conscious and unconscious experiences of CPTs, whilst allowing for the researcher's reflections to contribute to the findings (Smith et al.).

In other words, IPA allows for an in-depth analysis of the individual accounts, as well as for the researcher to learn about how interviewees (in this case, CPTs) make sense of their experiences, not merely through descriptions. Since the interviewees are 'defended subjects' (Holloway & Jefferson, 2013) and can only share what they consciously know, it is particularly helpful that IPA allows the researcher to present their own ideas about the meaning of transpiring subtleties (Smith et al.) and what the interviewees may be unconsciously communicating. For example, Luft (1969) describes the 'Johari window' model, relevant to IPA, where what is unconscious to the interviewee and unknown to the researcher, could be further revealed in the interactions between the two. The participants need not be aware of these experiences, and the researcher need not have thought of these experiences as being in existence, in order to explore them. However, in the interview—in the contact between participant and interviewer—they could stumble upon and discover, or simply become aware, of these experiences. As much as CPTs are trained to be aware of uncomfortable or challenging experiences as part of their daily work, being people, they too have unconscious experiences that they are naturally not aware of.

Smith et al. (2009, p. 59) describes that '[the] plan for IPA interviews is an attempt to come at the research question "sideways"', where instead of asking direct, closed questions, the researcher can set the scene at an abstract level, fostering a discussion on topics relevant to the research question, the analysis of which would reveal the required answers. This technique is employed in an attempt to broaden the understanding of the phenomenon.

Smith et al. recommends between 4 and 10 interviews for a professional doctorate. I conducted 5 interviews.

Smith et al. encourages researchers to analyse each interview before conducting the next, so that they might expand their own ideas of what could be known of the phenomenon and to thus tailor their approach to the next interview. I strived to follow this model. However, due to time constraints on both my and the participants' part, I only manage to follow this approach for the first and the second interview, whilst I carried out the remaining three interviews close together without analysing them in-between. However, since the interviews were very rich and lively, there were themes and questions from the preceding interviews that I was able to further explore with the last three participants.

My analysis plan followed the model suggested by Smith et al., where researchers using IPA are to explore their data, analysing each interview individually, before tracing and developing themes across all interviews, thus enabling a coherent, shared narrative to emerge. Smith et al. explains that IPA requires that the researcher achieves a detailed familiarisation with each interview, reading and re-reading it, and focusing on the descriptions of the experiences by each participant, as well as how they understand and make sense of their descriptions.

Following this model, I initially read the interviews without necessarily looking for themes, but allowing the data to naturally reveal its messages. Smith et al. (2009) postulates that the researcher is then able to identify units of meaning in the individual interview. At that level of analysis, I highlighted what felt to be important statements in the interview, without coding for themes related to the research question. After that, I began to code only those of the highlighted areas that were relevant to the research topic, and to categorise them as descriptive, linguistic (in this instance, linguistics includes not only verbal specifics, but also non-verbal communication), and conceptual (please see Appendix 2, which provides an illustration of the coding process). In this way, I began to make sense of these areas in terms of themes within the individual interview. I formulated the emergent themes, and then the superordinate themes in each individual interview.

Smith et al. suggests that the emergent themes could be formulated through abstraction (subthemes were united on the basis of similarities); subsumption (one of the emergent themes helps to organise other emergent themes, and contextualisation in order to understand the text better); polarisation (where the focus is on differences or opposition between the emergent themes); contextualisation (focusing on temporal, cultural, or narrative themes to explore local understandings); numeration (the frequency of emergence of the theme in different interviews); and function (based on the specific function of the theme to communicate meaning). These structured themes become the basis for writing a full narrative supported by anonymised vignettes from the interviews, including detailed commentary on interpretation of the researcher. Smith et al. also points out the importance of the researcher reflecting on their own perceptions. The impact of the researcher's unique

position and personal notions on the interpretation of the findings is an important finding in itself.

Following the suggestions of Smith et al., after the themes within each interview were shaped, I looked for similarities and differences across all the data, paying attention to the interplay between the content and themes within the individual interviews, and those across all interviews. Smith et al. stresses the importance of the dialogue between what the participants say and the researcher's understanding or interpretation of what is said.

The data was analysed with the following two research sub-questions in mind:

1. What do the CPTs think this patient group has in common, and how do the patients' perverse fantasies and/or harmful sexual behaviour play out in the therapy room, in CPTs' views?
2. What are the experiences of the CPTs working with such patients, and what are the challenges and the opportunities the CPTs face?

3.2.6 Ethics

This project was sponsored and supported by the Tavistock and Portman NHS Foundation Trust and received all relevant ethics and research governance approvals (Please see Appendix D and E). This process was overseen by the University of Essex.

All participants are adult CPTs who gave written consent about their participation in the research. As part of the consent form they confirmed knowing that their participation was voluntary, and that they were free to withdraw, without giving a reason, at any time up to one week after the completion of the interview. There was no payment or incentive available to the participants. The consent form included the CPTs agreement to the interviews being digitally recorded and transcribed verbatim, as described in the participant information sheet.

In the consent form, the CPTs were informed that direct quotes from the audio recording may be used in the research study, but that this would be made anonymous to the reader and held securely by the researcher. In addition to that, given the sensitive nature of the patient group, I also reminded all participants at the start of the interview to give examples that referred to patients in general, rather than specifying individual cases, so as to ensure that patient confidentiality is maintained. The consent form stated that the information they provide would be kept confidential, unless someone affected was deemed to be at risk. The document clearly stated that the nature of qualitative research included quotations, which the participants may recognise as their own. Participants were also informed that all possible measures would be taken to prevent third parties from being able to identify the author of any quotations used.

Given the sensitive nature of the topic, possible emotional distress arising during the interviews was considered. All participants are part of a service team and have their own support structure and supervision that they could turn to, if needed. The interviews were conducted within the participants' usual working hours to ensure other members of staff would be available. A debrief email (Please see Appendix I) was sent following the interviews,

which included the contact details for the researcher, the project supervisor, and the Head of Academic Governance and Quality Assurance (this information was also included in the participation information sheet).

In line with the 5th principle of the Data Protection Act (1998), which states that personal data shall not be kept for longer than is necessary to the purpose for it was collected, the participants were informed that their data would be retained for 3-5 years after completion of the research.

3.3 FINDINGS

The superordinate themes are here presented in line with the two research sub-questions, starting with how the CPTs make sense of what they think this patient group has in common, and this is followed by the themes focusing on the CPTs experiences.

I formulated some superordinate themes based on views discussed in all interviews. Other superordinate themes were formulated based on ideas expressed in only one or a few interviews (i.e., not all). Smith, et al., 2009 points out that since IPA explores the lived experience of each participant, the significance of each theme is not justified by how many times it is mentioned, or by how many participants mention it. Smith et al. explain that an idea may be mentioned only once, and could still be important enough to form a superordinate theme, if the researcher feels that it carries meaning that contributes to the understanding of the phenomenon. For example, the superordinate theme discussing the impact of the CPT's gender, has been shaped out of my interpretation across all interviews, despite the individual participants not speaking to it explicitly as central to their experiences. And the order of presenting the themes or the number of quotations illustrating them does not suggest that any one of the themes has higher importance than others (Please see *Appendix 3*. It illustrates how the final superordinate and subthemes were developed out of the themes emerging from each individual interview).

The formation of each superordinate theme and its subthemes is described in detail below. Where possible, direct quotes from the transcripts are used as titles of the themes, so as to

convey and emphasise the lively meaning of these themes. Smith et al. (2009) calls this 'in vivo coding', as it brings the analysis to life for the reader, like a gestalt or 'a nugget'. The interview number is indicated at the end of each quote. Due to the word-limit, only the most relevant quotations across all interviews are presented under each subtheme.

Figure 3 *Study Findings*

SUPER-ORDINATE THEMES	**CPTS VIEW PERVERSION AS AN ENTRENCHED SOLUTION TO EMOTIONAL PAIN.**	**"IT'S VERY, VERY DISTURBING TO GET HOLD OF THE PERVERSE PART OF THE PATIENT"**	**IN CPTS' VIEWS, STARTING PSYCHOTHERAPY SIGNIFICANTLY INCREASES THE RISK OF HARM TO SELF AND OTHERS, AND IT CANNOT BE CONTAINED INDIVIDUALLY.**	**CPTS' GENDER MATTERS**	**"AN ANTIDOTE TO THE DISTURBANCE"**
Sub-themes	• "Intimacy carries a huge threat to them." • "The commonalities are that the body has to be used in a sexual way to express not love, usually hatred…" • These patients appear to experience dissociation from reality and disconnect between mind and body. • These patients seem to seek being caught out. • CPTs see perversion as addictive.	• "It's a toxic environment, trauma, anyway." • "It's very easy to turn a blind eye." • "You can't trust what's being said."	• "Working with these patients on my own, that would be really though, and dangerous…" • These patients appear to be extremely sensitive.		• Having reliable and containing support system, makes it possible for the CPTs to bear the disturbing nature and the stigma of working with this patient group. • This work can be rewarding, allowing the CPTs to learn more about human nature and to have an impact on society on a larger scale.

*The super-ordinate theme named *CPTS' GENDER MATTERS* has no sub-themes.

3.3.1 Superordinate Theme 1: CPTS VIEW PERVERSION AS AN ENTRENCHED SOLUTION TO EMOTIONAL PAIN.

This theme is very rich of strands, reaching each and across all interviews. It was formed through 'abstraction', where the many emergent themes were pieced together, and given a new cluster name (Smith et al., 2009). This superordinate theme name is based on what the CPTs think this patient group has in common. All participants have stated clearly that there

aren't common perverse fantasies or typical harmful sexual acts that could characterise the individuals. The CPTs think that the psychological function of perversion is the common denominator, and the consequences this carries on an emotional, mental, and behavioural level.

'Intimacy carries a huge threat to them.'

And so their parents tend to be, or their experiences tend be, about gross intrusion into them, and neglect, and absence. So intimacy carries a huge threat to them. (Interview 2)

All interviewees say that these patients have reported having suffered severe emotional trauma, which has made close emotional contact with other people frightening and unbearable.

They're not trying to harm, or hurt, or be cruel. They're just trying to manage their anxiety of fragmentation that comes with being connected. (Interview 1)

Simultaneously, these patients don't seem to have given up their interest in relationships. The CPTs point out that perversion becomes an addictive solution to these contradictory tendencies. In CPTs' views, these patients imagine that they could control what might happen between them and other people by forcing others to have particular feelings, often pain, fear, disgust, humiliation (in some instances, these patients seem to treat their own body as if it is a separate object). Harming the patient's own body, or the body of another appears to be sexualised, giving an illusion of being powerful and cut off from one's own emotional pain.

I just made a link for her about why she's feeling something about her mom, about her actually feeling quite vulnerable and upset… and she says: 'Now, I think I'm getting aroused about you'. And I say… That means that I've said something that has made you feel understood… but slowly we can talk about these defences'. (Interview 1)

The CPTs described that the patients often speak of being aroused in the sessions, as a way to defend themselves against emotional closeness with the therapist. The arousal, or explicit sexual language, seem to be a way to evoke anxiety, fear, and disgust in the therapist. The CPTs understand this as a protective shield that the patients put up against the threat of intimacy and what the patients fear intimacy might do to them (for example engulf them, seduce them, create dependency, etc.).

So that, to have closeness with somebody, there's a sexual drive to closeness, but it gives rise to terror and fears which may take the form, in a growing boy, of no self-esteem, feelings of inadequacy, humiliation, rejection by females. All of these things are painful affects, and so to try to defend himself, he seeks to dominate the female or child. (Interview-4-male)

The CPTs view perversion as a way for these young people to manage their need for intimacy whilst being terrified by how their object of desire could unpredictably hurt and humiliate them.

If you think about being a child who's been sexualised by their mother, who's so confused between affection and sexualisation… A boy I worked with, whose mother used to have sex on the bed with anybody who came into the house… when the two boys were on the bed too. She used to watch pornography with them while she kind of had her arms around them, stroking their heads, and talking about school, while hardcore pornography was on. (Interview 1)

The CPTs have shared clinical examples, where their patients seemed preoccupied with their mothers. In these examples, the young people have spoken about bodily involvement with their mothers that has left them feeling confused about intimacy and its appropriate boundaries. The CPTs have conveyed different aspects of what they called being ''sexualised by their mother'' (Interview 1) such as: the patients having been sexually abused by a parent; having witnessed sexual abuse or sexual content; patients having spoken about feeling that

their parent has been inappropriately involved with their bodily care; patients having communicated their experiences of being treated as if they were a partner to the parent (rather than the child), having felt pressure to keep the mother happy or meet her needs for affection.

...I understand the perverse behaviour of the boys I see, as a way both of an attack on mainly the maternal objects, and aggression that can't be expressed in an ordinary way, particularly because of the terror of what it will do to needing to keep the mother in the mind alive but also wanting to attack her... Because, is it that they're sexualised early?… every single patient that I have, probably has been sexualised early. (Interview 5)

The CPTs pointed out that not all such patients have been sexually abused or witnessed sexual scenes as children, but they all have conveyed confusion about their role in relation to their mothers, and about who (mother or child) has the responsibility to meet the other's emotional needs.

'The commonalities are that the body has to be used in a sexual way to express, not love, usually hatred…'

In order to, kind of live in a world that isn't perverse, and come from a world that is perverse, perversion has to go underground, and goes through the hole in the wall… It's something to do with using other people's bodies to tell your story… You're not sitting in the room cutting or stealing. You're doing something to other people, getting rid of an experience, transferring it to someone else. (Interview 1)

The CPTs feel that such patients use their body to hurt others rather than to participate in mutually enjoyable pleasurable activities with them. These patients appear to consciously or unconsciously seek to violate others' bodies because every interaction could trigger the anxieties they have felt in relation to their primary carer.

In terms of the content of fantasies, there isn't a typical thing. You know, the common denominator is the way the body is used, and sex is used to express hatred… The commonalities are that the body has to be used in a sexual way to express, not love, usually hatred… Like sado-masochism… When the perversion fails, violence can erupt… and it's always a turning point when they realise the hatred. The hatred is almost never at the beginning... Ahm… they'd always talk about the sex… that they're using their body and their penises, when they're masturbating, in a hateful way, and they hate the child, not that they just hate what they do. And it's the perfect solution to experiences such as having been humiliated, or good aggression is not at your disposal, or when you feel belittled, he always goes there... (Interview 3)

The CPTs share their private theories, according to which hurting others' bodies via sex is linked to seeking to triumph over one's own vulnerabilities and dependency. It appears that hating their own need for love and goodness, these patients seek to make others vulnerable. Abusing others' innocence and need for affection may give the perpetrator the illusion of feeling cut off from pain by inflicting it on others.

These patients appear to experience dissociation from reality and disconnect between mind and body.

…the function of perversion is to get away from reality… it's something that takes the place of something worse that allows the person to hold themselves together, to somehow cope… (Interview 1)

These young people appear to experience dissociative states where reality, memories, and fantasies become blurred and confused. Thus, perversion is experienced as an alternative reality where they define the rules.

... it's almost as if they are offending in the moment, in saying the word, if that makes sense. So, it can feel very… like it's an act in itself when they're describing it. (Interview 2)

The CPTs suppose that these patients struggle to have a firm grip on what is real. They appear to confuse past and present, actions and words, feeling suddenly overwhelmed by their powerful emotions.

But when the… teenage boy you see, described what he had done, and described how he'd done it, how he went, found the sister in the night, and crawled in… and thought she was asleep. She didn't wake up. She never woke up. And then you realise the massive disavowal of reality about what he's doing, that his body is disconnected from his mind completely. He is not completely, fully grasping the intensity of what he's doing, and he really believes that the sister is asleep, although in reality she's frozen in fear. (Interview 3)

The interviewees observe a genuine confusion between reality and fantasy, and between right and wrong. They suggest that the patients dissociate both from the trauma they suffered and the trauma they inflict, as if cancelling it out.

And he may be really quite unaware of his capacity for strength, for doing harm. And this is coupled with another awareness, which is about the law. So, he may be genuinely surprised, when he gets into serious trouble with the law, not imagining that he could be put in prison for assault, not imagining that by simply grabbing a woman's arm in the street or on the train, that this is an assault, and this could be regarded as a serious crime. So, these things can be astonishing to a boy who's relatively immature, emotionally, maybe cognitively impaired as well. So, as a therapist one is often up against a degree of a sort of deficit in his understanding of what he is, where he is in relation to the law, and there may be a strong educational component that's needed before psychotherapy… There's guilt, but also an identification with the victim. And they will feel themselves to be the victim. Sometimes, that is a rationalisation, and a justification for offending... (Interview 4)

The CPTs consider that these young people may experience cognitive challenges. It is unclear if having been abused has impacted these patients' brain development and thus, have impaired their capacity to comprehend societal rules, or that their dissociative states prevent them from being in touch with the rules of the law.

These patients seem to seek to be caught.

So, we're hearing about what the children will become if they don't have treatment, these borderline, anti-social, very isolated, very dangerous adults. That's it when this hasn't been caught in time, and then many of them go to prison or mental health… (Interview 1)

In CPTs' views, getting caught means to these patients that somebody is willing to help them stop the vicious circle of hurting. The CPTs think that unless these young people have long-term therapy, they would be more likely to end up in prison or a mental health institution. The CPTs also warn about the importance of prevention. They suggest that the older a younger person becomes, the worse impact perversion has on their mental health.

I have a patient who sexually abused his sister, and you can't undo that, you have to kind of find a way to live with it. But when you do that, when you really experience that, I mean it's not about forgiveness, forgiveness is also a way of getting rid of something. If you acknowledge what has happened, you can understand, you can fully appreciate it, you're no longer behind the wall of shame, you've moved on, you feel guilty, worried. You know that you're never going to do it again. Then you begin to recover… Beyond this, especially this adolescent place, where you've done something terrible, it doesn't have to determine the rest of your life completely and really destroy your life from now on… Pay for it. But it's really, really difficult… Once you've been bad, you want punishment, a relief. (Interview 3)

The CPTs feel that these patients need a treatment that addresses the deep-seated emotions of shame and guilt, and that more strategy-based approach would not be significantly beneficial.

But when you feel you have no place to go, it actually fuels an escalation, you end up enacting, enacting more, and digging yourself a hole, and the only way to stop is to be arrested.. And until they are, and until they're caught… Being caught can do a fantastic thing. If they're not caught, they cannot attend to their difficulties. (Interview 3)

The participants have observed that being caught seems to have helped their patients to experience a sense of restoration of justice and reliable rules that could govern the relationships between people. The CPTs think that these patients not only benefit from, but

actively seek to be caught. In CPTs views, unless these patients get caught, they'd be left on their own with their torturing feelings of guilt and shame which fuel their urges to perpetually abuse others.

The better outcome for me, the ones that seem to be doing the best in therapy, are the ones who've been caught, and have been prosecuted, and have got away from their families, which they wouldn't have done otherwise… because, as I can understand it, there has been a boundary, they have to recognise what they've done. (Interview 5)

The interviewees suggest that having been victims of abuse, these young people see the world as unfair and unpredictable, where only being a perpetrator could prevent one from being a victim. Being caught, appears to give these young people a sense that there is somebody who knows right from wrong, and that there could be another way of living, where people don't have to hurt each other.

CPTs see perversion as addictive.

…for them, doing whatever they did was the best idea possible in the moment… Like a solution, and the most exciting, and the most everything… So, by being an addict, you'd constantly control all the vulnerability, or your violence, or whatever it might be, in a sado-masochistic way. It's always about control… in order to stop it, you need to be in control of the addiction, there's something that doesn't add up there, right? Because, in my point of view, if you want to abandon addiction, you need to find a way to be less in control, to emerge out of the sado-masochistic relationship, and to allow freedom for yourself and the object… 'OK, if I don't sadistically control her, she might still want to be with me, right'… Actually, understanding in psychoanalytic way… is not enough… It isn't, because it still leaves the addiction there in their body, especially with the abused ones… and you can only use your penis in one way, you can't use it in another way, and it's not exciting if you don't. And how do you do that? You really need to recondition your neurons about all your body to experience something different, or starve it from something. It's really, really difficult. (Interview 3)

The CPTs think that perversion is addictive. They warn that acting out painful emotions through the body appears to be compulsive, even if one has an insight into the links between

having been abused and perpetrating abuse. The CPTs describe perversion as a solution to feeling helpless and overpowered. Thus, perversion becomes associated with both relief from pain and excitement about triumph over one's vulnerability. The interviewees suggest that ordinary interactions could no longer be experienced as exciting. Moreover, the process becomes automated, where the moment one feels anxiety or pain, the urge to hurt others can't be helped. This supports the CPTs view that long-term treatment is essential for this patient group.

3.3.2 Superordinate Theme 2: 'IT'S VERY, VERY DISTURBING TO GET HOLD OF THE AGGRESSIVE, PERVERSE PART OF THE PATIENT'

This theme, like the previous one, was organised on the basis of 'abstraction'. It speaks directly to the core of the research question, describing the experiences of CPTs, working with these patients.

There is a high level of stress regarding risk. One participant spoke particularly of these patients feeling isolated and aiming to isolate the CPT, evoking emotions that are hard to share. The analysis suggests that the CPTs' gender is an aspect linked to their experiences. Since it has significance and depth in its own right, it is given representation in the 4th separate superordinate theme.

'It's a toxic environment, trauma, anyway.'

…but now I've had enough experiences to know what to do with these sorts of very graphic images that they push on me. But the other thing about it is that they'd often… make me…

finish it off in my mind. And that's very powerful, really, and disturbing. It's almost more disturbing… than actually being told exactly what it is that they want to do or have done. (Interview 2)

The interviews indicate that this work is not simply frightening. Some of its aspects linked to the sexualised nature of these young people's actions and fantasies could also be very disturbing. All CPTs point out that working with this patient group is distinctly different from working with delinquent or violent patients. The CPTs explain that working with these young people leaves on unsure how to think or what to say about the sexual content they share. The CPTs have expressed how difficult it is to know if listening to the content in the session is an important part of these young people feeling understood or they are consciously or unconsciously pulling the CPTs to collude.

It felt absolutely terrifying when I first started… I just couldn't understand how we'd not be calling Safeguarding, like all the time, and how he'll be able to help these patients... Ahm, I've forgotten your question in terms of how it feels, yes… But I just think with experience, it's just… ahm… a bit more able to contain these horrible feelings without needing to evacuate them through action, which is exactly what we're asking the patients to try and begin to do. Think not act. (Interview 2)

The participants have often paused unpredictably or their mind seemed to have gone blank when being asked how it feels to work with these patients. One wonders if remembering how it felt in the session could be so disturbing that it causes one's mind to switch off. Moreover, it appears that it's very difficult to find the right language and to put one's feelings into words that are both sensitive and accurately representing.

…it does take a lot, because you get exposed to a lot of trauma… what people could do to each other, all these disgusting things… So, over the years, I've tried not having it all about it. I have other friends, and other interests, and I don't watch dark Danish murder mysteries on Netflix… the difficulty is that you become a bit dark… there's something disturbing about it. Once you're exploring this a lot, you cannot recover a sense of yourself (Interview 3)

The CPTs have spoken about the lasting negative impact of this work on their personal life and emotions. It appears that working with this patient group makes it harder to be in touch with the enjoyable experiences in life or to feel hopeful.

It's a toxic environment, trauma, anyway. (Interview 4)

The CPTs have expressed that working with these patients stirs up very disturbing emotions, and being in touch with them on a regular basis, might sometimes make it difficult to keep in mind what is normal and what is not.

And one feels furious in a way, if one's a bit in touch with what's happened to this child, and it feels hopeless. And I don't want to hear these stories anymore. You forget that there's a normal world out there... But, ahm [longest pause so far]. I think it isn't realistic to see… if you're seeing 5 or 6 of these cases every day a week. That would be too much, but we don't do that. (Interview 5)

The CPTs have stressed that having huge caseload of such patients would be not be safe in regards to the clinicians' wellbeing and their capacity manage risk.

'It's very easy to turn a blind eye'

…with some you feel like you deny their aggression, you feel very kind of warm. And afterwards, you think: 'My God, where was the aggression?! What was I doing in this room in order to survive something I can't manage?!' …sometimes you really get excited at the idea of a patient, which is not always a good excitement. So, there's more of an invitation to collude with something… working with this type of patient… we do accept the invitation to get alongside but we have to try not to collude and you're sort of lined up for getting it wrong. (Interview 1)

The CPTs have communicated that working with this patient group could be incredibly anxiety provoking. They clarify that helping professions suggest one would be making things better

and helping a victim or a person in need, but it becomes invariably more disturbing and complicated to help somebody who is also a perpetrator or have failed to protect a child.

It's very, very difficult, going for the [pause] perversion. In the session, we all want to reassure, the sort of nicer, good bit. So, it's very shocking. So, for example, recently I'm working with a [parent], and [they] sort of, something happened to their child, and I think they allowed it to happen, and I think it's the expression of anxiety. It's both unconscious, but it was coming up to consciousness. You could miss it in the session because the pressure to go with 'But you did report it to the authorities'. Maybe I shouldn't say this, because it's very specific, see, I'm worried about confidentiality. (Interview 2)

The CPTs said that the therapist is constantly doubting their judgement, and that the most challenging, and anxiety- and guilt-provoking aspect is to bear the temptation to turn a blind eye to the perpetrator side of the patients. This seems to be illustrated between the contrast of ''shocking'' and ''minor'' applied to the same incident.

You [the therapist] don't let people [patients] take you for a ride… and sometimes you realise you don't want to run too deep, and be exposed to something you don't want to be exposed to… Most people who'd be writing about patients, it would be about their trauma, about how they've been victimised, about how they're at risk from others, and how they're at risk from themselves in a suicidal way. And in Portman, when we write about the Portman patients, it would be all that, plus how others are at risk from them, or how they've broken the law and continue to do that… Absolutely, you contribute to it going under the radar, because you don't want to work with bad people, you don't want to know about bad things. When I worked in CAMHS, I'm sure I worked with a lot of Portman patients but I didn't know. (Interview 3)

All CPTs have warned against the pull to turn a blind eye and not think about or address the perpetrator side of the patients. The CPTs convey that they have developed an awareness of one's natural wish to feel like a kind therapist who knows clearly who the victim is and who the perpetrator is. However, the CPTs voice how complicated it is when both are the same person. Furthermore, the CPTs have clearly outlined that working with perpetrators of sexual abuse is distinctly different from working with perpetrators of physical abuse, for example. One wonders if there is a sense that physical damage could be repaired or healed, whereas

damage of sexual abuse is so complex that it has irreparable consequences, and thus instinctively one doesn't want to be in touch with or know about such kind of pain.

That's always very shocking, when you realise that it's not real, and it might have started as a real close moment of honesty and openness, and then… It might last seconds, and then it turns into something hard and controlled, and managed by the patient. That feeling of sort of being dropped, and sort of the foolishness, and shame about that, you know, you do feel it. …being able to bear being humiliated, that you've believed them about something. You believed the lie… (Interview 2)

The interviewees have shared repeated experiences of feeling tricked in the countertransference, where the patients unconsciously communicate their own emotions by making the therapist feel very confused between what is a genuine emotion and what is a sadistic, abusive attempt to dominate another.

It's very, very disturbing to get hold of the aggressive, perverse part of the patient in the moment... It's very easy to turn a blind eye, and collude with this side of the patient who doesn't want to think about that. But that's what they're bringing you to do, that's your job, really to find a way of sort of switching the light on… There's something specific about working with patients who are turning a blind eye, or people have turned a blind eye to them... And if something… comes to mind or is around, and it's really bugging you, it's a sort of a way of addressing it and bringing it into the meeting, when everyone is turning a blind eye and keeping it out. (Interview 2)

The interviewees flagged up the temptation to turn a blind eye to the perverse part of the patient, and it seems that it could also be linked to the patients unconsciously communicating their own terror of being in touch with the emotional impact of having been abused. It appears that wanting to cut off from knowing about it could be associated with what Bion (1962) terms ''nameless dread'', a set of experiences that are difficult to be verbalised or explained, but feel like they could make one's whole world and mind disintegrate.

'You can't trust what's being said.'

So, you might be with a child who's leaping around or… telling you something that sounds as though it should be nice, but feels profoundly sad. So, the unconscious communication is really, really, I mean it's always important. (Interview 1)

All CPTs have described that they cannot rely on what the patients report they are feeling or doing. The interviewees explain that these patients are sometimes cut off from or confused about their experiences.

They're very, what [a colleague's name] would call 'backroom boys'. They've got a sort of place where they control. The person that they present in the world, is very sort of, victim-like and compliant, you know, and plausible. So, I suppose you can never take anything at face value, in terms of your experience. The one thing you have to depend on massively is your countertransference, which can be very different from what seems to be going in the room... a lot of the trauma we come across is preverbal. So, it's stored in the body without kind of necessarily being able to put it into words. (Interview 1)

The CPTs said that these patients often seem to hide or deny their actions to avoid being reported to the authorities. The participants think that these young people consciously or unconsciously attempt to control the CPTs' perceptions and responses.

3.3.3 Superordinate theme 3: IN CPTS' VIEWS STARTING PSYCHOTHERAPY SIGNIFICANTLY INCREASES THE RISK OF HARM TO SELF AND OTHERS, AND IT CANNOT BE CONTAINED INDIVIDUALLY

This theme was consistent throughout all interviews, and was largely supported by the participants' explicit comments. Based on 'subsumption', this initially emergent theme was given a superordinate status, thus combining different nuances expressed in the individual interviews (Smith et al., 2009). This theme outlines that psychoanalytic psychotherapy with

such patients seems to increase the risk of harming oneself and/or others which cannot be contained individually.

I decided to represent the heightened risk and the emotional fragility of the patients in two separate subthemes, because the latter is important in its own right. The CPTs stressed that these patients appear to be easily overwhelmed by powerful emotions which influences the whole therapeutic process. The CPTs thus need to be very careful about their approach to each patient. On the other hand, I have chosen not to represent this aspect in a superordinate theme because, according to the participants, what is distinct about this patient group is its direct link to high risk.

'Working with these patients on my own, that would be really tough, and dangerous…'

[A colleague's name] kept saying to me: 'But, is the risk being managed at the network?' And I didn't really know what that meant, and I said: 'Well, there's a probation officer' and he was saying: 'No, people always refer for psychotherapy 'cause they think this will help the risk. What I'm saying is that it doesn't help with the risk. If anything, it can make it worse. Before we take a child, they need to be settled... (Interview 1)

All CPTs highlighted the importance of being supported by colleagues and the network. The CPTs pointed out that having many such cases can easily overwhelm them, and compromise their capacity to manage the risk. The CPTs have said that starting psychotherapy seems to weaken the patients' defences, and puts them in touch with unbearably painful emotions.

And I'd imagine the moment when you clock that, not having all the supervision and the meeting with the team that we have at the Portman. If you are on your own, or your team isn't so alert to aggression as the main dominant driving force in a perverse way... It's very easy to turn a blind eye. (Interview 2)

In CPTs views, due to this patient group's specifics, supervision and a containing team are essential requirements for working safely. They also suggest that experience in or awareness of working with these patients is needed in order for the team to be able to adequately support each other.

Working with patients on my own, that would be really tough, and dangerous, and quite… Not to say that people don't, because cases like this happen in all sorts of CAMHS, but there's risk involved, I think. And we do turn a blind eye. (Interview 2)

The CPTs seem to differentiate between the risk of the clinicians feeling overwhelmed and the risk of these patients resuming offending others without this being known.

…but that was… aaa… aaa… a very disturbing example which alerted me to the dangers, the risks of seeing these youngsters, and how we need to be so very careful. Fortunately, I think he was stopped, before he did too much harm. The boy he abducted spoke out. So, it had not gone too far. There was some damage limitation. The boy was stopped. So, I don't have to punish myself too much about that... (Interview 4)

All CPTs have spoken about the level of responsibility when working with such patients and the powerful feelings of guilt in case they act out. One wonders if the pauses and the struggle to find words shows interviewee 4's distress, reflecting on what happened. All interviewees repeatedly stressed that working with these patients requires the involvement of the whole network, the home environment, the educational provision, and all the relevant authorities. They explained that since psychotherapy works with the patients' internal world, there must be institutions who can oversee and manage their actions in external reality.

He is isolated with his fantasies. He isolates his victim, typically, as means to abuse. Ahm, so isolation is the danger. Sharing things in a group, secrets coming out, is a cure against isolation. (Interview 4)

The CPTs have warned against lone working and seeing such patients in private practice or outreach services. The participants have pointed out the need for regular team discussions in addition to individual supervision, as more people's views would safeguard against the CPTs unconsciously colluding with the perversion.

I think we need to be careful with being so full of ourselves that we privilege our patient over the safety of another child. And I would… If he does tell me who that is, I would, I'm going to do something. There's a real balance, you need to get support, not to get carried away with what you're doing with your individual. It's not a very restful thing, I hate it when that comes in. What was I going to say… ahm… (Interview 5)

The CPTs spoke about the immense pressures, feeling pulled in all directions, to balance the need for sensitivity towards the patients against the risk of them hurting others.

These patients appear to be extremely sensitive.

You have to be really careful you don't humiliate them back. So, you're in a [pause]. It's always that very sort of fragile dance, really. (Interview 2)

The CPTs warned that these patients seem to be very easily overwhelmed by shame, guilt, humiliation, and hatred of self and others, and this amplifies the urge to push these painful emotions elsewhere via hurting either one's own body or another's.

They come in the sessions, and they talk as victims of themselves. They describe to you what the other part of them has done to them during the week or in the past, and that they really feel hurt about... they feel a lot of pain. There's shame, you know, there's a huge shame barrier to cross. (Interview 3)

The participant stressed that the more these patients get in touch with shame and guilt, the higher the risk is of reoffending, thus creating a vicious circle.

… to feel yourself to be a sex offender at the age of 16, you hate yourself, basically, and you might as well not bother to live. (Interview 4).

All interviewees have described that working towards integration of their experiences seem to increase these patients' suicidality. It appears that being in touch with emotional pain and guilt becomes unbearable, and suicide can be viewed as a way to stop these emotions, and a way to nullify the fact of the abuse. The CPTs feel that when these young people become aware of their guilt, they seem to feel overpowered and out of control, having no way out, no future for themselves, whilst simultaneously no longer being able to rely on perversion to defend themselves against their vulnerabilities.

3.3.4 Superordinate Theme 4: CPTs' GENDER MATTERS

Exploring the impact of the CPTs' gender was not initially planned for. As Smith et al. (2009) suggests, IPA allows for questions that have emerged in one interview to be further explored in the following ones, and for the interviewer to ask directly about what they have already discovered in a previous interview. Thus, I started exploring this in the following interviews, and the CPTs gender has turned out to have more significance than I initially suspected.

Formulating this theme is not to explore gender differences per se, but how the CPTs gender impacts their experiences with the patients. This theme was formulated on the basis of 'function', i.e. the researcher making sense of what has been said across all transcripts (Smith et al.). This theme does not rely on the explicit answers of the CPTs alone. It is formulated on the basis of what has been conveyed via the linguistics, i.e. my interpretation of what is said in some interviews, but not in others.

The analysis across all interviews suggests that the gender of the CPTs impacts their experiences and those of their patients. However, none of the interviewees seemed clear about how gender mattered. All CPTs said that they did not think that their gender could predict or influence the outcome of the treatment in terms of progress. The analysis merely suggests that the CPTs gender does influence the nature of the patient-therapist relationship, and therefore shapes both the CPTs and the patients' experiences.

This theme does not have any subthemes, as there are no defined aspects of this potential link. In two of the interviews, gender is not an emergent theme in itself, but is spoken about in relation to the description of the patients, and the account of the CPTs' own emotional responses to such patients. All CPTs stated that most of these patients are male. All CPTs described that these patients shared experiences of physical or emotional abuse by, or absence of a father figure, and having an unpredictable mother, described by the CPTs as sometimes ''smothering'' (Interview 2- female) and sometimes cold and distanced. According to the CPTs, these patients felt baffled and insecure in their relationship to their mothers.

I had a boy that I saw for many years, and I had cushions in my room. And the first thing he'd do, when he came in and sat down, was to put the cushion across his lap. And I had quite a few patients like that. I happened to have quite a few at that time who have all been sexualised by their mothers. So, I know that during the sessions, that boy, and probably most of the boys, were getting erections when they felt understood. And the cushion became their way of coping with that… But I don't know, if I'd have been male, if that would have happened. So, you think about the child that comes in, and you have to think about their background, and whether they need a mother or a father, and what kind of mother, and what kind of father. That boy would definitely have had a different experience if he had had a male therapist. (Interview 1- female)

The examples the female and male interviewees shared of working with such patients conveyed distinctly different experiences. Looking at the transcripts in depth, I have noticed that the female CPTs reported more frightening, shocking experiences, as well as incidences of visible physical responses in the patients' bodies.

And so, it would extend to who I become to them in the transference. It's very difficult to have an ordinary conversation about… The Easter break... I become very terrifying, a witch really, to them, punishing, I think… Women might have more valency towards taking on the transference of the smothering mother figure. (Interview 2- female)

Unlike the male, the female CPTs reported feeling as if they were punitive, frightening, or withholding support from the patients.

They have very particular kinds of mothers. So, we'd feel, sort of, 'Oh, this feels very familiar', or parents, maybe, less so if it's a relationship with the father. It tends to be more the mother… You know, and in the transference, I was this sort of very dead and grasping parent, and whether or not this happens less with my male colleagues, I don't think so, to be honest. That's just the sort of object we become. But maybe we have more valency as women to sort of take on that transference. But no, I think it sort of comes up for all of us, this sort of dynamic. We rarely have conversations about the gender of clinicians... It comes up but it's not… We just work with the object, I suppose. (Interview 2- female)

The CPTs expressed doubts if and how their gender may impact the therapeutic relationship. Despite that, all participants shared their observations where the patients communicated experiences of feeling intimidated and/or rejected by their mothers.

Yes, you want to know, to know what people do, even in extreme ways. It's just fascinating. And sometimes it's kind of disgusting, you know, shocking but you don't stay with that, that much, you just get on with the work, and with what it means... (Interview 3- male)

The female and the male therapists used different types of language. In my subjective experience as a female researcher, there appeared to be a difference in the way the female

and the male participants talked about the impact of their gender. I had a sense that when speaking to the female CPTs, there was a sense of comradery in sharing with another woman how painful and difficult this work could be. Whereas when interviewing the male participants, I had the impression that they had unique knowledge and private theories about how to bring up positive change in these young men.

…adult males, since we're usually talking about males, have significant bodily power and strength, and use his adult body to force and dominate particularly younger ones, particularly females… The child often represents the female, because the adult woman, or teenage girls, they are too frightening. So, the development of perverse sexuality will involve children as being easy to dominate. And sexual desires tend to accumulate and develop, finding the child as an erotic object. (Interview 4- male)

In CPTs' views, these patients appear to feel threatened by their dependence on maternal care and by women's seductiveness. And thus, these young men appear to seek to overpower women or children (whom they may perceive as extensions of women).

I think there's often a desperate need for a father figure, that's pretty obvious really, because it's their masculinity which has gone awry. They're developing a perverse masculine identity. And they need something a bit more solid, a bit more emotionally real. This might have been a lack in their life. They might have been with an abusive father, or an absent father… (Interview 4-male)

The participants convey that these patients seem to lack benign paternal presence. One wonders if the patients felt unable to express anger towards a father who is absent or violent and thus, they may have directed their unconscious anger towards their mothers and/ or have projected their own aggression onto her. She thus may become terrifying in their phantasy.

There are times when one aims to be a good dad to them. And I think that's what a lot of these boys need, which they've never had. Often, there isn't an idea in their mind of a good dad… almost never. And what it is like to be a man who can take notice of them, and be a kind of model for them. I think it's not… Obviously, you can do that as a woman, as well, but… It's hard when the gender stuff… because all my patients are men… How could it not matter [that the CPT is male]. It's what we are to them. They're all about bodies. And like I say, there's

something… I sort of do feel fatherly towards them. Fatherly stuff is important because these are young men who are mainly struggling with the core complex with their maternal figures. So, you might say, if there was more of a dad around, on the whole that would have taken him away from it. So, I think, in a way, that's what one is kind of trying to do for them, you know, without being… the danger getting too concrete about it. (Interview 5- male)

Unlike the female participants, the male ones reported more occasions of the patient perceiving them as a benign father figure, and a hopeful, protective presence. The interviews suggest a stark difference in the experiences of male and female CPTs and they are all left with the impression that bodies have a huge significance for this patient group.

3.3.5 Superordinate Theme 5: "AN ANTIDOTE TO THE DISTURBANCE".

This theme has been formulated partly via 'subsumption' and partly via 'polarisation', i.e., making sense of difference instead of similarities (Smith et al., 2009). All CPTs described the work as challenging. However, there were also points in all interviews where the CPTs spoke about the antidote to disturbance.

Having reliable and containing support system, makes it possible for the CPTs to bear the disturbing nature and the stigma of working with this patient group.

I've always thought of the Portman as a really creative place. I've never thought of it as a kind of a dark corner, where dodgy things go on… Someone said to me: 'Ooh, you don't want to be tarred with that brush.' 'What brush, what does that mean?!' I never saw it like that. I saw it as an opportunity to do proper work because there was an acknowledgement that the cases were complex and the disturbance was profound. (Interview 1)

The CPTs have communicated a sense that the supportive atmosphere at the Portman functions as an antidote to the stigma of working with perpetrators of harmful sexual behaviours. All participants have expressed their gratitude for having robust supervision. This seems to allow them to continue doing their work up to high professional standard rather than collapsing under the many pressures of these disturbing experiences.

I just love going to work, I really enjoy my job even though I know there's a flip side of it. I think 'I must be mad', you know. This, this must get me somehow, and 'Is this good for my health?' …I think, thinking about it, this must be an antidote to the disturbance, that you feel that this is a good place. It's not like we don't get identified with the badness, at times, and it can feel toxic at times. But on the whole, it feels like a good place... (Interview 2)

All CPTs have said that the nature of this small, contained organisation makes is possible for this difficult work to be hopeful and meaningful.

*You know that your life will be sh*t from now on unless something changes. And if you can get hold of this, with a boy's willingness to give himself a chance, then therapeutically you can feel hopeful… We have faith, and I suppose that's the ultimate basis for the Portman Clinic, that the staff shares a faith in the work, that change is possible.* (Interview 4)

Unanimously, the participants conveyed that there is a sense of comradery and trust at the Portman which safeguards against burn-out. The interviewees shared their private theories about the reasons behind their patients' perverse fantasies or acts. On many such instances, the CPTs changed the way they spoke, from '*I*' to '*We*'. This suggested that having a sense of belonging to a good team counterparts the disturbing emotions one feels when working with these patients.

This work can be rewarding, allowing the CPTs to learn more about human nature and to have an impact on society on a larger scale.

We're very little but you offer a home to people who, who are basically, rejected from mainstream society… So, when you offer them a place, which is a real place with you as a therapist, or you offer them a group, at the Portman… 'You can come here, you know, you're not rejected. You're looked after'…, it's a huge thing. Huge thing… But most often, they'd disclose [patients disclosing what professionals have told them in the past]: 'You don't belong with treatment, you belong with the police. You belong in court. You need to be judged, not helped'. These aren't contradictory things. Some people do need to be judged. But many people seek help, when they catch themselves, or when they've been caught by a partner, or they notice they're destroying their lives… The Portman is a place for people who hurt others, who have terrible secrets. It's essential. Otherwise, they have nowhere to go. (Interview 3)

Most CPTs have conveyed that they provide an emotional and mental home to these young people, which has been denied to them repeatedly by other institutions or professionals.

This is more severe and it's bad on a social scale. And some of them, you know, I've had quite a few patients, that I hated.. and after a while, this is what you give them, even one-to-one. They feel love, because this is what you give them really, because you've gotten to the core, you understand something about it, about them in a very deep way, and you're holding it together, and they feel that you deeply care about them… really… this is when something is very different. (Interview 3)

The CPTs stressed that this work allows them to have a positive impact on society on a much broader scale than with other patient groups, as both the patients and their potential victims are helped by preventing further abuse.

I'm not squeamish at all about what I hear. I've been at the Portman for a long time. In the beginning, it was like, every few months you hear something you've never heard before. And I'm just really curious about these things when I hear about it. Wow, people do this, it's amazing! It's really amazing! I'd love to know. (Interview 3)

The participants have highlighted that one could be interested in this work and approach it with professional curiosity which also acts as an antidote to the disturbing experiences.

3.4 DISCUSSION

As highlighted in the literature review, no published empirical research was found on the experiences of psychoanalytic psychotherapists working with young people experiencing perverse fantasies or harmful sexual behaviour (PsycINFO, PsycArticles, The Pep Archive, PsycBOOKS. And all the empirical findings on any other interventions with such patients focused on extreme violent behaviour (Bordium et al., 1995; Lawson, 2003; Ayland and West, 2006; Letourneau, 2009; Ikomi et al. 2009; Somervell & Lambie, 2009. Koritar, 2013)). Therefore, this study aimed at gaining important insight into the psychoanalytic work with such young people who were not incarcerated, and who had not necessarily perpetrated a crime.

Most of the current findings are in line with the existing psychoanalytic literature. However, this research has also revealed new ideas regarding the CPTs experiences and what they find these patients have in common. The participants see perversion as an entrenched solution to emotional pain. It seems to have significant negative impact on these young people's capacity to make and sustain relationships and on their perception of reality. The analysis also suggests that getting hold of the aggressive, perverse part of the patient is very difficult and disturbing for the CPTs. They stated that starting psychotherapy significantly increases the risk of harm to self and others. This project also raises questions regarding the impact of the CPTs gender on the nature of the work with such patients. And finally, this study has also discovered, beyond what the literature says, that this work can be interesting and meaningful. In what follows, I will discuss each theme in the context of the literature review findings. I will then present an analysis of the strengths and limitations of this study.

CPTs view perversion as an entrenched solution to emotional pain.

This theme provides insight into what the CPTs see as common for this patient group and how it manifests in therapy. In line with the literature findings (Morgan and Ruszczynski (2007); Schmirgel, 1985; Campbell, 2005, Nathanson, 2016), this study highlights that perversion is seen by the CPTs a highly addictive, entrenched solution to emotional pain. The current findings amplify the existing knowledge (Morgan and Ruszczynski, 2007) that perversion seems to allow these patients to cut off from their emotional pain, linked to vulnerability and dependency on their objects of love. Harmful sexual behaviours appear to enable these patients to force these feelings into others. Moreover, similarly to Morgan and Ruszczynski (2007), the therapists in this study also state that such patients express their feelings through the body. Such patients hurt their own and/or other bodies. The CPTs think that the emotional pain that the young individuals experience is too intense to be felt, and has instead taken the form of bodily pain, which feels more bearable. The current findings fit with Morgan and Ruszczynski's (2007) idea that the body is used for spreading hatred rather than as a benign reaching-out to others. In line with the literature (Glasser, 1979; Chassequet-Schmirgel, 1985; Woods and Alvarez, 2003; Campbell, 2005; Morgan and Ruszczynski, 2007; Wood, 2014), the CPTs in this study believe that in order to sustain fending off emotional pain, such patients rely on denial of, and dissociation from reality. This includes disconnect between one's own mind and body.

One discrepancy between the literature and the present findings has to do with the origins of perverse fantasies and harmful sexual behaviour. A few authors (Woods, 2003; Wood, 2014) express views that not all such patients have been victims of abuse. Woods and Wood suggest

that some of these young people are born with psychopathic, sadistic tendencies, and a harsh superego. They develop such fantasies or harmful behaviour due to an innate lack of ego capacity and innate excessive envy. However, all CPTs in the current study argued that all their patients were victims of abuse. The CPTs said that these patients were, in some instances, not victims of physical or sexual abuse, but they were all victims of emotional abuse and relational trauma.

Even though the empirical studies in the literature findings do not speak directly to the nature and origins of perverse fantasies and/or harmful sexual behaviour, one of them compares the psychopathological symptoms of adolescents who have experienced sexual violence as a victim and/or as a perpetrator (Ohlert et al., 2017). The study does not offer an understanding of the function or the origins of the problematic sexual behaviour, but it does evidence the huge overlap between having been a victim and then becoming a perpetrator of sexual abuse. This seemed to relate to the need to push one's own feelings of shame, humiliation, rejection, into others, by hurting them, and making them feel helpless and victimised. In this way, something felt is turned into an action directed towards someone else. Ybarra, et al. (2016) too, reports a significant overlap between victimisation and perpetration of physical, psychological, and sexual abuse.

The literature also speaks to how beneficial being caught is for these patients (Campbell, 1994, 2005; Morgan and Ruszczynski, 2007). However, the findings in this study go beyond this notion, stressing that in CPTs' views, these patients consciously and/or unconsciously seek to be found out. This is an important nuance. As Horne (2009), Morgan and Ruszczynski (2007), and Campbell (2013) state, many clinicians may feel tempted to avoid, or are

apprehensive of, reporting their suspicions of the patients' harmful actions to the authorities. These authors also point out that the CPTs may feel consciously or unconsciously pulled to not even discuss their suspicions with the patients in therapy. The authors link these difficulties to the clinicians' anxieties that such an approach could crush the young person, or break their relationship with the therapist. Knowing more about these patients' need to be caught could help the CPTs to be less apprehensive in addressing potential harmful behaviour with the patients and, if necessary, to report it to the relevant authorities.

'…it's very, very disturbing to get hold of the aggressive, perverse part of the patient.'

Like many authors (Chassequet-Schmirgel, 1985; Morgan and Ruszczynski, 2007; Campbell, 2013; Wood, 2014), the CPTs in this study described confusion and doubt as a major, constant feature of working with these patients. The interviewees distinguished between two separate aspects: the temptation to turn a blind eye to the abusive part of the patient, and the experience of not being able to trust what the patient is saying. In line with the existing literature, the interviewees spoke vividly of how terrible it is to be in touch with the abusive part of the patient. All CPTs in the present study said that this was the most challenging aspect of their work. Furthermore, as in the literature, all CPTs have spoken about an ordinary urge to see the vulnerable child in the patient, their need to be looked-after and loved, and to empathise with how brutally they've been wronged and abused by their carers. Similarly to the literature, the CPTs described how assuming such a stance would not only make the work futile, but it would also be dangerous both to the patients and to their potential future victims. The CPTs said that not addressing the perpetrator part of the patient would leave these young people alone to bear the guilt and shame of what they had done. According to

the CPTs, this would foster future enactments. This finding has important implications for clinical practice. It could raise all clinicians' awareness of, and thus serve as a warning against, this powerful tendency of turning a blind eye. This would not only alert the professionals to the dangers of not protecting future victims. Knowing that turning a blind eye causes pain to the patients themselves (not only the victim), and leaves them alone with the torturous guilt, shame, and anxiety about what they have done, could help the clinicians to be more confident, and aim at exploring and addressing the perpetrator side of their patients.

The CPTs in this study, in line with many authors (Chassequet-Schmirgel, 1985; Morgan and Ruszczynski, 2007; Wood, 2014) and Campbell (2005, 2013) in particular, stressed that working with such patients involves constant uncertainty about the nature of the connection to their patients. The CPTs explained that they often felt unsure about whether the young person is genuinely remorseful, in pain, or actively trying to mislead and manipulate the therapist. Both the psychoanalytic authors (Chassequet-Schmirgel, 1985; Morgan and Ruszczynski, 2007; Wood, 2014) and the CPTs argue that one cannot rely on what the patients say. Thus, in such work, reliance on counter-transference, including the bodily counter-transference, seems to be the only compass. This is an important distinction between patients with perverse fantasies and/or harmful sexual behaviour, and violent patients where sexuality is not involved. It becomes clear from both the CPTs' accounts and the literature that working with both patient groups evokes disturbing counter-transference (Chassequet-Schmirgel, 1985; Morgan and Ruszczynski, 2007; Campbell, 2013; Wood, 2014). Some aspects of their behaviour and emotions could overlap. However, working with these patients is markedly different in how confusion is a constant part of the CPTs experiences. In line with the

literature, The CPTs reported that they were not simply frightened or threatened, but that, on many occasions, they struggled to figure out what was really happening.

A possible explanation could be that these young people seem to deny reality, and if so, they need to cause confusion in the clinicians, in order to not let the CPTs interfere with the patients' own denial of emotional pain and the consequences of their actions (Morgan and Ruszczynski, 2007; Chassequet-Schmirgel, 1985; Wood, 2014). Fitting in with the existing knowledge, the CPTs have spoken about the patients consciously or unconsciously seeking to 'pervert' the mind of the therapist, as a defence against being in touch with reality and limitations (Morgan and Ruszczynski, 2007).

The present findings expand our knowledge on the nature of this denial and confusion, adding the aspect of difficulties regarding these patients' cognitive capacities. One side of it addresses the dissociative states of mind in which the young people appear unable to link their feelings of being victims to the damage they want to or have already done others. The CPTs describe that, in some patients, such dissociative states are expressions of a genuine inability to hold in their mind that they are the same person who was abused, as the one who abused others. Another side of this confusion is linked to development and maturation. The CPTs said that some of these patients seemed genuinely confused about what hurting others constituted, and about the appropriate boundaries, and the meaning of the law. This could also inform clinical practice, helping the professionals to tailor their approach to such patients. For example, being aware of this aspect of these patients' functioning, CPTs would not attempt to make complex transference-counter-transference interpretations at the beginning of therapy, or they would at least be mindful to phrase their interpretations in a

way that acknowledges the possible challenges in the patients' capacities to understand relationships, and their own impact on others.

In CPTs' views, starting psychotherapy significantly increases the risk of harm to self and others, and it cannot be contained individually.

This major theme, which emerged in all interviews, is in line with the psychoanalytic literature (Morgan and Ruszczynski, 2007; Woods and Alvarez, 2003), which states that the risk of harm to self and others increases significantly at the beginning of psychoanalytical treatment. Morgan and Ruszczynski (2007) explain that the risk of acting out increases in psychotherapy, because this type of treatment aims to help the patient understand why they resort to perversion, and what its links are to the patient's feelings. This involves being in touch with the painful emotions that perversion was employed to defend against, such as neediness, rejection, humiliation, shame, guilt, fear, hatred, etc. All interviewees have spoken vividly about these states, pointing out that this increases the risk of these young people hurting themselves or others. In line with the existing knowledge (Morgan and Ruszczynski, 2007; Woods and Alvarez, 2003), this study suggests that these patients seem to be extremely sensitive, leaving the impression that they struggle to make sense of and contain these emotions within themselves. What is more, The CPTs think that due to the confusion the patients appear to experience and project, they are also unable to clearly communicate their upset. These young people often act out, by hurting their own or someone else's body. This is why the literature and the CPTs in this research both stress that the clinical risk cannot be contained individually (Morgan and Ruszczynski, 2007; Woods and Alvarez, 2003), making working in a team and having supervision essential.

However, none of the empirical findings on other interventions with sexual offenders report increase of risk. Generally, they evidence for any structured programme being likely to provide containment to such patients. There appears to be a contradiction here. In fact, all the above-discussed empirical research aims to prove the effectiveness of some given treatment. Most of the empirical findings concern interventions ordered by the court or within a setting that is not confidential (the participants' progress was reported to their carers (Lawson, 2003; Letourneau et al., 2009; Joseph et al., 1963) or the authorities (Somvervell and Lambie, 2009; Keiley, 2015)). This is likely to have influenced the answers the young people gave to questions exploring their urges to re-offend. Actually, the discussed studies do not report having explored suicidal or self-harming thoughts at all. Keiley (2015), as part of the study 'Multiple-family group intervention for incarcerated male adolescents who sexually offend and their families', explores how the sexually offending behaviour diminishes. Keiley reported a decrease. However, as discussed in the literature review, due to the limitations of the design of the study, it is unclear whether this decrease is due to the young person being incarcerated or to the therapy. It is also uncertain whether diminishing of sexually offending behaviour actually means decreasing the urges of these young people to harm themselves or others, or whether they simply could not act these urges out because they were incarcerated.

This contradiction between the psychoanalytic literature and the empirical findings raises the question of whether the increased risk is specific to psychoanalytic psychotherapy. The findings do not answer this. Further research is needed on other therapies in order for us to understand if the increased risk is pertinent to psychoanalysis specifically, or to all treatments.

In any case, both the current study and the literature evidences (Morgan and Ruszczynski, 2007; Woods and Alvarez, 2003) that CPTs need to be aware that, when working with such patients, they cannot contain the risk individually.

The findings suggest that, unless such support if provided, it is likely that a patient might feel extremely overwhelmed following a session, and harm themselves or commit suicide. It is also possible that being in touch with these challenging emotions (such as shame, guilt, neediness, etc.), some patients may feel the urge to attack or abuse somebody else. It is highly likely, that if they were to do this, they would not share this with their therapist, as described by one of the participants in this study, and as Campbell (2013) stresses. He states that it is highly possible that offending actions could go on for a very long time without the therapist knowing about them or being able to report their suspicions to the authorities. Campbell explains that in psychoanalysis we work with the internal world of the patient, we do not actually have any way of knowing what they did or did not do in the external reality unless the patient tells us. The therapists in this study repeatedly warned against lone working with such patients and how dangerous it could be to treat such patients in a private practice, especially given the powerful pull towards turning a blind eye.

There might be financial and other pressures, especially in the current climate of reduced funding for mental health in the NHS, and long waiting lists (NHS providers website), to limit resources for supervision and team discussions. However, the current research and the literature (Morgan and Ruszczynski, 2007; Campbell, 2013; Woods and Alvarez, 2003) suggest that these patients pose a much greater risk than other patient groups. Bion (1962) stresses that the therapist needs supervision, as it provides essential containment for their emotions

in response to their patients, and thus enables them to think about the patients rather than being swept up by the feelings in the room. Joseph (1985), too, points out that therapists need to also be able to make sense of the overall presentation of the patients over the course of the sessions, rather than getting lost in the minute details of what the patients say in the here and now. She writes that this is greatly helped by supervision. Menzies (1988, 1989) and Obholzer and Roberts (1994) also write about the dangers where professionals belonging to institutions that lack sufficient containment lose their ability to think, especially when working with more complex patients.

CPTs' gender matters.

The findings of the present study suggest that the CPTs' gender has an impact on their experiences, and the ways the patients relate to them in therapy. Welldon's (1988, 2011, 2017) work has significantly contributed to our knowledge of the impact of gender. She points out that there aren't many authors researching this link which gave me the impression that the CPTs' gender might not have central importance to their experiences of working with such patients. Therefore, I originally did not plan to explore it. However, this turned out to be a prominent feature even in the first interview. On reflection, including questions regarding the role of CPTs' gender in the interview schedule from the start, could have yielded richer data. Due to the voluntary recruitment, it happened that the first two interviewees were female, and the rest were male. Since my impressions as a researcher, naturally, saturated over time, I ended up asking the male participants more specific questions regarding the CPTs' gender. In addition to that, being a trainee clinician-researcher may have inhibited me in exploring some aspects of the interviews as fully as I might have done with other participants. Being

aware of the invaluable work of the Portman Clinic as the only national service working with such patients, I may have consciously or unconsciously omitted to ask challenging questions. For example, it did not occur to me to explore further the experiences the male participants shared. For instance, I did not ask about their position of competence and expertise which is in contrast to the challenging experiences the female participants shared. However, the interviews also suggest that even if I had asked all participants from the beginning, they would not necessarily be able to give more definitive answers regarding the impact of their gender. The interviews indicate that both the female and male CPTs were not consciously aware of the depth and range of the impact of their gender.

Interestingly, many authors (Wood, 2003; Nathanson, 2016; Morgan and Ruszczynski, 2007) state that most of these patients are male, and shared experiences of having had an absent or abusive father figure, and an unpredictable mother (sometimes involved, sometimes neglectful or rejecting). According to the interviewees, the CPTs' gender does not in any way define the progress or the likely outcome of the therapy. However, the analysis has also revealed that the female participants reported more intense experiences of being seen and treated as a threatening figure, and more incidents of their patients displaying bodily responses (such as being visibly aroused). The male participants gave various examples of being experienced as a benign, protective father figure. These findings are in line with Yakeley's (2014) observations, as described in the literature review. She writes that these patients' early experiences inevitably colour the way they perceive the female psychotherapist, stirring infantile anxieties of dependency on a persecutory and frightening mother figure. Yakeley hypothesises that one possible explanation could be that the social stereotypes of what female and male are supposed to represent further complicate the

therapeutic relationship. She clarifies that these patients perceive the neutral stance of the female therapist as hostile, while it is not perceived as such in the male therapist.

Both the literature and the interviewees report instances where the young people spoke of their experiences having had a particular kind of mother. For example, Interviewee 1 referred to these patients as: ''who's been sexualised by their mother''; ''what we call 'a smother', a mother that smothers''. Interviewee 2 has described: ''…we find they have very particular kind of mothers. So, we'd feel, sort of, 'Oh, this feels very familiar', or parents, maybe, less so if it's a relationship with the father. It tends to be more the mother''. Interviewee 2 further reflects ''we can very often end up feeling angry and anti- the moms. And of course, you know, I learn from the information, what I feel in the countertransference, and very often I feel very much very smothering, claustrophobic, kind of grabbing feeling with the patient''. Interviewee 3 adds that these young people ''have a kind of Portman mother, who was using them as part of her body, for example…, and controlling them, this way.'' And finally, interviewee 4 gives a summary of how the mothers of these patients tend to be perceived: ''At the basis of a perverse sexuality, is a fear, terror of annihilation by the engulfing mother figure, fundamentally… Certainly one can become the claustrophobic, you know, the Core Complex mother.'' What the CPTs in this study have described echoes a range of publications on the subject, where Glasser (1979) has repeatedly described the mothers of such young people as ''smothering'', ''engulfing'', ''narcissistic'', ''seductive'', ''castrating''. Nathanson (2016, p. 279) writes about a patient who became ''free from his sex addiction and feeling separate from his highly intrusive smothering mother''. Furthermore, Nathanson, Music, and Sternberg (2021, pp. 2-25) explain that ''Typically, in the history of such patients, there is a mother whose narcissistic needs take precedence over her child's needs, so that the child

cannot experience a safe emotional closeness with her… The threat may be experienced as a direct assault, engulfment, smothering or abandonment to starve''.

The wording of the descriptions of these patients' mothers, both in the literature and in the interviews, could be exposed as colloquial, misogynistic, and anti-feminist. Moreover, despite the father often being described as absent or abusive, as interviewee 2 has said ''it tends to be more the mother''. Fathers seem to be omitted from the discussion. Given that most of the literature in this field is published by the Portman Clinic, we might wonder if this language is a product of institutional misogyny that creates the stereotype of the so called ''Portman mother'' (interview 3). Historically, psychoanalysis has expressed misogynistic views. For example, Freud (1925, 1931) has written about the male supremacy ''and the neurosis are characteristically feminine, and further, that in this dependence on the mother we have the germ of later paranoia in women. For this germ appears to be the surprising, yet regular, fear of being killed (? devoured) by the mother'' (1931, p. 227). Later on, Klein (1975) has written about the mother and even, the breast, as our first object of love and affections. Whilst this could be viewed as restoring the importance of the female figure, one wonders if it also serves sometimes as a basis for the mothers to be blamed, and to be expected to take sole responsibility for anything that might potentially go wrong with children.

On the other hand, all the literature included in this study and the participants supported their views with clinical material. According to the CPT, the young people reported experiences of intense and unpredictable relationship with their mothers. One wonders if this is a clinical phenomenon. If so, then perhaps the language describing this phenomenon needs to change to reflect it more accurately, and non-offensively, despite how difficult it could be

to find relevant words that capture the essence of this complex, multi-layered clinical picture. Also, even if we think about this as a clinical phenomenon, this does not explain why the role of the fathers seems to be omitted. One wonders if there are no expectations for fathers to be able to look after and take responsibility for their children? It is curious that the male participants described more rewarding experiences whilst the female participants described more occasions when they felt they would get it wrong. One wonders if, as a society, we tend to perceive women as the main carer and men as not expected to contribute either to the positive or to the negative outcomes of raising children. Glasser (1975, p. 297) writes: ''In the oedipal relationship, the father invariably has a lesser status in the individuals' emotional life than in the case of the normal child… The mother is often the predominating, castrating figure, and this anxiety may often be traced to the core-complex anxieties…'' One wonders if an attitude of blaming the mothers could be linked to our unconscious phantasies about women's bodies being pregnant. Yakeley (2014) suggests we tend to blame the mother due to anger against dependency on and need for being looked after. One may consider if there's tendency to view mothers as having all the resources. Klein (1975) has written about children's phantasies of the combined object, where they imagine the mother contains all past, present and future babies, all the breastmilk, and father's penis inside her body. Given that these patients seem to deny their awareness of the parental couple, and the generational boundaries, it is worth wondering if this may sometimes be unconsciously enacted by the clinicians when they find themselves being ''anti- the moms'' (Interview 2).

I wonder if only a few authors have explored the impact of CPTs' gender (Welldon, 1988, and Yakeley (2014), as not many CPTs work with such patients. Therefore, there might not be enough of a sample for such research to produce generalisable findings. I also consider the

possibility that there is something very uncomfortable about exploring why these young men, as suggested by interviewee 4, appear to associate children with a weaker version of women. Could there be something about the idea of the vulnerability of women's bodies that is difficult to think about?

"An antidote to the disturbance".

The CPTs reported that working with these patients could also be meaningful. This includes feeling hopeful, and having a sense of contributing to the society on a larger scale, in comparison to working with other patients, who are not likely to hurt others. I wonder if these positive aspects of the work were also linked to the particular setting at the Portman Clinic. All CPTs described their work environment as containing and reliable. All of them spoke of relying on a feeling of connectedness amongst colleagues, sharing a sense of humour, and there being a benign, supportive atmosphere. This does not seem to me to be universal, especially in large, busy, organisations such as general CAMHS, for example.

In addition to this, all CPTs pointed out that being able to offer open-ended therapy was one of the main reasons for finding this work professionally stimulating. This has important implications for clinical practice. One wonders if pressure to offer short-term interventions would make this work overwhelming for the clinicians. Perhaps brief work would not allow the clinicians to see enough of a progress in order to feel hopeful, or experience their contribution as meaningful. This may lead to low morale and less capacity to contain risk.

The CPTs also expressed that this work allows them to learn more about human nature, and to develop their creativity. Perhaps working with these patients gives CPTs a unique opportunity to explore rare psychoanalytic thinking and a chance to do such niche work.

The literature search did not reveal any publications acknowledging or exploring any of these positive aspects of the work. I wonder if it is very difficult for CPTs to convey to other professionals, or to the wider public, that they could genuinely be interested in aspects of working with patients who have perverse fantasies or engage in harmful sexual behaviour. I wonder if this might be linked to feelings of shame that these patients project onto the CPTs (Campbell, 1994). One of the CPTs shared that other colleagues tried to convince them against working at the Portman Clinic. Another participant shared that society tended to view CPTs working at the Portman in a negative light. And, as highlighted in the literature review, Morgan and Ruszczynski (2007) too, write about people being tempted to perceive these patients as evil. Perhaps, by extrapolation, their therapists might likewise be considered as having a different kind of moral compass.

However, given that many CPTs avoid this challenging work (Horne, 2003), being aware of these positive aspects could increase their interest in engaging in it. It could perhaps also counterbalance some of the negative prejudices against CPTs doing this work.

Strengths

Methodological strengths

The findings show that the design choice has proven suitable for this study. First of all, deciding to recruit CPTs that specialise in this work has yielded rich data, where experienced qualified clinicians give plenty of examples, revealing different nuances and layers of their experiences doing this work over the years.

Second, participants confirmed that the 14-25 age bracket is the age range within which most of their referrals fall. Moreover, the CPTs spoke of direct links between the likelihood of having perverse fantasies or engaging in harmful sexual behaviour, and the physical agency, sexual development, and authority (to not require parental guidance) characteristic of this age.

In addition, IPA has also proven to be a good fit for such a small sample, as has the fact that the participants all share the same work environment (one specialised clinic), as IPA is specifically designed to explore a phenomenon experienced by a coherent group of people (Smith et al., 2009). The richness of the interviews also suggests that IPA is indeed suitable for interviewing human beings about their subjective experiences (Smith et al.), rather than relying on quantitative methods, for example.

Choosing IPA to analyse the data has allowed access to the complexity of the participants' thoughts and feelings. With its 'double hermeneutics' (Smith, 2009), IPA has allowed me to make sense of the many layers of conscious and unconscious meaning conveyed in the CPTs' accounts. Employing IPA has also led to new insights on the topic, such as learning more about the impact that CPTs' gender has on their experiences. This would not have been possible had

I used a different method. Thematic Analysis, for instance, would have required me to stay very close to what the CPTs actually said, rather than allow for the interpretation of the differences in how CPTs told their experiences (Cresswell, 2007; Clarke & Braun, 2014). Grounded Theory (Cresswell, 2007, Bryant and Charmaz, 2007) is another example of a qualitative method that would have made it impossible for me to make sense of the linguistics and the differences across interviews, since I did not initially plan to explore the impact of gender.

Implications for clinical practice

This qualitative study is an important contribution to the literature, especially given that there are very few empirical studies in this field (Bordium et al., 1995; Lawson, 2003; Ayland and West, 2006; Letourneau, 2009; Ikomi et al. 2009; Somervell & Lambie, 2009) in the face of exponentially growing evidence for the impact of sexual offending on society (Keiley et al., 2015; Finkelhor, Ormrod, & Chaffin, 2009; Campbell, 1994).

This study provides important data on how CPTs need to tailor their approach to these patients, keeping in mind that perversion seems to be an entrenched solution to emotional pain. What is more, the CPTs are left with the impression that some of these young people experience dissociation from reality and disconnect between mind and body, which includes genuine confusion in relation to social boundaries, and the law. Progress is slow, which means that these patients need long-term, open-ended therapy.

Another important finding concerns the tendency where the clinician experiences a powerful pull to turn a blind eye to the aggressive part of the patient. Being aware of this could raise CPTs' vigilance and encourage them to work with both the victim and perpetrator sides of the patient. A key aspect linked to this is that even if the clinicians are in touch with their suspicion that their patients may be engaging in harmful sexual behaviour, whilst in therapy, they might be apprehensive to address this with them or report it to the relevant authorities (Campbell, 2013). And thus, the awareness that the patients appear to feel relieved when being caught, could give the clinician more confidence in exploring their doubts.

Moreover, all participants warned that these patients appear to be extremely sensitive, and starting psychotherapy could increase the risk of harm to self and others. The CPTs stressed that this risk cannot be contained individually. All of them explicitly said that in order to work safely with these young people, some fundamental institutional requirements need to be met. This has important implications for the wider practice, such as general CAMHS, where such young people could easily go under the radar due to lack of containment or expertise. In CPTs' views, these patients require a stable living environment (regardless if this is with their biological parent(s) or in alternative care), and a whole network of professionals around them, such as school, social workers, and youth offending officers, as necessary. The participants have repeatedly stressed the importance of regular supervision and a team of colleagues who know the case, but are not necessarily directly involved in it. The third superordinate theme depicts how dangerous, in terms of risk, it is for CPTs to work in isolation or in private practice with such patients. This is also applicable to how one can easily feel overwhelmed if one has to work with many such cases at the same time. The CPTs also stressed the importance of the team knowing one other and having a sense of community, in order to feel able to share very

disturbing and uncomfortable experiences with colleagues, which would not be possible in a large organisation with a high staff turnover.

And lastly, the views expressed by the CPTs that this work could be meaningful and professionally stimulating, could encourage more clinicians to consider working with such patients.

Limitations and future research

Despite these strengths, the study has notable limitations. Firstly, I am the person who designed the study, conducted the interviews, analysed them, and presented the results. IPA allows for sense-making on three levels: the participants' explicit statements; how they make sense of their own experiences, and the researcher's interpretation of the meaning of what has been said (Smith, 2009). IPA makes in-depth exploration possible, in a way that allow for both conscious and unconscious meaning to be made sense of (Smith, 2009). However, this means that the analysis is inevitably coloured by my subjectivity as a researcher. Tufford and Newman (2012, p.81) state that: 'The researcher is the instrument for analysis across all phases of a qualitative research project (Starks and Trinidad, 2007). This subjective endeavour entails the inevitable transmission of assumptions, values, interests, emotions and theories (hereafter referred to collectively as preconceptions), within and across the research project. These preconceptions influence how data are gathered, interpreted, and presented. Bracketing is a method used by some researchers to mitigate the potential deleterious effects of unacknowledged preconceptions related to the research and thereby to increase the rigor of the project'.

I am aware that my role as a researcher has not been one characterised by a neutral stance, especially given that I am aspiring to qualify as a CPT, and as such, I have had first-hand experiences with similar patients. I have also previously worked in a therapeutic school with primary school children who engaged in harmful sexual behaviour. This was an extremely challenging experience for me, where both my capacity to bear emotional pain, and my ability to protect myself from physical assault, was tested on a daily basis (such as by pupils attempting to rip the staff's clothing, touch staff inappropriately, punch, kick, spit, etc.). This has inevitably coloured the ways I read the data, and especially those examples that involved threats to clinicians. My own emotional response to the way the CPTs spoke during the interviews (including their facial expressions and body language), could have impacted my interpretation of their words in a way that would not be the case if I had only worked with the transcripts. I was mindful of how different my feelings were, at times, from those conveyed by the CPTs. For example, there were moments when I felt shock while the participants calmly described their patients' harmful sexual behaviour (such as a young man having raped his sister).

Conversely, it is possible that I might have missed to notice meaningful units of information in the interviews due to desensitisation, as a result of over-familiarisation with the data, where aspects of the text could have blurred in my mind, and thus seemed similar to me. I have considered the possibility that I might have coded or singled out those bits of information that seemed new, and thus more interesting, to me, rather than those that overlapped with what I already knew. Perhaps having some background knowledge on the subject may have limited my capacity to keep an open mind. I am a trainee at the Tavistock,

which is a sister-organisation to the Portman Clinic, and I am thus aware of the clinical work and the books published by the Portman, including the publications by some of the CPTs I interviewed. Moreover, it is possible that, during the interviews, I may at times have missed asking a clarifying question that could have revealed more on the subject, due to conscious or unconscious anxiety about the impression of ignorance or inexperience I might leave with a senior CPT. Analysing the interviews might also have been impacted by my anxiety about whether I would be able to do justice to the rich and in-depth answers the interviewees gave on this important subject. Being aware that my views are subjective, I have made every effort to reflect on, and convey in this text, the process of how I developed my thoughts and ideas. Tufford and Newman (2012) describe this process as one of the methods for 'bracketing', which conveys the idea that by acknowledging one's subjective stance, the researcher is better able to set her/his assumptions aside.

In any case, subjectivity is inevitable in qualitative research (Tufford and Newman, 2012). Therefore, it is also conceivable that another researcher could have understood the CPTs' answers differently. In order to minimise the impact of my codes not having been verified by an independent coder, my research supervisor determined the reliability on some anonymised segments of the transcripts. I did not have the chance to discuss the coding or to do inter-coder reliability tests with colleagues, but I discussed the theme structure with my research supervisor, and in a small research supervision group as a sounding board (please see Appendix 2, which provides an illustration of the coding process). However, there are different views on the impact of inter-coder reliability (ICR). On the one hand, 'In appropriate research contexts, ICR assessment can improve both the internal quality and external reception of qualitative studies. Key benefits include improving the systematicity,

communicability, and transparency of the coding process; promoting reflexivity and dialogue within research teams; and helping to satisfy diverse audiences of the trustworthiness of the research' (O'Connor, C. and Joffe, H., 2020, p. 11). On the other hand, in the same article, Connor and Joffe argue that ICR could also deplete the rich meaning that qualitative research can produce, which can only be derived from the sensitivity characteristic of the individual researcher's subjectivity.

What is more, I have also considered the possibility that the CPTs might have, consciously or unconsciously, filtered their responses due to anxieties about how their answers could be perceived (especially in relation to reporting risk), given that the interviewer is a trainee at the CPTs' sister-organisation.

Secondly, the small sample size poses further limitations. Smith et al. (2009) suggests that IPA should be applied to a smaller sample than most other qualitative methods, in order to allow for in-depth analysis of discovering meaning beyond what is being explicitly said. Basing the findings on 5 interviews indeed raises important questions. However, the small number of interviews does not produce sufficient data to answer them fully. Despite IPA aiming to capture the participants' individual lived experiences (Smith et al., 2009), more interviews would have given a clearer picture of the range of these experiences. Some of the themes discovered would have particularly benefitted from this, such as the impact of the CPTs gender. It would be interesting to see how the theme structure would emerge within a larger group of CPTs, in case this study is replicated with a larger sample size.

For example, one of the main findings is linked to the importance of the CPTs working in a team and having regular supervision. All CPTs have stressed how much they relied on and benefitted from there being a sense of community and connectedness at the Portman Clinic. There was not enough space in this research project to expand on the research question to include these nuances. For example, the CPTs have pointed out that the staff there feel free to employ their sense of humour and creative skills outside their therapeutic training to make sense of their own experiences and to convey them vividly to their colleagues. The supportive atmosphere and the provision of regular robust supervision by senior staff seems to allow the CPTs at the Portman clinic to be genuinely interested in this very challenging work , and to find it meaningful. It is important for further research to explore how these findings would relate to other teams. Is this lively, supportive atmosphere a result of the individual personalities of the Portman staff, or something all teams working with such patients need to aspire to?

Another limitation of the present study, which holds true for most small-scale qualitative research, pertains to the inability to generalise the findings. The current study focused on a particular team working at a specialised clinic. It is therefore not possible to generalise the findings. There would be value in carrying out the interviews with CPTs working with such patients in other clinics or communities. What is more, it would also be interesting to explore whether and how CPTs from different cultures and ethnicities would experience working with this kind of patient.

Given the scope of this study, I could only interview my participants once, and was unable to fit in follow-up interviews. Salkind (2010) argues that follow-up increases the credibility and

the effectiveness of the research. What is more, speaking to the CPTs only once meant that important questions that arose during and after the interviews could not be fully answered. For example, the analysis suggests that working with these patients is very specific and requires relevant training. It is perhaps for future research to further explore if CPTs with significant experience outside this area would need particular training in order to be adequately equipped to work with these patients.

The superordinate theme regarding the impact of the CPTs' gender also raises a lot of questions that open up for future research. These include exploration of the definition of gender, perceived gender roles, and/or physical appearance in society. As Yakeley (2014) argues, the social stereotypes of what feminine and maternal is, and what masculine and paternal is, influence how these patients' make sense of the stance of their therapist. This is just one of many possible interactions between what society implies in these roles, and how these prejudices impact the patients' overall perception of their therapist. This is relevant not only to how the patients perceived the CPTs' gender, as the current results show, but also how the patients perceive their own gender in terms of how we understand gender today, beyond the binary 'female-male' lense.

I feel it is also important for further research to explore why most of these patients are male (Morgan and Ruszczynski, 2007). One of the interviewees said, as discussed above, that these patients seek to dominate children and females because these young people perceive them as weaker. What could this mean more broadly? Does it mean that women and children are associated with physical weakness, i.e. body build, or with other kinds of vulnerabilities? And

how are these patients' ideas influenced by the societal perceptions of weakness and strengths?

One specific limitation of the current project has been posed by circumstances, rather than by choice. All interviews were carried out via video link, on Zoom, rather than in person, due to Covid-19 related safety measures. It is not clear how the remote way of conducting the interview has impacted the data. I have thought of the possibility that this could have instilled an unnecessary formality that made it more difficult for the CPTs to think of and share experiences that deeply moved them. For example, at the start of the meeting, Zoom plays an automated audio message recorded by a strict male voice, announcing that the meeting is recorded. I have made the participants fully aware of the fact, but I felt that this audio message created, even momentarily, an atmosphere of interrogation. In addition to this, I had agreed with the CPTs that they would be in a confidential space. However, despite this, they might have been anxious that somebody in their household could overhear whilst they were sharing very complicated aspects of their work. Except for this, the CPTs mentioned, as also highlighted in the literature review (Nathanson et al. 2021; Danziger, 2021), that many of their patients engaged in harmful sexual behaviour online. The CPTs said that this contributed significantly to experiencing working remotely as very uncomfortable. I wonder if this, by extrapolation, made speaking about their work via Zoom more uncomfortable than if the interviews had been carried out in person. This also suggests that it would be important for future research to investigate how the remote modes of psychotherapy impact the experiences of both CPTs and patients.

3.5 CONCLUSION

In the face of scarce knowledge on the subject, this study contributes to our understanding of perversion which is viewed by the CPTs as an entrenched solution to emotional pain, and seems to impact the whole of the patient's personality and relationships. Perversion appears to be linked to difficulties with being in touch with reality, and confusion between harming others and observing appropriate boundaries. The findings show that even though these patients seem to benefit from, and seek, being caught out, what they say in therapy cannot be trusted. What is more, working with the aggressive part of the patient is very challenging. The CPTs have warned against a powerful pull towards turning a blind eye to the patient's harmful sexual behaviour. Added to this is the fact that these patients present as extremely sensitive. Being more aware of their feelings and actions appears to overwhelm them very quickly. This results in high risk of harming themselves and others, which cannot be contained individually. This study has also raised important questions for further research, such as the impact of the CPTs' gender on the relationship with the patients as well as what could serve as an antidote to the disturbing nature of this work.

The present research has yielded rich findings which could inform clinical practice.

- These patients reportedly benefit from long-term, open-ended therapy.
- They seem to struggle at times to understand what constitutes abuse. In CPTs' views, this may be due to experiencing dissociative states and/ or developmental cognitive difficulties.
- The CPTs stressed the need to be vigilant not to turn a blind eye to the aggressive, abusive part of the patients.

- These young people seem to feel relieved by, and to benefit from their harmful sexual actions being found out and reported to the relevant authorities.
- The CPTs feel that regular supervision, team meetings, and reasonable caseload are essential, so that the increased risk of self-harm and acting out behaviour during therapy, could be managed safely.
- Working with this patient group requires a network of professionals and stable home placement. According to the CPTs, lone working and therapy with such young people in private practice is dangerous.

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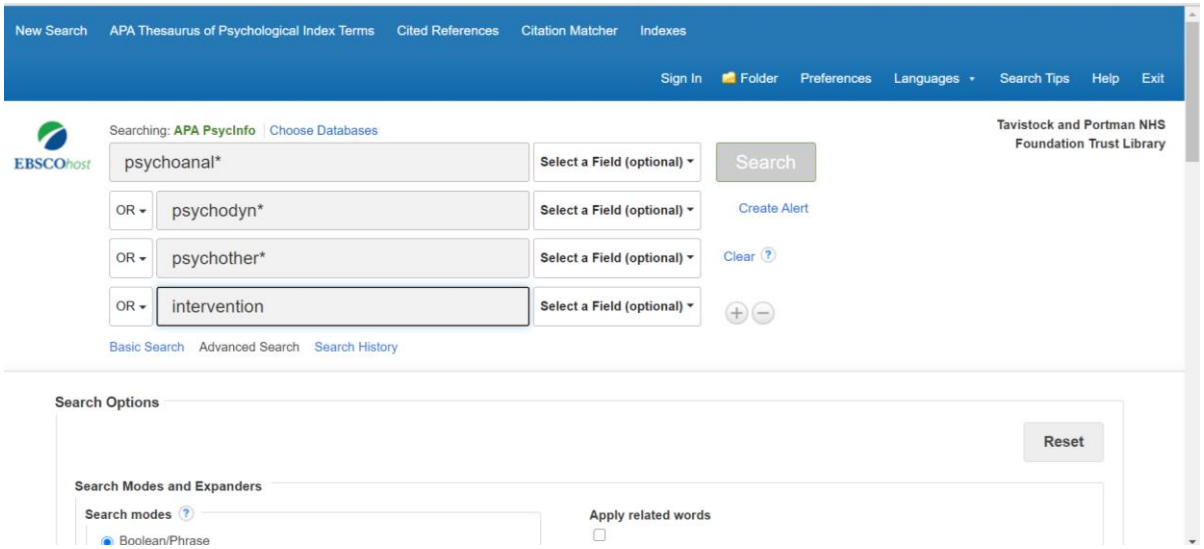
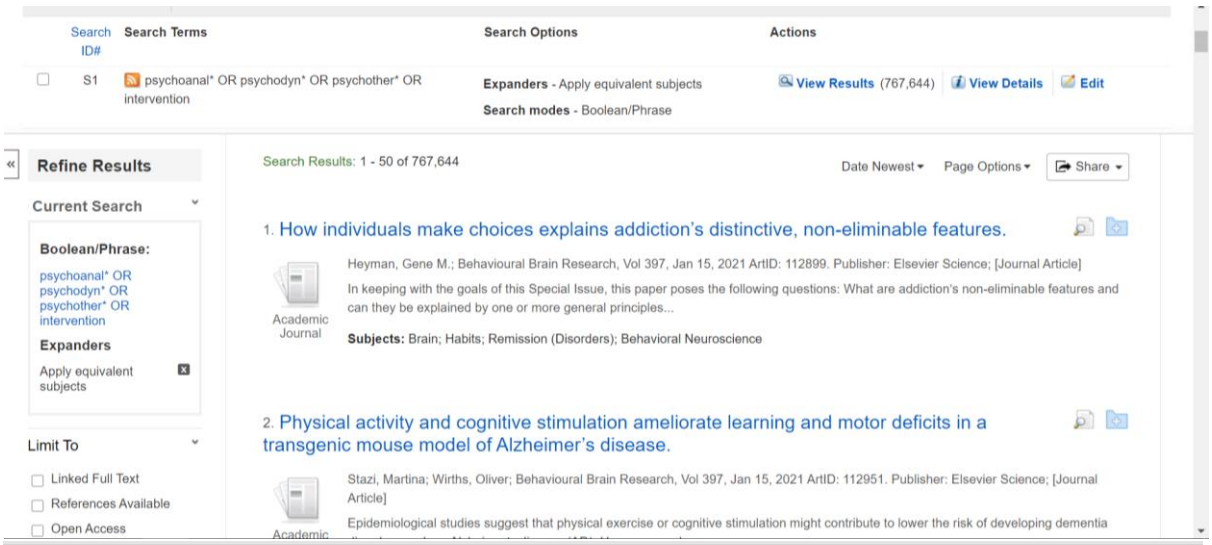
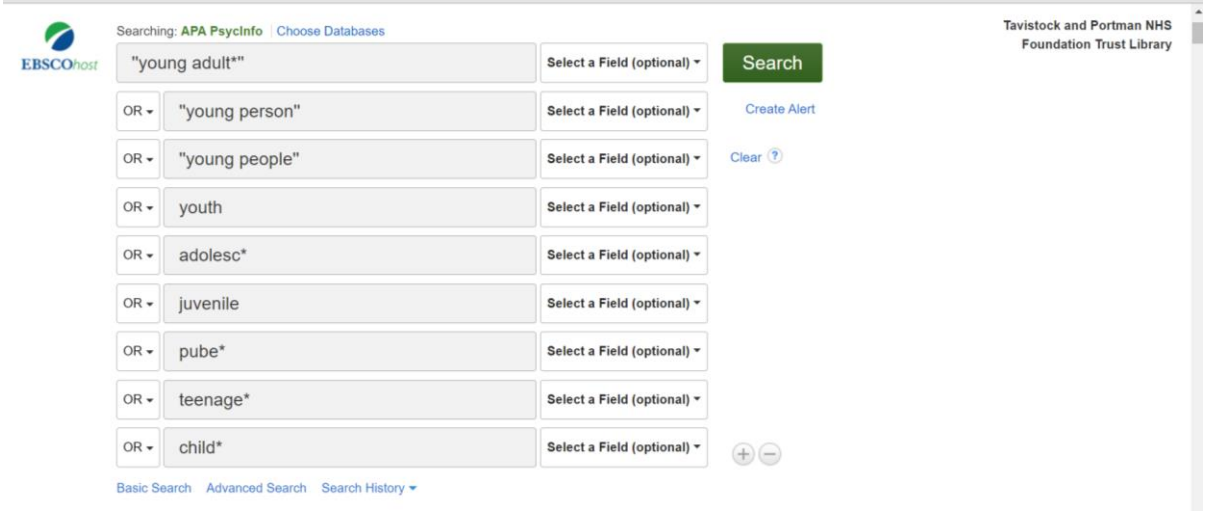
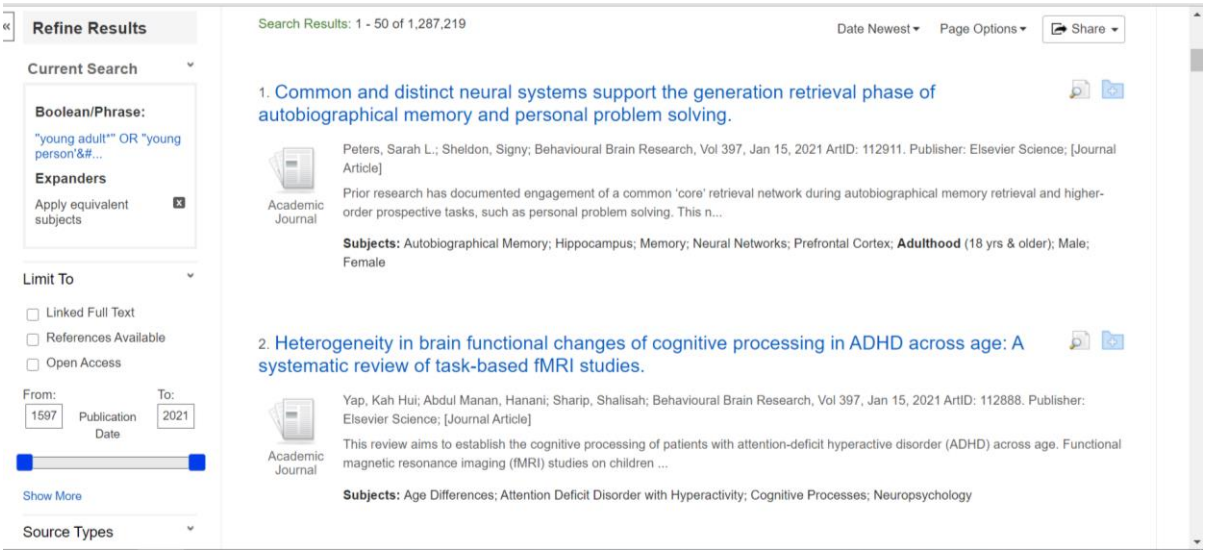
APPENDICES

Appendix A *Literature search*





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Expanders
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Limit To
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References Available
Open Access
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Publication Date
To: 2021
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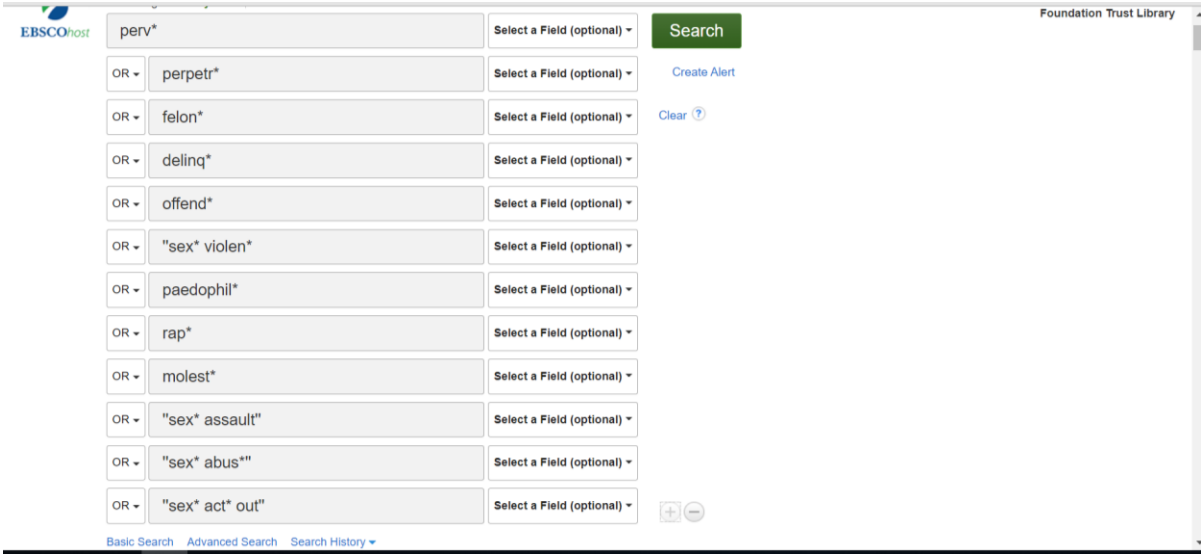
Source Types
1. Common and distinct neural systems support the generation retrieval phase of autobiographical memory and personal problem solving.
Academic Journal
Peters, Sarah L.; Sheldon, Signy; Behavioural Brain Research, Vol 397, Jan 15, 2021 ArtID: 112911. Publisher: Elsevier Science; [Journal Article]
Prior research has documented engagement of a common 'core' retrieval network during autobiographical memory retrieval and higher-order prospective tasks, such as personal problem solving. This n...
Subjects: Autobiographical Memory; Hippocampus; Memory; Neural Networks; Prefrontal Cortex; Adulthood (18 yrs & older); Male; Female
2. Heterogeneity in brain functional changes of cognitive processing in ADHD across age: A systematic review of task-based fMRI studies.
Academic Journal
Yap, Kah Hui; Abdul Manan, Hanani; Sharip, Shalisah; Behavioural Brain Research, Vol 397, Jan 15, 2021 ArtID: 112888. Publisher: Elsevier Science; [Journal Article]
This review aims to establish the cognitive processing of patients with attention-deficit hyperactive disorder (ADHD) across age. Functional magnetic resonance imaging (fMRI) studies on children ...
Subjects: Age Differences; Attention Deficit Disorder with Hyperactivity; Cognitive Processes; Neuropsychology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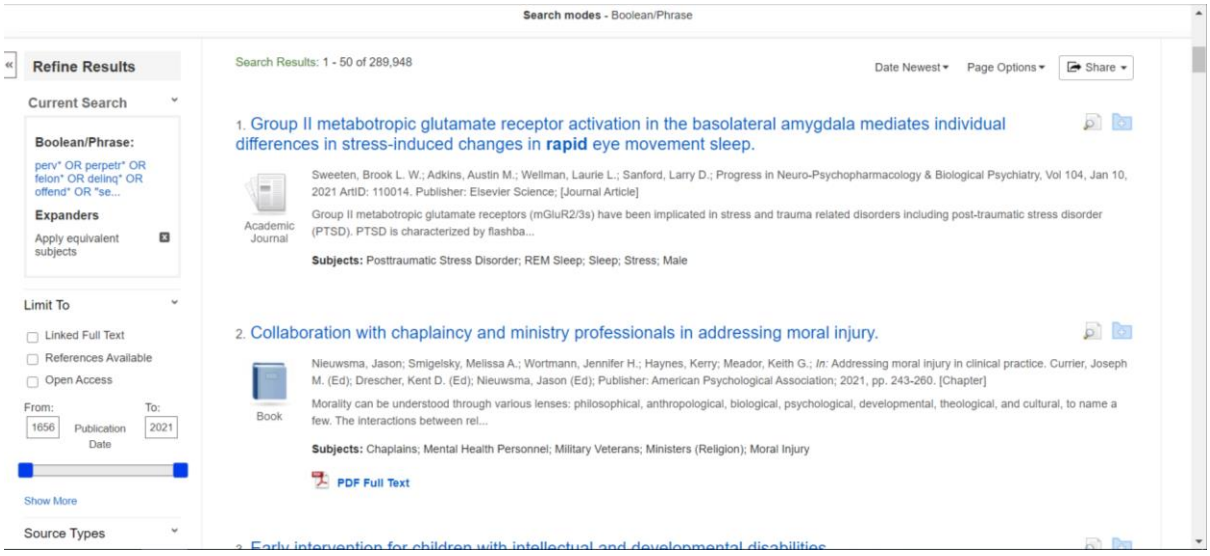
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Expanders
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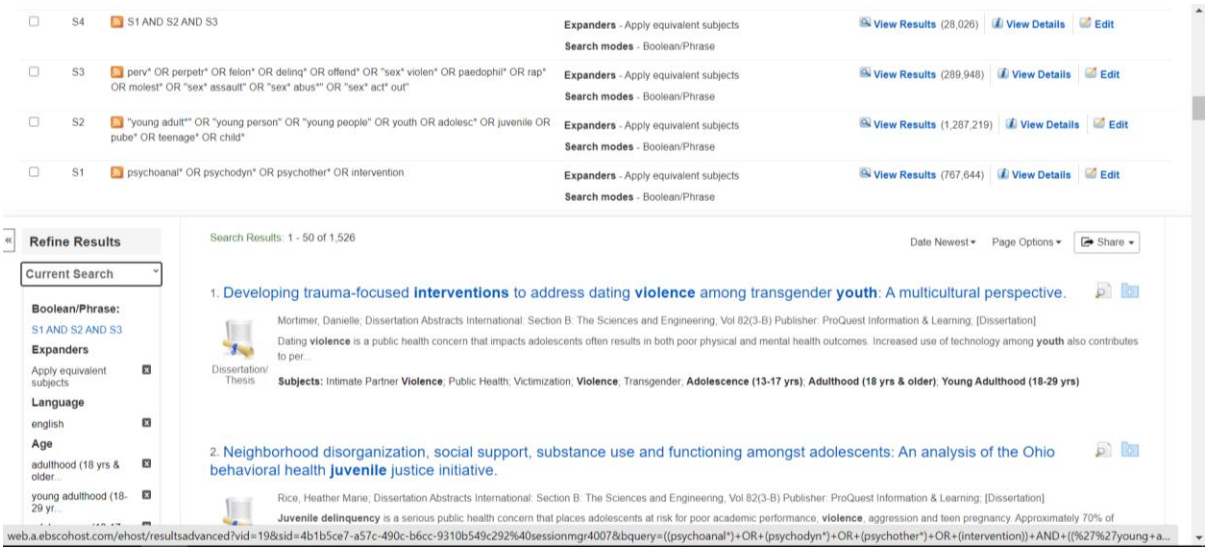
1. Group II metabotropic glutamate receptor activation in the basolateral amygdala mediates individual differences in stress-induced changes in rapid eye movement sleep.
Academic Journal
Sweeten, Brook L. W.; Adkins, Austin M.; Wellman, Laurie L.; Sanford, Larry D.; Progress in Neuro-Psychopharmacology & Biological Psychiatry, Vol 104, Jan 10, 2021 ArtID: 110014. Publisher: Elsevier Science; [Journal Article]
Group II metabotropic glutamate receptors (mGluR2/3s) have been implicated in stress and trauma related disorders including post-traumatic stress disorder (PTSD). PTSD is characterized by flashba...
Subjects: Posttraumatic Stress Disorder; REM Sleep; Sleep; Stress; Male
2. Collaboration with chaplaincy and ministry professionals in addressing moral injury.
Book
Nieuwsma, Jason; Smigelsky, Melissa A.; Wortmann, Jennifer H.; Haynes, Kerry; Meador, Keith G.; In: Addressing moral injury in clinical practice. Currier, Joseph M. (Ed); Drescher, Kent D. (Ed); Nieuwsma, Jason (Ed); Publisher: American Psychological Association; 2021, pp. 243-260. [Chapter]
Morality can be understood through various lenses: philosophical, anthropological, biological, psychological, developmental, theological, and cultural, to name a few. The interactions between rel...
Subjects: Chaplains; Mental Health Personnel; Military Veterans; Ministers (Religion); Moral Injury
PDF Full Text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adulthood (18 yrs & older...
young adulthood (18-29 yr...
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Date Newest Page Options Share
1. Developing trauma-focused interventions to address dating violence among transgender youth: A multicultural perspective.
Mortimer, Danielle; Dissertation Abstracts International: Section B: The Sciences and Engineering, Vol 82(3-B) Publisher: ProQuest Information & Learning; [Dissertation]
Dissertation/ Thesis
Subjects: Intimate Partner Violence; Public Health; Victimization; Violence; Transgender; Adolescence (13-17 yrs); Adulthood (18 yrs & older); Young Adulthood (18-29 yrs)
2. Neighborhood disorganization, social support, substance use and functioning amongst adolescents: An analysis of the Ohio behavioral health juvenile justice initiative.
Rice, Heather Marie; Dissertation Abstracts International: Section B: The Sciences and Engineering, Vol 82(3-B) Publisher: ProQuest Information & Learning; [Dissertation]
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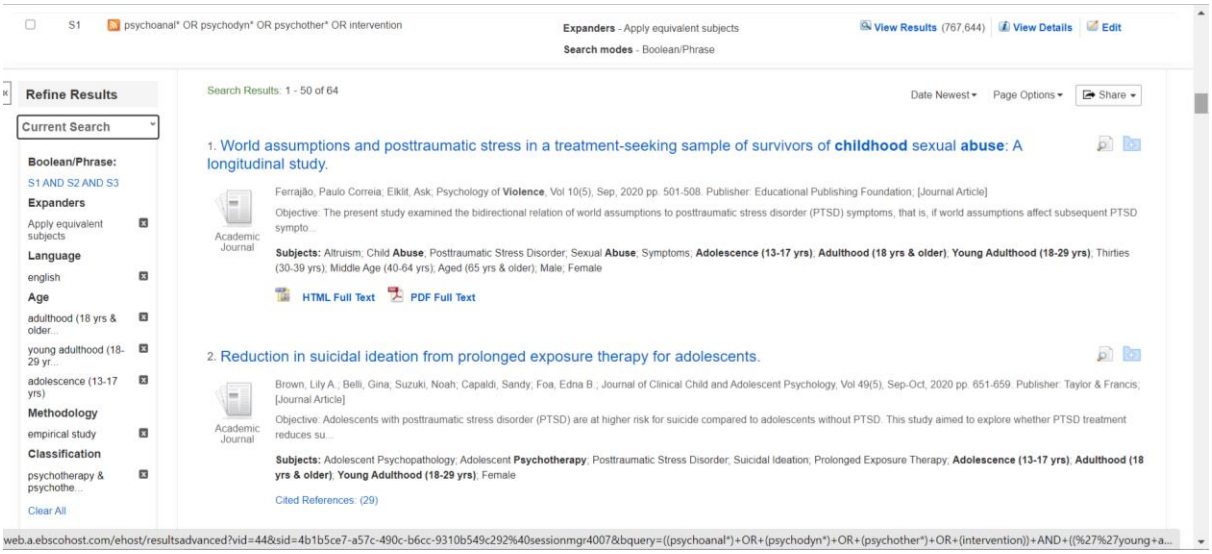
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adolescence (13-17 yrs)
Methodology
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Classification
psychotherapy & psychothe...
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1. World assumptions and posttraumatic stress in a treatment-seeking sample of survivors of childhood sexual abuse: A longitudinal study.
Ferrajão, Paulo Correia; Elklit, Ask; Psychology of Violence, Vol 10(5), Sep, 2020 pp. 501-508. Publisher: Educational Publishing Foundation; [Journal Article]
Academic Journal
Subjects: Altruism; Child Abuse; Posttraumatic Stress Disorder; Sexual Abuse; Symptoms; Adolescence (13-17 yrs); Adulthood (18 yrs & older); Young Adulthood (18-29 yrs); Thirties (30-39 yrs); Middle Age (40-64 yrs); Aged (65 yrs & older); Male; Female
HTML Full Text PDF Full Text
2. Reduction in suicidal ideation from prolonged exposure therapy for adolescents.
Brown, Lily A.; Belli, Gina; Suzuki, Noah; Capaldi, Sandy; Foa, Edna B.; Journal of Clinical Child and Adolescent Psychology, Vol 49(5), Sep-Oct, 2020 pp. 651-659. Publisher: Taylor & Francis; [Journal Article]
Academic Journal
Subjects: Adolescent Psychopathology; Adolescent Psychotherapy; Posttraumatic Stress Disorder; Suicidal Ideation; Prolonged Exposure Therapy; Adolescence (13-17 yrs); Adulthood (18 yrs & older); Young Adulthood (18-29 yrs); Female
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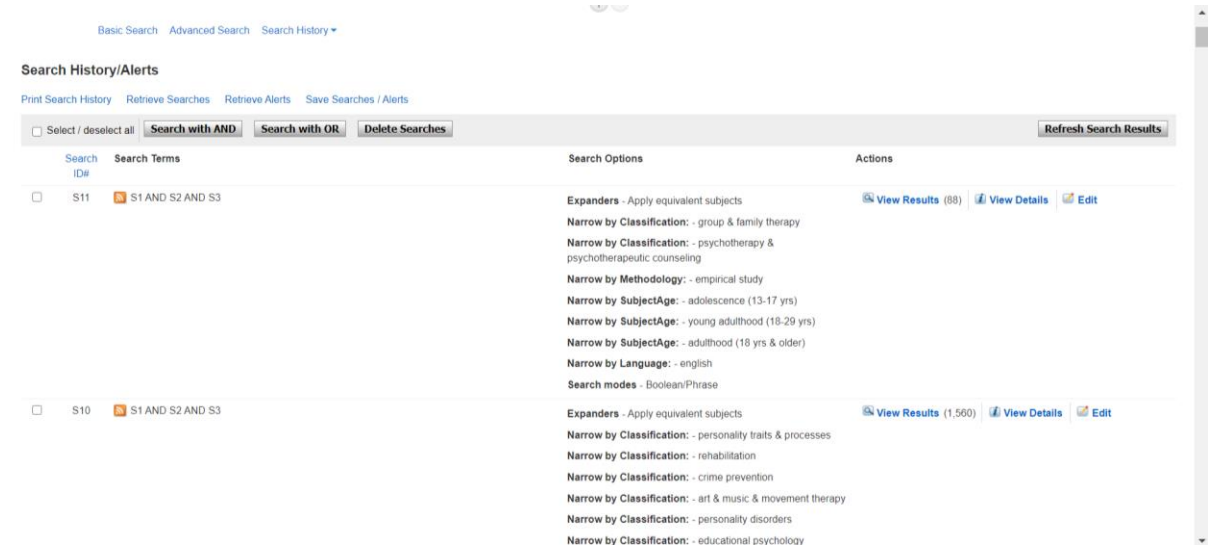
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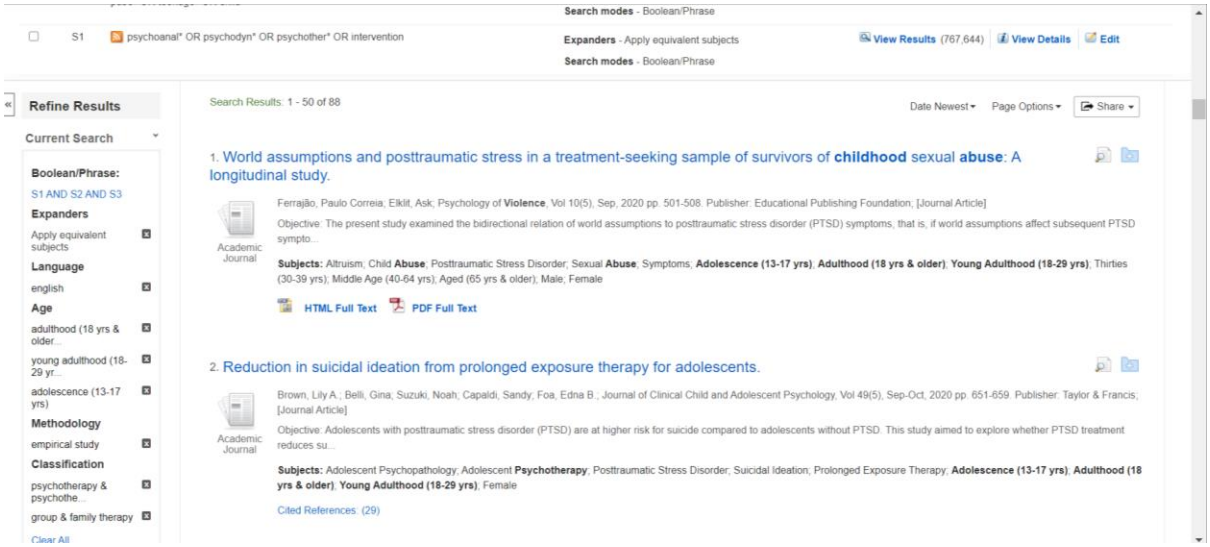
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1. World assumptions and posttraumatic stress in a treatment-seeking sample of survivors of childhood sexual abuse: A longitudinal study.
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Academic Journal
Objective: The present study examined the bidirectional relation of world assumptions to posttraumatic stress disorder (PTSD) symptoms, that is, if world assumptions affect subsequent PTSD sympto...
Subjects: Altruism; Child Abuse; Posttraumatic Stress Disorder; Sexual Abuse; Symptoms; Adolescence (13-17 yrs); Adulthood (18 yrs & older); Young Adulthood (18-29 yrs); Thirties (30-39 yrs); Middle Age (40-64 yrs); Aged (65 yrs & older); Male; Female
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Brown, Lily A.; Belli, Gina; Suzuki, Noah; Capaldi, Sandy; Foa, Edna B.; Journal of Clinical Child and Adolescent Psychology, Vol 49(5), Sep-Oct, 2020 pp. 651-659. Publisher: Taylor & Francis; [Journal Article]
Academic Journal
Objective: Adolescents with posttraumatic stress disorder (PTSD) are at higher risk for suicide compared to adolescents without PTSD. This study aimed to explore whether PTSD treatment reduces su...
Subjects: Adolescent Psychopathology; Adolescent Psychotherapy; Posttraumatic Stress Disorder; Suicidal Ideation; Prolonged Exposure Therapy; Adolescence (13-17 yrs); Adulthood (18 yrs & older); Young Adulthood (18-29 yrs); Female
Cited References: (29)

Appendix B *Examples of coding*

EMERGENT THEMES (chronologically)	Interview Transcript	EXPLORATORY COMMENTS: Descriptive	*Linguistic*	Conceptual
The function is a solution to pain by escaping reality, hold on to themselves, and not be a victim. The CPTs feel shock, confusion, fear. These patients cannot be contained individually. They need a team and robust network around them. Having private theories or relying on others' is needed to contain the shock. Experience	I: 'Firstly, I'm wondering… How would you described a typical perverse fantasy? What would patients usually share that would be a perverse fantasy in the minds of the CPTs?' Z: **'I think, maybe it's worth thinking about what the function of perversion is, first of all, because… ahm, the function of perversion is to get away from reality**. So, a young person who comes, for example… I had a boy who did fall into this age category, who came in because he had sexually abused his step…, his sibling. And it was shocking because he did it at dad's. The parents had split up. The father had another relationship and had moved in with the new relationship. This was the first weekend this boy was allowed to stay at the father's place with the stepmom. **In our terms, it was a relatively minor incidence in that it was fondling, it wasn't penetration**. But nevertheless, it was a… **huge disturbing thing** to do in this family and it caused all sorts of… (gesturing, indicating chaos and turbulence). It was the boys protest about what the father was doing and all of that. And he came into treatment but what became apparent during the treatment, is that the **disturbance** of this boy was not that he might be a paedophile, but his actual fear was that he was homosexual. It's as though, this… I'll call it paedophilia, that was **covering up a worse truth or a worse fear**, which was that he was homosexual. So, the function was to disguise the homosexuality. So, it's difficult to say what is a typical perverse fantasy… ahm… I think it's easier to say it's something that takes the place of something **worse** that allows to person to **hold themselves together**, to somehow cope not in a brilliant way. You know, this boy was **concerning… causing a lot of concern, he was very worrying and very vulnerable** but **not for the reasons that brought him to the clinic**. So, I don't know if this answers the question, I. Well, there might be typical fantasies about **watching child pornography in order to not be a victim, and identification with the perpetrator and stuff like that. These will be typical elements but I'm not sure I can say what a typical fantasy would be'.** I: 'Well, I guess, one thing that comes to mind, hearing this, in therapy… it's interesting you're talking about identification with the aggressor, and sort of… to cover up a truth that's more painful but then there's a question of… in the room, in treatment, how does one feel with somebody who could be a paedophile or hurt somebody who's younger or more vulnerable and to think about them falling apart [the perpetrator], and them having nothing to hold on to but the perverse idea… Sort of, how does one feel having to understand them whilst also thinking about something they do such as paedophilia or hurting somebody more	**Disturbing, fear, worse, concerning, worrying, vulnerable** **Minor-huge** **Typical fantasies could vary- child pornography, sibling sexual abuse, paedophilia, voyarism** **The function is a solution to pain by escaping reality, hold on to themselves, and not be a victim.**	*Pausing when speaking about the abuse.* *'minor vs hugely disturbing'* *'Our' terms vs how it is for others* *Not for the reasons that brought him to the clinic*	Having private theories or relying on others' is needed to contain the shock. Experience changes the perspective of 'normal' or 'minor disturbance'. 'our' - the need for the pain to be contained by many, a team. Unpredictability
These patients are frightened by their aggression and cannot openly express it in an ordinary way The CPTs experience anxiety about the patients' aggression either erupting in an explosive way, or them feeling like they are not allowed to work with it at all.	formulation. But I don't know, I feel like… Maybe I've worked with fewer patients really to be able to make the sort of broad assumption. I think there's always something about aggression and not being able to say and do aggression in a very sort of straightforward, ordinary way. There's something frightening for them about that or troubling. So, that's something that they have in common, that the aggression and the aggressive fantasy can be a sort of secretive one, that can't be…, or it explodes in massive way. It can't just be expressed in an ordinary, say OK way. Imagine in fantasy the catastrophe as a result of the aggression coming out is enormous. But it can vary so much because some have been convicted, so there's a relief. That's different, I think. Those patients who come and want to understand what happened… And they've had that guilt sort of elsewhere, because they've been caught. And the others, where it's a bit less clear, and they haven't…, maybe the police haven't found enough evidence, or they haven't been	**These patients are frightened by their aggression and cannot openly express it in an ordinary way. It becomes very secretive. It can explode.** **They feel relief when being caught.**		The CPTs experience anxiety about the patients' aggression either erupting in an explosive way, or them feeling like they are not allowed to work with it at all.

These patients feel relieve when caught. the SuperEgo is pretty harsh and frightening.' The CPTs are perceived as punishing and terrifying. It's hard to maintain the setting of the sessions It's very difficult to make sense of their communication, and to	convicted. So, that's different. There's an ever present authority that might come and get them. So, we might think of…, the SuperEgo is pretty harsh and frightening.' IR: 'So, in a way, somehow it always leads to punishment'? X: 'Yes. And so, it would extent to who I become to them in the transference. It's very difficult to have an ordinary conversation about… The Easter break and the dates they're coming back, you know. I become very terrifying, a witch really, to them, punishing, I think.' IR: 'Sort of, following on this, I'm wondering if perhaps this is something that distinguishes them from other patients, or other patient groups, the harshness, the punishment, and the inability to express things in a sort of more ordinary way'. IR: 'I think so, I think… It's hard to say, 'cause I don't want to generalise. That feels too conclusive *but there's something…* **You just get in it with them straightaway**. You become something really harsh and punitive. And so, they're much less likely to have a row with you in the session. *You can't sort of…*, it doesn't come out like 'I'm pissed off with you because…' Well, all patients are like that, really, but with this it feels like… it	**the SuperEgo is pretty harsh and frightening.'** **The CPTs are perceived as punishing and terrifying.** **The counter-transference feelings are immediate.**	*It's difficult to verbalise how the patient makes you feel.*	It's hard to maintain the setting of the sessions. It's painful to be seen as persecuting. The CPT's emotions are powerful. It's very difficult to make sense of their communication, and to know how

confidence in the CPTs. One needs to rely on private or professional theories. What the patients say and what they omit to say is disturbing, powerful, shocking, anxiety provoking. The patients experience a sense of triumph over the people around them who don't know about their perverse actions. Experience helps CPTs to be more receptive rather than taken over by shock. There is fear that one will be told something illegal. There's fear one would need to report the patients. They describe graphic images or don't describe it all, and the CPT is to imagine the worse.	And he was sort of like, when I was trying to sort of interject and stop to make sense of it, he was like 'No, no, I want to tell you more about what it is'. And it was almost sort of like going to a priest for a confession, which was relevant really to his history. **But the way he used me, I was really shocked, sort of, coming out of it.** And I took it to supervision and said 'He's told me everything'. Like there was no secret there. And yet his behaviour out in society, and with his friends, and with his family, is like the biggest secret ever. This is his triumph over them all, that they don't know really that he watches child porn. They don't know he's the worst of the worst. And this is his excitement about it, and yet he comes to me, and he's telling me everything. **What is going on there? That really surprised me because up till then…, and I think this is maybe something to do with experience, and I think maybe sort of gradually, I'm able to sort of convey a kind of that I'm receptive, and I can think about and stay with the young person when they're talking about it.** I think maybe early on in the training, they picked up on my anxiety about it as well **'Don't tell me something illegal. If you tell me something illegal, we're going to have to report you'. And all these anxieties, but now I've had enough experiences to know what to do with these sort of very graphic images that they push on me. But the other thing about it is that they'd often leave, so that was him, but then I've got another patient, similar age, sort of early twenties, and she will leave it in my imagination, what's happened.** *So, she builds a story, and she doesn't ever quite get there, and she makes me do the… you know, finish it off in my mind.* **And that's very powerful, really, and disturbing. It's almost more disturbing actually, than actually being told exactly what it is that they want to do or have done.'** IR: 'Well, you've mentioned confidentiality, and in psychotherapy that's quite tricky because we're supposed to have this setting and confidentiality in it, and yet with these patients you've mentioned there's a lot of secrecy. I'm wondering how does that feel?' X: **'It's felt absolutely terrifying when I first started. Maybe I had this very primitive harsh Superego going. That is around you know, in the clinic, and sort of I took on, as a sort of newest member of staff, I just couldn't understand how we'd not be calling Safeguarding, like all the time, and how he'll be able to help these patients**. Because some of them do come to the clinic to get help, to tell the right people what has happened, you know, to tell the authority and to do the linking, and that piece of work does happen, and we will do that. Ahm, I've forgotten your question in terms of how it	**The CPTs feel like the patients are confessing to them, as if to a priest.** **The feelings evoked in the CPTs are of shock, being taken by surprise.** **This is his triumph over them all** **What the patients say and what they omit to say is disturbing, powerful.** **There is fear that one will be told something illegal. There's fear one would need to report the patients.** **They describe graphic images or don't describe it all, and the CPT is to imagine the worse.** **It's very powerful, disturbing, terrifying**	*It' difficult to put words to what the CPT is made to feel.*	private or professional theories. They attack one's attempt to make sense. Experience helps CPTs to be more receptive rather than taken over by shock. It's very anxiety provoking. One feels intruded upon. The CPT is made to feel incompetent, unprepared, lacking. It's difficult to think how it feels, one tends to cut off

Appendix C *Formulating themes across all interviews*

Final Superordinate and sub-themes

Legend:

T1	**Perversion is an entrenched solution to emotional pain.** • 'Intimacy carries a huge threat to them.' • 'The commonalities are that the body has to be used in a sexual way to express not love, usually hatred…' • These patients experience dissociation from reality and disconnect between mind and body. • These patients seek to be caught. • Perversion is addictive.
T2	**'It's very, very disturbing to get hold of the aggressive, perverse part of the patient.'** • 'It's a toxic environment, trauma, anyway.' • 'It's very easy to turn a blind eye.' • 'You can't trust what's being said.'
T3	**Starting psychotherapy significantly increases the risk of harm to self and others, and it cannot be contained individually.** • 'Working with these patients on my own, that would be really though, and dangerous…' • These patients are extremely sensitive.
T4	**CPTs' gender matters**
T5	**This work can be enjoyable, professionally stimulating, and rewarding.** • This work allows you to learn more about human nature and develop your creativity. • This work can be hopeful and rewarding.

Final Superordinate and sub-themes	Preliminary Superordinate and sub-themes across all interviews	Interview 1	Interview 2	Interview 3	Interview 4	Interview 5
3. Starting psychotherapy significantly increases the risk of harm to self and others, and it cannot be contained individually.	Superordinate Theme: **Starting psychotherapy significantly increases the risk of harm to self and others.**	1 Superordinate Theme: **Therapy significantly increases the risk of harm to self and others.**	1 Superordinate Theme: **Therapy significantly increases the risk of harm to self and others.**	1 Superordinate Theme: **Therapy significantly increases the risk of harm to self and others.**	1 Superordinate Theme: **Therapy significantly increases the risk of harm to self and others.**	1 Superordinate Theme: **There is a lot of anxiety around risk and disclosure.** T2
'Working with these patients on my own, that would be really though, and dangerous…' These patients are extremely sensitive.	• Working with these patients on my own, that would be really tough, and dangerous… (Interview 2). • There's masochism and suicidality involved… (Interview 4).	• Risk is high. • These patients cannot be contained individually.	• Having many such patients is dangerous and unbearable. • Psychotherapy increases risk of harm to self and others. • These patients cannot be contained individually.	• Therapy increases the risk of suicidal ideation and of abusing others. • These patient feel a lot of shame and guilt. • There is constant anxiety about the patients' acting out. T2	• Therapy re-awakens perverse fantasies. The patients begin to have urges to abuse again. • There is a very strong self-destructive urge, masochism, and suicidality. There is often hatred towards oneself. • These patients cannot be contained individually.	

Final Superordinate and sub-themes	Preliminary Superordinate and sub-themes across all interviews	**Interview 1**	**Interview 2**	**Interview 3**	**Interview 4**	**Interview 5**
1. Perversion is an entrenched solution to emotional pain.	Superordinate theme: **Perversion is an entrenched solution to emotional pain.**	2 Superordinate theme: **These patients struggle to be in touch with their emotions.**	2 Superordinate theme: **These patients struggle to be in touch with their emotions.**	2 Superordinate theme: **Perversion is a solution to emotional pain and not being able to tolerate intimacy.**	2 Superordinate theme: **Emotional closeness is unbearable and the perverse action is an addictive replacement of it.**	2 Superordinate theme: **The perverse behaviour is an attack on a failed maternal object.**
'Intimacy carries a huge threat to them.' 'The commonalities are that the body has to be used in a sexual way to express not love, usually hatred…' These patients experience dissociation from reality and disconnect between mind and body. These patients seek to be caught. Perversion is addictive.	• Intimacy carries a huge threat to them (Interview 2). • The commonalities are that the body has to be used in a sexual way to express not love, usually hatred… (interview 3). • These patients experience dissociation from reality and disconnect between mind and body. • These patients seek to be caught. • For these patients perversion is addictive.	• Perversion is a solution to emotional pain by dissociating from reality. • Confusion between helpful and hurtful, caring and sexualisation. • These patients use their own and other people's bodies to tell a story. • Sexualisation of aggression is very addictive. • The progress is slow.	• Perversion is a solution to emotional pain and not being able to tolerate intimacy. • These patients are confused about the difference between thoughts/ fantasies and actions. • These patients are frightened by their aggression and cannot openly express it in an ordinary way.	• Not all such patients have been physically or sexually abused but they all have suffered a relational trauma. • These patients use sex to express hatred. Perversion is defence against violence. • These patients experience disconnect from reality and disconnect between mind and body. • These patients often feel stuck and can't move on emotionally from a feeling and practically with their activities.	• These patients are usually male, as there is a problematic idea of a father, either as abusive or as absent. **T4** • These patients associate children with powerless women who are easier to be dominated than grown up women. • These patients are isolated, and aim to isolate their victims. **T2** • These patient feel compelled to do perverse actions similarly to addictions.	• Perversion is a way of managing unbearable ambivalence towards an abusive maternal object. • These patient have difficulties with separation and managing aggression, and thus it becomes sexualised. • Such patients benefit from being caught. It also gives them a chance to be separated from abusive parents.
				3 Superordinate theme: **Perversion is addictive.**	3 Superordinate theme: **These patients often struggle with developmental difficulties impacting negatively their awareness of reality and the difference between right and wrong.** • They are emotionally immature as well as sometimes cognitively impaired as well. • These patients are not sufficiently in touch with the emotional impact of what they have done to the victims.	3 Superordinate theme: **These patients struggle to differentiate between right and wrong. They are confused about what appropriate boundaries are.**

Final Superordinate and sub-themes	Preliminary Superordinate and sub-themes across all interviews	Interview 1	Interview 2	Interview 3	Interview 4	Interview 5
2. 'It's very, very disturbing to get hold of the aggressive, perverse part of the patient.'	Superordinate theme: **It's very, very disturbing to get hold of the aggressive, perverse part of the patient (interview 2).**	3 Superordinate theme: **Working with these patients is challenging.**	3 Superordinate theme: **Working with such patients can be very disturbing.**	4 Superordinate theme: **CPTs get exposed to a lot of extreme trauma which is disturbing.**	4 Superordinate theme: **This work is toxic and traumatising.**	4 Superordinate theme: **Working with these patients is very challenging.**
'It's a toxic environment, trauma, anyway.' 'It's very easy to turn a blind eye' 'You can't trust what's being said.'	• You get exposed to a lot of trauma (Interview 3.) • It's very easy to turn a blind eye (Interview 2). • You can't trust what's being said (Interview 1).	• Working with these patients is very disturbing. • It is very difficult for the CPTs to think freely with these patients.	• The CPTs are made to feel like witnesses/ victims of abuse or like terrifying perpetrators. • Confusion, doubt and a wish to turn a blind eye are a constant concern for the CPTs. • Technique greatly relies on reading the bodily, non-verbal communication	• This work does impacts one view of the world in a negative way. • CPTs often feel confused, and misled and wishing to turn a blind eye.	• It might be more challenging for a female therapist to do this job. **T4** • This work evokes doubt, guilt, anxiety.	• This work is very disturbing. • It is much more bearable to be in touch with the victim part of the patient rather than with their perpetrator part. • This work is very challenging technically. • Gender does not matter. **T4**
Final Superordinate and sub-themes	Preliminary Superordinate and sub-themes across all interviews	Interview 1	Interview 2	Interview 3	Interview 4	Interview 5
5. This work can be enjoyable, professionally stimulating, and rewarding.	Superordinate theme: **This work can be enjoyable and meaningful.**	4 Superordinate theme: **Working with these patients is intellectually stimulating.**	4 Superordinate theme: **Working with these patients can be intellectually stimulating and enjoyable.**	5 Superordinate theme: **This work can be professionally stimulating and enjoyable.**	5 Superordinate theme: **This work can be rewarding.** **It is rewarding.**	5 Superordinate theme: **There is beauty in CPTs' ability to make sense of something awful and unbearable.**
This work allows you to learn more about human nature and develop your creativity. This work can be hopeful and rewarding.	• This work allows you to learn more about human nature and develop your creativity. • There's a life to be rebuilt. And by rebuilding this, you might also help some other people. (Interview 5)	• Working with such patients can be enjoyable and creative. • Working with such patients requires a lot of flexibility and adjustments of technique.		• It gives a sense of contributing to the wellbeing of society and preventing abuse on a larger scale. • The benefit of such work is knowing more about the human nature and developing one's creativity.	• Doing this work could give the CPTs a feeling of creating hope, where there is a lot of hopelessness, which is rewarding. • The negative aspects are counterbalanced by a sense of connectedness with one's colleagues.	
Final Superordinate and sub-themes	Preliminary Superordinate and sub-themes across all interviews	Interview 1	Interview 2	Interview 3	Interview 4	Interview 5
4. CPTs' gender matters	Superordinate theme: **Does CPTs' gender matter?**	5 Superordinate theme: **Gender matters**	5 Superordinate theme: **Gender matters**	6 Superordinate theme: **Gender does not matter**		

Appendix D *TREC Application Form*

The Tavistock and Portman NHS
NHS Foundation Trust

Tavistock and Portman Trust Research Ethics Committee (TREC)

APPLICATION FOR ETHICAL REVIEW OF RESEARCH INVOLVING HUMAN PARTICIPANTS

This application should be submitted alongside copies of any supporting documentation which will be handed to participants, including a participant information sheet, consent form, self-completion survey or questionnaire.

Where a form is submitted and sections are incomplete, the form will not be considered by TREC and will be returned to the applicant for completion.

For further guidance please contact Paru Jeram (academicquality@tavi-port.nhs.uk)

SECTION A: PROJECT DETAILS

Project title	**How do psychoanalytic psychotherapists experience working with young people who have perverse sexual fantasies and/or display such behaviours: A qualitative exploration.**		
Proposed project start date	September 2020	**Anticipated project end date**	September 2022

SECTION B: APPLICANT DETAILS

Name of Researcher	Silviya Dimitrova
Email address	dimitrova.silviya@gmail.com
Contact telephone number	07704481712

SECTION C: CONFLICTS OF INTEREST

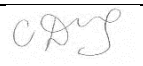
Will any of the researchers or their institutions receive any other benefits or incentives for taking part in this research over and above their normal salary package or the costs of undertaking the research? **YES** ☐ **NO** ☒ If **YES**, please detail below:
Is there any further possibility for conflict of interest? YES ☐ **NO** ☒ If **YES**, please detail below:

FOR ALL APPLICANTS

'Is your research being commissioned by and or carried out on behalf of a body external to the trust? (for example; commissioned by a local authority, school, care home, other NHS Trust or other organisation). *Please note that 'external' is defined as an organisation which is external to the Tavistock and Portman NHS Foundation Trust (Trust)	**YES** ☐ **NO** ☒ **NA** ☐
If **YES**, please supply details below:	
Has external* ethics approval been sought for this research? **(i.e. submission via Integrated Research Application System (IRAS) to the Health Research Authority (HRA) or other external research ethics committee)** *Please note that 'external' is defined as an organisation/body which is external to the Tavistock and Portman Trust Research Ethics Committee (TREC) If **YES**, please supply details of the ethical approval bodies below **AND** include any letters of approval from the ethical approval bodies:	**YES** ☐ **NO** ☒
If your research is being undertaken externally to the Trust, please provide details of the sponsor of your research? **NO**	
Do you have local approval (this includes R&D approval)?	**YES** ☒ **NO** ☐ **NA** ☐

SECTION D: SIGNATURES AND DECLARATIONS

APPLICANT DECLARATION I confirm that: • The information contained in this application is, to the best of my knowledge, correct and up to date. • I have attempted to identify all risks related to the research. • I acknowledge my obligations and commitment to upholding our University's Code of Practice for ethical research and observing the rights of the participants.

• I am aware that cases of proven misconduct, in line with our University's policies, may result in formal disciplinary proceedings and/or the cancellation of the proposed research.	
Applicant (print name)	Silviya Lachezarova Dimitrova
Signed	
Date	11.12.2020

FOR RESEARCH DEGREE STUDENT APPLICANTS ONLY

Name of Supervisor	Dr Felicitas Rost
Qualification for which research is being undertaken	Professional Doctorate in Child & Adolescent Psychoanalytic Psychotherapy (D.Ch.Psych.Psych.)

Supervisor –

- Does the student have the necessary skills to carry out the research?
  YES ☒ **NO** ☐
- Is the participant information sheet, consent form and any other documentation appropriate?
  YES ☒ **NO** ☐
- Are the procedures for recruitment of participants and obtaining informed consent suitable and sufficient?
  YES ☒ **NO** ☐
- Where required, does the researcher have current Disclosure and Barring Service (DBS) clearance?
  YES ☒ **NO** ☐

Signed	
Date	11.12.2020

COURSE LEAD/RESEARCH LEAD

- Does the proposed research as detailed herein have your support to proceed?
  YES ☒ **NO** ☐

Signed	
Date	11.12.2020

SECTION E: DETAILS OF THE PROPOSED RESEARCH

1. Provide a brief description of the proposed research, including the requirements of participants. This must be in lay terms and free from technical or discipline specific terminology or jargon. If such terms are required, please ensure they are adequately explained (Do not exceed 500 words)

Not much is known about the phenomenon and treatment of sexual perversion in young people. The proposed study aims to explore the experiences of Child and Adolescent Psychoanalytic Psychotherapists (CPTs) at the Portman clinic, who work with young people (aged 14-25) experiencing perverse sexual fantasies and/or behaviours. The Portman Clinic has been selected as it is a specialised NHS outpatient service providing psychoanalytic psychotherapy to such individuals. The study plans to investigate what characterises these individuals' presentation in therapy and how the therapeutic alliance develops. A further aim is to identify particular challenges—including issues of risk to self and others—and benefits the CPTs encounter in such work. For the purposes of this study, perversion is defined as outlined by Glasser (1979, p. 281), to mean deriving pleasure from and aiming 'to cause the object to suffer, physically or mentally, crudely or subtly'. Whilst it has received some attention among adults, little is known about the presentation and treatment of it in young adults.

Specialist CPTs from the Portman clinic will be invited to participate in an individual semi-structured interview which will last between 60 and 90 minutes, and will be audio recorded and subsequently transcribed verbatim. Interpretative Phenomenological Analysis (IPA) will be used to analyse the transcripts in order to answer the research question and objectives:

What are the CPTs' perceptions of young people suffering from perverse sexual fantasies and/or such behaviours, and what characterises their presentation in therapy?

How do CPTs make sense of the challenges and benefits they encounter in psychotherapy with such patients?

What are the CPTs' thoughts and feelings regarding confidentiality and risk of harm to self and others?

How do CPTs experience the development of therapeutic alliance with these young people?

2. Provide a statement on the aims and significance of the proposed research, including potential impact to knowledge and understanding in the field (where appropriate, indicate the associated hypothesis which will be tested). This should be a clear justification of the proposed research, why it should proceed and a statement on any anticipated benefits to the community. (Do not exceed 700 words)

There is increasing awareness of the significant impact of sexual offending on society (Somervell and Lambie, 2009; Ybarra et al., 2016). In his paper "Breaching the shame shield: Thoughts on the assessment of adolescent child sexual abusers", Donald Campbell (2007) quotes the Home Office

report of 1988, stating that about 30% of all sex offences were committed by adolescents. Campbell (2007) reports that in the US, adolescents were responsible for half of all child molestations. He also stresses that the emotional and physical changes experienced during puberty significantly increases the risk of abusive behaviour. Campbell (2007) also quotes Davis (1987), explaining that about 50% of adult offenders acted out their sexual deviancy during adolescence. Most importantly, Horne (2003) conveys how psychotherapy with children and adolescents presenting with sexual perversion could fundamentally change the course of their lives, and prevent future abusive acts.

The research findings on therapeutic treatment approaches for people suffering from problematic sexual behaviours, including perversions, are scarce (Bordium et al., 1995; Lawson, 2003; Ayland and West, 2006; Letourneau, 2009; Ikomi et al. 2009; Somervell and Lambie, 2009). Alvarez (2010, p. 215) quotes Gabbard (1994), stating that psychoanalytic literature has been 'remarkably silent' on the feelings evoked in CPTs regarding sexuality in general. Some authors (e.g. Morgan and Ruszczynski, 2007; Campbell, 2013) state that when CPTs learn more about their conscious and unconscious responses to such work, they would be more able to contain patients' anxieties and thus decrease the risk of patients harming themselves or others.

Although the definition of perversion is not straightforward, many authors agree that perversion damages relationships and that reality-obliteration phantasies are at its core, denying separateness, as well as generational and other fundamental differences. Basic social capacities, such as curiosity and creativity, are impaired and sometimes even the ability to work (Meltzer, 1973; Etchegoyen, 1989; Campbell, 1994; 2005; 2007; 2013; Bergmann, 2000; Horne, 2003; Woods, 2003; Santoro, 2005; Parfitt, 2006; Morgan and Ruszczynski, 2007; Masi, 2008; Ellis, 2009; Koritar, 2013; Wood, 2014; Music, 2016; Nathanson, 2016). The above-mentioned authors also stress the link between perversion and personal experience of abuse. However, society often perceives perpetrators of perverse acts as 'evil' (Stone, 2010; Music, 2016), and some clinicians avoid such work (Horne, 2003). Morgan and Ruszczynski (2007) suggest that society tends to fail to consider perverse people's experiences because of the unconscious wish to project one's own difficulties on perceived 'devils' (Music, 2016).

A comprehensive literature search unearthed a few publications that outline work with perversion. Most of them focus on exploring different aspects of extreme expression and behaviours, such as incest (Oglivie, 1995; Rudominer, 2002), zoophilia (Louis, 1950), exhibitionism (Holtzman, 2012), and fetishism (Greenacre, 1970; Bemporad, 1976; Parfitt, 2007). Some publications focus on physical violence, with some references to perversion (Massimo, 1963; Klein, 1984; Dembo et al., 2000; Ikomi et al., 2009; Ybarra et al., 2016; Dopp et al., 2017; Gordon and Kirtchuk, 2018) and making links to intellectual difficulties (Ayland and West, 2006) or psychopathy (Gacono, 2000; Ohlert, 2017).

There is greater focus on the nature of perversion in psychoanalytic literature, which seeks to understand its origins and how it impacts on personality and relationships. Glasser (1979) outlines how sexualisation of aggression forms the core of perversion. He differentiates between aggression as self-preservation—with the aim to eliminate or avoid threat—and sadism, where the aim is to hurt and control the object. Others describe perversion as involving 'fixed, repetitive behaviours involving unusual sexual stimuli, or may involve potential harm to the self or the other' (Wood, 2014, p. 423).

Horne (2003; Lanyado and Horne 2009) throws some light on CPTs' difficulties when working with fetishism and sexual abuse. Similarly, Morgan and Ruszczynski (2007) and Woods (2003) include some reflections on CPTs' experiences in this field. Alvarez (2010), writing about sexual

transference and countertransference, conveys challenges and points of interest for CPTs, although her article includes a much wider age and presentation range than that of the present study. Campbell's (2013) paper on doubt in the psychoanalysis of a paedophile is an in-depth account of the complexity of a clinician's experiences. However, as with most available research, Campbell's paper is based on work with adults rather than young people.

The present study aims to explore and throw light on the experience of CPTs working with young people who experience perverse sexual fantasies and/or engage in perverse sexual acts. Morgan and Ruszczynski (2007, p. 33) state that perverse patients unconsciously seek to pervert both their own and everybody else's thinking, especially those attempting to help them. Therefore, greater awareness of the experiences of CPTs working with perverse patients could be beneficial for the development of psychotherapeutic practices as well as to the wider community of helping professions.

3. Provide an outline of the methodology for the proposed research, including proposed method of data collection, *tasks* **assigned to participants of the research and the proposed method and duration of data analysis. If the proposed research makes use of pre-established and generally accepted techniques, please make this clear. (Do not exceed 500 words)**

This study proposes Interpretative Phenomenological Analysis (IPA) as a method by which to investigate how interviewees make sense of their experiences (Pietkiewicz and Smith, 2014).

Smith et al. (2009) writes that 'a qualitative research interview is often described as "a conversation with a purpose"' (p. 59), and clarifies that IPA interviews are guided by a particular question whilst simultaneously aiding interviewees to reflect on their own perceptions and experiences. Moreover, being semi-structured, the interviews allow the researcher to be led by the participant's answers, which facilitates greater understanding (Clarke and Braun, 2014).

Child and Adolescent Psychotherapists working at the Portman Clinic will be invited to take part in a semi-structured individual interview. A schedule has been developed that is informed by relevant literature and discussion with the research supervisor. It includes questions on how the participants make sense of their experiences of working with such patients (please see the Appendix).

The interviews will be audio-recorded and transcribed verbatim. The data will be analysed using IPA, following the approach described by Pietkiewicz and Smith (2014).

McLeod (2001) clarifies that IPA relies both on ontological (the core essence of the phenomenon), and on epistemological (what can be realistically learnt about the phenomenon) hermeneutics. IPA allows for in-depth individual accounts, and for researchers to learn about how interviewees (in this case, CPTs) make sense of their experiences, not merely through descriptions. Since the CPTs could be said to be 'defended subjects' (Hollway and Jefferson, 2013) as they can only share what they consciously know, it is particularly helpful that IPA allows researchers to present their own ideas about the meaning of transpiring subtleties (Smith et al., 2009) and what interviewees may be unconsciously communicating. Luft (1969) describes the 'Johari window' model, relevant to IPA, where what is unconscious to the interviewee and unknown by researchers, could, to some extent, be revealed in their interaction. As such, IPA's imbedded 'double hermeneutics', which corresponds

to the complexity of the conscious and unconscious experiences of CPTs, allows for the researcher's reflections to contribute to the findings (Smith et al., 2009, p. 8).

This study will follow Smith et al.'s (2009) suggestion that researchers using IPA are to explore their data, analysing each interview individually before tracing and assessing developing themes across all interviews, thus enabling a coherent, shared narrative to emerge.

SECTION F: PARTICIPANT DETAILS

4. Provide an explanation detailing how you will identify, approach and recruit the participants for the proposed research, including clarification on sample size and location. Please provide justification for the exclusion/inclusion criteria for this study (i.e. who will be allowed to / not allowed to participate) and explain briefly, in lay terms, why this criteria is in place. (Do not exceed 500 words)

Between 5-8 interviews are proposed for this project. All clinicians will be Child and Adolescent Psychoanalytic Psychotherapists working with young people—aged 14-25—at the Portman clinic. Although participants will be recruited on a voluntary basis, the researcher would aim to include a range of male and female therapists.

The clinicians will be approached by email. The email will contain a brief outline of the project, its aims, and how it will be conducted. The participant information sheet will be attached to the email, and it will give detailed information on the purpose of this study, how the data will be collected, and how the information provided by participants will be used and stored. I confirm that I currently have no existing relationship with any of the CPTs who might potentially participate in the project, or with the Portman Clinic.

This initial email will also provide my contact details and I will make an appointment with the interested clinician at the Portman clinic. The potential participant will be encouraged to ask questions about the project and their participation, and informed, written consent will be sought after outlining and explaining the study involvement, confidentiality, and their right to withdraw. If face-to-face interviews are impossible due to Covid-19 restrictions, the interviews will be conducted via Zoom, in a locked, password-protected meeting.

The study proposes a small sample in order to allow for rich and in-depth meaning to be explored across all interviews. Therefore, the answers given by individual participants would not serve to identify them. The nature of qualitative research, however, includes direct quotations, which participants may recognise as their own. Informed consent will be sought with respect to that. The consent form will clearly state that brief extracts of the interviews may be quoted, and therefore the participants may recognise them as something they have said. Participants will also be notified that all possible measures will be taken to prevent third parties from being able to identify the author of any quotations used.

5. Will the participants be from any of the following groups? *(Tick as appropriate)*

☒ Students or staff of the Trust or the University.

☐ Adults (over the age of 18 years with mental capacity to give consent to participate in the research).

☐ Children or legal minors (anyone under the age of 16 years)[1]

☐ Adults who are unconscious, severely ill or have a terminal illness.

☐ Adults who may lose mental capacity to consent during the course of the research.

☐ Adults in emergency situations.

☐ Adults[2] with mental illness - particularly those detained under the Mental Health Act (1983 & 2007).

☐ Participants who may lack capacity to consent to participate in the research under the research requirements of the Mental Capacity Act (2005).

☐ Prisoners, where ethical approval may be required from the **National Offender Management Service (NOMS).**

☐ Young Offenders, where ethical approval may be required from the National Offender Management Service (NOMS).

☐ Healthy volunteers (in high risk intervention studies).

☐ Participants who may be considered to have a pre-existing and potentially dependent[3] relationship with the investigator (e.g. those in care homes, students, colleagues, service-users, patients).

☐ Other vulnerable groups (see Question 6).

☐ Adults who are in custody, custodial care, or for whom a court has assumed responsibility.

☐ Participants who are members of the Armed Forces.

[1]If the proposed research involves children or adults who meet the Police Act (1997) definition of vulnerability[3], any researchers who will have contact with participants must have current Disclosure and Barring Service (DBS) clearance.

[2] 'Adults with a learning or physical disability, a physical or mental illness, or a reduction in physical or mental capacity, and living in a care home or home for people with learning difficulties or receiving care in their own home, or receiving hospital or social care services.' (Police Act, 1997)

[3] Proposed research involving participants with whom the investigator or researcher(s) shares a dependent or unequal relationships (e.g. teacher/student, clinical therapist/service-user) may compromise the ability to give informed consent which is free from any form of pressure (real or implied) arising from this relationship. TREC recommends that, wherever practicable, investigators choose participants with whom they have no dependent relationship. Following due scrutiny, if the investigator is confident that the research involving participants in dependent relationships is vital and defensible, TREC will require additional information setting out the case and detailing how risks inherent in the dependent relationship will be managed. TREC will also need to be reassured that refusal to participate will not result in any discrimination or penalty.

6. Will the study involve participants who are vulnerable? YES ☐ NO ☒

For the purposes of research, 'vulnerable' participants may be adults whose ability to protect their own interests are impaired or reduced in comparison to that of the broader population. Vulnerability may arise from the participant's personal characteristics (e.g. mental or physical impairment) or from their social environment, context and/or disadvantage (e.g. socio-economic mobility, educational attainment, resources, substance dependence, displacement or homelessness). Where prospective participants are at high risk of consenting under duress, or as a result of manipulation or coercion, they must also be considered as vulnerable.

Adults lacking mental capacity to consent to participate in research and children are automatically presumed to be vulnerable. Studies involving adults (over the age of 16) who lack mental capacity to consent in research must be submitted to a REC approved for that purpose. Please consult Health Research Authority (HRA) for guidance: https://www.hra.nhs.uk/

6.1. If YES, what special arrangements are in place to protect vulnerable participants' interests?

If **YES**, the research activity proposed will require a DBS check. *(NOTE: information concerning activities which require DBS checks can be found via https://www.gov.uk/government/publications/dbs-check-eligible-positions-guidance)*

7. Do you propose to make any form of payment or incentive available to participants of the research? YES ☐ NO ☒

If **YES**, please provide details taking into account that any payment or incentive should be representative of reasonable remuneration for participation and may not be of a value that could be coercive or exerting undue influence on potential participants' decision to take part in the research. Wherever possible, remuneration in a monetary form should be avoided and substituted with vouchers, coupons or equivalent. Any payment made to research participants may have benefit or HMRC implications and participants should be alerted to this in the participant information sheet as they may wish to choose to decline payment.

8. What special arrangements are in place for eliciting informed consent from participants who may not adequately understand verbal explanations or written information provided in English; where participants have special communication needs; where participants have limited literacy; or where children are involved in the research? (Do not exceed 200 words)

Not applicable. All potential participants in this research are adults who speak English.

SECTION F: RISK ASSESSMENT AND RISK MANAGEMENT

9. Does the proposed research involve any of the following? *(Tick as appropriate)*

☐ use of a questionnaire, self-completion survey or data-collection instrument (attach copy)

☐ use of emails or the internet as a means of data collection

☐ use of written or computerised tests

☒ interviews (attach interview questions)

☐ diaries (attach diary record form)

☐ participant observation

☐ participant observation (in a non-public place) without their knowledge / covert research

☒ audio-recording interviewees or events

☐ video-recording interviewees or events

☐ access to personal and/or sensitive data (i.e. student, patient, client or service-user data) without the participant's informed consent for use of these data for research purposes

☐ administration of any questions, tasks, investigations, procedures or stimuli which may be experienced by participants as physically or mentally painful, stressful or unpleasant during or after the research process

☐ performance of any acts which might diminish the self-esteem of participants or cause them to experience discomfiture, regret or any other adverse emotional or psychological reaction

☐ investigation of participants involved in illegal or illicit activities (e.g. use of illegal drugs)

☐ procedures that involve the deception of participants

☐ administration of any substance or agent

☐ use of non-treatment of placebo control conditions

☐ participation in a clinical trial

☐ research undertaken at an off-campus location (risk assessment attached)

☐ research overseas (copy of VCG overseas travel approval attached)

10. Does the proposed research involve any specific or anticipated risks (e.g. physical, psychological, social, legal or economic) to participants that are greater than those encountered in everyday life? YES ☐ NO ☒
If **YES**, please describe below including details of precautionary measures.

11. Where the procedures involve potential hazards and/or discomfort or distress for participants, please state what previous experience the investigator or researcher(s) have had in conducting this type of research.
N/A

12. Provide an explanation of any potential benefits to participants. Please ensure this is framed within the overall contribution of the proposed research to knowledge or practice. (Do not exceed 400 words)
NOTE: Where the proposed research involves students of our University, they should be assured that accepting the offer to participate or choosing to decline will have no impact on their assessments or learning experience. Similarly, it should be made clear to participants who are patients, service-users and/or receiving any form of treatment or medication that they are not

invited to participate in the belief that participation in the research will result in some relief or improvement in their condition.

The research would provide the participants with a space to reflect on their own experiences as clinicians working with this particular patient group. Being interviewed could also allow clinicians to think about the various experiences that different CPTs might have. The proposed investigation would potentially alert CPTs to challenges and advantages posed by the current policies and statutory framework. Once the research has been published, it may also be interesting for CPTs to see what common themes have been found across the conducted interviews and how an external interviewer, such as the researcher, has made sense of what CPTs have shared about their work. IPA, the chosen method of analysis, allows the researcher to use imbedded 'double hermeneutics' (Smith et al., 2009, p. 8) to reveal some experiences that CPTs had not necessarily been consciously aware of.

13. Provide an outline of any measures you have in place in the event of adverse or unexpected outcomes and the potential impact this may have on participants involved in the proposed research. (Do not exceed 300 words)

In the event of adverse or unexpected outcomes, I will:

- Offer to end the interview or stop recording
- Offer to reschedule the interview
- Offer debrief if needed

14. Provide an outline of your debriefing, support and feedback protocol for participants involved in the proposed research. This should include, for example, where participants may feel the need to discuss thoughts or feelings brought about following their participation in the research. This may involve referral to an external support or counseling service, where participation in the research has caused specific issues for participants. Where medical aftercare may be necessary, this should include details of the treatment available to participants. Debriefing may involve the disclosure of further information on the aims of the research, the participant's performance and/or the results of the research. (Do not exceed 500 words)

All participants involved will be part of a service team and will have their own support structure and supervision that they could turn to if needed. The interviews will be conducted within the participants' usual working hours to ensure other members of staff will be available. A debrief email will be sent out following the interviews, which will include contact details for the researcher, the project supervisor, and the Head of Academic Governance and Quality Assurance.

FOR RESEARCH UNDERTAKEN AWAY FROM THE TRUST OR OUTSIDE THE UK

15. Does any part of your research take place in premises outside the Trust? NO

☐ **YES,** and I have included evidence of permissions from the managers or others legally responsible for the premises. This permission also clearly states the extent to which the participating institution will indemnify the researchers against the consequences of any untoward event

16. Does the proposed research involve travel outside of the UK? NO

☐ **YES,** I have consulted the Foreign and Commonwealth Office website for guidance/travel advice? http://www.fco.gov.uk/en/travel-and-living-abroad/

☐ **YES,** I am a non-UK national and I have sought travel advice/guidance from the Foreign Office (or equivalent body) of my country of origin

☐ **YES,** I have completed the overseas travel approval process and enclosed a copy of the document with this application

For details on university study abroad policies, please contact academicquality@tavi-port.nhs.uk

IF YES:

17. Is the research covered by the Trust's insurance and indemnity provision?

☐ **YES** ☐ **NO**

18. Please evidence how compliance with all local research ethics and research governance requirements have been assessed for the country(ies) in which the research is taking place.

NOTE:

For students conducting research where the Trust is the sponsor, the Dean of the Department of Education and Training (DET) has overall responsibility for risk assessment regarding their health and safety. If you are proposing to undertake research outside the UK, please ensure that permission from the Dean has been granted before the research commences (please attach written confirmation)

SECTION G: PARTICIPANT CONSENT AND WITHDRAWAL

18. Have you attached a copy of your participant information sheet (this should be in *plain English*)? Where the research involves non-English speaking participants, please include translated materials. YES ☒ NO ☐

If **NO**, please indicate what alternative arrangements are in place below:

19. Have you attached a copy of your participant consent form (this should be in *plain English*)? Where the research involves non-English speaking participants, please include translated materials.
YES ☒ NO ☐

If **NO**, please indicate what alternative arrangements are in place below:

20. The following is a participant information sheet checklist covering the various points that should be included in this document.

☒ Clear identification of the Trust as the sponsor for the research, the project title, the Researcher or Principal Investigator and other researchers along with relevant contact details.

☒ Details of what involvement in the proposed research will require (e.g., participation in interviews, completion of questionnaire, audio/video-recording of events), estimated time commitment and any risks involved.

☒ A statement confirming that the research has received formal approval from TREC.

☒ If the sample size is small, advice to participants that this may have implications for confidentiality / anonymity.

☐ A clear statement that where participants are in a dependent relationship with any of the researchers that participation in the research will have no impact on assessment / treatment / service-use or support.

☒ Assurance that involvement in the project is voluntary and that participants are free to withdraw consent at any time, and to withdraw any unprocessed data previously supplied.

☒ Advice as to arrangements to be made to protect confidentiality of data, including that confidentiality of information provided is subject to legal limitations.

☒ A statement that the data generated in the course of the research will be retained in accordance with the University's Data Protection Policy.

☒ Advice that if participants have any concerns about the conduct of the investigator, researcher(s) or any other aspect of this research project, they should contact Simon Carrington, Head of Academic Governance and Quality Assurance (academicquality@tavi-port.nhs.uk)

☒ Confirmation on any limitations in confidentiality where disclosure of imminent harm to self and/or others may occur.

21. The following is a consent form checklist covering the various points that should be included in this document.

☒ Trust letterhead or logo.

☒ Title of the project (with research degree projects this need not necessarily be the title of the thesis) and names of investigators.

☒ Confirmation that the project is research.

☒ Confirmation that involvement in the project is voluntary and that participants are free to withdraw at any time, or to withdraw any unprocessed data previously supplied.

☒ Confirmation of particular requirements of participants, including for example whether interviews are to be audio-/video-recorded, whether anonymised quotes will be used in publications advice of legal limitations to data confidentiality.

☒ If the sample size is small, confirmation that this may have implications for anonymity any other relevant information.

☒ The proposed method of publication or dissemination of the research findings.

☐ Details of any external contractors or partner institutions involved in the research.

☐ Details of any funding bodies or research councils supporting the research.

☒ Confirmation on any limitations in confidentiality where disclosure of imminent harm to self and/or others may occur.

SECTION H: CONFIDENTIALITY AND ANONYMITY

22. Below is a checklist covering key points relating to the confidentiality and anonymity of participants. Please indicate where relevant to the proposed research.

☐ Participants will be completely anonymised and their identity will not be known by the investigator or researcher(s) (i.e. the participants are part of an anonymous randomised sample and return responses with no form of personal identification)?

☒ The responses are anonymised or are an anonymised sample (i.e. a permanent process of coding has been carried out whereby direct and indirect identifiers have been removed from data and replaced by a code, with no record retained of how the code relates to the identifiers).

☒ The samples and data are de-identified (i.e. direct and indirect identifiers have been removed and replaced by a code. The investigator or researchers are able to link the code to the original identifiers and isolate the participant to whom the sample or data relates).

☐ Participants have the option of being identified in a publication that will arise from the research.

☒ Participants will be pseudo-anonymised in a publication that will arise from the research. (I.e. the researcher will endeavour to remove or alter details that would identify the participant.)

☐ The proposed research will make use of personal sensitive data.

☐ Participants consent to be identified in the study and subsequent dissemination of research findings and/or publication.

23. Participants must be made aware that the confidentiality of the information they 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). This only applies to named or de-identified data. If your participants are named or de-identified, please confirm that you will specifically state these limitations.

YES ☒ **NO** ☐

If **NO**, please indicate why this is the case below:

NOTE: WHERE THE PROPOSED RESEARCH INVOLVES A SMALL SAMPLE OR FOCUS GROUP, PARTICIPANTS SHOULD BE ADVISED THAT THERE WILL BE DISTINCT LIMITATIONS IN THE LEVEL OF ANONYMITY THEY CAN BE AFFORDED.

SECTION I: DATA ACCESS, SECURITY AND MANAGEMENT

24. Will the Researcher/Principal Investigator be responsible for the security of all data collected in connection with the proposed research? YES ☒ **NO** ☐

If **NO**, please indicate what alternative arrangements are in place below:

25. In line with the 5th principle of the Data Protection Act (1998), which states that personal data shall not be kept for longer than is necessary for that purpose or those purposes for which it was collected; please state how long data will be retained for.

☐ 1-2 years ☒ 3-5 years ☐ 6-10 years ☐ 10> years

NOTE: Research Councils UK (RCUK) guidance currently states that data should normally be preserved and accessible for 10 years, but for projects of clinical or major social, environmental or heritage importance, for 20 years or longer. (http://www.rcuk.ac.uk/documents/reviews/grc/grcpoldraft.pdf)

26. Below is a checklist which relates to the management, storage and secure destruction of data for the purposes of the proposed research. Please indicate where relevant to your proposed arrangements.

☒ Research data, codes and all identifying information to be kept in separate locked filing cabinets.

☒ Access to computer files to be available to research team by password only.

☐ Access to computer files to be available to individuals outside the research team by password only (See **23.1**).

☒ Research data will be encrypted and transferred electronically within the European Economic Area (EEA).

☐ Research data will be encrypted and transferred electronically outside of the European Economic Area (EEA). (See **28**).

NOTE: Transfer of research data via third party commercial file sharing services, such as Google Docs and YouSendIt are not necessarily secure or permanent. These systems may also be located overseas and not covered by UK law. If the system is located outside the European Economic Area (EEA) or territories deemed to have sufficient standards of data protection, transfer may also breach the Data Protection Act (1998).

☐ Use of personal addresses, postcodes, faxes, e-mails or telephone numbers.

☒ Use of personal data in the form of audio or video recordings.

☒ Primary data gathered on encrypted mobile devices (i.e. laptops). **NOTE:** This should be transferred to secure UEL servers at the first opportunity.

☒ All electronic data will undergo secure disposal.

NOTE: For hard drives and magnetic storage devices (HDD or SSD), deleting files does not permanently erase the data on most systems, but only deletes the reference to the file. Files can be restored when deleted in this way. Research files must be overwritten to ensure they are completely irretrievable. Software is available for the secure erasing of files from hard drives which meet recognised standards to securely scramble sensitive data. Examples of this software are BC Wipe, Wipe File, DeleteOnClick and Eraser for Windows platforms. Mac users can use the standard 'secure empty trash' option; an alternative is Permanent eraser software.

☒ All hardcopy data will undergo secure disposal.

NOTE: For shredding research data stored in hardcopy (i.e. paper), adopting DIN 3 ensures files are cut into 2mm strips or confetti like cross-cut particles of 4x40mm. The UK government requires a minimum standard of DIN 4 for its material, which ensures cross cut particles of at least 2x15mm.

27. Please provide details of individuals outside the research team who will be given password protected access to encrypted data for the proposed research. N/A
28. Please provide details on the regions and territories where research data will be electronically transferred that are external to the European Economic Area (EEA). N/A
29. Will this research be financially supported by the United States Department of Health and Human Services or any of its divisions, agencies or programs? YES ☐ NO ☒
If yes please provide details:

SECTION J: PUBLICATION AND DISSEMINATION OF RESEARCH FINDINGS

30. How will the results of the research be reported and disseminated? *(Select all that apply)*

☒ Peer reviewed journal

☒ Non-peer reviewed journal

☐ Peer reviewed books

☐ Publication in media, social media or website (including Podcasts and online videos)

☒ Conference presentation

☒ Internal report

☐ Promotional report and materials

☒ Reports compiled for or on behalf of external organisations☒ Dissertation/Thesis

☐ Other publication

☒ Written feedback to research participants

☒ Presentation to participants or relevant community groups

☐ Other (Please specify below)

SECTION K: OTHER ETHICAL ISSUES

31. Are there any other ethical issues that have not been addressed which you would wish to bring to the attention of Tavistock Research Ethics Committee (TREC)? NO
In case face-to-face interviews are not possible due to the government guidance amid Covid-19, the interviews would be conducted via Zoom. Explicit written consent would be sought by the participants in advance.

SECTION L: CHECKLIST FOR ATTACHED DOCUMENTS

32. Please check that the following documents are attached to your application.

☐ Letters of approval from any external ethical approval bodies (where relevant)

☒ Recruitment advertisement

☒ Participant information sheets (including easy-read where relevant)

☒ Consent forms (including easy-read where relevant)

☐ Assent form for children (where relevant)

☐ Evidence of any external approvals needed

☐ Questionnaire

☒ Interview Schedule or topic guide

☐ Risk Assessment (where applicable)

☐ Overseas travel approval (where applicable)

34. Where it is not possible to attach the above materials, please provide an explanation below.

Appendix E *Sponsorship Letter*

The Tavistock and Portman NHS
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/

17 November 2020
By Email

To Whom it may concern

Researcher	Silviya DIMITROVA
Programme of study	Professional Doctorate in Child and Adolescent Psychoanalytic Psychotherapy

This letter is an early notification of how the Tavistock and Portman NHS Foundation Trust will provide ethical assurance for the small-scale educational research projects undertaken by its students as a requirement of their University of Essex validated programme of study.

Silviya DIMITROVA is registered on the Child and Adolescent Psychoanalytic Psychotherapy programme. I wish to confirm that the Child and Adolescent Psychoanalytic Psychotherapy programme is a Professional Doctorate programme, and that research undertaken as part of the validated programme is sponsored by the Tavistock and Portman NHS Foundation Trust. As such, the project will be reviewed by the Tavistock Research Ethics Committee (TREC) with respect to design and protocol. Once secured, Silviya DIMITROVA will forward TREC's formal confirmation of approval to proceed for your local records.

We anticipate that most doctoral projects will not require additional ethical review, with the exception of any for which full NREC approval is indicated. The Tavistock and Portman NHS Foundation Trust is registered to provide sponsorship and indemnity through the IRAS system in any such cases.

The outcome of ethical review by TREC or NREC will be provided to you when it has been obtained.

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

Yours sincerely

Simon Carrington PhD
Head of Academic Governance and Quality Assurance
For and on behalf of the Chair of the Tavistock research Ethics Committee

E: academicquality@tavi-port.nhs.uk

Appendix F *Recruitment Email*

The Tavistock and Portman NHS
NHS Foundation Trust

Dear colleague,

I am contacting you as I am recruiting participants for my M80 doctoral research project and was wondering if you would be interested in taking part.

The title of my study is *How do psychoanalytic psychotherapists experience working with young people who have perverse sexual fantasies and/or display such behaviours: A qualitative exploration.*

This study aims to explore the experiences of Child and Adolescent Psychotherapists at the Portman, working with young people (aged 14-25) who have perverse sexual fantasies or who are suffering from problematic sexual behaviours. Given that you have expertise in working with such patients, I would like to invite you to take part in a semi-structured individual interview.

My hope is that this study might throw some light on, and encourage thinking about, this mostly unexplored territory, which could be beneficial to the development of psychotherapeutic practice as well as to the wider community of the helping professions.

I would very much appreciate your willingness to contribute to the project. Please find the participation information sheet outlining the details of the project attached.

Please email me if you are interested in taking part.

Thank you.

Best wishes,

Silviya Dimitrova
Child and Adolescent Psychotherapist in Doctoral training
AYAS The Tavistock and Portman NHS Foundation Trust
020 8938 2326

Appendix G *Consent Form*

The Tavistock and Portman NHS
NHS Foundation Trust

Consent Form

Research project title**: How do psychoanalytic psychotherapists experience working with young people who have perverse sexual fantasies and/or display such behaviours: A qualitative exploration.**

- I_____voluntarily agree to participate in this research project. ☐
- I confirm that I have read and understood the information sheet for the above 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 and that I am free to withdraw, without giving a reason, at any time up to one week after the completion of the interview. ☐
- I understand that the interview will be digitally recorded and transcribed as described in the participant information sheet. ☐
- I understand that the information I provide will be kept confidential, unless I or someone else is deemed to be at risk. ☐

☐

- I understand that direct quotes from the audio recording may be used in this research study but will be made anonymous to the reader and held securely by the researcher.

- I understand that it is my responsibility to anonymise any examples referring to cases I chose to discuss during the interview. I understand I need to speak about cases in general rather than specifying individual patients. ☐

- I understand that the results of this research will be published in the form of a Doctoral research thesis and that they may also be used in future academic presentations and publications. ☐

Contact details:

Researcher: Silviya Dimitrova Email: SDimitrova@tavi-port.nhs.uk

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

Participant's Name (Printed):_____

Participant's signature:_____ Date:_____

Thank you for agreeing to take part in this study.

Your contribution is very much appreciated.

Appendix H *Participation Information Sheet*

The Tavistock and Portman NHS
NHS Foundation Trust

Research Project Title

How do psychoanalytic psychotherapists experience working with young people who have perverse sexual fantasies and/or display such behaviours: A qualitative exploration.

This information sheet invites you to take part in the above-titled research project. The information below describes the project and explains what you can expect if you decide to take part.

Aim of research project

This study aims to explore the experiences of Child and Adolescent Psychoanalytic Psychotherapists (CPTs) who work with young people (aged 14-25) with perverse sexual fantasies or who suffer from problematic sexual behaviours.

There is increasing awareness of the significant impact that sexual offending has on society (Somervell and Lambie, 2009; Ybarra et al., 2016). In his paper ''Breaching the shame shield: Thoughts on the assessment of adolescent child sexual abusers'' (2007) Donald Campbell quotes the 1988 Home Office report stating that about 30% of all sex offences were committed by adolescents. Campbell reports that in the US, adolescents were responsible for half of the child molestations. Campbell also stresses that the emotional and physical changes of puberty significantly increase the risk of abusive behaviours. He quotes Davis (1987) to explain that about 50% of adult offenders first displayed their sexual deviancy during adolescence. Horne (2003) conveys how psychotherapy with children and adolescents presenting with sexual perversion could fundamentally change the course of their lives, and prevent future abusive acts.

The research findings on therapeutic treatment approaches for people suffering from problematic sexual behaviours, including perversions, are scarce (Bordium et al., 1995; Lawson, 2003; Ayland and West, 2006; Letourneau, 2009; Ikomi et al. 2009; Somervell and Lambie, 2009). Alvarez (2010, p. 215) quotes Gabbard (1994), stating that psychoanalytic literature has been 'remarkably silent' on the feelings evoked in CPTs regarding sexuality in general. Some authors (Morgan and Ruszczynski, 2007; Campbell, 2013) state that when CPTs learn more about their conscious and unconscious responses to such work, they are more

able to contain the patients' anxieties and thus decrease the risk of patients harming themselves or others.

The study aims to throw light on, and encourage thinking about, this mostly unexplored territory. Morgan and Ruszczynski (2007, p. 33) state that perverse patients unconsciously seek to pervert both their own and everybody else's thinking, especially those attempting to help them. Therefore, greater awareness of the experiences of CPTs working with perverse patients could be beneficial for the development of psychotherapeutic practices as well as to the wider community of helping professions.

The research has been approved by the Tavistock and Portman NHS Trust Research Ethics Committee (TREC).

Who is conducting the research project?

My name is Silviya Dimitrova, and I am a Child and Adolescent Psychoanalytic Psychotherapist in Doctoral Training at the Tavistock and Portman NHS Trust. This project is being sponsored and supported by the Tavistock and Portman NHS Foundation Trust and has received all relevant ethics and research governance approval. This course is overseen by the University of Essex.

What does taking part involve?

If you agree to participate in this research project, you will be invited to take part in a semi-structured individual interview. I will ask questions about your experiences of providing psychotherapy to young people (aged 14-25) experiencing perverse sexual fantasies or suffering from problematic sexual behaviours. Both short- and long-term psychotherapy, as well as individual and group work would be relevant. For the purposes of this study, perversion would be defined—as outlined by Glasser (1979, p. 281)—to mean deriving pleasure from and aiming 'to cause the object to suffer, physically or mentally, crudely or subtly'. Whilst it has received some attention among adults, little is known about the presentation and treatment of such children and young adults.

The interview will take place at a time convenient for you, either in person at the Portman clinic, or over Zoom, should restrictions in relation to the Covid-19 pandemic prevail. The interview will last between 60 and 90 minutes and will be audio recorded.

Do I have to take part?

The participation in this study is voluntary, and if you choose to take part, you can withdraw the information you have provided up to a week after the interview, without having to state a reason. You do not have to take part but it would be much appreciated if you choose do so.

What happens with the information I provide?

The Tavistock and Portman NHS Foundation Trust is the sponsor for this study, based in the United Kingdom. I will be using information from you in order to undertake this study and will

act as the data controller for this study. This means that I am responsible for looking after your information and using it properly. I will keep identifiable information about you from this study for 5 years after the study has finished. The interview will be audio recorded and transcribed by myself.

Your rights to access, change, or move your information are limited, as I need to manage your information in specific ways in order for the research to be reliable and accurate. To safeguard your rights, I will use as little personally identifiable information as possible. I will use your name and the contact details you provide only to contact you about the research study. I am the only person who will have access to information that identifies you. I may be assisted in the analysis of this information by senior colleagues, but they will not be able to identify you and will not be able to find out your name or contact details.

Quotes from the transcript will be used in the write-up of the project but these will be de-identified. However, please note, it is possible that other colleagues who know you well may recognise you in some of the quotes used, although every effort will be made to prevent this. Any extracts from what you have said that are quoted in the research report will be entirely anonymous.

All electronic data will be stored on a password-protected computer. Any paper copies will be kept in a locked filing cabinet. All audio recordings will be destroyed after completion of the project. Other data from the study will be retained, in a secure location, for 5 years.

If you would like more information on the Tavistock and Portman and GHC privacy policies, please follow these links:
https://tavistockandportman.nhs.uk/about-us/contact-us/about-this-website/your-privacy/
https://www.ghc.nhs.uk/privacy-notice/

You can find out more about the legal framework within which your information will be processed by contacting the sponsoring Trust's Clinical Governance and Quality Manager, Irene Henderson: IHenderson@tavi-port.nhs.uk

There will be limitations to the confidentiality of information provided if it is deemed yourself or someone else is at risk.

What happens to the results of the project?

The results of this study will be used in my Research Dissertation Project and Doctorate qualification. They may also be used in future academic presentations and publications. If you wish, I would gladly send you a summary of the results. Please feel free to contact me with such requests, should you decide you may be interested.

What are the possible benefits of taking part?

There will be no direct benefits for you. However, the research would provide the participants a space to reflect on their own experiences as clinicians, working with this particular patient group. Being interviewed could also allow clinicians to think about the different experiences

individual CPTs could have. The proposed investigation would potentially alert CPTs to challenges and advantages posed by the current policies and statutory framework. It would also perhaps be interesting for the CPTs to see, once the research is published, what common themes the researcher have found across all interviews and how an external interviewer such as the researcher has made sense of what the CPTs have shared about their work.

Are there any risks?

The researcher does not envisage any direct risks to taking part in this study. However, given the nature of psychotherapy, which involves unconscious thoughts and experiences, some people may find the topic uncomfortable. Details of a confidential service you can access will be provided.

Contact details:

Researcher:
Silviya Dimitrova
SDimitrova@Tavi-Port.nhs.uk
Tel: 07704481712

Research project supervisor:
Dr Felicitas Rost
FRost@tavi-port.nhs.uk

If you have any concerns about the conduct of this research, the researchers or any other aspect of this project, please contact the Head of Academic Governance and Quality Assurance: Simon Carrington academicquality@tavi-port.nhs.uk

Thank you for considering taking part in this study and taking the time to read this information. If you are willing to take part in the research or have any further questions, please contact me.

Appendix I *Debrief Letter*

The Tavistock and Portman NHS
NHS Foundation Trust

Dear….

I am writing to thank you for your contribution to this Doctoral Research Project. I hope you found it meaningful.

If you have any questions or would like further information, please find my contact details below:

Silviya Dimitrova

Email: SDimitrova@tavi-port.nhs.uk.

Tel: 07704481712

If you have any concerns about how the study has been conducted or any other aspect of this research project, please contact the research project supervisor Dr Felicitas Rost (FRost@tavi-port.nhs.uk) or Simon Carrington, Head of Academic Governance and Quality Assurance (academicquality@tavi-port.nhs.uk).

If, following taking part, there are any issues that are concerning you, please be aware that you can access the support network around you (colleagues, supervisors and managers). I would also like to inform you that you can access the Trust confidential counselling service provided by the Staff Advice and Consultation Service (SACS). Details are provided on the Trust Intranet.

Kind regards,

Silviya Dimitrova