Developmental trauma in CAMHS: Internal and external experiences of patients presenting with trauma symptoms.

A mixed methods project.

Eleanor Shilliday

A thesis submitted for the degree of Professional Doctorate in Child and Adolescent Psychoanalytic Psychotherapy D.Ch.Psych.Psych

Department of Psychosocial and Psychoanalytic Studies

University Of Essex

Date of submission for examination: July 2022

Contents

Acknowledgements

I would like to express my deepest gratitude to my Doctorate Supervisor, Dr Rajni Sharma for her invaluable support, patience and feedback over the course of this project. I also could not have undertaken this project without the knowledge and input from my tutors and colleagues at the Northern School of Child and Adolescent Psychotherapy. In addition, this project would not have been possible if it were not for the generous support of my NHS Foundation Trust, Manchester University NHS Foundation Trust, and in particular, my previous and current CAMHS teams for which I am extremely grateful. Thanks also to the Tavistock and Portman NHS Foundation Trust and the University of Essex, including the expertise of the librarians.

I'd like to acknowledge a special thank you to my family and friends, who without their continued encouragement and emotional support I would not have been able to complete this project.

Abstract

This project takes a deeper look into the complex area of children who have experienced developmental trauma (DT); a vulnerable sub-group within the larger population of children entering the strained UK NHS Child and Adolescent Mental Health Services (CAMHS).

This is a single centre, interpretive service evaluation. It includes two-parts: a mixed methods, observational approach consisting of a survey of one year's worth of Post-Traumatic Stress Disorder (PTSD) referrals into CAMHS; alongside a thematic analysis of psychotherapy assessments of three children with developmental trauma.

The research questions are as follows:

Qualitative: *What themes emerge about the quality of three children's internal world post-developmental trauma, and the transference relationship with the psychotherapist during psychoanalytic assessments?*

Quantitative: *What can be understood about the characteristics of the population of children who have experienced DT by examining the referrals of PTSD patients into a Child and Adolescent Mental Health Service?*

Prominent patterns emerging from the survey of trauma referrals particularly highlighted the relational aspects to trauma symptoms. Emerging from the psychotherapy assessments were three main themes of 'Persecutory parental objects'; 'Fight, flight, freeze or fawn (4Fs)' and 'Absence of maternal containment'.

The findings highlight that there are key characteristics of children who have experienced DT and that from this, recommendations can be made to take these findings into consideration during the assessment and formulation period in CAMHS, to better understand what treatment would be most appropriate. Further research is required to expand on these findings and to gain additional insight into how these results compare with a larger population.

Keywords: child and adolescent psychotherapy; PTSD; Developmental Trauma; Assessment; CAMHS

Introduction

This project was chosen following my first year of Child and Adolescent Psychotherapy Professional Doctorate training whereby the majority of the children I was treating had experienced significant trauma in their early years. I wanted to understand more about how their traumatic history was being communicated and how it was affecting their quality of relating, by looking deeper into our therapeutic relationship.

Alongside this, the Manchester Arena Attack in 2017 brought the issue of trauma to the forefront my mind, alongside many of those living and working in Manchester at this time. I observed an interesting phenomena during the months and years following this tragedy, which added to my curiosity and drive for this project; there were some children who had been at the arena bombing, that were accessing mental health support, whilst others were not. I was interested in how some children had struggled to recover from the incident, and wondered if the difference between the two groups was whether they had previously experienced trauma or not.

When this project was in it's infancy, developmental trauma was a relatively under-researched topic with most of the existing clinical knowledge drawn from work with adults. In recent years, there has been a significant increase in trauma research with children and therefore this project arrives at completion during a time when trauma is a top of interest and debate, from within mental health services to the Houses of Parliament. Consideration of the unconscious dynamics involved in trauma and it's consequences presentations however, remain limited. Therefore, this project offers a unique perspective as it examines the experiences of a set of children in a CAMHS

clinic, both internally; through investigating unconscious processes, and externally; by gathering data about the characteristics of the population, with a psychoanalytic lens.

The conceptual framework lends itself to understanding a co-created reality of objective and subjective truths, and the internal and external experience of the child. The project aims to integrate the multiple realities of the child's experiences to identify the most common themes and patterns, to add unique findings to the existing knowledge about this patient group.

The aims of the project are as follows:

1) *To gather key data about PTSD referrals in CAMHS by reviewing a years worth of data. This will be investigated using a quantitative survey to identify commonalities and themes.*

2) *To identify common themes which emerge from the analysis of psychoanalytic assessments with three children who have experienced developmental trauma. This aim will be addressed in the qualitative part of the project whereby thematic analysis will utilised to draw out key themes.*

3) *To draw some important conclusions about this specific population of children, to add value to professionals working with them.*

The project considers the context within which children presenting with trauma are referred into the service, as well as gaining a deeper understanding of the internal world of three child psychotherapy patients.

To explore the context, the survey of PTSD referrals focuses on their journey from initial referral to discharge; examining key information and demographics, to discover objective conclusions about the reality of their external experience. It also allowed for an exploration of trends in the data set, including patterns which may inform new understanding about current theory.

For a more focused exploration of the internal world of this patient population, the thematic analysis of three psychotherapy assessments uncovers their experience of relating, including examining my own counter-transference experience and drawing on key themes and patterns, in relation to the research question.

The assessment process referred to in this project is a ‘generic CAMHS initial assessment’ as delivered by multi-disciplinary clinicians working within the particular CAMHS involved in this project, whilst the thematic analysis is looking at psychoanalytic assessment sessions as delivered by myself during my training. The initial assessment refers to the first one or two appointments with a patient, when a gathering of vital information is being taken with the aim of making a formulation and, if necessary, a treatment plan. There is a standardised form which acts as a guide for the clinician to follow, which includes a section on ‘developmental history’.

As many authors (e.g., Wilson & Rachman, 1983) have noted, a study of any kind is only as reliable as the data it contains. There are limitations to the interpretations of this data due to the small scale of the project, however, as presented in the findings chapter, some of the key characteristics of this patient population have been captured.

Recently, there has been growing recognition at government level of the importance of children's mental health and safeguarding those who are more vulnerable, with national reports such as Future in Mind (NHS England, 2015), Five Year Forward View for Mental Health (2016), National iThrive programme (Wolpert et al, 2019) and the NHS Long Term Plan (NHS England, 2019).

Future in Mind focuses on prevention, resilience and early intervention, as well as access for the most vulnerable children such as the children included in this project. The NHS Long Term Plan and the Five Year Forward View for Mental Health focus on improving access to mental health services including out of hours and beyond the clinic settings. The i-Thrive programme aims to provide a more person centred and needs led approach to mental health care.

More locally, Manchester's Transformation Plan (Manchester Health and Care Commissioning, 2015) was created in response to the fore-mentioned reports and alongside this, M-Thrive is Manchester University Foundation Trust's local service using the national i-Thrive model.

In regard to trauma-focused services in particular, there has been a focus on trauma resources following the Arena Attack in 2017, such as the Greater Manchester Resilience Hub and the Trauma Project 2018 at 42nd Street, a third sector organisation. St Mary's Sexual Assault Referral Centre, and the Harbour Project also offer a provision to young people who have been affected by sexual assault and domestic abuse.

In the following chapter the literature review will be presented where further theory and research will be discussed and explored.

Literature Review

In order to meet the aims of this project, the literature review honed down the vast number of papers relating to the subject of trauma, to identify papers which were relevant and related to the research question.

Literature review approach

The literature review uses a narrative approach which, due to its method of identifying and building upon existing literature to identify themes and patterns, is most suited to the research question.

To begin the process, **key search areas** were identified. These were:

1) *Defining developmental trauma, including other types of trauma and the differences and similarities*
2) *The significance of early experiences and relationships on emotional development, including childhood trauma*
3) *Assessing childhood trauma in NHS CAMHS*
4) *Psychoanalytic perspective on developmental trauma including causes and presentations*

The four points were broken down into **key concepts and definitions**, pulling out specific search terms, which were narrowed down to:

1) *Trauma*
2) *(CAMHS) assessment*

3) *Psychoanalytic/psychodynamic perspective*

Limiters were set limiters on the search criteria which shaped the inclusion criteria, these needed to be narrowed down due to the vast number of published articles about the topic. The **limiters** were:

1) *Publish date: no minimum, maximum present day (2020)*

2) *Age group: childhood (all categories 0-18)*

3) *Methodology: empirical*

4) *Language: English*

5) *Source type: Academic Journals*

6) *Publication: Due to the vast number of search results I omitted certain journals which I did not think would be relevant such as the Journal of Paediatric Surgery.*

The following **data bases** were used for the search:

1) *Psych Info*

2) *Psych Articles*

3) *Psych Books*

4) *Psychology and Behavioural Sciences Collection*

5) *PEP Archive*

6) *MEDLINE*

7) *Google Scholar*

The initial search combined the **three key topics** and were searched using the terms ‘Trauma’ and ‘CAMHS’ and ‘assessment’ and ‘psychoan*’ and ‘psychodyn*’

This produced, with limiters added, **51 papers**. I narrowed this down to **10 papers** initially, ensuring that they including all four of the essential elements of my research topic: children, psychoanalytic approach, assessment, and trauma. It was not essential for the setting of the paper to be focused on CAMHS but four of the papers were based in a CAMHS setting.

The snowballing technique (Wohlin, 2014) was then used to search for further papers of relevance. This was followed by a hand search of journals and books of relevance such as the reading list for the Psychoanalytic Observation Studies course (M7), Clinical Training (M80), and Understanding Trauma: Principles and Practice and its Aftermath (D18) (2018-2021).

From the search results, the majority of the most relevant papers appeared in the Journal of Child Psychotherapy and were case studies by child psychotherapists, describing their work with children. Most of the other papers were published in similar journals such as International Forum of Psychoanalysis and Child and Adolescent Mental Health.

Qualitative research was the predominant method with a smaller number of mixed method and quantitative approaches. The papers which focused more on trauma from a ‘PTSD’ diagnostic approach, were predominantly quantitative and found in psychiatric publications with a more medical focus.

I observed that there was few papers which combined the two, as I have aimed to do in this project. In the following sections of the literature review I will present the findings, from describing seminal psychoanalytic papers to recent research findings. To begin this, I will outline some of the key psychoanalytic concepts that will appear throughout this paper, for further context.

Key psychoanalytic concepts

Throughout this thesis, several psychoanalytic concepts will be referred to, some of which form the basis for the interpretation of the results of the study. All of them inform the way in which the data is thought about. I will describe some of the key concepts below:

- The **'transference'** as initially defined by Freud (1905) and developed by Klein (1952) can be defined as the 'transferring' of 'the child's sense of who he is and how others will react to him, influenced by expectations based on his past and present family relationships'. (Lanyado & Horne, 2009 pp160).

- The internal relationship prototypes that the child has introjected through primary relational experiences are known as **'internal objects'** (Klein, 1937) which can sometimes be presented as, **'internal mother/father/sibling'.** These colour the way in which the child views others and what they project and introject in the transference, throughout their life.

- **'Projective identification'** is defined by Klein (1946) as an unconscious phantasy in which aspects of the self are split off, and transferred into an other in a way in which the other not only contains bad parts of the self but 'becomes' the bad object. Bion (1962) developed this to include normal projective identification during healthy development as part of his theory of **'containment'**, whereby the primary caregiver is required by the infant to receive their projections of unbearable anxieties and return them to the infant in a digested and manageable form.

- The **‘counter-transference’** (Freud, 1915; Heimannn, 1950); is the therapist’s response to what is being transferred to them and is linked closely to projective identification.

- The **‘paranoid-schizoid position’** (Klein, 1946) and the **‘depressive position’** (Klein, 1935;1940) describe the two positions in which different configurations of object relations occur, alongside the defences used to protect oneself. In the former, the child experiences **‘persecutory anxieties’** (Klein, 1946) concerned with defending one’s own safety, whereby in the latter the concern is for the object; including guilt, empathy and reparation.

Defining trauma

Traumatic experiences can be understood as a physical ‘wound’ (Laplanche and Pontalis, 1973) or psychically; as a ‘piercing’ of the mind (Freud, 1920).

The first formal recognition of trauma symptoms, was the inclusion of Post-Traumatic Stress Disorder (PTSD) in the Diagnostic and Statistical Manual of Mental Disorders (DSM-111) in 1980. Prior to this, symptoms appeared in various medical literature, including the International Classification of Diseases (ICD 6, 1948) and DSM-I (1952) under different guises. The descriptions of the effects of trauma have, however, appeared in art and literature for hundreds of years including Shakespeare’s King Henry IV (1598) and Homer’s ‘The Odyssey’, written in 8th century BC (Weisaeth, 2014).

The introduction of a physical as well as mental connection to trauma emerged around the 1860s with ‘irritable heart’ or ‘railway shaking’ (Figley, 2012;2013). The majority of this research was focused on adults and war, with a later acknowledgement of the prevalence of child sexual abuse and its effects in 1896 (Spiegal, 2013).

In 1948, the ICD-6 produced the first diagnosis which captured PTSD symptoms, named ‘Acute Situational Maladjustment’ (Henderson, 2001). This was joined by further recognition of childhood trauma, particularly in the US, with diagnoses such as ‘Battered Child Syndrome’, and ‘Abused Child Syndrome’. It was not until the 1980s, however, that Post-Traumatic Stress Disorder was officially recognised as a separate diagnosis in its own right, in the DSM-II.

Trauma research in regard to children began to take more shape in the 1960s and 70s, with the emergence of Attachment Theory (Bowlby, 1969; Ainsworth, 1978) and discoveries in neuroscience, which continued throughout the 1990s and 2000s. Recognition that there was similarities between PTSD symptoms, and the presentation of children who have experienced neglect or abuse, was emerging.

Developing from this was the introduction of ‘Complex PTSD’ in 2013 (ICD-11) describing the experience of chronic and cumulative trauma. Studies on C-PTSD have demonstrated that patients meeting these criteria are significantly different in terms of their functional impairment and type of trauma history than PTSD patients (Cloitre et al., 2013). For example, Van der Kolk (2000) found in a study of children who had been exposed to multiple and/or prolonged interpersonal trauma, fewer than 25% met the diagnostic criteria for PTSD.

To capture the experiences of children who have experienced complex trauma, which may not meet the criteria for PTSD or C-PTSD; professionals and researchers (e.g. Music, 2019) named their experiences ‘developmental trauma’, or ‘cumulative trauma’. Developmental trauma (DT) is currently known as a ‘provisional diagnosis’ (Teague, 2013), which acknowledges the need for a diagnosis to capture this particular patient population’s experience and subsequent difficulties.

DT is understood to be the experience of a child not being provided with the love, care and attunement that they are hard-wired to need and expect in order to develop and function normally; ‘experience expectance’ as Music (2010, p11) describes, or when their ‘pre-conception’ to the concept of linking with the other is not made into a reality (Bion, 1967).

Winnicott (1963) describes the experience of DT as repeated ‘impingements’ from the external world, onto the child’s ongoing sense-of-being which disrupts their development, sometimes shutting it down completely; whilst McGilchrist (2010) adds that the poor quality of the child’s earliest relationships mean that they need to adapt to survive.

DT in the form of child abuse can be physical; emotional; sexual; or neglect. Several studies have revealed that the most damaging form of abuse is interpersonal, particularly from the child’s primary caregiver, and is more likely to lead to PTSD symptoms than any other traumas (Van der Kolk, 1989, Music, 2010). Children who are neglected are subsequently at a higher risk of being abused in other ways due to their vulnerability, and therefore often children in these environments suffer from more than one category of abuse.

The impact of traumatic childhood experiences

In a healthy baby-caregiver relationship, the child has the experience of ‘maternal reverie’ (Bion,1962) where their catastrophic terrors can become meaningful and bearable through the process of ‘containment’. This experience is crucial to what Ainsworth (1967) describes in her important work on establishing a secure ‘attachment style’. Secure attachment, which is her definition of a healthy attachment, develops as a result of repeated experiences of containment from the caregiver. If this early experience goes well, the child introjects an internal maternal object who has the capacity to manage their unbearable anxieties.

In the absence of containment and in the presence of abuse or neglect, problems develop. The depth, quality, and duration of the DT, along with genetic strengths and vulnerabilities, must be considered in regard to what has shaped the child’s response to the trauma (Frigerio et al, 2009). In general however, the more severe the deprivation, the worse the effects on the brain and the mind.

The ‘first 1001 days’ of the child’s life in particular, is a crucial period for essential development and growth that has a lifelong impact; a term captured for a campaign regarding preventative work in relation to mental health and child development (HM Government, 2021). If these 1001 days are disrupted by DT, ordinary thinking and being in touch with reality; two essential aspects for a healthy mental life, are compromised. Trowell (1997) for example, captures this in relation to children who are being sexually abused and facing extreme pressure to believe that what is happening is normal.

The relationship to the person inflicting the trauma has an impact on the child's response. For example, abuse inflicted by the child's parents is particularly damaging. As a result of parental abuse, some children emotionally shut down, becoming unreachable (Henry, 1974), whilst others are unable to make simple decisions and manage ordinary thinking (Van der Kolk, 2000). Bick (1986) suggests that, due to disturbances to the development of the depressive position, these children cannot cope with subsequent persecutory and depressive anxieties. This has serious implications for treatment and recovery. Winnicott (1960a) captures the significant effect this has on the development of the self, with the 'false self' developing instead of a genuine identity.

Long after the DT has stopped, the child may remain stuck in a continuous cycle of reliving the traumatic memories and preparing for associated threats (Shalev,1993) This is often referred to as the 'fight, flight, freeze or fawn' response (Gerhardt, 2004; Stubley, 2020; Walker, 2013). Flashbacks of traumatic experiences can be as vivid as if they were occurring all over again, and to complicate the matter further, it is common for the child to be unable to articulate what is happening to them (Blank, 1985).

Jo Stubley, who leads the Tavistock Trauma Service discusses how the ordinary anxieties about danger or death, to oneself or a loved one are particularly stirred up in those who have had some of these fears realised (Stubley, 2020). The child's trust in their internal and external relationship is disturbed and the boundary between fantasy and reality is compromised.

DT patients are often the most vulnerable in the wider group of trauma victims, many being adopted or Children Looked After, in kinship or foster care. They are at high risk of poor psychosocial outcomes, often denied access to treatment or offered an ineffective treatment due to a lack of psychiatric diagnosis or a mis-diagnosis, often presenting with physical difficulties in addition to mental ill health (Breslau, 1991). The Adverse Child Experiences (ACE) study (Felitti, 1998) which identifies key experiences during childhood that, alongside attachment style, help predict the quality of mental well-being; suggests adults with DT have a greater risk of developing heart disease; cancer; stroke; and diabetes.

The transition into adulthood for children who have experienced DT, can be extremely difficult and may worsen with the additional life pressures that come with growing older. Taylor (2007) found that a PTSD diagnosis often precedes further psychiatric diagnosis in adults with DT, who subsequently present with other mental health difficulties.

There is also a risk of having children whilst carrying unprocessed trauma, as research suggests that trauma can be ‘inherited’ unconsciously to the next generation (Danieli, 1998; Perry, 1997). There are extreme examples of this in the family history of those responsible for serious incidents such as school shootings (Seals & Young, 2003); violent attacks (Garbarino, 1999); child abuse (Dodge et al, 1995); and domestic violence (Davies, 1991).

Co-morbidity

Co-morbidity refers to a presentation that spans across multiple diagnostic categories, and sometimes, this is an appropriate way to understand children and adults who experienced DT during their early years. However, as touched on in the previous chapter, there is often a ‘spectrum’ (Van der Kolk, 2000) of difficulties related to the trauma, depending on the social, environmental and relational factors, as well as the age when the trauma occurred. Golding (2020) argues that without the context of the difficulties being consider, children are at risk of acquiring diagnoses which are not appropriate nor helpful.

Often, on initial impressions, trauma and neurodevelopmental disorders can appear to be similar. Rutter et al (1999) presents work which demonstrates similarities between the terribly neglected Romanian orphans and some children who are severely autistic, such as ‘dead eyes, staring into space and rocking’. Unimaginative play; rigidity to routines; delayed speech; ‘second skin’ defences (Bick, 1968) and ‘adhesive relating’ (Meltzer, 1975) can be observed in some DT children along with an apparent lack of empathy and an inability to understand another’s point of view. These may result in the child being placed on a Social Communication assessment pathway, with the possibility of an Autism Spectrum Condition diagnosis at the end.

Similarly, Attention Deficit Hyperactive Disorder is a diagnosis often given to DT children due to presentations such as distractability, daydreaming, restlessness, chaotic behaviour and impulsivity, but these may be caused by DT rather than ADHD. However, research does suggest that when the baby is in utero, which would likely be the case in environments where ACE’s occur, then key, mood regulating

hormones in the mother can be effected. As a result, the baby may be permanently impacted (Music, 2010).

Post-natal attachment difficulties also feature prominently in several research studies on the links between ADHD and the child's relationship to their caregivers (Green, 1978; Lewis, 1992; Frank et al, 2009) suggesting a relational aspect to the disorder.

Understanding the impact of DT has also impacted the way in which other conditions are defined. For example, there is increasing evidence in recent years linking Borderline Personality Disorder (BPD) to childhood trauma, especially sexual abuse (Sansone et al, 2011), with studies showing that more than 70% of BPD patients report experiencing traumatic events in childhood (Blasczyk-Schiep et al, 2014). This offers a more empathetic view on a patient population which is often viewed as difficult to treat, with complex behaviours such as self-harm and suicide attempts (Merza, 2017).

The mind-body connection and neuropsychoanalysis

The research that has been undertaken to understand trauma from a physiological perspective is vast and evolving. Findings suggest that brain development and hormonal regulation are affected significantly, during and following trauma leading to a ‘fight, flight, freeze or fawn’ response which releases hormones such as cortisol, resulting in a ‘corroding’ of the brain (Stubley, 2020; Gerhardt 2004). This extreme emotional arousal impacts the central nervous system significantly, preventing integration and leading to the absence of coherent narrative but the presence of sensory elements. The results of this occur during ‘flashbacks’ and nightmares.

Particular approaches to working with children who have experienced DT such as the story stem technique (Hodges et al, 2003) take into account that the play is likely to be less symbolic and more a re-enactment of the trauma, similar to the aforementioned flashbacks (Osofsky, 2007).

Neuropsychoanalysis, a term coined by Solms and his work (Solms and Turnball, 2011) brings psychoanalysis and neuroscience together. The roots of this concept began with the Freudian theory of instincts and was developed by Panksepp and Biven (2012). For this research, they systematically stimulated different areas of the brain chemically or electronically, and then mapped out the subsequent behaviour responses of the subjects. It was discovered that ‘fear’, ‘rage’ and ‘panic/grief’ have as their basic function, tissue protection; they generate dysphoric affect and they are not interpersonal instincts. This discovery that panic/grief propels the need for others by calling out with distress signals, provides vital information to assist in our

understanding of children that don't call for help when they need to. This links to the 4Fs and the defence of 'freeze' in particular.

As touched on earlier, in addition to a 'fight' or 'flight', there are also 'freeze' and 'fawn' reactions. Research suggests that 'freeze' is the most primitive response to danger, involving a shutting down of all our 'systems, immobilization and dissociation' (Stubley, 2020) mediated by the Parasympathetic Nervous System through the Dorsal Vagus Nerve. A third element of this nervous system is the Ventral Vagus; which is considered the most advanced component, linking the heart, stomach, brainstem, other internal organs and facial muscles (Porges, 2011). Porges suggests that activating the Ventral Vagus, which is involved in attachment, bonding, empathy and social communication, helps the body manage the effects of hyper-arousal.

In regard to the 'fight' response, a number of studies demonstrate that patients who have experienced chronic trauma have decreased hippocampal volumes, which may play a role in the presence of dissociation and misinterpretation of information in the face of a perceived threat, with a vulnerability to react with aggression or withdrawal (Bremner, 1995; Gurvits, 1998; Adamec, 1991). This shutting down may also be linked to the inability to control early startle reflexes, meaning that evaluating sensory stimuli and mobilising appropriate levels of physiological arousal are compromised in DT patients (Shalev, 1993). Similarly, Tozzi (2020) found that childhood maltreatment affected regions of the brain related to perception, and theory of mind.

There are different views on whether the therapeutic work with a child who has experienced DT, requires them to be able to verbalise what has happened to them. As described above, this is complex and careful work and there is some evidence to

suggest that these children will not be able to put their trauma into words, at the beginning of therapy. Rauch et al (1996) for example, observed during a PET scan study of PTSD patients, that when exposed to triggering memories, the brain demonstrated activity in the right hemisphere only, with activity in the left hemisphere, where language is formed, decreasing. Schore's (2003;2012) finding's develop this idea, demonstrating significant level of brain development that occurs before the mind is able to consciously remember, and thus does not have meaning in the way of language. Expanding further on the mind-body connection, Balbernie (2001), suggesting that through intersubjectivity of a child's early relationships, their 'mind' is made through the brain patterns created. This can be understood as the distinction between the brain as a physiological entity, and the mind as a conceptual way of describing that which holds our emotional world.

Assessing a traumatised child in CAMHS

Children can be usually be referred to their local CAMHS by their GP, school, third sector services, or their parent/guardian. Each CAMHS varies in terms of approach, waiting times, and balance of specialist modalities available but collectively they have a duty to comply with National Institute for Health and Care Excellence (NICE) guidelines.

In the particular CAMHS where this project is based, pathways are created to assist the assessment and treatment of children as advised by the NICE guidelines. For suspected PTSD, it is recommend that the clinician should 'ask people specific questions about re-experiencing, avoidance, hyper-arousal, dissociation, negative alterations in mood and thinking, and associated functional impairment.' This is in addition to enquiring whether the child has 'experienced 1 or more traumatic events (which may have occurred many months or years before)' (NICE, 2005, amended 2018).

As previous chapters have described, assessing a traumatised child is a complex and challenging task which goes beyond asking questions; the clinician will have a counter-transference experience which can be used to assist in their assessment of the, at times, confusing and contradictory emotions of the child. Taylor (2007) describes that, to enable a good assessment, there needs to be 'meaningful contact' between the assessor and the patient/family, which can sometimes be the start of freeing something up for recovery to happen. Music (2019) describes a helpful image of the patient being in a 'ditch' and that, in order for the clinician to reach them emotionally, we must strike the balance of not falling into the ditch with them, nor

remaining too aloof and ‘above’ them. Other aims of the assessment include deciding whether it is the right time for intervention and which intervention would be most appropriate, as well as considering who is looking for help (Margaret Rustin, 2004).

One of the most important reasons for a robust and efficient assessment is to prevent, as far as possible, some of the most deprived children from experiencing what Emanuel (2002) termed ‘triple deprivation’, a repetition of their early trauma with the additional layer of neglect from services. This is especially true for children looked after and adopted children who have already experienced loss. As Klein (1923) discovered, the absence of a good experience is felt by the child to be the presence of a ‘bad object’. CAMHS, like other services involved with the child, could, as a result of initial failures, become a bad object and the child may then disengage from further treatment.

As the research presented so far has suggested, children who have experienced DT may not present with PTSD symptoms and, conversely, children with PTSD symptoms may be stuck in this state of mind due to DT rather than the single event which may have triggered the involvement of services (Garland, 1998). This makes assessing this population more complicated. Most treatment-seeking patients have, in fact, suffered a number of traumatic experiences in their life by the point of assessment (Van der Kolk, 2000). The rhesus monkey study echoed these findings, demonstrating that although normal functioning was possible, when put in a stressful situation, they resorted back to previous maladaptive and odd behaviours (Suomi, Novak, & Well, 1996).

It is at the core of psychoanalytic thinking that a traumatic event will stir up the unresolved conflicts, pains and emotional experiences of the earliest chapters of one's life. Therefore, when a child or young person presents at CAMHS with trauma symptoms from something that is occurring in the present day, they are bringing with them a much younger self too. Developmental history taking is part of the process of exploring this and beginning to make links between the past and present difficulties, whilst evaluating resilience to what has happened before (Lee at al, 2020).

With traumatised children, it may become apparent during the assessment that everyone in the family will have their own definition of what has happened, and that the word 'trauma' encompasses so many different experiences such as bereavement, emotional cruelty or poverty (Lanyado, 2009).

How the child presents regarding which of the 4Fs they identify with may also assist in the formulation. For example, Walker (2013) argues that the tendency to 'choose' one of the 4F's depends on the childhood abuse/neglect pattern, as well as birth order and genetic predispositions. He describes the types as 'narcissistic' (fight), 'obsessive/compulsive' (flight), 'dissociative' (freeze) and 'codependent' (fawn).

Trowell's (1997) work with children who have been a victim of sexual abuse, observed their tendency to dissociate or 'freeze'; whilst neglected children as presented by Music's (2019) and Spitz (1945) are children that exist in the background, and may fall within the 'fawn' category due to their quiet compliance.

Perry et al (1995) discusses this further in his work with Romanian orphans, noting that in scans of the children's brains, there is a chronic underdevelopment,

particularly in areas concerned with cognitive function, motor development and language. An assessing clinician may therefore not be inclined to view the child as in need of treatment, and this comes at a high cost for the child, who is in a terrible state.

Many children who have experienced DT would fit the ‘fight’ response with their presentation of defensive aggression. This may be a result of exposure to violence and neglect in their early months and years of life but can become embedded in their internal world, and sometimes, lead to a diagnosis of Conduct Disorder or Anti-Social Personality Disorder (Alveraz, 1999).

Gender, ACE's and Developmental trauma

In regard to gender and DT; females were significantly more likely than males to report a range of Adverse Child Experiences (ACEs); mental, social, and emotional difficulties in adulthood according to a study by Haahr-Pedersen (2020).

Foa & Tolin's (2006) research also suggests that around 10% of females are likely to experience PTSD in their lives and get a diagnosis (Lenferink, 2020) compared with 4% of males, despite some studies suggesting that males are more likely to experience traumatic events throughout their lives (Breslau et al., 1998; Kessler et al., 1995; Norris, 1992). This data may be partly influenced by females being more likely to seek help, verbalise their experiences, and engage in self-harming behaviours (Campbell & Eaton, 1999; Music, 2019), whilst males are more associated with externalising disorders such as ADHD or conduct disorder (Lenferink, 2020) but are more likely to complete suicide (Music, 2019).

A complication of assessing children is that their caregivers need to be involved, emotionally and practically to support the child. This involvement can be a deciding factor in how successful the treatment is, but with the common complication of trans-generational trauma, it can also be a barrier to progression.

There is value in exploring the parent's own experience of childhood during this initial assessment period as well as the child's, as several studies have confirmed the relationship between the child's Strange Situation (Ainsworth, 1978) classifications and their mothers' attachment style, as assessed with the Adult Attachment Interview (van IJzendoorn, 1995). The Strange Situation experiment classified children's

attachment to their caregiver into categories such as ‘secure’ or ‘avoidant’ and ‘dismissive’, and this theory can be interpreted in relation to how child psychotherapy patients come and go to their session and in how they respond to breaks.

Haselgruber et al (2020) adds that the perspective of the family should not be dismissed nor taken as the truth but examined for meaning within the limitations it contains. On the contrary, if the child is Looked After, there may be large chunks of the child’s history missing, putting more emphasis on the clinical judgement and counter-transference experience of the clinician. Lanyado (2009) observes that, whether the child’s family is there or not, the clinician often has an experience of the previous generations’ presence in the room. As Winnicott (1942) captured, the baby is always considered in relation to their primary caregiver.

There is increasing evidence to suggest that it is the unprocessed trauma which is the most problematic for the future generation; when the understandable wish to leave one’s traumatic experiences in the past has, instead, meant the children, and even grandchildren, of the individual have become the ones who carry the burden unconsciously. This is seen in the case of Holocaust survivors, as captured by Jucovy (1992) and is described by Fraiberg et al (1975) in her paper ‘Ghosts in the Nursery’.

Measures and the use of counter-transference

Amidst all of the uncertainty and complexity during the initial assessment processes; standardised guidelines, manuals, and 'evidence-based' approaches to guide the clinician and inform the formulation can be helpful. Problems may occur, if they are used defensively rather than to aid thinking in an open and flexible manner.

Pre-1980; assessment, formulation and treatment plans were predominantly completed using information gathered from clinical case examination (Bloch, Silber & Perry, 1956; Newman, 1976) and/or reviews of case records (Levy, 1945). Terr's examination of children following a school bus kidnapping (Terr, 1979) and other studies of children exposed to violence and disaster (Eth & Pynoos, 1985) demonstrates the effectiveness of directly interviewing children regarding their experiences and responses.

Post-1980, instruments to measure psychiatric conditions were becoming mainstream; including measures of depression (e.g. Birleson, 1981), anxiety (e.g., Reynolds & Richmond, 1978), fear (e.g., Ollendick, 1983), and adult trauma scales for children (e.g., Horowitz et al, 1979).

Nadar (2014) states that it is widely believed that one type of assessment for children's trauma is not the most accurate approach, and that measures need to be repeated over the course of treatment to gain an understanding of the changes that occur around the trauma and the child's presentation to ensure that the formulation and treatment plan continues to be appropriate.

Another reason for the introduction of diagnostic instruments was to ensure that they could be used in epidemiological and therapeutic research. However, Taylor (2007) argues that there can be a tendency to lose contact with the child and with this, their counter-transference experience. The psychoanalytic approach values this experience as a route to the child's unconscious, providing important data about their internal world. Bion (1962) suggests that an excessive use of projective identification and therefore a particularly powerful or unusual response to a child may be indicative of a child who did not have an opportunity to use this mechanism at the appropriate stage of infancy.

Depending on the quality and strength of the counter-transference experience, it can have a powerful influence on the formulation. Henry (1974) describes how the clinician be misled into thinking the child doesn't need help; a hopelessness about therapy for this child; or a mirroring of the child's defences. Similarly, the clinician may experience an overly optimistic, maternal, or rescue fantasy instigated through identification with an idealised object.

Youell (2002) suggests that children who leave the clinician confused may be picking up that the child is very different internally than they are presenting to the outside world. These children may require additional time to assess and a robust communication to the professional network to ensure that the reality of the child's emotional experience is heard.

Formulation and Treatment

Treatment, when offered, depends on several factors including assessment and formulation, but also practical matters such as availability of the recommended treatment. There is also the reality of the patient and/or their family's willingness and readiness to engage in the work that is required.

Treatments currently recommended by NICE Guidance for PTSD in CAMHS are Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) and Eye Movement Desensitisation and Reprocessing (EMDR). Medication may also be offered should the child or young person be struggling with symptoms such as depression or anxiety but these are not recommended for PTSD alone (NICE guidelines, 2018). Psychoanalytic Psychotherapy is recognised as a treatment for long standing PTSD and DT in many CAMHS clinics, including the NHS Trust in which this project was undertaken.

If child and adolescent psychotherapy is offered as the most suitable treatment for the child then the child would be seen for a psychotherapy assessment, then may commence brief or long term work. Sometimes, the caregivers may be the ones to be offered the sessions as a parent work model.

Usually, the child may have engaged in other treatments before psychotherapy that were unsuccessful. Sometimes, it is evident that they will be unable to engage in a cognitive-based therapy and apparent that their difficulties do not have words or meaning. There may be other, clear reasons why the child is referred to psychotherapy such as the level and complexity of trans-generational trauma, or, as

described in earlier chapters, the child evokes a powerful response in the clinician which enables them to understand something of the child's needs.

Whichever treatment is offered to the child, it is likely to be complex and challenging work, often requiring a multi-disciplinary and sometimes multi-agency approach. Bion (1959) points out that the very realisation from the patient of the acute deprivation they have experienced, brings about feelings of resentment which become aimed at the therapist in projection. Preparing for how stirred up the patient may get as a disruption to their defences begins, is helpful, which may include safety planning. Containing the child with a robust network is essential, alongside regular supervision for the clinician working with them as the child works through their unbearable memories.

Processing traumatic events is thought to be closely linked with a need to mourn, and recovery can be seen as a renewed ability to symbolise (Segal,1957). To mourn, however, one needs to be able to know about the reality of what has happened to them, which means relinquishing processes of denial. Denial may have been a helpful mechanism during or after the trauma, to help the individual process the trauma in a gradual way, but if used excessively when reality is felt to be completely unmanageable, then it can become problematic as discussed in earlier chapters about dissociative states.

Therefore, as the treatment progresses, the child should gradually be able to get more in touch with the links to their early history and begin to put meaning, and eventually words, to the experiences. In psychotherapy, for example, the therapist would assist with this process by listening and naming them as a 'grammar of

description' (Alvarez, 1997) and by themselves being someone different to the patient's traumatising objects (Henry, 1974); a 'good enough mother' (Winnicott, 1953).

Bion (1962) describes this in the sense of the mother being able to experience the baby's disturbed feelings without being overly disturbed themselves, thus helping to transform 'beta elements', the unprocessed sense impressions into 'alpha function', offering the possibility of surviving them.

Limitations of therapeutic outcomes must be accepted, regardless of how thorough and robust an assessment may have been, and 'goals' for of treatment can assist this. They can also help the clinician and the family to reflect on whether the treatment is 'successful', which can be difficult to quantify.

Conclusion

The literature search produced a vast number of papers, covering numerous strands of trauma research using different methodologies. With limiters added, the results became more relevant to my research questions, with the majority of these being psychoanalytic papers using case studies.

The research and seminal psychoanalytic papers presented in this chapter aimed to offer a sense of the journey from discovering the psychological effects of trauma to developmental trauma is treated in CAMHS clinics in the present day. The psychoanalytic papers and theories presented a way of thinking about childhood trauma which brings the nuances of non-verbal communication to the forefront by examining the unconscious.

Several of the papers recognised similar core themes in the children they worked with that are very similar to the themes which emerged from this project such as the 4Fs and relating to adults as persecutory objects. Further research is required in the area of complex developmental trauma in CAMHS, from a psychoanalytic perspective. Including an element of quantitative research on a larger scale than was possible for this project, would be a valuable contribution.

In the following chapter, I will present the methods of this project and how the richness of a qualitative study alongside the robustness of a quantitative contribution have been combined.

Methods

Introduction

To meet the requirements of the clinical doctorate, I designed a mix methods project which included examining unconscious dynamics, with three psychotherapy assessments of children who had experienced DT; contextualised by a survey of PTSD referrals into a CAMHS clinic.

The research method used for this project will be described in the following chapter including the aims of the work, design, participants, data analysis approaches, and an outline of the processes used.

Design

This project is a single centred, interpretive, evaluation of how trauma is assessed and treated in CAMHS. The project uses a two-part, mixed methods, observational approach and took place within an NHS Tier 3 specialist CAMHS clinic which is open to children and young people from age 0-18 years.

As mentioned in the introduction chapter, the clinic is based in an urban city in the North West of England with a population of over 200,000 of which the majority ethnicity is White British. Children can be referred to the clinic by their GP, school, self/parental-referral or another professional service such as social services. Children are referred for a variety of acute mental health difficulties which are often long-standing and complex.

A service evaluation of which this project is modestly based, is defined as: ‘A set of procedures to judge a service’s merit by providing a systematic assessment of its aims, objectives, activities, outputs, outcomes and costs.’ (NHS Executive). The project is the first of its kind to be conducted in this clinic and aims to provide a rich and detailed explorations and outcomes which may be applicable to other CAMHS services, as well as an opportunity for further research.

The **aims of the project** as initially presented in the introduction chapter are as follows:

1) *To identify common themes which emerge from the analysis of psychoanalytic assessments with three children who have experienced developmental trauma. This aim will be addressed in the qualitative part of the project whereby thematic analysis will utilised to draw out key themes*.

2) *To gather key data about PTSD referrals in CAMHS by reviewing a years worth of data. This will be investigated using a quantitative survey to identify commonalities and themes.*

3) *To draw some important conclusions about this specific population of children, to add value to professionals working with them.*

Mixed methods approach

A mixed methods approach was chosen as it lends itself to one of the overarching themes of the project; that of the external and internal. As explored in the literature review, one of the tasks of any clinician assessing a child with DT is to have in mind the transference relationship with the patient to assist their understanding of the problem. The psychotherapist working with the child in a psychotherapy assessment, will use this as a prominent tool of understanding the child's internal world. As the transference also extends to group and systemic levels in terms of the clinic, staff team, and wider network around the child, the two parts to this project provide a broader picture of the experiences of these children and young people.

Both quantitative and qualitative approaches carry weight and add their own unique value to research; this can also be said for the patients' internal and external experience. The qualitative part of the project will provide the depth of examining the internal world of the patients; focusing on the counter-transference experience of the therapist and the written words of the session, including spoken words and observational commentary. Qualitative research aims to make sense of, or interpret things in their natural setting by using a holistic approach (Denzin & Lincoln, 2011).

Qualitative research is also becoming more recognised as valuable in the evidence-based research field (Mays & Pope, 2000) and, alongside quantitative, they can bring increased validity to a complex research area if applied together (Gilgun, 2010). This is particularly the case when reflexivity is used to think about issues such as bias.

The quantitative part of the project will capture the external reality faced by children with PTSD symptoms, entering the CAMHS system. From the data available on the CAMHS electronic system, interpretations will be made about how their journey progresses through CAMHS. The data will also be examined for insights into key demographics of this set of children, which will be discussed in the findings and discussion chapters in relation to the general population and the qualitative participants. The strength of quantitative analysis is it's reliability, and some research suggests that quantified results are more accessible and digestible, in the simplified numeric form (Greenhalgh, 2014).

The following **data sources** were used for this mixed methods approach:

Data sources

1) *One year's worth (n=25) of PTSD referrals into one CAMH Service*

2) *Psychoanalytic assessment sessions (n=9) from three patients with a history of developmental trauma*

Quantitative – Evaluating the external.

The research question that this part of the research is addressing is: *What can be understood about the characteristics of the population of children with developmental trauma by examining the referrals of PTSD patients?*

The **aims** of this are as follows:

1)*To gain an understanding of the commonalities and differences between the patients in this population*

2) *To compare the initial assessment notes in regard to developmental history taking and what this information suggests about the patient and the assessing clinicians approach*

3) *To discover the treatment outcomes of this population in regard to discharge summaries or continuation of treatment*

The survey of trauma referrals is based modestly on a clinical audit process which the Department of Health (1993) describes as '...systematically looking at the procedures used for diagnosis, care and treatment, examining how associated resources are used and investigating the effect care has on the outcome and quality of life for the patient'. As this description suggests, the possible uses of an audit are varied, and can be used to examine a variety of patient care, but the core function of a clinical audit is to systematically reflect upon and review practice through a clinical audit cycle.

This project is able to draw upon the aims of clinical audit whilst accommodating the time restrictions and resource limitations that prevented a full audit from being possible. Varieties of clinical audit such as this one are still able to produce high-quality results (Black, 1992).

The quantitative data was collected from the CAMH Service's electronic patient record system where the number of referrals for 2016/2017 with a primary/secondary diagnosis of PTSD were included.

The data was already partially categorised into key demographics on the system, such as 'age', 'date of first appointment in CAMHS', and 'assigned clinician'. The organisation of the data took shape by omitting any data which could not be anonymised and would compromise the confidentiality of the patients, such as 'postcode' and 'date of birth'. The data was then organised into a new spreadsheet, with the information anonymised and categorised for the second time for the purpose of this project. All of the patients were included in the analysis.

Additional categories were then added which were specific to the research question such as whether the patient's developmental history was documented and if the patient had returned to the service again after discharge (see Appendix 3). The additional categories helped to draw out themes about the children's experiences. The existing literature about childhood trauma was drawn upon when discussing the data set and results.

Qualitative: an exploration of the internal.

This part of the project addresses the research question: *What themes emerge about the quality of three children's internal world and the transference relationship with the psychotherapist during psychoanalytic assessments?*

The **aims** of this were as follows:

1) *To discover whether a greater understanding of the patients' inner world from a psychoanalytic perspective may help us identify some of the nuances which present themselves in the aftermath of developmental trauma*

2) *To use thematic analysis to identify themes which reveal the quality of the children's internal world*

3) *To examine what the thematic analysis suggests about the transference relationship with the psychotherapist*

As briefly presented earlier, the data used for the qualitative part of the project consisted of three psychoanalytic assessments with three children, occurring between 2016-2018. The patients all had a background of developmental trauma but, only Laura and Polly had a diagnosis of PTSD.

The three participants; Laura (14), Jack (7) and Polly (11) were chosen from six possible patients according to the inclusion criteria. They were referred for psychotherapy due to complex presentations which spanned over several years of their life and formulations which suggested co-morbid conditions. All three patients were presenting with symptoms of trauma when they were referred to psychotherapy.

The children's histories and presentations will be explored further, in the findings and discussion chapters.

The three psychotherapy assessments were all discussed within supervisory settings, whether this be service supervision; group supervision; or specialist workshops as part of my clinical training programme. All psychotherapists involved in this were registered with the ACP to ensure standardisation. The joint thinking during these supervisions helped address my own bias and expand perspective, therefore helping reflexivity. Greenhalgh (2014) suggests that this is how many new ideas begin, when something is created by an individual, but shares the ideas with others who can relate and are interested in finding new way of thinking and working with it.

Sample and generalisability

Quantitative

Purposive sampling was applied for this part of the project, whereby the year 2016-2017 was chosen. This was to ensure that the referrals were as up to date as possible and relevant to the research question, whilst still allowing enough time to be able to examine the patients' journey after they had been accepted into CAMHS.

Inclusion criteria

- *Must have been referred to CAMHS with PTSD within the year 2016-2017*

Exclusion criteria

- *Repeated referrals; if patient had been referred in more than once in the year, the earliest referral chronologically was the one used for data analysis. Any further referrals within the same year were not analysed but noted on the patient's data analysis results.*

Qualitative

Participants for this part of the project were recruited using theoretical sampling, chosen from a small sample of six children and adolescents who had undertaken a psychoanalytic assessment with myself in CAMHS due to trauma symptoms.

Inclusion criteria

- 0-18 years old
- History of complex developmental trauma
- To have completed an assessment for psychoanalytic psychotherapy or a psychoanalytic state of mind assessment

Exclusion criteria

- Still in treatment with myself

Three patients was enough to be able to provide a variety of cases within the limitations of the project. This smaller number also ensured that that each case got the adequate attention and focus that it required for the aims of the project. Three patients was also estimated to be the equivalent to the quantitative number of participants, with around three of the PTSD referrals being seen for psychotherapy assessments per psychotherapist, per year.

Data collection

Quantitative

Data was collected using clinical file notes and service data statistics information from the electronic patient record system in the CAMHS clinic this project was set in.

The specific standards that were examined in relation to the research question were:

1) *Is the assessment conducted using the appropriate Routine Outcome Measures (ROMS): Impact of Events Scale; RCADS; CPTI, GBO? (Yes / Some / None)*
2) *Was early history taken (Yes / No) If yes – (Detailed / Partial / Brief / Other / None)*
3) *Is there any evidence of early traumatic experiences? (Yes /No)*
4) *Has the patient been referred to CAMHS before? (Yes/No)*
5) *What treatment were they offered? (Psychiatry / Psychology / Psychotherapy / Family therapy / Parenting / Others..)*
6) *Have they returned to CAMHS since discharge, or do they remain in CAMHS? (Yes/No*)

The following **categories** around demographics, diagnosis, and route into CAMHS were also specified and included:

- *Age; Gender; Ethnicity; Diagnosis criteria and Referrer.*

The **process** of the patient's journey in terms of time frames was tracked

chronologically using the following information:

- *Date of referral; clinical priority (e.g. emergency, routine); first offered appointment; first attended appointment; second attended appointment; number of sessions offered; number of sessions attended; duration in CAMHS (weeks); status (open or closed); reason for discharge and outcome.*

Qualitative

The data for the thematic analysis was collected from my written process notes of the psychotherapy assessments, saved on my personal file on the CAMHS clinic drive. Only retrospective assessments were considered for use due to the need not to interrupt any future therapeutic relationship by introducing the task of using their assessment for research. This also prevented bias as neither myself nor my patient were aware at the time that the assessment would be used for research.

Each session was written up immediately after the appointment, from memory of the experience. The content of the write up is a detailed account of the 50-minute session from collecting the patient in the waiting room at the start of the session, to escorting them back to their caregiver at the end. The process notes contain careful observations, spoken words, non-verbal communication, and transference and counter-transference experiences, from my therapeutic perspective.

Data analysis approaches

The data analysis for the survey of trauma referrals was a modified version of the Trust's standard audit method and guidelines as discussed in previous chapters. A particular analytic approach was not necessary for what the data is being used for, which is to complement and inform the qualitative part of the project. Therefore, a simple evaluation approach was sufficient.

For the thematic analysis method Braun & Clark's (2019) method of Reflexive Thematic Analysis (RTA) was followed. This updated version of the original approach (Braun & Clark, 2006) encourages more creativity whilst still utilising the original six-phase method.

Thematic Analysis

RTA is a method for 'identifying, analysing and reporting patterns (themes) within data', organising and describing it in rich detail (Braun & Clark 2006). Boyatzis, (1998) argues that it goes further than this and can interpret various aspects of the research topic. It is also an accessible approach in regard to its suitability for someone new to research methods, fitting particularly well the creative methods used in psychotherapy to make sense of relationships and communications, in terms of themes.

Whilst there are a number of versions of thematic analysis such as Aronson (1994) and Tuckett (2005); Braun & Clark's method has the flexibility of an analytic method, rather than a methodology. For this project RTA is used as a phenomenological method, as many researchers have suggested it is most likened to (Guest et al., 2012; Joffe, 2011). The data was analysed from a deductive or 'top down' approach,

whereby the research question guided the direction of the method whilst remaining open to to new theories and ideas which may emerge from the data.

Qualitative data analysis can face criticism in terms of validity in particular, however as Braun & Clark (2006, 2019) argue, the subjectivity of qualitative research does not provide bias which undermines the research, but rather it is essential to good qualitative research practice. This is in accordance with the researcher addressing the decisions which they make during the research process, and recognising them as decisions. In addition, the process of 'how' the thematic analysis was conducted needs to be particularly clear alongside the what and why (Attride-Stirling, 2001). This is presented in the following section.

Process

The aim when coding the data was to look for themes within the assessment data which related to my research question, therefore, I used a theoretical approach Hayes (1997). Whilst it can appear to the reader that themes 'emerge', the process is more active than this and patterns and themes were identified which met the aims of the analysis (Taylor and Ussher, 2001). Ely et al (1991) argue that themes 'reside' in our minds and therefore there is a process of linking and digesting of the data as we begin to understand it. This sentiment links well to the concept of transference and counter-transference; that it is an acutely personal experience which could never be exactly replicated or experienced by an other.

As previously introduced, for the process of coding, I followed Braun & Clark's (2006, 2019) six-phase approach, which is outlined below. Despite the use of 'steps', this

approach is not a linear process but instead movement is ‘back and forth’ as required (Braun & Clark, 2006). This is reflected in the complexity of the themes and the complex journey to creating them.

Step 1

The first step of of the process was to give time to re-familiarising myself to the data; this meant becoming immersed into several readings of the session material; getting further in touch with the depth and breadth of the content. The patient’s session notes were examined separately, to allow themes to emerge for each session. As this process developed, any ideas which came to mind were noted down. These are known as ‘first order codes’ which relate closely to an extract of the data.

This initial step was an active process; I had the research topic in mind and also remained engaged with my literature review, which as Tuckett (2005) argues, can enable you to notice more subtle features of the data. The first stage is particularly helpful as, although I knew the material well, it had been written over two years prior. The re-familiarising which occurred during this stage, helped me to notice patterns, associations, and interesting features of the data which may not have struck me at the time of the assessment.

Due to the data being my writing about my own experience, I also knew the patients, the outcomes of the assessments, and further contextual information which meant that I was unable to conduct the analysis ‘blind’. However, I immersed myself in the data with an open mind.

This stage was a lengthy one, taking several weeks to allow to read, digest, and return to the data again. This process enabled ideas and associations to form over time. Jotting ideas and notes down continued throughout the entire analysis process to help track the journey and keep the original notes to refer back to.

Step 2

I created a table for each session and began to formalise the initial ideas into first and second order codes. The first codes simply stated what I understood the extract of session material was communicating, without further interpretation. The initial codes are often referred to as the most 'basic' elements of the data that can have some meaning attached (Boyatzis, 1998). Although the process involves an analytic element, the codes may be more specific or niche than the eventual final themes, which are broader (Tucket, 2005) but involve more of an interpretative analysis, in relation to the research area.

Most of the session material had a code attached to it, with only a small amount discarded due to not being relevant or interesting; such as parts of the session which did not contain any meaningful or symbolic communication. A latent approach to coding was utilised; which meant coding the data according to how I interpreted the material in terms of underlying ideas, patterns and assumptions of the participant and myself in the counter-transference.

The use of session material is suited to this approach as it complements the writing style of process notes, whereby the therapist reflects on what is happening unconsciously during the session, and includes this in the write-up. The second order

codes were an interpretation of the first order codes, created by merging the first order codes into more specific sets, using commonalities. This immersive process was emotive and enabled me to draw upon memories of the original session.

Step 3

Once the initial first, and second order codes had been gathered, the process of identifying ‘third order codes’ – also known as ‘themes’, commenced. I approached this by, similarly to merging the first and second order codes, looking for common second order codes; putting into groups; and noticing outliers which did not fit a common theme.

Throughout this lengthy process, I would check back to the data source to ensure that the themes could be traced back to the initial data and therefore did not lose the context (Bryman, 2001). The notes were also to assist in the, often contradictory, nature of data sets; for example, when one data extract may produce two opposing themes. This process had several layers as I conducted the process for each session first; then each patient; before bringing the whole data set together to create three final themes.

Appendix 5 demonstrates the themes for each session, put into sets under each patient’s name. From across each patient’s data set I colour coded themes according to commonalities. Finally, I settled on three themes for each patient, which was an adequate amount to capture the content without producing an excess of data. Each theme was given a draft name which would be used to inform the final themes across the whole data set.

Step 4 and 5

The next two steps of the process brought the themes for each patient together, to see if and how they would fit, with the aim of eventually narrowing them down to three main themes of the entire data set.

This was conducted firstly, by deciding which of the nine themes went together, to create a map of the analysis. Next a theme name was decided upon; for example, ‘trauma responses’ which had been a common theme across all three patient’s data sets, involved into the name ‘Fight, flight, freeze or fawn’. This change occured due to noticing the presence of the 4Fs in the themes and how each child presented a different aspect of this trauma response.

‘Unsafe adults’ (x2) and ‘abusive adults’ became ‘Persecutory parental objects’ as this latter title captured the nuances of the previous theme names in a way which suggested adults were not only unsafe or abusive but also withholding, depriving, cruel and neglectful ‘bad objects’. ‘Persecutory’ was an appropriate term to capture this theme as reflected in the literature review chapter.

The third and final theme which brought together ‘vulnerability’, ‘vulnerable children’, and ‘child not held in mind’, was named ‘Absence of maternal containment’. This theme emerged from the details of the session themes which in general communicated a sense of a lack of adequate containment. The theme reflects the literature regarding the consequences of inadequate experiences of containment in the early years. ‘Maternal’, in this sense can be understood as a term for the primary caregiver whether this be the mother or another caregiver.

Once the final three themes had been created, I populated each theme with what I will now change to the ‘second order codes’ for clarity of explanation.

Appendix 6 demonstrates which second order codes came under each theme, and the prevalence of the theme in the entire data set – highlighted with the same colour. For example, ‘Fight, flight, freeze or fawn’ had the largest number of second order codes, whilst ‘Absence of maternal containment’ had the largest amount of common codes across all three patients. Other second order codes which fitted under the theme but were not common with more than one patient are included but not colour matched to demonstrate that they are codes only relevant to one patient.

There was a small number of outliers in this process which did not fit into a theme. These are not highlighted in appendix 5 as they did not link with any other session, and thus do not appear on appendix 6. Examples include, ‘unstable sense of self’ (Laura); ‘disguised disturbance’ (Jack); and ‘the world is viewed as topsy turvy’ (Polly).

Once the second order codes had been populated under each theme, the next process was to narrow down the second order codes to prevent repetition and to capture the main second order codes that made up the themes. Any second order code which only appeared once across all of the data set and therefore an uncommon code (the non-highlighted codes on appendix 6) were discarded.

The remaining codes, which presented more than once in each theme and therefore were prevalent across more than one patient, were merged into one code. For example, under the theme ‘Fight, flight, freeze and fawn’ there is ‘detached

responses' (Laura) and 'appearing detached' (Jack). These were merged to 'appearing detached' to capture the essence of the communication whilst streamlining the codes.

To ensure detail and nuance was not lost, if the codes were very similar but would lose an important meaning if merged, then they remained separate despite being colour coded together on appendix 6. This only occurred during the organising of the theme 'Absence of maternal containment', whereby there were some codes which offered the position of the mother and why they might be absent mentally or physically such as 'mother carrying a lot on her shoulders' whilst also capturing the child's experience of this; 'high level of unmet need'. It was important to keep this dyadic experience alive in the findings, particularly as it was unique to this theme.

Naturally, there is a crossover with some of the codes in regard to the possibility of them fitting into more than one code. This will be discussed further in the discussion chapter.

Step 6

The final stage is writing up of the findings. This was a further and last opportunity for analysis, as the process offered an additional thinking space for reflection. This stage will be presented in the findings chapter.

Ethics

Participants and parents were provided with an information sheet and a consent form which contained all relevant information and the right to withdraw at any point (see Appendix 2). The consent form explains the reasons for asking to use the patient's information and that it is the psychotherapy assessment data specifically, that is being used for research.

The form mentions the theme of PTSD/developmental trauma and how the child has had difficult experiences in their past. This diagnosis/formulation is something which had been discussed with the patient and family during their assessment period in CAMHS therefore was not the first time they were reading about this in relation to their child. The risk of intrusion or shock to the family when reading the consent form cannot be completely illuminated but measures were put in place to prevent this. For example, the style of writing about the patient's past experience and diagnosis is tailored for the reader as appropriate, depending on whether it is written to the child or the parent/carer. Participants and their parents/carers were able to ask further questions, seek clarification, and discuss any doubts. Contact details for this dialogue were made clear on the information and consent forms. If there was to be a discrepancy with the consenting parties, the plan was to take this to my supervising tutor to discuss. Should any safeguarding issues emerge, this was to be discussed with my tutor unless the concerns were urgent in which case the Trust's safeguarding policies were to be followed, taking immediate action as appropriate.

As the data collection was retrospective, consideration was given to the issue of the patients not being aware whilst undergoing the assessment that it was possible that it

could be used for research purposes. The patients and their families may begin to think back to their assessments and this may stir up difficult and complex feelings about their experience at the time.

Consideration was given to the possibility that patients may feel very different to when they had their assessments and this reminder of that period of their life could cause conflicting and exposing feelings. Anonymity was essential and patients their parents/carers were reassured about this robust process being in place and how this would be protected and maintained.

The study was approved by the local NHS Trust and the Tavistock and Portman Trust Research Ethics Committee (TREC) prior to beginning.

In the following chapter I shall introduce the findings of quantitative data, followed by the qualitative. These findings will be discussed and explored in more detail in the discussions chapter.

Findings: Survey of trauma referrals

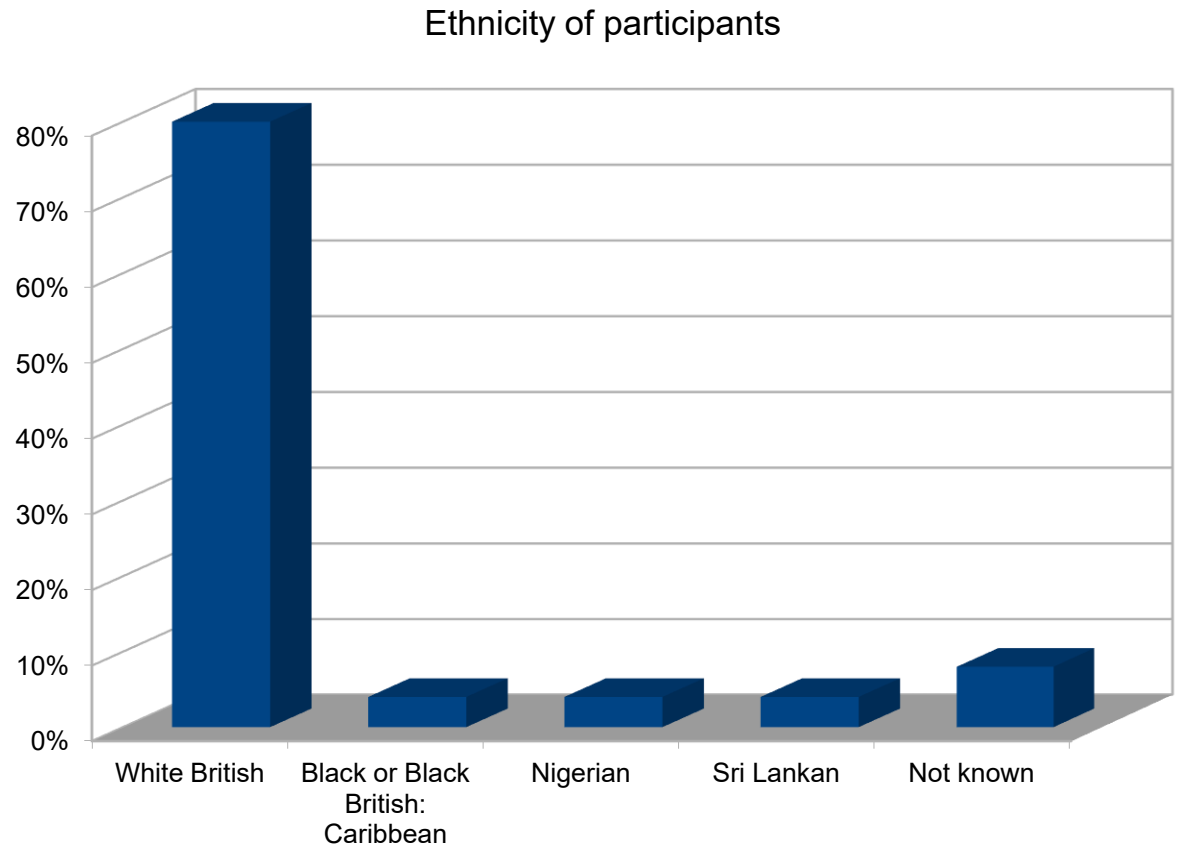
This part of the project sought to discover more about the realities of the traumatised child's lived experience in CAMHS, including formulation, treatment and outcomes, as well as getting to know some of the unconscious processes that can occur. From this, insights into this vulnerable population were sought with the aim of arriving at some helpful outcomes.

The quantitative part of the project specifically aimed to address this part of the research question: *What can be understood about the population of children with developmental trauma by examining the referrals of PTSD patients?*

The data used for this was one years worth of PTSD referrals in the service, which was 25 patients. Significant details were extracted from the CAMHS electronic records regarding these children to be examined. The findings are presented below.

Key demographics

The ages of the patients at referral ranged from 6-17, with the mean age being 11 and the modes being 11, 12 and 14. There were significantly more females (72%) than males (28%), and a majority race of White British.



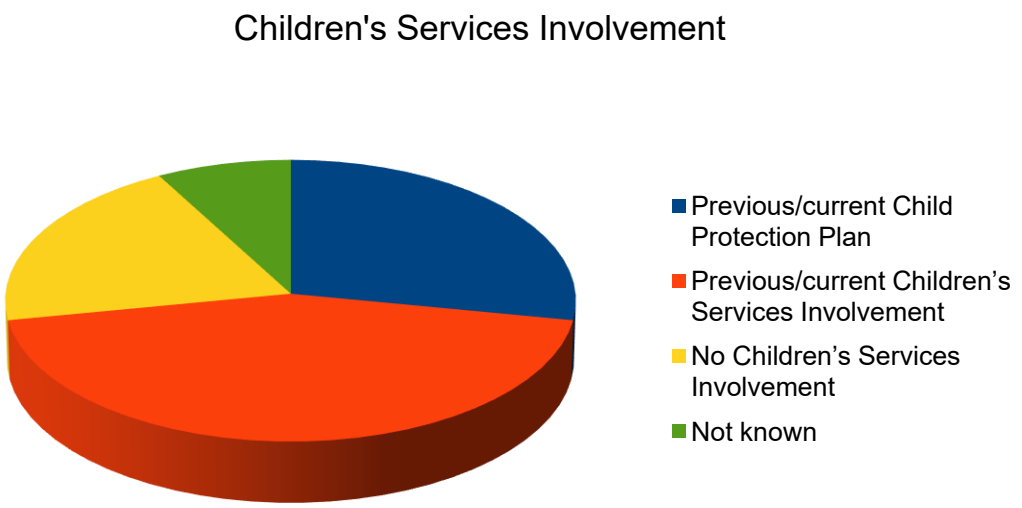
Referrals

68% of the referrals came from the GP, with the remainder from the A&E Department (16%); Self-Referral (8%); Community Paediatrician (4%); and the Voluntary Sector (4%). The large majority of the referrals were Routine (4-12 weeks) apart from the A&E referrals which were Emergency (0-1 week).

History

40% of the referrals were previously known to CAMHS. Of the full number of participants, only a very small number had not previously or currently, been involved with Children's Services; with a significant percentage having been on a Child Protection Plan.

Two of the patients' histories of Children's Services were recorded as 'Not Known', due to non-engagement following the referral being accepted. The data does not include involvement with any other services.



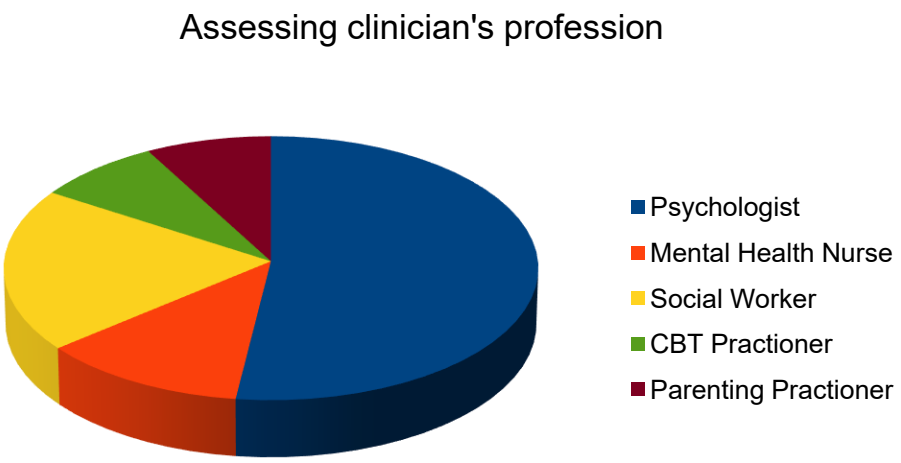
Diagnosis

All of the referrals were referred to CAMHS with PTSD symptoms as the main concern. 72% were recorded as having this as their Primary Diagnosis at the point of being accepted into CAMHS. The remaining 28% patients had the following varying

Primary Diagnosis' with Self-Injurous / DHS being slightly more significant than the others: Emotional Dysregulation; Social Anxiety / Phobia; Assessment for Social Communication / Autistic Spectrum; Self-Injurous / DSH; Depression; and Family Relationship Difficulties.

Assessing clinician

All of the 25 referrals were initially assessed by a qualified member of the CAMHS staff team. The balance of assessing clinicians is naturally influenced by who is in the team at the time, but the process of allocating initial assessments was at random and aimed to be a fair and equal distribution of new referrals depending on clinician's job plan. The majority of the patients were assessed by a psychologist.



Routine Outcome Measures

ROMs were used for all of the patients at the initial assessment where data was attainable (92%). The most common form of ROM which was used was the Strengths

and Difficulties Questionnaire (SDQ); and the Revised Children's Anxiety and Depression Scale (RCADS). These questionnaires were completed for 100% of the patients where the data was available.

Only 1 out of the 25 patients completed the full set of ROMS for children with PTSD as recommended by NICE, and this was done several months into the child's involvement with CAMHS.

Developmental history

Whilst it was possible to attain a significant amount of the participants' data from the electronic patient record system, to gather information about their developmental history I required their full clinical file. Unfortunately, due to the use of paper files in the Trust, this presented me with some obstacles. Two of the files had been damaged in a flood in the clinic in 2018, three had been sent to other services, and four were missing. One patient's file was closed prior to any further appointments due to non-engagement therefore there was no opportunity to gather history.

This left 17 patients whose files were accessible. One of the patients did not attend their initial appointment, therefore, 16 patient's files were examined. All 16 clinicians had made some notes in the Developmental History section. I organised the assessment of the data into the following categories:

Detailed – a detailed account of the child's history including pregnancy, birth, early years, and time up to CAMHS referral.

Partial – either meeting the detailed category but with less information, or meeting some of the detailed category but with some information or developmental stages missing.

Brief – some information about some development stages, without much detail or with significant stages missing.

Other – to be specified.

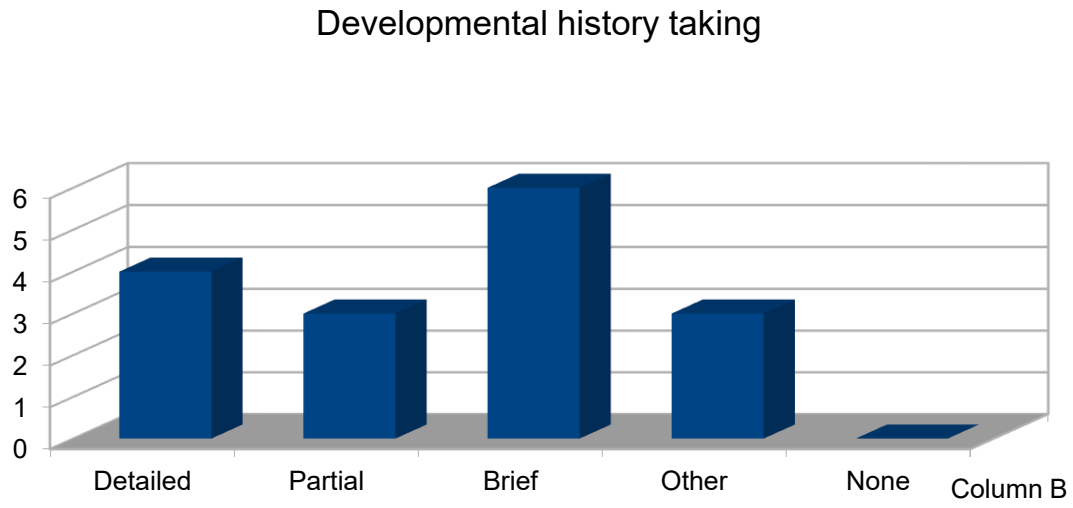
None – no information gathered or none recorded in the file.

Using these categories, only four of the patients had a detailed account taken of their early history. The assessing clinicians in these cases were psychologists (n=3) and a social worker (n=1).

Three patients had a partial account taken, and within this was a pattern of noting significant events and previous traumas, but missing out chunks of time and potentially lacking information which may have provided a richer and more in-depth understanding of the child.

Six patient files met the brief category. Within this category there was a prevalence of noting some information about the child's current situation, for example, the issue for which they were attending CAMHS, with no information about anything before this.

Three patients had a detailed account taken at a later date from a different clinician (psychotherapist, psychiatrist, and psychologist) so therefore would fall into the 'other' category.



Trauma history

Out of the 16 patients of which data was attainable, 100% had experienced previous trauma prior to attending CAMHS at this time. As noted above, eight files were unattainable resulting in a lack of opportunity to gather information about trauma history, however out of these eight patients, four had recorded involvement with Children's Services in their past, with one having been on a Child Protection Plan. We may assume from this information that there is likely to have been some form of maltreatment in their history.

Six of the 16 patients were reported to have witnessed domestic violence in their early years; eight were reported to have experienced sexual and/or physical abuse; twelve had a parent or carer with significant mental health difficulties; and two had experienced war, torture, and extreme violence in their native country prior to moving to England. Some of the patients had experienced more than one of these and so fell into more than one of these categories.

Nine of these patients were referred to CAMHS with trauma as a secondary diagnosis. For example, an episode of self-harm or an ASD assessment was the reason for referral.

Treatment

36% of patients actively engaged in a therapeutic treatment in CAMHS following their assessment. Over half of these patients were offered more than one treatment over the duration of their time in CAMHS. The treatments offered included:

- Psychoanalytic Psychotherapy
- Clinical Psychology (treatment unspecified)
- CBT
- Trauma-focused CBT
- EMDR
- Psychiatry (including risk reviewing and medication reviewing)
- Graded Exposure Therapy

- Family therapy

Sadly, non-attendance and/or non-engagement was prevalent, with 32% of patients disengaging after one or more appointments. Two of these patients were signposted to a specific service for Sexual Assault victims; and one patient was discharged due to the physical presentation of his symptoms. Three patients were in a stage of continued review and/or risk management without a particular treatment offered.

Outcomes

36% of patients remained open to CAMHS in 2020, four years after their referral.

For the children that had been discharged, four were reported as ‘Problem’s remaining the same’; six were reported as ‘Problem’s partly/largely resolved; six were reported as ‘Problems resolved’ and the remainder were ‘Not Known’, ‘Other’ or ‘Assessment/Opinion only’.

Re-referral

10 of the 16 patients that were closed to CAMHS since their 2016/2017 referral, have returned to CAMHS. One further patient is reported to be receiving counselling in school.

This translates to 64% of the 25 patients either remaining in CAMHS or returning to CAMHS at a later date. It is also important to note that out of those children that did not return to CAMHS, all except two would have been over the age limit and therefore would be referred to adult services if they required further help, not CAMHS.

It is only possible to conclude therefore, that **only two patients out of 25, did not either remain in CAMHS by 2020 nor return to CAMHS.**

Findings: Thematic Analysis

In this chapter I shall present further details of the children who make up the qualitative part of the project; Laura, Jack and Polly. The results of the thematic analysis will then be presented including the main three themes and the second order codes.

Extracts from the raw data of the assessment material will be presented to demonstrate the link from the material to the theme and to capture the sense of transference experience for the reader. The findings will be discussed in the next chapter.

Brief case history of each child

Laura

Referral

Laura was 14 at the time of referral to psychotherapy. She had been referred into CAMHS via A&E, following an overdose. Laura had also been self-harming for several months and was presenting with low mood and anxiety. She found everyday life very difficult, struggling at school, unable to make and retain friendships and

battling with authority figures. Laura found changes in routine difficult and was getting into trouble at school regularly, often resulting in seclusion, with a looming threat of permanent exclusion. There was a sense of Laura having embodied an identity as a a ‘problem child’.

History

Laura had a very difficult start in life, from as early as conception. In utero, her mother abused drugs and alcohol, and when Laura was born she had to go through a painful withdrawal process.

Laura remained with her biological mother for one year; where she was subject to neglect due to her mother’s ongoing substance abuse. During the latter part of that year, her mother became pregnant again. When Laura’s younger brother was born, he and Laura were immediately taken into foster care.

The foster carer who looked after Laura and her brother went on to adopt both of them when Laura was almost three years old. Helen, Laura’s adoptive mum is a single woman of grandparental age. She has a biological adult son who lives independently.

Assessment

There was a sense of desperation when I initially met Laura and Helen, with the family appearing in crisis. Laura’s brother had recently disclosed sexual abuse by a neighbour, and the police and social services had been investigating. Helen was struggling to manage Laura’s behaviour, sharing that she did not feel able to care for her any more.

There was some support in place through school and social services with Laura accessing some support from the school counsellor, and a family assessment was underway. I agreed to offer Laura an assessment for psychotherapy to see if this was something which could be helpful for her.

A significant complication was that I was pregnant, and due to go on maternity leave a few months later. Therefore, my supervisor and I agreed that I would conduct the assessment, whilst my she would offer the long term work if this was indicated.

Jack

Referral

Jack was seven years old at the time of assessment. He was referred to CAMHS due to his adoptive parents' concern that some of his behaviours were problematic and may be linked to his early trauma. These included behaviours of a regressive quality such as soiling and mimicking an animal. Jack found school very difficult, in particular, struggling to manage changes in routine and transitions. Jack struggled to make friends and would require constant one-to-one care by an adult.

History

Jack was the fifth child in his birth family and, at four months old, he and his siblings were placed on a Child Protection Plan. Jack remained in the family for a further two years where he suffered significant abuse and neglect. The abuse was described as

particularly cruel and sadistic. He was eventually removed from the home into foster care before he was adopted at four years old. Jack is the only child of his adoptive parents, who are a same sex female couple.

Assessment

Due to Jack's presenting difficulties and the parent's ambivalence about the timing of therapeutic input, the assessment was offered as a Psychoanalytic State of Mind Assessment (PSOMA). There was clearly a need to gain further understanding about Jack's struggles and add to his current formulation, but the uncertainty about whether it was the right time for him to begin was a barrier. Jack was relatively settled at home with his adoptive parents and they were coping fairly well with him although some of his behaviours were stressful and upsetting, resulting in parents needing additional support to manage him through the adoption support fund. There was a sense of Jack's parents wanting to see if Jack was able to make progress over time, without input from services.

Polly

Referral

Polly was ten years old at the time of referral to psychotherapy. She had been in CAMHS for two years, struggling with PTSD symptoms. Polly had been offered several other therapeutic interventions prior to her psychotherapy referral, such as EMDR and CBT, but the improvements had been minimal or short-lived.

History

Polly was the eldest of three children, suffering neglect by their birth parents and eventually being removed to live with their grandparents on a Special Guardianship Order (SGO) when Polly was around seven years old.

Polly witnessed domestic violence, drug use, and sexual activity from a young age and as a result, suffered with PTSD symptoms such as insomnia, flashbacks, and severe anxiety. Although Polly was in a stable home when we met, her grandparents were elderly, and her grandma was not in good health having received a diagnosis of terminal cancer a few years earlier. This presented Polly with further complications in regard to loss and the ability to feel contained.

Assessment

Polly was struggling with anxiety and panic attacks on a daily basis at the time of her psychotherapy assessment. She struggled to sleep; had a lack of appetite; and worried about her future survival without a caregiver. Grandparents were finding it difficult to offer support to Polly and were worried about her deterioration. Gathering Polly's history and current concerns, I offered her an assessment to explore whether psychotherapy could be helpful for her.

Themes

The three main themes that emerged from the thematic analysis of Laura, Jack and Polly's psychotherapy assessments will be presented below, the process of which was described in detail in the methods chapter. For each theme, the second order codes will be presented, including relevant material from each child's psychotherapy assessment. Appendix 4, 5, and 6 assist in the understanding of this process and how the final themes were created.

Theme 1: Persecutory parental objects

With second order codes: *Punishing, predatory adults; cruel, withholding mother; mistrustful of adults; asking permission; adults lacking robust boundaries; muddle between good and bad care; children unsafe at home.*

Examples in the session material:

Laura

In Laura's second session she told me about school and in particular, when her class is scheduled to have P.E outside. Laura explained that she doesn't like taking part in

this due to a sense of being unsafe. Laura says:

'I don't like it because it's too open. They're building here so the fences have come down and it's just all open, anyone can come in or out.' I comment on the sense of anxiety, suggesting that this idea makes Laura feel very unsafe. I ask her what she has in mind, who is 'anyone'? Laura responds: 'Just anyone who isn't supposed to be there. Like there was a man with his dog the other day just walking across the school field and it's like, what is he doing there it's a school field, he just shouldn't be there'.

- Laura's 'adults lacking boundaries' was merged with Jack's 'blurred boundaries' to create the second order code 'adults lacking robust boundaries' which contributed to this first theme (appendix 5 & 6).

Jack

For Jack's third session he arrived late due to his mum's car getting a flat tyre earlier in the day, resulting in them needing to get a taxi. Jack was clearly anxious about this late arrival and was keen to know if this meant I would offer him extra time to make up for it:

'Walking to the therapy room, Jack rushes, keen to get through the doors. His mum talks to me about the date of the review meeting and Jack pulls me in the other direction. In the room he seems relieved but has a pressing issue; 'How much did I miss? Can I stay longer now?' I immediately feel like I am a cruel object, and tell him that I won't be able to see him for longer. Jack looks at me and in the counter-

transference I feel like a depriving mother, unwilling to give him what he is asking for.'

- This material which was initially coded 'cruel, withholding mother', was merged with Polly's 'withholding, depriving adults' to create the second order code 'cruel, withholding mother' (appendix 5 & 6) to contribute to this first theme.

Polly

In Polly's first session she was cautious around me and appeared frozen to the spot, she asked for my permission to do simple things such as take off her coat and sit down, as though frightened of me and my response. She was unable to move freely around the room, explore and relate to me in a benign, rather than persecutory way:

'Polly looks coy, she stands still looking at me. Eventually she asks, 'Can I take off my coat?'. I nod, and she removes it awkwardly. She looks at the chair, 'Can I sit there?' I feel as though I am in the position of a controlling, persecutory adult who might snap at any time and become angry.'

- This material was coded 'asking permission' and was merged with Jack's 'worried about therapist being cross' to make the second order code 'asking permission'. This second order code contributed to this theme of 'persecutory parental objects'.

Theme 2: Fight, flight, freeze or fawn

With second order codes: *Psychosomatic symptoms; presenting a false self; mistrustful; appearing detached; needing the toilet when frightened; checking surroundings; appearing self-sufficient; confusion between reality and fantasy.*

Examples in the session material:

Laura

For Laura's first session she appeared detached and spaced out from the first interaction, across the transition from waiting room to therapy room. Several times throughout the session she seemed to drift off, and she was able to put some words to that experience when I notice her disconnect from me:

'Laura is silent then turns to me and shakes her head, 'Sorry, I just spaced out then. I do that all the time…' I ask her, where did you go when you spaced out? Laura says, 'Nowhere, I just freeze. I do it all the time at school and it's really annoying, because I miss things. Or teachers say I'm not listening, but I can't help it.'

- This material, which was coding 'detached responses' was merged with Jack's 'appearing detached' (appendix 5 & 6) to create the second order code 'appearing detached'. This contributed to the creation of this second theme of 4Fs.

Jack

In Jack's first session it was apparent that he was experiencing some physical sensations at different points in the session. I observed how closely impacted his bodily functions seemed to be in response to what was happening on an emotional level. On this occasion Jack had been acting out a frightening scene when his non-verbal communication changed:

'Jack stopped what he was doing, holding the frightening dinosaur on the roof, where it had been scaring the babies inside. As though suddenly overwhelmed I noticed Jack become still. I say, 'Jack?' gently. Jack doesn't look at me and I feel like something very frightening is happening for him. I try to keep talking to him about what he might be feeling, then I notice a smell. He moves slowly and I can see from the way he is walking that he has soiled himself.'

- This material created Jack's code 'needing the toilet when frightened' which merged with Polly's 'needing to get rid of bad feelings in the toilet' to make the second order code 'needing the toilet when frightened'. This second order code contributed to the creation of this theme of 4Fs.

Polly

In Polly's third session she continues to present herself in a way which did not feel authentic. This was particular pertinent at transitional points in the session such as the beginning:

'I observed how Polly looked upset when I collected her from the waiting room, before she saw me there. When she did notice me, she changed her expression, forcing a sweet smile, walking towards me on her tip toes as light as a feather. Her smile, which became a fixture on her face the whole way to the therapy room, did not match the puffy, red eyes that told a story of sleeplessness and tears.'

- This material was coded 'masking true feelings' and was merged with Laura's 'presenting a false self' and Jack's 'smiling during disturbing play' to create the second order code 'presenting a false self'. This was a common code for all three children and therefore a significant contribution to the final theme of '4Fs'.

Theme 3: Absence of maternal containment

With second order codes: Absent mothers; high level of unmet need; mother carrying a lot on her shoulders; painful losses; fear of death; child feeling unseen and excluded; adults preoccupied with their own difficulties; child worrying about mother.

Examples in the session material:

Laura

In Laura's third session she tells me about what she feels she struggles with, and makes a list for me. The list is long and thorough, and she explains it to me in a way which communicates that she does not expect I will see her for who she is, and notice what she needs from me:

'Laura takes a piece of paper and black felt tip and writes 'primary school – concentration, getting along / socialising, anger'. Next to this, she draws a flower. Underneath she writes 'High school – concentration, anger, reflecting, zoning out'. Laura points at the paper and tells me, 'This is what I have, and this is what I am struggling with.' She then makes a new list and writes, 'What I struggle with.' During this session Laura attempts to lead the session and keep my attention focused clearly on her in a structured way, making it difficult for me to have any space to think and relate to my own internal objects.

- This material was coded 'feeling unseen by adults' and merged with Jack's code 'adults preoccupied with their own difficulties' and Polly's 'Child feeling excluded' to make the second order code 'child feeling unseen and excluded'. This was a common code amongst all three children and therefore contributed greatly to this final theme.

Jack

In Jack's second session he continued to play out disturbing scenes of violence and aggression from adults towards children, which I was to witness helplessly. At a point which felt appropriate I offered an interpretation about the mother of these babies

who was being played out also as a helpless bystander, getting attacked. Jack responds:

‘‘Oh oh! Mummy’s gone.’ He laughs. I say ‘oh no!’ acknowledging the loss, but Jack seems to hear this as a collusion with this neglectful mother and says, ‘She didn’t care anyway. Do you think she cared? She left those babies for 13 hours. 13 hours. Do you think she cared about them?’ In this moment I felt stuck, silenced by the pain and anger behind his eyes.’

- This material created the code ‘neglectful mother’ which merged with Laura’s ‘baby not held in mind’ and Polly’s ‘absent mothers’ to form the second order code ‘neglectful mothers’. This was a common code for all three children and therefore was a significant contributor to the final theme of ‘absence of maternal containment.’

Polly

In Polly’s second session she brings her concern about separation and shares a communication that whilst she finds separation difficult, she also has an internal maternal object who she is concerned about when they are apart. This is complicated for Polly as in reality she has an absent mother and a terminally ill grandmother who is her main carer. Polly says:

‘I’m going to make grandma a painting. She said it is boring in the waiting room’. Polly momentarily appears to panic about what she has said but then quickly smiles and holds my gaze. I suggest that she is worried grandma is left out, and it is difficult for Polly not to check if she is ok.’

- This material was initially coded ‘worrying about mother’ and was merged with Jack’s ‘worry about vulnerable mother being excluded’ to make the second order code ‘child worrying about mother’. This contributed to this theme of ‘absence of maternal containment’.

The themes will be discussed in more detail in the next chapter, where they will be explored and linked to psychoanalytic theory as appropriate.

Discussion of findings

Patient demographic

The average age of patients referred into this particular CAMHS for PTSD symptoms in 2016/2017 was 11 years old, which aligns with the mean age of the qualitative participants at age 10. Some of the children had prior input from CAMHS but the data from this study is not able to inform us in detail about what occurred during these earlier experiences with services.

This age group, who are on the cusp of adolescence, are enduring a time of significant change internally and externally. It is also a time of opportunity, including a reworking of Oedipal dilemmas and unresolved childhood difficulties that may have been lying dormant during latency. Brain elasticity is also more flexible, mirroring the toddler years in regard to the possibility of genuine change.

The data on gender is significant in terms of the dominance of females in both the quantitative and qualitative participants. This reflects the research presented in the

literature review, which outlined that females were significantly more likely than males to report a range of ACEs and mental health, social, and emotional difficulties manifesting in self-harm in particular (Music, 2019; Haahr-Pedersen 2020); including PTSD (Lenferik, 2020; Foa & Tolin, 2006).These findings are concerning in regards to the gender inequality in accessing treatment for males however, as the literature also suggested that males and females process trauma differently and therefore males are presenting for help with a different issue such as ADHD symptoms.

It is notable that several of the males in the quantitative part of the project who did present at CAMHS with PTSD symptoms had experienced war/trafficking. This type of trauma may be more socially acceptable to seek help for than relational trauma.

With regards to race, White British was the majority of the PTSD referrals at 76%, and all three of the participants for the qualitative part of the project were White British. This was below the figure of 84.4% of people who identify as White British (2011 UK Census) in the CAMHS catchment area, and similarly, quantitative participants who identified as Black or Black British including Nigerian were above the area's average at 8% to 2.8%. This suggests that when it comes to trauma, ethnic minority groups, in particular Black people, over-represent. There is a notable absence of most other minority groups.

This is an important finding within this small project which supports the papers in the literature review which suggest Black people are more likely to experience PTSD at some point in their lives (8.7%) compared with Whites (7.4%); having a higher risk of child maltreatment, and in particular, witnessing domestic violence (Roberts et al, 2011). This information highlights that there is a group of people within this

population with known vulnerability to trauma, which is at risk of becoming passed down the generations (Seals & Young, 2003; Garbarino, 1999; Dodge et al, 1995; Davies, 1991).

In regard to the referral process; the data demonstrates that a significant number of the PTSD referrals accessed CAMHS through A&E (16%). Similarly, one out of the three qualitative participants; Laura, was first known to CAMHS after taking an overdose and subsequently attending A&E for treatment. This project does not have access to the data around referral sources, to understand further the referral processes at this time and how this group of patients compares to the broader picture of referrals at the time. Nevertheless, it is important to consider the mental state of these children and young people who required emergency services before being referred into CAMHS.

Of the quantitative participants, at least 50% of them were engaging in self-injurious behaviour when they attended A&E. This data supports the literature (e.g. Arnold, 1995) that demonstrates a link between self-harm and child abuse; something which the majority of the quantitative and qualitative participants had experienced. The data does lack some detail in regard to how these children came to present at A&E, for example, they may have not met the threshold for CAMHS until this point of crisis, or they may have been holding themselves together very tightly until something, perhaps a further trauma, stirred up unbearable feelings. As captured in the literature review, whether a child has the resilience to cope with a traumatic event is likely to depend on their earliest experiences (Youell, 2002).

The majority of the entire participant group was known to Children's Services, a proportion of them were deemed the need so severe that they required a Child Protection Plan. This reflects the literature review findings (e.g. Frigerio et al, 2009).which suggested that the longer, and more severe the DT, the worse the outcome.

Diagnosis

All of the quantitative participants had a primary or secondary diagnosis of PTSD, with 'Self-injurous behaviour' / 'Deliberate self-harm (DSH)' as the next most frequent diagnostic category. Polly had 'PTSD' whilst as her primary diagnosis whilst Laura had the additional 'DSH'. Jack was the only qualitative participant to have 'attachment difficulties' on his range of diagnostic categories and this may be due to his age as a younger child in CAMHS.

Depression; Emotional Dysregulation; and Family Relationship Difficulties, were the next most common co-morbid diagnoses respectively. As demonstrated in the literature review (e.g. Van der Kolk, 2000), co-morbidity is common in those who have experienced DT. It is important to note that aside from a primary diagnosis, the electronic patient records system utilised in this particular CAMHS does not require the clinician to complete any further diagnostic categories unless they choose to, therefore it is unclear why some patients only had a primary diagnosis. Nevertheless, from the data collected, depression features highly as a secondary diagnostic

category for this patient group and this reflects the literature (e.g. Gros et al, 2012 and Rytwinski et al, 2003) that there is a prevalence of co-occurring Major Depressive Disorder with trauma.

Assessing clinician

The assessing clinician data reveals that the majority (over 50%) of participants included this project were assessed by a clinical psychologist. The implication of this is that most of the children are being assessed by clinicians with a particular training and approach to working with trauma. However, the number of 'detailed' developmental history that was taken by psychologists was relatively high – with four of the seven most detailed histories being taken by this profession.

Clinicians with a background of social work training were disproportionately represented in the 'brief' history taking category. For a profession who often work with families who have experienced trans-generational trauma, abuse and neglect, it is interesting why assessing the patient's history is not common practice, as suggested from the limited data of this study.

Themes

The thematic analysis pulled out a rich and large number of first and second order codes from the data of three psychotherapy assessments. The second order codes formed three main themes which reflect the data set as a whole. Below I will discuss the themes in more detail.

Theme 1: Persecutory parental objects

With second order codes: *Punishing, predatory adults; cruel, withholding mother; mistrustful of adults; asking permission; adults lacking robust boundaries; muddle between good and bad care; children unsafe at home.*

Discussion

This theme was created from common second order codes from all three children's data. Originally 'unsafe adults' (Laura and Polly), and 'abusive adults' (Jack); the presence of a dangerous internal parental object was clear. Whilst I used the term 'adults' originally, as the thematic analysis progressed it became apparent that the 'adults' in the material, as well as the therapist in the counter-transference, were in

care-giving roles and thus, either actual parental objects or adults who parental objects could fittingly be projected onto.

The second order codes forming the foundation of this theme were predominantly contributed by Polly, followed by Jack, and lastly, Laura. All three of the children had been subject to abusive and neglectful parenting, but Polly had not been removed from this situation until she was seven years old. Additionally, whilst Laura and Jack had been adopted into stable homes, Polly, who was taken into paternal grandparents care on an SGO, did not have a stable home life. Polly's grandparents were elderly and her grandma was terminally ill with cancer. Alongside this, Polly still had contact with her father regularly and her mother made attempts to contact her through social media. Therefore, Polly's 'persecutory parental objects' presented as more presently alive inside her, as reflected in her relationship to the therapist in the room and the material she brought to her sessions.

The most commonly occurring second order code for this theme was the codes that made up 'punishing, predatory adults', as this was made up of a code from all three of the children (appendix 6). The other second order codes were made up from two of the children's codes merging, predominantly Polly and Jack together.

The codes that were not used for a final second order code, due to them only appearing for one of the children were: 'expecting adults to be tricky and unsafe' (Laura); 'intrusive communications' (Laura); and 'breaking in' (Jack). Whilst these were not common enough to form a second order code, they are closely linked to the theme and thus if there was more children in this part of the study they may have been more common.

All of the second order codes which formed this first theme embody a parental object who is both harmful and neglectful, both ‘doing to’ the children, and ‘not doing’ the basic caring for the children. This captures the abuse/neglect pattern. The parental object emerging from the data can also be tricky, whereby the children cannot trust them and as such have become muddled between good and bad.

It is evident from Polly in particular, that the children have had to find ways to manage this internal object and this links to the second theme of ‘fight, flight, freeze and fawn’, whereby the child’s presentation is captured in relation to their internal objects and how they learnt to survive. From the data, it is apparent that the children are adopting defence mechanisms to manage feelings of threat to survival; psychic and/or physical, when referring or relating to adults.

This sense of persecution in relation to others belongs within the paranoid-schizoid position as discussed in the literature review (e.g. Klein, 1946). This suggest that these children may not have been able to develop a depressive way of relating whereby they would be able to relate to the therapist as a benign or helpful figure.

The strength and impact of the persecutory parental object varies slightly with each child and this is captured in the second theme where each of them present with different defence mechanisms. As reflected in the literature review, genetic strengths and vulnerabilities will also have an influence on how the child experienced their abuse and their level of resilience (e.g. Youell, 2002; Frigerio et al, 2009; and Walker, 2013).

One of the most damaging aspects of carrying this type of parental object inside is how it prevents goodness from getting in as well as ‘badness’, in fantasy. This stifles the child’s ability to create and maintain good relationships including the therapeutic relationship.

There is also the complication as captured in the second order codes, of not being able to differentiate between good and bad and thus, being vulnerable to repeat history by entering into abusive relationships. This way of relating, depending on how rigid the defence is, is problematic in therapy where trust and dependency is a crucial aspect of development. The therapist is on the receiving end of powerful projections and as captured in the assessment material extracts, can become identified with, for example, a cruel mother.

This theme also mirrors the data found through the quantitative analysis, whereby the large majority of the children were involved with children’s services and as the research suggests, interpersonal trauma from the child’s carer is more likely to lead to PTSD symptoms than any other traumas (Van der Kolk, 1989, Music, 2010).

Theme 2: Fight, flight, freeze or fawn (4Fs)

With second order codes: *Psychosomatic symptoms; presenting a false self; mistrustful; appearing detached; needing the toilet when frightened; checking surroundings; appearing self-sufficient; confusion between reality and fantasy.*

Discussion

This theme of ‘fight, flight, freeze or fawn’ was created from the second order codes of each psychotherapy assessment. Initially named ‘trauma responses’ (Laura, Jack and Polly), there was a clear common theme between all three children which became more specific once the second order codes were collated.

‘Fight or flight’ is one of the most widely recognised features of trauma, as captured in the literature review (e.g. Gerhardt, 2004; Music, 2019). However, whilst this is the more commonly used expression to describe this state of sympathetic nervous system, for these children, the material provided evidence of the ‘freeze’ and ‘fawn’ features in addition, captured in the literature by Walker (2013). This theme was present for all three of the children and reflect the literature in regard to how varied the consequences of DT can be depending on the individual.

As touched on in the literature review, a number of studies demonstrate that patients with chronic PTSD have decreased hippocampal volumes, which may play a role in this presence of the 4Fs for the three children in this study (Bremner, 1995; Gurvits, 1998; Adamec, 1991).

Laura’s data produced the largest number of ‘trauma responses’ codes, closely followed by Jack, and lastly, Polly. This is in contrast to the previous theme where Polly produced the largest number of codes.

From the second order codes, it is evident that Laura both verbally communicated her trauma responses as well as expressing them non verbally. She presented as more conscious of her difficulties and yet felt unable to change them. With Jack, his play was the method of communicating his trauma and there was no evidence to

suggest that he had processed his experiences. As captured in the second order codes, Polly commonly presented with the ‘fawn’ aspect of the 4Fs and therefore her trauma responses were more covert.

There were two second order codes from this theme, which were common for all three children. These were ‘psychosomatic symptoms’ and ‘presenting a false self’.

As presented in the literature review, individuals who have experienced DT / ACE’s are more likely to present with physical ailments alongside psychological (Breslau, 1991). Due to the level of DT these children suffered with, and the evidence of unconscious disturbance and unprocessed trauma, they are vulnerable to somatising to cope with these ‘beta elements’ as Bion (1962) described. The psychosomatic symptoms were particularly powerful in the room for Jack, where he would break wind or soil himself during moments of severe fright. In Jack’s presence I would also experience bodily sensations in my gut during these moments suggesting an excessive use of projective identification, which, Bion (1962) argued was a feature of a child who has been unable to appropriately use this function during their infancy.

Polly, as mentioned earlier was more covert in her symptoms but would use the toilet after the sessions in an apparent effort to get rid of something bad inside her. Laura, as touched on previously was more able to verbalise her symptoms but would let me know about debilitating headaches she would suffer with that would result in her falling into a deep sleep. The fact that Laura was able to contain herself enough until she got home before these headaches began links to the ‘presenting a false self’ code.

The ‘false self’ theory relates to the Winnicott’s (1960a) work on identity and how the forming of a true self is compromised by DT. All three of the children appeared to be presenting a ‘false’ version of themselves as captured in the codes. Polly’s was her ‘fawn’ tendency where

she would smile and sweeten her communications whilst the non-verbal communication and transference experience said something very different. Similarly, Jack's conscious communication was not congruent to the unconscious communication through his play and that which was felt in the counter-transference. He could present as detached and internally fragmented, resulting in the 'freeze' response in a moment when suddenly, Jack appeared to be in touch with a frightening reality.

There were several other codes which were common across two of the three children, and these were a mixture of combinations, such as Jack with Laura; or Polly with Jack. There were some outliers, which, although relevant to the theme, were not common with any other children, for example, Laura's 'hyper-alert to changes in the room' and usually would present in a hostile 'fight' manner. This was a feature of her trauma response but was not evident in the material from the other children's assessments.

Theme 3: Absence of maternal containment

With second order codes: *Absent mothers; high level of unmet need; mother carrying a lot on her shoulders; painful losses; fear of death; child feeling unseen and excluded; adults preoccupied with their own difficulties; child worrying about mother.*

Discussion

This third theme was originally coded 'child not held in mind' (Laura); 'vulnerable children' (Jack); and 'vulnerability' (Polly). With further analysis, the final theme emerged as 'absence of maternal containment'. This theme had the highest number

of common codes across all three children, suggesting that this is the most prevalent theme for these children. Polly was significantly more represented in this theme, followed by Jack and then Laura. As discussed in theme 1, this aligns with the reality of Polly's experience both historically and currently, where the ability to feel contained continues to be compromised by the poor health and old age of her caregivers.

As mentioned in the findings chapter, maternal in this case does not necessarily refer to the mother, but instead captures the essential role of the primary caregiver. What became evident from the data analysis is that these three children did not appear to have had an experience of a caregiver who, in reverie with them as an infant, was able to receive their projections, reform them into something digestible, and respond to the child with what they need in the moment. A process that Bion (1962) described as 'containment'.

As captured in the literature, too frequent an experience of being without a containing mind and someone who can meet the child's basic physical needs, leaves the child alone with all of the sensations and emotions which are nameless and meaningless; 'beta elements' (Bion, 1962).

This theme links with the previous two, as it is the result of this absent experience that leads to the 4Fs, as described in the literature review. This theme also provides a helpful precursor to imagine how a 'persecutory parental object' is formed, when, as Klein (1923) described, the absence of a good object becomes the presence of a bad one.

There were some interesting outliers for this theme which were specific to a particular child, for example, Laura was struggling to manage at school and in particular, the relationships with authority. In the thematic analysis it became apparent that school represented a maternal object that Laura did not feel contained her and as such, it became unsafe. Whilst Jack also found school difficult, the quality of Laura's relationship to the school was unique to her, potentially as she was in secondary school.

Another interesting element to this theme was the lens through which, particularly Jack and Polly, viewed the maternal object. Rather than the 'fight' response that Laura tended to take up, Jack and Polly also showed concern for the object. However, unlike the quality of 'depressive position' concern for the object as Klein (1946) described, but rather, a paranoid-schizoid anxiety about what their own destructive parts of themselves have done to their objects in fantasy.

In the following chapter, I shall summarise some of the key recommendations that have been drawn from the findings of this project and the literature review chapter.

Recommendations

The findings of this study bring to light important recommendations for future research and practice.

The primary recommendations are:

- Asking about previous service involvement and developmental history may allow for a more thorough assessment and formulation, leading to the appropriate intervention. Further research into developmental history taking and staff modality would be helpful in understanding the approach to assessment. Training for all professionals working in CAMHS about developmental trauma may be helpful. Without knowledge of this, clinicians do not have all the required information to be able to offer a thorough assessment.
- Services that address preventative and early intervention such as ante-natal support or post-natal treatment may prevent children being exposed to developmental trauma. Asking parents in CAMHS about their experience of conception, pregnancy and birth may help the clinician to understand how

emotionally available the parents were when the child was in their first 1001 days. This would provide insight into children who display signs that there was an absence of maternal containment.

- Consider that children who display the 4Fs may not have PTSD, but may have developmental trauma which may change the recommended intervention. In this case, consider offering them a psychotherapy assessment for further insight. Consider psychotherapy for children who have tried cognitive or skilled based treatments with little to no changes, due to the engagement with the unconscious including pre-verbal experiences which addresses developmental trauma. Similarly, notice children who carry around a persecutory parental object as this may be a sign that they have experienced neglect or abuse from their caregiver and this would need further investigation. Consider that if this is the case, it may mean engagement and trust is more difficult to establish which would mean a different approach and a longer length of time may be required
- There is a disproportionate number of Black children presenting in CAMHS with symptoms of trauma and an absence of males. Further research into this is important. This would assist in informing targeted preventative services and interventions for these populations. Research into the representation of minority populations within CAMHS staff groups would be insightful.
- As many of the children in this study presented at A&E before being referred to CAMHS, consideration of consultation to A&E staff to think further about the

management of this population and what they might be seeking from this experience

- Further research into how referrals are made, what language is used, and how it is decided whether they are accepted into the service would be helpful in understanding which path these children take. Similarly, insight into how diagnostic categories are decided upon at the initial stages would be helpful as these are some of the key deciders when treatment is being offered

- It would be an interesting addition to this project to formally assess the child's attachment style and include this as further insight into the child's internal world and style of relating.

Conclusion

This project was inspired by my experience of working with children who had experienced developmental trauma, during my first year of child and adolescent psychotherapy training. This, alongside the Manchester Arena Bomb in 2017, catapulted trauma to the forefront of the agenda in CAMHS. The interest in the consequences of trauma has continued to grow on a local and national level in government policy since the beginning of this project, although there is still more to be understood.

On my journey of researching and writing the project, my perspective and knowledge around trauma has expanded, and with experience I am more in touch with the dynamics and nuances of trauma than before. As captured by the literature review chapter, there is a vast range of past and present research demonstrating the impact and long term effects of trauma. The majority of the most relevant papers for this project were psychoanalytic, whilst there is increasing value in the combining of neuroscience and psychoanalysis as demonstrated in the literature.

One of the key findings from the literature review is that unprocessed and unconscious difficulties occurring in the child, are at the root of some of the most complex cases, and the longer and most severe the DT; the worse this is likely to be. This is demonstrated from the key characteristics of the children in the quantitative data, alongside the themes which emerged from the analysis of the psychotherapy assessments.

The most common patterns emerging from the survey of PTSD referrals were that the majority of the children were involved with social care at some point in their childhood and a large number no longer lived with their birth parents. The majority of the children had a birth parent with significant mental health problems and the birth parents were the perpetrators of neglect or abuse for the majority of the children.

All of the children who's notes were accessible had experienced previous trauma prior to attending CAMHS and almost half of the children were previously known to CAMHS. However, there are issues with engagement with services and ending treatment. This was despite the fact that all the children either remained in CAMHS or returned to CAMHS after the data was recorded.

From these findings, there are many similarities between the characteristics of the children referred in for PTSD and the literature describing the consequences of developmental trauma. The discoveries about the children in this part of the project also mirrored the findings from the thematic analysis of the children who had psychotherapy assessments.

The three most common themes from the thematic analysis were ‘persecutory parental objects’, ‘fight, flight, freeze and fawn (4Fs)’, and ‘absence of maternal containment’. These themes were created from the material of each child’s assessment, with the latter theme being the most prominent of the three. The themes mirror the literature which captures the experiences that a child requires in order to establish psychological well-being and the developments that need to happen in order to grow. The literature also mirrors the findings regarding the consequences if these experiences are absent, with the themes of ‘persecutory parental objects’ and the ‘4Fs’.

Developmental history taking was found to be poor in the initial assessments, a process that psychotherapists tend not to be part of in this CAMHS. As presented in the recommendations chapter, this may be an area where psychotherapists could contribute to.

In conclusion, this project has provided some unique contributions to the field of research on PTSD and developmental trauma in children and adolescents in a CAMH service. The findings have illuminated areas of already well established understandings of this population, as well as introducing new ideas and recommendations for future research and practice. The combination of psychoanalysis and neurobiology is a growing area of research and this would support the understanding of the mind-body connection.

References

Adamec, R. E. (1991). Corticotrophine releasing factor—a peptide link between stress and psychopathology associated with epilepsy? *Journal of Psychopharmacology*,*5*(2), 96–104.

Ainsworth, M. (1967) Infancy in Uganda: Infant care and the growth of love. Baltimore: Hopkins University Press

Ainsworth, M.D.S. (1978) Patterns of Attachment : A psychological study of the strange situation. Hillsdale, NJ: Lawrence Erlbaum Associates, Inc.

Alvarez, M.A. (1997) Projective Identification as a Communication: Its Grammar in Borderline Personalities. In: Psychoanalytic Dialogues 7:753-768.

Arnold, L. (1995) Women and Self-injury – A Survey of 76 Women. Bristol: Bristol Crisis Service for Women.

Aronson, J. (1994). A Pragmatic View of Thematic Analysis. The Qualitative Report, 2, 1-3.

Attride-Stirling, J. (2001). Thematic networks An analytic tool for qualitative research. Qualitative Research, 1, 385-405.

Balbernie, R. (2001) Circuits and Circumstances. In: Journal of Child Psychotherapy 27, 3:237-255.

Bick E. (1968). The experience of the skin in early object-relations. *The International journal of psycho-analysis*, *49*(2), 484–486.

Bick, E. (1986) Further Considerations on the Function of the Skin in Early Object Relations: Findings from Infant Observation Integrated into Child and Adult Analysis. British Journal of Psychotherapy 2:292-299

Bion , W.R. (1959) “Attacks on linking”. *Int. J. Psycho-Anal.* Vol. 14

Bion , W.R. (1962) *Learning from Experience*. London: Heinemann

Bion, W.R. (1967) *Second Thoughts.* London: Karnac.

Bion, W.R. (2015) War Memoirs 1917–1919, ed. Francesca Bion. London: Karnac, 2015, second edition.

Black, N. (1992) The relationship between evaluative research and audit. Journal of Public Health Medicine; 14: 361–366.

Blank, AA. (1985) The unconscious flashback to the war in Vietnam veterans: clinical mystery, legal defense, and community problem. In: Sonnenberg SM, Talbot JA, eds. The Trauma of War: Stress and Recovery in Vietnam Veterans. Washington, DC: American Psychiatric Association. 1985:293–308.

Blasczyk-Schiep, S., & Jaworska-Andryszewska, P. (2014). Negatywne doświadczenia w dzieciństwie, stres a zachowania samouszkadzajace i tendencje samobójcze u osób z zaburzeniem osobowości typu borderline [Negative experiences in childhood, stress and self-injurious behavior and suicidal tendencies in people with borderline personality]. *Polski merkuriusz lekarski : organ Polskiego Towarzystwa Lekarskiego*, *36*(216), 389–393.

Bloch, D. A., Perry, S. E., & Silber, E. (1956). Some factors in the emotional reaction of children to disaster. *The American journal of psychiatry*, *113*(5), 416–422.

Bowlby, J. (1969) *Attachment and Loss* (Vol. 1 Attachment). London: Hogarth

Boyatzis, R. E. (1998). Transforming qualitative information: Thematic analysis and code development. Sage Publications, Inc

Braun, V. and Clarke, V. (2006) Using thematic analysis in psychol-ogy. Qualitative Research in Psychology, 3 (2). pp. 77-101.

Braun V., Clarke V., Hayfield N., Terry G. (2019) Thematic Analysis. In: Liamputtong P. (eds) Handbook of Research Methods in Health Social Sciences. Springer, Singapore. https://doi.org/10.1007/978-981-10-5251-4_103

Bremner JD., Randall P., Scott TM., et al. (1995) MRI-based measured of hippocampal volume in patients with PTSD. Am J Psychiatry. 1995;152:973–981.

Breslau, N., Davis, G.C., Andreski, P. and Peterson, E. (1991) Traumatic Events and Posttraumatic Stress Disorder in an Urban Population of Young Adults. Archives of General Psychiatry, 48, 216-222.

Breslau, N., Kessler, R. C., Chilcoat, H. D., Schultz, L. R., Davis, G. C., & Andreski, P. (1998). Trauma and posttraumatic stress disorder in the community: The 1996 Detroit Area Survey of Trauma. Archives of General Psychiatry, 55, 626 – 632

Bryman, A. (2001). Social research methods. Oxford: Oxford University Press.

Campbell, D.W. and Eaton, W.O. (1999), Sex differences in the activity level of infants. Inf. Child Develop., 8: 1-17.

Cloitre M., Garvert D. W., Brewin C. R., Bryant R. A., & Maercker A. (2013). Evidence for proposed ICD-11 PTSD and complex PTSD: A latent profile analysis. European Journal of Psychotraumatology, 4, 20706

Danieli, Y. (1998) International handbook of multigenerational legacies of trauma. New York: Plenam Press.

Davies, D. (1991). Intervention with male toddlers who have witnessed parental violence. Families in society: The journal of contemporary human services, 72(9), 515-524

Dodge, K.A., Bates, J.E., Pettit, G.S., & Valente, E. (1995) Social Information-

processing patterns partially mediate the effect of early physical abuse on later

conduct problems. Journal of abnormal psychology, 104(4), 632-643

Ely, M., Anzul, M., Freidman, T., Garner, D., McCormack-Steinmetz, A. (1991) Doing qualitative research: circles within circles. Psychology Press.

Emanuel, L. (2002). Deprivation × 3. Journal of Child Psychotherapy. 28. 10.

Eth, S., Pynoos, R. S (eds) (1985) Washington: American Psychiatric Press, pp. xvi 186. *Behavioural Psychotherapy, 16*(1), 71-71.

Felitti VJ., Anda RF., Nordernberg D., et al. (1998) Relationship of childhood abuse to many of the leading causes of death in adults: the adverse childhood experiences (ACE) study. Am J Prev Med;14:245–258.

Figley, C. R. (Ed.) (2012) Encyclopedia of Trauma: An Interdisciplinary Guide. SAGE Publications.

Figley, C. R. (Ed.) (2013) Trauma and its wake: The study and treatment of Post-Traumatic Stress Disorder, pp. 5-14. New York: Routledge

Foa, E & Tolin, D (2006) *Sex Differences in Trauma and Posttraumatic Stress Disorder: A Quantitative Review of 25 Years of Research* Psychological Bulletin 2006, Vol. 132, No. 6, 959 –992

Fraiberg, S., Adelson, E., & Shapiro, V. (1975). Ghosts in the nursery. A psychoanalytic approach to the problems of impaired infant-mother relationships. *Journal of the American Academy of Child Psychiatry*, *14*(3), 387–421.

Freud, S. (1905). Fragment of an Analysis of a Case of Hysteria (1905 [1901]). The Standard Edition of the Complete Psychological Works of Sigmund Freud, Volume VII (1901-1905): A Case of Hysteria, Three Essays on Sexuality and Other Works, 1-12

Freud , S. (1915), The unconscious. *Standard Edition*, 14 : 166-215.

Freud (1920) 'Beyond the Pleasure Principle'. Standard Edition, 18:7.

Frigerio, A., Ceppi, E., Rusconi, M., Giorda, R., Raggi, M. E., & Fearon, P. (2009). The role played by the interaction between genetic factors and attachment in the stress response in infancy. *Journal of child psychology and psychiatry, and allied disciplines*, *50*(12), 1513–1522.

Garbarino, J. (1999) Lost boys: why our sons turn violent and how we can save them. New York: The Free Press.

Garland, C (1998). Understanding Trauma. A Psychoanalytic Approach. London: Routledge

Gerhardt, S (2004) 'Why Love Matters. How Affection Shapes a Baby's Brain. London and New York: Routledge.

Gilgun, J.F. (2010) Reflexivity and qualitative research. Current issues in Qualitative Research 2010;1(2):1-8

Golding, K. (2020) *Understanding and Helping Children who have Experienced Maltreatment.* Journal: Paediatrics and Child Health, 30:11, 371-377

Green, AH. (1978) Self-destructive behavior in battered children. Am J Psychiatry;135:579–582.

Greenhalgh, T. (2014) How to read a paper: The basics of evidence-based medicine. Fifth Edition. Wiley Blackwell. West Sussex.

Gros, D. F., Price, M., Strachan, M., Yuen, E. K., Milanak, M. E., & Acierno, R. (2012). Behavioral Activation and Therapeutic Exposure (BA-TE): an investigation of relative symptom changes in PTSD and depression during the course of integrated behavioral activation, situational exposure, and imaginal exposure techniques. *Behavior Modification, 36*, 580–599.

Guest, G., MacQueen, K., Namey, E. (2012) Applied Thematic Analysis. Sage Publications, Inc.

Gurvits T., Shenton M., Hokama H., Ohta., et al. (1998) Magnetic resonance imaging (MRI) study of hippocampal volume in chronic combat related posttraumatic stress disorder. Biol Psychiatry; 40:1091–1099.

Haahr-Pedersen, I., Perera, C., Hyland, P., Vallières, F., Murphy, D., Hansen, M., Spitz, P., Hansen, P., & Cloitre, M. (2020). Females have more complex patterns of childhood adversity: Implications for mental, social, and emotional outcomes in adulthood. *European Journal of Psychotraumatology*, *11*(1)

Haselgruber, A., Sölva, K., & Lueger-Schuster, B. (2020). Perspective matters: Differences between child- and caregiver-reports of emotion regulation mediating the relationship between cumulative childhood trauma and mental health problems in foster children. *Child Abuse & Neglect*, *107*.

Hayes, N. (1997) Theory-led Thematic Analysis: social identification in small companies in Doing Qualitative Analysis in Psychology, Hove, Psychology Press, 93-115.

Henderson, A. S. (2001). Central Issues in Psychiatric Epidemiology. In: Henn, N., Helmchen, H., & Lauter, H. (Eds.). Contemporary Psychiatry (pp. 29-46). Springer Science & Business Media. ISBN 3642595197.

Henry, G. (1974) Doubly Deprived *Journal of Child Psychotherapy,* 1974; v. 3D (4), p15, 14p.

Hodges, J. *et al.* (2003) 'Changes in Attachment Representations Over the First Year of Adoptive Placement: Narratives of Maltreated Children', *Clinical Child Psychology and Psychiatry*, 8(3), pp. 351–367.

Horowitz, M., Wilner, N., Alvarez, W. (1979). Impact of Events Scale: A measure of subjective stress. Psychosomatic Medicine, 41, 209-218

HM Government (2021) The Best Start to Life: A vision for the 1001 critical days. Online via The_best_start_for_life_a_vision_for_the_1_001_critical_days.pdf (publishing.service.gov.uk)

Joffe, H. (2011). Thematic Analysis. In D. Harper, & A. R. Thompson (Eds.), Qualitative Research Methods in Mental Health and Psychotherapy: A Guide for Students and Practitioners, Chichester: John Wiley & Sons, Ltd.

Jucovy, M. E. (1992). Psychoanalytic contributions to Holocaust studies. The International Journal of Psychoanalysis, 73(2), 267–282.

Kessler, R. C., Sonnega, A., Bromet, E., Hughes, M., & Nelson, C. B. (1995). Posttraumatic stress disorder in the National Comorbidity Survey. Archives of General Psychiatry, 52, 1048 –1060.

Klein, M. (1930) The Importance of Symbol-Formation in the Development of the Ego. In: (1975) Love, Guilt and Reparation and other works 1921-1945. London: Hogarth.

Klein, M. (1935) A Contribution to the Psychogenesis of Manic-Depressive States. In: (1975) Love, Guilt and Reparation and other works 1921-1945. London: Hogarth.

Klein, M. (1937) Love, Guilt and Reparation. In (1975) Love, Guilt and Reparation and other works 1921-1945. London: Hogarth.

Klein, M. (1940) Mourning and its Relation to Manic-Depressive States. In (1975) Love, Guilt and Reparation and other works 1921-1945. London: Hogarth.

Klein, M. (1946). "Notes on some schizoid mechanisms". *Envy and gratitude and other works 1946-1963*. Hogarth Press and the Institute of Psycho-Analysis (published 1975)

Klein, M. (1952). The origins of transference. The International Journal of Psychoanalysis, 33, 433–438.

Klein, M. et al. (1955) “On Identification” in: *New direction in Psychoanalysis*. London: Tavistock

Lanyado, M. (2009) ‘Psychotherapy with severely traumatised children and adolescent. Far beyond words.’ In: The Handbook of Child and Adolescent Psychotherapy, Psychoanalytic Approaches. Edited by Lanyado, M and Horne, A (2009).

Lanyado, M., and Horne, A. (2009) ‘The Therapeutic Setting and Process’. In: The Handbook of Child and Adolescent Psychotherapy, Psychoanalytic Approaches. Edited by Lanyado, M, and Horne, A. (2009) pp. 160.

Laplanche, J. & Pontalis, J.-B. (1973) The Language of Psycho-analysis Published by The Hogarth Press and the Institute of Psycho-Analysis London

Lee, D., Yu, E.-S., & Kim, N. H. (2020). Resilience as a mediator in the relationship between posttraumatic stress and posttraumatic growth among adult accident or crime victims: The moderated mediating effect of childhood trauma. *European Journal of Psychotraumatology*, *11*(1).

Lenferink, L. I. M., Egberts, M. R., Kullberg, M.-L., Meentken, M. G., Zimmermann, S., Mertens, Y. L., Schuurmans, A. A. T., Sadeh, Y., Kassam-Adams, N., & Krause-Utz, A. (2020). Latent classes of DSM-5 acute stress disorder symptoms in children after single-incident trauma: Findings from an international data archive. *European Journal of Psychotraumatology*, *11*(1).

Levy, D. M. (1945): Psychic Trauma Of Operations In Children. *American Journal of Diseases Of Children* (January) 69, (1), 7-25.

Lewis, D.O. (1992) From abuse to violence: psychophysiological consequences of maltreatment. J Am Acad Child Adolesc Psychiatry. 1992;31:383–391.

Mays, N., Pope, C. (2000) Qualitative research in healthcare: assessing quality in quantitative research. BMJ: British Medical Journal 2000; 320(7226):50

McGilchrist, I. (2010) The Master and his Emissary. New Haven: Yale University Press.

Meltzer, D (1975) ‘Adhesive Identification’. Contemporary Psychoanalysis, 11:3, 289-310.

Merza, K., Harmatta, J., Papp, G., & Kuritárné Szabó, I. (2017). Gyermekkori traumatizáció, disszociáció és szándékos fizikai önsértő viselkedés borderline személyiségzavarban [Childhood traumatization, dissociation and nonsuicidal self-injurious behavior in borderline personality disorder]. *Orvosi hetilap*, *158*(19), 740–747.

Music, G. (2010) Nurturing Natures: Attachment and Children's Emotional, Sociocultural and Brain Development, Routledge: London.

Music, G. (2019) Nurturing Children: From Trauma to Growth Using Attachment Theory, Psychoanalysis and Neurobiology, Routledge: London.

Nadar, K. (2014) Understanding and assessing Trauma in children and adolescents: Measures, methods and youth in context. Routledge, London.

Newman, M. A. (1976). Movement tempo and the experience of time. *Nursing Research, 25,* 173–179.

Norris, F. H. (1992). Epidemiology of trauma: Frequency and impact of different potentially traumatic events on different demographic groups. Journal of Consulting and Clinical Psychology, 60, 409 – 418.

Ollendick, T.H., (1983) Reliability and validity of the Revised Fear Survey Schedule for Children (FSSC-R), Behavior Research and Therapy, 21, 685-692

Osofsky, J.D., (2007) *Young children and trauma: Intervention and treatment.* New York: Guildford Press.

Panksepp, J., and Biven, L. (2012) *The Archeology of Mind.* New York, NY: Norton

Perry, B.D., Pollard, R.A., Blakley, T.L., Baker, W.L. and Vigilante, D. (1995), Childhood trauma, the neurobiology of adaptation, and “use-dependent” development of the brain: How “states” become “traits”. Infant Ment. Health J., 16: 271-291.

Perry, B.D., (1997) Incubated in terror: Neurodevelopmental factors in the “Cycle of Violence”. In J. Osofsky (Ed.), Children, youth and violence: The search for solutions (pp. 124-148). New York: Guildford Press

Porges, S.W. (2011) The polyvagal Theory: neurophysiological Foundations of emotions, attachment, communication and self-regulation. New York: Norton

Rauch SL., van der Kolk BA., Fisler RE., et al. (1996) A symptom provocation study of posttraumatic stress disorder using positron emission tomography and script-driven imagery. Arch Gen Psychiatry; 53:380–387.

Reynolds, C.R., & Richmond, B.O., (1978) What I think and feel: a revised measure of childrens manifest anxiety. Journal of abnormal child psychology, 6(2) 271-280

Roberts, A. L., Gilman, S. E., Breslau, J., Breslau, N., & Koenen, K. C. (2011). Race/ethnic differences in exposure to traumatic events, development of post-traumatic stress disorder, and treatment-seeking for post-traumatic stress disorder in the United States. *Psychological medicine*, *41*(1), 71–83.

Rustin, M.E (2004) Learning from the Victoria Climbié Inquiry. Journal of Social Work Practice. 18 (1), pp. 9-18.

Rutter, M. (1999). Resilience Concepts and Findings: Implications for Family Therapy. Journal of Family Therapy, 2, 119-144.

Rytwinski, N., Michael, D. Scur, N. C. Feeny, E. (2003)The Co-Occurrence of Major Depressive Disorder Among Individuals With Posttraumatic Stress Disorder: A Meta-Analysis. Volume26, Issue3: 299-309 Journal of traumatic stress

Sansone, R. A., Hahn, H. S., Dittoe, N., & Wiederman, M. W. (2011). The relationship between childhood , trauma and borderline personality symptomatology in a consecutive sample of cardiac stress test patients. *International journal of psychiatry in clinical practice*, *15*(4), 275–279.

Schore, A. (2003) Affect Dysregulation and Disorders of the Self. New York: Norton.

Schore, A. (2012) The science of the art of psychotherapy. W. W. Norton & Company.

Seals, D., & Young, J. (2003). Bullying and victimization: prevalence and relationship to gender, grade level, ethnicity, self-esteem, and depression. Adolescence, 38(152), 735-747.

Segal, H. (1957) Notes on Symbol Formation. International Journal of Psychoanalysis 38:391-397

Shalev AY., Rogel-Fuchs Y. (1993) Psychophysiology of PTSD: from sulfur fumes to behavioral genetics. J Ment Nerv Dis;55:413–423.

Solms, M. & Turnball, O. (2011) *What is neuropsychoanalysis?* Neuropsychoanalysis 13, 133-145.

Spitz , R.A. (1945) “Hospitalism. An Inquiry into the Genesis of Psychiatric Conditions in Early Childhood” in *Psychoanal. St. Child* Vol. 1 . New York: International University Press

Stubley, J (2020) The early response to Covid 19 – a psychoanalytic and trauma perspective. Tavistock and Portman NHS Foundation Trust.

Suomi, S.J., Novak, M.A., & Well, A. (1996) *Aging in rhesus monkeys: Different windows on behavioural continuity and change.* Developmental Psychology, 32(6), 1116-1128.

Taylor, G. W. and Ussher, J. M. (2001) Making Sense of S&M: A Discourse Analytic Account. *Sexualities*, 4(3), pp. 293–314.

Taylor, D (2007) *The Psychodynamic Assessment of Post-Traumatic States* In: Understanding Trauma: A Psychoanalytic Approach, Garland, C (2007) Karnac: London.

Teague, S (2013) Journal of Aggression Maltreatment and Trauma, 22(6), pp. 611-625

Terr, L.C (1979) Children of Chowchilla, The Psychoanalytic Study of the Child, 34:1, 547-623,

Tozzi, L., Garczarek, L., Janowitz, D., Stein, D. J., Wittfeld, K., Dobrowolny, H., Lagopoulos, J., Hatton, S. N., Hickie, I. B., Carballedo, A., Brooks, S. J., Vuletic, D., Uhlmann, A., Veer, I. M., Walter, H., Bülow, R., Völzke, H., Klinger-König, J., Schnell, K., … Frodl, T. (2020). Interactive impact of childhood maltreatment, depression, and age on cortical brain structure: Mega-analytic findings from a large multi-site cohort. *Psychological Medicine*, *50*(6), 1020–1031.

Trowell, J. (1997) 'Child Sexual Abuse' in, N. Wall (ed.), Rooted Sorrows, Bristol: Family Law

Tuckett, A.G. (2005) Applying Thematic Analysis Theory to Practice A Researcher's Experience. Contemporary Nurse, 19, 75-87

van der Kolk B.A. (1989). The compulsion to repeat the trauma. Re-enactment, revictimization, and masochism. *The Psychiatric clinics of North America*, *12*(2), 389–411.

van der Kolk B. (2000). Posttraumatic stress disorder and the nature of trauma. *Dialogues in clinical neuroscience*, *2*(1), 7–22.

van IJzendoorn, M. H. (1995). Adult attachment representations, parental responsiveness, and infant attachment: A meta-analysis on the predictive validity of the adult attachment interview. *Psychological Bulletin, 117,* 387–403.

Walker, P (2013) Complex PTSD: From Surviving to Thriving: A GUIDE AND MAP FOR RECOVERING FROM CHILDHOOD TRAUMA. CreateSpace Independent Publishing Platform.

Weisaeth L. (2014). *The history of psychic trauma.* In: Friedman M. J., Keane T. M., Resick P.A., (Eds). Handbook of PTSD: science and practice (2nd ed.), pp. 38–59. New York: Guilford.

Wilson, G. T. , Rachman, S. J. (1983). Meta-analysis and the evaluation of psychotherapy outcome: Limitations and liabilities. Journal of Consulting and Clinical Psychology, 51, 54-64.

Winnicott, D.W. (1942) Why children play. *New Era in Home and School*, 1942, *23*. Also published in *The child and the outside world: Studies in developing relationships* (pp. 149–152). London: Tavistock, 1957

Winnicott, D.W. (1953)Transitional objects and transitional phenomena: A study of the first Not-Me possession [1951]. International Journal of Psychoanalysis 1953, 34, 89–97.

Winnicott D.W. (1960a). Ego distortion in terms of true and false self. In *The Maturational Processes and the Facilitating Environment*. New York: International Universities Press, 1965, pp. 140–152.

Winnicott, D.W. (1963) 'From dependence towards independence in the development of the individual'. In: D. W. Winnicott, (1965) The Maturational Processes and the Facilitating Environment. London: Hogarth Press.

Wohlin, C. (2014). Guidelines for snowballing in systematic literature studies and a replication in software engineering. ACM International Conference Proceeding Series. 10.1145/2601248.2601268.

Youell, B (2002) 'The child psychotherapist and multi-disciplinary assessments for the family courts.' The Journel of Child Psychotherapy, 28:2, 201-2015.

.

Appendices

Appendix 1: NICE Guidelines

Due to the significant length of the NICE Guidelines I have included some extracts within the paper, but the full guidance can be found using the following link:

https://www.nice.org.uk/guidance/ng116/resources/posttraumatic-stress-

disorder-pdf-66141601777861

Appendix 2: Participant consent form (parent)

NHS
Manchester University
NHS Foundation Trust

PARENT COPY

Evaluation of the service at Salford Child and Adolescent Mental Health Service for children with PTSD/developmental trauma.

Information and consent form.

Why have we contacted you?

I am currently undertaking an evaluation of how children who have experienced trauma are managed in a community CAMH Service and would like to ask for your permission to use information from your child's assessment for psychotherapy. This information sheet provides details of how information will be collected, used and stored. Please read the sheet carefully, and ask questions if you would like more details or if anything is unclear.

What is the purpose of the Evaluation?

To gain an understanding of how a child who has had a difficult early experience(s) is assessed and treated in a Community CAMH Service.

Why are we asking your child to take part?

The aim of this evaluation is to understand how a child might express their difficult experiences within a therapeutic relationship. Your child is being asked to take part in the evaluation because they had an assessment for psychotherapy after it was felt that they had experienced some difficult things in your past which they might be struggling to manage. Research like this is crucial in ensuring children like yours are understood and are provided with the appropriate treatment.

What will happen to the information from your child's assessment?

Your child's assessment will be looked at to see if and how their difficult early experiences present within the therapeutic relationship. It may be quoted and used in parts of the evaluation to illustrate themes. Data from the assessment will be stored securely as electronic files and will be password protected and encrypted. Any paper files will be kept in a locked cabinet. After the data has been analysed, any data which does not need to be kept on file for service requirement purposes will be disposed of through confidential waste.

We will follow appropriate ethical and legal practices throughout the process. This means all the information about your child will be dealt with in the strictest confidence. In order to maintain anonymity, there will be no way of identifying your child in the evaluation report and their name and any identifying information will be changed.

Suppose I change my mind & want to pull out of the evaluation?

If after agreeing to take part in the evaluation, you decide that you do not wish to continue being part of this evaluation process, please let us know as soon as possible. We will make sure that none of the information which has not already been processed at the point of notification will be used in evaluation reports, publications or publicity materials.

Who you can contact if you want more information?

If any of the information in this sheet is unclear, or you want to know more about the evaluation you can contact **Ellie Shilliday, Child and Adolescent Psychotherapist in Clinical Training, on 0161 XXX XXXX**, or email me at **XXXXXXX@XXX.XXX.XX** Before: **August 2019.**

Participant Consent Form (child copy)

Please complete this form and return it to show that you give your consent to take part in the evaluation process and for us to use the information you provide. If you require more information about the evaluation, please contact **Ellie Shilliday**, as detailed on the information sheet. Please tick and sign the following if you consent to taking part in the evaluation:

Please tick and sign the following if you consent to take part in the interviews:	**YES √**	**NO √**
I have received information about the purpose of the evaluation		
I am happy for my/my child's assessment to be used for the evaluation		
I have been able to ask questions and am happy with the responses given		

I understand that any information I have/my child has shared will be kept securely		
I am happy for the information that I share/my child has shared to be used for a service evaluation and to be included in presentations and service evaluation publication		
I understand that my/my child's name or any details which identify me/my child will not be mentioned in any presentations, publications or reports		
I understand that I/my child can withdraw at any time and ask for my comments to be excluded from the evaluation		
I am happy to take part/for my child to take part in the evaluation		

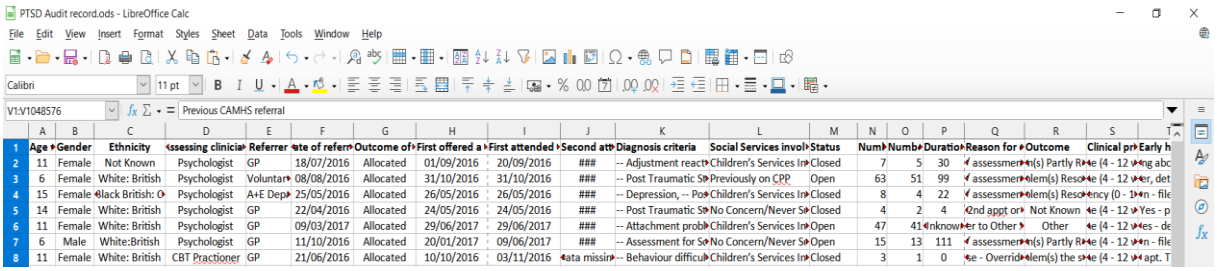
Participant Name (please print) _____

Participant signature _____

Researcher signature _____

Date_____

Appendix 3: Example of the initial stages of organising the survey data.



	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T
1	Age	Gender	Ethnicity	ssessing clinicia	Referrer	ate of referr	Outcome of	First offered a	First attended	Second att	Diagnosis criteria	Social Services invol	Status	Numb	Numb	Duratio	Reason for	Outcome	Clinical pr	Early h
2	11	Female	Not Known	Psychologist	GP	18/07/2016	Allocated	01/09/2016	20/09/2016	###	-- Adjustment react	Children's Services In	Closed	7	5	30	assessmen	n(s) Partly R	e (4 - 12	ng abc
3	6	Female	White: British	Psychologist	Voluntar	08/08/2016	Allocated	31/10/2016	31/10/2016	###	-- Post Traumatic St	Previously on CPP	Open	63	51	99	assessmen	olem(s) Reso	e (4 - 12	er, det
4	15	Female	Black British: O	Psychologist	A+E Dep	25/05/2016	Allocated	26/05/2016	26/05/2016	###	-- Depression, -- Po	Children's Services In	Closed	8	4	22	assessmen	olem(s) Reso	ency (0 - 1	n - file
5	14	Female	White: British	Psychologist	GP	22/04/2016	Allocated	24/05/2016	24/05/2016	###	-- Post Traumatic St	No Concern/Never S	Closed	4	2	4	2nd appt or	Not Known	e (4 - 12	Yes - p
6	11	Female	White: British	Psychologist	GP	09/03/2017	Allocated	29/06/2017	29/06/2017	###	-- Attachment probl	Children's Services In	Open	47	41	nknow	er to Other	Other	e (4 - 12	es - de
7	6	Male	White:British	Psychologist	GP	11/10/2016	Allocated	20/01/2017	09/06/2017	###	-- Assessment for S	No Concern/Never S	Open	15	13	111	assessmen	n(s) Partly R	e (4 - 12	n - file
8	11	Female	White: British	CBT Practioner	GP	21/06/2016	Allocated	10/10/2016	03/11/2016	ata missin	-- Behaviour difficul	Children's Services In	Closed	3	1	0	e - Overrid	olem(s) the s	e (4 - 12	apt. T

Appendix 4: Example of the process of creating themes for a session

Laura's assessment session 1:

Phrases from the text which support the theme (Evidence)	**First Order Codes**	**Second Order Codes Interpretative codes**	**Third Order Codes THEMES**
She walks with pace and almost walks into me holding the door, and then past me.	Almost walks into me and then past me	Spaced out on transition from waiting room to therapist	
I say 'hello', and Laura stands and walks straight to me, looking ahead and focusing her gaze as though shutting out the others in the waiting room.	Shutting out others in the waiting room		**Detached responses during transition periods**
Laura is silent then turns to me and shakes her head, 'Sorry, I just spaced out then. I do that all the time...'	Spacing out all the time	Freezing and spacing out all the time	

I ask her, 'where did you go when you spaced out? '	Freezing all the time at school		
Laura says, 'No where, I just freeze. I do it all the time at school and it's really annoying, because I miss things. Or teachers say I'm not listening, but I can't help it.'			
Laura nods but is silent. The walk seems long and I am tempted to talk but don't.	Walk is silent and seems long		
		Anxious on walk to therapy room	
As I lead the way down the stairs I can feel the anxiety cutting through the air.	Anxiety cutting through the air on walk to room		
We begin to walk and Laura looks slightly spaced out, I let her know that we are in a room downstairs today, just to the end of the corridor.	Spaced out on beginning of walk to therapy room		
They were sat directly in my eye line and both held a firm gaze, mum more relaxed, relieved even, and Laura looking quite frightened, eyes wide.	Laura looking frightened as our eyes meet	Frightened to begin assessment	**Frightened at start of new relationship**
Mum gives me a look which seemed to translate to me as though she was pleased that Laura was here, and a sort of nod to how nervous Laura was.	Mum communicating how nervous Laura is		
When making Laura's box up, I noticed how pre-occupied I was being, in making sure the box was neat, varied in materials, and had given her more felt tips and pencil crayons that I would have usually, because I knew she liked art.	Therapist pre-occupied with making sure box is correct	Therapist nervous before assessment	
As I step down the steps my legs feel a bit wobbly as though my knees could give way and I realise that I am nervous too.	Therapist nervous on walk to room		
She picks up the set of thicker pens. 'The red is missing. I can't make a rainbow if the red is missing.'	Notices red pen is missing	Noticeably observant in surroundings	**Hyper-vigilent checking of surroundings**
I take a seat and Laura stands, looking at the other chair and the couch.	Laura looking at where to sit		

Laura sits on the chair, she looks ahead out the window which faces onto a children's playground.	Looking out the window		
She then picks up the normal felt tips and begins inspecting these. She checks the red, taking the lid off.	Checking and inspecting the pens	Hyper-vigilent checking	
I say that it might be helpful if I introduce myself again, as it's been a while since we saw each other, Laura nods, still staring, and I add that I will also go through the plan for the assessment again.	Laura staring as I introduce myself		
I wait for a moment or two, and sensing the tension I say that this is one of the psychotherapy rooms, Laura looks around.	Tension in the room at start		
'...What's the plan then?' She says. It felt slightly aggressive.	Aggressive questioning	Aggressive, forceful questioning of therapist	**Intrusive communications**
It is time to end and I let Laura know we have just a minute, was there anything else she wanted to ask today? 'Do you work for social services?' She says, loudly and forcefully, startling me slightly, again looking straight at me. 'Cos on this website it says that you work for social services. Do you?'	Forceful questioning about social services at end of session		
'Like I need to know what's happening, I like a plan. If I don't have a plan, I don't like it. '	Needs to know what the plan is	Pressure on therapist to communicate plan	
I say that she 'might want to know the plan for here too, but perhaps it doesn't feel as straight forward both because it's something unknown but also because we don't know what the outcome might be, from these 3 sessions.'	Wants to know the plan for the assessment		
I say that she 'might be anxious about today, it is a new situation, and she doesn't really know me yet.' Laura nods, 'I don't like change. I take ages to get used to stuff. '	Doesn't like change	Hates changes, changes feel sudden	
'Yeah. It's like, at school, it's turning into a co-op so they're building this wall and changing loads of things and I don't like it.' She says.	Doesn't like changes at school		**Changes feel catastrophic**

Laura says, 'Yeah I just don't like random change. I need to know what's what and I hate it when people just tell me stuff suddenly and then I have to deal with it.'	Hates dealing with sudden, random change		
'It's like in the morning I have a routine of how I get ready, and I stick to it. I set my alarm at the same time every morning, then I do my hair. I put my tie and blazer on last. I get the same bus, but from one bus stop which isn't the closest, but we've got 3 near us to I go to this one I like the best. '	Has a particular routine every morning	Needs things to be kept the same	
'I have a plan B if plan A doesn't work out but it usually does. '	Has a plan B if plan A doesn't work out		
I say we need to finish there. Laura says, 'Are we in this room again next week?' I say 'yes we will be in this room every week.'	Checking if she will be in the same room next week		
Laura nods and says, 'I'll remember it. There's a sticker on this table which says, I helped tidy up. And that clock there.' I feel on edge that things won't be exactly the same when she comes back.	On edge that things won't be the same		
'The only time it doesn't is when someone else ruins it, like my brother, he always messes up my plans.'	Someone else like brother messes up plans	Idea of 'sibling' baby messing up plans	
I say that 'thinking about change, there is something that I wanted to tell her early on because she might begin to notice me changing as the weeks go on, in that I am expecting a baby.'	Therapist expecting baby		
I say that I 'think she's letting me know that she is struggling to think she could see me for some time and then it end, and be alright about that, be able to make something of the time she has here. '	Going to struggle to end assessment	Struggle with endings	Preoccupied with loss
I add that she 'has a relationship with them and perhaps she feels that it is broken when someone leaves, perhaps she feels broken. '	Feels broken when someone leaves		
'It annoys me when people just think they can replace people, like… it's a person.'	Can't just replace people		

‘I don’t tell people stuff unless I know they’re not gonna leave. ‘	Only tell people stuff if they’re not going to leave		
		Feels betrayed when someone leaves	
‘Like Ms P, she knows that if she left then I would never talk to anyone else again the same as I did with her.’	Can’t talk to anyone again if trusted person leaves		
‘It’s like, how can I explain it, say there’s a full circle’ she draws a circle in the air with her fingers ‘There’s a bit missing. It’s not a full circle.’	There’s a bit missing		
I add that I ‘think she is trying to work out just now if she can trust me, and that this is one of the ways she is doing it. ‘	Working out if she can trust me		
		Cautious about trusting others	**Mistrustful of adults**
‘I will be here until September.’ Laura says, ‘Ok.’ She then seems to think and says. ‘I take ages to trust people. Like, the things I’ve told you today, loads of people already know about them.’	Takes ages to trust people		
‘I hate it when people break your trust as well. Like I used to talk to this teacher, she was the safeguarding lead, and I told her loads of stuff and then she went straight to social services.’	Hate it when people break your trust		
		Experiences of trust being broken	
‘ I didn’t even know until we were sat in a meeting and she just spilled the whole story out to them in front of me. I was like, oh cheers. Thanks.’ Laura looks deflated.	Deflated at feeling trust is broken		
I say yes so her sessions are private, but if there’s anything that I am worried about, her safety, or the safety of someone else for example then I will have to tell someone about it, but that I will always speak to her about it first. ‘Yeah cos she didn’t. That woman.’	Woman didn’t speak to her about confidentiality		
I say there seems to be an idea of a me who is tricky and actually, who isn’t safe. Laura thinks and then says, ‘I suppose children would be supervised in there anyway, so maybe the planks are ok. But I don’t like the bush.’	Idea of tricky and unsafe adult		
		Sense of adults being tricky and unsafe	Expectation that adults will be tricky and unsafe
Laura puts the pens down, ‘Yeah and also that playground outside. I don’t like it. Why is it empty. And why are there planks of wood with nails in on the floor, that’s just dangerous. Also I don’t like that bush, why is it flat like that, it’s like someone’s just cut it.’	Empty, dangerous playground		

Laura continues to inspect the felt tips. 'They look the same, but there's different markings on the bottom of some of them.' I say that 'it is as though she think somebody, me, is tricking her.'	Thinks somebody is tricking her		
'I don't like it when there are missing pens at school. Or worse, when people swap the lids. Why would you do that? It's just mean.'	People swapping pen lids		
I say that I think she is 'asking me what my relationship is like with them, and maybe this comes back to the trust thing, and her privacy.' 'Yeah, do you then?' Aware of the time and needing to finish, I say that I don't work for them, but we are linked in that we both help children but in different ways. Laura nods slowly. 'So you don't work for them.'	Concerns about link with social services	Concerns about transparency and predictability of therapist	
'Yeah, you'll be changing like.. mood swings and stuff.' Again this takes me by surprise, and I almost laugh, I say that 'I was talking more about physical changes but maybe she is letting me know that she is concerned that she wouldn't know what kind of therapist she would be coming to each week.'	Concerned about therapist's stability		
Laura lights up and looks at me properly for the first time, 'A boy or girl?!' She exclaims excitedly, eyes lit up. It takes me completely by surprised and feels quite manic, I find myself unable to think and say that 'I don't know.'	Manic, excited response to pregnancy news	**Over excited, manic responses**	**Manic responses**
I say 'yes it's yours.' Again, catching myself being a bit over enthusiastic.	Over enthusiastic		
Silence follows for a minute or two. I say that I also wanted to let her know that this is her box, which has a few things in it which she might want to use during her assessment. Laura says excitedly, 'Ooo. Can I have a look in it?'	Excited about box	**Appearing very excited about box**	
'Oooo!' She spots the ball immediately, 'A rainbow! Love that.' She rolls the ball around in her hand, looking further into the box.	Loving the things in the box		
She appears older than her years, maybe nearer 15, and very adolescent, with her skirt rolled up and a sort of pseudo confidence.	Pseudo confident adolescent	**Sense of needing to look after self**	**Expectation of not being held**

I don't like the pens they have at school so I bring my own. Hah.' She says, slightly smugly.	Bringing own pens to school		**in mind**
Laura says, 'School are doing this in the middle of the year as well and I don't get why they couldn't wait until a new school year. Like they did with the behavioural stuff, they changed the behaviour charts and we came back in September to them but that was fine because it was a new year.' I say that she 'might also feel a bit wobbled or confused about the starting of this assessment, in the middle of the year, maybe she wishes this could have started alongside the start of her school year.'	Doesn't like that the assessment doesn't match term timetable		
At the time of Laura's session I went to collect her from the waiting room, and I notice her and mum straight away, which takes me by surprise as I thought her image in my mind might have faded somewhat since our last meet.	Expectation that they would have faded in mind	**Expectation of not being held in mind**	
Before the assessment, I had written a letter to Laura and her mum, separately outlining the dates and the plan for the assessment. I'd done this because it had been a while (3 months) from the first meet until the assessment. I had then called mum the day before just to check in and remind them about their appointment.	Unusually detailed following up prior to assessment		

Appendix 5: Bringing the themes together

Laura

Coding key:

Pink = unsafe adults

Purple = trauma responses

Green = child not held in mind

Session 1 – detached responses during transition periods, frightened at start of new relationship, hypervigilent checking of surroundings, intrusive communications, changes feel

catastrophic, preoccupied with loss, mistrustful of adults, expecting adults to be tricky and unsafe, manic responses, expecting to not be held in mind

Session 2 – High level of unmet need, baby at risk of neglect, hyper-alert to changes in surroundings, problems at school: exclusions and misunderstandings, adults lacking boundaries, omnipotent in uncertainty, constantly feeling unsafe, psychotic element to anxiety, baby is not held in mind, developmental trauma, living in a frightening mind, significant psychosomatic pain

Session 3 – appearing self-sufficient, unstable sense of self, experiencing adults as punishing, idealisation and denigration of others, experiencing gaps as painful losses, feeling unseen by adults, controlling behaviours, presenting a false self.

Jack

Coding key:

Blue = abusive adults

Pink = trauma responses

Green = vulnerable children

Session 1 – loss of relationships, comings and goings, dangerous adults, class differences, worried about therapist being cross, needing the toilet when frightened, vulnerable children, witnessing harm, disguised disturbance, unsafe environment, freeze responses, muddle between milk and blood (good and bad), blurred boundaries, spilling out, trauma response.

Session 2 - breaking in, fear of intrusion, no entry responses, mummy left to be attacked, mother carrying a lot on her shoulders, mummy and baby separated, adults preoccupied with their own problems, neglectful mother, adults fighting, child always checking for danger and risk, child hyper-vigilent in responses, children witnessing abuse, lack of trust.

Session 3 – appearing detached, freeze responses, daydreaming, babies in danger, predatory adults, mothers are attacked, absent mothers, smiling during disturbing play, painful ending, not having enough, trumping and soiling in session, therapist feeling somatic symptoms in gut, depriving mother, cruel withholding mother, worry about vulnerable mother being excluded, muddle between affection and pain (good and bad), scary therapist.

Polly

Coding key:

Yellow – vulnerability

Blue – Unsafe adults

Pink – trauma responses

Session 1: mask-like smile, intrusive relating, the world is viewed as topsy turvy, therapists maternal rescue fantasies, vulnerable mother, therapist as scary adult, asking permission, feeling helpless, adults are punishing, trying to please therapist, confused about good and bad care, frightened of angry feelings, separation anxiety, clumsiness, unsafe home.

Session 2: scary adults, broken families, wanting to sweeten therapist, maternal protective urges, underweight, absent mothers, not held in mind by adults, deceptive adults, deprivation, child worrying about mother, breaks feeling painful, withholding mother, adults keeping the best for themselves, concerns about safety, psychosomatic symptoms, cruelty to dependants, self-sufficiency.

Session 3: false smiles, lack of impact on adult, painful separation, neglectful adults, depriving adults, mothers feeling excluded, withholding adults, confusion about reality, mistrustful of adults, unable to assert oneself, intrusive questions, child feeling excluded, fear of rejection, difficulty in being truthful, masking true feelings, fear of death, high level of need in both mother and child, needing to get rid of bad feelings in the toilet.

Appendix 6: Creating final themes

Theme	Second order codes (Laura)	SOC (Jack)	SOC (Polly)
Persecutory parental objects	Experiencing adults as punishing	Predatory adults	Adults as punishing
		Cruel, withholding mother	Withholding, depriving adults
	Mistrustful of adults		Mistrustful of adults
	Adults lacking boundaries	Blurred boundaries	

		Muddle between affection and pain	Confused about good and bad care
		Children witnessing harm	Unsafe at home
		Worried about therapist being cross	Asking permission
	Expecting adults to be tricky and unsafe	Breaking in	
	Intrusive communications		
Fight, flight, freeze or fawn	Psychosomatic pain	Psychosomatic symptoms in therapist (counter-transference)	Psychosomatic symptoms
	Presenting a false self	Smiling during disturbing play	Masking true feelings
	Mistrustful	Lack of trust	
	Detached responses	Appearing detached	
		Needing the toilet when frightened	Needing to get rid of bad feelings in the toilet
	Checking of surroundings	Always checking for danger in the room	
	Appearing self-sufficient		Self-sufficiency
	Psychotic element to anxiety		Confusion about reality
	Manic responses	Freeze responses	Concerns about safety
	Hyper-alert to changes in the room		Wanting to sweeten therapist

Absence of maternal containment	Baby is not held in mind	Neglectful mother	Absent mothers
	High level of unmet need	Mother carrying a lot on her shoulders	High level of need in mother and child
	Experiencing gaps as painful losses	Loss of relationships	Fear of death
	Feeling unseen by adults	Adults preoccupied with their own difficulties	Child feeling excluded
		Worry about vulnerable mother being excluded	Child worrying about absent mother
	Problems managing education setting	Mothers left to be attacked	Separation anxiety
	Expecting not to be held in mind	Not having enough	