Exploring clinicians' experience and understanding of psychoanalytic psychotherapy with children who are perpetrators of sexual violence: an interpretative phenomenological analysis

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CONTENTS

ABSTRACT

This thesis explores the experience and understanding of Child and Adolescent Psychoanalytic Psychotherapists working in a specialist provision with children who have perpetrated sexual violence. Part one reports a literature review carried out to establish and critically appraise relevant theoretical psychoanalytic literature concerning the origins of sexual perversions, as well as relevant research literature examining the experience of working with this population psychoanalytically. Part two reports a small-scale empirical qualitative research study. Five Child and Adolescent Psychotherapists participated in semi-structured interviews which were analysed using Interpretative Phenomenological Analysis. Results revealed four group experiential themes: (a) the experience of the therapist, (b) matters of approach and technique, (c) conceptualising the roots of perpetrating behaviour, (d) considering the function of therapeutic work. Working with enactments is found to be a fundamental part of the work as is the therapeutic use of the countertransference. The findings are discussed in detail, considering the complexity of the therapeutic process and managing patients' difficulties with intimacy, as well as how to engage meaningfully with powerful, disturbing clinical material, whilst allowing an understanding of its meaning and function to develop. Key aims of therapeutic work are explored including the integration of the victim and perpetrator parts of the patient's identity and the development of healthy aggression. Methodological, theoretical and clinical implications of the findings are examined with consideration of the study's limitations. In conclusion, the study highlights the need for perpetrating behaviours to be uniquely hypothesised and worked with using an applied version of traditional psychoanalytic technique. Long-term interventions are required to treat this patient group effectively, as well as preserving space for therapists to share and digest their experience within a supportive team.

Key words

psychoanalysis, psychotherapy, children, adolescent, sexual violence, perpetrator, harmful sexual behaviour, perversion, enactment

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1. INTRODUCTION

In this project I explore how Child and Adolescent Psychoanalytic Psychotherapists understand and experience work with children who have perpetrated sexual violence. I have sought the input of those working within a specialist, forensic psychotherapy[1] service offering consultation, assessment and long-term therapeutic intervention to children, young people and adults exhibiting problematic sexual, violent or criminal behaviour. This service is unique in its scope and history, offering psychoanalytically informed psychotherapy to this client group.

1.1 - Rationale

It has been suggested that 'around a third' of child sexual abuse is perpetrated by children (NSPCC, 2024). This is a cautious approximation with other significant research pointing to a higher percentage (Vizard et. al., 2007; Radford et. al., 2011). Many of those who have perpetrated sexual violence are thought to have a 'dual history', also having experienced sexual victimisation (NSPCC, 2024). Exact figures are difficult to establish, exacerbated by a culture of shame and secrecy that surrounds child sexual abuse/abusing.

Research has repeatedly demonstrated that children who are sexually harmful have often had multiple adverse childhood experiences (Barra et al., 2017; Hackett et al., 2013; Jensen et al., 2020). A meta-analysis of 'general explanations' of adolescent sexual offending challenged the notion of enactment being linked primarily to 'general antisocial tendencies' and supported the idea of formative adverse experiences, including sexual abuse history, as a significant linked factor (Seto & Lalumiere, 2010). Clinically, it is also observed that patients seeking support because of harmful sexual enactment have often experienced sexual victimisation (Nathanson et. al., 2021). It is important to note that whilst links are observed, both clinically and in the literature, the majority of children who have been sexually abused will not go on to enact further sexual harm (NSPCC, 2024).

[1] Forensic psychotherapy is 'the application of psychological knowledge to the assessment, treatment and management of mentally disordered offenders and patients who commit violent or destructive acts against others or themselves' (Yakeley, 2021, p.259)

Whatever the exact statistics and personal histories of these individuals, the research draws sobering conclusions, pointing to a crisis in child and adolescent populations. Evidence suggests that abuse occurs in cycles, with onward transmission transforming an individual once considered a victim into someone labelled a perpetrator. This is a disastrous outcome for all involved. High quality, effective therapeutic work is required to address the psychological components that underlie these cycles of abuse; treatment aimed at tackling the transmission of sexual trauma and the devastation it effects. Hearing from individuals engaged in this work is imperative in demystifying the process and understanding more about the mechanics of such interventions.

1.2 - Position of the researcher

For several years I worked in a service with children who had experienced sexual abuse and exploitation and for the last four years I have offered psychotherapy to those who have perpetrated sexual violence. I have seen the damage caused from both perspectives, spending time with the real people who exist beyond the pre-conceptions. It seems to me that neatly delineated identities of 'victim' and 'perpetrator' are unhelpful, attracting value-based judgements about those who deserve help and those who should be demonised. A driving force behind this research has been to support understandings of a highly complex patient group, challenging a tendency towards one-sided understandings of ‘forensic patients’. From my experience working with this specialism, I have witnessed how perceptions both within the general population, and the Child Psychotherapy profession, of children who perpetrate sexual violence, rely heavily on ‘splitting’ processes to draw their conclusions (Klein, 1946).

I intend this project to advance awareness of a patient group who, by-and-large, straddle a victim/perpetrator dichotomy artificially upheld in society. I consider these not to be exclusive positions, believing it to be more beneficial to examine how such concepts can be seen as aspects of the same person, as ‘interlocking roles’ (Bentovim, 1995). This idea supports a more ‘depressive position’ functioning, a key developmental achievement in

psychoanalytic theory, demonstrating a capacity to integrate complex, contrasting feelings (ibid.).

The world is becoming an increasingly divisive place with conflict and extreme political polarisation causing devastating effects for humanity. The proliferation of 'paranoid-schizoid' processes of splitting and projection (ibid.) does very little to address the underlying problem. This also applies to how we think about sexual abuse and abusing and associated ideas of 'goodies' and 'baddies', with people who do bad things often simply being considered as 'evil' and cast out of society. Whilst a desire to disavow extreme disturbance is understandable and allows temporary relief, it is ultimately fruitless in addressing the factors that contribute to the onset of such devastating acts. It is essential to look towards disturbance and darkness to find a way to effect change, hence the focus of this study. Psychological intervention in childhood has the potential to change the course of a child's life and deserves a wider breadth of research, unpicking some of its inherent complexities.

My personal position in relation to the subject matter will be considered throughout this thesis.

2.LITERATURE REVIEW

2.1 - Introduction

This chapter reviews published literature relating to children who have perpetrated sexual violence. It is divided into two main sections utilising a narrative and systematic approach. The aims are to:

- Detail the findings of a self-selected narrative review of psychoanalytic theory, grounding this study in a body of theoretical work.

- Approach empirical (quantitative and qualitative) and non-empirical literature systematically using relevant databases to understand more about the delivery of associated clinical work.

The following questions guided my reviews:

- **Narrative Review:** *'What does psychoanalytic theory reveal about the development of childhood sexuality and the origins of perversions?'*

- **Systematic Review:** *'What does the literature denote about clinical experiences and understandings of psychoanalytic work with child and adolescent perpetrators of sexual violence?'*

I will describe the methodology and report and discuss the findings separately.

A note on the semantics of 'perversion'

For the purpose of this thesis, I am defining sexual violence as a 'perversion' of consensual, age-appropriate sexual activity, causing harm to both self and other. In DSM-IV (APA, 1994) the term 'perversion' was updated and referred to as 'paraphilia', the:

> "[A]rousal in response to sexual objects and situations that are not part of normal arousal-activity patterns and that in varying degrees may interfere with the capacity for reciprocal, affectionate, sexual activity." (p.685)

Modern diagnostics create some distance from moralistic notions of 'right' and 'wrong' perhaps inextricably linked to the term perversion. However, as this is a psychoanalytic study, a discipline where the term retains clinical meaning and is featured in much of the pertinent literature, I employ this terminology critically. The epistemological positioning of my thesis considers perversion as something of psychological significance, which can be understood as a communication and expression of internal world dynamics.

2.2 - Narrative review

What does psychoanalytic theory reveal about the development of childhood sexuality and the origins of perversions?

I sought to answer this question through narrative means, using hand-searched data sourced from the Tavistock and Portman Library (online and in person). Due to the volume of relevant literature and the parameters of this project, this is not an exhaustive review, but a curated, critical examination of key writings. I explored ideas about the 'healthy' development of sexuality in childhood, considering foundational work by Freud and its Kleinian developments, before examining literature on the emergence of 'perversions'. Many of these authors have been selected due to the integral position they hold in the post-Kleinian school of Child and Adolescent Psychotherapy in which I have trained. Psychoanalytic papers on the development of perversions were selected largely based on recommendations from specialist clinicians, foundational texts frequently discussed in

forensic clinical team meetings, and papers from the training school reading lists. A 'snow-balling' approach (Ridley, 2012) was also used to gather complimentary literature.

A theory of psycho-sexual development

Sigmund Freud's (1905) theory of psycho-sexual development is both pioneering and controversial. He positioned the origins of sexuality in infantile experience, defining this as developmentally necessary for laying, or mislaying, the foundations for later mature patterns of sexual functioning. At the time, this radical idea was considered by some as perverting the 'innocence' of childhood, challenging an understanding of sexuality as established in later life (Zeuthen & Gammelgaard, 2010). The implications of his theory can still provoke discomfort in the modern day although the sense of a developmental path between infantile and adult sexuality is more widely appreciated (ibid.). Freud's overarching conceptualisation focussed on 'libido theory', namely the infant's desire to satiate libidinal drives through obtaining pleasure; a satisfaction achieved through the experiences of the body. He considered approximately the first six years of a child's life to present sequential developmental stages, shifting the focus of pleasure onto different areas of the body (oral, anal and phallic), before culminating in the turbulence of the Oedipal period, a stage to be grappled with to reach latency. The calm waters of the latency period were considered to offer respite from the more chaotic internal states of infancy; a time for the child to focus on the acquisition of knowledge through formal education before the re-awakening of infantile conflicts during adolescence, with newfound power due to the burgeoning capacities of the developing body. Freud's psycho-sexual phases and the focus on deriving pleasure independent of reproductive aim, posited the infant as 'polymorphously perverse', a pull towards pleasure positioned as integral to the psyche and life itself (Freud, 1900).

Object relations theory

Melanie Klein (1921, 1923), whilst interested in Freud's 'drive theory' and ideas on libidinal satiation, offered a fundamental shift of focus, centring the dynamic relationship between baby (subject) and primary caregiver (object). This theoretical position was informed directly by her work psychoanalysing children. Klein considered the infant's needs to be 'object

related', rather than predicated on independent satisfaction of a biological urge (the Id). These object relations mature through an unintegrated 'part-object' stage, where the satiating 'good' and withholding 'bad' aspects of the primary object's body (i.e. the mother's breast) are unconsciously separated, before reaching a more complete appreciation of the entirety of their object. Klein (1946) detailed the infant's shifting feelings of both love and hatred towards the breast, recognising these emotions as existing side-by-side in the internal world of the infant, but needing to be 'split-off' and communicated through 'projective identification', to manage unbearable anxiety. She termed this as the 'paranoid-schizoid' stage of development, something essential to the prosperity of the psychically fragile infant. Her emphasis on destructive, hateful urges, present from birth, an extension of Freud's (1915) theory of the death instinct, recognised how central aggression was to human existence, positioning it as fundamental to meeting one's psychological and material needs. Klein's (1946) theory posited a maturational shift towards a more integrated 'depressive position' functioning where the co-existence of love and hatred towards the object could be tolerated. A significant lack of integration of the more destructive aspects of the self and over-reliance on primitive splitting was seen as a precursor to destructive behaviour in later life. It could be argued that a lack of working through of fundamental anxieties contributes to levels of splitting and projection seen in the presentations of children who exhibit sexually violent behaviours.

The Oedipus complex

Both Freud (1909) and Klein (1945) placed emphasis on the pivotal moment in a child's life characterised by Oedipal conflicts, a time of psychic complexity where a child grapples with the realisation that they are not the sole sexual focus of their desired opposite sex parent, nor bound in an exclusive relationship with them. With this developmental stage comes an understanding that they are in competition with the same sex parent for the affections of their object and that the relationship they had considered binary is triangular. The awareness of an external relationship between the parental couple leaves the child feeling excluded, prompting a painful realisation that "the parents' relationship is genital and procreative; the parent-child relationship is not" (Britton, 1989, p.85). Such revelations upset the child's sense of place in the world, challenging an omnipotent belief of ownership of

their object and destabilising a narcissistic notion of centrality, which takes its toll on their fragile developing psyche. In optimum conditions, this psychological disturbance requires the containment of an attuned caregiver to aid psychic metabolisation (Bion, 1962). Whilst Freud considered there to be a sequential working through of the disillusionments of the Oedipal situation to reach a sense of resolve and a subsequent settling into latency, Klein considered there to be less of a permanent mastery of such complex psychic dynamics, stressing how they are continually revisited as the struggle between hate and love can never truly be resolved.

In a good enough situation, a burgeoning recognition and acceptance of external reality, as opposed to internal fantasy, supports maturation pivotal for the child's psychological wellbeing in later life. Young (2001) characterises this period of psychic negotiation as a:

> "Precondition for being a responsible person who can love and make moral and intellectual judgement […] and be capable of integrated insights and deep concern for others." (p.29)

This is something with which those exhibiting sexually violent behaviours seem to struggle, perhaps linked to their difficulty managing Oedipal conflicts. Klein (1935) saw the negotiation of the Oedipal situation as pivotal in developing the psychic integration characteristic of the depressive position, a toleration of external reality without relying on splitting and projection, to shield oneself defensively from anxiety. The recompense for surviving this conflictual stage of life being a "capacity for symbol formation and rational thought" (Young, 2001, p.30). A journey from the fantasy world of the infant to a more reality-based appreciation of the external world brings with it:

> "A capacity for seeing ourselves in interaction with others and for entertaining another point of view whilst retaining our own, for reflecting on ourselves whilst being ourselves." (Britton, 1989, p.87)

This capacity is a developmental milestone, important for engaging in public life, upholding the respect and awareness required for maintenance of society. An internal sense of oneself

in triangular relationships with others supports the development of realistic relationships, remaining aware of their limitations and formulating the difference between internal and external experiences. Most importantly, this means that internal desires and impulses can be symbolised and thought about, rather than enacted. This is of central importance when considering the problems of enactment and struggles with thinking exhibited by the patients discussed in my thesis.

Symbolisation

Hanna Segal (1957) writes about the developmental achievement of symbolisation and the bearing this has on a child's experience of the world. The realisation that every impulse and desire cannot be satisfied means omnipotent defences are challenged. Ideally, fantasies thwarted by the moral restrictions of society and the development of its internal counterpart, the superego, find a way to be explored through symbolic representation.

A capacity to symbolise effectively is aided by the availability of a containing and supportive environment. This means primary caregivers who can support the child in tolerating the continual disillusionment of omnipotent fantasies and manage associated psychic pain and distress. The achievement of symbolic representation allows for a capacity to transform an impulse into a thought, something akin to that which Bion (1962b) considered as being achieved through the application of 'alpha function'. A capacity to symbolically work an internal experience through, deters a pull to act-out through bodily means. As is perhaps the case with sexually violent individuals, acting out offers a solution when there is 'symbolic impoverishment' (Kohon, 2010). It can, in some instances, be prompted by unconscious compulsion to repeat or re-enact a situation that cannot be thought about, offering the potential for understanding in its continued presence (Freud, 1914).

Perversion as solution

Much of the theory exploring the aetiology of perverse acting out situates its origins in an inability to navigate the complexities of the Oedipal situation. In 'A Child is Being Beaten', Freud (1919) draws reference to the defensive function of perversion as a way of combatting

the anxieties of the Oedipal situation, something McDougall (1972) takes up as offering a psychotic solution through the eroticisation of castration anxiety. This way of inverting an experience of intolerable vulnerability into a sense of mastery or control, provides a sense of a solution through deviancy.

Welldon (2011) also theorises about complications in the individuation process and its bearing on the establishment of perversions. She describes how a perversion can be seen as a manic defence against depression rather than a clinically diagnosable disorder, seemingly offering a solution to the anxiety of psychic disintegration at the disillusionment of a child's Oedipal longings. She considers how individuals with a perversion lack the ability truly to cathect their object, relating at a part object level, something Klein (1946) would consider as a stalling in of a child's development.

Glasser's (1979) conceptualisation of the 'core complex' illuminates the universally experienced psychic dilemma of the infant attempting to find their place in relation to a primary attachment figure, navigating issues of closeness and separation. There is a desire to be in complete union to manage paralysing fears of abandonment, as well as a terror of being engulfed and annihilated by this oneness. These anxieties leave the child in an incredibly difficult position. The perceived threat to psychic homeostasis from being too close can prompt aggressive, destructive urges which, if acted upon, would bring about complete abandonment through loss. Glasser posits that in perverse individuals these anxieties can be particularly intense. A defensive solution is to unconsciously sexualise aggression, transforming it into sadism. In establishing a controlling, sado-masochistic situation exhibited through perverse bodily enactment or relational dynamics, the link with the object can be preserved. Destructive desires appear mitigated by the fusion of aggression and sexuality. In Glasser's clinical experience, perverse patients have experienced a particularly problematic relationship with a narcissistic primary caregiver, at times intrusive, at other times neglectful and unable to prioritise the child's needs above their own. This dynamic appears to amplify their claustro-agoraphobic anxieties. It seems likely that the legacy of these early dynamics, alongside struggles with a capacity to symbolise and choose thought over action, can lead to a propensity to unconsciously seek solutions through enactment.

Impact of trauma

Much of the theory on perverse acting out considers the impact of trauma, abuse and the failure of parental protection. In his writing about abuse, Freud (1893) noted how trauma "acts like a foreign body which long after its entry must continue to be regarded as an agent that is still at work" (p.6). This underlines the place that early traumatic experiences can hold in the aetiology of perverse sexual enactment. Stoller (1975) elaborates on this, suggesting that hostility is at the centre of perversion; an anger borne in the child through a sense of victimisation originating in the relationship with their primary caregiver. He writes that "in perversion, trauma becomes triumph" (p.59), meaning there is an unconscious sense of reversing their experience. This understanding of perversion as an erotic form of hatred informs an idea of enactment as revenge or punishment. The re-enacting of a traumatic experience allowing the individual the relief of a different outcome where they ascend the ranks from victim to victor. Limentani (1984, 1989) supports this idea, positioning perversion as an attack on an unbearable reality and as being inherently defensive in nature. He describes how early traumatic experiences cast a shadow on the functioning of later life. Haunted by the memory of vulnerability, the development of a revengeful sexual fantasy proposes a possible solution through delinquency, offering excitement in the process.

Anna Freud's (1936) theory of identification with the aggressor considers the potential for the individual who has endured traumatic experience to "transform himself from the person threatened into the person who makes the threat" (p.113). Passing on an experience of fear and pain allows an evacuation of those feelings into the other, a defensive solution to psychic disturbance that Klein (1946) described as projective identification. Donald Campbell (1989) notes how this temporary, defensive solution to internal distress can become addictive, the enactment offering a repeated 'hit' of power over an internal sense of vulnerability or hopelessness.

The bad object

Meltzer (1973) details how the child internalises the experience of being parented by a seriously disturbed caregiver, leading to the formation of a sadistic super-ego. He notes the tendency for allegiance with this 'bad' internal object and the dismissal of the 'good' object in infancy, developing a blueprint for deviant and perverse states in later life. Williams (1997) later described this as turning to a destructive alliance internally, as a vote of no confidence in the 'good' internal object. The internal promise of becoming a powerful victor in light of past humiliation appears too tempting to be in touch with the reality of the destruction caused in its wake. Joseph (1982) might characterise such functioning as an 'addiction to near death'. This defines perverse acting out as an addictive solution to manage the painful anxieties underneath, a tendency towards destruction perhaps akin to alcoholism or anorexia.

2.2.1 - Discussion

As outlined, psychoanalytic thinking about perversion has developed from 'drive theory' initially postulated by Freud (1915), to something understood relationally, fitting with Klein's (1921, 1923) theory of object relations. Perverse enactments are described by multiple authors as offering a 'solution' to experiences of vulnerability and victimhood experienced in childhood, with particular attention paid to disturbance in the relationship with the primary caregiver and its implications for the resolution of Oedipal conflicts. It is noted how struggles in negotiating this developmental stage can result in the stalling of a capacity to symbolise, with the literature suggesting a resultant pull towards action instead of thought. The importance of a containing environment is underlined as vital to the successful navigation of this pivotal moment in a child's development. Thought is given to the emergence of addictive processes involving the sense of mastery achieved by projecting disturbance through enactment, as well as the implications of an over-reliance on an internal 'bad' object in establishing perverse practices.

The findings of this narrative review suggest that early disruptions of development, especially those of a traumatic and abusive nature, hold vital sway over problems of sexual

acting out in later life. This idea supports the importance of my research and the need for therapeutic intervention with children. However, it is important to note that this is a typically psychoanalytic perspective and does not represent views and opinions from other schools of thought. For example, 'rational choice theory' (Thomas et. al., 2022), considers the enactment of sexual violence to involve a rational, conscious, cost/benefit analysis conducted by the potential perpetrator. There remains a lack of clarity in the reviewed psychoanalytic literature, disentangling why, for some, a perverse fantasy remains a thought as opposed to being physically acted out. Ideas about antecedent factors are offered but there is a sense of incompleteness, e.g. does the link between failures in symbolisation and acting out really capture the phenomenon of perverse enactment in its entirety? Complementary empirical research is required to aid discussion and understanding of causality and correlation, particularly exploring the place of 'external world' factors.

The availability of a secure holding environment, whether the presence of a 'container' (Bion, 1962), a 'secure attachment figure' (Bowlby, 1973), or a 'good-enough mother' (Winnicott, 1953), is unavailable to many children for a multitude of reasons, often linked to generational repetitions of trauma and its implications for parental mental health. As Fonagy (1999) explains, if "internal experience is not met by external understanding; it remains unlabelled and confusing, and the uncontained affect generates further dysregulation" (p.12). The reviewed papers do not account for the realities of oppression and injustice or consider what additional complexities can play out at the intersections of race, class etc., and how these might influence development. These factors hold unquestionable influence on a child and their trajectory and deserve further consideration. It is unclear what these psychoanalysts thought about how diversity and difference correlate with the development of perversions and unconscious fantasies, largely because this discourse was mostly unheard of in psychoanalytic circles at the time. This absence highlights a crucial area in need of further exploration.

2.3 - Systematically informed review of treatment literature

What does the literature denote about clinical experiences and understandings of psychoanalytic work with child and adolescent perpetrators of sexual violence?

My second aim was to conduct a systematically informed review of published literature to address the above question, bearing in mind the hierarchical principles of research evidence (Ingham-Broomfield, 2016). I first looked for 'gold standard' quantitative studies, starting with randomised controlled trials, non-controlled naturalistic studies and cohort studies, before broadening out to search for formal empirical qualitative studies and finally a wider exploration of all other published qualitative literature including individual case studies.

2.3.1. - Methodology

Inclusion/exclusion criteria

To answer the review question, I defined my inclusion criteria as follows:

- Literature with a primary focus on clinical work with children and adolescents (aged 0-25) who have perpetrated sexual violence.

- Literature centring a psychoanalytic modality or psychoanalytic ideas.

As the focus is on understanding the unique ways of working integral to a psychoanalytic approach, studies that did not include a primary focus on psychoanalytic concepts or where the treatment modality was not explicitly psychoanalytically or psychodynamically informed, have been excluded. Studies that lacked specificity, including a poorly defined group of 'psychotherapists' were also excluded. Papers with a focus on aggression and violence rather than specifically sexualised violence were also excluded, as were papers that did not address the target age range. I discounted unpublished dissertations due to issues with access rights.

Search strategy

To capture pertinent literature, the full range of EBSCO Host databases available through Tavistock and Portman online library services were utilised (APA PsychInfo, APA PsycArticles, APA PsycBooks, APAPsycExtra, Psychology and Behavioral Sciences Collection, PEP Archive, Education Source, ERIC, SocINDEX, MEDLINE, CINAHL, GreenFILE and LISTA). This was necessary as suitable research findings may have been published in journals of different disciplines, e.g. social care, criminal justice, legal etc. Additionally, literature was hand-searched drawing from recommendations and bibliographic references within previously sourced texts.

I identified key terms fundamental to the question as 'psychoanalytic', 'child/adolescent', 'perpetrators' and 'sexual violence'. I then considered synonymous or similar terms that might produce additional findings. I considered how words might be truncated to capture associated terms, using the asterisk (*) to access a wider selection of papers with marginal variations on the theme (e.g. psychoanal* to include psychoanalysis, psychoanalytic, psychoanalytical etc.). I used inverted commas around key terms I wanted to be searched in their entirety e.g. 'child psychotherapy'. I accounted for variations in spelling between American English and English by using the wild-card symbol '?' e.g. 'harmful sexual behavio?r'. The APA Thesaurus of Psychological Index Terms was useful in suggesting additional synonyms. In the initial stage I used the Boolean operator 'OR' to cover as much ground as possible. The search criteria are detailed in Table 1 below, with the initial number of results found:

Table 1: Search terms and initial number of results:

Psychoanal*	Child*	Perpetrat*	'Sexual violence'
Psychodynamic	Adolescen*	Abus*	'Sex* offen*'
'Child Psychotherapy'	Teen*	Offend*	'Harmful Sexual Behavio?r'
'Psychoanalytic Psychotherapy'	'Young People'		Rape
	Youth		'Sexual Abuse'
	Juvenile		'Sexual Assault'
365,956	9,922,517	1,203,303	213,864

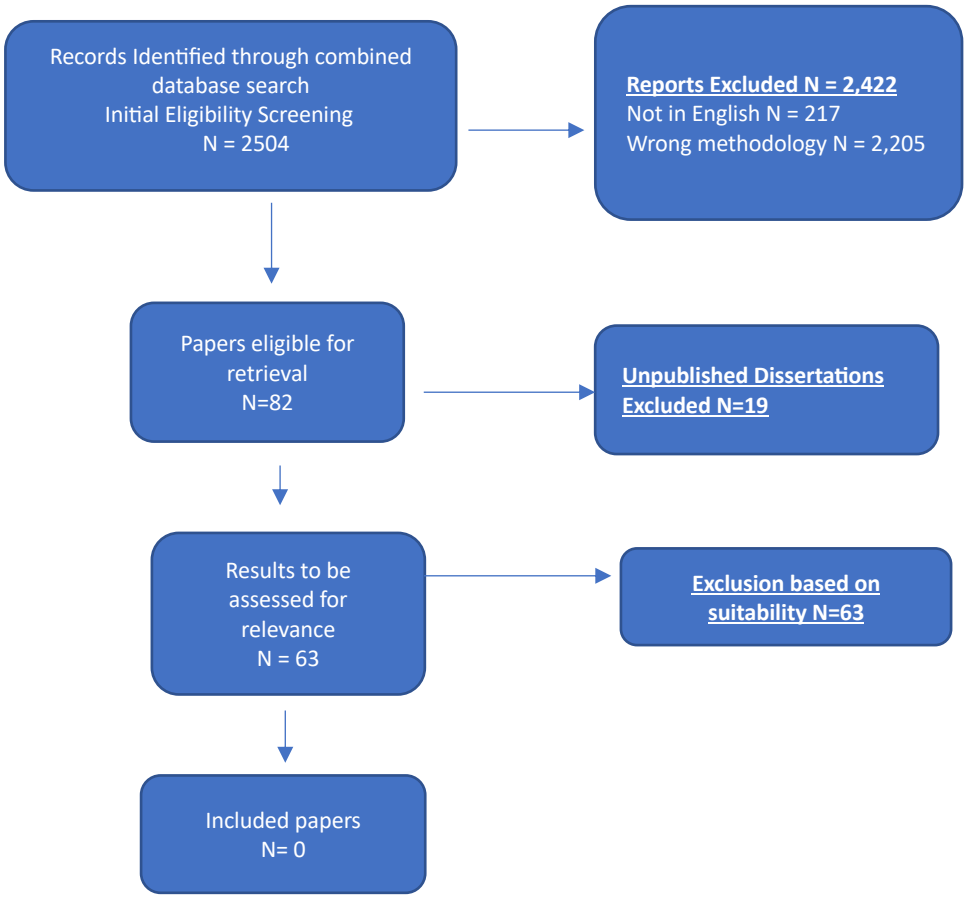
Next, I combined these four searches to narrow the results, using the Boolean operator 'AND', filtered for results in the English language, then shuffled findings to rank according to relevance. As I was initially looking for quantitative findings, I then included this as a specific limitor within the 'methodology' drop down box. I did not include any further limitors at this stage as there were a relatively small number of results (N=63). I reviewed the findings, considering titles and abstracts to assess relevance.

I repeated the search replacing the 'quantitative' limitor with 'empirical' methodologies. As this produced a much wider set of results, I used the age limitors of 'childhood birth-12 years', 'adolescent 13-17 years' and 'young adult 18-29 years' to capture the demographics treated within the service of interest.

2.3.2 - Results

The process of the search and my findings are summarised in Figure 1 below. As illustrated, my first search revealed no relevant empirical studies.

Figure 1: PRISMA diagram of search for empirical studies



When broadening out to accommodate empirical qualitative research, literature remained scarce. My search revealed only one study by Shevade et. al. (2011) exploring clinicians' experiences working with children displaying sexually problematic behaviours and the complex set of feelings emerging in the countertransference. Authors draw reference to the power of projective processes, evoking feelings of powerlessness, sadness, being deskilled, and most disturbingly of all, a sense of themselves as abuser. The study highlights the importance of practitioners remaining sensitively in touch with the impact of such work, examining the systemic anxieties stirred up during its delivery, and emphasising the need to self-manage responses to safeguard both child and therapist. The research makes use of Reflexive Thematic Analysis to analyse the data from the nine participants. Arguably, a study designed as an 'exploration of therapists' reactions' would have benefitted from employing Interpretative Phenomenological Analysis to fine-tune the focus to the specific, idiosyncratic details of individual experiences. It could have also been interesting to understand more

about how the therapists' identity influences their experience, e.g. gender or length of time in the service.

Contextualising the lack of empirical research

The systematic review has highlighted the dearth of empirical research addressing the specifics of my question. It is notable that pertinent treatment research, including randomised controlled trials, exists from other disciplines such as multi-systemic therapy (e.g. Borduin et. al., 1990) and cognitive behavioural therapy (e.g. Carpentier et. al., 2006). The psychoanalytically orientated empirical studies that did not match the search criteria included a modest number that looked at treatment of 'victims' of sexual abuse (e.g. Price et. al., 2004). Whilst this was predominantly focussed on adult survivors of childhood sexual abuse, a small handful of child studies exist, including a systematic review of effectiveness of psychoanalytic methods with child survivors (Parker & Turner, 2014). There was also a number of psychoanalytically informed studies detailing the treatment of adult perpetrators of sexual violence (e.g. Becker & Hunter, 1992).

It is important to question why there is this deficit of relevant psychoanalytically informed literature. As noted in the narrative review, the notion of childhood sexual deviance is controversial. Whether people want to think about children who have caused sexual harm is an important question. As Music (2021) notes, it may be too societally uncomfortable to think about children in this way, making it particularly difficult to navigate the bureaucracy of large-scale quantitative studies and secure the necessary funding and ethical approval for research. A systematic review of psychoanalytic treatment with child sexual abuse survivors (a category into which many child perpetrators would also fall), suggests that this subject is somehow more bearable, perhaps reinforcing a pull to separate out and prioritise 'victims' in line with mainstream societal perspectives. There may also be the avoidance of an unbearable recognition of the potential to cause harm, something Chasseguet-Smirgel (1983) describes as present within all of us. The lack of research could be considered along the conceptual lines of a perpetrating identity not being fixed in childhood and it therefore being considered politically inappropriate to explore sexual perversion in relation to children. Perhaps this is why there are more studies in adult populations where there is

arguably a greater solidification of identity and, rightly or wrongly, a 'criminal' label is more easily applied.

2.3.3 - Case study evidence

Due to the limited findings, I broadened the literature search to incorporate clinical case studies and texts focusing on clinical practice. Whilst the 'case study' approach historically accounts for the majority of research in the psychoanalytic field (Midgley, 2006), the search revealed a relatively small amount of relevant literature, with much of it originating from a group of clinicians working in Central London settings. I will now go on to discuss the 20 papers retrieved.

Multiple authors (e.g. Campbell, 1994; Sinason 1996; Hodges et. al., 1994) consider the psychic impact of a child's experience of abuse and the part that this plays in a perpetuation of abusing behaviours. Woods (2016), for example, describes the emergence of abusive behaviours as a correlate of individual experiences of abuse and its internal world implications. Using the example of nine year-old Rick, and drawing reference to Bentovim's (1995) theory of a 'trauma organised system' in children who have experienced abuse, Woods describes how, by sexually abusing Rick, his father 'neutralised' an internal caring capacity meaning the prevalence of internal abusive dynamics. This led Rick to externalise his experiences through the abuse of another, as well as transferentially establishing his therapist as the victim during treatment. Woods details how he contained these dynamics through his presence as a non-abusing adult figure to be re-introjected in treatment, and how the therapeutic use of play allowed Rick to find symbolic representation for some of his internal conflicts and process his early experiences.

Sinason (1996) is similarly interested in what makes an abuser go on to abuse, also discussing the impact of the internal world on how one manages stressful situations. She considers the implications of trauma and distress on how a 'forensic' individual might respond to a situation, as opposed to a person with an alternative history. She states there is little surprise that the sexual abuse many abusers have suffered shatters their functioning and informs a need to transmit pain and other complex emotions, leading to abuse or

perversion that can become compulsive. Sinason details clinical work exploring the painful histories of individual abuse victims who turn to abusing as a psychic solution to their pain, often linked to problematic parental dynamics and unresolved Oedipal issues. She portrays a convincing argument about the way in which psychic damage can lead to an unconscious belief that abusing holds the answer to distress.

Hodges et. al (1994) offer reflections on their work at Great Ormond Street Hospital, specifically their extended psychotherapy assessments with adolescent male abusers. Breaking with the psychoanalytic tradition of long-term work, they offered a 12-week intervention with eligible participants. Their paper utilises clinical vignettes to think specifically about the internal factors at play within children who have not themselves been sexually abused (reportedly) but have sexually abused others. They discuss the risky nature of this work and the importance of the external holding environment to contain the adolescent as they explore complex aspects of their experience, noting the potential increase in suicidality during this time. In a further break from traditional ways of working they discuss their understanding of the benefits of using structured tools such as questionnaires, alongside analytic techniques to encourage insight difficult to procure through short-term therapeutic work alone. The authors discuss their hesitancy in using transference interpretations in such brief work but discover an ability on behalf of some boys to make good use of this. There was an idea that some internalised a capacity to stop and think, rather than resorting to acting out as a result.

Whilst recognising the importance of considering the transference with a patient group who are risky and at risk, Woods (2003) deems it insufficient to follow rigidly analytic ways of working, detailing the need to defer sometimes to external reality. He recognises that other therapeutic techniques including directive CBT approaches can also be helpful, however this does not supplant a need for deeper work truly to reach the patient and understand the complexity of their functioning.

Lanyado et. al. (1995), discuss an extended assessment with 12 year-old Frank who *had* experienced sexual abuse before going on to abuse. The authors stress the importance of a thorough assessment to understand potential responsivity to treatment and the risk a child

poses to others. This is an imperative Campbell (1994) takes up, underlining the importance of good assessments in considering whom to treat psychoanalytically to help break the cycle of sexual abusing in childhood and later offences as an adult. He centres his thinking around clinical vignettes taken from the assessment of adolescent sexual abusers, centralising the importance of incorporating a developmental history to formulate properly a differential diagnosis as abusers are not identical. He discusses the interference to development caused by sexual abuse and how this alters the child's developmental trajectory and the onset of latency, compromising the establishment of regulatory defences such as shame that might ordinarily encourage self-control, and leading to maladaptive processes. Keogh (2012) furthers Campbell's ideas, arguing heterogeneity amongst sexual offenders and the need for modifications to treatment to facilitate unique understandings and meet individual needs. He foregrounds a conception that the internal world of the offender holds the key for understanding the cause and function of behaviour, the ultimate task being to understand what the behaviour affords the patient and to what it offers a solution.

Campbell (1994) notes the need for careful examination of the transference with this group, as often there is an expectation that the therapist will be both intrusive and rejecting, a re-enactment of parental dynamics. This means a likelihood of masked compliance and co-operation in keeping with their experiences of being parented. This highlights the need to understand internal conflict first before any attempt is made at behaviour change, as the abuser's 'sneakiness' needs to be conceptualised. Campbell emphasises the primary importance of this, otherwise any change is short lived. In a later paper (Campbell, 1996), he argues the need for long-standing psychoanalytic treatments for 'delinquent' patients, and the insufficiency of quick fix behavioural solutions to resolve 'bad behaviour'.

Woods (2003) also draws reference to transference dynamics, describing how there will always be an invitation into sado-masochistic ways of relating, something common for these children because of their own early experiences. He states the need for the therapist not to use interpretations defensively, although this can be a tempting response to the provocations of the client group. He describes how psychoanalytic interpretations have the potential to be used as weapons and how this can be counterproductive to the delicate nature of such work with complex, emotionally fragile patients.

Kahr (2018) recognises the function of psychotherapy to interrupt a cycle of abusing, in part by demonstrating a considered response to the patient's challenging enactments. He draws attention to viscerally challenging transference dynamics, noting how the patient's early experiences of abuse "barge into the consulting-room, before the psychotherapist has opened the door, providing archaic evidence of the need to 'break and enter'" (p.101). He considers that being open to working with the liveness of such moments is integral to successful treatment.

Breer's (1987) 'The Adolescent Molester' adds a more instructive focus to the literature (see also, Rich 2011). In his discussion he notes a tendency for 'pre-oedipal transferences' in this patient group, with the need to separate professionals into all bad or all good. He notes how shiftable the transference can be, oscillating between good and bad throughout treatment. He also describes 'paranoid transferences', a belief that the therapist is going to cause harm deliberately and is a powerful persecutor. Breer details a specific difficulty for male therapists when working with a patient who has a history of being seduced by male figures. He considers how this confusing relationship, characterised by hatred but also affection and attention, may be sought out in relationship with the therapist. This often plays out differently with female therapists, with something of the difficult relationship with the mother coming to the fore in the form of a 'sadistic transference'.

Repetitions of trauma and cycles of abuse is something Rolene Szur (1983) focusses on in reference to neglected children looking to right the wrongs of their experience by unconsciously, and perhaps sometimes consciously, seeking out distorted, abusive relationships with adults and other children. She postulates a tendency for 'looked-after' and adopted children to develop a sense of themselves as the "waste product of a bad intercourse" (p.56) rather than borne from a creative coming together, and how this sentiment can become mobilised to destructive ends. She goes on to describe how victim and perpetrator roles move around in the therapeutic transference and the need to remain cognisant of this to understand the workings of the child's internal world which accommodates both identities.

Music (2021) also takes up the idea of conflicting aspects of the child's identity and how there can be a pull to splitting in professionals to deal with uncomfortable truths. He names how hard it can be to look at the horror of what children can do, whilst retaining a sense of hopefulness, arguing the need for nuanced thinking to achieve positive outcomes. He describes the effect that such cases often have on professional networks, describing them as 'hot potato' children that stir up such anxiety through their troubling identities, that no one wants to handle them, leading to issues of insufficient containment. Later in his paper he draws reference to neuroscience, noting what happens when defences become addictive.

A focus on perverse sexual enactments and the link to addictive processes is the focus of Nathanson's (2021) paper from the same edited volume. He describes his experience working with adolescents struggling with an internal relationship involving "reliance on a bad object which both enables and relies upon sexually perverse enactments" (p.138). He describes how managing emotions through sexualisation of hatred and aggression appears to offer a solution to 'core complex' anxieties. According to Nathanson, the theoretical grasping of this as an addictive cycle is fundamental to understanding perpetrators and is parallel to the 'solution' other addictions such as drugs or alcohol appear to offer. He posits that the aim of psychoanalytic work is to help an individual develop an ability to tolerate deep-rooted 'core complex' anxieties. He goes on to define how patients can find addictive comfort in an internal state characterised by an absence of hope. Such addictive leanings can result in a tendency towards 'pressing the fuck-it button' as a response to an experience of trauma or victimisation that allows a shift from passivity towards action. Nathanson considers this as not simply an identification with the aggressor but a more pervasive "triumphing over any abuse by nullifying it, inoculating themselves against any future or past pain in a world where love is hate and abuse is love" (p.141). He examines ways the addictive nature of such enactments can be clinically worked with by helping the patient develop an awareness of the process involved, slowing down the cycle and allowing greater room for thought.

Horne (2013, 2016) describes how, for clinicians, there can be anxiety about being unable to contain the 'outrage' at what these children have done, something so controversial and visceral that it becomes hard to hold in mind their victim and perpetrator parts. She writes

that for some a 'disgusting' or 'bad' identity seems preferable to being in touch with the vulnerability inherent in their victimhood. She underlines the importance of supporting the thinking process of this work through supervision and consistent network working, particularly as these cases tend to challenge thought due to their emotionally challenging and visceral nature, something Allan (2016) also emphasises.

In an earlier paper Horne (2001b) discusses a trend in this patient group of unprocessed pre-verbal trauma, which is corporeally stored, a result of the underdeveloped ego being overwhelmed. She considers how this can lead to a use of the body in unconscious repetition compulsion and the need to adjust technique from traditional forms of psychoanalytic approach to think more about the body (see also Horne, 2001a). She emphasises the therapist's need for negative capability (Bion, 1970), the uncomfortable experience of tolerating what is happening in the room without prematurely acting, to understand truly the perverse psychic working of these patients, underlining that pacing is key.

Extending a consideration of the effect of overwhelm on the development of the ego in childhood, Parsons (2009) turns her attention to the superego. She considers the importance of working with the different aspects of a child that acts out violently, the need to see the non-perverse as well as the perverse parts to help them to expand their sense of themselves as more than just dangerous and condemned. She considers this as pivotal to the restructuring and reconstitution of the superego, allowing an internal shift and integration, which requires a considerable amount of work.

2.3.4 - Summary and discussion

The aim of this systematic review was to identify published research considering clinical experiences and understandings of psychoanalytic work with child and adolescent perpetrators of sexual violence. As highlighted, there was a dearth of research studies indicating the need for a body of empirical evidence to back-up this important clinical work. Only one qualitative study was found which discussed a range of anxieties and complex

feelings evoked in therapists' undertaking this work. These findings have important clinical implications if they can be replicated or substantiated by further studies.

Although, the review identified appropriate case studies, 20 cannot be considered a large evidence base. This again highlights the scarcity and need for further research. The case study literature considers aspects requiring attention for developing clinical understanding and informing best practice. Many focus their writings on the function of the individual's perpetrating behaviour, tracing this back to the standing of their internal world and its shaping through early experiences often involving sexual/non-sexual abuse. Some authors elucidate how victim and perpetrator dynamics become enacted in the transference and theorise the patient's compulsion to repeat as an unconscious attempt at mastery of a past experience of powerlessness. This adds to the existing psychoanalytic thinking summarised in the narrative review. Examinations of transference dynamics pay attention to the visceral experiences stirred up through unconscious processes and the impact on the therapist.

Some authors consider the function of treatment as a way of slowing down cycles between thought and action. Others pay attention to the external world and the need for creating a safe enough environment for the work to be held, both within a therapeutic service, and also in relation to the wider network of the child. There are some differing thoughts about duration of an 'effective' treatment, but a consensus on the need for preservation of thinking spaces to be able to process its complex features. An examination of technique and adjustments to traditional ways of working is considered in attempts to meet the heterogenous needs of the patient group. Here, the beginning of important additions to the existing psychoanalytic theory from the narrative review emerge, thinking more about the link between theory and clinical practice.

Much of the reviewed literature focuses on perversion as a solution to internal world matters, drawing attention to the impact of adverse childhood experience on the development of problems of enactment. This is understandable, however there is little mention given to most individuals who do not go on to 'identify with the aggressor' (Freud, 1936) through the passing on of their traumatic experience. What are the factors that might make an individual more likely to progress in this direction? Some ideas and theories stated

appear quite dated, for instance those that prioritise phallocentric notions such as 'castration anxiety' which are difficult to reconcile with contemporary feminist and post-modernist ideas. There is a tendency to focus on the maternal dyad as a contributing factor in much of the disturbance in perverse individuals, an idea that not only pathologises the mother above other caregivers, particularly in relation to a much less present father, but also assumes a hetero-normative model of parenting that is not the reality for many individuals. There also appears to be a prioritising of a specifically Western approach to parenting and child-rearing which is not universally applicable.

Moreover, boys and young men are largely the focus of these case-study examples, an understandable leaning as male patients form the majority of those treated for issues relating to sexually harmful behaviours (Woods, 2003). There is very little written about sexual violence perpetrated by young women and girls, something that does happen but does not draw the same focus in literature. When women's perpetration is discussed it tends to focus instead on harm caused to the self (Welldon, 2011). This is largely unexplored in the papers that form this review and could benefit from further examination.

2.3.5 - Conclusion

The theoretical thinking detailed in the narrative review, as well as that derived from case studies, has shaped the clinical landscape for work with children who have perpetrated sexual violence. Whilst it is a small body of literature, it has allowed opportunities for these individuals to receive the focus they require and access suitable treatment to address the underlying issues behind their enactments. This is extremely important for reducing levels of sexual violence, breaking cycles of abuse and mitigating further suffering.

Historically, psychoanalysis has placed greater emphasis on the 'case study' as a tool for communicating the individual research of the consulting room, dating back to Freud's case histories such as the 'Wolfman' (1918) or 'Little Hans' (1909). The tradition of publishing qualitative research that does not aim to answer questions neatly but communicate an experience of a phenomena is complicated in the modern day when the evidence sought for service-level decision making is predominantly quantitively focused. Many maintain that the

case study is the most appropriate research methodology for capturing something close to the live exchange of the psychoanalytic consulting room (Midgley, 2006), but there is a call from others to modernise, converging with related disciplines such as clinical psychology or psychiatry, to ensure the evidence base for psychoanalytic practices does not fall behind (Fonagy, 2009). Perhaps there is a need for a both/and approach which maintains the traditions of psychoanalysis well established over the years, yet recognises the current social context and need for 'hard' evidence.

In order to align with the requirements of modern health care systems, it would seem advisable for single case studies to be substantiated by case series, gathering the perspective of treating clinicians. Formal qualitative studies conducted by 'objective' researchers into the experience of both clinician and patients, would also be beneficial, highlighting that, in order to understand a phenomena, the work should be considered from a variety of angles. The following small-scale study will contribute something important to a field where there is a dearth of literature and be part of building an empirical evidence base to support the unique contributions and understandings psychoanalytic psychotherapy can offer this population.

3. EMPIRICAL STUDY

3.1 - Introduction

This empirical study will explore clinicians' experience of psychoanalytically oriented psychotherapy with children and adolescents who have perpetrated sexual violence.

The study aims to:

- Seek insight from a group of psychoanalytic psychotherapists' experience, demonstrating the thinking and approach fundamental to developing their nuanced understanding.

- Prioritise a position of thoughtfulness and deeper knowing, allowing heightened attention to conscious and unconscious processes and how these are handled in psychotherapy.

Research illustrates the need for good quality, thoughtful intervention with a patient group of children who have perpetrated sexual harm (Hackett, 2014). 'Psychotherapeutic approaches' are recommended within NICE guidance (2016) for treatment, however there is minimal literature focusing specifically on psychoanalytically informed work (see literature review). This study will begin to address the dearth of empirical studies with the intention to further research/practice links and demystify this often misunderstood area.

This project is a starting point, with a greater volume of research required. Ideally this would include studies examining the experience of service users as well as evidence of treatment efficacy derived from randomised control trials and naturalistic outcome studies. This could be helpfully disseminated within psychotherapeutic communities including generic provisions such as CAMHS. Learning from services with specific expertise could also prove helpful in supporting colleagues from different settings, including social work, probation, police, youth workers and support staff.

The following research questions were selected as a skeleton for the interview process, with further questions posed where appropriate:

- Can you tell me about your experiences of working with children or adolescents who have a history of perpetrating sexual violence?

- What are your thoughts on and associations to the term 'perpetrator' as it relates to the patients you see?

- Are there unique features that you have observed and thought about in relation to the work?

- What would you consider to be a successful treatment with this patient group?

3.2 - Method

3.2.1 - Study design

The study follows a qualitative approach. This was appropriate as qualitative enquiry is geared towards capturing the minutiae of an individual's lived experience and has the capacity to capture the more subtle processes of a complex, multi-faceted treatment like psychoanalytic psychotherapy. Work with children with a history of troubling enactments is multi-layered and highly complex, therefore "sacrificing breadth for depth" honoured the intricacies of such a venture (Smith & Osborn, 2003, p.56).

Interpretative Phenomenological Analysis (IPA) has been used to analyse my data. IPA is a methodology with an epistemological approach foregrounding individual meaning and experiential perspective (Eatough & Smith, 2017). It is designed to "describe, explore and

analyse the ways that people create meaning in their lives" (McLeod, 2015, p.92), lending itself to the finely tuned examination and understanding of one's individual experience, and fitting with the fundamentals of the research question. The process of IPA employs a 'double hermeneutic' designed to carefully consider the constituent parts of a participant's perspective as captured in their verbatim account, as well as employing the researcher's interpretative process to distil meaning and develop discernible units of information (ibid.). This process of examining facets of description without assumption and offering possible meaning through interpretation, has strong parallels with psychoanalytic psychotherapy and therefore seemed highly suited methodologically (Rustin, 2019).

3.2.2 - Research setting

I interviewed colleagues, past and present, from the Child, Adolescent and Young Adult team at the specialist NHS service where I work. This clinic has a long, esteemed history of providing psychoanalytic psychotherapy to a patient group of children who have perpetrated sexual violence, something unique within mental health services. It therefore seemed a fitting place to conduct specialist research of this kind, with access to a well-informed and clinically engaged group of practitioners immersed in the process of this work. Due to the time pressures involved in interviewing, focussing the study on a single site meant recruitment could be streamlined. As I was also training within the service, I understood the workings of the clinic and had insight into how research could be conducted effectively in this setting.

3.2.3 - Sample and recruitment

As inclusion criteria, all participants were ACP accredited, qualified Child and Adolescent Psychoanalytic Psychotherapists, with at least four years' experience working in the specialist team. There were no specific exclusion criteria. I chose these as it was important to be thinking with individuals immersed in this complex and technically challenging work, looking to this specialist team as a baseline from which to understand more about the approach. This is a relatively homogenous sample, selected using a purposive sampling approach, as is suitable for IPA (Pietkiewicz & Smith, 2014).

Recruitment involved firstly discussing the research with colleagues in the service team meeting. All participants stating interest were, at the time, part of the team, however when interviews took place one had left. This meant that further contact about the specifics of the interview was made by email sent through the clinic service manager, so not requiring confidential, personal email addresses. Those happy to participate were provided with a participant information sheet outlining the research and their contribution, and were asked to complete a consent form clearly stating that participation was voluntary and consent could be withdrawn at any time (see appendix for examples). Participants expressed an interest in participating in the project as it focused on their specialist work, something they felt deserved more attention and empirical grounding.

IPA calls for a small sample precipitating an in-depth, idiographic focus on the material during analysis (Smith, Flowers & Larkin, 2022). Therefore, five participants were recruited, two male clinicians and three female clinicians. Participants were all white with the majority having English as a first language. If not, there was fluency in English. Participants had varying lengths of service within the team, the minimum being five years and the maximum fourteen years. The majority hold teaching and supervisory roles within the trust where the clinic is based. This seniority and level of experience was helpful for obtaining insightful and detailed responses.

In discussing the findings, participants have been given pseudonyms to protect their confidentiality and identifying information of patients, places, etc. have been omitted or abstracted. The following table outlines specifics about participants that are relevant to my findings.

Table 2: Participant Details

Pseudonym	**Male/Female**	**Experience (Years)**	**Interview Online / In Person**
Rose	Female	5	In Person
Angela	Female	8	In Person

Samuel	Male	14	Online
Joseph	Male	7	In Person
Eve	Female	9	Online

3.2.4 - Data collection

Semi-structured interviews were conducted, following guidance on obtaining data for IPA (Reid, Flowers & Larkin, 2005). This approach allows the introduction of the topic and some general guiding of the conversation whilst allowing freedom of movement for the participant. Formulating open questions led the interviews in different directions, allowing a creative process with natural development of thought. There were further sub-questions and prompts provided if required. Participants' responses were audio recorded for later transcription. Interviews were kept to approximately one hour, to be mindful of time constraints. Participants were interviewed either in person or on secure video conferencing software (Zoom), depending on availability. A reflective diary was completed to accompany the interviews, making a note of relevant thoughts and ideas emerging during the process that would aid the interpretative analysis. This included my countertransference responses, and what this may be highlighting about the participants' embodied experience.

3.2.5 - Data analysis

The second edition of Smith, Flowers & Larkin's 'Interpretative Phenomenological Analysis: Theory, Method and Research' (2022) has informed the steps of the data analysis, as well as meeting regularly with my research supervisor for consultation. A predominant focus of the approach is matters of convergence and divergence between participants, capturing the idiosyncratic nature of personal experience whilst examining how this collectively builds towards group experience. Integral to this process has been an appreciation of the 'hermeneutic circle', considering the bi-directional relationship between the constituent parts of the data and the whole project. The IPA methodology is iterative in nature, requiring the revisiting of individual stages of the process and adjusting and adapting to 'fine-tune'. The appendix provides examples of the stages of the process illustrated below.

1. Familiarisation with the data

Audio recordings of the interviews were listened to multiple times to become immersed in the data, before transcribing these verbatim. Transcripts were re-read with the audio accompaniment to hear the voice of the participant when considering the text. Notes were made on tone of voice, non-verbal communications etc. This encouraged a high level of familiarity with the data and an ability to tune in to the finer details.

2. Exploratory noting

As the data became more familiar, the process of 'exploratory noting' began, annotating the transcripts with anything that stood out as noteworthy, without any wider intention (Smith, Flowers & Larkin, 2022, p.79). This was completed transcript by transcript in the first instance. Notes captured thoughts at different 'levels', some descriptive in nature, others providing a summarising function, and others the use of language. 'Higher order' notes were also recorded which considered more conceptual ideas relating to the interviewee and their interview.

3. Experiential statements

Exploratory notes were reviewed to metabolise this new additional data, before using it to form 'experiential statements'. These reflected the participant's experience of the phenomena and stayed close to their verbatim account, adding some interpretation but avoiding overly abstracting. The statements distilled the data, producing a 'concise and pithy' summary to capture crucial aspects of the interview (Smith, Flowers & Larkin, 2022, p.87).

4. Personal experiential themes (PETs)

Ways of grouping experiential statements were considered to capture the salient themes emerging from the participant's response. A hard copy of the statements was printed and individually cut out to consider different ways in which they could be meaningfully grouped. This involved trying different formations and ways of linking. The whole interview was considered to test whether a true essence of the participant's account was captured through the proposed groupings (an example of the hermeneutic circle).

5. Group experiential themes (GETs)

After completing the PETs for each interview, ways they could be linked between participants was considered to capture prevailing aspects of the group experience relating to the research question. Criteria for a GET required there to be at least three of the five participants identifying it, indicating it was a suitably shared experience at group level. The range of responses falling within the GET was noted, to capture convergence and divergence. Again, this process centred the hermeneutic circle, considering the bi-directional relationship between GETs and the raw data.

3.3 - Ethical issues

Kitchener (1984) posits that there are four vital elements of which to remain mindful to ensure best practice in research: beneficence, nonmaleficence, autonomy and fidelity. These were centred within the research process to consider potential ethical issues. As a trainee carrying out a clinical placement at the service where the research is based, I have interviewed colleagues and needed to consider how pre-existing relationships between myself and the team may have impacted the interviews. This could have played out differently, potentially easing the flow of conversation due to a level of familiarity, with less concern about misunderstanding or a hostile response. Alternately, individual dynamics

between myself and colleagues perhaps meant certain thoughts and feelings were difficult to share, resulting in 'defended subjects'. It is important to consider this when examining and interpreting meaning, bearing in mind that "[D]efences will affect the meanings that are available in a particular context and how they are conveyed to the listener (who is also a defended subject)" (Holloway & Jefferson, 2009, p.299).

Whilst the impact of the pre-existing relationship could not be controlled for, to temper the effect, participants were presented with the skeleton interview schedule before the interview date to prepare them for the discussion. This was intended to manage some anxieties and give participants time to consider what they wish to share and its potential impact. The anxiety that might be around was acknowledged before the start of the interview and they were encouraged, in as far as possible, to set aside the fact that I am a colleague and consider me as a researcher with whom they are not familiar. I have remained cognisant of the potential implications of these dynamics throughout the process and will return to these in the reflexive discussion to ensure consideration of any impact on the findings.

I similarly considered that participants had pre-existing relationships with one another and emphasised that interview data would be confidential, reminding participants to also keep details of their interview confidential from colleagues. As direct quotations have been used, participants may recognise their own words or be able to guess the contribution of others, something addressed in the consent form. It was stressed that every effort would be made to disguise anything that may make the source of the quotations easily identifiable. Details of how confidentiality would be maintained within the study, including the anonymisation of the clinic involved, was discussed with participants, as well as the process of redacting any patient identifiable data.

Whilst adverse or unexpected outcomes during the research were not foreseen, I was mindful that this subject area is sensitive. Speaking with participants experienced in the field hopefully meant there had been a degree of processing of their experiences, however it was made clear from the outset that the interview could be terminated if necessary and breaks incorporated where required. All participants were engaged in their own psychotherapy

and/or regular clinical supervision, allowing them space to process the work and its impact, as well as anything exacerbated by the interview process. Participants were provided with details of alternative avenues of support outside of the work setting if required.

This research was approved by TREC (Tavistock Research Ethics Committee) on 02/11/2022.

3.4 - Reflexivity

It has been important to consider how my findings have developed, recognising that the interpretation of meaning is undoubtedly influenced by my epistemological position as a trainee working within this specialist field. This is not a 'neutral' position, something which is arguably difficult to achieve. Qualitative approaches, particularly IPA, require the researcher to reflect on the ways in which meaning is made, in this case between both patient and clinician and clinician and researcher (Smith, Flowers & Larkin, 2022). Fundamental to this is an appreciation that the creation of knowledge does not happen in a vacuum and is influenced by contextual factors. I am of the belief that the patients seen within the service deserve to be treated with compassion and thought about as whole, rather than conflated with their enactments. There will be others in society who do not hold this stance. It is important to consider how the lens through which I am looking may shape or colour my findings, perhaps influencing the questions I asked and how I looked for meaning in the data. I have returned to this throughout the iterative process of data analysis, both individually and with my supervisor, with the intention to focus on the participant's response and stay true to the data rather than overly abstracting through interpretation and ideological positioning.

I am an 'insider researcher' within this project (Asselin, 2003; Kanuha, 2000; Simmons, 2007), someone with historical links and relationships with those being interviewed. This means there are elements of shared identity/group membership to be considered. I am a significantly more junior clinician and exist within a hierarchy of the service, having been supervised directly or otherwise supported by all the interviewees. It is important to consider how some clinicians may have experienced my questioning of them, perhaps there

were feelings of guardedness when discussing complex areas with me, particularly in relation to work they found particularly challenging. My position as team member, as well as researcher, may have led to a greater level of defensiveness on the part of the participant during the interview process. The pre-existing relationship may also have made the interviews a little too smooth with an expectation of shared understanding.

I have endeavoured to check-in continually with myself over matters of bias and have made sure not to assume I instantly understood what a participant was saying, choosing instead to probe further so it was spelled out more explicitly. Whilst this has been my intention, it is likely that my dual role has have had some implications for the way I conducted the interviews and interpreted the data. Was there an unconscious desire to 'protect' the service, my colleagues and the patients from critical outside eyes, meaning some findings were over/under reported? Did I collude with pre-existing dynamics within the team, prohibiting me from going 'deeper' in the interviewing process? Perhaps my focus was guided in certain directions in an attempt not to agitate or disrupt. The 'insider-researcher' issue will require further consideration during the discussion section.

It is important to consider in the discussion of the findings, how gender and other individual differences infuse participants' perspectives. It may also prove illuminating to examine aspects such as how time working within the service may impact thinking and interview response. Would a longer duration mean participants felt more or less defended against anxiety linked to the work? Would those employed for a shorter length of time have a different focus, perhaps carrying more of the visceral experience of being with these patients? Homogeneity in the participant group, particularly in terms of ethnicity and class, may also result in a particular lens through which the work is seen. The makeup of the patient population is more ethnically and culturally diverse than the staff group, an important matter that warrants further thought but cannot be adequately examined within the parameters of this research.

4.FINDINGS

Table 3 provides an overview of the group experiential themes (GETs) and sub themes derived from the IPA data analysis, including the number of participants who contributed to each sub-theme. Due to the limitations of the word count I am unable to record the full extent of contributions by participants. Some points have been paraphrased and others use quotes to evidence the findings. The analysis yielded four GETs, which capture different elements of the experience and understanding of work with children who have perpetrated sexual violence and show the multi-faceted focus of Child Psychotherapists within the specialist service. The identified sub-themes metabolise the focus of these larger group themes. These will be discussed in the following section.

Table 3: Group experiential themes and sub-themes

Group experiential theme	**Sub-themes**
The experience of the therapist	• Feelings about forensic work (5/5) • Abusive dynamics (4/5) • Powerful bodily experiences (5/5) • The complexity of contrasting feelings (5/5)
Matters of approach and technique	• Transparency (4/5) • Working with enactments (4/5) • Countertransference (4/5) • Breaking with tradition (4/5) • The importance of pacing (4/5)
Conceptualising the roots of perpetrating behaviours	
Considering the function of therapeutic work	• Addressing cycles of enactment (5/5)

	• Integrating victim and perpetrator parts (5/5) • Containment (3/5) • Developing good aggression (3/5) • Relational developments (4/5)

4.1 - GET 1: The experience of the therapist

All therapists spoke about a variety of feelings evoked for them relating to their work with patients who have been sexually violent.

Subtheme 1.1: Feelings about forensic work

All therapists described strong feelings about their personal engagement with the specialism. They each described their work with perpetrators as interesting but placed different emphasis on the positives and negatives. For example, Rose described the work as both fascinating and gruelling and spoke of the reward of challenging societal perspectives of a victim/perpetrator dichotomy:

> *"It is for people who don't like systems [laughs], don't want to be sort of boxed in to how to think, and how to be, and how to behave, and the societal kind of margins of, you know, what's moral. If you want to push those boundaries a bit, or if that's your character, I think then you would be interested in this kind of work."* (Rose)

Angela also spoke of wider societal views expressing some trepidation about how "helping perpetrators" might be perceived. Whilst she believes in the importance of the work, she also described powerful associations to do with how it could be misconstrued, as if the clinician may be somehow guilty by association:

"I sort of had this fantasy about being in the dock and being accused by Daily Mail readers of sort of, you're on the side of paedophiles, kind of thing. And it gets me thinking, no, no, but you've got this wrong. Actually, we're completely the opposite of that, we're trying to prevent and treat paedophilia, we're trying to protect children." (Angela)

In contrast, Samuel focussed on perspectives within the wider Child Psychotherapy profession. He described how those outside the field might feel "squeamish" about working with patients who have been sexually violent because they take it "too personally" and over identify with the victim, perhaps thinking about the impact on their own children. Samuel described the experience of the work as "not a big deal". He stressed how work with perpetrators improves the clinician's capacity to see both sides of an individual, victim and perpetrator, something that would be helpful for those working with other client groups.

Joseph described perpetrator work as "real work", not with the "worried well":

"Y'know maybe there's some kind of masculinity thing going on, where you feel like you're doing some kind of proper work, where, where it doesn't feel like a proper man's job, I'm caricaturing myself, to be a psychotherapist." (Joseph)

He spoke passionately about the culture and way of thinking within the specialist service and how offering long-term therapeutic work allows the opportunity to see real change and movement with patients, affording a sense of sustainability and longevity for the clinician.

Eve vividly explored how important it felt to offer this work. She spoke of "a mountain to climb" to understand the child. When describing beginning therapeutic work she used the simile of a jewellery box:

"I've always thought of it, it's a bit like, opening a jewellery box, that has been neglected for five years, 10 years, 12 years, 14 years, and all the necklaces, they've all got tangled up together, and you look at it and you go, how am I ever going to sort that out? And … that's daunting. But if you are drawn towards this sort of work,

there's also something quite erm … [pause] enticing about it. Add to that a young person, that makes you sort of feel like it's urgent, you know, it's really important, because that's what they're carrying around inside them." (Eve)

She tempered this with a recognition of how therapists should be cautious of responding to deprivation in a patient group by giving more of their time than is healthy and the need for 'self-care'. Rose also examined the other side of the work and how it can have an addictive quality, leaving the therapist feeling cynical about the world, something about which one should remain vigilant. She too described a need for clinicians to seek balance and manage the impact of the work, recognising that there can be consequences from being around something that can feel deadly for too long.

Subtheme 1.2: Abusive dynamics

Rose, Eve, Samuel and Angela spoke about the emergence of victim and perpetrator dynamics in psychotherapy sessions, noting the tendency to be "positioned" in one way or the other. Rose described how the work is about action so these dynamics will always be enacted and experienced by the therapist. She emphasised the need to "not be afraid" as it is something important for the development of the work, stressing the need to strike a balance between "cut-offness" and being in touch to manage it. She gave an example of being "symbolically groped", demonstrating how the intrusive nature of patient interactions can be both physical and psychological, leaving the therapist with an experience of victimhood:

"I had a patient who was kind of like, well, he was a groper, he would sort of touch people in the street … inappropriately, sexually inappropriately. And so, in the room, early on in the work, he sort of tried to, he would kind of symbolically grope me in a way where he would try and get in intrusively, to kind of try and say something against me, or say something about me, or try and find out something. And then, it sort of moved closer and closer to him trying to touch me. So, he would like, move close, very close erm … and once tried to touch my nose." (Rose)

The power of victim experiences and intrusion in the sessions was noted by Eve, Angela and Samuel. Eve spoke of how an interaction, such a playing a game, can begin in a benign way but can lead to being pulled into "creepy and controlling exchanges" involving a patient ultimately wanting intrusively to initiate physical contact. Samuel also commented on the intense power this experience holds for the therapist and how it can be infused with a sense of culpability for not standing up or fighting back. He considered how sometimes one only understands the pathology of the patient and their abusive potential when becoming part of such victim/perpetrator dynamics:

> *"I remember working with a young rapist once, he sat there for weeks, I couldn't relate anything about him to him being a rapist. It was just, just an adolescent, I mean, nothing much to talk about, but I couldn't see the rapist until at some point he, he had something on his phone, a music video and he wanted me to see and I said no, I don't want to see you can tell me about it. He said, no, no watch, watch. It's alright. It's alright. You can watch. I said no, I don't, I don't want to, you know, I don't want to watch. I didn't get up and say no. And in my mind, I became a bit of a therapist defensively and said, let's see what happens. And obviously what happened was a few seconds later, I had the screen in my face. Nothing sexual. But then I knew he was a rapist. Because there was no sense of him being able to respect no, it was like it didn't exist."* (Samuel)

Angela noted how evocative finding oneself positioned in one way or another can be, describing how this is only somewhat mitigated by years of experience. She also spoke of feeling, at times, somehow responsible for her experience of victimhood in the therapy but at other times feeling like an "intrusive perpetrator in the transference". She picked up on Rose's earlier point noting how, whilst this was disturbing, such moments provide an area for further exploration in the therapy:

> *"There was something intrusive that got going in the transference with the patient, on my part, that I noticed. There was a sort of dynamic around rape that was happening quite live, and it took me by surprise, I hadn't had that before. [Said*

carefully] And I'm glad it's come, because it means I can start working with it." (Angela)

Subtheme 1.3: Powerful bodily experiences

All five participants spoke of a potential for the work to impact their body. Angela, for example, commented on how the task of therapy is difficult in both academic *and* bodily ways. Samuel described how there was something specific about how the body is employed in work with this patient group, hinting at powerful experiences:

> *"It's therapy a bit with the extreme, you know, both with victims of sexual abuse and perpetrators. You work with extremes, because bodies have been violated, and therefore the experience is more visceral, and sometimes it gets into your own body before it gets into your mind. Be ready for it. But again, if you want to be a psychotherapist, this is what you need to be prepared to do."* (Samuel)

Rose supported this idea, describing how preverbal, unprocessed experiences of trauma in the patient's body have the potential to find their way into the work triggered by elements such as smell or sound and can then, in turn, be felt in the body of the therapist. She picked up on a particular bodily sensation of numbness:

> *"Well, I've had with one patient, where I would start feeling really numb. My body, like my body would feel numb. Errm and it would often happen. And I, it sort of took me a while to understand like what he was talking about, and what kind of was triggering that."* (Rose)

Angela commented on how this numbed, "slowed down" feeling affected her capacities to manage ordinarily what was happening in the room. She described this as being "flooded", conjuring a powerful image of drowning in something unpleasant, which hints at the force of such experiences.

Joseph considered how he looks out for bodily experiences such as sickness or anxiety, but he doesn't feel them powerfully and would "like to be more in touch with it". Interestingly, when describing the impact of his consultation work with professionals, his use of phrases such as being "weighed down", "bent out of shape" or how it "can do your head in", did seem to connote something about a sense of his bodily integrity being compromised.

Subtheme 1.4: The complexity of contrasting feelings

All participants spoke of complex, multi-faceted feelings towards their perpetrator patients and how these can develop throughout treatment. Samuel, for example, explained:

> *"There are different types, let's say that there are perpetrators that I can connect to very quickly and not reject, and not hate to start with. But sometimes it takes a bit of time for love to be present in the sessions."* (Samuel)

Participants described how patients can often leave the therapist feeling intense negative feelings towards them. This bad feeling is often in relation to what the patient is 'doing' to the therapist with their actions. Angela spoke of disorientation, suspicion, and hatred, and how these feelings must be tolerated to find meaning in the work. She also vividly spoke about feeling angry. For example, she described the treatment of a teenage patient and his disgusting actions (farting in the sessions) which felt antagonistic but revealed to her something important about his mental state:

> *"It's quite hard to know how to work with farts [laughs]. Urrm, and you know, there's something that can be quite humiliating about it, or if you're ignoring it then you're just allowing them to sort of fill you with a bad smell. And I think he does want to fill me with a bad smell. He's feeling quite suicidal, increasingly, recently, he's having a bit of a sort of adolescent crisis, an early adolescent crisis. And so there's this farting going on and this smell. And usually, he sort of sniggers about it. And I might say something, because I'm angry, really, to be honest, you know, I feel like oh no, d'you know what, this is disgusting."* (Angela)

Joseph, in thoughts echoed by Samuel, also picked up on a sense of anger about the way he is used by patients, describing disgust, shame, and aggression towards them. He spoke of feeling particularly aggravated by those he feels are not taking the work seriously:

> *"I had one patient who must have been 15 or 16, who was ambivalent, like properly ambivalent about the work and had phases where he was interested in it and phases where he was going through the motions and was more interested in looking at the* [illegal] *images and where I felt manipulated and furious with him. And you could see him going on to become a paedophile and criminal, and unapologetically. So I can remember feeling really angry and quite violated by him, manipulated."* (Joseph)

All the participants described disturbing feelings towards the patient as a vital part of the work, with Angela, Eve and Rose expressing the need for a place to take these experiences so they do not bleed into other parts of the therapist's life. Angela described how work with cut off, deadened patients, can lead to a feeling of being in a "dark place with them" and there is need to contain this through conversations with colleagues. Eve echoed the idea of having a team around to handle the impact of what can be stirred up, particularly if the work triggers something personal "leaving you feeling low and anxious". She described how the therapist often needs to carry the more lonely, hopeless, pulled-down feelings of the patient and how these are projected into the therapist for this very purpose.

Eve considered how feeling stupid and useless when trying, and failing, to reach the patient is "not nice, but not the end of the world" and it is better that the therapist hold this than the patient. She emphasised the importance of feeling safe in the clinic to mitigate feelings of anxiety but stressed how the sense of dread that can accompany work with some patients does not inhibit the therapist from providing something helpful, as long as it can be thought about.

On a different note, Eve and Joseph spoke about feelings of compassion and sympathy for those who have been sexually violent, often stressing the need to understand their actions through a lens of complex trauma and repeated failures. Joseph considered the difference between how the actions of these patients are viewed by the "outside world", who can be

quick to feel disgusted, as opposed to the specialist clinic who find a way to "genuinely understand". He pondered how understanding the child's trauma history before their act(s) of perpetration is often more disturbing than the act itself as there is an appreciation of the level of damage that has been done. Joseph went on to discuss work with children who view images of child sexual abuse, describing his sympathy for those who end up "criminalised", often linked to their own experiences of being groomed online.

Interestingly, several of the participants noticed an absence of feelings that one might expect to be present in work with patients who have exhibited sexual violence, perhaps as a way of challenging outsider perspectives:

> *"I've often thought about myself in the room as …. a mother or a grandmother. And very rarely felt under any sort of … sexual threat. I've never, I mean, that might just be me. Because, you know, I'm, I'm quite robust in a way."* (Eve)

Rose took this further noticing how there might be something defensive in the fact that she rarely feels fear in the room with patients. Joseph also considered a defensiveness that might account for the absence of fear or vulnerability. He wondered whether this was influenced by his gender and level of experience in the team.

4.2 - GET 2. Matters of approach and technique

All participants spoke about technical aspects of treatment and the use of an applied psychoanalytic approach to work with patients who have enacted sexual violence.

Subtheme 2.1: Transparency

Four of the five participants spoke about the importance of transparency in approaching the work. Eve described how "naming" the sexually violent behaviour is most helpfully done at the outset of treatment so the patient is clear that their act of perpetration is known. Angela also spoke of how "putting on the table" what the patient has done allows a proper assessment of motivation for treatment but recognised this is not a fool-proof approach:

"I think it's more complicated than that. Because, you can always put what they've done bad on the table, and you can ask them about their motivation. And they can give you whatever answer and you sort of almost already are in a game. They need to know that you know it. But in terms of sort of how to actually engage them in a meaningful way in in the assessment. Yeah, you have to state the perpetrator side. And that is your starting point." (Angela)

Rose described how a capacity to take some responsibility for their actions needs to be clearly assessed before the work starts, otherwise the patient may present only one part of themselves, delaying a more complete exploration. She noted how transparency around naming perpetration must be handled sensitively:

"It's not like we're assigning blame or anything like that. It's more like, look, you've done this, and this is why you're here like, we establish that I think quite clearly. I think if we don't do that from the start, then, then you can spend a long time in the kind of erm … so that's another thing is like deception … deception might be kind of rife." (Rose)

On a related note, Samuel spoke about how transparency in awareness of the more troubling aspects of the patient and what they have the potential to 'do', makes the work of psychotherapy easier:

"We have it easier because the people we see have already not only acted out, but this has become known. Or they're clearly asking for help for it. So they come and tell us about it. Or they told other people, or they acted out and got caught. A lot of other patients will be going into psychotherapy not telling their psychotherapists why they're really there. Sometimes it's not available to them, and sometimes, it's because they're too ashamed." (Samuel)

Angela also reflected on the unique permission granted by clarity in relation to the patient's troubling history. She considered it a chance to get to the unpalatable, difficult parts "from

the outright" compared to more generic services where it could take much longer to get to the victim/perpetrator duality she regards as present in all patients.

Subtheme 2.2: Working with enactments

The need to be able to think about and work with enactments in the therapy room is something about which four out of the five therapists spoke. Samuel discussed how enactments are inevitable and should be anticipated in the treatment, describing how the therapist will often become involved in the patient's actions. He described how attempts to resist enactments, through interrupting the patient's action too soon, would "kill the therapy" as it provides real insight into the individual's perverse ways of functioning. He notes how finding a way to notice carefully and reflect on enactments in real time is essential to the treatment.

Rose also described the importance of enactments in the therapy and the need to think about and work with them, to offer something developmentally important to the child:

> *"You have to bear their, you know what no one has been able to feel for them, like their objects haven't been able to bear the stuff they've been through without retaliating or acting on it. So, you have to be that person who can take it and then keep thinking."* (Rose)

Angela spoke of how enactments do not mean the patient is not "making use" of their therapy. She describes needing slowly to get alongside the enactment to understand fully how the patient relates and their mind works, but this can feel like "collusion" prompting uncomfortable feelings for the therapist of being a "slippery, adult figure". She reflects on how this is different from how something might more immediately be called out in a non-specialist setting. Here, there is a need for the enactment to be "mapped out" in the therapist's mind so it can eventually be tackled with the patient once it has been understood. She described something of this process with the patient who repeatedly farted in the room, eventually finding a way to talk about the enactment through a shared language that facilitated a joint appreciation of what was happening:

> *"Somehow it came to me to say 'a fart has entered the arena' and he absolutely loved that, not in an excited way. But there was suddenly a space, it's like I'd said, there is a space, me and you are in it. And you have done something to the space, rather than you've done something to me, and you're inside my nostrils and you want to get inside me."* (Angela)

She stressed bearing in mind the specifics of perpetrator patients' core-complex anxieties and issues around intimacy when approaching the topic of enactment, describing the importance of finding the "right temperature" of interpretation.

Eve discussed a necessity to think about enactments in the wider environment, stressing the importance of a strong network around the child to manage risk thoughtfully towards self and other, making therapeutic work safer; something particularly important as patients may become riskier due to the lowering of defences in therapy. She described the therapist's role in helping the external network look "underneath" reactive perpetrator enactments to consider how best to manage them, without becoming "frozen by risk":

> *"When you work with these young people, if their needs are met, the risk goes down, if their needs are not met, the risk goes up. So if you've got a child who needs to feel connected to other young people, and you're not doing that, the risk of them acting out is going to increase."* (Eve)

Rose and Eve spoke of the importance of supervision when working with patients who have the potential for disturbing enactments. They described this extra set of eyes and ears as offering containment as well as providing additional thinking power to develop understanding and make the work more possible.

There was a shared appreciation amongst participants, of a need to understand fully what the patient gains from enactments, so it can be effectively worked with in treatment. Samuel spoke of putting yourself in the mind of the patient to see what the enactment offers, welcoming an understanding of the "perverse solution" so it can be known fully and thought

about. He described the need for something important in the mindset of the therapist, allowing them to understand that anybody, including themselves, could function in such a way. Rose also commented on how crucial it is to understand the enactment from the patient's perspective as well as finding a way slowly to alert them to the implicit destructiveness of their actions and help them move towards life. She commented on how an element of collusion on the therapist's part is integral to this "tricky" process as one gets to know the "part of them that needs to perpetrate or is proud of perpetrating".

Subtheme 2.3: Countertransference

The therapist's countertransference was mentioned by four of the five participants, as being of special importance; a particularly lively aspect of treatment that can be used creatively to get to something happening in the room that is outside of words.

Eve noted how perpetrator patients are often very experienced at dealing with professionals (social care etc.) and can be skilled at saying what they think professionals want to hear, rather than what they feel. She considers a therapist's countertransference to be their "greatest tool" in understanding the patient's true communication. Angela elaborated on this, detailing how she observes and utilises her countertransference:

> *"There's something about my countertransference, at the beginning, that I have to metabolise in a way and sort of sit with. So rather than transference interpretations, or something a bit sort of intellectual, urm there's something about my liveliness that needs to get going, usually. When I notice, I sort of try and take their unconscious by surprise, and I don't do it deliberately. It's something spontaneous that happens very different to what they're expecting, you know, they're trying to sort of cut you off, it's all very deadened, and you're in a dark place with them, an internet kind of scrolling deathly kind of feel. And if you can get a moment where it's like you've really metabolised something, and then you, yourself, are coming up for some air and saying, we need to stretch, shed some light on this, what the hell was that? All I can describe it is as something bodily that comes together with your words, that then comes out of your mouth."* (Angela)

Rose also described a need to “take risks” in naming and not avoiding countertransference feelings. She considered how a denial of the therapist’s experience can mirror the patient’s tendency towards avoidance and splitting their own victim/perpetrator experience.

Subtheme 2.4: Breaking with tradition

Breaking with the traditions of psychoanalytic technique to work effectively with a patient group easily shamed and humiliated, was a recurrent theme in four of the five interviews. This involves taking risks, doing things differently and avoiding over-intellectualising:

> *“I don't think there's much room for a cliched psychoanalytic, poker faced, neutral, analyst in this kind of work. You have to build up an authentic relationship and that involves being yourself with them. And yes, interpreting that, but not interpreting from a kind of neutral basis. I just think they’d feel terribly, terribly judged. It's not neutral. I think that the danger is that the therapy room becomes the court.”* (Joseph)

Eve described how the presenting problem of enactment amongst the patients means they struggle to think and instead rely on action, therefore traditional interpretations based on a capacity to think and a trust in words, have a low chance of working:

> *“There’s one child that I worked with, who had been trained to lie to the police, to social services, he'd been taught to shoplift at a very early age, you know, so working with him, there's no way I could sort of just use words and say, ‘Well, I think you might be feeling’, I mean, I tried it and he told me [pained voice] ‘Oh, stop it with your noise. Just stop it with your noise’.”* (Eve)

She described the importance of playfulness and that meaningful communication can happen through noise, such as whistling, when words can’t be tolerated or carry no meaning. She insisted that an adaptive therapist is what these children need to avoid further disappointment in professionals, someone who will “shake the tree from every angle” to

reach them. Rose also describes how classical interpretations are not used with this group and that she may interpret more through her body:

> *"This work is like so much in the body so, sort of being really aware of that. And not necessarily speaking about the body but using your body, I guess that would be more like with the little ones but erm, you kind of have to find some space in between, you can't interpret directly, you have to find this like third space where it's manageable."*
> (Rose)

Angela elaborated on this third space idea, explaining the need to interpret what is happening in the room in a "side-by-side" way as if you are observing something together in the "middle of the room". She considered this more suitable than examining what is happening between the patient and therapist, as this would antagonise "core complex, claustrophobic agoraphobic anxieties". Joseph shared this sentiment noting how something is trying to be understood together and too great a use of the transference can be "too close for adolescents". He also described how at times he will go even further in divergence from strictly psychoanalytic methods to borrow from other psychological disciplines:

> *"I don't know what you'd call it psychoeducational, motivational, but I think it's not enough just to think about, to understand, you have to kind of think about how you're going to live your life, which isn't psychoanalytic. I think that's quite important."*
> (Joseph)

Subtheme 2.5: The importance of pacing

The topic of pacing of the work was a focus for four of the five participants in various important ways. Eve noted how the patient's resistance can sometimes present questions about their suitability for treatment, and described how building a foundation of trust is often slow paced because of the child's experiences of being damaged and let down. She stressed the need to go at their pace but how difficult this can be when the network is holding a sense of urgency because of concerns about risk.

Joseph also reflected on the slow development of the work, noting how information is revealed over time to build a picture with the patient and that they do not need to tell you immediately everything about their past experiences and family histories. With reference to a specific patient, he described how information may gradually appear that helps make sense of their presenting difficulties:

> *"Something had been unspoken about the unprocessed sexual trauma in his father, but which must have been communicated to him around his early sexual development, there must have been, there must have been so much anxiety about abuse. You formulate that sexual exploration must have become loaded in his mind with something abusive and something traumatic, and that would have had a big impact on him. But you find out these things over time and try to build up a picture with a patient."* (Joseph)

Rose described how brief work is suitable for consultation only but not for therapy due to the difficulty engaging patients and the time it takes to glimpse their internal world. She noted how even in once weekly work it can be difficult to get hold of a patient and each session can feel like beginning again. Angela stated that the duration of treatment offered in CAMHS would not be sufficient for perpetrator patients who have such complicated issues around intimacy that being in the room itself becomes a problem, meaning it can take a long time to see progress:

> *"They've done research in the clinic, which is sort of in the third year, their actual sort of personality changes. So, symptoms might reduce six months to a year in. But, and I do see that in year three, there are changes and you can't quite believe who they were and what was going on compared to sort of three years in."* (Angela)

4.3 - GET 3. Conceptualising the roots of perpetrating behaviours

All participants discussed their understanding of what caused perpetrating behaviours in the patient group, with psychoanalytic principles underpinning much of their formulations. There was a recognition of a lack of uniformity in psychical and environmental conditions in the patient's early life, and that the function of an individual's acting out behaviour is unique.

There was a shared appreciation among all participants of what Joseph described as the "implicit" link between experiences of victimhood and the onset of perpetrator behaviours. Samuel elaborated on this stating:

> *"Victimhood is connected sometimes even as kind of symbolically as in content ways, what has been done to me I am now doing to someone else, especially in sexual abuse."* (Samuel)

He discussed how an experience of grooming and sexual abuse can cause victims to experience themselves as inherently bad at the core and how, in certain cases, sexual solutions can be sought to deal with the humiliation and shame of their victimhood. He detailed how these can range from increased masturbation, promiscuity, perversion, or harm against self and/or others. He described that victims who have perpetrated have "moved to the other side", using their sexuality to express hatred and hypothesised the act of abusing as unconsciously suicidal against their "victim self" which carries the heft of their painful experience. He also considered how projection can be an attempt to rid the individual of painful experiences:

> *"I would say that what leads perpetrators to act in the first place is the sense that the victim self is disconnected, is not looked after, their seeking revenge is kind of full of humiliation and shame. And that is acted out by projecting it into someone else."* (Samuel)

Joseph spoke of an attempt to establish "triumph and power" by taking up the aggressor position rather than remaining the disempowered victim. Similarly, Eve considered the struggles some patients have with a "double identity" as both victim and perpetrator, and the need to manage this by prioritising one position over another:

> *"That's what the child wants, you know, that's why they are a perpetrator. They're a perpetrator as a defence against being a victim. Because they've been a victim, most of them, you find that out within, you know, a short space of time. They have been the victim of either, of abuse or violence or whatever. And so the best way not to be a victim, again, is to become a perpetrator, and make someone else the victim."* (Eve)

Rose and Angela shared an understanding that patients have all experienced victimhood of one kind or another, although not necessarily sexual abuse. Joseph discussed cycles of abuse, focussing on his work with patients who view online images of child sexual abuse. He detailed how, for one patient, confusing, abusive experiences online led to the subsequent development of compulsive viewing of illegal material:

> *"He was basically having online interactions with older men. And he thought, as a kid does, that was exciting and cool. And that involved the sending back and forth, images of child sexual abuse, that was baked into what he was doing, it was a leap for him to see that what he thought he was doing, voluntarily, well he was essentially being sexually abused. He would meet up with these men and have sex with them, you know, as a young adolescent, he didn't see it that way. The internet led him to situations where he was being sexually abused, but unaware of it essentially, then led to him using the internet to look up pornography."* (Joseph)

He described how vivid and powerful compulsions to access images of child abuse can be more overwhelming in those who have been sexually abused as abuse exists in their body from a young age, often accompanied by feelings of inadequacy. This can lead to them developing a "fixation point" on that age of child and developing something addictive in the use of illegal images. He hypothesised how looking at these images can become an act of

aggression, either against the self, where they become the most disgraced, shameful person they can be, or against their parents.

Samuel focussed on how the act of perpetration can provide a different unconscious function, with being caught allowing the perpetrator to re-establish a sense of safety in the world after their own experiences of abuse, leading to them eventually "coming out" as a victim:

> *"From the perpetrator point of view, they unconsciously acted out in a way that will get them caught very quickly. It's very strangely optimistic, because adults move in, they separate the perpetrator and victim, they make it very clear to the perpetrator, this is absolutely wrong. And make it very clear to the victim, this shouldn't have happened. They make it clear that the world is actually a safe world in which we'll not allow for these things to happen freely. And the perpetrator, strangely, although they might be in a terrible position at that point, have for the first time, this very clear experience that actually this is wrong. And actually, there are available adults to stop it from happening. And strangely, it makes them feel safe for the first time, and even more strangely, it means that, you know, they could use therapy."* (Samuel)

4.4 - GET 4: Considering the function of therapeutic work

The final group theme that emerged for all participants focussed on understanding what the work is aiming to achieve. This theme could be categorised into two areas: that which is developed internally through the process of the work, and how change and development might manifest externally.

Subtheme 4.1: Addressing cycles of enactment

All therapists spoke of a key function of their work being a reduction in sexually violent behaviours. Samuel described how a successful treatment means the patient will never "cross the body boundary" again. There was agreement between Samuel and Rose that this is facilitated by the patient developing an understanding of the addictive cycle of

perpetration and a protective capacity to think, rather than act. They both noted how this is a gradual process and moments when the patient willingly jumps back into destructive perpetrating behaviours may remain; something Samuel described as pressing the "fuck it button". He posited that the patient can improve but will not go to "zero addiction":

> *"They begin to know what's going on. Then even if something goes wrong or if they find themselves in their old cycle, they're not going to spend a week beating themselves up. There'll be kindly putting themselves out of the cycle. Yes, they have done this addictive thing. This is not about hurting someone else. This is mostly self-perpetuating addictions. And they'll be able to lessen the guilt, come out, come into the light and move on."* (Samuel)

Rose described how patients often come to therapy full of shame and humiliation and the goal of the work is to help uncover the painful feelings they defend against, developing a capacity to reflect on themselves and what they do. She described how some patients hope for an almost surgical removal of their perpetrator parts but that this is not a realistic expectation:

> *"They'll still have sexual or violent kind of thoughts, but are able to, to have another option, I guess. To give themselves a way out. I guess to know, another way of being. But not meaning that they're gonna be different, but just that they have another option that's possible through the therapy. I mean, there's some people who come in, some patients who come in and just like, never want to have a sexual thought again. And that's obviously not going to happen. I guess for them, they want something to be taken away. I guess, like cut off?"* (Rose)

Joseph recognised how the work is a 'joint project' between patient and therapist and that most patients want to be involved collaboratively in addressing their behaviours and the underlying causes. He recognised that this does not stop at just developing an understanding, but it is also vital to help them find other ways to meet their needs.

Eve expanded on the idea of “meeting the child’s need”, thinking about work that needs to be done with the network around the child to develop understanding of their internal world and the meaning behind their perpetrator behaviours and reduce risk. She posited how the therapy will never be “complete” but when the child ends therapy, the work undertaken hopefully means future difficulties will be handled differently:

> *“You have to let go, you have to trust. You can't make these children whole. What you can do is you can help them understand themselves so that they know that if they start wanting to punch someone that they need to go and tell someone about that. Or that you know, that they need to be able to manage themselves. And so, you know, it's not just what's going on in the therapy room.”* (Eve)

Subtheme 4.2: Integrating victim and perpetrator parts

The five participants shared a general sense that fundamental to the treatment was the integration of the victim and perpetrator aspects of the patient’s identity. They all spoke about the splitting processes that surround these patients with a pull to seeing them as either a victim or perpetrator, something that can happen within the patient, the therapist, the network or wider society.

Samuel described a false belief that to work with perpetrators they should be seen as victims, but they need to be seen as both, “more than” just one or the other. He recognised that integral to tackling enactments is finding a narrative that allows the patient to examine authentically their abusive behaviours as well as what lies underneath: often severe abuse and neglect. He believes that connecting to these different aspects of the self can take a long time but if the victim position cannot be properly linked up with the perpetrator position, guilt and shame remain, meaning addictive cycles of enactment cannot be fully addressed. He discussed how patients sometimes come to therapy having survived the psychic and sometimes physical suicide attempts on their perpetrator parts. The desire to kill off this part defensively stops the patient thinking about their perpetration which can lead to further acting out as a solution, continuing the cycle. He spoke of a need to be kinder to the perpetrator aspects of the patient to facilitate change:

"The first phase is, is to allow the perpetrator to live, to be a bit kinder to the perpetrator. Perpetrators of that kind, when they come to therapy, their internal errrr harshness and cruelty and rejection of the perpetrator is, is very similar to, to a paedophile hunting gang, that bang on the white police van, they're ruthless to themselves. Whatever you can offer them will be much kinder to what they offer to themselves. So the first phase is to, is to kind of address this, address the ruthlessness see what they do to themselves, which is defensive, because if you're so ruthless and, and suicidal, you don't actually see the perpetrator for real, what they really have done and take it on, and you don't see the victim, either. You're just there, you want it all to finish and just feel extremely depressed, suicidal, and or kind of caught up between that, and cycles of shame and guilt and addiction of various kinds." (Samuel)

Eve considered how a patient might bring either side of their victim/perpetrator split to the work and the therapist's aim is to move towards integrating these parts:

"You might get a child that comes to the clinic, who presents as a perpetrator and comes into the room and is all controlling and all of that. And what you have to do, as a clinician, you look at them, you go, okay, that's my journey is to get the victim into this room, because that child needs to be able to feel things, and they're too scared to feel them. So they're all locked up and defended. And, they're you know, just reacting. You also get a child who will come into the clinic and only present as a victim, you know, because they're afraid of what they've done, and how you'll feel about it. So, they'll come in, and they'll be really, like, you know, passive and compliant, and all of that, and you need to get the perpetrator part into the room, in order for them to have forwards movement." (Eve)

Joseph described this integration as especially difficult with some patients as the "blurry nature" of their experiences mean they have a distorted view of their own abuse and don't understand that they have also been victims. Angela described how taking an interest in what has happened to the patient is important, but this needs to be handled carefully so the therapist is not seen as making excuses for their actions of letting them "off the hook". She

described how patients can facilitate such splitting by focussing on “PTSD and trauma”, but it is essential that they begin to take responsibility for their actions.

Rose alluded to how something evasive can occur in the work where the patient might present as “changed”, but it remains important to get to their perpetrator part and, more importantly, the motivation behind it. She described the potential impact of examining these different parts of the self, focussing on the sense of shame that is at the heart of the patient’s experience:

> *“They'll say like, they're never going to do what they've done again. Erm and it's sort of, they're not sort of connected to that part and sort of saying they've changed. And, they don't want to be that person anymore. But actually, what's quite important, is to get to that part of them and why they had to do what they did. But they'll be quite attached to being seen as the victim. I can think of some patients where if you uncover what they've done, and they, they kind of, they're able to connect to it in a real way, they realise that they've done what, what was done to them. And that can be so, so full of guilt and shame.”* (Rose)

Subtheme 4.3: Containment

Three therapists spoke of the importance of providing an experience of containment for perpetrator patients, something they have seldom experienced. Angela described it as akin to creating an internal home where thoughts can live and be examined, rather than acted out on “other people’s bodies and minds”.

Eve described patients as emotionally taken in by treatment, experiencing an emotional safe space that challenges their expectations of rejection. The therapy can become a dependable space to “spray their cynical, twisted, hopeless parts”, where they have a chance to be who they are without having to hide it. She spoke of how patients could be contained by how they are “taken in” by the clinic:

"They come somewhere and they're not pushed out. And somebody asks their name. And somebody says, 'Would you like something to eat and why don't you come and sit by the fire, because you look a little bit cold?' And, you know, 'here's a little kitten, why don't you play with this kitten, and there's a nice bed for you to sleep in over there.' I just think that that's what it's like, emotionally, for these children. They're taken in, we take them in. People think they're disgusting. That's what they've been told, that they're worth nothing. And we can give them a different experience just by … being there and being open and being curious. And, you know, not, not pushing them away." (Eve)

She stressed that the full attention of the therapist helps disconnected children feel more coordinated and together, considering this kind of experience to be how expectation of a different kind develops. This entails the building of hope that something can go well, the therapist often holding the hope for the treatment and slowly imparting it so they, in turn, may feel a bit hopeful, and can "breathe out and relax".

Rose similarly underlined the importance of a consistent experience of safety, being listened to and understood and that this has the potential to last beyond the end of therapy. She spoke of this feeling being internalised and offering "maybe some kind of protection" allowing a "capacity to think a bit more rather than act".

Subtheme 4.4: Developing good aggression

Eve, Angela and Samuel focussed specifically on the development of "good aggression" in therapy as opposed to "bad aggression" or violence. Eve stressed the importance of developing this capacity. She considered how aggression, as a concept, has negative connotations but is a hugely important part of an individual's life. She described how important it is to support a re-conceptualisation of its necessity, commenting that a less loaded description would be "lifeforce", suggesting it as something essential for driving development.

Angela acknowledged how there is a serious issue with the "normal" expression of aggression and this is something that needs to be addressed. She described how if this doesn't happen it can become disguised in sexualisation of another:

> *"It is about aggression, and how aggression is expressed. What we tend to get here more of is something where aggression has become sexualized. But it's often a sort of way of expressing, so you might think of that as sort of graphically violent sexual attack. But actually, more often, I think we get patients here where there's something a lot more sort of urm hidden, the aggression towards the other is much more sort of hidden in the sexualisation."* (Angela)

Samuel noted how if aggression is experienced as only bad, the patient will either not do it, victimise themself, or it becomes toxic and is expelled through a violent injection into someone else. He recognised that the most important function of treatment, and indication that the work has been successful and can come to an end, is the development of good, positive aggression, for example an assertion of one's rights in the face of injustice:

> *"When they come back, and they have used this aggression or being assertive, you know, saying no, this is not yours, this is mine, this is my coffee, or can I, simple things. Once they can use this capacity, that means that they are done. When you go through life, and you don't have it as a capacity, it means that instead you have moments in life in which you should use it and you don't, all these moments are then registered as moments of humiliation and shame, and then need to be rectified through addiction, or other things. Bad things, that are part of the old cycle."* (Samuel)

<u>Subtheme 4.5 – Relational developments</u>

Four of the five therapists commented on the emergence of a newfound focus and capacities through the course of treatment. Angela described how the content and the feel of therapy sessions can change, moving away from dead repetitive cycles and developing a link to the "real world":

> *"So I've got one patient, she's in her third, maybe even fourth year. And I think we're going to work towards an ending in, you know, the end of the year, because it started coming into the material, sort of descriptions of adults, safe adults who she likes, and who seem to like her, and who she asked for help in, in quite benign ways. It's quite sort of small, little things. But, I think she's letting me know that her internal world and her external world is more lively. And there are more options available."* (Angela)

Angela recognised that a patient's sense of humour can develop during treatment, something she linked to a burgeoning capacity to symbolise. Eve also picked up on the development of humour and the patient beginning to tell jokes as treatment progresses, as well as the emergence of other capacities such as sitting down, drawing a picture or telling you something about their day.

Samuel, Eve, Joseph and Angela described there being more "life" available to the young person through their therapy and how this might be noticeable through shifts in their engagement with the external world. Samuel spoke of how a successful treatment can allow a capacity to make some reparation and feel entitled to a life:

> *"When they are able to see their own trauma and the victimhood and have a bigger story rather than I'm bad, I'm bad and I'm ashamed and then I'm furious and humiliated. When they move on from that, then their life opens up. And then if they can actually get a life, and get even some love from other people and friendships and a job then then they can, you know, then they can be okay even if some aspects of them will stay kind of damaged and difficult." (Samuel)*

Eve also considered an emerging ability to engage in the world in a healthier way and the reward that this can provide the patient: a life with friends, a capacity to engage in sports or extra-curricular activities. She described how this might allow them to feel "good at something", an experience she deemed "transformational".

Joseph described the journey through treatment as an endeavour to bring the patient from a narrow, underground life, out into fresh air:

> *"Whatever kind of addictions or perversions that they have, I would sort of tend to think about them as the underground cave, antisocial world, which is, you know, which provides an illusion of meeting your needs, but it doesn't meet your need. Versus the kind of fresh air and the outside world where you're, you're with people, living life."* (Joseph)

He elaborated how the work helps the patient find value in themselves, friends and relationships, making life meaningful. He considered how a focus of therapy should be on helping a patient find healthier ways to meet their needs practically and should not stop at only developing an understanding of their behaviours. Angela supported this idea, suggesting that treatment helps the patient develop relationships, move out of home, go to college, or ask for help.

5. DISCUSSION

This empirical study has examined Child and Adolescent Psychoanalytic Psychotherapists' experience and understanding of work with a patient group who have perpetrated sexual violence; a project influenced by the dearth of formal empirical studies in this area. The group experiential themes formed from the interviews illustrate four important aspects of the therapists' experience and understanding of their work, suggesting a taxonomy for their practice. This incorporates multiple areas, ranging from an examination of the impact of the work on the therapist and the powerful feelings evoked, to careful consideration of the specifics of technique. There is exploration of how the therapists come to understand their patients' difficulties and conceptualise the psychic function of acts of perpetration, as well as what can be achieved through engagement with psychotherapy. For the sake of brevity, I am unable to consider each theme fully, I will instead focus on specific aspects which, from my epistemological position, I believe hold particular importance and warrant further examination.

GET 1. The experience of the therapist

The finding that work with perpetrators of sexual violence evokes powerful feelings for the therapist, corroborates existing case study findings (e.g. Shevade et. al., 2011; Woods, 2003; Kahr, 2018; Szur, 1983; Allan, 2016; Horne 2001a & 2001b). This study found that the psychotherapists interviewed have a great deal of pride in their profession and gain huge satisfaction working within the specialism, something not communicated to the same extent in the existing literature, which tends to focus more on the challenging experiences for clinicians (e.g. Kahr, 2018; Breer 1987; Horne 2016). Whilst the demands inherent in the work and its gruelling nature were also highlighted, the findings place a heightened focus on the sense of pride and reward gained. Participants described how their clinical work presents many challenges due to its complexity but enhances their professional skills and abilities. This is in line with Shevade et. al's (2011) research detailing clinicians' sense of 'personal growth' developed through their work. This study highlighted something additional, namely a political motivation for the work involving critiquing mainstream societal perspectives, something perhaps in-line with the therapists' personalities that draws

them to work considered 'controversial' in nature. Participants were conscious of how therapy with sexually violent individuals can be viewed negatively by outsiders, reflecting on the contrast that exists between those working within the specialist field and wider societal views. There was a sense of privilege in being granted access to these patients' worlds, with clinicians feeling included in something urgent and important. One therapist used the simile of the contents of a jewellery box in disrepair, demonstrating a belief that she is handling something precious that needs to be repaired and maintained. The overall conclusion drawn from this could be that it is complicated work but worth the effort.

Participants seemed to be describing a unique perspective and insight gained through working with patients existing on the fringes of society, illuminating and challenging tendencies on a societal level that seek to manage disturbance through 'paranoid-schizoid' functioning, artificially separating the concepts of victim and perpetrator (Klein, 1946). I wondered if at some level a greater leaning towards the sense of reward inherent in the work could be a way of managing some of the powerful feelings of disturbance and be key to achieving longevity in the specialism. There was a sense of shared identity and mission amongst participants, something with an air of exclusivity that could perhaps prove bolstering, offering a defence against the professional burn-out Woods (2003) warns of as an occupational hazard. This is something some participants hinted at when they described a need to examine their personal relationships with the speciality, and to take care to maintain a sense balance.

The description of an inevitability for the therapist being pulled into enactments with the patient, with a victim/perpetrator dynamic recreated in the transference, was also revealing. The therapists stressed that this is something unavoidable when working with a patient group that prioritises action over thought, a notion supported by the literature, with some authors discussing it in reference to clinical material (e.g. Lanyado et. al., 1995, Welldon, 2011), and others looking to pre-existing paradigms to consider how the therapist can shift 'positions' during treatment (Horne, 2001a). The only empirical qualitative study identified in my literature review describes such positioning, noting how deeply uncomfortable the sense of being the 'abuser' can be for the therapist, but does not go as far as to mark it as

'inevitable' (Shevade et al., 2011). It would thus be an interesting question to explore in further research.

Study findings highlight the power of the emergence of intrusive dynamics and the impact on the therapist, as well as detailing an experience of culpability and powerlessness relating to their experience of 'victimhood'. The therapists articulated the need to welcome such transference situations into the work as a fundamental aspect of treatment, describing how these precipitate an understanding of the patient's functioning through visceral personal experience; insight perhaps not possible if enactments were defended against. This is in line with Woods' (2003, 2016) idea that sado-masochistic ways of relating are commonplace because of the traumatic histories of this client group and Kahr's (2018) notion that handling such 'liveness' in the patient/therapist dynamic is imperative to treating perpetrators. Underlining this formative aspect of the work is a helpful elaboration, meaning it is something clinicians can be aware of and prepared for. There is a sense, however, that this can take its toll on the therapist. The language used by interviewees, such as "needing to not be afraid" or being "suitably cut off", might indicate that despite its inevitability and clinical helpfulness, managing such transference dynamics can be incredibly challenging. I wonder if choosing to specialise within this area might mean that the therapists unconsciously remain one step removed from being fully in touch with what the work can stir up in them, as a self-preservation strategy. Again, a question requiring exploration in further research.

The idea of there being intense bodily communications in perpetrator work, which occur outside spoken language but have the potential to affect the therapist's body, support Horne's (2001a, 2001b) and Allan's (2021) ideas. One participant described how, with a patient group whose bodies have been abused, and who then use their body to abuse another, the body becomes a powerfully visceral method of communication in their future interactions, including in therapy. This seems to be particularly the case when early trauma exists in the body and seems only possible to be communicated in a body-to-body way, something felt before being understood. The therapists suggested that reflecting on their bodily countertransference is particularly intense in work with perpetrator patients. This is in line with Horne's (2001b) notion of a link with the prevalence of pre-verbal trauma in the client group, something unable to be processed or symbolised in language. This could be a

contributing factor to a patient's deficit in a capacity to symbolise and a tendency towards action rather than thought (Segal, 1957).

Shevade et. al (2011) note “physical sensations” as a common feature in this work, for example describing feelings of sickness, a feature also named by a participant in my study (see also Lanyado et al., 1995). The overall findings expand on this by drawing attention to a different kind of physical sensation, namely an experience of numbness, or feeling “slowed down”. Participants described being “flooded” with this feeling, hinting at the powerfully visceral nature of the experience. Whilst they did not hypothesise on what can be understood from this, I wondered if it could be related to a projected empty, cut-off state experienced through projective identification (Klein, 1946). It could also be a legacy of the impact of traumatic life experiences on the patient's capacity to think and tendency towards being switched off, out of touch or inoculated, as discussed by Fonagy (2008).

It was interesting to note that it was the female participants who went into greater detail about the specifics of their bodily experiences in the work, whereas male participants spoke more of a theoretical potential for something bodily, or a lack of bodily experience. This could point to something unique in a female therapist’s experience of work with perpetrators, a finding that links with Dimitrova’s (2022) doctoral research with a similar group of clinicians. I also wonder if this could be understood in relation to something societal. Perhaps the ability to speak about the vulnerability of one’s body to external forces could be linked to the limits of culturally defined notions of masculinity/femininity, with men perhaps less willing to accept this.

From a different perspective, Yakeley’s (2014) notion that female clinicians stir up something particularly powerful in the transference with perpetrator patients, linked to disturbance of the early maternal relationship, is also a potential explanation. This fits Welldon’s (2011) understanding of the place of unresolved Oedipal issues in the establishment of perversion. It is also worth considering whether being interviewed by me, a male researcher, meant male participants felt less able to speak about physical impacts on their body because of something existing in the dynamic between us and the ‘normative’ ways in which men relate (i.e. not wanting to be too in touch with vulnerability).

Findings indicate the presence of highly complex, contrasting feelings experienced by the therapist towards the patient, including disorientation, suspicion, disgust, anxiety but also compassion and sympathy. This again supports the pre-existing literature (e.g. Shevade et al., 2011; Music, 2021; Allan 2016). This study adds to this by emphasising the presence of hateful and angry feelings towards perpetrator patients particularly in relation to how they 'use' the therapist. It appears that the therapist becomes a kind of vessel for the patient's projected difficult feelings, something which comes at a cost. Participants consider this disturbing but vital to the work, stressing the necessity of support from colleagues to manage the impact and the need to preserve thinking space within the clinic to process the complexity.

Much of the case study literature places heightened focus on the emotions and feelings of patients and how they treat their therapist, without going into detail about the complex, and challenging feelings experienced by the clinician as a result. For example, Lanyado et. al., (1995) discuss the therapist's sense of her patient as 'sadistic' but do not provide further commentary on how this left her feeling about 'Frank'. The study findings go further than Shevade et al. (2011) and Campbell (1994) who do focus specifically on the therapists' embodied experience but appear to present something more palatable in the therapists' response, describing feeling 'uncomfortable', 'powerless' and 'suspicious'. A more cautious approach is understandable, perhaps revealing too much of the therapist's personal experience in writing is best avoided to protect their patients and themselves. I wondered if the pre-existing relationship between myself and the participants allowed them to express something more raw and unfiltered about the intensity of their feelings, with the sense of this being something shared and understood, a possible benefit of being an 'insider researcher' (Asselin, 2003).

This links with a wider understanding emerging from the findings about the need to confront and examine the messy, disturbing reality of perpetrator work, rather than a pull towards amelioration. This resonates with Winnicott's (1947) understanding of the prevalence of negative feelings, specifically hatred, towards antisocial patients. He considered the vital importance of thinking about this aspect of the therapist's experience to ensure it does not

lead to hateful enactments. The study findings appear to offer permission to experience authentically such powerful feelings without minimising, welcoming disturbance, and an invitation for the therapist to think about and work with it. It is a liberating idea to be open to the darker, more disturbing aspects inherent in the therapeutic dynamic; something that contradicts an idea of feeling 'unconditional positive regard' (Rogers, 1967) towards the patient, seen by some as essential to being a 'good' therapist, particularly one who helps children.

The findings demonstrate that powerful, evocative material is the raw data of work with perpetrator patients, bringing the therapist closer to the disturbance of the patient's mind. This poses questions about the impact for the therapist of having things 'done' to them transferentially to be truly in touch with the work and perhaps links with a recognition, by some participants, that they often have a defensive absence of fear or vulnerability. A thorough examination of the impact of the work on clinicians appears somewhat underdeveloped in this study, which is interesting. Perhaps this is to do with my interviewing and an avoidance that emerged between myself and the participant, linked to my 'insider' position, but may also represent a need of the therapist to be less in touch with the force of what they face clinically. It perhaps reflects the necessity of something being unconsciously guarded against in its true form to have longevity in the profession. This matter warrants greater thought and exploration in future research.

GET 2 – Matters of approach and technique

The need for openness and transparency about the patient's act of perpetration and their damaging, destructive and aggressive parts is an important finding of this research. The therapists stress this as a priority when working work with those who have a 'forensic' profile, something that deviates from a more generic approach to psychotherapeutic assessment and treatment. Participants emphasised that acknowledging this should happen at the outset to avoid colluding with a patient's potential for avoidance or deception. This fits with Campbell's (1994) understanding that a thorough assessment must include the exploration of the patient's abusive act, Kohon's (2016) notion of finding a way to put words to something unspeakable, and Nathanson et al's (2021) assertion that a fundamental

indicator of suitability for treatment is a patient's capacity to acknowledge their perpetrator actions.

Participants indicated that transparency around the patient's more troubling parts facilitates the 'work' of therapy and helps grapple with complex and disturbing aspects of the self. They also stressed the importance of recognising a victim experience without prioritising one over the other. This suggests that all individuals, sexually violent or not, are multi-faceted beings with both victim and perpetrator parts. It encourages a sense of 'completeness' in how they are viewed clinically, avoiding a pull towards splitting which means the 'real' work of understanding and integration can start sooner. A chance to have this in the open is considered by the therapists as hugely beneficial as the complexity of the patient can be reached earlier in the treatment, compared to generic work where more disturbing aspects of the individual can be more easily concealed. A recognition of these more troubling parts is possibly something from which many would wish to shy away, perhaps particularly so in work with children, with a desire to overlook their potential to cause harm (Music, 2021). An acknowledgement of this reality and a willingness to confront it within the forensic approach fits with the importance Alvarez (1995) places on looking evil right in the eye in order truly to make inroads. It is seen as important to be honest about the totality of the individual, recognising the conflicting and contrasting parts. I wonder if this is especially important with perpetrators as there is a concerted effort not to replicate the culture of deception and collusion integral to the perpetuation of abusive dynamics. It demonstrates a tolerance of the ugly aspects of selfhood, recognising this as universally present, even within the therapist (Chasseguet-Smirgel, 1983). The ability to acknowledge and work with this appears integral to doing this work well.

Therapists understand working with enactments to be a vital part of therapy with a patient group prone to acting out. This fits with the existing literature which emphasises the central part action will play in work with perpetrators (Nathanson, 2016; Woods, 2003; Welldon, 2011). It also supports Nathanson's (2021) belief that "taking on the enactment makes it less an attack on linking and more of a communication, akin to a dream, that needs to be understood to further development" (p.152). Participants describe a need to be with enactments in 'real time' to map them out and make use of the information they provide, as

a resistance to this would mean something fundamental to the therapy had been 'killed off'. This process involves understanding what the enactment appears to offer the patient, meaning it can be tackled with greater awareness. My findings suggest that key to this is using 'collusion' as a therapeutic technique. This involves allowing the enactment to progress without prematurely intervening so it can be felt and understood by the therapist allowing the development of a shared language around it. This fits with Woods (2016) notion that the clinician must show the patient that their perverse inner workings can be tolerated and that they can conceptualise their 'action as solution' (Nathanson, 2016).

This 'collusion' is considered necessary to facilitate a true appreciation of the perverse solution, a different perspective to Lanyado et al. (1995) who state that the therapist must remain "unequivocally in the sane, ordered world, and not get drawn into the patient's perverse world" (p.235). These research findings indicate the need to allow oneself to enter the patient's perverse world, whilst maintaining one foot firmly outside. This therapeutic 'straddling' allows the opportunity to experience the inner workings of their world, providing the insight required to examine its false promise. This is more in keeping with Horne's (2001b) notion of remaining grounded and sane but without shutting off access to experiencing fully the patient's perversity. The containment of supervision is recognised as pivotal to stabilising the therapist as they engage in working with these disturbing enactments.

This way of being both 'in' and 'out' of the perverse workings of the patient's mind fits with an understanding emerging from the findings that therapy with this group involves facilitating a controlled environment where perverse functioning can play out and be thought about, free of the risk of physical harm to others. This precipitates a fuller understanding that can then be shared with networks around the patient to reduce 'external world' risk factors. Feeding back this insight is seen as essential to helping manage risk effectively, without resorting to overly punitive restrictions, particularly as participants acknowledge patients' risk level can increase as therapy begins to examine their defences, something Hodges et. al (1994) also elucidate.

The countertransference was considered by participants as a particularly important therapeutic tool with those who have perpetrated sexual violence. They describe how this patient group is often heavily 'service-experienced' with a heightened understanding of what professionals want to hear, meaning the countertransference provides insight for the therapist of what is being consciously/unconsciously omitted or concealed. This supports the findings of Dimitrova's (2022) doctoral research examining child psychotherapists work with a similar patient group, as well as other literature (Campbell, 1994; Chasseguet-Smirgel, 1985; Morgan & Ruszczynski, 2007). Participants detailed how taking a risk on naming the countertransference can bring fresh life and possibility into the work, particularly if the therapy becomes stuck in something deadly. There was a sense that utilising this tool should happen 'spontaneously', a result of the therapist's authentic experience, rather than an intellectualised or rote interpretation that would be unlikely to reach the patient. Interestingly, it was the female participants who spoke in the most detail about their use of countertransference and its heightened importance, fitting with the previous finding detailing gender differences in how participants spoke about the impact of the work on their body. Male therapists appeared to focus more on theory and the function of therapy and female therapists provided richer more detailed accounts of the feelings and experiences of undertaking the work. This supports an idea that the gender and embodied experience of the therapist might be a mediating factor in how the work impacts them, an area that Breer (1987) touches on exploring how the transference varies with male/female clinicians.

This would be an interesting aspect to think more about in further research, considering how features of the therapist's 'identity' (gender / experience level / time within the service), might influence their understanding, engagement with and experience of the work. It is also notable that all participants in this study were white with European heritage. It could be illuminating to consider how factors such as race of the practitioners impact ways of thinking about the topic, if at all. Seeking diversity in the participant group could add richness to the findings, something perhaps particularly important as the authors of the body of literature forming the literature review are almost exclusively white. Likewise, thinking more about how the race of the patient intersects with the way they are thought about by the therapist could also be extremely interesting as a focus of further research.

Participants described that there is innovation and flexibility required with the traditions of the psychoanalytic method to make contact with patients who are highly prone to shame and humiliation. This supports Woods' (2016) and Horne's (2001b) emphasis on the delicacy and creativity of technique required to reach these individuals. Participants stressed the need to remain cognisant of Glasser's (1979) concept of the 'core-complex', finding the right 'distance' for an interpretation to manage issues of intimacy that can act as barriers to therapeutic contact. This requires an adaptation of a traditional psychoanalytic model of prioritising working in the transference as this is too 'close', with therapists suggesting it can also feel overly intellectual/theoretical and lacking in the authenticity required to reach this patient group. They also described how an over-reliance on words can be ineffective as patients are often highly mistrustful, therefore thinking outside the box and using sound, the body or other innovative techniques can facilitate contact.

This finding supports Woods' (2003, 1997) idea of using 'creative forms' with this population, including borrowing from other psychological disciplines such as CBT. One participant discussed how psychoeducational work can be helpful with this group, something other than relying on transference interpretations as the therapist's only tool (see also Keogh, 2012; Hodges et. al. 1994). The ability to adapt and adjust, fits with a notion of the therapist as a 'developmental object', someone flexible enough to meet the unique needs of the child rather than expecting them to adhere to the traditions of psychoanalysis (Hurry, 1998). Some participants described how finding a 'third space', side-by-side way of interpreting what is happening in the room appears to create a safer distance. This seems to offer an opportunity to explore a potential for triangulation, something that, developmentally, many of this group have struggled with (Britton, 1989).

Pacing is considered to be of the utmost importance to developing understanding and effectively reaching the patient, a sentiment mirrored by Horne (2001b) and Campbell (1996). There is consensus that work needs to be long-term enough to establish a trusting relationship without triggering the patient's core-complex sensitivities; something that cannot be rushed. This is at odds with Hodges et al. (1994) implementation of a brief intervention with this group as part of a pilot project and their belief that significant work can be undertaken in the short-term. Participants in this study recognised that a slow pace

can be difficult when there are external concerns about risk and a feeling of urgency expressed by the professional network. They elaborated on the therapeutic work being a finely tuned endeavour that must be approached tentatively without a pre-conceived agenda. This is in-line with the concept of negative capability (Bion, 1970), the slow development of understanding through appreciation of the ephemera of the mind, rather than a pull to premature conclusions and action which mirrors the action-oriented mindset of the patient. The reality of this finding presents unique challenges when working with patients who stir up great anxiety in professional networks, as Music (2021) describes. There is also the matter of a struggling NHS dealing with financial shortages and with a desire for inexpensive, quick fix solutions that appear unsuitable for this extremely complex and disturbed patient group.

GET 3 – Conceptualising the roots of perpetrating behaviour

The findings of this research support much of the theoretical literature that considers the act of perpetration as a sexual solution to an experience of trauma, a way of projecting onto another a painful experience of humiliation, shame and victimhood (Stoller, 1975; Limentani, 1984 & 1989; Freud, 1936; Campbell, 1989). Participants drew attention to the inter-generational transmission of trauma and cycles of abuse and abusing. There is the idea of an 'implicit' link between an underlying experience of abuse (sexual or non-sexual) and acts of perpetration in later life, suggesting that taking up a perpetrator identity helps triumph over victimhood (e.g. Nathanson, 2021; Woods, 2016 & 2003; Sinason, 1996; Campbell, 1994). Key to this is a conceptualisation of there being a victim within the perpetrator (Nathanson et al., 2021). Participants highlighted the need to formulate the unique ways in which perpetrating offers a solution as it is different every time. A lack of homogeneity amongst perpetrators supports Campbell's (1994) notion that no two abusers are identical.

Lanyado et. al's (1995) paper suggests that patient 'Frank' needed first to be able to talk about his trauma and sexual abuse before thinking about his sexual offending. The study findings examine this idea from a different perspective, considering how the unconscious function of perpetration is necessary to allow the patient to 'come out' as a victim by

bringing themselves to the attention of professionals who can help them. The therapists suggested that entering therapy through the 'perpetrator door' can facilitate an opportunity for the patient to get in touch slowly with their experiences of victimhood in a safer environment. These different ways of viewing the journey of the patient further support an idea of heterogeneity amongst the client group and the need to consider carefully the specifics of each case to find meaning behind their presentation.

GET 4 – Considering the function of therapeutic work

The therapists considered a fundamental treatment aim is to address the addictive cycle that underpins perverse enactments to reduce risk to self and other, supporting Nathanson's (2021) theory of how an addictive/pathological reliance on something deadly or destructive can develop in certain individuals that require treatment (see also Meltzer, 1973; Williams, 1997; Joseph, 1982). Participants described how the optimum outcome is not to rid a patient of a compulsion to enact, something deemed highly improbable, but through the process of therapy, they develop a capacity for thought, equipping them with an alternative to action. This idea is in keeping with Bion's (1962b) notion of the development of alpha function in therapy to help transform beta elements into a thinkable unit, ultimately meaning in this population that the patient's body ceases to be a weapon as the underlying process can be conceptualised and addressed differently. Such a developmental shift involves the emergence of a capacity to symbolise (Segal, 1957), a milestone many of these patients have struggled with due to inadequate early experiences, as discussed by Fonagy (1999, 2008). This is deemed essential as therapy is finite and patients will eventually have to manage their addictive tendencies in the 'outside world'. An important aspect is helping the network support the child to understand the cycle of enactment and meet their needs differently, a finding consistent with the perspectives of Horne (2016) and Woods (2016).

A slight difference in my findings is the focus on enactment as a solution to humiliation and shame which therapy begins to allow the individual to bear. Nathanson's (2021) emphasis considers enactment as a way to manage core-complex anxieties and issues of intimacy. Whilst these two factors are likely highly related, it is not quite clear how they link up. Could it be that the implications of core-complex anxieties lead to a predisposition towards

humiliation and shame? Or perhaps issues around intimacy arise from an experience of trauma and the resultant humiliation and shame. It would be interesting to attempt to disentangle this and expand on these ideas further.

Closely linked to the previous finding, the study suggests that a pivotal factor in overcoming addictive tendencies towards enactment is the patient's capacity to link up and integrate the victim and perpetrator aspects of the self. Therapists suggested that this has the potential to mitigate the guilt, humiliation and shame which fuels the addictive cycle of enactment, when one aspect cannot be owned and there is an unconscious suicidal attempt on the unwanted part. This idea of needing to marry up the conflicting aspects of one's identity is a theme in much of the literature and supports the central idea of there being a victim within the perpetrator (Nathanson et. al., 2021; Allan, 2016). The findings echo Horne's (2016) understanding that there can be a desire for a patient to choose one identity over the other. She focusses specifically on how a perpetrating identity can offer something preferable to the vulnerability inherent in the individual's experiences of abuse. The interviewees expanded on this, demonstrating how such splitting of the identity can also work the other way round, with a patient tied to a victim identity and avoidantly dismissing the destructive, perpetrator aspects of their history. Connecting the contrasting aspects of one's experiences clearly relates to Klein's idea of a shift towards integration as a sign of psychic development, progressing from paranoid-schizoid functioning to the onset of the depressive position (Klein, 1946).

The psychotherapists detailed the fundamental role containment plays in a patient's psychological development, in line with Woods (2016) assertions. They described how a key factor in integrating their perpetrator parts is helping to develop the patient's mind as a 'home' where disturbing aspects can be contained and examined. This suggests that if perverse and disturbing aspects of the self can be tolerated, with compulsions understood and metabolised, then external world action is not required. This part of the identity can be thought about and owned, eventually internalising a capacity to hold this destructive aspect of the self and think about it independently. Some of the almost fairy tale like descriptions of this process symbolically capture the sense of nurture and nourishment offered through psychotherapy. One participant detailed how key to facilitating this in therapy is the

therapist holding hope for something different for the patient, offering containment through the holding of their mind. Whilst the concept of containment is well established in psychotherapy (Bion, 1962), it seems that for this patient group the level of deficit is so great that an experience of this has an even more urgent importance.

The research findings underline that perpetrator patients need to be helped to discover a 'healthy', non-perverse aggression which can be expressed adequately to avoid its sexualisation. This finding is in-line with Glasser's (1979) theory of the mechanics that underlie perversion and is similarly supported in the clinical case study literature (e.g. Nathanson, 2021; Horne, 2001b). Participants described how the suppression of healthy aggression means it can become toxic, darker and harmfully disguised in sexualisation and manifesting in projection into another. This fits with Stoller's (1975) conceptualisation of perversion as an erotic form of hatred. There was an understanding amongst the psychotherapists that aggression is a fundamentally important and developmentally necessary emotion required to progress through life and attend to one's needs. They stressed a need to re-conceptualise negative associations with aggression and to see it as a vital life skill.

Finally, the therapists described how the positive impact of therapy is often observed in a patient's developments in the external world, including new relationships and developed relational capacities such as humour and reparation. Participants placed emphasis on the need not to examine just the trauma and disturbance of the patient's history and help them understand their behaviour but to support them in finding something else to meet their needs in the future. This is in-line with the idea of the psychotherapist as developmental object (Hurry, 1998) and recognises the importance of the external world, as well as the internal, as Woods (2003) emphasises. Participants noted how evidence of treatment helping the child progress developmentally is seen in their capacity to be 'in life' instead of revelling in darkness and underground perversity, something that chimes with Parsons (2009) discussion of the importance of recognising the non-perverse parts of the individual to bring about a reconstitution of a punitive superego.

5.1 – Clinical Implications

This small-scale study contributes to the dearth of existing literature, offering a nuanced account of the experience and understandings of Child and Adolescent Psychoanalytic Psychotherapists working with a patient group who have perpetrated sexual violence. The study findings provide rich data encompassing different aspects: the theoretical roots, an understanding of the impact on the therapist, an examination of technique and approach and a way of conceptualising change. This suggests a 'taxonomy of approach' to consider when working with this patient group. The spectrum of experience captured contributes to an understanding of the mechanics of the psychoanalytic work and provides important, detailed insight for those with lesser experience in this area, including trainee and qualified Child and Adolescent Psychotherapists. Developing understanding of this patient group is of particular importance as there is increasing evidence to suggest that not only is sexual violence amongst children becoming 'commonplace' (McNeish & Scott, 2023), it is on the rise (Moodie, 2021; Savage, 2024). Therefore, broadening awareness of the clinical situations as it pertains to this demographic is particularly important if there will be a need for increased clinical work of this nature in the future.

As this research project elucidates, there can be a multitude of powerful experiences evoked for psychotherapists, both bodily and otherwise, when working with those who have perpetrated sexual violence. A preparatory grounding in what could be expected during such interventions is helpful for those with lesser experience or not practicing as part of a specialist team, alleviating some of the anxiety that this work can produce. The research indicates the need to provide clinical work which is longer in duration as well as adequately supervised, in order to negotiate complicated issues of intimacy amongst the client group, as well as manage the many dynamics that can arise clinically. There is practical thought given to how to adapt more traditional ways of working psychoanalytically, to meet the needs of a group of patients who are often exceedingly 'hard to reach'. This is all helpful information for approaching this clinical work. An awareness of the pride that clinicians feel about forensic work and the associated rewards, might encourage greater interest in this area.

One of the most important findings for all clinical practice, is the assertion that there is a victim and perpetrator part universally present within every patient. The research suggests this is not exclusive to those who have a 'forensic' profile. This is a reminder for clinicians not to become pulled into seeing a patient through only one lens or resorting to a distorted viewpoint arising from splitting processes. It is also a wider reminder, at a societal level, that the notion of exclusively 'good' and 'bad' people is misrepresentative and denies that complex psychic reality that exists within all of us. This perspective is helpful to re-iterate in response to a growing rhetoric of blame and scapegoating which can be readily observed at a geopolitical level.

5.2 - Strengths, limitations and future research

The complexity inherent in 'forensic' work is clearly described in this research, teasing out myriad themes and multi-faceted ideas, incorporating both conscious and unconscious processes. The participants, all highly experienced and immersed in specialist therapeutic practice with the group of interest, provided detailed accounts well suited to exploration using Interpretative Phenomenological Analysis (IPA), an approach designed to "describe, explore and analyse the ways that people create meaning in their lives" (McLeod, 2015, p.92). Psychoanalysis as a theoretical orientation is grounded in the minutiae of individual experience and the methodological approach has tapped into the wealth of knowledge of the specialist clinicians to understand how the work is undertaken from a specific orientation (Smith & Osborn, 2003, p.56). The complexity of the findings supports the decision to use IPA, allowing subtleties to be explored between participants as well as incorporating additional layers of interpretation through the 'double hermeneutic' approach (McLeod, 2015).

Despite its strengths, this study has also a number of limitations. It could be argued that many of the strengths of IPA could be considered, conversely, as its weaknesses. Whilst an informed decision was made that this was the most suitable approach to data analysis, it is important to bear in mind the potential shortfalls. The intention of this project is not to arrive at a definitive, objective answer to a question of how to work effectively with this complex client group, but instead to develop a more nuanced understanding of aspects of

the work, guided by the thoughts and experience of specialist clinicians. This is the kind of research IPA is designed to analyse. However, the methodology has been considered by some as having limited standardisation, being overly descriptive and implicitly subjective (Giorgi, 2010; Brocki & Wearden, 2006; Hefferon & Gil-Rodriguez, 2011). As I am the sole researcher of this study, responsible for planning, implementing and analysing its findings, it would be impossible for the project not to carry my individual stamp and be influenced by my subjectivity. Although subjectivity has been considered an inevitable fact of qualitative research (Tufford & Newman, 2012), it has important limitations. In an attempt to mitigate somewhat the effect of bias, theme construction was discussed in detail with my supervisors and members of the research study group. Yet, interpretations of the findings do need to be viewed in light of my potential bias and frame of reference, especially as I am a white, male clinician who also works within the service where the research is based. It was important to remain conscious of my epistemological position and continuously return to this to consider the impact of this on the data analysis and discussion.

As both a researcher and trainee psychotherapist within the team, I was an 'insider researcher' (Asselin, 2003). This appears to have had some real benefits in allowing participants to speak freely about the more disturbing experiences of the work (e.g. feelings of hatred towards the patient). However, our close professional relationship may, in some instances, have acted as an impingement. A number of the participants had supervisory responsibilities for me, which may have meant they felt the need to hold back on some aspects of discussion, e.g. some of the thinking about the impact of the work, to protect me and my training experience. There may also have been some parts of their process they did not want to explore with a more junior colleague, meaning they could be considered 'defended subjects' (Holloway & Jefferson, 2009).

Similarly, the patient group which is the focus of this study was the same demographic I worked with on a daily basis, therefore I had a professional investment in the subject area. I also undoubtedly had a transference to the institution and participants and an investment in the psychoanalytic modality. I was therefore certainly not a 'neutral' researcher. Thus, this may have influenced my examination of interview data and findings as there was potential for bias/pre-conceived ideas about what should be interpreted to fit with my own

conceptualisation of the work. In order to mitigate this as much as possible, I remained alert to this as I oscillated between my position as colleague/psychotherapist/researcher, but it would be misleading to suggest that this could be disentangled neatly without some 'overspill' influencing the reporting and interpreting of the data. As the findings demonstrate, there is something political that infuses the work and drives the therapists, and it would be remiss to suggest I was not party also to this way of viewing the subject matter. Perhaps, on an unconscious level, there were certain things I did not want to reveal or focus on about my place of work, a desire to protect or maintain the 'inner circle' and not let outsiders too close. I also wondered about my desire to protect a highly vulnerable patient group from potentially critical outside eyes.

I attempted to stay abreast of these matters through continual self-examination during the analytic process, working to ensure I stayed close to the data without overly abstracting based on personal knowledge and assumption. If the research were to be replicated on a larger scale it could be helpful to have findings coded and interpreted by a second coder, perhaps someone without any prior experience of work within this specialism. It could be illuminating to see how someone with a different 'lens' found meaning in the results, examining commonalities and hypothesising about differences as a way of considering subjective bias.

Another, methodological limitation pertains to the sample size. The study included a small and relatively homogenous sample. IPA does not call for a large sample size as the focus is the idiographic rather than nomothetic (Smith, Flowers & Larkin, 2022). However, it needs emphasising that findings are not generalisable to other samples or services. Even within an IPA study, the inclusion of more therapists would have affected the resulting group experiential themes. Participants all work within the same well-established institution, a centre which holds much influence in this specialist forensic area of psychotherapy. This means there is the possibility of an 'echo chamber' effect, perhaps prioritising a particular school of thought. Much of the case study literature referred to is also written by one-time colleagues of my interviewees. This might explain why, on the whole, there appears to be a great deal of consensus between that literature and my findings, indicative of a legacy of thought developed by a linked group of therapists. Whilst the aim of this study is not to

achieve a universal perspective of Child and Adolescent Psychoanalytic Psychotherapists on this work, further research could illuminate the diversity of experiences. This could incorporate perspectives of those working in other services with children who are perpetrators of sexual violence, e.g. youth offending, forensic CAMHS or generic services who may have different ways of working.

Another notable limitation is the broadness of the term 'sexual violence' and that this could have been interpreted by participants in different ways. One participant, for example, had worked with a large number of patients who had viewed illegal images of child abuse online and there was a wider question for him about whether this was sexually violent or a sign of restraint by not 'crossing the body barrier'. The lack of specification left the door open for a range of responses but also perhaps diluted the specificity of the study. Whilst I purposely left this open to see what interviewees would make of this term and its applicability to their patient group, in retrospect this might have caused confusion and I could have been more specific in my definition, for example, focusing specifically on contact offenses. It would be an interesting research development to think comparatively about the harm of online sexual violence and the understanding and experiences of psychotherapists focusing on this work to see if there are differences.

Furthermore, I did not specify the age group in which I was particularly interested within the 'child and adolescent' range. Whilst my intention was to think about the wider demographic, it came across in the interviews that technique and thinking about patients varies based upon their age, although interestingly it did not come up as a theme. As the psychoanalytic literature review describes, there is a great deal of development across stages of childhood and adolescence. Perhaps, by not having a more localised age focus, the specifics of experience and understanding became diluted. In future research it would be helpful to have a clearer definition of the specific age group, carefully thinking about the unique aspects of work and how they are targeted to the age of the patient. It could also be fruitful to interrogate how gender of the patient influences the understanding and experience of the work. Whilst there are female children and adolescents who enact sexual harm, the service in this study sees mostly males. It is therefore likely that this demographic was the focus of much of my interviewees' thought process. Some specific consideration of young women

who offend could offer an interesting companion study, exploring if societal understandings of masculinity and maleness influence thinking about perpetrators. It would also be important and illuminating to conduct research with the patients directly, to understand more about their experience and perspective.

5.3 - Conclusions

This study makes an important statement about the ways in which children and adolescents who perpetrate sexual violence can be understood and considers in detail the approach to working clinically with them. Findings clearly emphasise that the notion of a perpetrator cannot be considered without exploring the co-existence of an experience of victimisation. Attention is paid to how these two identities exist alongside one another, either displacing, covering up or potentially becoming integrated parts of the individual's experience. As emphasised by the study participants, work with this patient group is clearly extremely challenging and impactful for the therapist, including managing powerful countertransference experiences and the emergence of disturbing dynamics, however it also proves to be immensely rewarding. The 'liveness' of the experience with the patient and its powerful effect is the raw material that must be worked with to bring about development, with enactments and provocations providing essential information for elucidating their inner world, developing understanding and helping gear therapeutic approach accordingly. Based on the unique information gained in the consulting room, there is an appreciation that perpetrating behaviours need to be uniquely hypothesised and understood based on the specifics of the patient.

The work of psychotherapy provides a controlled environment in which the most perverse, shameful and humiliating parts of the patient's selfhood can be contained and explored. This allows an opportunity for these hated parts to be housed, worked through and eventually integrated. A fundamental development is the de-toxification of sexualised aggression and a burgeoning capacity for healthy aggression. From the therapist's perspective it is evident that an applied version of psychoanalytic practice is required to meet the needs of the patient group, working flexibly and creatively to find a way to reach individuals who have deep-rooted issues with trust and intimacy. Participants spoke of a need to "shake the tree

from every angle" to reach the patient. This evidently requires rigour and therapeutic muscle to gain leverage on a seemingly rigid and immobile presentation. Tolerance and patience is required as well as a fine-tuned ability to spot incremental changes, some of which first may be observed outside of the therapy room. Fundamental to the success of this work is the preservation of spaces where therapy can be expertly held through the delivery of long-term interventions, settings that allow the space and time needed for development of the extremely neglected and maltreated parts of these patients. Integral to this is preserving thinking space for clinicians to grapple with the many facets of undertaking this work and for them too to find themselves 'housed' within an institution providing the nurturance and secure base required to face bravely the troubled worlds these patients inhabit.

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Appendix A – Consent Form

The Tavistock and Portman NHS
NHS Foundation Trust

Consent Form

Project title: Exploring clinicians' experience and understanding of psychoanalytic psychotherapy with children who are perpetrators of sexual violence: an interpretative phenomenological analysis

Researcher: Tom Robinson

- I_____ agree to participation in this research. ☐
- I have read the information sheet and had the chance to ask questions and discuss any concerns with the researcher. ☐
- I am a voluntary participant and understand I can withdraw my data up to three weeks after the interview has been completed. ☐
- I understand that my interview will be recorded and transcribed. ☐
- I understand that my contribution will remain confidential unless there are concerns about risk. ☐
- I understand that quotes may be used in this research. These will be anonymised and securely held by the researcher. As this study is small in scale, colleagues may be able to guess the source of certain responses. ☐
- I understand that I should anonymise case examples discussed during the interview. If identifying information is included this will be anonymised. ☐
- I understand that the research results will be published as a doctoral research thesis. They may form part of future academic publications and presentations. ☐

Contact details:

Researcher: Tom Robinson Email: trobinson@tavi-port.nhs.uk

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

Participant's Name (Printed):_____

Participant's signature:_____ Date:_____

Thank you for your participation it is much appreciated.

Appendix B – Participant information leaflet

The Tavistock and Portman NHS
NHS Foundation Trust

Research Project Title

Exploring clinicians' experience and understanding of psychoanalytic psychotherapy with children who are perpetrators of sexual violence: an interpretative phenomenological analysis

This information sheet is to help you decide whether to take part in a doctoral research project. The study will be described in detail outlining your involvement if you decide to participate.

Purpose of this study

I want to understand more about Child and Adolescent Psychotherapists' clinical experiences and understandings of working with children and adolescents (<26 years), who have perpetrated sexual violence.

Background to research

It has been suggested that about a third of child sexual abuse is perpetrated by children (NSPCC, 2019). Exact figures are difficult to establish, contributed to by a culture of shame and secrecy that surrounds child sexual abuse/abusing that impacts on disclosure levels. Anecdotally, within the XXXXXXXXX, it is observed as a common theme that patients seeking support as a result of a harmful sexual enactment have also experienced sexual victimisation. It is also important to note that whilst links are observed both clinically and in the literature, the majority of children who have been sexually abused will not go on to enact further sexual harm (ibid.).

For those that do, research illustrates that there is a great need for good quality, thoughtful intervention (Hackett, 2014). 'Psychotherapeutic approaches' are recommended within NICE guidance (2016) for treatment, however there does not appear to be a great deal of literature that focusses specifically on psychoanalytically informed treatments. A notable exception are psychoanalytic contributions made by Woods (1997, 2003) and a more recent collection of theoretically informed clinical case studies from the CAP team at the Portman Clinic (Nathanson et al., 2021). These texts place at the heart of the thinking, the parts of the self a child may bring to therapy and the importance, and associated challenges of, attending to these varying aspects to enable most effective treatment. An expanded body of empirical work from a psychoanalytic research perspective, further exploring the clinical approach involved in this intricate and challenging area would add to the literature. This will helpfully elaborate on technique and demonstrate some of the dilemmas that clinicians may face, allowing heightened attention to unconscious processes and how these are handled in therapy. This could further theory/practice links by developing understanding of the intricacies of an abuser child's psychic space and the meanings of their behaviour.

Research into psychoanalytically derived treatments could expand on more action-oriented behaviour change models which often hold a preliminary focus of 'fixing' what may be considered a maladaptive behaviour. Whilst both approaches can be meaningful individually or in conjunction, allowing understanding of the function of the behaviour for the child from a psychoanalytic perspective can be an essential part of facilitating change, illuminating something of the complex internal worlds of children often demonised because of harmful acts. Intervention at this stage of

development has the potential to change the course of a child's life and deserves a wider breadth of research to help unpick some of the inherent complexities.

Who is running the study?

I am Tom Robinson, a researcher at the Tavistock and Portman NHS Foundation Trust where I am also completing doctoral training as a Child and Adolescent Psychotherapist (certified by the University of Essex). This research is being supported and sponsored by The Tavistock and Portman and has passed relevant ethical approval (TREC).

What will my participation involve?

You will be invited to participate in a semi-structured interview. I would be interested to hear how you think about (from your training and clinical experience) the 'categories' of perpetrator, your approach to work with children (age <26) fitting this description and your observations and thoughts on the complexities and dynamics that may emerge in clinical work.

Interviews will take approximately 60 minutes and will be digitally audio recorded. The intention is for these interviews to be conducted face to face at the XXXXXXXXXXX, however, if this is unable to happen for reasons relating to COVID-19 they will be conducted via Zoom.

If the interview is face to face it will be at the XXXXXXXXXXXXXX. This will be done within working hours.

Is my participation compulsory?

No, participation is your choice. You can withdraw without at any time (up to three weeks after the interview) without disclosing why. This timescale has been decided upon as after this time data will have been processed. If you withdraw all data collected within the time-frame described above will be immediately destroyed.

Participation Criteria:

- Accredited status as a Child and Adolescent Psychotherapist
- Experience of work within the Child Psychotherapy Team at the XXXXXXXXXXX
- At least 4 years experience working with children with a history of perpetrating sexual violence

What will happen to my information?

The Tavistock and Portman NHS Foundation Trust sponsors this UK based study. I will be using your information in this study and I will be the data controller. I will look after your information and use it properly. Identifiable information about you used in the process of this study will be kept for 5 years post study completion. Interviews will be recorded and transcribed myself. All identifiable information will be anonymised.

Rights to change, move or access information are limited, this is because I will handle your information in specific ways for the research to be deemed accurate and reliable. I will use the minimum identifiable information possible. Your name and contact details will only be used to make contact about this study and I have sole access to your identifiable information. I may receive

assistance by supervisors and teachers to aid in analysing the information. I will ensure that they are unable to identify you individually.

Direct quotes will be used in the project write up, but again these will be anonymised. It may be possible that your colleagues may recognise the source of some quotes, although I will aim to prevent this from happening where possible.

Electronic data will store confidentially and password protected with any paper copies locked away. Audio data will be destroyed when the project is completed. Other study data will be kept securely for 5 years.

For information on Tavistock and Portman privacy policies please visit the below sources:

https://tavistockandportman.nhs.uk/about-us/contact-us/about-this-website/your-privacy/

Further information about the legal framework relating to how your information will be processed can be found by making contact with the trust's Data Protection Officer: dpo@tavi-port.nhs.uk

Limitations to confidentiality/information apply when there are matters of risk.

What will happen to the research results?

Study results will be used as part of a research dissertation and doctoral qualification. Results may be used in future publications and presentations for academic purposes..

A summary of results can be sent to you if you make a request to me directly.

What are the potential benefits of taking part?

There will be no direct benefits, however, you will be contributing to empirical research within this specialist field and enhancing the recorded knowledge base. Research findings could be helpfully disseminated to other professionals. It is hoped that the interviews provide a space for you to reflect on your experience in a way that may be interesting and helpful for future work.

Are there risks involved?

There are no direct risks. However, this is a sensitive and evocative subject matter and it is possible that discussion may at times be uncomfortable/cause distress. Details of a confidential service will be provided to access further support.

Contact details

I am the primary contact for this research. If you have questions about the project or for further discussion please contact me directly. My contact details are:

Tom Robinson
Email: trobinson@tavi-port.nhs.uk

Alternatively, concerns can be directed to my research supervisor:

Dr Felicitas Rost

Email: Frost@tavi-port.nhs.uk

If you have concerns about the conduct of this research, the researcher or other aspect of this project, you can contact Helen Shaw, Head of Academic Governance and Quality Assurance (academicquality@tavi-port.nhs.uk).

Thank you for considering participating in this study and reading the above information. If you would like to take part please complete and sign a consent form.

Appendix C – Letter of local approval

To whom it may concern

London, 27.07.2022

Approval for psychotherapy doctorate research project at the XXXXXXXXXX

I understand that the trainee, Mr Tom Robinson, is asking to approach XXXXXXX staff for participation in his research project that he's carrying out as part of the DProf in Child and Adolescent Psychotherapy (M80).

I have seen the protocol and copies of the provisional information sheet and consent forms and within my role as Director of the XXXXXXXX, can confirm that I am happy for Tom Robinson to approach staff working at the XXXXXX in accordance to his protocol.

Yours sincerely,

Dr XXXXXXXXXXXXX
Director, XXXXXXXXXX

Appendix D – Recruitment email

Dear

I am soon to be commencing my doctoral research project as part of my Child and Adolescent Psychotherapy training. I am making contact to see if you might be interested in taking part.

The project title is: **Exploring clinicians' experience and understand of psychoanalytic psychotherapy with children who are perpetrators of sexual violence: an interpretative phenomenological analysis.**

I am interested in exploring clinician's experience and understandings of working with child and adolescent perpetrators of sexual violence.

I would like to invite Child and Adolescent Psychotherapists with experience of working as part of the team at the XXXXXXXXXXX to take part. For inclusion you will need to be ACP accredited, have over 4 years experience working with children who have displayed sexual violence. You will be asked to take part in an audio recorded interview guided by me which will last approximately 60 minutes. This will take place at the XXXXXXXXXXX or via Zoom.

If you are willing to contribute, please find participant information sheet attached for your information. I have included a provisional interview schedule which will give you an idea of some of the questions I will be asking. Please let me know if you have any further questions about the project.

If you are happy to go ahead, could you advise when you usually have some time and we can try to schedule the interview.

With best wishes

Tom Robinson

Appendix E - Debrief Letter

The Tavistock and Portman NHS
NHS Foundation Trust

Dear …

I am writing to thank you for your contribution to my doctoral research.

I understand the sensitive nature of this work and appreciate how evocative it can be thinking about sexual abuse. If there are any issues that are concerning you, I hope you can access the support network around you (colleagues, supervisor and managers). However, if this isn't possible there is a confidential counselling service provided by the Tavistock and Portman NHS Foundation Trust:

Carefirst – Employee assistance programme for wellbeing and support

The Tavistock and Portman HR department have commissioned an employee assistance programme to help with health and wellbeing matters. This is provided by Carefirst, an independent provider of employee support services. Carefirst employs professionally qualified counsellors and information specialists experienced in helping people to deal with issues such as wellbeing, relationships and issues in the workplace.

You can access this service by visiting **www.carefirst-lifestyle.co.uk** and logging-in with the below information:

Username: tavistock
Password: employee

You can also call 0800 174319 to speak confidentially to a counsellor or information specialist.

If there are questions or you require further information my contact details are:

Email: trobinson@tavi-port.nhs.uk

If you have any concerns about how the study has been conducted please contact myself, my supervisor Dr Felicitas Rost (frost@tavi-port.nhs.uk) or Helen Shaw, Head of Academic Governance and Quality Assurance (academicquality@tavi-port.nhs.uk).

With best wishes

Tom Robinson

Appendix F – TREC ethical approval

The Tavistock and Portman NHS
NHS Foundation Trust

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

Tel: 020 8938 2699
Fax: 020 7447 3837

Thomas Robinson

By Email

18 November 2022

Dear Thomas

Re: Trust Research Ethics Application

Title: 'Understanding experiences of psychotherapeutic work with children who are both victims and perpetrators of sexual violence. An Interpretative Phenomenological Analysis of Clinicians' Perspectives.'

I am pleased to inform you that subject to formal ratification by the Trust Research Ethics Committee your application has been approved. This means you can proceed with your research.

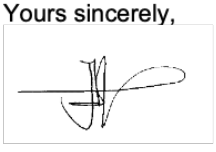
Please note that any changes to the project design including changes to methodology/data collection etc, must be referred to TREC as failure to do so, may result in a report of academic and/or research misconduct.

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

I am copying this communication to your supervisor.

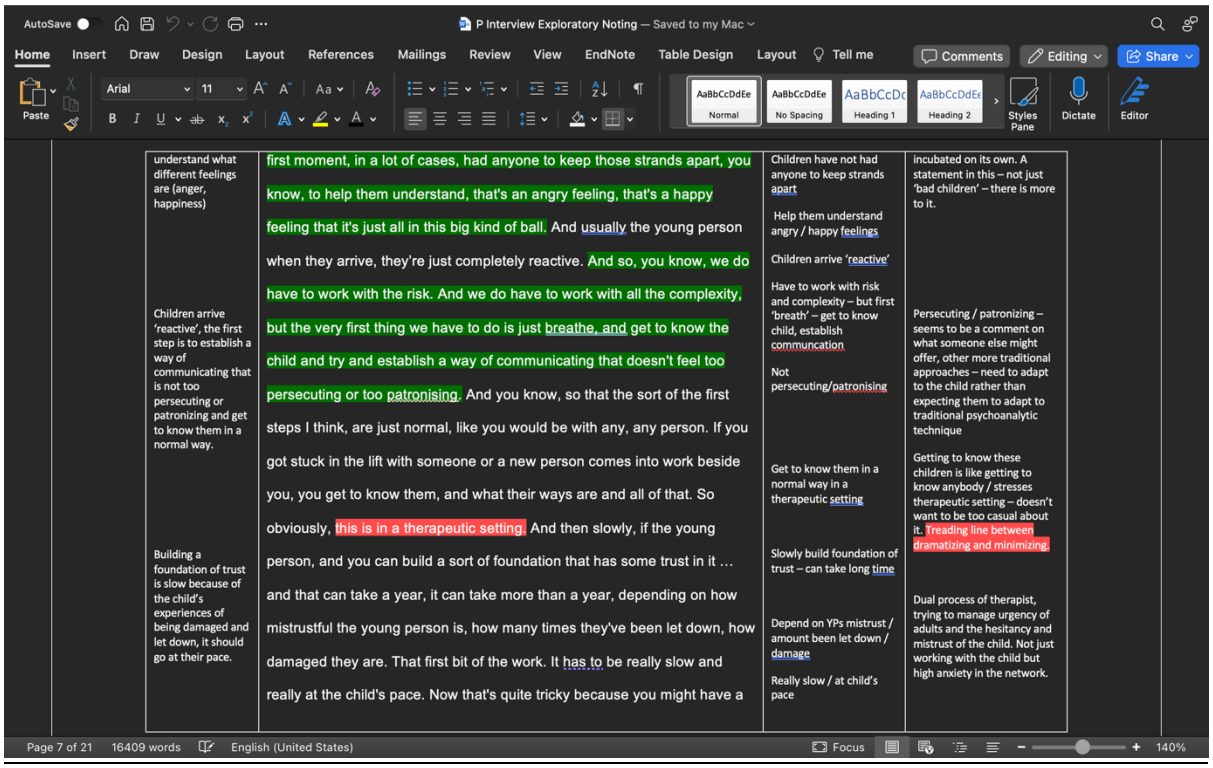
May I take this opportunity of wishing you every success with your research.

Yours sincerely,

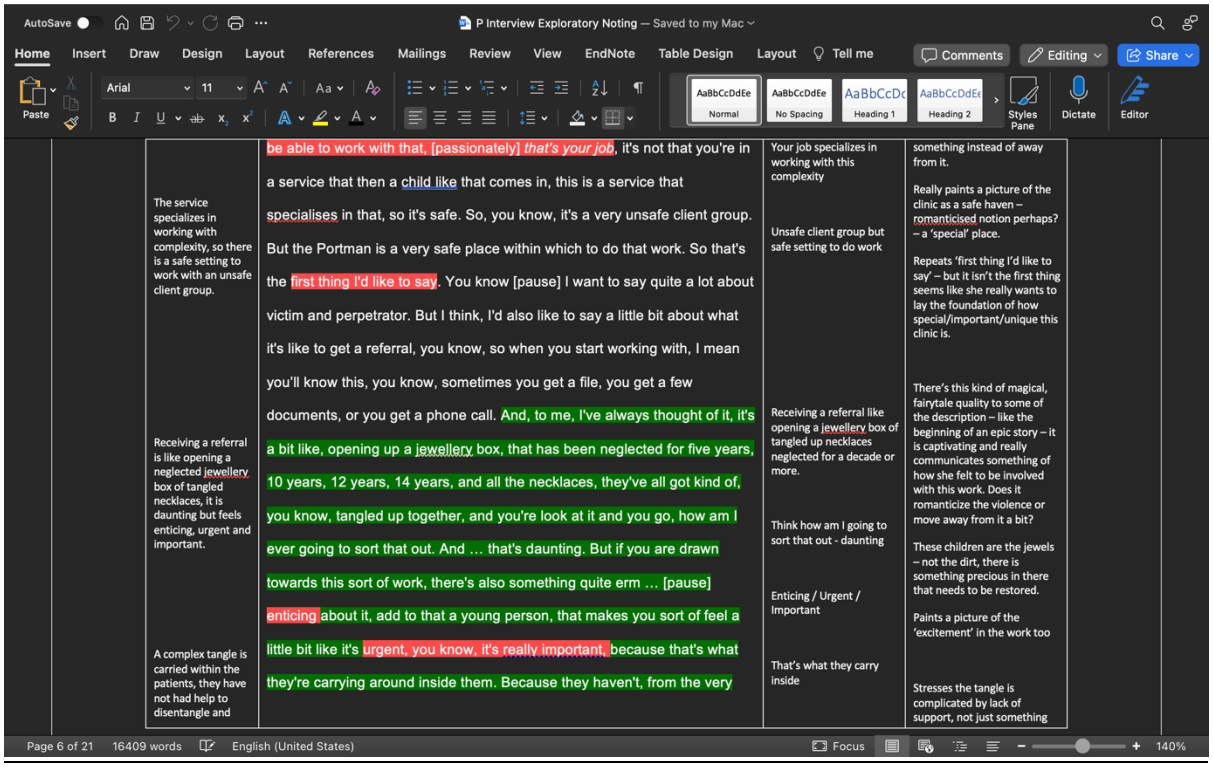


Paru Jeram
Secretary to the Trust Research Degrees Subcommittee
T: 020 938 2699
E: academicquality@tavi-port.nhs.uk

Appendix G – Examples of exploratory noting / experiential statements

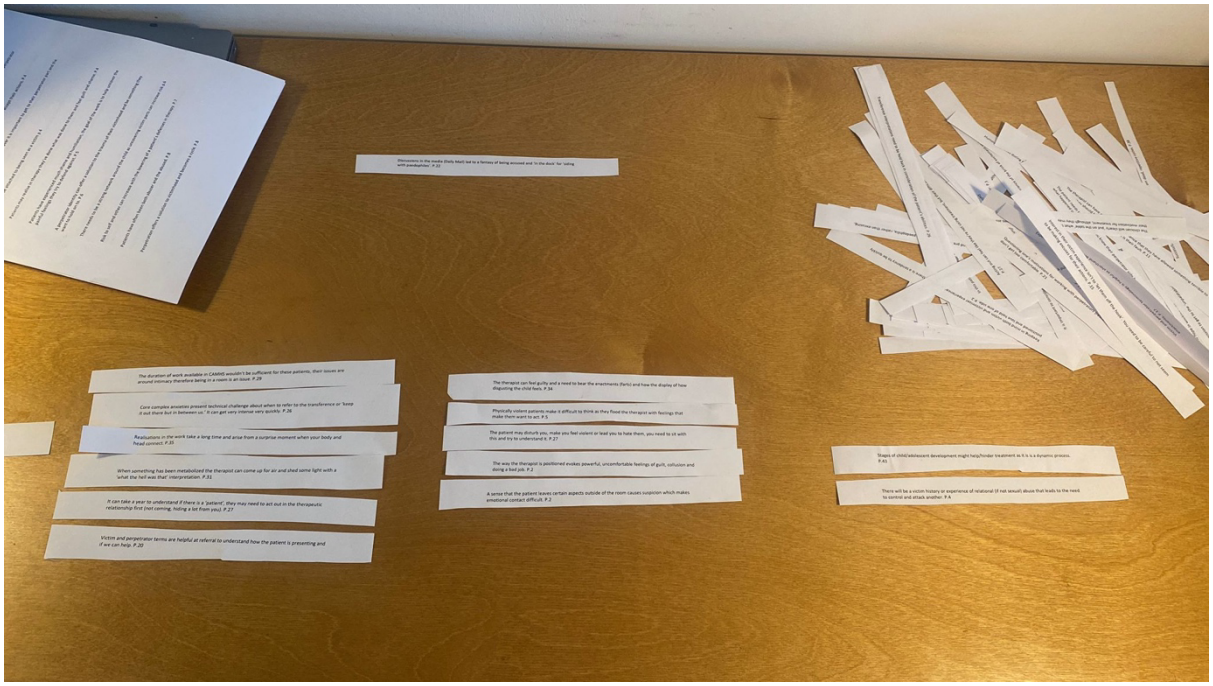


understand what different feelings are (anger, happiness)	first moment, in a lot of cases, had anyone to keep those strands apart, you know, to help them understand, that's an angry feeling, that's a happy feeling that it's just all in this big kind of ball. And usually the young person when they arrive, they're just completely reactive. And so, you know, we do have to work with the risk. And we do have to work with all the complexity, but the very first thing we have to do is just breathe, and get to know the child and try and establish a way of communicating that doesn't feel too persecuting or too patronising. And you know, so that the sort of the first steps I think, are just normal, like you would be with any, any person. If you got stuck in the lift with someone or a new person comes into work beside you, you get to know them, and what their ways are and all of that. So obviously, this is in a therapeutic setting. And then slowly, if the young person, and you can build a sort of foundation that has some trust in it … and that can take a year, it can take more than a year, depending on how mistrustful the young person is, how many times they've been let down, how damaged they are. That first bit of the work. It has to be really slow and really at the child's pace. Now that's quite tricky because you might have a	Children have not had anyone to keep strands apart Help them understand angry / happy feelings Children arrive 'reactive' Have to work with risk and complexity – but first 'breath' – get to know child, establish communcation Not persecuting/patronising Get to know them in a normal way in a therapeutic setting Slowly build foundation of trust – can take long time Depend on YPs mistrust / amount been let down / damage Really slow / at child's pace	incubated on its own. A statement in this – not just 'bad children' – there is more to it. Persecuting / patronizing – seems to be a comment on what someone else might offer, other more traditional approaches – need to adapt to the child rather than expecting them to adapt to traditional psychoanalytic technique Getting to know these children is like getting to know anybody / stresses therapeutic setting – doesn't want to be too casual about it. Treading line between dramatizing and minimizing. Dual process of therapist, trying to manage urgency of adults and the hesitancy and mistrust of the child. Not just working with the child but high anxiety in the network.
Children arrive 'reactive', the first step is to establish a way of communicating that is not too persecuting or patronizing and get to know them in a normal way.		
Building a foundation of trust is slow because of the child's experiences of being damaged and let down, it should go at their pace.		



The service specializes in working with complexity, so there is a safe setting to work with an unsafe client group.	be able to work with that, [passionately] *that's your job*, it's not that you're in a service that then a child like that comes in, this is a service that specialises in that, so it's safe. So, you know, it's a very unsafe client group. But the Portman is a very safe place within which to do that work. So that's the first thing I'd like to say. You know [pause] I want to say quite a lot about victim and perpetrator. But I think, I'd also like to say a little bit about what it's like to get a referral, you know, so when you start working with, I mean you'll know this, you know, sometimes you get a file, you get a few documents, or you get a phone call. And, to me, I've always thought of it, it's a bit like, opening up a jewellery box, that has been neglected for five years, 10 years, 12 years, 14 years, and all the necklaces, they've all got kind of, you know, tangled up together, and you're look at it and you go, how am I ever going to sort that out. And … that's daunting. But if you are drawn towards this sort of work, there's also something quite erm … [pause] enticing about it, add to that a young person, that makes you sort of feel a little bit like it's urgent, you know, it's really important, because that's what they're carrying around inside them. Because they haven't, from the very	Your job specializes in working with this complexity Unsafe client group but safe setting to do work Receiving a referral like opening a jewellery box of tangled up necklaces neglected for a decade or more. Think how am I going to sort that out - daunting Enticing / Urgent / Important That's what they carry inside	something instead of away from it. Really paints a picture of the clinic as a safe haven – romanticised notion perhaps? – a 'special' place. Repeats 'first thing I'd like to say' – but it isn't the first thing seems like she really wants to lay the foundation of how special/important/unique this clinic is. There's this kind of magical, fairytale quality to some of the description – like the beginning of an epic story – it is captivating and really communicates something of how she felt to be involved with this work. Does it romanticize the violence or move away from it a bit? These children are the jewels – not the dirt, there is something precious in there that needs to be restored. Paints a picture of the 'excitement' in the work too Stresses the tangle is complicated by lack of support, not just something
Receiving a referral is like opening a neglected jewellery box of tangled necklaces, it is daunting but feels enticing, urgent and important.		
A complex tangle is carried within the patients, they have not had help to disentangle and		

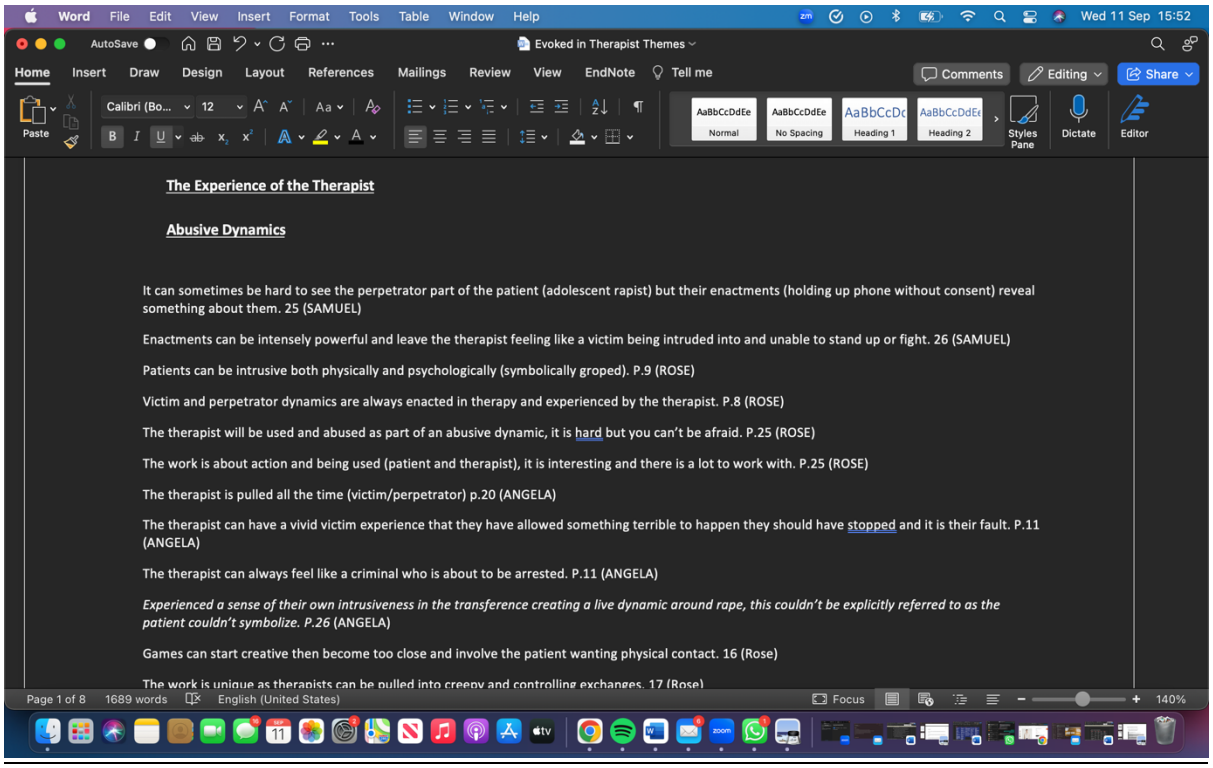
Appendix H – Example of assembling personal experiential themes



Appendix I – Table of personal experiential themes

Samuel	Rose	Joseph	Eve	Angela
Being with the patient The Victim Experience Moving on From Abuse Function of Enactments Against Others Psychotherapists views and Societal Perspective from outside the Forensic Speciality Function of Therapy	Sustainability of the Work External Factors and Risk Managing issues of intimacy of the work Meaning Making Victim or Perpetrator? Therapeutic Technique Therapists emotional / physical experience in the working dynamic (IMPACT?) Personal Beliefs Function of Therapy	Therapeutic Technique and Ways of Working Function of Therapy Impact of the Work on Therapist Meaning Making Patients' Perspectives Therapist's Perspective Defining Violence	Network Working Conceptualising Patient Presentations Managing the Work Therapeutic Approach Being with the Patient Function of Therapy	Therapists emotional / physical experience in the working dynamic THERAPEUTIC APPLICATION PERSONAL BELIEFS / APPREHENSIONS IMPACT OF THE WORK FOR PATIENTS MEANING MAKING Expectations of Treatment Limitations of Victim / Perpetrator Terminology

Appendix J – Evidencing group experiential themes



The Experience of the Therapist

Abusive Dynamics

It can sometimes be hard to see the perpetrator part of the patient (adolescent rapist) but their enactments (holding up phone without consent) reveal something about them. 25 (SAMUEL)

Enactments can be intensely powerful and leave the therapist feeling like a victim being intruded into and unable to stand up or fight. 26 (SAMUEL)

Patients can be intrusive both physically and psychologically (symbolically groped). P.9 (ROSE)

Victim and perpetrator dynamics are always enacted in therapy and experienced by the therapist. P.8 (ROSE)

The therapist will be used and abused as part of an abusive dynamic, it is hard but you can't be afraid. P.25 (ROSE)

The work is about action and being used (patient and therapist), it is interesting and there is a lot to work with. P.25 (ROSE)

The therapist is pulled all the time (victim/perpetrator) p.20 (ANGELA)

The therapist can have a vivid victim experience that they have allowed something terrible to happen they should have stopped and it is their fault. P.11 (ANGELA)

The therapist can always feel like a criminal who is about to be arrested. P.11 (ANGELA)

Experienced a sense of their own intrusiveness in the transference creating a live dynamic around rape, this couldn't be explicitly referred to as the patient couldn't symbolize. P.26 (ANGELA)

Games can start creative then become too close and involve the patient wanting physical contact. 16 (Rose)

The work is unique as therapists can be pulled into creepy and controlling exchanges. 17 (Rose)