How do child psychotherapists hold their patients' history in mind? Intersecting unlaid ghosts of intergenerational trauma when working with gender-variant young people presenting with mental health comorbidities.

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Abstract

This qualitative research project explores the experiences of child and adolescent psychotherapists (CAPs) when encountering intergenerational trauma while working with gender-variant patients presenting at CAMHS with mental health comorbidities. It focuses on exploring the transmission of intergenerational elements in family histories, how CAPs recognise this and manage this alongside live trauma that this patient group might experience.

The literature review explores the complex history of psychoanalysis and gender, intergenerational trauma, gender and family history, the role of the therapist's mind and a summary of the Cass Review 2022/2024. It considers the vast multitudes of projections that a young person (YP) and clinician encounter from society, bringing to light how a YP identifying as gender variant is facing more than just a sense of not belonging to their prescribed natal body but an intersection of challenges.

Three CAPs with relevant experience were interviewed twice following a Free Association Narrative Interview approach (FANI) using Interpretative Phenomenological Analysis (IPA), which acknowledges a reflexive approach at every stage and subjectivity of the participants' and researcher's lived experiences.

The interviews yielded five Group Experiential Themes (GETs): 'Noticing GAPs', 'Enactment', 'Active Management', 'It's Personal' and 'The Whole Person and Safety'. The GETs describe how the participants held in their mind a combination of both trauma and intergeneration/familial and interwoven themes.

The five themes illustrate the CAPs' ability and role of noticing gaps and associated losses in complex trauma and familial systems, the speed that defences easily become enacted and how to respond creatively, actively and sensitively to manage this risk and vulnerability of interconnected, multigenerational and societal jigsaw pieces. Overall, the results highlight the implications for the CAP in the ongoing political heat of our society's responses to gender-questioning YP and adults in that gender moves from a highly individualised personal experience to becoming everyone's business.

Keywords: intergenerational history, familial trauma, child and adolescent psychotherapy, gender, third mind, countertransference.

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Terminology

I have used the language gender variant, gender diverse or trans/ transgender throughout the report as an umbrella term to include a broader spectrum of gender diversity that includes binary transgender individuals, non-binary individuals, those who do not have a traditional gender binary of male or female, or who are gender questioning or "undecided individuals" (Willo, 2020, p.8). This also includes the Cass Review (2024, p.19) definition of "gender non-conforming" – which is used to describe "those individuals who do not choose to conform to traditional gender norms and 'gender-questioning' as a broader term that might describe children and young people who are in a process of understanding their gender identity".

I define comorbidity as the simultaneous presence of two or more health conditions (either physical or mental) for which a young person may seek help or that can be present.

As the Cass Review (2022/2024) is the most up-to-date independent review of gender identity services for children and YP, I have cited its following definitions that may be used throughout the report:

> Gender incongruence is the term used in the *International Classification of Diseases Eleventh Revision* (ICD-11) (World Health Organization, 2022) to describe "a marked and persistent incongruence between an individual's experienced gender and the assigned sex". It has been moved out of the "Mental

and behavioural disorders" chapter and into the "Conditions related to sexual health" chapter so that it is not perceived as a mental health disorder. It does not include references to dysphoria or dysfunction…

In the *Diagnostic and Statistical Manual of Mental Disorders*, 5th Ed., Text Revision (DSM-5-TR) (American Psychiatric Association, 2022) definition gender incongruence has to be associated with clinically significant distress or impairment of function. Younger children with gender incongruence may not experience dysphoria, but it commonly arises or increases as they enter puberty.

Gender dysphoria is the term used in DSM-5-TR (American Psychiatric Association, 2022). Gender dysphoria is the more commonly used term in research publications, as well as clinical settings. It is also most likely to be familiar to the lay public since it has been used widely in mainstream and social media. Like depression, it is a label that is used colloquially to describe feelings, as well as being a formal diagnosis. (Cass Review 2024, p.18)

Abbreviations

ACE	Adverse childhood experience
ASC	Autism spectrum condition
ADHD	Attention deficit hyperactivity disorder
CAP	Child and adolescent psychotherapist
CAMHS	Child and Adolescent Mental Health Service
EDI	Equality, diversity and inclusion
GIDS	Gender Identity service
LGBTQIA+	Lesbian, gay, bisexual, transgender, Queer (or questioning), intersex, asexual, plus is a glossary or working vocabulary that may also include other terms such as non-binary, genderqueer, genderfluid, agender, which people may use to describe their experiences of gender, sexuality and other physiological sex characteristics
MDT	Multidisciplinary team
NHS	National Health Service
PTSD	Post-traumatic stress disorder
TREC	Tavistock and Portman Trust Research Ethics Committee
YP	Young person/people presenting in a mental health setting with co-morbidities

CHAPTER ONE: INTRODUCTION

This chapter gives an overview of the project and my reflexive interest in how CAPs hold a family's history in mind. I wanted to explore clinicians' experiences of this area and working with gender-variant YP with different mental health presentations or co-morbidities. It includes my aims and an overview of the context of the thesis.

1.1 Background to the project

I have worked in CAMHS for ten years, previously as an art psychotherapist and in various community settings. This project was influenced by a case study arising from my Masters in Art Psychotherapy (Sharp, 2014), which explored the role of systemic practice in individual child art psychotherapy in the community, "unravelling the wounds of the family in bereavement" whilst working for a children's hospice in the community. As I approached this project, I realised my interest in the impact of familial history on patients has been longstanding. My training in both professional identities, but more recently as a CAP trainee, meant I worked with YP who identified as gender variant but presented with numerous difficulties or co-morbidities in my local CAMHS service. This experience also meant dual working closely with the national Gender Identity Service previously known as GIDS.

It was during my CAP training (and my countertransference fine-tuning) I realised that, on occasion, I had a feeling that I was missing something in the presentation of the YP. Further to this, I realised that this feeling was more pronounced with those who identified as gender variant. I wondered about the role or impact of intergenerational

trauma – some of the families I worked with had disclosed their own background of trauma. I likened my feeling to that of an “intruder”, of intergenerational ghosts making mischief or intersecting with the YP’s presentation in their session (Fraiberg et al.,1975, p.165). It led to thinking about the CAP’s mind being subject to a crossfire of familial or intergenerational projections that get lodged in them. I further wondered on how one could manage this in their clinical work. I was left holding something I was unsure what to do with but could see it ricocheting painfully around the YP at times.

As a white, middle-class cisgender psychotherapist with second-generation South American heritage, identifying as she/her, I have also realised my own concurrent intergenerational ghosts shaping the intersection of cultural norms and background. I regard myself as an LGBTQIA+ ally in my family. This personal disclosure feels important, as Meltzer (1994) describes, “it is equally important for the analyst to remember that his mind and character are exposed to his patient no less than the patient’s are to his analyst” (p. 555).

1.2. Developing the research question and aims

The aim was to explore the research questions: how do CAPs hold their patients’ history in mind? Do they encounter intersecting unlaid ghosts of intergenerational trauma when working with gender-variant YP presenting with mental health comorbidities? If so, how do they recognise this and then manage this?

1.3. The question of causality

My thesis makes no assumption of correlation between the research aims above or to examine this area with the intention of making a direct link to intergenerational trauma causing gender variance. Gender, historically and through to the present, appears to be used in a particular way, as highlighted in my literature review (Bell, 2020; Butler, 2024; Cass Review 2022/20224; Evans, 2023; 2024). The Cass Review (2022/2024) points to a climate of fear amongst professionals working in this area and at times this reveals itself within my initial research proposal and research process, as evidenced in field diary notes.

It is important to lay out that I started this project with this assumption that it is commonly accepted in the psychoanalytic field that all YPs may be affected by their families' histories of intergenerational trauma. The most commonly known research reflecting this is the Holocaust's impact on second- and third-generation family members, noted by therapists and academics such as Garland (1993), who describes "ordinary adolescent aggression can be seen by the parents as a return of oppressor, making normal separation and individuation difficult" (p.77). At the Portman Clinic, clinicians routinely gather developmental history that crosses three generations as part of their clinical practice to acknowledge the impact on the current family's situation and to recognise the intersection of past and present ghosts (Motz, 2020).

Therefore, I developed the research from my own clinical experience. I was curious to explore in-depth the personal experience of a small group of CAPs on how they manage this in particular with a patient group known to have more vulnerability.

1.4 Conclusion

In conclusion, gender has become a “highway” (Harris, 1996, p.4) for projective forces that contribute to the complexity of the YP’s experience of not aligning themselves to their natal body and how the world experiences this. It has shifted from the deeply unique personal experience of feeling misaligned with one’s own body within the climate of social norms of gender, sexuality and cultural forces into a landscape whereby everyone has an opinion. How then should the CAP hold in mind the YP’s experience of these issues alongside the potential additional vulnerability of identifying as gender variant, with the intersection of potential familial intergenerational trauma?

1.5. Thesis Overview

Chapter 2’s literature review includes a brief history of psychoanalysis, gender and sexuality, a brief review of literature on trauma, a section focusing on intergenerational trauma and how this has been explored by researchers in relation to gender, as well as a systematic search of research and a snowballing approach of authors writing about gender, family history and the therapist’s state of mind. Lastly, there is a summary of the Cass Review, 2024.

Chapter 3 illustrates the research project design, including the research design, its methodology and my own reflexivity.

Chapter 4 presents my findings, followed by Chapter 5's discussion of the results and relevant literature, including project limitations, implications for future practice and research, and a final conclusion.

CHAPTER 2: LITERATURE REVIEW

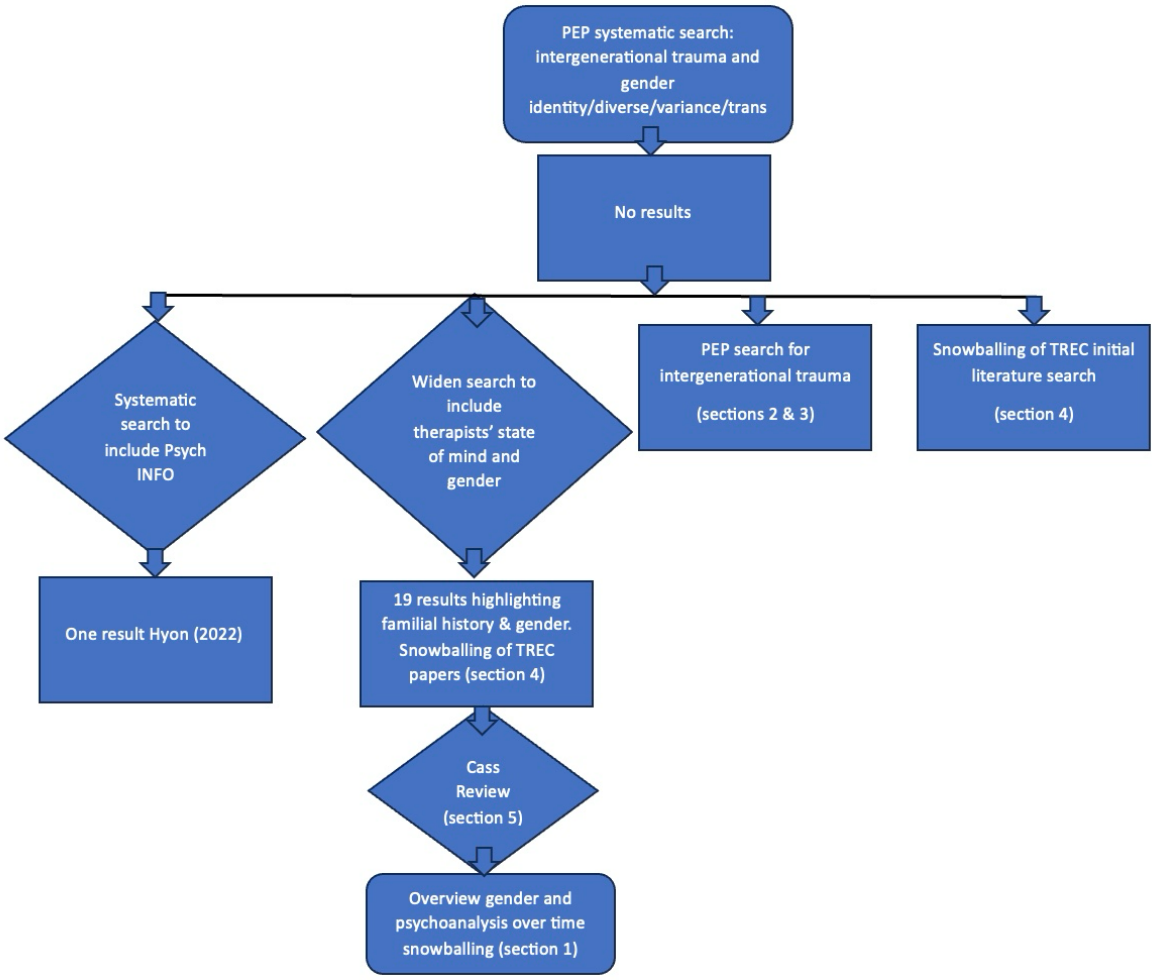
2.1 Introduction

This chapter provides a narrative literature review that explores what CAP clinicians are holding in mind when working with gender-variant YP and find themselves locating intergenerational trauma. For the purpose of this literature review, gender identity is thought about; however, this cannot ever be exclusive, as other intersectional identities such as sexuality and race will collide with gender, which is included in the section on how psychoanalysis has regarded gender over time.

The literature search focuses on the impact of intergenerational trauma, its management and how it may interact with this patient group's vulnerability. Gender variance may or may not include distress around gender identity but includes comorbidities of presenting issues in a mental health setting. Saketopoulou, (2011, p.1) proposes finding more nuanced ways to "address the emotional dimensions of gender fluidity", which feels aligned to this literature search.

I used a systematic literature search strategy, which will be outlined in the following flow chart of the process below (see Diagram 1). However, due to the limited research in this field, which became apparent after the first systematic search, the literature review became an organic iterative process as I discovered relevant papers through snowballing authors.

Diagram 1. Literature review flow chart



The final publication of the Cass Review 2024 was published in April 2024 after I completed the data analysis. Although the Cass Review was specifically focused on gender dysphoria treatment and pathways, which is not the focus of this research, it still felt a significant document to include as some of the literature was relevant to the project. It is worth noting that at the time of its release, GIDS closed in March 2024 after much media controversy (Barnes, 2023). In the discussion section I will reflect further on the political climate of gender and impact on the writing up of the research. The reflexive journey of writing the literature review, alongside the analysis of the

data, included developing further understanding of the cultural and societal backdrop of gender. Therefore, my supervisor and I felt it was necessary to include in the literature review a further section with an overview of gender and psychoanalysis over time.

The literature review is divided as follows:

Section 1 – gender over time in psychoanalysis, an overview;

Section 2 – psychoanalytical overview of trauma; defining trauma to understand the intersection of intergenerational trauma;

Section 3 – intergenerational theory and its link to trauma and family history;

Section 4 – gender experiences, family history and the CAP's management; and their links with familial/intergenerational trauma

Section 5 – the Cass Review: Independent review of gender identity services for children and young people

2.2 Literature search methodology

The systematic literature search strategy involved a structured and pre-planned approach to identify relevant research. From the research question, I have identified key concepts and relevant search terms. This is then translated into search strategies, which involved using Boolean operators, truncation and other search techniques to maximise the retrieval of relevant articles. The search was first conducted using the Psychoanalytic Electronic Publishing (PEP) archive (see Diagram 1 above), which was rich in terms of intergenerational trauma and its

transmission but revealed no relevant publications when searched alongside “gender identity”, “trans”, “gender diverse”, “gender variance/variant”. Including Psych INFO revealed one article relating to intergenerational trauma with clinicians as participants from the LGBTQIA+ community (Hyon, 2022).

When I widened the bracketed search terms to include the therapists’ states of mind when working with YP and the search terms “gender identity”, “trans”, “gender diverse”, “gender variance/variant”, nineteen of the sixty-eight generated results were relevant to review. This literature is reviewed in Section 4, alongside the literature retrieved by snowballing authors that have a specialist interest in this area. This included authors that I had discovered as part of my initial TREC literature search (see Appendix 1).

2.3 Literature

Section 1 – Gender over time in psychoanalysis; an overview

Lemma and Lynch (2015) helpfully introduce us to five strands of Freud’s (1905) thinking around sexuality, which is important in the understanding of how gender and sexuality have become intertwined. To summarise: Freud believed that sexuality is, alongside other processes, a product of a person’s development from early infancy and experiences with attachment figures; he looked at infantile sexuality in the unconscious and at the role of fantasy and conflict; he captured the normative aspect of abnormal sexuality, believed that object choice and drive are separate, and importantly that normative sexuality includes aspects of perverseness. Stoller (1979, cited in Lemma and Lynch, 2015, p.5) took up the idea of perverse aspects of

sexuality as a means of managing trauma through sexualisation of anxiety. Lemma and Lynch (2015, p. 5) discuss that this was explored by Glasser (1979), that sexualisation can be used as a defence of primitive “terrors in relationship” rather than body intimacy. Perhaps most relevant in thinking about gender is Freud’s notion that all humans exhibit bisexuality, and that libido is “distributed over objects of both sexes” (Lemma and Lynch, 2015, p.5). However, Lemma and Lynch discuss that many psychoanalysts have suggested – in particular, McDougal (1993,1995, 2000, 2001, p.5) – that a “normative” development means mourning our bisexuality, desire to be or identify with both parents, their genitals and magical powers for heterosexual identifications. Finally, Freud believed sexuality evokes powerful emotional forces, and not just biology, as Freud’s theory of Oedipus complex is an “emotional attachment” (Freud, 1925, as cited in Lemma and Lynch, 2015, p.6).

Heller’s (2022) doctoral thesis helpfully provides further consolidation of Freud on gender and sexuality, which for him was in the rooting of anatomical difference. Heller (Horney, 1933, as cited in Heller, 2022) discusses that the cultural “castration” of penis envy remains valid as the child struggles to make sense of what they “do not have” (p.38). Heller (2022, p.38) points out that understanding the psychological aspects of anatomy “sets the scene for a multitude of potential developmental possibilities or compromise formations of self and gender identity”.

Butler, a feminist theorist (Butler,1995, as cited in Lemma and Lynch, 2015, p.6), expands Freud’s theory describing the child who desires to be and have both parents as experiencing a lost identity and a disavowed sexual orientation, and culture not allowing a mourning of this. Several further theorists (see Butler, 1990,

1993; Chodorow, 1994; Harris, 1991; Goldner, 1991, 2011; Drescher, 2015) have discussed the cultural systemic forces that impact or “frame” sexuality and gender, most notably, the idea of gender being socially and relationally constructed, which challenged the “certainty of biology” (Heller, 2022, p.31).

However, the embedded stance of heterosexuality as a compromise formation (Chodorow, 1994) and as the normative indicator of health has only recently been acknowledged in the 2011 *British Psychoanalytic Council 6.2* (BPC)’s statement: “It does not accept that a homosexual orientation is evidence of disturbance of the mind or in development”, (accessed on 3 July, 2024).

Newbigin (2019, p.19) characterizes the history of the object relations theory school of thought (the Tavistock’s predominant ideology), as a move away from Freud’s original nineteenth-century drive model not on “adult sexuality but interpersonal dynamics around emotional quality of attachment, seen through the lens of infant/parent dynamics”, which made psychoanalytic ideas more acceptable. Herzog (2015, pp.19–20) describes psychoanalytic thinking showing resistance to postwar Kinsey reports (1948, 1953), which revealed a “higher incidence of homosexuality” and more variance in human sexuality than previously thought. Giffney (2017) describes psychoanalysis as differentiating what is “normal” and what is “pathological”, from a position of power that “concretizes” thinking on human sexuality (p.27). Frosh (2006) states that psychoanalysts have, too frequently, with some exceptions, enacted “homophobia of the dominant culture” (p.245).

In contrast, Queer theorists[1], have used psychoanalytic concepts to explore the "interrelation between internal and external environments". In this sense Giffney (2017, p.33) reflects that it takes "psychoanalysis outside of the clinical setting" for political purposes; however, she acknowledges this means Queer theory has a tendency to idealise positions deemed to be radical. Goldner (2011) discusses that Queer theorists have been influenced by the philosopher Foucault and his concept of the "gaze" (Foucault, 1988), with its "hierarchies of normality and morality" (p.2).

Rose (2016) recounts the first distinction of gender variance given by the psychiatrist and psychoanalyst Stoller in his 1968 study titled "Sex and Gender" and in his second volume "The Transexual Experiment" (1975). Rose (2016) states that the transgender category will always be pathologised, and that the particular violence and inequality towards trans-people makes it unavoidably politicised. Butler (2024) likens the escalation of targeting sexual and gender minorities as a dangerous projection of gender – fantasy or "phantasm" (p.7). Many political structures across the world fear gender is a "nuclear bomb"[2] needing dismantling as it threatens civilisation and therefore has to be extinguished in order to return society to a world before gender, a "patriarchal dream-order" that never existed (p.7). To paraphrase Butler (2024), if the phantasm is a mechanism of organising the world's fear of destruction, then I wonder if gender simultaneously becomes the scapegoat.

[1] from the academic disciplines of poststructuralist feminism, as well as lesbian, gay, bisexual and transgender studies.

[2] Butler (2024, p.7) discusses the inflammatory language of the Vatican, "ideological colonization, likening it to "Hitler Youth", and Russia likening it a threat of national security and other conservative and right-wing political systems in the world.

Giffney cites Elliot (2014), confirming the “relationship of psychoanalysis to transgender people is exceedingly fraught” (p.28). Giffney (2017, p.28) identifies a number of psychoanalytic attitudes, including homosexuality as a “developmental arrest” (Segal, 1990) to transsexuality continuing to be seen “as a marker of a psychotic structure” (Millott, 1990). Equally, Stryker and Whittle (2006, as cited in Pearce, 2018) describes a history of psychoanalysis linking self-affirming of gender sexuality as “psychotic” and a “curable sexual “inversion” (p.21). Evans (Evans and Evans, 2021, 2023, 2024; Goldsmith et al., 2023) in light of the Cass Review (2022, 2024) challenges psychoanalysis to consider the “developmental complexities” in underlying comorbid presentations, due to the uncertain pathway of how to treat gender dysphoria to help establish “a mind and identity of their own” (Evans 2024, p.223).

Frealand (2022, p.20) discusses a history of psychoanalysis embracing ideologies that form an “entrenched psychoanalytic culture” and “a professional identity”, resulting in a psychoanalytic elitism that can be blind to its own subjectivity or bias. As Frosh (2006) describes, the analyst may be “embarrassed perhaps by the subversiveness of their own discoveries and by the secrets that they are privy, and trying to establish their professional credentials” (p.245). Stryker (2017) helpfully suggests that while Queerness is associated with homosexual feelings around sexual difference, unlike transgender feelings, it is “rarely doubted”, describing the difference for transgender, or people identifying as gender variant, is in “a profound sense inappropriate or unsuitable for oneself, or that one’s embodiment does not

communicate the intelligibility of one's self to others and therefore must be transformed" (p.422).

Stryker (2017) challenges psychoanalytic theory: if it really takes on a non-pathologising reality of the subjective experience then it needs to rework concepts of sexual difference and ontologised binary positions of "man" and "woman" but be more expansive of difference. She highlights Kaplan's (2017) psychoanalytic hope of a non-pathologising way of working that asks: "how might the individual concerned best live?" (p.423).

I feel that Harris (1996, p.4) summarises the ongoing paradoxical journey of how gender is seen, experienced and used in the history of psychoanalysis and society; "an idealised mental construct" beyond the self. She sees it as a highway for projective forces that contribute to the complexity of the YP's experience of not aligning themselves to their natal body and how the world experiences this.

> Gender is variously a self state, a representation, ideal or degraded, an island, a transitional space, a boundary-making structure. Robust, imaginative, flexible, richly elaborated, or hauntingly empty, gender structures are the traffic for an astonishing range of psychic and interpersonal business. (Harris, 1996, p.4)

Section 2 – Psychoanalytic overview of trauma

Alford (2015) challenges that trauma first must be defined, to then understand intergenerational trauma. He starts with the definition of post-traumatic stress disorder (PTSD) in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM)

(American Psychiatric Association, 2013), namely that it requires “the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened, death or serious injury, or a threat to the physical integrity of self or others” (p.264).

Lemma and Levy’s (2004) helpful introduction to psychoanalytic thinking around trauma expands further Alford’s understanding; the authors suggest that all events at their core cannot be understood as simply external, and that trauma therefore is not just “an internal affair” in how an individual responds to it. They state that trauma attacks our security in our relationships, affecting our capacity to mourn effectively, in what Freud (2017, as cited in Lemma and Levy, 2004) cites as a “perversion of loss” (p.5). Rather than goodness being taken in, feelings are acted out. They further cite Garland’s 2002 work, indicating that trauma breaks down symbolic thought so the reality cannot be held by memories but in flashbacks, allowing the events to become “real” all over again (p.5).

2.3.1 Trauma as a wound

Garland (1998) indicates that the Greek word for trauma is wound, and describes a traumatic event as one whereby the mind is “flooded” with stimulation, which, for some, can feel too much to manage. It “mirrors the violence that it felt to have happened, in the external world” (p.11), leaving the individual vulnerable to an awakening of “fresh” primitive anxieties, impulses and fears as trust has been broken in their relationships to good objects internally and externally. Lemma and Levy (2004) also note this collision of external trauma events with trauma experienced

internally, discussing Freud's "protective shield" as a "skin to the mind, constantly sorting and processing what can enter and what needs to be shut off from consciousness" (p.7). This puncturing of the "wound" can impact the ego to the point it can cause a loss in symbolic thinking.

Young (1998) references Kleinian perspective that "all events are in phantasy felt to be caused by good and bad objects, depending on the nature of the event" (p.64), further explaining the individual experiencing a traumatic event internally feels "left to the mercy of hateful and hating objects, felt to have caused the trauma" (p.64).

The above authors explain how trauma interferes, causing a complex situation between internal and external realities and difficulties within the individual protective shield. Emanuel (1996, p.220) reminds of the challenges of unprocessed trauma and it remaining "liable to be repeated", citing Freud (1909), "like an unlaid ghost it cannot rest until the mystery has been solved and the spell broken". Emanuel (1996, p.220) states that this is "a further source of trauma" and that where there is no container to hold and process the original trauma, there is a potential for a carer to "actively or passively" project this on.

Evans and Evans (2021, 2022) have extensively carried out clinical work on trauma when working with YP who identify as trans. They have observed that a trans identity can at times be linked to earlier trauma; the trans identity in those patients has developed as a means to achieve Steiner's "psychic retreat" (Steiner, 1993, as cited in Evans & Evans, 2022, p.269). Their extensive work discusses that for the YP developing a trans-identity, powerful primitive anxieties may be avoided, noting that the identity provides respite to anxieties connected to physical and emotional

development. Evan's subsequent (2023) paper explores how early trauma, such as illness or separation, can interrupt the internalisation of a good object figure to support the young adults in their study group with early primitive anxieties. These young adults experienced internalised object figures that had fragile egos, which meant that reflecting on their feelings may have felt too overwhelming and lead to structuring an alternative mechanism to manage quite harsh internalised object figures and a critical superego (Bion,1959). Evans (2023, p.69) argues there might often be a problem in separating and fearing "irreparable damage"; therefore, to avoid separating mind and body, there is a setting up of a new body. Evans explains it is not without its challenges as there are sometimes grievances against their primary object. Evans argues that psychoanalysis enables a space for these grievances to be examined (2023, 2024), to understand the unconscious defences at play, and that it is not about causality. Evans and Evans claim that the innate and universal desire is often to blame badness on something or to psychoanalytically project this on to someone externally or internally through the vehicle of projection identification. Klein (1946, p.15) viewed projective identification as a defence or vehicle to get rid of unwanted parts of the self or to control the other; it is also a means of communicating through the object figure receiving the communication. However, Klein stated that if the projection cannot be digested by the carer the patient will be filled with the remaining anxiety and be in a "greater state of disintegration" (1946, p.15). Therefore, there may be additional introjection and projective processes of damaged, hateful objects and some identifications with the dead from one generation to another, alongside live trauma experienced by the YP.

2.3.2 Conclusions

It is important this brief overview of trauma is considered through the lens that the therapist's mind may be subject to associated assaults or amplified projections in transference when CAPs work with patients' trauma histories and their families' trauma histories. The infant's own live experience of trauma punctures their own "shield" as well as the familial "shield" (Freud, 1917, as cited in Lemma and Levy, 2004; Garland, 1998). Therefore as Evans suggests, multiple parts of the infant dropped from the familial/carer's mind (2023). The dropping of the infant is a familiar psychoanalytic concept named by Bion (1962) in the baby's sense of nameless dread when there is insufficient containment from a carer in infant early years.

Section 3 – Intergenerational trauma and its link to family history

2.3.3 Introduction

Freud (1909, as cited in Marsoni, 2006, p.312) defined intergenerational trauma as being unprocessed trauma, in the form of unlaid ghosts reappearing when something was not understood or processed. By this definition it is possible for ghosts to also reappear not just from the YP's early life but from those of the "variants" – ghosts from the familial histories[3].

[3] The *Oxford Dictionary* has collated 165 meanings of ghost (22 June, 2024), the first being: "A ghost from one's (also the) past and variants; a person or thing which makes an unexpected reappearance after a prolonged period of time." (oed.com)

Abraham and Torok (1994) also use a ghostly analogy but describe intergenerational trauma as the beginning of unconscious communication, passing from the parents' unconscious to the child, which has never been conscious for "good reason". Alford (2015) cites that Abraham and Torok's phantom is a formation of the unconscious found there not because of the subject's own repression "but on account of a direct empathy with the unconscious or the rejected psychic matter of a parental object" (p.181). Evans (2022, 2023, p.70) stops short of theorising that the composite case study of a gender-dysphoric YP is directly linked to intergenerational trauma but it is implied in his description of Sam's mind being inhabited by "an unwanted and haunting maternal presence". Commentary by Goldsmith et al. (2023, p.80), which includes Goldsmith as a CAP, and trainee psychiatrists' commentary on Evans's 2023 paper, in contrast names a "developing view" that intergenerationally transmitted trauma is significant in the "matrix of presentations" in early trauma. This supports Evans's theory of the role of gender dysphoria being a psychic retreat due to early primitive anxieties not being contained by the traumatised infant carers.

A seminal paper by Fraiberg et al. (1975, p.164) explores intergenerational ghosts in the relationship between child and family, discussing that all nurseries have ghosts but parents view the ghosts as "intruders" and "malevolent". It further states that even in the most stable of homes, "ghosts can play mischief in their burial place" (p.165) and take up rights of citizenship several generations previously. The study goes on to describe this becoming visible between the parent and the child when inadvertently something gets repeated or "re-enacting a moment or a scene from another time and a different set of characters" (p.165).

2.3.4 Intergenerational trauma – psychoanalytical understanding through Holocaust literature and research

I reviewed literature on intergenerational trauma and the Holocaust due to its links to psychoanalytic thinking about how its transmission is considered by the CAP. Berger (2014) focuses on Holocaust literature studies of transmission of intergenerational trauma (M. Bergmann and M. Jucovy, 1982 study group), including their own studies and that of a group of analysts examining clinical papers of second-generation survivors and child survivors. Berger applies Bion's work group psychoanalytical theory to note there is an inevitably of transmission. She argues for a multi-layered and interwoven theoretical approach to the individual within the family group to help clinicians work with "collective trauma". Berger's "Whose trauma is it?", paper reveals the intricacies of what clinicians may be holding in the room. She feels that the interrelational perspective can be useful in extending this to all intergenerational trauma of slavery, race and homophobia.

Prince's (1985) literature review on the second-generation effects of historical trauma, namely the Holocaust, notes the effect of "psychic numbing" (Liftin, 1976, as cited by Prince 1985, p.9), recognising that the conscious and unconscious interchange between family members – incorporating cultural processes – influences on the transmission of intergenerational trauma, independent of the Holocaust, class, Jewish heritage and immigration status. Cultural social process, therefore, is recognised here and considered in my understanding of intergenerational trauma in relation to the patient and the CAP.

I have focused on a section of Alford's (2015) research paper that reviews other researchers' work (Abraham & Torok,1994; Caruth, 1996; Davoine & Gaudillière, 2004; Solkoff, 1981) on intergenerational transmission of children of survivors. Alford's research project involved him looking at some of the earliest unstructured video interviews in the 1970s of 250 Holocaust survivors together with their children, collated by a psychiatrist and child Holocaust survivor. Of note is that the children appeared to Alford as more traumatised than their parents.

Alford's paper gives another perspective of intergenerational trauma as the interrelational aspect of the child needing to experience their parents' trauma to fill an absence psychically between them: if you can't share a large part of your parents' minds, if something is permanently closed off, then the child survives by locating a place for themselves in their parents' minds, through trying to share their experience. However, this "leaves its survivors with an experience which is difficult to convey" (Alford, 2015, p.265), which they embody. Alford (2015, p.272) reviews theories that raise questions around interruption of development by second-generation trauma survivors, stating they "suffered from an over-involvement with their parents' suffering at the price of their own development". Alford (2015, p.274) acknowledges this is his interpretation but feels it is "in line with what children of survivors say about themselves". Psychoanalytically he references the child's imprisonment by their parents' suffering akin to carrying Bion's undigested beta elements (1962) – which he identified as occurring prior to thought – that there is a passage of which is "beyond time and place" intergenerationally projected into the child (Alford, 2015, p.274). It unites them but also leaves them with the undigested.

2.3.5 Intergenerational trauma in CAPs' case studies

This section below links more traditionally intergenerational themes and trauma to CAPs' case studies, focusing on discussion about the management of intergenerational trauma within a CAP's role.

Barrow's paper (1999) thinks about how clinicians manage the ghosts in the transference and how her patient actively listens out for her parents' ghosts and of her "harbouring something frightening" (p.10). Barrow reflects on the awareness of the parents' own internal ghosts that disapprove of emotions and in the transference with the familial ghosts. Barrows describes the helpfulness of recognising the ghosts, which allowed a push from hopelessness to understanding her conflict between her own positive and destructive feelings. Barrow (1999, p.3), in a straightforward way, thinks about Fraiberg et al.'s (1975) paper as being the ghosts "from the parents' childhoods who take up residency in the nursery of their own children and dominate their current relationships". Barrow states that the extent of the ghosts' influence depends on repression levels and suggests the parents manage their pain by unconsciously passing on the suffering to the "new generation". She describes splitting in her patient, which she thinks of as being unique as a form of protection from the parental ghosts.

Pozzi (1999, p.2) discusses the impact of intergenerational patterns of relating or "intergenerational dysfunctions" within her presentation of two consultations in a psychodynamic counselling service for under-five's. She draws on systemic work theorists (Byng-Hall, 1995) to introduce the effects of intergenerational trauma through Byng-Hall's work on 'family scripts' of intergenerational dysfunctions that are at the core of presenting difficulty encountered by the CAP. She describes, through

careful sensitivity with parent and child in the room together, a shared thinking of what might have been inadvertently passed down from the parent to the child. She describes vividly the first session and what is encountered by the therapist and the family members, describing the projective material as oscillating between “raw”, “unthinkable”, “chaotic” and “sadistic” (p.54).

2.3.6 Conclusions

The literature above suggests a need to hold the impact of intergenerational themes or the family’s history on the unconscious and conscious interchange (Prince, 1985) with the patients and their family members. Barrow’s work (1999, p.17) is particularly helpful in making links to Bion’s (1962) theory and to understanding when intergenerational trauma can get relocated into a patient when there may be a vulnerability to “parental internal objects and projections”. Barrow (1999) discusses the complexity of the internal split in how a person manages their feelings alongside what may belong internally and externally to the parents, or generation above, in the case of her patient.

Similarly, Alford, Abraham and Torok and Freud theorise an unconscious taking on of familial /intergenerational projections in review of Holocaust survivor interviews and their families. Indeed, Alford (2015) suggests the presence of the child’s unconscious processes to fill the psychic gap between them and their traumatised parents. Moreover, Berger’s work (2014) highlights the importance of recognising the potential impact of intergenerational trauma being enacted and its risks. She notes that additional intersectional prejudices, such as racism and homophobia, can compound the original trauma, which then interrupts family healing and changes

their view of their relationship with their external world; this also features in Hyon's thesis. Berger (2014, p.16) therefore argues for considering the "family" as a work group based on Bion's theory of group relations, which offers the clinician possibilities for decreasing the potentially destructive impact of intergenerational transmission of trauma.

In relation to my own research, this literature takes me to the questions: if a YP comes into the clinic with intergenerational undigested beta elements, what does this look and feel like for the relationship between patient and clinician? How is this expressed? If, as the literature indicates, intergenerational trauma is often unknowable / unconscious, what does this mean for the CAP? I have thought about it being represented as an internalised intergenerational ghost (Fraiberg et al., 1975) when the YP has their own identifications to the ghosts of the past and particular sensitivities to it (Alford, 2015).

Section 4: Gender experiences, family history and CAPs' management and how all three of these link with familial / intergenerational trauma

2.3.7 Introduction

Hyon's (2022) as-yet-unpublished thesis at the time of writing (accessed, 6 Jan, 2023)[4], is a qualitative study of intersectional cumulative trauma based on a purposive sample of nine Queer therapists of colour. Hyon discovered that for all participants, two of whom identified as trans females and one as a gender Queer non-binary person, intergenerational trauma and familial trauma was a dominant superordinate theme that included colonisation, post-slavery internalisation and work discrimination. Hyon's concluding remarks were to think about trauma as part of social identity that included intergenerational trauma. Research recommendations included the therapist's own practice of reflexivity and their relationship to the androcentric (male) heteronormative social context as well as the attunement to clients' personal and social identities and the reframing of symptomology to consider eco-social contexts, "holding a space for clients to connect" with their external world.

Hyon's work was the only systemic result linking intergenerational trauma with three gender-variant therapists and feels key to extend the thinking of psychoanalytic intergenerational ghosts around issues of social identity, and on the social cultural position of CAPs and their patients.

[4] Accessed via Hyon's video VIVA (1hr, 45 min).

2.3.8 Intergenerational trauma and gender dysphoria

One of the authors addressing intergenerational trauma, but specifically in relation to gender dysphoria, is Bell (2020), a psychiatrist and psychoanalyst who worked in the GIDS 1995–2020 and released a "controversial" report (Cooke, 2021, 2 May, *the Guardian*) about its activities. Although he himself stresses to make the distinction between YP suffering from dysphoria and transgender YP, the themes discussed include intergenerational trauma. Indeed, he states:

> Serious family disturbance is common, often with intergenerational transmission of major trauma such as child abuse in the mother/maternal line (sometimes a source of the mother's not wanting a girl child). Some families have suffered other major traumas. (Bell, 2020, p.1031).

He also discusses that other difficulties can be located in gender distress seen in the recent high prevalence of natal girls presenting at GIDS who discovered their sexuality preferences were being located in gender, suggesting possible unconscious internalised homophobia. Therefore gender as a category obscures a discussion of sexuality[5] that does not require medicalised treatment.

2.3.9 Gender, the body and familial history: a starting position

Lemma (2022) encourages clinicians to see gender variance and their role in supporting gender-variant YP through respectful dialogue and notes that any theory building needs to be rooted in the "patient's phenomenological experience of their body in their given external context" (p.11). Below, a summary of Lemma's extensive

[5] mentioned also in the Cass Review 2024.

clinical work with transgender patients is presented, which can be seen as potentially crude but is here critically valuable in thinking about the patients' experiences of the quality of their embodied experience with their caregiver and the body and mind of the therapist, especially when it comes to questions arising from a history of trauma and intersection of intergenerational trauma. Lemma states that:

> "..being-in-a-body requires the body and mind of an other to encourage the capacity to mentalise one's bodily experience and hence to regulate affective experience" (p.44).

Lemma's themes within her clinical work included: a sense of "incongruity" between the given body and the body identified as the "right" physical home, which was then difficult to communicate to key attachment figures when first experienced; difficulties with being unseen, scrutinised (which left them feeling rejected and /or shamed) or feeling like a "stranger to myself"; an urgency "to search for the body that is anticipated to relieve themselves of this intolerable experience" (Lemma, 2012, p.45).

These themes appear essential to hold in mind when working with YP and adults who identify as gender variant and then their relationship with possible intergeneration trauma projections. Winnicott (1956, as cited in Lemma, 2022, p.45) and Bion (1967) discuss the importance of the process of mirroring the child's experience by their object figure to aid their own self -representation; however, if the child's internal experience is incongruent to their natal body and not related to their carer this poses a disruption in this mirroring experience. Lemma (2022, p.46) describes the risk of an "alien self" developing. However, Holocaust literature

(already discussed) suggests there may be a further interruption by intergenerational trauma projections between the caregiver and YP (Berger, 2014; Alford, 2015), which may affect this mirroring. Lemma's evidence suggests the clinician needs to pay more attention to these areas in their work with gender-variant YP.

Goldsmith and Cowen are CAPs (2011, p.17) and, like Lemma (2022), discuss the importance of the therapist working with the body as it reveals what the mind cannot, in two cases whereby the child was left holding the parental familial history of grief of a sibling's death in utero. They refer back to Fraiberg's (1980) paper around distortion of vision where "relational trauma may distort the parent's recognition of their infant" (Goldsmith & Cowen, 2011, p.15) by the parent of the child. This links to the dominant themes within Lemma's 2022 work; the disruption to being either seen or unseen for the transgender YP.

Silverman (2015a, p.14), similarly to Lemma, also identifies interconnected themes of gender, trauma and the body but acknowledges patient case study limitations as it cannot be generalised. She focuses on the investigation of her countertransference to explore this, namely that the interaction of trauma and gender is lived in the mind and in the body for both therapist and patient and how sight was experienced as intrusive. She reflects on enactments of trauma history between them in the "experience of intense shame and anxiety in the transference–countertransference relationship". Silverman's countertransference of feeling her thin boundary between her patient is permeable in the paper. Silverman recognises the powerful nature of parents carrying unprocessed trauma and its impact on being able to reflect back to the child their experience (Lyons-Ruth, 2006, as cited in Silverman, 2015a), namely

her patient had an unconscious awareness that someone else's mind was lodged in her own, a "foreign body" as such (p.51).

Harris (1996) concentrates on theoretical discussions on contemporary gender theory, feminism, Queer theory and relational psychoanalysis, and accompanying clinical material via case studies discussing the body as a site for trauma, and the therapist's subjectivity. Harris discusses the context of trauma within the family (Litin et al., 1956; Coates, 1995, 1991) and the unconscious projections in the family system. This literature has felt important to include regarding theorists recognising the unconscious familial system, where gender construction is part of social construction (Butler, 1990/1993; Foucault, 1978, as cited in Harris, 1996). Harris (1996) introduces the idea of the child being a "social matrix" and the thinking is similar to Lemma about the interrelational unconscious between the patient and analyst. Harris focuses on how both therapist and patient are subject to distortions in the transference relationship as both the material body and the psyche can be sites of projection through the family's meaning systems in the wider cultural context. Harris (1996) summarises Coates's (1991) papers and the theme of loneliness of the child identifying as trans as a depletion of self in servicing another – for the child *not* to be something, as a kind of "anti-identity" through the parents' own fantasies of gender that may be prohibited (p.7).

Winograd (2014) explores feelings related to the exploration of gender and sexuality in the course of a clinical treatment. Winograd's clinical case of a young adolescent recommends that the therapist needs to hold an open mind in order to tolerate long painful periods of not knowing (also described by Tsoukala, 2018) as their identity slowly emerges. Halberstam (1998), a Queer theorist, similarly picks up on the

theme of mutation of gender suggesting a moving away from subscribed heteronormative binary positions, from a “flesh border” of the body to a more fluid shape (Halberstam, 1998, as cited in Wren, 2020, p.207), which can illustrate visually the importance of a fluid-type space the CAP could hold in mind for their patient.

Drescher (2015), an openly gay training analyst, although criticising Silverman’s paper (2015a), for the bias of her cisgender lesbian countertransference to Ava, a young adult trans female to male, helpfully asks the reader to consider amongst many things the role of gender policing and internalisation of this role for trans patients and sexuality. Drescher concludes the therapist needs to be aware of their own internalised gender police.

Silverman (2015b) and Drescher’s critical correspondence opens up a transparent discussion around the interaction of gender, culture and the transmission of intergenerational trauma, as well as how the patient’s own trauma may have impacted experience of gender in the past and in the here-and-now lived experience. Silverman clearly states her task was to explore “*how* my patient’s experience of gender emerged and developed, and what meaning that experience has had and can have for him” (p.52) rather than causation. Silverman’s (2015b) paper highlights her own concerns about research in this area being conceived as a search for causation or pathologising gender variance rather than exploring multiple forces that can impact on the patient and CAP. Silverman helpfully summarises the importance of holding a patient’s history in mind: “This does not mean we are looking for a cause but for a deeper, multigenerational sense of how our patients came to be who they are” (p.52).

This revelation of the sensitivities of working with gender-variant patients when intergenerational trauma may be intertwined with gender feels key to the explorations within my own research.

2.3.10 Vulnerability themes in working with trans YP, and the CAP's state of mind

Sadowski and Gaffney (1998, p.133), when thinking about depression and suicidality in the trans-diverse population, recognise that adolescents experience internal splits alongside "additional confusion about their own identity in their environment, especially with parents, siblings and peers". Often this confusion leads to rejection and can "elicit hostile responses" (Sadowski and Gaffney 1998, p.133), suggesting that gender-diverse YP and their parents/carers are perhaps more vulnerable to intergenerational projective processes.

Willo's qualitative study (2020, p.18) exploring a CAP's function when working with transgender YP in local CAMHS highlights the clinician's key function "to be that of acceptance towards the young person's gender identity" and to respond reflexively and explore their own gender identity definitions (p.18). Willo reflects that clinicians are left with a heightened sensitivity when working with this population and recommends further CAPs training on cultural normative ideas for those who work in this area as well as increased awareness of owning "their own internal conflicts around gender identity", in order to provide "effective and meaningful" care (p.197).

Wren's qualitative study (2002, p.393) on the parents of eleven white British families with transgendered adolescents (aged 14–19 years) attending Tavistock's GIDS,

using grounded theory, hints at a paradox within therapeutic work, that both parents and clinicians, by being empathetic and tolerant, may be supporting the child's wish to live in an opposite sex, which may be viewed critically by writers as coming from a disturbance in the family. This literature perhaps reveals the pressure on the clinician and indeed the family, exploring how to find a position that supports but encourages an exploration of the YP's decision[6].

Wren in 2020 goes on to cite a number of authors (Goldner, 2011; Harris, 2005; Rose, 2016, as cited in Wren, 2020, p.199) who look at the relationship between "gender diverse experience" and "troubled relational histories, emotional difficulties and past trauma" to make sense of possible mind and body incongruence experienced by gender-diverse YP. Wren (2020, p.199) powerfully advocates for the role of meaning-making for gender-diverse children from family and community environments that are "hostile to their feelings and wishes", advocating the necessity of working with parents. Wren highlights that parents can sometimes split their position to shut down their suffering, which brings decisiveness and closure rather than tolerating a more meaning-making space that allows a YP to shift in their feelings about their treatment.

Di Ceglie (2009, p.4) explicitly identifies the professional's vulnerability when working with this population, describing the intensity of feelings aroused as "very basic issues of identity" and belonging, and of being left "at the edge" when working with families and YP, which mirrors the adolescent's mental state or the family's experience. Di

[6] See link to further recommendations in Cass Review (2024) summary of key findings, Section 5, which also highlight risks and vulnerability.

Ceglie identifies that the state of mind of a YP or their family are located through the psychoanalytical tool of projective identification within the professional, stating that the professional's task is to survive the projection and "respond" in ways to enable the family to "cope with the states of mind" without acting out these feelings (Di Ceglie, 2009, p.4).

2.3.11 Gender, familial systems and the function of CAPs' holding in mind

Evans and Evans (2021, p.72) (also discussed in Section 2) note the shared territory of some degree of developmental trauma in early infancy, of colliding internal and external forces of the child and family conflicts. However, they normalise that all mental health presentations cannot exist in isolation of the family unit or "structure" and this is "integral" to the development of the child and needs to be thought about. The latter was a central argument in various criticisms of the decommissioning of GIDS (Barnes, 2023). Barnes suggested an unprecedented demand for GIDS's services meant it did not allow space to think for GIDS clinicians. Evans and Evans (2021) highlight the complexity of when gender evolves as a possible avoidance of psychic conflict within the YP's early developmental history that can be transferred "into the body" p.73. Evans and Evans (D'Angelo, 2019, as cited in Evans and Evans, 2021, p.75) suggest the need to look at comorbidity with the MDT, as parent work and family work can help reveal aspects of the family relationship dynamics (losses, separation and family mental health), and build an important alternative picture rather than collude with the fantasy of removing a part of the self through transitioning. They do not mention intergenerational trauma but noted that paying attention to family dynamics is part of the assessment process.

2.3.12 Managing parental projections and the role of therapist as a third

Evans (2023) and Evans and Evans (2021) papers, as already discussed previously, describe the transference between a therapist and a patient as a gradual moving towards a triangular position. They referred to Britton (1989) and the process of mourning of the ideal object figure Oedipally, therefore, there is a separation of the couple through the creation of a third position. Evans (2023) presents the triangular position in which the therapist symbolically comes to represent female and male aspects of the patients' internalised object figures – this provided a "model of an object" that supported patients in thinking about their experience (p.71) Evans (2023, p.71) introduces Bell's (2020) criticism of transgender ideology of encouraging adopting "rigid gender groupings" and the value of patients being able to explore feminine and male aspects within their therapist and gradually within themselves and identifications to them as defences softened. Similarly, Perelberg (2020) also reflects on the temporality in creating a third space to incorporate the here-and-now and there-and-then, focusing on the psychic representation of the body, namely its sexuality. Owen (2013) also considers a third space, leaning to the importance of an external multiple mind via the MDT in understanding the child alongside the internal psychic third space provided by the therapist.

The above literature reveals the complexity faced by a therapist working with patients, their families and a possibly unknown familial history while being aware of their own intersections and norms. It suggests how the mind of the therapist can become a space where the different identities of a patient can be experimented and seen.

Section 5: The Cass Review: Independent review of gender identity services for children and young people

The Cass Review is included as a separate section as it was published after the analysis of my data and when most of this thesis was already written. It is the most comprehensive systematic review of international data on care for YP seeking support from services in regards to gender to date[7]. It highlights the complicated political landscape within which CAPS are working and provides recommendations[8].

Although, as discussed in the literature review introduction, it focuses on those YP seeking support for gender dysphoria, it reveals the complexity of cases, including the lack of clinical guidance in working with this patient group. NHS England commissioned Dr Hilary Cass to review and make recommendations on the UK's gender identity services. The report aimed to establish clarity about expected support, service availability and its organisation.

[7] The University of York, commissioned by NHS England, conducted a series of six independent systematic reviews and narrative syntheses (using databases including Medline, Embase, CINAHL, PsycINFO, Web of Science), which were searched to April 2022, two international surveys part 1 and 2 of a review of clinical guidelines, an online international survey of gender services for children and adolescents across EU-15+ countries (Gender Identity Service series, 2024a) and new research was conducted with engagement from YP, parents and other professionals.

[8] The recommendations suggested: the service must offer equal standards to other YP services; YP receive holistic needs/mental health assessments, developmental condition screening and an individualised care plan; support for parents/siblings; a separate pathway for pre-pubertal children with priority for early parental discussion; a regional service support centre for 17–25 for those considering de-transition; discussion at a national MDT for all over-16s considered for medical treatment.

The report reviews the change in the mix of YPs seeking support, and the increased complexity of referrals alongside gender distress (Hall, Taylor, Heathcote et al., 2024a).

The systemic international review by Taylor, Hall, Langton, et al., (2024b) found that ACEs that include trauma, were few, due to not being routinely asked about. However, those that were, included familial trauma, abuse, loss and abandonment from a parent. Moreover, it found a high rate of coexisting comorbidity presentations (ASC, ADHD, anxiety, depression, suicidality, self-harm, eating disorders and ACEs) in the significant increase (twofold to threefold) of referrals to specialist gender services over time "appearing higher than seen in the general population of children and adolescents". Their conclusion recommended the collection of ACEs data from referral and alongside the pathway to "support care" (p.6).

The most illuminating of the evidence in Part 2 of the systematic review to this study (Taylor, Hall, Langton, et al., 2024 b) is that there was no international live consensus about the process of assessment, the timings and basis of when a psychological intervention needed to be offered. This exposes the vulnerability and fear of clinicians in not knowing and there being no clear evidence pathway of how to manage the complexity of presenting difficulties.

The Cass Review's key findings are as follows:

- There is not one single explanation for gender incongruence but a "complex interplay between biological, psychological and social" factors that needs to be individualised;

- There are conflicting views about clinical practice and fear located in some clinicians of working with gender-variant YP's despite their presentation being similar to other service users;
- The strengths and weaknesses of evidence-base care are misrepresented;
- The controversy of medical treatments has taken focus away from individualised care;
- Clinicians are not able to determine which YP will develop an enduring trans identity;
- For the majority of YP, medical pathways may not be the best way to manage distress, and the wider mental health and "psychosocially" challenging problems also need to be addressed.

2.4. Conclusions of literature review

The literature on intergenerational trauma highlights the developmental vulnerability of YP in stirring up intergenerational projections held in the family (Owen, 2013). It has made me reflect on what happens when, in the clinical room, the transference is filled with the parents' intergenerational fantasy object figures, which the child has absorbed, as seen, for example, in Lemma's 2022 work.

In other work, it has been suggested and theorised that gender dysphoria patients seem to develop an idealised new self from the failed ideal figure that is criticised and subjected to hostile forces by a critical superego (Evans, 2023). Although the focus of this literature review has not been about the genealogy of dysphoria, the reported literature raises important questions for this research area. For instance, if the new gender identity comes from a position of a composite of intergenerational

internalised object figures and parental object figures internalised, it leaves the therapist needing to be actively holding them somewhere in their minds.

Alford's Holocaust literature reveals an unconscious role of the child to take up intergenerational ghosts, noting that intergenerational trauma is a two-way process. This signifies it's not just a matter of recognising Fraiberg et al's ghosts but understanding the relational experience of the YP needing to understand unconsciously the link to their parent's history and to be included in that. This then raises questions of the CAP's experiences of intergenerational trauma and its unconscious link to the YP they are working with.

The complexity and multilayering of these processes in the YP and then in the clinical work of CAPs who are with them are framed in a particularly unclear societal, cultural and political context. As suggested by Evans (2023) and Bell (2020, p.1033) the current gender ideology and identity politics is itself involved in defining norms perhaps in a similar way to the development of heteronormative norms being "fixed" and "narrow", with critical engagement being silenced as the enemy. Bell (2020, p.1032) discusses that the pressure on services means the services turn to a non-thinking "procedural model" rather than aiming at understanding a patient's individuality in depth.

How does then the current climate of gender politics affect a CAP's ability to do their work when, as the Cass Review reports (2024), a significant finding was a feeling of fear for clinicians working in this area, with a lack of consistent guidance of care pathways? The literature above places the importance of the liveness of the therapist's own internal gender identifications, but also the need to explore the impact of their own interwoven political environment and possible intergenerational

trauma. However, the literature also suggests an overwhelm, due to media pressures: “The current media frenzy sometimes makes it hard to think clearly” (Gender specialists report, 2021, p.29, as cited in Cass Review, 2022/2024). The dilemma then is how CAPS maintain a thinking space about a patient’s history, attempt to explore those ACEs as recommended by the Cass Review (Taylor, Hall, Langton et al., 2024b), alongside the complexity of presenting difficulties.

This feels like an important stance for the CAP to be reflexive in terms of their own personal experiences of gender seen in the body of literature on gender, feminine, Queer and relational psychoanalysis and being able to hold a third position (Britton, 2004; Evans, 2023) of the family’s intergenerational history and their gender and societal changing norms.

This thesis aims at drawing more of a three-dimensional insight of the multiple layers, individual, group and society’s unconscious into how CAPS recognise the transmission of intergenerational elements of families’ histories within their clinical work with their patients. It also explores how CAPS manage families’ histories transmitted intergenerationally in their work with YP who identify as gender variant.

CHAPTER 3: THE RESEARCH PROJECT DESIGN AND METHODOLOGY

3.1 Introduction and Aims

This qualitative research project explores the CAP's experience and state of the mind when working with YP who identify as gender variant, gender diverse or trans and present in mental health settings with various comorbidities[9].

This exploration implies trying to unpack the therapist's mind as '*a third state of mind*', meaning the CAP's position when they need to hold the interrelational and intersectional internal and external worlds of the YP, the family's system and history and as well as themselves as a therapist and as a person[10].

Therefore, I intended to explore how CAPs specifically locate intergenerational trauma when working with a YP and their family, the different tools and skills utilised and the impact on the YP and clinician. Moreover, I also intend to explore how they are able to differentiate intergenerational trauma from the live trauma experienced by

[9] Defining comorbidity as the simultaneous presence of two or more health conditions (either physical or mental) for which a YP may seek help or that can present. I have included the following comorbidities, which are not exhaustive: depression, anxiety, PTSD, developmental trauma, complex trauma, Autistic Spectrum Conditions, body dysmorphia, gender dysmorphia, eating disorders.

[10]See reference to Meltzer's position (1994) in the introduction section (p.14) and importance of reflexive transparence of the interrelational position between therapist and their patient.

their patients and how CAPs manage and work with this group of patients' projections.

It has been highlighted the difficulties of psychoanalytic discourse to date around gender variance and the tendency to wish for secure knowledge in this area, which results in a "foreclosure" of thinking (Gozlan, 2013). CAPs have been encouraged to see gender variance and their role in supporting gender-variant YP through respectful dialogue and any theory building needs to be rooted in the "patient's phemonological experience of their body in their given external context" (Lemma, 2022, p11).

The research question I intend to address is:
How do child psychotherapists hold their patients' history in mind? Do they encounter intersecting unlaid ghosts of intergenerational trauma when working with gender-variant YP presenting with mental health comorbidities? If so, how do they manage this?

To address this question, three specific objectives were formulated:

1. to explore the transmission of intergenerational elements of families' histories within the CAP's transference;
2. to explore how CAPs recognise this in their work;
3. to explore how CAPs manage this transmission of trauma intergenerationally, specifically with YP who identify as gender variant, alongside the live trauma this patient group might be experiencing.

The overall goal of the project is to contribute to the reflections and the thinking about the management of intergenerational trauma for this patient group in the future. As seen in the literature review in the previous chapter, there is an added complexity for the gender-variant YP.

3.2 Ethics Application Procedure and Approval

The sensitivity and the complexity of this research project is also reflected within the ethics approval process I went through. Ethical approval was sought through the Tavistock and Portman Research Ethics Committee (TREC); a first application was submitted in October, 2022; this was not successful as the assessor required further justification about the intent of the research, in the form of significant amendments. These were addressed and submitted through a letter to TREC (see Appendix 1) in December, 2022. TREC completed its approval after requesting significant amendments and backdated this approval to 22 November, 2022 (see Appendix 2).

The TREC assessor asked to revise the title of the project; the revised title makes explicit that the YP would be presenting in a mental health setting with two or more co-morbidities. I extended the project to specifically cover different co-morbidities in presentation in mental health settings, as outlined in the introduction above.

In addition, I also gathered further literature to clarify my ideological position: that there is no assumption of correlation between intergenerational trauma and YP who

identify as gender diverse or variant. It was important to give the TREC assessors the psychoanalytic thinking around intergenerational trauma.

It is commonly accepted in the psychoanalytic field that all YP may be affected by their families' histories of intergenerational trauma. The most commonly known research that indicates this is the impact of the Holocaust on second- and third-generation family members (Garland 1993).

I also included good practice considered by the Portman Clinic (Part of Tavistock's and Portman Trust) illustrated by Motz (2020, p.25) gathering developmental history that crosses three generations as part of their clinical practice[11].

3.3 Researcher Reflexivity

As a recent CAP and qualified art psychotherapist for six years before this current training, as already discussed I became interested in the role of our mind when it felt like I was intersecting unlaid ghosts in clinical work, particularly with two long-term YP patients who identified as transgender or gender-variant. Both presented with different co-morbidities and familial history. Throughout the research I have also examined my own relationship to intergenerational trauma and discussed where my reflexivity came into the frame of the research in supervision.

[11] As discussed in the introduction, the Portman clinic recognises the impact of the current family's situation and that of "ghosts" from the past intersecting with the present.

In my clinical work, at times I am left wondering if a ghost has entered the room, which does not directly belong to the YP. I have wondered about the timing of the ghosts appearing or being resurrected through resistance to work from parents or at times of transition or change[12].

I was also curious about my own experience. I kept a field diary throughout the research project to enable me to observe my own countertransference, to the process and participants' data. This allowed me to be more conscious of the iterative process of interpretative phenomenological analysis (IPA), during the interviews, coding, analysis and the links made reviewing the literature. I have tried to document this reflexive interest in every section of the research, to be transparent regarding my own exploratory journey alongside the participants and when our ideas have collided or have led to further questions alongside the research. Although I am a white cisgender clinician I have had a longstanding commitment to learning and thinking about LGBTQIA+ themes not just within my own family but for my patients.

Since the start of the interviews, I was transparent with each participant about my clinical experience and interest, which led me to develop the project. This personal information was also present in the information sheet to participants and in the initial advert (see Appendix 3).

[12] As explored in my TREC proposal (see Appendix 1).

3.4 Research Design

This research project uses a qualitative research design using semi-structured interviews with FANI (Hollway and Jefferson, 2013) and IPA (Smith, et al., 2020) as a method of data analysis. FANI's approach maximises the countertransference response of the clinician and encourages open-ended narrative questions to allow a less defensive position to take place. FANI complements IPA as it acknowledges the reflexive approach that inherently "the researcher is implicated at every stage". I decided to use IPA in order to be able to account for and explore the subjectivity of my own experience and awareness to exist alongside the parallel process of analysing the "lived" experience of other CAP clinicians (Smith et al., 2020, p. 7). As part of this parallel process, my reflexivity diary alongside the research process allowed me to be explicit about my own meaning making, process, interpretation and evolving ontology landscape.

FANI and IPA allow for an in-depth analysis of the subjective experience of each participant but also the researcher's own understanding and interpretation is central to understanding the participants' lived experience. The combination of FANI and IPA offers complementary strengths: FANI acknowledges unconscious processes and defences that influence narratives, exploring what participants may not explicitly articulate; it encourages participants to be open-ended and associative in the telling of their experiences. IPA focuses on how participants make sense of their lived experiences, emphasizing their interpretative engagement with their experiences.

The participants making sense of their experience is pertinent to the meaning-making that participants became part of through the FANI approach, which actively allows this as it entails a two-stage interview process. The second stage, a shorter follow-up interview two weeks after the first interview, indeed allowed participants to reflect on their answers and on the interview process. This is discussed in further depth as in part of the research methodology section below.

While the meaning-making in FANI is framed within the interviewing processes, in IPA this continues at the level of data analysis. IPA's phenomenological approach used in Smith et al. (2020) includes interpreting the contextual meaning within the initial transcripts and making exploratory notes before formulating the experiential statements. Smith, et al. guides the researcher to make "Conceptual" notes, which considers both the participant's and the researcher's understanding of potential meanings and potential interpretation-making. This helped me as researcher to keep track and stay on task when I needed to check my interpretation. In addition, as outlined in IPA methodology, "Descriptive notes" summarises the participants' thoughts at face value. "Linguistic notes" pay careful attention to linguistic features and helps uncover deeper layers of meaning in participants' accounts as well as researcher's reactions during the interview. This aspect of IPA analysis goes beyond simply recording what was said to examine how it was expressed, capturing nuances that might be missed through content analysis alone. In the analysis, I also used it to note my own surprising stuttering in brackets as a linguistic note to one of the interview's content and associated countertransference. This will be thought about further in the discussion.

The advantages envisaged of using the combined approach were:

- to allow for rich, nuanced data that captures both conscious and unconscious dimensions of experience;
- both methods emphasise the importance of the researcher examining their own responses and assumptions;
- to acknowledge that experiences in psychotherapy aren't straightforward and may involve ambivalence, contradictions and defence mechanisms;
- to prioritizes participants' meaning-making and narrative construction rather than imposing researcher frameworks;
- both approaches value the social, cultural and relational contexts shaping experiences.

It was important to be aware that FANI and IPA come from different theoretical traditions (psychoanalytic versus phenomenological), potentially creating inconsistencies in analysis, and both approaches require extensive time for data collection, transcription and analysis. Moreover, the depth required typically restricts sample sizes, limiting generalisability. This was particularly relevant as the FANI approach has its challenges because of the large amounts of data it produces. It collected six sets of rich data due to the two-stage interview technique per participant, which implied the reduction to recruiting only three participants to stay within the size of a professional doctorate research study. This produced some questions about the suitability of a such small sample size for an IPA analysis, which for a doctoral thesis is recommended to be four to six participants. With hindsight, other methodologies could be considered when gathering free-association unstructured narratives seen in the FANI. Discourse analysis, narrative analysis,

thematic analysis and grounded theory focus on the construction of meaning-making and can complement the open-ending nature of the FANI interview. For example, with grounded theory the social process of context may have been more suitable given the political heat of the research area.

However, IPA and FANI combined seemed particularly suitable in order shed light on the understanding of how meaning-making occurs in participants within the therapeutic relationship with their YP, while investigating sensitive topics where defensive reactions might be anticipated, within complex, multifaceted experiences of psychological distress or healing. This combined approach, while challenging, offers rich potential for generating nuanced insights into psychotherapeutic experiences that honour both the explicit narratives participants share and the deeper psychological processes that may influence them.

The initial design of the research also envisaged an exploratory focus group following the individual interviews of the participants. The aim would have been to explore at a group level some of the themes that emerged from each interview, however, due to the limitations of the size of this research and the considerable data collected through the individual interviews, I evaluated that I had overestimated the scope of the project. While each participant was available, when asked, to take part in the follow-up focus group, this was not pursued.

Qualitative research was deemed to be the best research design in order to explore the CAPs' minds as a third space when working with the transmission of intergenerational/transgenerational trauma and to explore how CAPs manage the complexity of this in and outside the clinical room when working with co-morbidity of

patient groups who identify as gender variant. A qualitative research approach was chosen as it allowed an examination of the phenomena of the everyday experiences or essential structures/assumptions employed as a CAP. Moreover, a phenomenological approach to philosopher Edmund Husseri enabled “seeing the essential nature of things” through multiple perspectives or “imaginative variation” (McLeod, 2011, p.25). McLeod further describes this process as a separating off or “bracketing off” of phenomena that might be “contingent” on “circumstances” in contrast to the remaining constant phenomena or, in other words, the “essence”. This separating-out process enables a “peeling off the layers of assumptions and projections” (p.26). In this way a qualitive research project can examine a psychoanalytic process: the impact of past and present culture on gender and family history.

Qualitative research is a form of “narrative knowing”; understanding and recognising that we live in a social relational world and in this sense its starting position reflexively is subjective, as opposed to a quantitative “paradigmatic” knowledge that is “objective”’ and deterministic (Bruner, 1986, 1990, 2002, as cited in McLeod, 2011, p.2). Both forms of methodological approach have value as seen in the triangulation of methodologies employed by the Cass Review in 2024. However, my starting point for this research adopts the aim of wanting to explore and understand the narrative subjective position of CAPs’ experience in relation to their patients and their families and carers, which is inherently complex and layered, and arriving from a multitude of different perspectives.

3.5 Research Methodology

Recruitment process

I recruited for the project through the Association of Child Psychotherapists (ACP) newsletter. I had one reply from the initial advert (see Appendix 3) but this was from a CAP working abroad who was then excluded from the criteria. A second advert went out via the ACP but with no respondents. The difficulty recruiting left me thinking about the current political landscape and Hannah Barnes's, *Time to think* (2023), which evaluated the "collapse" of GIDS. This will be further discussed in the limitations and further research section.

After discussion with my research supervisor and tutor of the research supervision group, I forwarded the ACP advert on to trainees, who then asked their clinical supervisors for their interest. I had one participant who responded through this. Within the wider trust I also asked other qualified CAPS not in my locality, and had two responses.

Once eligible participants were identified, they were all sent the information sheet (see Appendix 4). Consent forms (see Appendix 5) were gathered electronically as well as at the time of the interview. Reminders were given about the timings of withdrawal from the research within the timescales specified.

The disadvantage of gathering a sample through this process is that there was no choice regarding the demographic make-up of my sample. In addition, I contacted qualified CAPS who had already written about working with transgender children in

case the project would be of interest but one declined as they were already committed to several projects.

Participants

A total of three participants were recruited with the revised inclusion and exclusion criteria. The inclusion criteria were:

Participants have to be registered with the ACP as CAPS. Purposeful sampling to include CAPS currently working in the UK.

Participants' intersectionality is embraced and they can be of any race, gender, sexuality, age, class and from any culture.

Clinicians with at least two years of post-qualification experience in working with YP who identify themselves as gender variant or gender diverse, who present at least two mental health conditions (co-morbidities). The YP who the participants will report on can be of any race, sexuality, culture, religion and class.

Clinicians with experience and interest in the transmission of intergenerational trauma.

The exclusion criteria were:

CAPS with no post-qualification experience or with experience of fewer than two years working with YP who identify themselves as gender variant or gender diverse.

CAPS who are not registered with the ACP.

While the aim was to recruit between four to six participants, the two stages of FANI interview provided a very rich set of data, and, keeping in line with IPA's requirements in terms of sample size, a sample of three participants, with a total of six interviews, was deemed suitable in supervision to address the aims of this research.

Therefore, all participants were qualified CAPs. They had at least two years' experience of working with YP who identified as gender variant.

I anonymised the participants to protect confidentiality using pseudonyms rather than numbers and, in no particular order, assigned gender, age and sex.

Semi-structured interviews

The semi-structured interview themes were designed using the FANI principles and procedures, as outlined by Hollway and Jefferson (2013)

1. The creation of open-ended questions
2. To elicit stories
3. To avoid "why questions"
4. Following up respondents' ordering and phrasing (pp.32–34)

The fourth principle required a follow-up interview (no more than two weeks apart) in order to allow for follow-up questions with a greater depth of narrative and to give participants the opportunity to add anything they thought about, following the first interview.

The FANI maximises the countertransference response of the participants and encourages open-ended narrative questions to allow a less defensive position to take place.

The semi-structured interview and its themes are included in Appendix 6.

Lokke's (2023) thesis focused on exploring psychoanalytical research methodologies and I am grateful for her extensive research on the FANI interview technique whilst preparing for the interviews[13]. Lokke developed a nine-point guide as part of her thesis and I selected the three points below that were specifically related to the use of the FANI methodology:

1. Describing the process to be expected in the use of silence and following the "train of thought" or stories (Lokke, 2023; Hollway and Jefferson, 2013);
2. Gathering the interviewees' "fantasies" regarding participating in the research (Lokke, 2023, p.50);
3. Psychoanalytic supervision between interviews to capture the unconscious. (Lokke, 2023, p.21).

The first of Lokke's points I specifically used in my preamble before the interview (see Appendix 6) to help prepare the participants. The second point was relevant to

[13] Lokke's (2023) literature review of researchers using this method alongside explicit guidance from Hollway and Jefferson (2013) suggested critical pre-interview information that would be helpful in preparing interviewees and transparent signalling of the ethical position of interview consent that works with the part of the mind that is unconscious.

the FANI's second interview follow-up. Lokke describes that it allows “opportunities for points or omissions to be followed up and tentative hypotheses shared” (Lokke, 2022, p.50). Lokke focused on Young’s work (2011, p.21) of interrelational reflexivity as participant and interviewer enter a relational space in regards to what both may want to get out of it[14].

Hollway and Jefferson (2013, p.50) discuss that, through the asking of stories, a way of following meaning in participants’ lives emerges, rather than explanation and aligning or “reproducing” our own discourse. They discuss the second interview process as allowing permission to explore themes that may have been significant through their absence, and to test emergent hunches. Further, the second interview is resuming the established relationship and the expectation that stories are valued, relevant and interesting (p.41).

Data collection procedure

I invited participants to be interviewed, which was semi-structured and audio recorded. I wanted the interviews to be conducted face-to-face where possible, to maximise the opportunity to fully enable all aspects of communication in the

[14] Lokke (2023, p.21) identifies that the “informant” or participant can be involved in co-creation of interpretation, which Hollway and Jefferson discuss as different than therapeutic interpretation. I wondered at the time of compiling my themes for the participant information sheet whether the gathering up of fantasies may be more accessible in the follow-up second interview space.

interview to be thought about. A further second follow-up interview, no more than two weeks apart from the first one, was offered, of approximately 30 minutes' duration.

Participants were given the themes of the interviews, as outlined in the previous section, seven days before the interview took place. The introduction to the above themes was important, to allow the participants some reflection on those cases that they may have wished to bring, and to prepare, which enabled more free association between us by knowing what were the areas to be discussed.

As indicated earlier, the FANI interview is a two-stage interview process with a two-week short follow-up interview after the first interview. Dates for each stage of the interview were planned with the participants by email, explaining the purpose of this. The first interviews were face-to-face for two of the participants, with follow-up interviews online. One participant's interviews were all online due to their geographical location and preference to interview online.

All the interviews took place between July and August 2023. Gathering the data of the two interviews quickly enabled me to see I had overestimated the scope of the research project because of the depth of the data in the interviews. The initial interview lasted for approximately 60–90 minutes – this time frame includes the explanation of the FANI process, which was given in the information sheet as well as at the beginning of the interview. The second interviews were only 30 minutes long, in keeping with the methodology guidance of the purpose of the second follow-up interview.

Participants understood that interviews were audio recorded and transcribed using a business Zoom license by my workplace. The video function of the recording was turned off and participants' attention was drawn to this. All participants at times gave examples of their clinical work. I deliberately omitted identifiable information about the patients and selected vignettes that concentrated on each clinician's experience.

All data is stored confidentiality and all participants' details are confidential with pseudonyms. At the end of the interview process, participants were given the debrief information sheet (see Appendix 7) with resources available for further support, if needed.

In accordance with ethical requirement on data protection, hard copies of the transcripts will be kept for five years and then data destroyed after the research project, to protect anonymity. The only person who read the transcripts was my supervisor but only after they had been anonymised using an initial numbering system. Participants were informed of the above through the participant information sheets and consent forms.

The field diary recorded my feelings immediately after the interview and during the two-week gap until the second follow-up interview and afterwards. The field diary (see Appendix 8) also recorded my iterative reflections of the process of the research, which helped me to notice a particular preoccupation or when I made links to my initial thoughts around this research. The diary included comments after I presented my findings at the Tavistock's research supervision group.

Due to the sensitivity of this subject area I directly addressed to participants in the recruitment and the beginning of the interview that I was not seeking to address causality of intergenerational trauma and gender variance but to explore the impact of its communication on the clinician's mind and their management of this.

3.6 Data Analysis

IPA (Smith, Flowers & Larkin, 2020) was applied as data analysis methodology. IPA is an idiographic methodology understanding phenomenon in context, therefore, the hoped-for initial sample size was going to be small and based on individual transcripts of each semi-structured interview.

As outlined before, the FANI technique used for the interviews allows a methodology to complement IPA as it acknowledges the reflexive approach that inherently "the researcher is implicated at every stage". The reflexive diary I kept allowed me to be explicit about my own meaning-making, process, interpretation and evolving ontology landscape[15]; the tension of this is discussed further in the strengths and limitations section in the discussion chapter.

[15] The reflexive diary has been invaluable to keep track of the iterative process of my thinking and responses to the different stages in the research. However, throughout the research I have had to remind myself that the interpretations using IPA need to come from an inductive position: the emerging data from participants and their lived experiences. I therefore monitored my own reflexive interest in the field diary, which became alive in the interview process due to the FANI methodology, which is aligned to a psychoanalytic approach of exploring the unconscious.

IPA researchers draw upon the philosophical work of Heidegger and use a hermeneutic lens, namely that our being in the world is perspectival and partially "in relation-to" (Smith et al., 2020, p.13), which allows me to explore a psychoanalytic clinician's experience of intergenerational communication and their patients' family histories through their countertransference.

3.7 Data Analysis Process

All the interviews were transcribed verbatim by myself and checked for their accuracy by listening to the transcripts several times. The familiarisation of the data in the first stage focused on staying with the participants' words and reflection, "not jumping to conclusions" (Smith and Nizza, 2022, p.33). I then followed the suggested guidance to do this by hand as it can be more helpful in learning the IPA methodology (Smith and Nizza, 2022).

Exploratory notes were made as part of the transcript in a right-aligned column next to the transcript (see Appendix 9) and meaning-making of the nuances of the participants' words and speech.

After exploratory notes I started to formulate experiential statements in a column to the left of the transcript, adhering Smith and Nizza's advice for rich and dense statements that are data-based but conceptual enough to capture the "psychological substance of text", keeping the statement open as much as possible. I referenced the corresponding lines of the transcript from where I made the experiential statement underneath it.

The next stage was clustering the experiential statements, which was done by hand, only after I had repeated the above exploratory notes for both interviews. They were cut out to get a "bird's-eye view" (Smith and Nizza, 2022, p.43) (see Appendix 10) before then clustering them together as personal experiential themes or PETs (see Appendix 11). For each PET I had the corresponding line from the transcript attached to aid the context during the analysis. To differentiate the first interview from the second interview, I coded them as "1"… for the first, "2"… for the second interview. This helped in analysing the data and differentiating the journey of the participants through the raw data between the two interviews. Due to the volume of data produced by the FANI, I transcribed after each interview, coded and made individual PETs[16].

After this stage of data analysis all the PETs were compared to find links or commonalties to produce group experiential themes (GETs). In selecting the GETs between the three participants, I paid attention to subtle convergences and divergences between them. In Appendix 12 there were ten initial GETs; however, as I explored the links between them I was able to see commonalities addressed across just five themes. It was clear from this stage that all the participants experienced the same GET but their individual experiences were apparent from an early stage. I am not sure whether this became apparent because of the depth of the psychoanalytic processes during each interview; however, for the purpose of ease, I have listed

[16] Ideally, I would have wanted to do each stage of analysis at the same time for all the participants; however, the project's time constraints ruled this out.

these differences as subthemes in the GETs tables. The individual GETs displayed a strong theme of commonality, therefore I prefer to define the subtheme as a particular “lens” of viewing their own experiences of working with YP in this area of research.

CHAPTER 4: RESULTS

4.1 Introduction

Interpretative Phenomenological Analysis (IPA) undertaken produced results at an individual participant level, retrieving Personal Experiential Statements (PETs) for each participant and, at a group level, making sense of such individual experiences among the three participants, tracing communalities and divergences in their experiences.

The PETs were formed after careful analysis of the individual transcripts, analysed to capture the essence of each participant's experiences, and are listed in Table 1 to Table 3 below, leading to the following PETs. The tables below demonstrate the nuances of each participant's experience.

Table 1: Personal Experiential Themes – Petra

Theme 1: Clinician locating the trauma Subtheme: The body/somatic locating trauma
Theme 2: Enactment of trauma – Clinician Subthemes: Enactment of trauma by system *(falling out of mind)* Enactment in interview process
Theme 3: Interview as live 'third' thinking space
Theme 4: Gender and sexuality safety / confusion
Theme 5: Noticing gaps and YPs' intergenerational trauma /management Subtheme: Shared minds to manage

Table 2: Personal Experiential Themes – Alex

Theme 1: It's personal and active Subtheme: Passion to shape practice Aliveness of the interview mirroring CAPS' role
Theme 2: GAPS and the sensing body
Theme 3: Enactment in interview
Theme 4: Complexity of CAP role and management Subtheme: Multiple minds holding
Theme 5: The whole person and trans identity

Table 3: Personal Experiential Themes – Tom

Theme 1: Management through active creativeness – applied CP
Theme 2: Neglect and external management
Theme 3: Enactment in interview process
Theme 4: GAPS and early trauma
Theme 5: It becomes personal Subtheme: Parallels of questioning in body (YP, clinician, participant)
Theme 6: Going back to basics (CAP management)

The tables above show the nuances of each participant's individual experience and the framing of their unique meaning-making of their experience.

The IPA of the data has then revealed five predominant GETs as shown in Table 4 below. In order to keep as close as possible to each clinician's individual experience, each GET incorporates slightly different lenses or variations. The lenses are indicated by keeping the individual subthemes linked to each central GET. The subthemes illustrate the individualised phenomenological meaning for the

participants, which are discussed further in the GETs as “subthemes”. For example, with Alex’s themes, their passion and aliveness during the interview were dominant, which also merged with the deeply personal experience of their work. Alex’s themes, for example, contributed to GET 4 “It’s Personal” and GET 3 “Active Management”, seen below. Whilst in Tom’s PETs, his creative application of child psychotherapy is seen in his PET theme, “Management through active creativeness”. This then contributed to the final Theme 3 in GET, Active Management. The final analysis of patterns observed across the PETs’ individual subthemes that can be demonstrated in Table 5. Extracts from the original transcripts of the interviews throughout the results also illustrate the particular nuances of the individual’s phenomenological experiences in the GETs results.

After each theme I reflect on my own interview experience, on the relationship established between the interviewee and interviewer during the interviewing process (if specific to the theme), and on my interpretation of their experience drawn from my field diary (Appendix 8).

Table 4: Group Experiential Themes

Theme 1: Noticing Gaps
Theme 2: Enactment
Theme 3: Active Management
Theme 4: It’s Personal
Theme 5: The Whole Person and Safety

Table 5: Group Experiential Themes with subthemes

Theme 1: Noticing Gaps		
Subthemes (Petra)	Subthemes (Alex)	Subthemes (Tom)
● Noticing Gaps and YPs' intergenerational trauma / management ● Gaps in shared minds	● Gaps and the sensing body	● Gaps and early trauma
Theme 2: Enactment		
Subthemes (Petra)	Subthemes (Alex)	Subthemes (Tom)
● Enactment of trauma – to clinician ● Enactment of trauma by system *(falling out of mind)*	● Enactment in interview process	● Enactment in interview process
Theme 3: Active Management		
Subthemes (Petra)	Subthemes (Alex)	Subthemes (Tom)
● Interview as live "third" thinking space to manage clinical material	● Complexity of CAP role and management ● Multiple minds holding	● CP management through active creativity ● Neglect and external management
Theme 4: It's Personal		
Subthemes (Petra)	Subthemes (Alex)	Subthemes (Tom)
● Clinician locating the YP's trauma in their own body/somatic	● It's personal and active ● Passion to shape practice ● Aliveness of the interview mirroring CAP's role	● It's personal – parallel of questioning in their own body and the interviewee
Theme 5: The Whole Person and Safety		
Subthemes (Petra)	Subthemes (Alex)	Subthemes (Tom)
● Gender/sexuality and risk management	● Locating the whole person with trans YP and keeping safe	● Enactment in interview process of clinical themes

4.2 Theme 1: Noticing Gaps

The GET “Noticing Gaps” illustrates both the participants’ experience of gaps in knowledge about the YPs’ familial history as well as their observed and felt experience of the YP’s trauma. I have used the word “trauma” to include all types of trauma experience including intergenerational or familial. In this way, “Noticing Gaps” is a representation of the clinician’s experience of trauma for their YP.

Therefore, it encapsulates experiences that go beyond the specific use of the word “gap”, incorporating the gap of not knowing a YP’s history because of their entry into the care system, for example. Here, the participants attempted to make their own links to what is not known by the YP, their history, whether it is forgotten, undocumented, or not able to be spoken to by the family or possibly represents a desired objective of the family to forget the past.

During the interviews, the noticing of gaps and the different ways in how each CAP consciously observed and “felt” the gaps in the clinical setting also included noticing other clinicians sensing gaps in the external network and observing how it comes to the fore. For all the interviewees, the “Noticing Gaps” was specific to holding in mind their patients’ experiences of trauma and the wondering about the intergenerational family’s trauma, at times wondering when something is being unconsciously repeated. For all participants, universally, the untangling of live and past trauma and familial trauma felt far out of reach. Noticing, feeling and sensing trauma, however, was a common experience underlying this theme.

The subthemes below illustrate how the “Noticing Gaps” influenced how the participants managed this in their therapeutic relationship with the YP and the convergences and divergences among them. For the clinicians this also included trying to “make sense” of the gaps in the YP’s developmental and complex trauma. This will be discussed further below by discussing the variations for each individual interviewee within this shared GET.

Petra

Subtheme: Noticing Gaps and YP’s own intergenerational /trauma management

Petra spoke of noticing gaps in her patient’s familial history and the impact of these gaps in particular, on the absences, interruptions or losses relating to a previous trauma being felt by the wider network in accident and emergency. The clinician reflected on the noticing gaps and the live dynamic of not being able to talk about the “what” that was missing in her patient’s life. In addition, the clinician highlighted below the unusual entry into her service whereby the standard initial consultation was also missed because of her patient entering the care system as a mid-adolescent:

> . . . they missed out on an experience, I suppose that’s the case with the loss of not having the initial consultation notes, they slipped into the service without having those really good structures in place and then I suppose they miss out on it as well. Petra 1.156

Petra summarises the dilemma that she and the wider network were holding, that the YP could not find words or the ability to express themselves in the clinic as shown in the following extract:

> **Petra**:…what's missing is being able to reflect on this with the YP, and I was desperate to talk about this with the YP but they would never come into the room at a time to talk about, there was always this massive, *Casam, chisem*,
>
> **Me**: mm . . . chasm ?
>
> Petra: yeah . . . between us . . . I think lots of people felt similar even in the hospital that wasn't mental health trained but said "who is talking to this young person about why they continuously phone the ambulance . . . " and those conversations never really happened so I suppose there is kind of an interplay of generational trauma, in these multiple systems on so many levels, but there are no words . . . Petra 1.64

Here, it is illustrated how Petra's gap in not finding expression in words was perhaps also being re-enacted by the network's difficulty to find words to speak about the gaps or losses in the YP's life. However, interestingly there was a parallel process of linking and noticing the gaps; other adults in the YP's life noticed what wasn't being spoken about and its possible link to their repeated admission to accident and emergency. Petra discussed her own experience of feeling this gap when she described this experience as a "chasm". Petra's word choice suggests the complexity of working with all levels of trauma in that it could cut deep into the emotional landscape of the YP and the network that works with them. This noticing of the gap could have a duality of something feeling missed but the gap has to be felt by the network in order for it to be noticed in the first place.

Alongside the noticing gaps, Petra also spoke about the YP bringing their own sense of gaps related to their infantile needs for comfort. In this specific way, her patient could find a way to share their own sense of gaps in their developmental history. The clinician spoke about this being the only time that they could bring something of themselves into the clinic room that was more meaningful and needing to be noticed:

> **. . .** ermm having a dummy at home but they were really irate that it was lost, had lost their blanket and their previous foster carer had stolen it and they became very agitated and angry, the social worker said we can get it back but it felt all related to the lost baby part of themselves and they were sharing things about their family… and the level of neglect - Petra 1.33-34

Subtheme: Gaps in shared minds

When reflecting on the pattern of the YP's relationships, as illustrated in the next extract, Petra mentions how the missing gaps, possibly in relation to the developmental trauma, were being repeated unconsciously in relationships, and that this would be something that Petra felt the YP became part of and she "fell into":

> . . . there was a pattern of being quite heavily involved . . . a close relationship and this person would last for a couple of weeks and then would be some sort of blow up in the relationship, then they would get fired and then it would be the next person and next person which is similar to what I fell into**.** Petra 1.91

This seems to indicate something perhaps being a bit messier than just noticing gaps; illustrating the complexity of the CAP's position, of often feeling like they are tipping into a repetition of past trauma. Petra, during the interview, spoke about her sense of "acting in", which happens when the unconscious is powerfully live to the point that they are compelled into meeting the YP outside the constraints of the clinic boundary.

> I'm trying to think of other differences, …. I never break boundaries, that's just unheard of. Petra 1.143

Petra observed the repetition of the breakdown in relationships with the YP but also a repetition of potential familial trauma for the patient's siblings when they also had similar presentations in A&E to Petra's YP. In the extract below she observes the wider institutional gap by services in not being able to link through a "conversation" or hold in mind all of the siblings and their potential familial intergenerational trauma. However, she also makes a link to the siblings' experiences of needing to act in a dramatic way in order to be seen by birth parents, which she describes as "noise" to be noticed or paid attention to. This "noisy" way of being noticed also appears to be repeated unconsciously, indicating a possible prior repetition of their trauma through the severity of their presentations at A&E.

> . . . so if one sibling took an overdose it was highly likely in two days, two of the siblings or one of them would pop up in A&E, or with a ligature recently, so there is that level too, in terms of something being replayed without those conservations of how hard it was for those young people to have remained in their parents mind or to be noticed or accepted

or umm (breath) . . . how it must have been hard to make so much noise . . . right in front of parents' face in order to be seen. Petra 1.66

However, Petra is left not knowing whether the making of emotional "noise" by the YP was a reaction to trying to communicate something to their parents that perhaps wasn't being heard. Therefore the volume had to be increased through the YP's behaviour of setting an alarm level, perhaps? Petra's sense was that the YP struggled to be held in their parents' mind without resorting to high-risk acting-out communication. What we do not know is whether the parents' own history influenced their ability or struggle to hold their children in mind.

Alex

Subtheme: Gaps and the sensing body

Alex spoke about the noticing of gaps or absences during their work with a YP through the sensing of this specifically in the clinician's body or their countertransference, diverging from Petra. Alex, as it is illustrated by the below vignette, discussed how the CAP needs to hold tightly or purposefully on to the psychoanalytic toolkit of countertransference as a form of projective identification between the CAP and the patient:

Alex: You feel it though the countertransference, that visceral experience
I'm not sure of what you experience, it's very visceral, it gives me a sense, particularly in working with complex trauma a sense that something is going on that has to be in the body, going on in the body (sic)

Me: yeah

Alex: our very early experience are bodily experiences

Me: mmm, so when you mean visceral something that is held, a feeling within your body? Alex 1.120-121

Alex goes into more detail in their description of a sense of gaps as a loss or felt "absence". In the following example, Alex goes on to describe another experience of a gap or absence felt in their body when working with a trans female YP who also identified as neurodivergent. The patient shared an experience of a waking dream whereby they were just on the edge of sleep but they were a boy in their neonatal gender.

When I was with this child I was really struck by a very absent ermm you know, emotional world, just couldn't tell me what was going on in their mind (fire alarm in the building starts 28.38) .. "a world where I would be a boy" (pause) and I found this very profound, very profound (quietly), and even talking to you now, I feel very upset about it. Alex 1.94

Alex was particularly moved by recounting this experience during the interview, which was interrupted by a fire alarm in the building – I later sought further clarification around what Alex meant by a "waking dream". In the extract below, Alex describes that it was only through the medium of a sleepy pre-dream state that the YP had been able to access their feelings about their neonatal gender. At this recollection of this shared relational experience, Alex was visibly emotional. Alex described something being shut off in the YP to be able to think about themselves in

their natal sex but also importantly to be able to bring this to the attention of Alex in their session together.

Alex: my response felt disturbed

Me: so your response . . . your countertransference?

Alex: I felt disturbed, you know, you talked earlier about where is the live trauma, maybe that's the live trauma, you know that this young one couldn't just be, had to be either or

Me: mm

Alex: couldn't actually be linked into his natal sex, gender

Me: mm, unless it was a . . .

Alex: a dream. Alex 1.106

Both Alex's and Petra's experience illustrates, in different ways, the emotional needs of the YP communicated via their countertransference: to *hold* a sense of something being missed in both their own past and potentially in their family's but also the turning of this into a live experience in the here and now with the patient.

Tom

Subtheme: Gaps and early trauma

The theme of noticing gaps for Tom was observed in feeling certain developmental stages or landmarks were "absent" in his patients, which he linked to possible neglect and complex trauma. These absences seem to indicate shared convergences across all interviewees of sensing gaps in the YPs' experiences of parental/carer attunement, as shown similarly in some of Petra's experiences. Tom felt the absence of care not just through the not knowing the developmental history

of the YP but also by noticing the YP's response to these absences: the fear that the members of the network would let them down, which reflected the YP's care needs not being attended to by their primary caregivers. In this way, Tom diverges from Petra and Alex, as he describes the absence felt as a fear of "abandonment" observed by both the CAP and YP. This is illustrated below by the clinician's noticing that it seems to be a live dynamic in their own therapeutic relationship but also with others in the network around them:

> . . . I think it's (Tom says 'it', meaning trauma/IG when thinking about a long-term case with a YP) present by its very absence. It is very hard to kind of touch upon and I see it through the external relationships with current caregivers, and the professional network. And particularly around that fear of abandonment, it kind of gets played out and certainly in my experience of one particular person this being a powerful part of the relationship, anticipation that I will let them down . . .Tom 1.8-9

Tom talks about the gaps of the past or trauma history, without differentiating between intergenerational and the YP's own trauma, linked to their being a YP in care where their needs could not be met by the family system. In the vignette below, Tom then discusses his concerns around potentially greater vulnerabilities in the YP, or the CAP missing an important area for a trans YP, because of the difficulties of talking about the past, a past for this particular YP where there was a different gender identification:

> I think one of the challenges I've had, has been in thinking about gender identity, I think about the past and the difficulties to touch upon that, but also the difficulty that that

> past means another agenda and another person, almost literally, like another person and to be curious about that person erm in a way that maintains respect for the decisions and ermm but I am curious about that aspect of the YP of being looked after, and have had these experiences of abuse but I think in my experience, they were just not ready for that and wanted to stay stable in the here and now. Tom 1.58

This extract illustrates the complexity of holding both the live trauma / past trauma and a history of intergenerational trauma when working with a YP identifying as trans; being curious while maintaining respect. The key task or role of the CAP for Tom was to be able to stay within the gap – as expressed by the comprehension that the YP was "not ready" to think about the past self – and creating something secure in the here and now of the therapeutic work. This clearly has its challenges for the CAP and sensitivity is needed. It diverges with the other two participants in that Tom was able to specifically speak to the gap that CAPs have to manage, or hold in mind, perhaps staying curious about the person's past natal sex identity and its link to their current presentation until the YP is ready.

4.3 Reflections of this theme

During the interview I was acutely aware of a feeling of the live enactment of possible clinical material in relation to this theme of Gaps. Petra came in with a note pad, which indicated that perhaps the material felt too much to hold or there was a fear that something would not be remembered.

I'm just writing this down otherwise it might slip from my mind otherwise, I don't normally bring pen and paper to something like this but I felt like things would really slip from my mind. Petra (1.53)

Similarly with Alex in the reflexive column (see Appendix 1 of the transcript, as illustrated below), I noted my own countertransference during that moment of the interview. I felt the liveness of the interview theme, which mirrored my noticing at that time of a gap in our connection because of the fire alarm. It had halted the interview for five minutes. At the time, it reflected my experience of missing something in a similar way to the CAP's experience wherein the YP was only able to think about all aspects of their natal sex and gender expression via a dream.

97. Me: and so yeah, it's usually a test at this time and I was just wondering about then your sense of internally describing a rich environment ermmm in the dream . . . I just need to double check A: go for it 98. Going to mute for a second (door banging) I need to go outside, for you is it possible in five minutes? It will be reset, or shall we reschedule another time or shall we continue when I come back…	97. struggling to attend in interview 98. fire risk and enactment of risk in room and needing to go back to an earlier stage	97. does this mirror something about gaps in emotional thinking?

4.4 Theme 2: Enactment

The theme of enactment illustrates the participants' experience of trauma being repeated. All the participants voiced that enactments (aspect of the trauma and / or intergenerational trauma that spills out) occurred externally to the session, within the wider network. Within the interview process there was often a live digestion of clinical material between the participants and me. In this theme, the FANI approach was particularly relevant as it allowed psychoanalytic reflection. I therefore observed my own countertransference in a separate reflexive column during the gathering and coding of the transcripts, when something had become defensive during certain stages of the interview. The second follow-up interviews allowed both the CAPs and me to attend to the process of the interview and what may have been "acted in" or enacted.

Petra

Subtheme: Enactment of trauma to clinician

Petra described a powerful experience of delivering clinical work alongside the dual role of lead practitioner or care coordinator of a complex and at times disturbed care-experiencing YP whereby high risk was very much present. The clinician felt this through their countertransference of "something being done to them".

So, I was drawn to keep this YP in therapy as knew it had to be their agenda or no agenda. So different people were brought into the therapy and they were completely in charge. Normally I would have a voice to say it starts now and finishes now but they were

so in charge of where we were going to meet so I suppose my… (voice disappears)… I normally feel very much like in charge of the session and know what the boundaries are and stick to them but I was led to change them. I suppose that this person. . . (silence) . . . maybe would become angry with me and potentially very violent . . . Petra 1.147-150

In this vignette, Petra felt forced to change her usual boundaries of the therapeutic frame in fear of a threat of violence but also worry of losing this YP.

Subtheme: Enactment of trauma by the system

Petra also reflected on the enactment that had been experienced by the YP in the past, but was also being seen through the repeated risk behaviours faced by the YP and their multiple siblings also in care, seen in the vignette in Theme 1 for Petra (Gaps in shared minds): if one sibling took an overdose and subsequently attended A&E, the others quickly followed. This same vignette also illustrates Petra noticing gaps being felt by the system of making sense of presenting behaviours through creating a "noise" or an enactment of shared familial trauma/intergenerational experience of all the siblings but this wasn't taken any further, for example, by a wider systemic care plan of all the siblings. The overlapping theme or symptom of "noise" illustrates enactment within the wider network of its inability to manage the siblings (see below) seen in the severity of the risk.

Petra in Theme 1 (Gaps in shared minds) seemed to suggest that the enactment also communicated a difficulty with the YP, which was also felt by their siblings, of feeling they had fallen out of the minds of the professionals through amplifying the

volume (“noise”) of their internal needs via the high-risk behaviours. This is linked to Petra’s observations reported in Theme 1; of the difficulty of putting something into words, which provoked her sense of “gaps”.

The high likelihood of the YP displaying high-risk behaviour occurred in three subthemes for Petra: Gaps in shared minds (Theme 1); Enactment of trauma to clinician and to system (Theme 2), and; Gender/sexuality and risk management (Theme 5). This seems to demonstrate an additional layer of complexity in holding familial history in mind for the CAP when there is the potential threat of life.

Petra, in addition, also noted the additional impact of the enactment on her YP by the wider system or network. She refers to this as a “double missing out” (see below) in not being able to access support or the repetition of neglect by professionals / adults in the here and now. This leaves the YP unattended to both in their external reality and in their internal world, a belief that the adults cannot be trusted. This illustrates the additional impact of potential intergenerational trauma on the YP as the enactment is felt beyond the clinic room and pervades all areas of their life in the “fall out”.

> . . . it was like a double missing out as clearly missed out . . . not having a chronology and erm things like that but then also when the YP was given options for psychotherapy or other forms of support, it was really hard for the YP. To actually access the support because of their attachment difficulties so they might start off one or two sessions but then something wouldn’t be right or there would be a fall out or . . . someone would leave, adults constantly leaving them and . . . when they accessed the type of therapy . . .

. . . then that practitioner turned out to be not to be trusted either and so there is a double whammy, professionals unconsciously being neglectful and then the young person also not being able to fully access what other young people could. Petra 1.38-40

Alex

Subtheme: Enactment in interview process

The theme "Enactment" can be seen in the relational experience of Alex and I, which potentially enacted the experience of the YP, feeling easily pathologised. The interviewee appropriately challenged me from the start about my research question. Alex shared that the holding in mind of familial history was in itself pathologising and contained my bias.

Alex: you know, but I wouldn't be holding that at the forefront of my mind, very much at the back

Me: "at the back" (repetition for emphasis)

Alex: at the back and certainly no, I wouldn't be going to any team meetings or writing any reports saying based on this, this and this. Alex 1.37-39

As the interview progressed, I became aware of our working through this, and something became more mutually and consciously understood about how we, as CAPs, may feel that an intergenerational element of trauma might be recognised but it was not appropriate to raise it with the YP or family. This is shown in the vignettes below when Alex acknowledges it in our work as CAPs, but also talking about our different positions as researcher and clinician.

> One thing I did learn . . . that I felt from another experience of working with intellectually disabled ermm, children and also adults, how do we avoid pathologising or having fancy hypotheses, "interpretation formulations" that we think are fantastic but not helpful for the YP in that moment and time. Alex 1.29

> **Alex:** . . . our really fancy formulations, we might be right, (silence) but . . .
>
> **Me**: . . . but actually how helpful is that?
>
> **Alex:** . . . you know, it's just the place *I'm in now* in terms of really working at the coal face, and if I was sitting and thinking more and writing I would think differently.
>
> Alex 1.77-80

Alex reflects on the timing of when something might be shared with the YP. They reflect about how the CAPS' insight might potentially cause an enactment or retraumatisation from the therapist to YP, as illustrated in this vignette:

> **Alex:** I suppose it depends, how it lands on us, the relationship that we have with the patient, what is safe and right, what is felt too damaging, that's too much for the patient's defence, we want our patients to be less defended, not more, right? (smiling)
>
> **Me:** yeah completely, (laughing),
>
> **Alex:** right? (we both are laughing), I think using a trauma-informed approach, I mean Ricky Emanuel has written about it very well recently. Alex 1.215-216

Tom

Subtheme: Enactment in interview process

Tom discussed his sense of “blockage” of countertransference in the interview and made a parallel of a similar experience that a specific YP had with him in therapy. He reflected on the need to think about this blockage experience alongside the holding of a history of abuse and neglect in mind:

> . . . I’m aware I want to name that really, a process I’m noticing about myself in our, our (sic) exchanges really, something happening there, almost a blockage sometimes, that I know happens in the room with him but I’m noticing it’s happening a bit in the feeling between us. I think . . . about on one hand, I feel like I don’t have a full sense of history for the YP I’m working with or enough of a sense of history or a formulation as we understand it of abuse or neglect. Tom 1.62

During the second follow-up interview, Tom reflected about what was being enacted in the research interview in relation to his own countertransference of not being good enough, understanding further the parallel process happening between him and me, and him and the YP:

> . . . but I also noticed times for myself wondering what I am inadvertently or playing out in the countertransference, you know, do I end up enacting something . . . issues of my own identity coming to the fore, am I being a good enough therapist? Is this the right thing that I’m doing in the room with them? Tom 2.4

Tom’s reflection on their own doubts of not being a good therapist was triggered by his feeling of not knowing enough about his patient’s history.

The theme of enactments followed a similar convergence path for all participants, and it was striking how live this was felt in the interview (see reflections).

4.5 Reflections of this theme

The reflexive column of the original transcript and field note diaries demonstrated I felt defensive and hypervigilant in interactions with them around differences of opinions and wanting to be understood. It seems that my defensive countertransference might illustrate a sense of not being good enough as a researcher but also still being a trainee at the time of the interviews. Alex appropriately identified the careful need to be sensitive in this area and the possibility of an enactment of insensitivity coming from my research process, which mirrored how trans YP feel towards clinicians.

Reflective diary extract of Alex after interview 1:

My experience of this live in the room and research potency	1.35 Me: mm, so then how do you maybe get . . . that naturally brings us onto the sense of then in terms of dealing with both, In terms of what the YP is coming to you with and then . . .	35. Is this me being defensive or holding onto my research area too tightly? My bias?

	But then also your sense of ummmmm, your sense of intergenerational themes . . . I just wondered, yeah, around how that have may come unconsciously, or unconsciously ermmmm	

4.6 Theme 3: Active Management

The GET of "Active Management" illustrates how across all participants there was a need to extend the CAP role from working with internal processes in the clinic room, to hold a family's system in mind in a more direct, active and creative way. A commonality was that all participants spoke about their practice moving from beyond the session boundaries to needing to work in the external system. The subthemes, as shown in Table 2, seem to illustrate ways, with particular lenses, to manage the powerful "meddling ghosts" of Fraiberg et al. (1975), which will be expanded upon in the sections below for each participant.

Petra

Subtheme: Interview as live "third" thinking space to manage clinical material

Raw and unprocessed disturbing clinical material featured during the interview with Petra, which was a divergence from the other participants. Neither the CAP nor I had expected to have a live third thinking space, as experienced during the interview:

. . . but it feels a bit of relief sharing in a way. Petra 1.95

This seemed to connect to Petra's experience of feeling of shame, which presented itself as an embodied experience, possibly revealing the enormity of this complex case. This is further illustrated in the next GET "It's personal", however, it also feels relevant to this theme as there were elements of the work that were managed by the CAP that reflected needing to be more active within their role. Shame is also further addressed in this theme's reflexive section.

The clinician reflected below that they needed to share the complexities of the case with wider agencies, however, the research interview process also appeared to become a partial vehicle to do this. The clinician was able to reflect on this in our follow-up second interview when observing feeling differently about the case after the first interview:

Petra: That first interview felt like someone else was, maybe taking in connections about something that kind of, had been playing on my mind

And I hadn't really been able to just . . . really talk like that, about the young person, really before

Me: mm

Petra: so yeah, I hadn't had really many thoughts about the young person, which is kind of interesting in itself that . . . like literally none (silence). Petra 2.12-14

Although this subtheme of the first interview as a third mind thinking space is different than the other subthemes for the other interviewees, there was commonality

among participants in the need for more active management, as all of the cases were complex and needed network management. Petra reflected and observed her role in the active management in the case during the second follow-up interview:

> There is something that comes to . . . when you were talking before about my mind, it made me think about the network meetings that we used to have . . . fifteen different professionals at twice-weekly network meetings and that wasn't including lots of different people from the home (the residential home of the YP). Petra 2.75-76

Alex

Subtheme: Complexity of CAP role and management

Alex discussed the active management in the role of the CAP due to the complexity of the clinical material, which included neurodiversity and parents identifying as trans:

> . . . trying really hard for me to hold on to (the different elements of the case) and not get caught up in it. Alex 1.255.

Alex demonstrated this in a really visual way through their body movement during the interview. The hand movements illustrated a symbolic gesture of action and processes that were going on in the CAP's mind as a result:

> The super complexity of these threads of holding and what is sometimes almost impossible (hands moving in the frame), I was just thinking of the mind going back and forth of different areas in our minds. Alex 1.256

Subtheme: *Multiple minds holding*

In the following extract, this was followed by their gratefulness of working "actively" with their colleagues; the act of sharing with their colleagues extended the CAP's ability to hold complex themes in their mind through sharing with their MDT colleagues' minds. It illustrated an additional support mechanism, or third shared mind, to manage the complexity in the CAP's work.

> It was a bit distressing as I said I took it back, so it can be thought about, contained by more of my colleagues, so together, there was an analytic thinking space . . . Alex 1.107

For Alex there was a divergence, not mentioned with the other participants, in the important containing function of sharing it with their team, which seemed distinct and not expressed by Tom and Petra. Alex shared their experience of having an MDT team that actively embraced difference and encouraged safety to disclose. In this way, Alex's experience of the emotional containment from their team seemed far more active, which Alex indicated contrasted with other past workplaces. Alex valued the openness in thinking about differences in the team:

> …but there was a real safety to do that, other than in supervision – which is only you and someone else.. Alex 1.230

The context of working in an MDT where EDI was so important for their gender-variant patient also meant the need to actively manage cases through sharing with their colleagues. This became a vital process of containment, as Alex explores further:

> You know, there is something about widening out, making something transparent but on the other hand there is something about working with these children that feels very exposing and it's probably the political landscape, yeah and that. Alex 1.257

Here, Alex talks about the importance of transparency enabling containment in the MDT but the vignette suggests it's also linked to the "landscape" or area of working with trans YP. Alex illustrates perhaps that the vulnerability of working with this patient group is not only with the patients but with the staff.

Tom

Subtheme: CP Management through active creativity

Tom also discussed vigorously the need to extend the CAP's role to be actively working with the external network in the three vignettes below. The theme of being active is seen in Tom by the belief in applying the CP role. Tom expands on the theme of managing complexity through adaptions to a CAP model: that the past may not want to be spoken about as a goal or outcome of the work. Firstly, he describes that "adaptions" need to be made to the CAP model.

> . . . for some people the journey isn't going right back to the origins and talking about it, actually it's not necessarily the outcome they are seeking or wanting.
> But just being aware of that kind of, the adaptations to the model . . . I'm noticing in the trans YP I'm working with but also other YP in the service that I'm currently working with a theme of more complexity, around working with them. Tom 1.26-27

Subtheme: Neglect and external management

For Tom, the theme of active management is seen in direct communication to manage the enactment of neglect by the system to the YP. Tom reflects below on how the original trauma can be enacted and "reinforced" by the external network by the inability to be clear with the YP as to what can be provided. Tom observes that professionals fail to take up a "system" role or lead practitioner/care co-ordinator role in order to emotionally contain the network and, in turn, this impacts the YP.

> …ermm whereas in terms of the external there have been other adults that have offered to take on the system role for them and said that they would, but they haven't done, so foster carers placements have broken down, moving from residential home to residential home so, there have been so many placement breakdowns, which kind of reinforces something of the original experience. Tom 1.21

Tom does not make a distinction between the enactment described above being intergenerational trauma or the trauma in the here and now. However, he does suggest an expression of the original trauma is repeated through the "breakdowns"

and the importance of naming this as part of actively managing the unconscious repetition of trauma. Tom explains:

> **Tom:** Here is something about the external, this is so important that is happening between me and the YP, understanding what is happening between us, the unconscious, but part of naming that is doing it with the network as its being played out everywhere . .
>
> **Me:** Mmm
>
> **Tom**: And need to recognise what's happening and communicate it, is really vital.
>
> Tom 1.77-78

Tom also spoke about the generational differences he had observed in the adults in the YP's network compared to the YP's peers. Tom suggests that the adults are more closely linked to projecting shame into the YP, rather than their peers, who viewed their gender variance within a normative experience. Tom reflects on this below, perhaps illustrating the important role of the CP to digest and vocalise transparently what may be enacted and where this might be located, in the network's own identifications to gender. Tom reflects on the impact of the YP who may internalise the shame when it is located in the intersectionality of adults of a certain age struggling with the atypical gender normative culture accepted by the YP's peers.

> **Tom**: . . . I think about shame, then, and coming back to what's been quite striking is actually how the peer group is not holding judgement about who they are, they are holding it in themselves and sadly it kind of gets played out within some of the care services and adults, those with parental . . . actual parental roles.
>
> **Me**: So the sense of shame, shame gets passed on? Tom 1.27

Tom illustrates here an interesting divergency of the potential enactment of something intergenerational around gender normative culture through the mechanism of shame.

Interestingly for both Petra and Tom, shame was observed in projective psychoanalytic processes. Although it diverged in its location, for Petra it seemed within herself seen in the unprocessed material and for Tom located in the YP from the adults of a certain age in their network struggling to understand their gender identity. More broadly speaking, Alex recognised the importance of a close MDT that embraces intersectional differences and diversity in order to support clinical thinking. Perhaps all participants are suggesting the need to actively consider the impact of normative cultural processes and how quickly shame can be evoked internally in the therapeutic relationship or in the network. All three participants appear to have converged on the complexity of their cases, which resulted in a far more active practice of their CAP roles.

4.7 Reflections of this theme during the interview process

The reflexive column after transcribing the interview process revealed my thinking about the role of shame for Petra, which is difficult to locate and isolate where this may be coming from. In this way the complexity of the case was felt by both of us. The narrative of shame in this GET evidences the importance of actively managing trauma and how it can manifest itself either through enactment repetition in the network (Tom) or not having an MDT (Alex) to be reflexive with.

Reflective diary extract of Petra:

1.76	76. P: My emotions were all over the place to begin with, think how I have been drawn in a really sexualised way and so trying to think about . . . trying to get some distance from it and get some words for it but then there was this anger and aggression that was so awful (long silence) So it was really hard (silence) That's just stopped our thinking (murmuring) I've gone off track	76. Many silences in room Clinician's worry that she has gone off track – linked to shame?

4.8 Theme 4: It's Personal

"It's personal" describes the common experience of each participant experiencing and being touched at a very personal level by their work with the patients reported in the interview. For each participant their feelings about their own intersectionality and identity as a clinician seemed linked with working with gender-variant YP. The results suggest a parallel process of vulnerability of the YP with gender variance with different co-morbidities.

This theme is linked to two GETs; "the active management" and "noticing gaps" and the "how" we hold the sense of a family's history in mind. All three participants, on one hand felt the need to be active in their role of managing trauma and intergenerational trauma when they get re-enacted by the network; on the other

hand, they experienced trauma on a personal level through their countertransference. However, the “It’s personal” theme appeared to go beyond projective processes as it touched the CAPs and their ongoing narrative in a live and moving way during the interview. Indeed, this was revealed by the iterative process of IPA and two staged FANIs.

The individual lenses seen in Table 2, in which the participants reflect on their personal feelings evoked by working in this area, illustrate their shared convergences in this theme. All participants demonstrated their commitment, depth of working and passion to their patients in particular ways as illustrated below.

Petra

Subtheme: Clinician locating the YP's trauma in their own body/somatic

This theme describes Petra’s experience of her patient and it being located at a bodily level. The risky and complex trauma work required with this particular patient was located either emotionally, through their countertransference of feeling something being done to them, or in a very physical form, of body intrusion.

> Because there wasn’t much else that they brought that wasn’t just something slapping me in the face._Petra 1.124

Petra illustrates this further below as either a gesture of penetration or as a physical assault, describing her somatic countertransference:

. . . felt like quite dangerous or excitable not really constructive . . . there was something . . . I don't know it is really hard to explain, that I think it's the feeling I got when I was with this young person, often. Something kind of sexual . . . they were screaming at me and shouting . . . I felt so violated. Petra 1.74-75

Petra recognised a parallel process of trauma in the YP's body in response to visiting their birth mother.

Me: So, that repetition of a wound of something . . .

Petra: Yeah , yup and when they . . . this is something that just comes to mind . . . when they used to visit their mum they would have more of the seizures.

Petra 1.113-114

The role of some form of trauma in the YP seemed to be reactivated when visiting their birth mother; located in their seizures, which seemed to be described as somatic defences linked to a physical manifestation of something getting in the way for them of progressing externally, such as future education, as further explained in the extract below:

Petra: It was specific to that practitioner they wanted to see for psychological work

Me: Ok . . . (soft)

Petra: It happened a lot with her and with college before they went into big rooms of maths and literacy GCSE but was related to stress and anxiety.

Petra: something really cutting and jagged, getting in the way of something more smooth if that makes sense*?* Petra 1.118

In this extract Petra uses adjectives, “cutting” and “jagged”, which are in themselves a description of a visceral emotional wound due to their physical attributes. Petra describes the aggravation of her patient’s earlier trauma, which is not distinguishable as intergenerational, revealed through a somatisation of trauma, that of having seizures. However, there is an additional aftermath of the seizures affecting their ability to access their learning at college and an attempt to start with another practitioner. The triggering of the seizures appears to be linked with seeing their birth mother, illustrating something getting interrupted by the familial contact. The theme is not about evidencing a link with intergenerational trauma; however, it does illustrate the complexity of what gets passed on or what gets projected into the CAP and how the CAP and YP then manage this.

Tom

Subtheme: It’s Personal – parallel of questioning in their own body and the interviewee

This theme was illustrated in Tom’s experience of feeling the need to defend the YP and their loyalty towards them during the second follow-up interview process, as described below:

> I think I noticed how difficult it was and it surprised me. . .
>
> I mentioned before this not being a supervision space and that being where I would talk about the particular young person I spoke of . . . the discourse, is not the same to and fro you may have about a clinical conversation ordinarily, but I think I was also struck by that

sense of not wanting to betray the confidence, and I wondered about that and my own resistance. Tom 2.3

Similarly to Petra, Tom's experience with his YP was felt at a bodily level. Tom described his countertransference of needing to protect his YP and the YP's feeling of vulnerability evoked by the interview process and his own discomfort with the different frame of an interview rather than supervision. "It's personal" illustrates how closely something becomes stirred up within the CAP's own identity, the need to protect, as already seen with the convergence of Alex's process of feeling uncomfortable.

The second follow-up interview allowed Tom the opportunity to reflect on the countertransference he was left feeling during the interview process. Tom reflected on the link between his own countertransference as "withholding to me" and the neglect within the histories of looked-after children or care-experienced children in particular. Below, he also introduces when the CAPs might be limited in not really knowing anything about the possibility of intergenerational trauma when working with children in care as the parent can't be asked about it.

Tom: I came up with the word, withholding afterwards, the field I'm in with looked-after children and what they haven't had from their maternal figure or their parental figure and the difficulty in that exchange with us and worried that I wasn't kind of giving enough, or comprehensive enough kind of explanation/ conversation, does that make sense?

Me: Yeah

Tom: Kind of left with that a bit , rather that the work I do with the YP . . . Errmm, it's the parallels I'm experiencing through the research with you and the parallels with my YP. Tom 2.3-6 and 2.9

Conversely, Tom reflexively drew parallels to something being stirred up in himself during the interview, which was noticed reflexively during my interview with Petra. In the vignette below Tom questions his own vulnerability of professional competency, not focused on gender but instead on the possible shared experience with his patient and how this might be resonating with Tom's own feelings of vulnerability:

Tom: I have questions . . . not just in their gender identity but in terms of who they are as an individual, a young person that has gone through a journey of being in care, and various homes and that fragmentation that occurs, that kind of me seeing something in my own identity, so there is that as well . . .

Me: Mm . . .

Tom: …that kind of gets evoked you know, of that question mark, am I good enough, that our YP experience permanently. Tom 1.25

Alex

Subtheme: It's personal and active

The theme of "It's personal" was expressed by Alex in noticing their intersectional differences to their patient. Alex used this as a tool to think about differences between themselves and their patient in a lively way.

> **Alex**: And so when I'm with children, it's like, (raised voice) "Where are you from?" And all kinds of fantasies around and how do we work with that?
>
> And you know because I'm from a different part of the country it's much more live and present. Alex 2.39-40

Alex's variation of "It's personal" highlights how the clinician became activated and adapted their response to how they would work with a YP clinically. Alex reflects on this during the second follow-up interview and how revealing their own vulnerability, in this case of getting something wrong, can be helpful for their trans patients:

> I just took a chance. I could have failed spectacularly, terribly, and I think that is something I learnt working with trans children, if it goes all wrong can I be brave enough to say I got it wrong, I was so silly, oh dear, you know. Alex 2.16

Subtheme: Passion to shape practice and aliveness of the interview mirroring CAPs' role

During the interview the theme of adopting a personal way of working as illustrated above also evidenced Alex's passionate practice and desire to be authentic as a CAP and reflected on our shared motivation for working in this area:

> . . . but we just have to support these people at where they are at . . . and with our professional experience and it's personal, we are also a person and it's very hard to divide that, we don't think about this anymore, but we are not a blank screen, it's very

hard, why are we doing this particular type of work, why have I trained as a child psychotherapist, why am I working in complex trauma.

it says something very much about us, like why are you doing this project, right?

Alex 1.224

4.9 Reflections of this theme during the interview process

I was struck in the second follow-up interview (coding as 2. in each vignette) all participants were able to explore the personal aspects of their work, and the shared experience of feeling this together in the room allowed richer depth of results seen in Petra's vignette in Theme 3, interview as live "third".

I also noted in my reflective diary with all participants that when in my countertransference we touched on material that felt pertinent to clinical material, I also stuttered, which was not noticeable in my clinical work.

See reflexive diary extracts below:

Jagged experience that the patient was passing on and speed of transition and heat of interview	1.119.120.121	120. Me: ermmm, I think . . . (stutter) . . . I was just (long silence) I guess I was just curious because it felt like such a rapid transition, in terms of when you started work, it feel like, quite rapid P: mmm, mmm

Interview feeling unsafe, mirroring clinical material?	1.35, 36	Me: . . . something very simple but there was something within me, something was provoked, maybe, maybe (stutter) the the (stutter) point is important that this happened rather than how it happened.

4.10 Theme 5: The Whole Person and Safety

The GET, "The Whole Person" and the area of safety became a consistent narrative in how the participants thought about their YP patient and specifically those YP who identify as trans. The theme suggests that the whole body and whole person and their difficulties need to be thought about alongside a concurrent narrative of how CAPs keep the YP that they work with safe.

Within the GET extracts of Theme 1 "Noticing gaps" and Theme 2 "Enactment", there were illustrations of when the CAP has to manage risk, either in relation to the complexity of the possible trauma presentation, or intergenerational trauma. This was, for example, witnessed by the multiagency professionals working with Petra, seeing a potential repetition of risk behaviours in the YP's siblings lives or in enactments of trauma by the network in Tom's evidence. Therefore, the theme of needing to think about the trans YP in their entirety, including whether they feel safe

or not, seems to be a theme for all the participants who were involved in the management of the YP's risk.

Even in this GET, each participant is illustrating it with variations, as seen previously in Table 2.

Petra

Subtheme: gender/sexuality and risk management

This subtheme illustrates Petra's experience of the riskiness of the YP and the representation of the YP's history of neglect regarding missing or lost symbolic objects to the young person. It is also illustrated by the gaps in their history and the unusual route into Petra's service without a "standard consultation" (see GET, "Noticing Gaps"). This meant that perhaps Petra's need to be vigilant in regard to risk behaviours was to focus on the whole person in relation to their body and mind and how they could be kept safe. Interestingly, throughout Petra's clinical work with this YP, the times during which their developmental needs were held in mind by Petra, felt too overwhelming for the YP. To sustain and accept such focus, which tipped into enactment behaviours; a sexual perpetrator type role towards the clinician. This suggests a particular level of complexity of how clinicians have to tread carefully because of the sensitive reverberations that come with trauma and possible familial/intergenerational trauma background. As described by Petra:

> I guess something that came to my mind then was what we did know, that their mum didn't protect them, a number of times, and neither of their parents, their mother didn't

> come and visit them when I was working with them in any of the placements they were at even though they lived quite close.
>
> It made me think about what would it be like for them to have someone interested in them, I wonder whether me being interested in them was just so tantalising that it became sexual. Petra 1.184

Petra identified that her patient's gender identity changed a couple of weeks after starting therapy with her, which coincided with a significant traumatic event. She observed that her patient's change of identity allowed them to experience a sense of belonging in that community.

> They were bi . . . and so again that is different ermm and within those sessions we didn't really talk about their gender identity and despite trying to help them get to groups to support themself, they did actually have a lot of friends that were trans, at one point they fell out with most of them but at that point, it did feel they had a sense of belonging. Petra 1.170

The importance of the gender of adults around them was also an important interpersonal and intersectional quality that made them feel safer. This is illustrated by them wanting their male social worker to attend their initial session. The social worker remained the longest-serving member of the network, providing safety for the YP. The YP also reported being able to identify with other males in their network.

> **Petra**: . . . and the only . . . the social worker's status is male and the manager of where they lived has stayed . . .

Me: Who's male?

Petra: . . . is male and everyone else has gone over time.

Me: Mmm . . .

Petra: A lot of, yeah . . . breaks in attachments and people disappearing and just physically not being present anymore. Petra 1.62-63

Alex

Subtheme: Locating the whole person with trans YP and keeping safe

Alex also discussed the theme of totality of the YP, to be seen as a whole. Alex shared the necessity of a "lightness" in approach by CAPs and how we need to hold in mind a patient's history. The clinician thought about how this may be expressed in thinking about a YP's safety within the family, which shouldn't just be focused on their gender identity.

. . . these are children that I have found need help to have their voices heard so they can have lot of things on their mind, it doesn't just have to be about gender identity**.** Alex 1.117

Alex described looking at the whole body and all experiences of their patient, including sexuality and societal normative definition. As we are aware, Alex experienced a diverse and rich experience of an MDT that embraced intersectionality of clinicians. This perhaps aided all experiences of identity to be thought about in a more natural, inclusive way.

Alex: . . . their experience was good and valid, so the work wasn't, you know about working with being transgender, it was a different piece of work to really coming to thinking about the relationship to the body, relationship with masculinity, femininity, what does that mean?

Me: Mm . . .

Alex: (pause) you know, being criticised and hate, this kind of feeling of where does hate go, how it is expressed in self-harm, how do we think about self-harm in that context, talk to the family about it, how can they be sufficiently alarmed about it. Alex 1.56-57.

The subtheme of safety in relation to the whole person, like Petra's, was also very present in Alex's work but had a particular focus on creating safety to think about gender diversity.

. . . it was very very interesting to talk like that and there was a feeling of safety and we were always trying to recreate this with our YP, can this be a safe space to think about being gender diverse. Alex 1.16

I was cautiously aware that I became more animated in the following extract during the interview of Alex, possibly because of the initial defensiveness around the bias in my research question regarding my own reflective experience of working with trans YP, which became transparent during this section of the interview. Therefore, this may have impacted this GET and its analysis of what is important to hold in mind when working with this patient group and their family history.

Alex: YES exactly (we both get excited and we talk over one another in the interview)

Me: so I think . . .

Alex: . . . the totality of a person, whether they are trans or not is insignificant.

Me: Yeah, I think . . .

Alex: [interrupts] . . . always hold this in mind, this is a person. Alex 1.218-2.19

Tom

Subtheme: Going back to basics to manage the whole person

Tom illustrates this theme in the context of desiring to "get back to basics" as part of the role of the CAP. He reflected on the essentials in a therapeutic relationship that the YP needs us to understand, namely that our task is to be authentic with them. In this theme there wasn't a direct reference to safety, but safety was implied through paying due attention to the entirety of the YP, not just identity, and this being a form of safety or emotional containment.

I think the authenticity is about being true to our word that the experience of another, of somebody actually noticing what it's like, being able to not just name it but sitting with it and knowing that it's okay… So, whatever the origins of why they may identify their gender differently to whatever they were assigned . . . to know that's okay to be, to be yourself that's what we are all searching for, isn't it? Tom 1.25

Tom reflected a mixture of the necessity to apply CAP's principles but also to extend the traditional sense of how we hold a YP and their family in mind. This holding might never include addressing what has gone on before in the past by attending to it in the mind of CAP but meeting the person in the here and now:

. . . stay with it even if we have to stay with it ourselves for a bit to be palatable for them Ermm bringing that jigsaw together in our minds, so I think that's a strength that we CAPs hold . . . silence. Tom 1.42

Tom evidences that the application or putting into practice a holding in mind is always with care and that "live sharing" may be as much as naming something for the YP that allows a coming alongside them. Tom reflects on the essentials or value of stripping something back to basics that means seeing all of them, a coming alongside,

Me: it seems like, that that that (sic), the careful naming of something is when something quite live is shared?

Tom: Live shared but that's that, it doesn't mean that it will open up the door to deeper, ermm reflections or opening up of other events but that was what I wanted you to get from today's session . . . (laughing) ermm . . . to be alongside is all that's wanted, because actually that's been deeply missing from their life. Tom 1.50

4.11 Reflections of this theme

I am aware of my own internal bias, which became more dominant during the interview with Alex with this GET. I have reflexively wondered whether it was partly due to this being the only interview held online for the first set of interviews, which concentrated the intensity of our meeting. We in this way were both working hard to make sure something was understood in the animation of our voices and tone. I am

also always aware of my underlying gratefulness for their participation in a subject area that is so politically “hot”.

4.12 Interlinking the GETs

In this section of the results, the links between the five GETs is explored through a graphical representation of their interconnections in Figures 1 and 2. Through the use of IPA and its inherent iterative process, I indeed started to notice an overlapping or interconnection of themes, which seem to show how CAPs manage the complexity of trauma cases and the management of risk with YP identifying as trans, and the impact of such work on them. It could be said, this is part of the role of all CAPs when working in a generic mental health setting but that it is possibly more alive in the area of trauma due to its unconscious repetition and what is unknown. In addition, the complexity of the specific vulnerability of CAPs working in this area and the transgender YP themselves is threaded in the GETs findings, especially with more emphasis of the wider holding of the external, risk and changing political landscape of work with patients.

Figure 1: Model of interlinking GETs

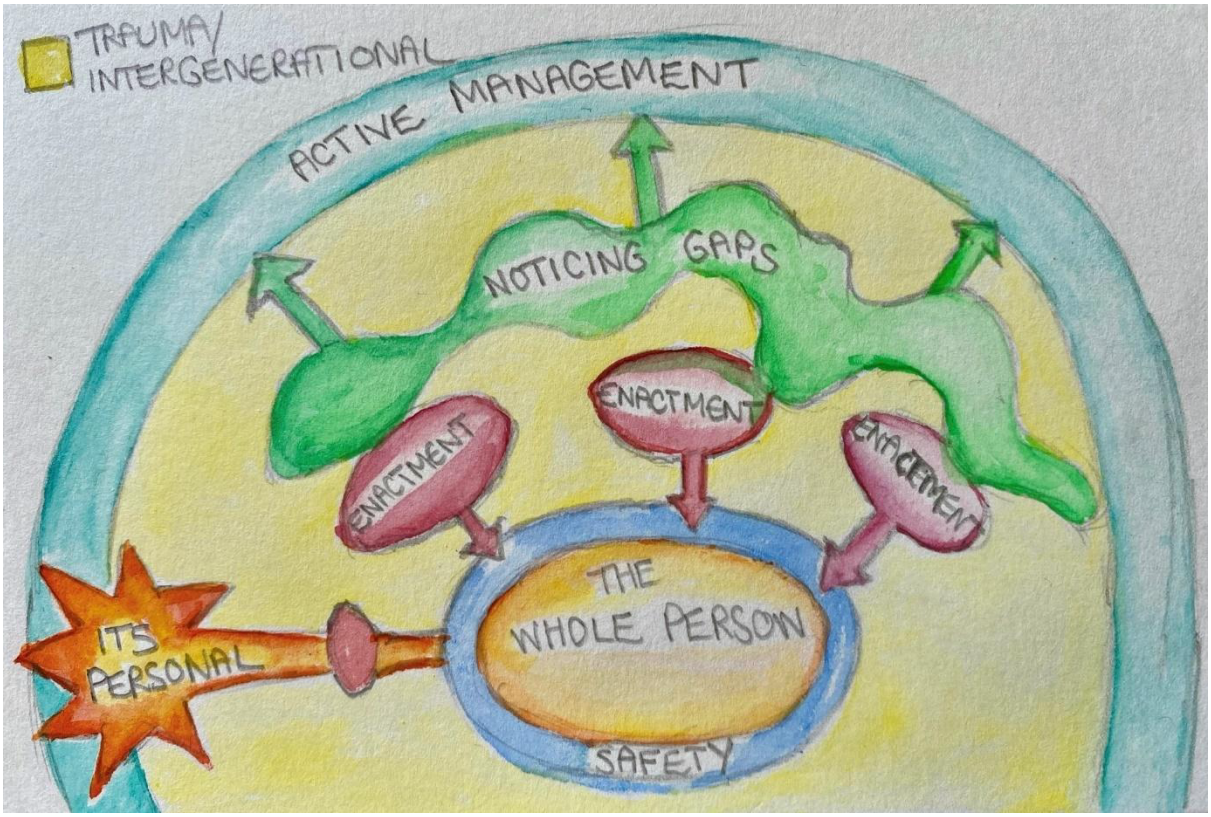


Figure 2: Visual Codes of GETs model

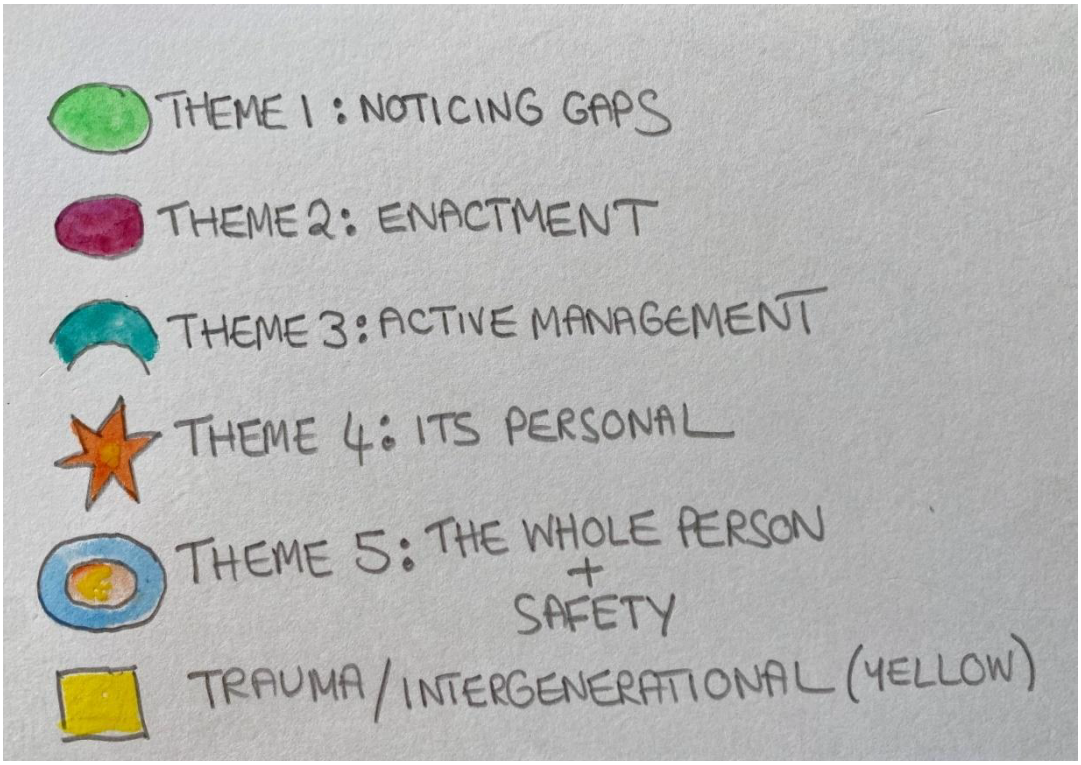


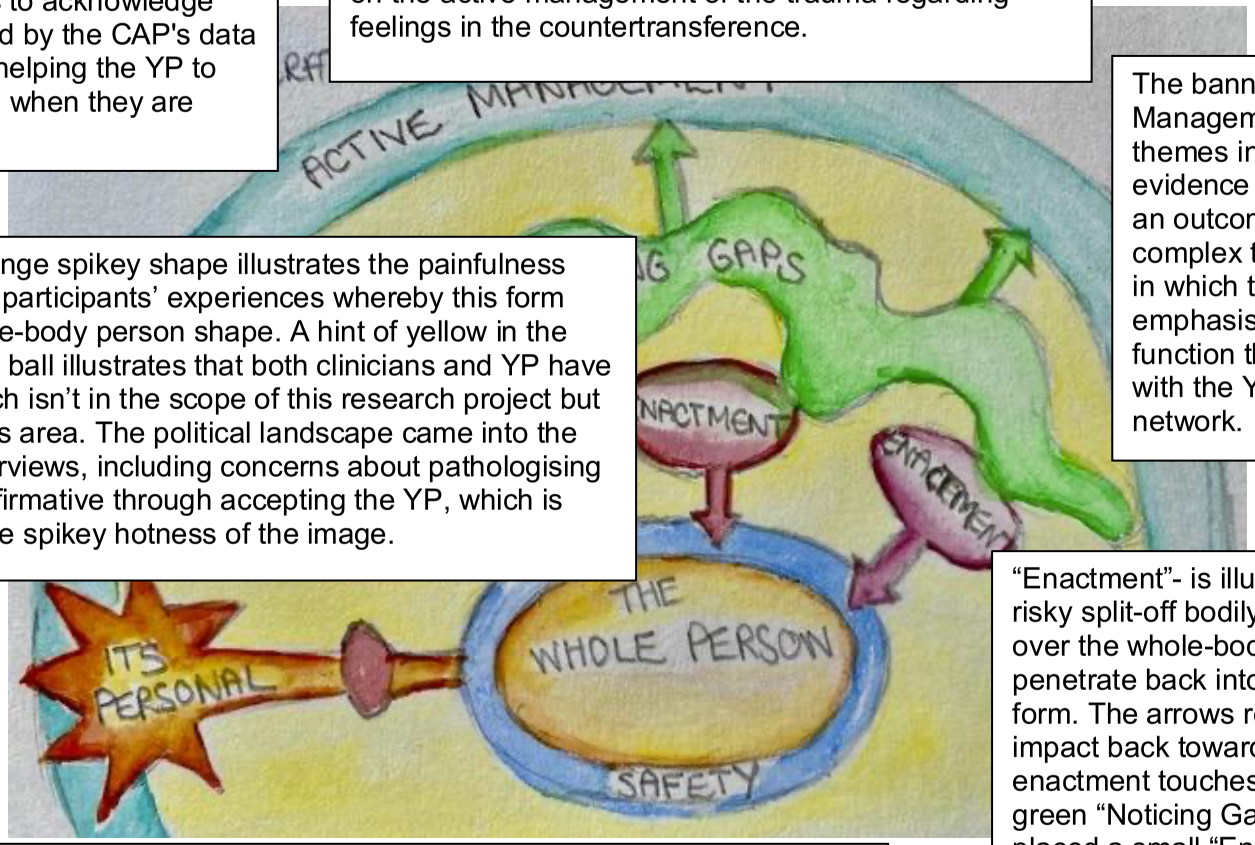
Figure 3: Model of interlinking GETs with notation

Yellow code - To show trauma and intergenerational trauma as being indistinguishable at times, it has been used to surround the visual representation. This is to acknowledge that the task evidenced by the CAP's data is in noticing this and helping the YP to understand this, if and when they are ready.

The "Noticing Gaps"- theme is represented in a green fluid shape for the participants that moves and comes into the CAP's mind, and the arrows indicate the impact on the active management of the trauma regarding feelings in the countertransference.

The banner of "Active Management"- holds all the themes in place as the evidence suggests that this is an outcome of managing complex trauma and is a way in which the CAP's role emphasises a containment function through transparency with the YP, working with the network.

The "It's Personal" orange spikey shape illustrates the painfulness and tenderness of the participants' experiences whereby this form touches the YP's whole-body person shape. A hint of yellow in the "It's Personal" - spikey ball illustrates that both clinicians and YP have their own trauma, which isn't in the scope of this research project but is acknowledged in this area. The political landscape came into the fore across all the interviews, including concerns about pathologising or being seen to be affirmative through accepting the YP, which is illustrated in the orange spikey hotness of the image.



"Enactment"- is illustrated through red risky split-off bodily forms that are floating over the whole-body shape, which can penetrate back into the whole body YP form. The arrows reflect the directional impact back towards the YP but also enactment touches and bleeds into the green "Noticing Gaps"- themes. I have placed a small "Enactment"- form touching the stem of the 'It's Personal' spikey object to acknowledge that for all the participants they fell into enactments as part of their work.

The blue "Whole Person and Safety" - edge around it is illustrated as a complete form, as all the participants saw the importance of seeing the YP in their entirety and how managing a YP's safety regards to what may be re-enacted is a vital part of a holding in mind the YP.

CHAPTER 5: DISCUSSION

5.1 Summary of aim and research questions

This qualitative research explored the experiences of CAPs encountering intergenerational trauma when working with gender-variant patients presenting at CAMHS with mental health comorbidities.

The literature review illustrated the complex history of psychoanalysis and gender, and how a YP identifying as gender variant likely also faces an intersection of challenges. My enquiry focused specifically on how intergenerational/familial trauma may impact the CAP's work with this patient group. A total of three CAPs with relevant experience with this patient group was recruited and interviewed twice following the FANI (Hollway and Jefferson 2013) approach.

The aim was to explore the research questions: how do CAPs hold their patients' history in mind? Do they encounter intersecting unlaid ghosts of intergenerational trauma when working with gender-variant YP presenting with mental health comorbidities? If so, how do they recognise and then manage this?

To address the research questions, the following three objectives were formulated:

1. To explore the transmission of intergenerational elements of families' histories within the CAP's transference;
2. To explore how CAPs recognise this in their work;

3. To explore how CAPs manage this transmission of trauma intergenerationally, specifically with YP who identify as gender variant, alongside the live trauma this patient group might be experiencing.

5.2 Summary of Main Results

The IPA (Smith et al., 2020) of the interviews yielded five GETs: “Noticing Gaps”, “Enactment”, “Active Management”, “It’s Personal” and “The Whole Person and Safety”. The first two themes, “Noticing Gaps” and “Enactment”, focus on how the CAP observes and detects the transmission of intergenerational /familial trauma, addressing the first objective. The latter three GETs, “Active Management”, “It’s Personal” and “The Whole Person and Safety”, addressed the last two objectives of how CAPs recognise trauma and manage this within their work with patients who identify as gender variant presenting in CAMHS with comorbidities.

Through the results, universally across each GET, it has not been possible to untangle the patients’ live and past trauma as presented by the participants or to discern whether this was familial or intergenerational trauma; it felt far out of reach – therefore, the following GETs describe how these participants held in their mind a combination of both trauma and intergeneration/familial. When trauma is mentioned, unless specified, it will be a combination of both.

In the following sections each of the five GETs are discussed in light of the previous literature. Moreover, the clinical implications, the strengths and limitations of this

research as well as suggestions for further research are addressed in dedicated sections.

5.3 Discussion of main results in light of the literature

Each GET is discussed here, to maintain the specificity and uniqueness of the themes for the participants while also discussing any interlinks amongst them (see Figure 3).

Theme 1: Noticing Gaps

For all the participants, the theme “Noticing Gaps” was a representation of their experience of the trauma lived by their YP through noticing, feeling and sensing trauma. All participants felt a gap in their knowledge about their YP’s trauma experiences as well as something much more profound, something missing or an abandonment or loss lived by the clinician in their countertransference. The participants described and noticed at times a repetition of something being unconsciously repeated by external professionals/networks, suggesting in their minds a link to an early developmental loss. This was seen previously by Evans’ (2022; 2023; 2024; Evans & Evans, 2021) research on early life losses within the family[17]. Both Evans (2023) and Lemma (2022) indicated how early object loss – and the possible management or defence against this loss – can at times be linked to the creation of a new self through a different body.

[17] Evans links this to Bion’s (1962) concept of nameless dread experienced by the infant.

Lemma's (2022) research illustrated the bodily/physical experience of the YP when feeling the incongruity between the given body and body identified as the right physical home and suggested the vital importance for CAPs to pay particular attention to their visceral sensing and bodily changes in their countertransference. This reinforces and gives further importance to the sensory experience felt in the countertransference of the participants of this research, who linked it to something missing or lost.

Freud (1917, cited in Lemma and Levy, 2012) as well as more recently Garland (1998) talk about the potential of trauma to puncture the defensive shield of our mind. This highlights then that something can either get lost or escape from that wound of trauma. The participants' sense of gaps can perhaps be an indication of such a puncture. Butler (1995, p.6, as cited in Lemma and Lynch, 2015) theorises there is a failure to mourn, the bisexual desires to be and have both parts of their parental genitals. Society's rejection of this for a heterosexual normative sexuality disavows a "lost identity" exposing a potential wound around sexual identity (Bell, 2020; Cass Review, 2024). For the participants this link to theory touches on theme five "The Whole Person and Safety", and the importance of seeing and working with the whole person, which includes sexuality.

Berger's (2014) application of Bion's work group (1967) to reflect on the intrapsychic and interrelational context of managing trauma transmission seems relevant here to achieve a better understanding of how the participants noticed professionals may take up the losses either as a consequent enactment or by replaying gaps in the

care. The YP unconsciously behaves in a risky way, as seen for the participants in the subtheme "*gaps in shared minds*", to show their network how unsafe they feel, perhaps due to something being missed in their life, as seen in Petra's experience. Berger's (2014) model takes up "the socio-analytic concepts of boundary, authority, role, and task", which are important in understanding the work group and the impact of trauma affecting the family, as well as the valence in taking up a role in the family in order to manage and alleviate some of the natural anxieties (p.4). I feel this valency and the containing or strengthening function of how psychoanalysis thinks about boundaries is a most helpful theoretical position in thinking about the transmission of trauma by group unconsciousness. The results showed how the usual professional boundaries of the participants broke down under the weight of the complexity of trauma.

The repetition of this loss, and the participants' experiencing their YP not being able to escape from it, was noticed by all participants, which touches on the second GET of enactment, whereby professionals missed information or did not take up a networking role in order to contain the YP's system. These suggest a wider-scale impact of losses that get repeated in the present. This repetition, alongside the CAP's countertransference of sensing a gap, or loss of knowing, may be a way in which the YP stays connected unconsciously to their early carer and the consequent enactment. This adds another layer of complexity for the CAP, which has implications on how a CAP chooses to hold this part of the YP in their mind. This is illustrated by research into second-generation Holocaust survivors' literature

(Abraham and Torok,1994; Alford, 2015) [18] and the potential deeper level of defences related to familial trauma that CAPs need to be aware of. This is further discussed in more depth below in relation to the "Active Management" GET.

The Cass Review (2024) also suggests potentially traumatic events that occur in childhood (ACEs) in addition to other complex presentations[19] should be routinely asked about because of the possible impact of early trauma when presenting with gender distress[20]. This theme and the supporting literature points to a complicated set of identifications, or missed identifications, the impact of cultural norms as well as additional familial trauma on loss felt by the CAPs. This has the potential to heighten the unconscious reasons behind the infant or YP's mind; the feeling of not being held and how this may link to managing risk of the YP (seen in GET 5, "The Whole Person and Safety").

[18] Alford (2015) cites his evidence of second-generation survivors not being able to share the part of their parents' mind, and adapting themselves as if they are "prisoners to their parents". Abraham and Torok's (1994) and Alford's (2015) Holocaust research also theorises this is a way to connect with their parents' closed-off unconscious ghosts, meaning the child can't let them die. Identifications with past ghosts not related directly to the child are entangled with the child as a means to stay connected to their early carer. Both authors discuss that familial trauma, therefore, remains unconscious for good reasons.

[19] – as shown in the systemic review by Taylor, Hall, Langton et al. (2024b).

[20] Although this research is not linking intergenerational trauma to gender dysphoria, the results do indicate that the participants' experiences were of observing and feeling a representation of loss also seen in the subtheme of gaps and early trauma by one participant (Tom).

Theme 2: Enactment

For all the participants an overriding second GET of “Enactment” was narrated by complex clinical material reflecting an aspect of the trauma and / or intergenerational trauma that spilt out and became difficult to contain, leaking into either their sessions, or the interview process of this research, and into the network of professionals often working with the YP. I was not expecting the interview process to contain such a live demonstration of clinical material as experienced between two of the participants and me. As discussed in my reflections reported in the previous chapter, I wondered if the FANI methodology allowed an expression and observation of this. As with all the GETs (see Figure 3), “Enactment” and its overlap with theme four, “It’s Personal”, revealed an additional unexpected finding of the deeply personal experience of working in this area and underlying fears and anxieties that clinicians may hold onto. This has complications then of what resources are then needed by the CAP working in this field. These will both be discussed below in the limitations of the project in Section 5.5 and implications on clinical practice and the profession in Section 5.6.

All of the participants brought clinical material that was powerfully potent as it touched them on a personal level and, for one participant, led to enactment through acting out of the boundaries of their usual contained practice. As already discussed, the participant’s noticing in their countertransference gaps, lead to enactment by the network and the YP. For example, this was seen in the high-risk behaviour of Petra’s YP and the siblings requiring A & E admission. Figure 3 is an attempt to graphically demonstrate how enactment, illustrated by the red shapes, can spill or

bleed into the other themes of “Noticing Gaps” and “The Whole Person”, beyond gender to safety and risk management (Theme 5). Psychoanalytic understanding of enactment is a common feature within the work of clinicians and all the participants illustrated an experience of projective identification (Klein,1946; Freud, cited in Lemma and Levy 2004; Emanuel 1996; Garland 1988). Paramount to this theory is the availability of a carer who can receive the projection of primitive anxiety; if not, there is an amplification or felt “disintegration” and a puncturing of our mental shield that protects the mind. Emanuel (1996) describes that if there is no original containment, this in itself becomes an additional source of trauma, as in the present research identified by all the participants. Prince’s (1985) examination of Holocaust literature of second-generation survivors uses the term “psychic numbing”[21] of thought and symbolisation involved in enactment processes. This feels relevant literature as it gives a better understanding of the levels of “noise” being literally amplified, for example, by Petra’s YP and siblings whereby risk can be seen as an external barometer of such enactment and lack of containment by the network. Barrow’s (1999) case study describes the vulnerability of her patient to parental internal objects including intergenerational objects of trauma from the grandparents, which seemed to be highly possible in the understanding of the presentation of Petra’s YP and multiple siblings to A & E. Berger (2014) and Alford (2025) highlight the valency of enactment to unconsciously work things through the original trauma as Fraiberg also describes in her seminal “ghosts in the nursery” paper. However, Alford’s (2015) research evidences a two-way process of the ghosts of Fraiberg et

[21] ”(Lifton, 1976, as cited by Prince 1985, p.9).

al.,[22] which, for this participant's YP and siblings, it is particularly poignant as a means of unconscious communication because they were in care.

Enactment in the interview was a strong subtheme for two of the participants, with a particular lens of concern that their YP may be pathologised by the research. The participants' experience of this in the interview process seemed to mirror powerfully the experience of the YP, and was not something I expected. Alex's insight that my research question was in itself pathologising with a premise of a "fancy formulation" was appropriately exposing and helpfully challenging. This subtheme really brought the current historical climate towards gender into my view and mirrored the clinician's experiences. This was also indicated in the Cass Review (2024), which names a "fear" and finding a difficulty to think in light of political pressures from working in an area where there is a lack of evidence-based guidelines. Alex's comparison of my ability as a researcher to think about this area of work, compared to the day-to-day pressures on the clinician, prompted a reflexive anxiety of the research process[23]. Alex's suggestion of managing familial histories by holding it at the back of our minds made me think of the layering of the "how" CAPs manage the sensing of familial trauma, when enactment is a strong possibility. Namely, that there needs to be sensitive but conscious holding, remaining sensitive to enactments of trauma,

[22] Alford (2015) describes firstly, the meddling of familial ghosts when something has not been recognised or acknowledged in the family; secondly, the YP and the siblings' unconscious response through the enactment behaviour to perhaps fill a psychic gap between themselves and their parents. Alford highlights that for the child they may embody or share their parent's trauma in an attempt to locate a space in their parents' mind.

[23] See field diary extract (Appendix 8, p.203 and reflexivity of this in Section 5.5 of the discussion.

suggesting a different kind of holding as will be discussed in the section related to theme 3, “Active management”.

The FANI methodology allowed me to explore this theme in more detail in the second follow-up interview, giving all participants an important thinking space about how the interview had gone and when enactment had occurred. This reflection caused Tom to think about his own vulnerability of feelings towards his identity and credentials to work with this patient group, questioning his level of experience. Willo’s (2020) research reinforces that clinicians are left with a heightened sensitivity when working with this population, which is also highlighted in the commentary response by Goldsmith et al. (2023) to Evans’ 2023 paper based on their clinical experiences working with YP identifying as gender variant:

“Clinicians may feel pushed into enactments, such as becoming overly involved and highly anxious or, at the opposite extreme, cut off and unreceptive” (p.79).

The theme of enactment for the participants and their vulnerability to it is also highlighted in the experiences of other clinicians for Goldsmith et al. and in Willo’s research. It was also evidenced possibly in the political sensitivity to the present research topic by the TREC ethics committee[24], the implications of which are discussed in Section 5.6 and 6.

[24] As discussed in the methodology section, the theme of causation, although explicitly and transparently spoken about in my first submission to TREC, needed to be readdressed in the second submission. It highlights the political and cultural sensitivity in this area, which the Tavistock is perhaps at the heart of, due to the decommission of the national GIDS clinic in March 2024.

Theme 3: Active Management

All the participants spoke about extending their usual role of being a CAP in clinical sessions to needing to attend to the effects of trauma or internal processes of projective identification and enactment by being more active in their style of work. This was also particularly evidenced in the subthemes of: "*having a passion to be creative*" and "*questioning of their own intersectionality*" when participants sensed the transmission of trauma and its effect on their YP. The participants identified that care for their patients was not being given in some circumstances; it was missed out and, at worse, omitted. One participant noticed the somatic effect on themselves and of being left with projective material. These complications mirror the complexity of the lived experiences of the YP that they work with. I have wondered if this enhanced creative active approach is not just about managing the projective processes of clinical work but if it has been developed during the CAP's training and afterwards post-qualification when working with complex clinical co-morbidities.

Lemma (2022) also considers the participants' need to be more active in their approach in her gathering of evidence of patients' incongruity of being seen / looked at, which can provoke feelings of rejection alongside also the feeling of not being recognised or feeling unseen[25]. Therefore, it can be argued that CAPs might feel

[25] This theme of incongruity between their given body (natal) and body identified as the right home was difficult to communicate to key attachment figures. Although Lemma's work is focused on gender dysphoria specifically, this indicates particular areas of sensitivity for the trans YP and how this should be thought about and managed, which indeed all participants reflected on.

driven to be more active due to a conscious and unconscious sense of the sensitivity of the YP with gender variance not feeling seen.

Due to the complex interplay of biological, psychological and social factors of gender identity, Cass's (2022/2024) recommendations that there needs to be a thorough individualised assessment of needs and mental health, which could be seen as an active holding, linked to the present GET. Moreover, clinicians are not able to determine which YP will develop an enduring trans identity, while historically the literature suggests that the professional "*knows best*", a belief that is encapsulated in a heterosexual normative indicator of health (Frosh, 2006; Giffney, 2017; Frealand, 2022; Chodorow, 1994; Rose, 2016). Goldner (2011) explains that society's dominant ideology is one of placing identity into social categories, which are inherently entangled. This places a responsibility on the CAP to be active in their management but also hold a vigilance to the unconscious interplay of societal ideology of gender, its role on mental health settings and how they manage unconscious projective material, the meddling of ghosts and its impact on their work together with the YP. The complications of this are further discussed in Section 5.6. Evans (2024) highlights that, when working specifically with gender dysphoria, the CAP's role is to actively provide a space for their patient to "establish a mind and identity of their own" (p. 223). Evans's overview of the CAP's role seems to equally reflect a process in which CAPs struggle to manage all the sensitive areas related to their YP, from which derives the importance of actively holding the YP in CAPs' minds. Evans (2023) theorises this over many years of clinically working in this field; gender identity comes from a composite of intergenerational object figures and parent object figures, which may be unclear as the idealisation and the establishing

of a new self, that is loved by the superego, is a “fantasy” self. This is illustrated and interlinks with one participant’s subtheme of “sensing gaps” in Theme 1 ‘Noticing Gaps”, whereby Alex described a poignant experience of fantasy/dream, whereby the YP could explore their natal body only in this state. It made me think of the potential hybridisation of two sets of internalised objects and of the relationship of the “fantasy” objects alongside the natal sex object, which the CAP has to accommodate in their mind.

The interview became an opportunity for the participants to reflect on their experiences with gender-variant YP, becoming a third thinking space (Britton, 2004)[26]**.** The interview also became a surprising vehicle to do this, mirroring the role of the CAP, to think about familial trauma.

The subthemes of this GET – “complexity of CAP role and management”, “multiple minds holding” and “creative management of the external network” – are interlinked in illustrating the participants’ experiences of different layers of complexity when working with patients of different co-morbidities alongside identifying as trans. The function and value of the MDT is shown in its valency of safety, in sharing vulnerabilities and complexity of cases, in particular noticing effects of EDI.

[26] This is highlighted in Britton’s (2004) role of analysis to provide a shared space that exposes our defences but at the same time gives us an opportunity to explore them. He draws upon ideas of the third position, or triangular space, of being able to be in the observer position, when there is a dyad (Oedipal position) to observe self and our encounters with others.

This GET suggests the need to actively consider the impact of normative cultural processes in the network and in the family (and intergenerationally) and their interlink with the feeling of shame both at an individual and at a group level. Indeed the results show how quickly shame can be evoked internally in the therapeutic relationship or in the network. Moreover, all three participants appear to have converged on the complexity of their cases, which also perhaps resulted in a far more active practice in their CAP roles. Wren (2020) highlights this complexity, reflecting on family and community environments that can be hostile to the trans YP's wishes and feelings, and discusses the interplay of the social factors with gender identity (Cass Review, 2024). The cultural disturbance of gender located in the family and feelings of shame are also discussed by Harris (1996), who also discussed the role of unconscious parental child dynamic[27]. The therapist receives projections onto the body and the mind from the familial system, not only from the patient. This literature evidences the complexity that all the participants were managing, which may be expressed in being more active in how they worked with their patients. Moreover, Silverman's single case study (2015a) is helpful in further understanding such complexity as was experienced by all the participants; it highlights the interplay of shame, either internal or external, through the examination of the clinician's countertransference as a tool to think about the transmissions received by the network and its effect on the YP and CAP. Silverman valued her connection to her patient's shame by really staying with her countertransference.

[27] Harris (1996) reviews Litin, Griffin and Johnson's (1956) clinical account of gender and sexual disturbance. At first, the paper appears pathologising; however, the author considers the important role of the unconscious familial system and the impact of the therapist's mind as experienced by their patient in the transference relationship.

Similarly, Lemma (2022) argues about the need for therapists to have an embodied experience with their patient and discusses the powerful history of trauma being enacted with her patient and herself and the interrelational aspect of their relationship. In addition, the transmission of cultural ideas[28] towards gender by psychoanalysis was evidenced by one participant's experience, who reported on the impact of cultural norms towards gender to his patient.

The above literature helps bring insight to the participants' reflections and experiences in their work within the network by observing the potential of cultural forces that impact the enactment of past trauma causing further neglect. The cultural normative assumptions, which can be related to the age of the network members, were difficult to untangle, but even if this was highlighted just by one participant, it points out how such normative assumption or transmission of gender norms can still be at play and how YPs might unconsciously be invested in this to connect with their own familial trauma (Abraham and Torok, 1994; Alford, 2015;)[29]. This leads to further questions of how the CAP needs to hold all these complexities in mind.

[28] Critical theorists have described the roots of psychoanalysis seeing gender identity as a form of psychotic reality (Stryker and Whittle, 2006, as citied in Pearce 2018; Elliot, 2014 as cited in Giffney, 2017) akin to the treatment of homosexuality as needing to be cured based on the dominant cultural background of society.
[29] Previously discussed in GETs 1 & 2.

Theme 4: It's Personal

This theme demonstrates the very moving experience of each participant, each of whom were touched at a very personal level by their clinical work. For each participant their feelings about their own intersectionality and vulnerabilities of their identity as a clinician seemed linked with the experience of working with gender-variant YP. The results suggest a parallel process of vulnerability of the YP[30] with gender variance with different co-morbidities and the participants' experience in their countertransference.

Indeed, Lemma and Lynch (2015) theorise that any diversity challenges the dominating cultural ideas of society and that it is emotionally charged. Hyon's (2022) thesis was the only paper so far linking intergenerational trauma with gender[31]. Hyon points out the importance of therapists' reflexivity to the heteronormative social context and their own role or position with their patient. This reinforces the results of my research as, although the participants of my research did not specifically talk about their own experience of trauma/intergenerational trauma, they were all aware

[30] This is illustrated in the interlinks of Figure 3 (p.113) as a spikey orange form that potentially influences the themes of "Active management", "Noticing Gaps" and the "why" we hold the sense of a family's history in mind. The spikey orange form was chosen to graphically illustrate how it's been hazardous and painful at times for the participants.

[31] The author qualitatively researched through IPA the intersectional impact of nine therapists' identities and thinking of trauma, including intergenerational trauma. All participants identified as LGBTQIA+ therapists of colour. The results highlighted the impact of intergenerational trauma within the participants' own histories and sense of social identity.

of their own intersectional differences, their investment in the work and its impact on their work with their patients.

This was felt in different ways by the participants, who located the YP's trauma in their own body/somatic experiences of their countertransference. This is similar to what has been reported on Pozzi's (1999) work on intergenerational trauma[32]. This illustrates that there may be a particular quality in the countertransference when coming across intergenerational trauma, which Pozzi describes as a passing on from one generation to another and which is felt transferentially by the therapists.

This GET shows how countertransference plays a pivotal role as a tool for understanding the complexity of transmission and what it is that is transmitted, particularly when working with gender-variant YP with mental health comorbidities. This theme also points to a fragility of the YP, felt by the all the participants, for example, when reporting a countertransference experience of "feeling not good enough" or feeling "vulnerable". Harris's (1996) research is again relevant as she discusses Coates's (1995) account of transgenerational trauma and its relevance to the vulnerability of the LGBTQIA+ community. Coates reports on experiences of loneliness and a depletion of the self (Harris, 1996). Sadowski and Gaffney's (1998) research develop this, suggesting there is an additional vulnerability or internal splits for the trans adolescent because of their confusion about identity and the feelings of those around them. Winograd's (2014) case study research concludes that the

[32] Pozzi in consultations to families in an under-5 service; describes richly her countertransference as "raw, sadistic, unthinkable, chaotic" of the type of projective identifications in the room to the family members and herself, which is similar to Petra's violent adjectives of her countertransference.

therapist needs to tolerate long periods of not knowing and endure painful suffering of patients as their identity emerges.

The results show that all of the participants seemed to be working in the way that Winograd suggests by reflecting on their own intersectionality, vulnerability and differences with their patients to provide transparency and activeness in using parts of themselves to make more of a connection. Di Ceglie (2009) also highlights his experience as the lead psychiatrist setting up GIDS that the intensity of the feelings aroused in clinicians are due to the basic issues of identity through projective identification. He states the task of the therapist is to survive the projection and allow the family to cope with the state of minds but notes the professional is often "left at the edge". This links with GET 1 "Noticing Gaps", particularly illustrated by one of the participant's countertransference of noticing a "chasm" of unknown territory.

The Cass Review (2024) reflects on a different kind of vulnerability of clinicians working in this area – a bewilderment and uncertainty of the appropriate treatment amongst professionals, noting there is no agreed consensus. This needs to be thought about, in addition to what Rose (2016) reflects on, when stating that transgender people are being spoken about in a violent way in the media and politics, which is reflected in hate-crime murders. Di Ceglie (2009, p.4) also speaks about a "knife edge" vulnerability due to the political landscape. The literature above highlights the violence and inequality located in trans YP, which can also leave the clinician themselves feeling exposed. The results shown throughout this GET seem to report on a similar experience for the participants, that working in this area is acutely personal and the fragile complexities of this patient group may also be

experienced by the CAP. The vulnerability of working in this field, as demonstrated by this research and the embedded relational stance that is integral to the CAP's practice with all patients and varied co-morbidities, has further implications for the professional training schools and ongoing supervision requirements post qualification. Surprisingly, supervision was discussed minimally by all the participants, which is why it is absent from the data. Alex predominately advocated the role of their MDT in thinking about complexity. All the participants were required to have at least two years post-qualifying experience and therefore the implications will be further discussed in the next theme and Section 5.6.

Theme 5: The Whole Person and Safety

The theme of the whole person, not just the YP's trans or gender-variant identity, was felt and illustrated strongly in this last GET. The impact of trauma – live, past and intergenerational – seems to be evidenced in the levels of repetition of the trauma through risky acting-out behaviours by the YP but also by the networks, whereby something is missed or a cycle of enactment around the YP is at play. In the model of interlinking GETs (Figure 3), this GET is placed as a circular form with a "safety" outer ring at the bottom of the picture, to illustrate that all the participants appeared to be holding the whole person in mind. However, the red enactment objects might puncture this safety ring and to the left of the painting is portraited the "It's Personal" GET with the spikey shape, which is attached to the YP's whole body shape. As already described above, this shows some of the pain and friction experienced by participants, who were personally affected by the difficulties faced by their YP.

The sensitivity needed in approaching the YP was thought about by all participants. The Cass Review (2024) recommends all aspects of a YP need to be held in mind. This is evidenced in the results; one participant explicitly named this need in “seeing the totality of the YP”, while another spoke about totality by referring to a “jigsaw” of all the different pieces of the YP that a CAP needs to hold in their mind. Evans and Evans (2021) and Evans (2022; 2023; 2024) consider those pieces presented in co-morbidities and developmental complexities in order to see the YP as a whole, to help the YP establish through a psychoanalytic space a mind and identity of their own.

All participants were reflective about the area of risk in relation to trauma experiences, which then influences the need to actively manage the risk and work closely with family and professionals, overall, when there has not been a space in the family to do this. Evans (2023; 2024) and Evans and Evans (2021) highlight the role of the CAP in the creation of a thinking space for their patients and how the therapist can symbolically represent female and male aspects of the child’s internalised object figures. In this way the CAP acts as a third state of mind, or “triangular perspective” (Britton, 1989) to enable separation from a defensive ideal object figure.

The participants’ thinking about the totality or whole of the YP is also in accordance with Bell (2020), who criticises adopting rigid gender groups and speaks about the value of psychotherapy in allowing patients to explore all their identifications in themselves and within the therapist. Evans (2023) shares that a psychoanalytic

model can be seen as transphobic as it doesn't adhere to an affirmation model and, similar to the Cass Review findings, suggests that a fuller more balanced view about gender is needed by professionals. Drescher's (2015) critique of Silverman's (2015a) work is important here as he reflects on the work by the therapist to be aware of their own internalised gender police. Together with the evidences of the experiences of vulnerability by the participants reported in the previous GET "It's Personal", the results from this GET and the relevant literature seem to point to the need for the consideration of further analysis post-training, along with training for supervisors who support CAPs to recognise these heightened dynamics and the additional emotional toll on the CAP when working with this patient group.

All of the participants highlight the importance of working with the MDT in sharing the complexities of a case and in some cases co-working, which is supported as discussed by Owens (2013) and Evans and Evans (2021), which cite D'Angelo's 2019 work that also promotes cross-disciplinary working through parent work and family work to encourage alternative positions of how the complexity of a case may link together. Although, the research is limited by the small sample size as discussed in the methodology section, the importance of gender and the interplay of sexuality in looking at the whole person as part of the normal developmental phase of adolescence and young adulthood was not featured in the data. This would routinely be thought about as part of a CAP's training. I have wondered whether the fear that may grip clinicians in working in this politically hot area dissipates both the CAP's thinking of developmental processes and is superseded by both cultural forces and the complexity of working with complex trauma including intergenerational trauma. In a similar way to all of the participants' felt vulnerability, supervisors may also feel

impacted by the unknown and changing landscape of gender and identity. This will have an impact on the supervisory relationship and whether it can be a safe place to examine this vulnerability unless consciously named.

5.4 Reflexivity in the research process

My reflexive experience of using the two-staged FANI process of first and second interviews was that the "stories" were vivid and alive. The opportunity and spacing of the second follow-up interview allowed a level of reflexivity from both participants and me. In this way the two-stepped interview process facilitated a co-curated thinking space or linked-up space, which added richness to the initial data. The GETs from across all interviews meant that the data analysis included this additional co-curation of themes between the first and second follow-up interview. This meant I underestimated the amount of data and therefore could only analyse three participants. In addition, the methodology of IPA[33] enabled a level of self-reflection of the YP's experiences of their body and further analysis of my own familial history, intergenerational trauma and embedded intersectional experiences of identity.

[33] IPA allows the clinician to think about what it is like growing up in a predominately heteronormative world with its structure and routines and the disturbance this perhaps elicits when you do not identify to this worldly experience. Smith et al. references Carel's (2020, cited in Smith et al., 2020, p.15) work around "embodied disruptions" or "bodily breakdown", which "force" each of us to act as if we were phenomenologists when using IPA. This description of the role of IPA as a research methodology is in relation to physical illness, but it has a parallel value when exploring the impact of gender identity themes, when one's natal body does not quite feel its own. Therefore, the selection of IPA as a methodology recognises the importance of body disruption to meaning-making and how this would benefit thinking about the particular difficulties and impact of intergenerational trauma on the YP.

5.5. Limitations and further research

There are limitations, as discussed in the methodology, with the FANI methodology and IPA, which impacted on the limited sample size due to the vast amount of data produced by the FANI. An alternative methodology other than IPA could have provided a more aligned narrative emphasis complementing the FANI's open-ended questioning, while empathising the structure and tone, unconscious avoidance and inconsistences (Lukac-Greenwood and Van Rijn, 2021) to examine the participant's experience. This may have assisted me further with the complexity of undertaking research in such a contentious area as I am a novice researcher. The FANI did reveal my own bias. Lokke (2023, p.37) helpfully discusses the critical reflection of using the FANI by Archard (2021), noting that although interpretation is kept to data analysis itself, even minute gestures by the therapist interviewer have "unconscious significance" and are necessary in ensuring "understanding has taken place". He calls for alertness to the clinician and researcher identity to avoid "interpretative comments that go beyond the research brief" (Lokke, 2023, p.37). I feel my reflexive position through the project attempted to minimise this and the second interview enabled unconscious processes, as highlighted by the participant, to be explored. However, my minute gestures, seen in my excitement with Alex and in my bodily responses (involuntary stammer) that were noted in my field diary extracts, demonstrate my newness and inexperience of being a researcher. As discussed above in the reflexive section and in the introduction section, I made conscious links to my own familial history of intergenerational trauma during the project and my

interest in this research. The field diary attempted to minimise this as much as possible.

In addition, the literature and research process, including the difficulty in recruiting CAPs, and the TREC panel's perceived reticence with engaging with the research subject due to its links with the Tavistock's decommissioned GIDS, demonstrated the "hotness" of gender in the current political climate[34]. I found just three participants willing to take part in the study despite advertising twice in the ACP. Even though it was, in any case, not possible to have more participants due to the quantity of data produced, it suggests some possible uncertainty and fear in being involved in the research area. Alongside these difficulties there has also been the complexity of doing this research. Its multifaceted nature at times challenged the project's focus when embarking on this research topic at this particular time in the Tavistock's history, alongside this relatively new research area. It could be perceived as ambitious but I have been driven by my personal clinical experience to examine the research's question and aims. This has at times led me into a highly personal arena whereby I have been challenged as to how I sensitively write about this topic and do justice to the participants' (and their patients') honesty and braveness in coming forward. The potency of the participants' experiences with their patients identifying as gender variant felt deeply moving and individual at times during the interview process. This is in stark contrast to the political hijacking of gender, which implies it is everyone's business, and its role in oppression, polarisation and rigidity in gender categories and superior control in the face of fear of the world's destruction (Butler,

[34] Seen in the sudden increase and change in referral demographics to gender services in the Cass Review (2022/2024).

2024). Whilst, research suggests the experience is always unique to the individual (Bell, 2020; Cass Review, 2024; Evans 2021, 2023, 2024; Goldsmith et al., 2023). The hotness of attempting to do research in this field [35], which includes a fear the project would be misrepresented to causality, might have influenced the study; I had anxiety of offending and misrepresenting the YPs and their families and felt the need to protect the participants who chose to take part in the research. I also had anxiety that I was not representing accurately those theorists well enough who choose and endeavour to create an exploratory open thinking space through their research of their clinical experience. I deliberately chose to write on the whole about YP rather than "patient", deciding that I did not want to medicalise their gender identity, even though the complication is that YP who come through the doors of a mental health setting often have more than one referral into the service (due to higher thresholds of entry) and have complex and often severe co-morbidities that perhaps in itself minimises the seriousness of their experience. In this sense, I was never going to get it "right" but my profession as Kaplan (2017) suggests, needs to think about "how might the individual concerned best live?" (p.423).

There were particular nuances in the subthemes of the GETs, which highlight the potential of the participants' own experience of familial / intergenerational trauma but for the purpose of this research it was not possible to explore these[36]. A larger group

[35] See the need to provide further reassurance and evidence to the TREC panel via second proposal (Appendix 1) around causality and confirming my inclusive stance regarding inclusion and exclusion criteria.

[36] If I had the scope of facilitating an exploratory group interview, I would have liked to explore this further. However, due to the personal content of data and political "hotness" of this subject this forum would have needed far greater research preparation to make it a safe enough space for participants.

of participants would have been preferable to increase intersectionality characteristics. However, the results of the Cass Review (2024) clearly state the need for further systematic research, in particular that of gathering assessment data to pick up complexities of presentations and ACEs, which include different experiences of trauma.

5.6. Implications on clinical practice and the profession

Even if the results cannot be generalised and are illustrated at an individual level, together with the evidence brought from the literature review, this research shows how there is a need to address the additional vulnerability of CAPs when working with trans-gender YP. This is in order to provide a meaningful and effective therapeutic workplace, in a context where this work can be perceived as an additional pressure and burden on an already overstretched and time-limited service.

Moreover, it has implications on the training of CAPs, supervisors and care networks to receive training in gender and cultural intersectionality (Willo, 2020) but I feel it has to go further than this. MDTs and networks need to examine their own internalised objects and group unconscious processes that may numb the psychic pain of these YP from being seen and heard. I feel CAPs require a top-down level of supervisory support to explore when their own identifications, the MDTs and the NHS may tip into enactment and into societal oppression, which means intergenerational ghosts may meddle on a systems level. The participants were all experienced and yet there was little mention of the role of supervision and their own

training psychoanalysis, perhaps suggesting that this, and the gaps in its perceived value, needs to be considered further as an exploratory research topic – or perhaps gender complexity superseded the thinking about this during the research and / or the impact of the pressures of the clinical work because of increased risk. Supervision – both individual and in groups – is a core part of a CAPs training, requirement to practise and therefore a notable absence. It was not within the scope of the project to ask how, in practice, CAMHS settings and the CAP profession can think about the specialist training that supervisors may need to receive, along with the intersection of multiple areas impacting identity as a whole. In this way, the *vulnerability* of gender should be everyone's business – rather than the notion of gender itself – in order to identify the unconscious processes that allows trauma, in all its guises, to be painfully repeated.

CHAPTER 6: CONCLUSION

6.1 Summary

Overall the results of this research describe how the three therapists' vulnerability to projections of trauma and intergenerational trauma and their ability to feel them in their countertransference were critical to receiving and understanding some of the unconscious communication, sense of dislocation and alienation that their gender-variant patients were feeling. Frealand's (2022) research thesis shows, however, how psychoanalytic culture may hold on to an entrenched identity of elitism, which means that the analyst disavows their vulnerability. The results indicate the importance of being aware of this, as the CAPs' role is perhaps to deliberately embrace their own vulnerabilities to make meaning with their patients and sense of their own body and mind. In effect, it is always going to be personal if the CAP allows this.

The research has implications, in particular, on the ongoing political heat of our society's responses to gender-questioning YP and adults. How do clinician's find ways of supporting one another, to examine themselves and their personal identifications, in order to hold in mind the complexity for their YP and the unconscious role of intergenerational projections? The study's five themes are clearly interwoven; they illustrate the CAP's ability and role of noticing gaps and associated losses in complex trauma and familial systems, the speed that defences easily become enacted and how to respond creatively and actively to manage this risk, as well as finding a space in the CAP's mind to hold the YP as a whole with all

their presenting co-morbidities, conscious and unconscious, where gender identity may be just one jigsaw piece.

Surely, psychoanalysis has a unique position, because of our training involving reflexivity and being analysed, to understand these projective processes but it has to be from a non-pathologising mind. The CAP must be willing to potentially undergo a self-inspection – in an ongoing way as society's landscape changes – of their own internal objects to gender and personal history of intergenerational trauma. This unfortunately hasn't been within the scope of this project to examine. Perhaps then the CAP needs to hold the multigenerational familial jigsaw lightly, to borrow the words of one participant, "at the back of our minds", whereby we might never know all the pieces but can at least be aware of the concurrent vulnerability this will entail when working in this area.

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Lectures

Prof Perelberg, R. J. (2023, May, 13th & 20th) *Psychoanalytic seminars: Summer 2023, Sexuality, Excess and Representation: A series of four seminars on sexuality with 13th May - Sex, Gender, and Sexuality; 13th May - Sexuality, Excess and Representation, 20th May - The Feminine in Both Sexes, 20th May - Paternal Function. https://psychoanalysis.org.uk/civicrm/event/info%3Fid=1383&reset=1*

Appendix 1 Letter response to TREC amendments & TREC proposal

4th December 2022

Dear TREC Committee,

The requested significant amendments, as stated in your letter dated 22.11.2022, have been addressed and explained below in this letter, following the order and number of each condition. The same changes have been applied in the TREC application and relevant supporting documents and are all highlighted in yellow.

1. **Selection Criteria - The researcher needs to clarify the inclusion and exclusion criteria vs. not just gender but culture, race and ethnicity too.**

Intersectionality of race, class, culture, ethnicity, sexuality and how it presents in the research will be reflexively thought about in all the interviews as research material however I am wishing to focus on the particular experience of clinicians with young people identifying as gender variant. I have now highlighted this further when addressing Q2 in page 5 of my TREC proposal, I have added the following:

The communication of intergenerational trauma is accepted as part of our analytical work but should CAP's be more sensitive to this especially with the more potentially vulnerable section of our clinical population? Wren (2002) highlights the vulnerability of gender diverse people, namely that conventional discourses of sex and gender "do not allow the possibility of transgenderism as a legitimate and valued experience of self" (p. 377).

In addition, I have highlighted at page 6, why I include gender variance as a specific inclusion criteria within the clinician's skillset or experience, by adding the following paragraph:

It is hoped that the project can contribute to the management of intergenerational trauma sensitively and with care for this patient group in the future. Indeed, my initial literature search reveals that there is a complexity for the gender variant young person as their sense of identity is already challenged.

Therefore I am including experience of working with gender variant young people in my inclusion criteria. Race, class, culture, ethnicity, sexuality is not an exclusion criteria.

On page 8, section 4, as now highlighted below, I discuss the importance of gathering a sample which embraces all intersectional aspects of a respondent's life, I still wish to encourage a wide range of intersectionality and maximise the homogeneity of the sample. I will therefore make this more explicit in my inclusion criteria and as requested I have added my exclusion criteria.

The inclusion criteria are:

Participants have to be registered with the Association of Child and Adolescent Psychotherapists (ACP) as Child and Adolescent Psychotherapists (CAPS). Purposeful sampling to include CAPS currently working in the UK.

Participants' intersectionality is embraced and they can be of any race, gender, sexuality, age, class and from any culture.

Clinicians will have at least 2 years of post qualification experience in working with young people that identify themselves as gender variant or gender diverse that present at least two mental health conditions (comorbidities). The young people that the participants will report on can be of any race, sexuality, culture, religion, and class.

Clinicians will have experience and interest in the transmission of intergenerational trauma.

Exclusion criteria are:

CAPS with no post-qualification experience or with experience of less than 2 years with young people who identify themselves as gender variance or gender diverse.

CAPS who are not registered with the ACP.

2. Project Proposal - The researcher needs to clarify the relationship as she conceptualizes this between intergenerational trauma and gender variance and expand what she means by co-morbidity. This will need doing even if the researcher makes clear that the gender variance refers to the location of the research, rather than playing a central role in the theory behind the research

Original title: “How do clinicians hold their patients’ family system and history in mind? Intersecting unlaid ghosts of intergenerational/transgenerational trauma: the role of the state of mind of the therapist when working with (co-morbidity and gender variance. See my comments on this below)

This is a working title and therefore a clearer amended title for the project would be corrected and included on all documents:

Revised title: “How do clinicians hold their patients’ family system and history in mind? Intersecting unlaid ghosts of intergenerational/transgenerational trauma: the role of the state of mind of the therapist when working in a mental health setting with young people that identify as gender variant or gender diverse presenting with two mental health conditions."

The following is a further explanation of the research project and it has been added in the TREC application in Q2 at page 5 highlighted in yellow.

The project is focusing on the state of the mind of the therapist when working with young people that identify as gender variant or gender diverse or trans

but present in mental health settings with various co-morbidities. I define co-morbidity as the simultaneous presence of two or more health conditions (either physical or mental) for which a young person may seek help or can present.

I have included the following comorbidities which are not exhaustive but include depression, anxiety, PTSD, developmental trauma, complex trauma, Autistic Spectrum Conditions, body dysmorphia, gender dysmorphia, eating disorders. Gender dysphoria - is a term that describes a sense of unease that a person may have because of a mismatch between their biological sex and their gender identity - is not a mental illness, but, as reported on the NHS website (https://www.nhs.uk/conditions/gender-dysphoria/), some people may develop mental health problems because of gender dysphoria. Indeed, this sense of unease or dissatisfaction may be so intense it can lead to depression and anxiety and have a harmful impact on daily life.

The focus is therefore on the CAPs experience and state of mind when working with a specific and complex population of young patients who identify as gender variant or gender diverse, and present with two health conditions as listed above.

The aim of this is project is to explore the clinician's mind as a third state of mind when working with their patient's family system and histories. Firstly, I would like to explore the transmission of intergenerational elements of family's histories within the transference and develop a thinking space about how Child and Adolescent Psychotherapists (CAPs) recognize this within their clinical work. Secondly, how they manage this transmission of trauma intergenerationally specifically with young people that identify as gender variant, alongside the live trauma this patient group might be experiencing.

It important to clarify that there is no assumption of correlation between these two aims. However, it is commonly accepted in the psychoanalytic field that all young people may be affected by their families' histories of intergenerational trauma. The most commonly known research which indicates this is the impact of the holocaust on second and third generation family members (Garland 1993). Garland (1993, p.77) describes "ordinary adolescent aggression can be seen by the parents as a return of oppressor, making normal separation and individuation difficult". At the Portman clinic, clinicians routinely gather developmental history which crosses three generations as part of their clinical practice to acknowledge the impact on the current family's situation and that ghosts from the past intersect with the present. Motz for example (2020, p.25) discusses the unconscious transgenerational transmission of maternal violence across 3 generations and that the economic impact of bringing up of children with limited resources means that the mother or parent may feel "depleted and persecuted to offer her children the emotional and physical care they need".

Therefore, I start the research from these two aims described above which has led me because of my own clinical experience to ask how do CAP's specifically locate intergenerational/transgenerational trauma when working with a young person and their family, what are the different tools that they use to manage this particular type of transference, which may include their own counter transference of the

intergenerational trauma. CAP's may experience their own families' transferences of intergenerational trauma at the same time during working with a family.

I therefore am curious around how they manage this in particular with a patient group that is known to have more vulnerability surrounding them as highlighted in the literature search in the TREC proposal. Does this mean CAP's have to be more consciously active or self aware when working with particular vulnerable groups such as young people that identify themselves as gender variant. Does the CAP need to consider the impact of their own family's intergenerational trauma, is more training for CAP's needed to think about this vulnerable group alongside other intersectional characteristics? What is the role of the clinician's mind in holding the intersection of a family's intergenerational trauma with the young person's presenting co-morbidity?

3. Methodology. The researcher needs to clarify and justify why she is not using the standard procedure for FANI

I have re-evaluated the research methodology in relation to FANI procedure and I will now follow its standard procedure following the
4 principles (Hollway and Jefferson, 2013 pp32-34).

I have amended the methodology section in Q3 at page 7 and the relevant patient information sheet as follow:

The FANI principles and procedures will be followed, as outlined by (Hollway and Jefferson, 2013 pp32-34), which entails:
1.The creation of open ended questions
2.To elicit stories
3.To avoid "why questions"
4. Following up respondents' ordering and phrasing

The 4th principle requires a follow up interview (no more than two weeks apart) in order to allow for follow up questions with greater depth of narrative and gives participants the opportunity to add anything that they thought about following the first interview.

4. Does the research require ethical approval/consent from Stonewall or another trans organization?

Brinley Yare is liaising with the Chair of TREC in regards to Question 4

The Tavistock and Portman NHS
NHS Foundation Trust

Tavistock and Portman Trust Research Ethics Committee (TREC)

APPLICATION FOR ETHICAL REVIEW OF STUDENT RESEARCH PROJECTS

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

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

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

FOR ALL APPLICANTS

If you already have ethical approval from another body (including HRA/IRAS) please submit the application form and outcome letters. You need only complete sections of the TREC form which are NOT covered in your existing approval

Is your project considered as 'research' according to the HRA tool? (http://www.hra-decisiontools.org.uk/research/index.html)	No
Will your project involve participants who are under 18 or who are classed as vulnerable? (see section 7)	No
Will your project include data collection outside of the UK?	No

SECTION A: PROJECT DETAILS

Project title	**Revised title:** "How do clinicians hold their patients' family system and history in mind? Intersecting unlaid ghosts of intergenerational/transgenerational trauma: the role of the state of mind of the therapist when working in a mental health setting with young people that identify as gender variant or gender diverse presenting with two mental health conditions."		
Proposed project start date	As soon as possible	**Anticipated project end date**	**September 2024**
Principle Investigator (normally your Research Supervisor): Lucia Genesoni			
Please note: TREC approval will only be given for the length of the project as stated above up to a maximum of 6 years. Projects exceeding these timeframes will need additional ethical approval			
Has NHS or other approval been sought for this research including through submission via	**YES (NRES approval)** ☐ ☐		

Research Application System (IRAS) or to the Health Research Authority (HRA)?	**YES (HRA approval)** ☐ **Other** **x** ☐ **NO**
If you already have ethical approval from another body (including HRA/IRAS) please submit the application form and outcome letters.	

SECTION B: APPLICANT DETAILS

Name of Researcher	Miranda Sharp
Programme of Study and Target Award	Professional Doctorate in Child & Adolescent Psychoanalytic Psychotherapy (D.Ch.Psych.Psych.)
Email address	[redacted]
Contact telephone number	[redacted]

SECTION C: CONFLICTS OF INTEREST

Will any of the researchers or their institutions receive any other benefits or incentives for taking part in this research over and above their normal salary package or the costs of undertaking the research? **YES ☐ NO x☐** If **YES**, please detail below:
Is there any further possibility for conflict of interest? YES ☐ NO x☐
Are you proposing to conduct this work in a location where you work or have a placement? **YES ☐ NO x☐** If **YES**, please detail below outline how you will avoid issues arising around colleagues being involved in this project:

Is your project being commissioned by and/or carried out on behalf of a body external to the Trust? (for example; commissioned by a local authority, school, care home, other NHS Trust or other organisation). *Please note that 'external' is defined as an organisation which is external to the Tavistock and Portman NHS Foundation Trust (Trust)	**YES ☐ NO x☐**
If **YES**, please add details here:	
Will you be required to get further ethical approval after receiving TREC approval?	**YES ☐ NO ☐ x**

If **YES**, please supply details of the ethical approval bodies below AND include any letters of approval from the ethical approval bodies (letters received after receiving TREC approval should be submitted to complete your record):	
If your project is being undertaken with one or more clinical services or organisations external to the Trust, please provide details of these:	
If you still need to agree these arrangements or if you can only approach organisations after you have ethical approval, please identify the types of organisations (eg. schools or clinical services) you wish to approach:	
Do you have approval from the organisations detailed above? (this includes R&D approval where relevant) Please attach approval letters to this application. Any approval letters received after TREC approval has been granted MUST be submitted to be appended to your record	**YES ☐ NO ☐ NA x☐**

SECTION D: SIGNATURES AND DECLARATIONS

APPLICANT DECLARATION

I confirm that:

- The information contained in this application is, to the best of my knowledge, correct and up to date.
- I have attempted to identify all risks related to the research.
- I acknowledge my obligations and commitment to upholding ethical principles and to keep my supervisor updated with the progress of my research
- I am aware that for cases of proven misconduct, it may result in formal disciplinary proceedings and/or the cancellation of the proposed research.
- I understand that if my project design, methodology or method of data collection changes I must seek an amendment to my ethical approvals as failure to do so, may result in a report of academic and/or research misconduct.

Applicant (print name)	MIRANDA SHARP
Signed	[redacted]
Date	10.10.2022

FOR RESEARCH DEGREE STUDENT APPLICANTS ONLY

Name of Supervisor/Principal Investigator	Lucia Genesoni

Supervisor –

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

Signed	
Date	19.09.2022

COURSE LEAD/RESEARCH LEAD

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

Signed	
Date	07.10.2022

SECTION E: DETAILS OF THE PROPOSED RESEARCH

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

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

Aims

My aim is to explore how CAPS recognise within their clinical work with their patients the transmission of intergenerational elements of families histories' within the transference. Secondly, my aim is to explore how CAPS manage families

histories transmitted intergenerationally in their work with young people that identify as gender variant. The project's objective is to explore the therapists' mind as a third state of mind. As explained above, when referring to a third state of mind I am referring to the CAP's position to hold an overview of the interrelational and intersectional internal and external worlds of the young person, the family's system and history and themselves. Meltzer (1994) is reflexively transparent of the interrelational position between therapist and their patient; "it is equally important for the analyst to remember that his mind and character are exposed to his patient no less than the patients are to his analyst" (p. 555).

The project is focusing on the state of the mind of the therapist when working with young people that identify as gender variant or gender diverse or trans but present in mental health settings with various comorbidities. I define comorbidity as the simultaneous presence of two or more health conditions (either physical or mental) for which a young person may seek help or that can present.

I have included the following comorbidities, which are not exhaustive, but include depression, anxiety, PTSD, developmental trauma, complex trauma, Autistic Spectrum Conditions, body dysmorphia, gender dysmorphia, eating disorders. Gender dysphoria - is a term that describes a sense of unease that a person may have because of a mismatch between their biological sex and their gender identity - is not a mental illness, but, as reported on the NHS website (https://www.nhs.uk/conditions/gender-dysphoria/), some people may develop mental health problems because of gender dysphoria. Indeed, this sense of unease or dissatisfaction may be so intense it can lead to depression and anxiety and have a harmful impact on daily life.

The focus is therefore on the CAP's experience and state of mind when working with a specific and complex population of young patients who identify as gender variant or gender diverse or trans, and present with two health conditions as listed above.

It important to clarify that there is no assumption of correlation between the two aims above. However, it is commonly accepted in the psychoanalytic field that all young people may be affected by their families' histories of intergenerational trauma. The most commonly known research which indicates this is the impact of the holocaust on second and third generation family members (Garland 1993). Garland (1993, p.77) describes "ordinary adolescent aggression can be seen by the parents as a return of oppressor, making normal separation and individuation difficult". At the Portman clinic, clinicians routinely gather developmental history which crosses three generations as part of their clinical practice to acknowledge the impact on the current family's situation and that ghosts from the past intersect with the present. Motz for example (2020, p.25) discusses the unconscious transgenerational transmission of maternal violence across 3 generations and that the economic impact of bringing up of children with limited resources means that the mother or parent may feel "depleted and persecuted to offer her children the emotional and physical care they need".

Therefore, I start the research from these two aims described above which has led me because of my own clinical experience to ask how do CAP's specifically locate

intergenerational/transgenerational trauma when working with a young person and their family, what are the different tools that they use to manage this particular type of transference, which may include their own counter transference of the intergenerational trauma. CAP's may experience their own families' transferences of intergenerational trauma at the same time during working with a family.

I therefore am curious around how they manage this in particular with a patient group that is known to have more vulnerability surrounding them as highlighted in the literature search in the TREC proposal. Does this mean CAP's have to be more consciously active or self aware when working with particular vulnerable groups such as young people that identify themselves as gender variant. Does the CAP need to consider the impact of their own family's intergenerational trauma, is more training for CAP's needed to think about this vulnerable group alongside other intersectional characteristics? What is the role of the clinician's mind in holding the intersection of a family's intergenerational trauma with the young person's presenting co-morbidities?

Rational and Background

Reflexively, as a Child and Adolescent Psychotherapist, I became interested in the role of our mind holding a third position when it felt like I was intersecting unlaid ghosts in the clinical work whilst working long term with two transgender young people. I will make this reflective position transparent as part of the research process.

Freud (1909 cited in Marsoni 2006) examined the communication of intergenerational trauma when he talks about unlaid ghosts reappearing when something has not been understood or processed, "it cannot rest until the mystery has been solved and the spell broken" (p. 312). In my clinical work at times I am left wondering if a ghost has entered the room which does not directly belong to the young person. I have wondered if the ghosts appear to be resurrected through conflict from parents triggered by the work at CAMHS or at times of transition or change. This may be especially when the parents may feel defensive, judged, persecuted and attacked by clinicians, reviews or threatened by the confidentiality of the individual work and the individuation process as part of the work. Perhaps ghosts within the family that have not been laid bare or explored fully in the parent work which are being shaken up by the young person entering the CAMHS psychotherapy pathway.

Fraiberg's seminal paper (1975, p.164) explores this further in the relationship between child and family discussing that all nurseries have ghosts but parents view the ghosts as "intruders" and are "malevolent". Fraiberg (1975, p.165) writes that even in the most stable of homes, "ghosts can play mischief in their burial place" and takes up rights of citizenship several generations previously. Fraiberg (1975, p.165) describes this becoming visible between the parent and child when inadvertently something gets repeated or "re-enacting a moment or a scene from another time and a different set of characters". In addition, there may also be intergenerational communication of gender norms and family values which may

adhere itself to potential trauma and losses in particular for gender diverse young people.

The communication of intergenerational trauma is accepted as part of our analytical work but should CAP's be more sensitive to this especially with the more potentially vulnerable section of our clinical population? Wren (2002) highlights the vulnerability of gender diverse people, namely that conventional discourses of sex and gender "do not allow the possibility of transgenderism as a legitimate and valued experience of self" (p. 377).

Di Ceglie (2009 p.4) explicitly identifies the vulnerability of the professional when working with this population and describes the intensity of the feelings aroused because it affects "the very basic issues of identity " and belonging. He describes the professional's position using the metaphor being left "at the edge'" when working with those families and young people, which mirrors the mental state of the adolescent or the family's experience (Di Ceglie 2009 p.4).

Therefore, through interviewing CAPS working with gender variant young people, I am going to explore how they hold their patients' family system and history in mind, trying to shed light on any intersecting unlaid ghosts of intergenerational/transgenerational trauma within their clinical work and on the role of their state of mind when working with co-morbidity for young people that identify as gender variant.

It is hoped that the project can contribute to the management of intergenerational trauma sensitively and with care for this patient group in the future as my initial literature search reveals that there is a complexity for the gender variant young person as their sense of identity is already challenged. The research might hope to generate a bringing together of thinking in our professional body. To date there is no special interest group in ACP of clinicians working in this area of diversity. The last CP special edition of gender and sexuality was in 2018.

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

Research Project Design:

This project will use a qualitative research design using semi-structured interviews to explore the Child and Adolescent Psychotherapists' (CAP) mind as a third space when working with the transmission of intergenerational/transgenerational trauma and to explore how CAPs manage the complexity of this in and outside the clinical room when working with co-morbidity of patient groups that identify as gender variant.

Following the semi-structured interviews, a focus group might be organised to further explored some specific common patterns of themes that have emerged in the individual interviews, as explained below.

Methodology of Data Collection and analysis:

1. Individual interviews

The semi-structure interview will be designed following the FANI's approach; the free association narrative interview maximises the countertransference response of the clinician and encourages open ended narrative questions to allow a less defensive position to take place.

The FANI principles and procedures will be followed, as outlined by (Hollway and Jefferson, 2013 pp32-34), which entails:
1.The creation of open ended questions
2.To elicit stories
3.To avoid "why questions"
4. Following up respondents' ordering and phrasing

The 4th principle requires a follow up interview (no more than two weeks apart) in order to allow for follow up questions with greater depth of narrative and gives participants the opportunity to add anything that they thought about following the first interview.

Interpretative Phenomenological Analysis (IPA, Smith, Flowers and Larkin (2020) will be applied as data analysis methodology. The FANI technique allows a methodology to complement IPA as it acknowledges the reflexive approach that inherently "the researcher is implicated at every stage". As part of this parallel process I will keep a reflexivity diary alongside the research process in order to be explicit about my own meaning making, process, interpretation and evolving ontology landscape.

The schedule of the interview will include the following themes:

- Experience of holding a family's histories in mind
- CAPs experience of when transgenerational communication is potentially being transmitted
- How does transmission of transgenerational trauma feel different from the live trauma in the room.
- What aspects have felt important to hold in mind
- How has the CAP managed this
- Their experience of the gender variant young person in the room and their families history
- The role of their mind in this work

Interviews will be audio recorded and transcribed.

Following the IPA procedures, each of transcriptions of the interviews will then be read, re-read and notes will then be made before then emergent themes being identified. The emergent themes will then be merged into super-ordinate themes and sub-themes. The analyses will then be performed across the all interviewed and common patterns and themes will be identified. Verbatim extracts will be used to demonstrate the elicit themes and a narrative account of the results across participants will be created.

0. Group interview:

I would also like to potentially arrange a group interview if there were enough interested CAPs as a follow up to the original individual interviews.

I wish to pursue a reflexive qualitative research methodology which means shared interpretation of phenological experience in this area will inevitably evolve and breathe as the research develops. I will attempt to be explicit about this and that this may mean that after the FANI interviews, depending on the interest and theme emerged in the individual data, that a further exploration will be offered bringing together the clinicians to further explore and contrast shared themes.

As for the interviews, this will be audio-recorded, transcribed and analysed using IPA.

All data will be stored confidentiality, all participants details will be confidential and pseudonym's will be used where relevant.

SECTION F: PARTICIPANT DETAILS

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

Participants:

As IPA is an idiographic methodology understanding phenomenon in context, therefore, the sample size will be small (4 – 5 interviewees) and based on individual transcripts of each semi – structured interview.

The inclusion criteria are:

Participants have to be registered with the Association of Child and Adolescent Psychotherapists (ACP) as Child and Adolescent Psychotherapists (CAPS). Purposeful sampling to include CAPS currently working in the Uk.

Participants' intersectionality is embraced and they can be of any race, gender, sexuality, age, class and from any culture.

Clinicians will have at least 2 years of post qualification experience in working with young people that identify themselves as gender variant or gender diverse that present at least two mental health conditions (comorbidities). The young people that the participants will report on can be of any race, sexuality, culture, religion, and class.

Clinicians will have experience and interest in the transmission of intergenerational trauma.

Exclusion criteria are:

CAPS with no post-qualification experience or with experience of less than 2 years with young people who identify themselves as gender variance or gender diverse.

CAPS who are not registered with the ACP.

Recruitment procedure:

Preliminary contact has been made with the ACP (Association of Child Psychotherapists) who confirmed that after ethics approval I can advertise the project in the ACP Bulletin with a written information sheet which will include a summary of the project and my reflexive interest in this area.

Following the responses that I will receive through the advertisement of the research, I hope to conduct a purposeful sampling as IPA focuses on the idiographic but, even within such a small sample size, I wish still to encourage a wide range of intersectionality and maximise the homogeneity of the sample.

Upon agreement, the researcher will gain informed consent as to whether each clinician would be willing to participate in both elements of the project; the individual interview and the group interview. All parts of the research will be conducted within their usual work setting to minimise disruption to participants however If an online appointment is preferred this will be considered using a secure platform.

Consent will be gained for any information about them to be de-identified and used for the purpose of the research project. Consent will also be gained for information regarding cases they may choose to discuss on a general level to be used in the project. They will also be made aware that they will be responsible for anonymising these during the interview and will be asked to talk about it generally rather than in an identifiable way.

All participants will be made aware they can withdraw from the project up to three weeks after the interviews without any consequences. After three weeks analysis may have begun and therefore this will no longer be possible.

0. Please state the location(s) of the proposed research including the location of any interviews. Please provide a Risk Assessment if required. Consideration should be given to lone working, visiting private residences, conducting research outside working hours or any other non-standard arrangements.

If any data collection is to be done online, please identify the platforms to be used.

1)
The individual interviews and the group interview will ideally be face to face .If more appropriate for the interviews they will be conducted online, via zoom and security of the relational account will be provided. In case participants may wish to do the interview face-to-face I will try to facilitate this by going to their workplace if located within a 60 mile area or would be coming to the Tavistock.

2)
Clinicians will be given whereby possible for the interviews to be conducted face to face, however, if this is not possible due to COVID-19 they will take place via telephone or video link. The interviews will be conducted within their usual place of work if face to face and if at all feasible within limits of travelling time and within working hours to ensure other members of staff will be around and contactable if needed.

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

☐ Students or Staff of the Trust or Partner delivering your programme.

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

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

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

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

☐ Adults in emergency situations.

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

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

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

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

☐ Healthy volunteers (in high risk intervention studies).

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

☐ Other vulnerable groups (see Question 6).

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

☐ Participants who are members of the Armed Forces.

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

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

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

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

For the purposes of research, 'vulnerable' participants may be adults whose ability to protect their own interests are impaired or reduced in comparison to that of the broader population. Vulnerability may arise from:

- the participant's personal characteristics (e.g. mental or physical impairment)
- their social environment, context and/or disadvantage (e.g. socio-economic mobility, educational attainment, resources, substance dependence, displacement or homelessness).
- where prospective participants are at high risk of consenting under duress, or as a result of manipulation or coercion, they must also be considered as vulnerable
- children are automatically presumed to be vulnerable.

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

If YES, a Disclosure and Barring Service (DBS) check **within the last three years** is required. Please provide details of the "clear disclosure":

Date of disclosure:
Type of disclosure:
Organisation that requested disclosure:
DBS certificate number:

*(NOTE: information concerning activities which require DBS checks can be found via https://www.gov.uk/government/publications/dbs-check-eligible-positions-guidance). Please **do not** include a copy of your DBS certificate with your application*

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

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

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

N/A

SECTION F: RISK ASSESSMENT AND RISK MANAGEMENT

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

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

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

☐ use of written or computerised tests

☒ **interviews (attach interview questions)**

☐ diaries (attach diary record form)

☐ participant observation

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

☒ audio-recording interviewees or events

☒ video-recording interviewees or events

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

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

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

☐ Themes around extremism or radicalisation

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

☐ procedures that involve the deception of participants

☐ administration of any substance or agent

☐ use of non-treatment of placebo control conditions

☐ participation in a clinical trial

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

☐ research overseas (please ensure Section G is complete)

0. Does the proposed research involve any specific or anticipated risks (e.g. physical, psychological, social, legal or economic) to participants that are greater than those encountered in everyday life?

YES ☐ NO ☒

If **YES**, please describe below including details of precautionary measures.

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

The researcher is a qualified HCPC art psychotherapist and a trainee Child and Adolescent Psychoanalytic Psychotherapist trained to work with adults and children who experience discomfort and/or distress. It is hoped that participants if touched by themes reflected on would use their supervisory structures and or personal support network.

0. Provide an explanation of any potential benefits to participants. Please ensure this is framed within the overall contribution of the proposed research to knowledge or practice. (Do not exceed 400 words)

NOTE: Where the proposed research involves students , they should be assured that accepting the offer to participate or choosing to decline will have no impact on their assessments or learning experience. Similarly, it should be made clear to participants who are patients, service-users and/or receiving any form of treatment or medication that they are not invited to participate in the belief that participation in the research will result in some relief or improvement in their condition.

By taking part the participants will be given the opportunity to consider this growing area of practise. .

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

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

- To end the interview or stop recording
- Reschedule the interview
- To debrief if needed

0. **Provide an outline of your debriefing, support and feedback protocol for participants involved in the proposed research. This should include, for example, where participants may feel the need to discuss thoughts or feelings brought about following their participation in the research. This may involve referral to an external support or counseling service, where participation in the research has caused specific issues for participants.**

Clinicians will all be ACP professionals and it is hoped that will have their own support structure and supervision that they will be encouraged to make use of if needed.

In the event that this is not sufficient it will be recommended in writing they they refer themselves to independent counselling service or seek support from their trust's own employer counselling programme.

A debrief email will be sent out following the interviews. This will include the contact details of myself, my supervisor , the Head of Academic Governance , Quality Assurance.

0. **Please provide the names and nature of any external support or counselling organisations that will be suggested to participants if participation in the research has potential to raise specific issues for participants.**

As discussed above it will be encouraged for all participants to consider their supervisory practices If further issues arise regarding gender variance, I would signpost to the following specialist national agencies that work with this client group and their families:

Gendered Intelligence - Gendered Intelligence is a not-for-profit Community Interest Company, work with the young trans community

Mermaids - Supports trans young people and their families.

GIRES advice and training for professionals on trans issues

Stonewall - promotes the safety and rights of the LGBT community.

WPATH - is the association for transgender health established in 2011.

LGBT Switchboard

Barnardos

LGBT Consortium UK

TGEU - worldwide trans rights and social justice movement

Kaleidoscope - human rights organisation with LGBT communities

Amnesty International

Out - provides direct health services

Galop - LGBT support group for hatecrime, criminal justice system difficulties

LGBT Foundation - national charity

Mindout

0. Where medical aftercare may be necessary, this should include details of the treatment available to participants. Debriefing may involve the disclosure of further information on the aims of the research, the participant's performance and/or the results of the research. (Do not exceed 500 words)

dical aftercare should not be necessary with this project

FOR RESEARCH UNDERTAKEN OUTSIDE THE UK

0. Does the proposed research involve travel outside of the UK? ☐

YES ☒ NO

If YES, please confirm:

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

☐ I have completed ta RISK Assessment covering all aspects of the project including consideration of the location of the data collection and risks to participants.

All overseas project data collection will need approval from the Deputy Director of Education and Training or their nominee. Normally this will be done based on the information provided in this form. All projects approved through the TREC process will be indemnified by the Trust against claims made by third parties.

If you have any queries regarding research outside the UK, please contact academicquality@tavi-port.nhs.uk:

Students are required to arrange their own travel and medical insurance to cover project work outside of the UK. Please indicate what insurance cover you have or will have in place.

0. Please evidence how compliance with all local research ethics and research governance requirements have been assessed for the country(ies) in which the research is taking place. Please also clarify how the requirements will be met:

SECTION G: PARTICIPANT CONSENT AND WITHDRAWAL

0. Have you attached a copy of your participant information sheet (this should be in *plain English*)? Where the research involves non-English speaking participants, please include translated materials. **YES NO ☐** If **NO**, please indicate what alternative arrangements are in place below:
0. Have you attached a copy of your participant consent form (this should be in *plain English*)? Where the research involves non-English speaking participants, please include translated materials. **☐ YES NO ☐** If **NO**, please indicate what alternative arrangements are in place below:
0. The following is a <u>participant information sheet</u> checklist covering the various points that should be included in this document. ☒ Clear identification of the Trust as the sponsor for the research, the project title, the Researcher and Principal Investigator (your Research Supervisor) and other researchers along with relevant contact details. ☒ Details of what involvement in the proposed research will require (e.g., participation in interviews, completion of questionnaire, audio/video-recording of events), estimated time commitment and any risks involved. ☒ A statement confirming that the research has received formal approval from TREC or other ethics body. ☒ If the sample size is small, advice to participants that this may have implications for confidentiality / anonymity. ☒ A clear statement that where participants are in a dependent relationship with any of the researchers that participation in the research will have no impact on assessment / treatment / service-use or support. ☒ Assurance that involvement in the project is voluntary and that participants are free to withdraw consent at any time, and to withdraw any unprocessed data previously supplied. ☒ Advice as to arrangements to be made to protect confidentiality of data, including that confidentiality of information provided is subject to legal limitations.

☒ A statement that the data generated in the course of the research will be retained in accordance with the Trusts 's Data Protection and handling Policies.: https://tavistockandportman.nhs.uk/about-us/governance/policies-and-procedures/

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

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

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

☒ Trust letterhead or logo.

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

☒ Confirmation that the research project is part of a degree

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

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

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

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

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

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

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

SECTION H: CONFIDENTIALITY AND ANONYMITY

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

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

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

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

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

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

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

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

0. Participants must be made aware that the confidentiality of the information they provide is subject to legal limitations in data confidentiality (i.e. the data may be subject to a subpoena, a freedom of information request or mandated reporting by some professions). This only applies to named or de-identified data. If your participants are named or de-identified, please confirm that you will specifically state these limitations. **YES ☒ NO ☐** If **NO**, please indicate why this is the case below:

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

SECTION I: DATA ACCESS, SECURITY AND MANAGEMENT

0. Will the Researcher/Principal Investigator be responsible for the security of all data collected in connection with the proposed research? YES ☒ NO ☐ If **NO**, please indicate what alternative arrangements are in place below:
0. In line with the 5th principle of the Data Protection Act (1998), which states that personal data shall not be kept for longer than is necessary for that purpose or those purposes for which it was collected; please state how long data will be retained for. ☐ 1-2 years ☒ 3-5 years ☐ 6-10 years ☐ 10> years

NOTE: In line with Research Councils UK (RCUK) guidance, doctoral project data should normally be stored for 10 years and Masters level data for up to 2 years

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

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

☒ Research data will only be stored in the University of Essex OneDrive system and no other cloud storage location.

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

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

☐ Research data will be encrypted and transferred electronically within the UK.

☐ Research data will be encrypted and transferred electronically outside of the UK.

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

Essex students also have access the 'Box' service for file transfer: https://www.essex.ac.uk/student/it-services/box

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

Collection and storage of personal sensitive data (e.g. racial or ethnic origin, political or religious beliefs or physical or mental health or condition).

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

☐ Primary data gathered on encrypted mobile devices (i.e. laptops).

NOTE: This should be transferred to secure University of Essex OneDrive at the first opportunity.

☒ All electronic data will undergo secure disposal.

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

☒ All hardcopy data will undergo secure disposal.

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

0. Please provide details of individuals outside the research team who will be given password protected access to encrypted data for the proposed research.
NA
0. Please provide details on the regions and territories where research data will be electronically transferred that are external to the UK:
NA

SECTION J: PUBLICATION AND DISSEMINATION OF RESEARCH FINDINGS

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

☒ Peer reviewed journal
☒ Non-peer reviewed journal
☐ Peer reviewed books
☐ Publication in media, social media or website (including Podcasts and online videos)
☒ Conference presentation
☒ Internal report
☐ Promotional report and materials
☒ Reports compiled for or on behalf of external organisations
☐ Dissertation/Thesis
☐ Other publication
☒ Written feedback to research participants
☐ Presentation to participants or relevant community groups
☐ Other (Please specify below)

SECTION K: OTHER ETHICAL ISSUES

0. Are there any other ethical issues that have not been addressed which you would wish to bring to the attention of Tavistock Research Ethics Committee (TREC)?
No

SECTION L: CHECKLIST FOR ATTACHED DOCUMENTS

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

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

☒ Recruitment advertisement

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

☒ Consent forms (including easy-read where relevant)

☐ Assent form for children (where relevant)

☐ Letters of approval from locations for data collection

☐ Questionnaire

☒ Interview Schedule or topic guide

☐ Risk Assessment (where applicable)

☐ Overseas travel approval (where applicable)

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

Appendix 2 TREC Ethics Consent

The Tavistock and Portman NHS
NHS Foundation Trust

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

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

Miranda Sharp

By Email

22 November 2022

Dear Miranda

Re: Trust Research Ethics Application

Title: "How do clinicians hold their patients' family system and history in mind? Intersecting unlaid ghosts of intergenerational/transgenerational trauma: the role of the state of mind of the therapist when working with co-morbidity and gender variance.

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

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

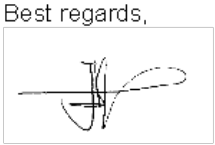
If you have any further questions or require any clarification do not hesitate to contact me.

I am copying this communication to your supervisor.

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

Yours sincerely,

Best regards,



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

Appendix 3 ACP Advert

The Tavistock and Portman NHS
NHS Foundation Trust

Version number 2, date 04.12.2022

ACP Advert – expression of interest

"How do clinicians hold their patients' family system and history in mind? Intersecting unlaid ghosts of intergenerational/transgenerational trauma: the role of the state of mind of the therapist when working in a mental health setting working in a mental health setting with young people that identify as gender variant or gender diverse presenting with two mental health conditions."

Who is conducting the study?

My name is Miranda Sharp. I'm a researcher who is training at the Tavistock and Portman NHS Trust completing a Doctorate in Child and Adolescent Psychotherapy.

I am interested in intergenerational/transgenerational transmission of trauma and how this is expressed in the clinical room by patients and lived by their therapist, specifically in relation to patients who identified themselves as gender variant. I have been influenced by my long term psychotherapy work as a CAP trainee and previously as an art psychotherapist with two young people identified as gender variant and their families. I understand the sensitivity of this subject area and wish to be transparent that with this research project there is no assumption of any causality link between intergenerational trauma and gender variance. Lemma (2022) highlights the need to move towards an evolving progression of care and support for this patient group through 'respectful dialogue' and learning from one another which I hope to facilitate through the project.

What is the purpose of this study?

The aim of this is project is to explore the clinicians' mind as a third state of mind when working with their patient's family system and histories. I would like to shed light on the transmission of intergenerational elements of families histories' within the transference and explore how we recognize this within our work as Child and Adolescent Psychotherapists. Secondly, I would like to investigate how do Child and Adolescent Psychotherapist manage this transmission of trauma intergenerationally alongside the live trauma in their work with young people that identify as gender variant.

It is hoped that the project can contribute in the clinical management of intergenerational trauma sensitively and with care for gender variant young people in the future.

The inclusion criteria are:

Participants have to be registered with the Association of Child and Adolescent Psychotherapists (ACP) as Child and Adolescent Psychotherapists (CAPS). Purposeful sampling to include CAPS currently working in the Uk.

Participants' intersectionality is embraced and they can be of any race, gender, sexuality, age, class and from any culture.

Clinicians will have at least 2 years of post qualification experience in working with young people that identify themselves as gender variant or gender diverse that present at least two mental health conditions (comorbidities). The young people that the participants will report on can be of any race, sexuality, culture, religion, and class.

Clinicians will have experience and interest in the transmission of intergenerational trauma.

Although I identify as a CIS white straight therapist I am particularly interested in seeking a diverse intersectional representation of interviewees at ACP if at all possible.

What will participating in this study involve?

If you agree to participate, I will arrange a convenient time to interview you about how you manage a families history and system in mind whilst working with co-morbidity of young adolescents with gender variance.

Interviews will be in a two-step semi-structured format, but with a narrative free association feel and will last about one hour. A second interview will be held within 2 weeks to give you the opportunity for reflection on the first interview.

I will give you a copy of the interview themes ahead of the interview to give you time to consider your responses but we can free associate material as and when it is reflected upon. The interviews will be recorded and transcribed.

If possible, I might request a 'time 3' interview with some other participants as a group, depending on availability and desire of participants to meet as a group to explore any further thinking relating to the research question.

Inclusion Criteria

Participants' intersectionality is embraced and they can be of any race, gender, sexuality, age, class and from any culture currently working in the UK.

Clinicians will have at least 2 years of post qualification experience in working with young people that identify themselves as gender variant or gender diverse that present at least two mental health conditions (comorbidities). The young people that the participants will report on can be of any race, sexuality, culture, religion, and class.

Clinicians will have experience and interest in the transmission of intergenerational trauma.

If you have any questions about the study, please do not hesitate to ask. My contact details are:

Miranda Sharp, Trainee Child & Adolescent Psychotherapist, [redacted]
Tel: Email: [redacted]

This research has received formal approval from TREC.

Appendix 4 Participant Information Sheet

The Tavistock and Portman NHS
NHS Foundation Trust

Version number 2, date 04.12.2022

Participant Information Sheet

"How do clinicians hold their patients' family system and history in mind?"
Intersecting unlaid ghosts of intergenerational/transgenerational trauma: the role of the state of mind of the therapist when working in a mental health setting with young people that identify as gender variant or gender diverse presenting with two mental health conditions"

Thank you for expressing an interest in participating in the research study, which will form part of my professional doctorate in Child and Adolescent Psychoanalytic Psychotherapy.

Who is conducting the study?

My name is Miranda Sharp. I'm a researcher who is training at the Tavistock and Portman NHS Trust. I am working towards becoming a fully qualified Child and Adolescent Psychotherapist and am currently completing a Doctorate in Child and Adolescent Psychotherapy. The training is overseen and certified by the University of Essex. This research project is being supervised and supported by the Tavistock and Portman NHS Trust and has received ethical approval by TREC.

What is the purpose of this study?

The aim of this is project is to explore the clinicians mind as a third state of mind when working with their patient's family system and histories. I would like to explore the transmission of intergenerational elements of family's histories within the transference and develop a thinking space about how Child and Adolescent Psychotherapists (CAPs) recognize this within their clinical work, and secondly how they manage this transmission of trauma intergenerationally specifically with young people that identify as gender variant, alongside the live trauma this patient group might be experiencing.

What will participating in this study involve?

If you agree to participate, I will arrange a convenient time to interview you at your chosen place of work or through a protected zoom link online about how you manage a families history and system in mind whilst working with co-morbidity of young adolescents identifying as gender variant.

Interviews will be a two step process in a semi-structured format, but with a narrative free association feel and will last about one hour. A second interview will be held within 2 weeks to give you the opportunity to reflection on the first interview.

I will give you a copy of the interview themes ahead of the interview to give you time to consider your responses but we can free associate material as and when it is reflected upon. The interviews will be recorded and transcribed.

If possible, I might request a 'time 3' interview with some other participants as a group, depending on availability and desire of participants to meet as a group, to explore any further thinking relating to the research question.

Confidentiality and Safeguarding

A transcript of your interview and of the group interview will be produced from the recording. Your name will be kept separately from the transcript, and any identifying details removed from the transcript (e.g. place of work). Any extracts quoted from your interview will be entirely anonymous. Although I would use pseudonyms, there is a possibility that due to the size of the study, you or the location of the study could be identifiable. However, the patients you discuss in the interview would be completely unidentifiable. I would encourage you to contact me (see details below) at any point prior to or following the interview to discuss any concerns about confidentiality.

As we are talking about patients where there is a history of traumatic events in the family and possible current trauma, it is likely that we may touch upon safeguarding issues. There will be limitations to the confidentiality of information provided if it is deemed yourself or someone else is at risk and the Trust's Safeguarding Policies and Procedures would need to be followed

What will happen to any information I give?

I will be using information from you gathered at the interview in order to undertake this study and will act as the data controller for this study. This means that I am responsible for looking after your information and using it properly. The interview will be audio recorded and transcribed by myself.

I will use your name and the contact details you provide only to contact you about the research study. I am the only person who will have access to information that identifies you.

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

All electronic data will be stored on a password protected computer. Any paper copies will be kept in a locked filing cabinet. All audio recordings will be destroyed after completion of the project. Other data from the study will be retained, in a secure location, for 5 years, following the Trusts 's Data Protection and handling Policies.:
https://tavistockandportman.nhs.uk/about-us/governance/policies-and-procedures/.

If you would like more information on the Tavistock and Portman privacy policies please follow this link:
https://tavistockandportman.nhs.uk/about-us/contact-us/about-this-website/your-privacy/

Do I have to take part?

Participation in the study is entirely voluntary. However, your contribution would be invaluable. If you do agree to take part, you can change your mind without giving me a reason up to three weeks after the end of the individual interview. After that time your interview will be processed and analysed.

What are the possible benefits of taking part?

It is hoped that the project will benefit the work of CAPs and that can contribute in the further understanding of intergenerational trauma so that this can be handle with further sensitivity and with care.

Are there any risks?
There are no specific risks to clinicians although the data around trauma may touch on some sensitive issues therefore I will be bound to limits of confidentiality if there is a live safeguarding issue which has not been addressed. In addition, if the clinician needed more support after the interview I will encourage them to use pre-existing supervision support structures.

What will happen to the results of the study?
The results of this study will be used in my thesis for the professional doctorate, academic papers and presentations.

If you have any questions about the study, please do not hesitate to ask. My contact details are:

Miranda Sharp, Trainee Child & Adolescent Psychotherapist, [redacted]
Email: [redacted]

Alternatively, any concerns or further questions can be directed to my research supervisor:
Dr Lucia Genesoni, [redacted]

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

This research has received formal approval from TREC.

Thank you for considering taking part in this study and taking the time to read this information. If you are willing to take part in the research please complete the consent form provided

Appendix 5 Consent Form

The Tavistock and Portman NHS
NHS Foundation Trust

Version number 2, date 04.12.2022

Informed consent form

Prof Doc research project: “How do clinicians hold their patients’ family system and history in mind?" Intersecting unlaid ghosts of intergenerational/transgenerational trauma: the role of the state of mind of the therapist when working in a mental health setting with young people that identify as gender variant or gender diverse presenting with two mental health conditions.

Investigator: Miranda Sharp Participant Initials in box

1. I confirm that I have read the information sheet – version 2, dated 04.12.2022 which provides details of the nature of the research and how I will be asked to participate. I have had the opportunity to consider this information and ask any questions that I might have. ☐
2. I understand that the research project is part of a professional doctorate degree ☐
3. I understand that my interview will be recorded, transcribed and analysed for the purposes of the study. ☐
4. I understand that my agreement to participate is voluntary and that I am free to withdraw it at any time without giving a reason, up to three weeks after my interview. ☐
5. I understand that, following the interviews I will be asked if I would be interested in one off follow up group discussion with fellow CAPS that also have been interviewed that may work for the NHS or independently in the UK. ☐
6. I understand that any identifiable information linked to my participation in this project will be anonymised by de-identification and held securely by the researcher. I understand that direct quotes from the audio recording may be used in this research study but will be made anonymous to the reader by de-identification procedure and held securely by the researcher. I will not be identified in any resulting publications, papers or presentations produced for the professional doctorate. ☐
7. I understand that the information I provide will be kept confidential, unless I or someone else is deemed to be at risk. ☐
8. I understand that due to the small sample size of this study, even if the researcher will make all efforts to anonymised my data, I might be identifiable to people who know me and my work well. ☐

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

5. In the event of adverse or unexpected outcomes, I will offer: ☐
   To end the interview or stop recording
   Reschedule the interview
   To debrief if needed

6. I confirm that I have understood what is required of me and consent to participate in this study. ☐

Participating clinician's name (BLOCK CAPITALS):

Signature:

Date:

Investigator's name (BLOCK CAPITALS):MIRANDA SHARP

Signature: [redacted]

Date:16.05.2023

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

Appendix 6 Interview Schedule and Themes

The Tavistock and Portman NHS
NHS Foundation Trust

Version number 3, date 12.06.2023

How do clinicians hold their patients' family system and history in mind? Intersecting unlaid ghosts of intergenerational/transgenerational trauma: the role of the state of mind of the therapist when working with co-morbidity and gender variance.

The research project hopes to examine the CAP's (child and adolescent psychotherapist) mind as a third space when working with the transmission of intergenerational/transgenerational trauma and to explore how they manage the complexity of this in and outside the clinical room. Is the CAP subject to a cross fire of projections that get lodged in them and if so how do they use, think and manage this in their clinical work?

Interview schedule
Below is a list of interview themes and questions that are indicative of those that will be asked in the interviews. Each of the headed sections will be addressed in each interview. However, due to the nature of FANI (Free association narrative interview) and IPA (Interpretative phenomenological analysis), the interview schedule may be adapted to follow the participants' narrative and further explore particular responses. The interview is seen as an 'event' which facilitates discussion.

Reflexive interest:
I became interested in the role of our mind holding a third position when it felt like I was intersecting unlaid ghosts in the clinical work whilst working long term with two transgender young people. External themes of withdrawal of engagement by parents were felt to ricochet both in and outside the clinic room which made me think about the families own developmental history of trauma which included adoption and abuse.

I therefore would like to shed light on the transmission of intergenerational elements within the transference and explore our mind as a unique third thinking space, focusing on what may be being stirred up / transmitted intergenerationally in your work with young people that identify as gender variant and your thoughts on how we as CAPS can manage this sensitively and with care.

Themes and possible prompts:

Preamble

May be silences or pauses between us and following the 'train of thought' or stories that evolve.

Introduction

Could you tell me about what interested you in this area to take part?

The schedule of the interview will include the following themes:

- Experience of holding a family's history in mind
  (Can you tell me something about how you are left feeling when working with young person. Can you tell me something about how you are left feeling when working with a parent/carer, what was the effect on the child – what was the effect on you – what was the effect on the family you were working with?)

- CAPs experience of when transgenerational communication is potentially being transmitted
  (What's your sense or understanding of transmission of intergenerational trauma and its communication in the clinic room?)
- How does transmission of transgenerational trauma feel different from the live trauma in the room
  (How do you feel you manage current trauma - losses and ruptures - alongside intergenerational trauma?)
- What aspects have felt important to hold in mind
  (Can you tell me something about what you are hold in minding when working with intergenerational communication?)
- How has the CAP managed this?
- Their experience of the gender variant young person in the room and their families history
  (Can you tell me your experience of working with intergenerational communication and young people with co-morbidity presentations identifying as gender variant? Has your experience differed with this population? Can you tell me whether this feels different than other presentations at CAMHS?)
- The role of their mind in this work
  (What do you think is necessary to hold in mind when working with intergenerational communication, how do you manage the complexity of these themes, how do you think about intersectionality of our patients with intergenerational trauma within the family's history?)

End

Are there any areas or themes which have come up during this interview that have resonated with you.. can you tell me a bit about this

Would you be interested in a follow up group discussion to explore potential commonalities of themes that came up in the individual interviews with other CAP's?

Appendix 7 Post-Interview Information and Debrief Letter

The Tavistock and Portman
NHS Foundation Trust

Version 1 date 10.08.2022
TREC ID:

Post-Interview Information and Debrief Letter

ProfDoc research project title: **How do clinicians hold their patients' family system and history in mind? Intersecting unlaid ghosts of intergenerational/transgenerational trauma: the role of the state of mind of the therapist. (working title)**

Principal Investigator: Miranda Sharp

Thank you very much for taking part in my study.

I hope that through your invaluable contribution, this project will aim to progress our understanding of our mind as a potential third state of mind in managing transmission of intergenerational trauma within our patient's family's history and systems especially those young people identifying as gender variant. Additionally, I hope the project's insights may grow our understanding and development of work in this area, potential sensitivities and what CAP's find helpful in managing this.

Unforeseen questions or concerns may arise for you now your part in the study has ended. If you would like to speak with someone, please do contact The Association of Child Psychotherapists, who will help or signpost you:

By telephone: 020 7922 7751

By email: admin@childpsychotherapy.org.uk

By post: The Association of Child Psychotherapists, CAN Borough, 7-14 Great Dover Street, London, SE1 4YR

I have also added at the end of this sheet national agencies who work with gender variant young people in case any of our discussions have raised for exploration or need for additional support or information in this area.

If you have any concerns about my conduct over the course of this interview or any other aspect of this research study, you can discuss this with me [redacted], my supervisor Dr Lucia Genesoni [redacted] or Simon Carrington, Head of Academic Governance and Quality Assurance, Tavistock and Portman NHS Foundation Trust (academicquality@tavi-port.nhs.uk).

Thank you again,

Miranda Sharp HCPC Art Psychotherapist
Child and Adolescent Psychotherapist in Doctoral Training,
[redacted]

Specialist national agencies that work with this client group and their families:

Gendered Intelligence - Gendered Intelligence is a not-for-profit Community Interest Company, work with the young trans community

Mermaids - Supports trans young people and their families.

GIRES advice and training for professionals on trans issues

Stonewall - promotes the safety and rights of the LGBT community.

WPATH - is the association for transgender health established in 2011.

LGBT Switchboard

Barnardos

LGBT Consortium UK

TGEU - worldwide trans rights and social justice movement

Kaleidoscope - human rights organisation with LGBT communities

Amnesty International

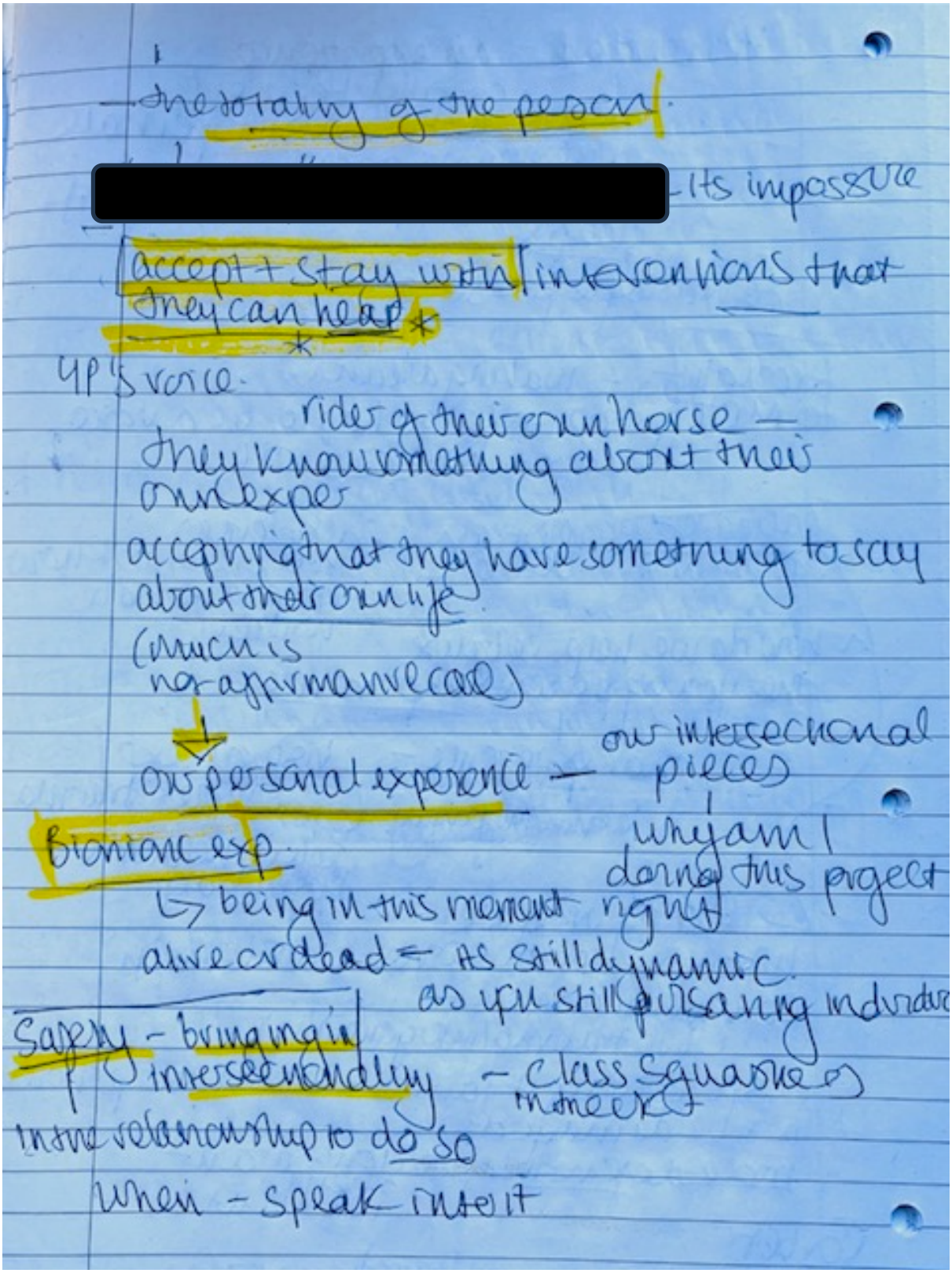
Out - provides direct health services

Galop - LGBT support group for hatecrime, criminal justice system difficulties

LGBT Foundation - national charity

Mindout

Appendix 8 Extract of field diary



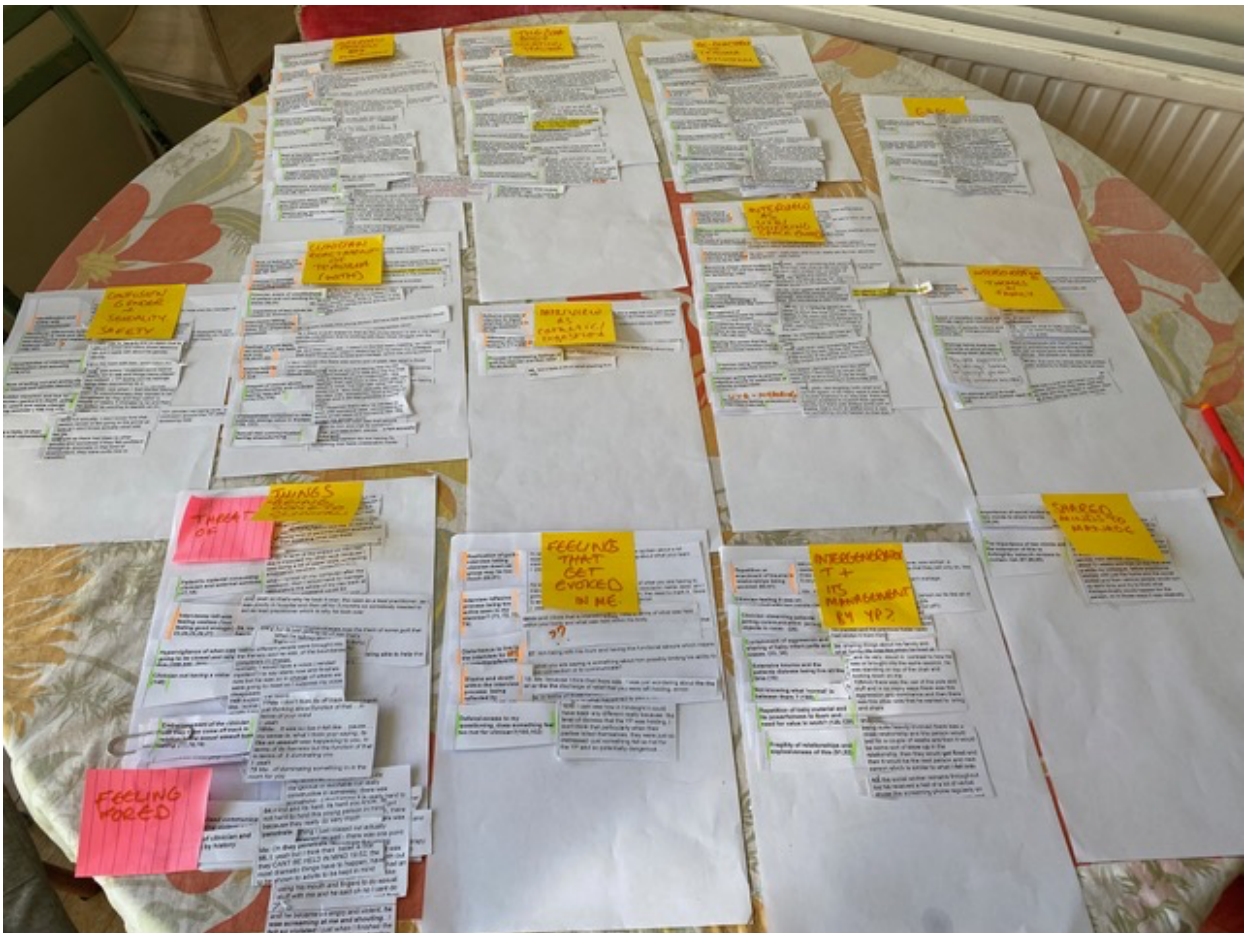
Appendix 9

Example of exploratory notes

Transcript	**Exploratory notes**
8.I f this [redacted]	8. shame of negativity
9.I [redacted] ly gui person	9. shame of negative thoughts - *still left feeling responsible.. guilt?*
10 [redacted]	10. intrusive action in the work
11.now I'm feeling **relief** that ermm that I'm not feeling like that anymore, ermm and	11. **relief - function of the interview to discharge intrusion?**
12. That first interview felt like someone else was, maybe taking in connections about something that kind of, had been playing on my mind	12. function of interview - another holding third mind?
13. [redacted] like Me : mm	13. [redacted] *pro*
14. [redacted] t the which is kind of interesting in itself that..like literally none (silence)	14. absolutely no thoughts and relief of this
15. Me: Ok (surprised), when before that maybe it would have been a bit different ?	15. Clarification of pre interview and post interview feeling

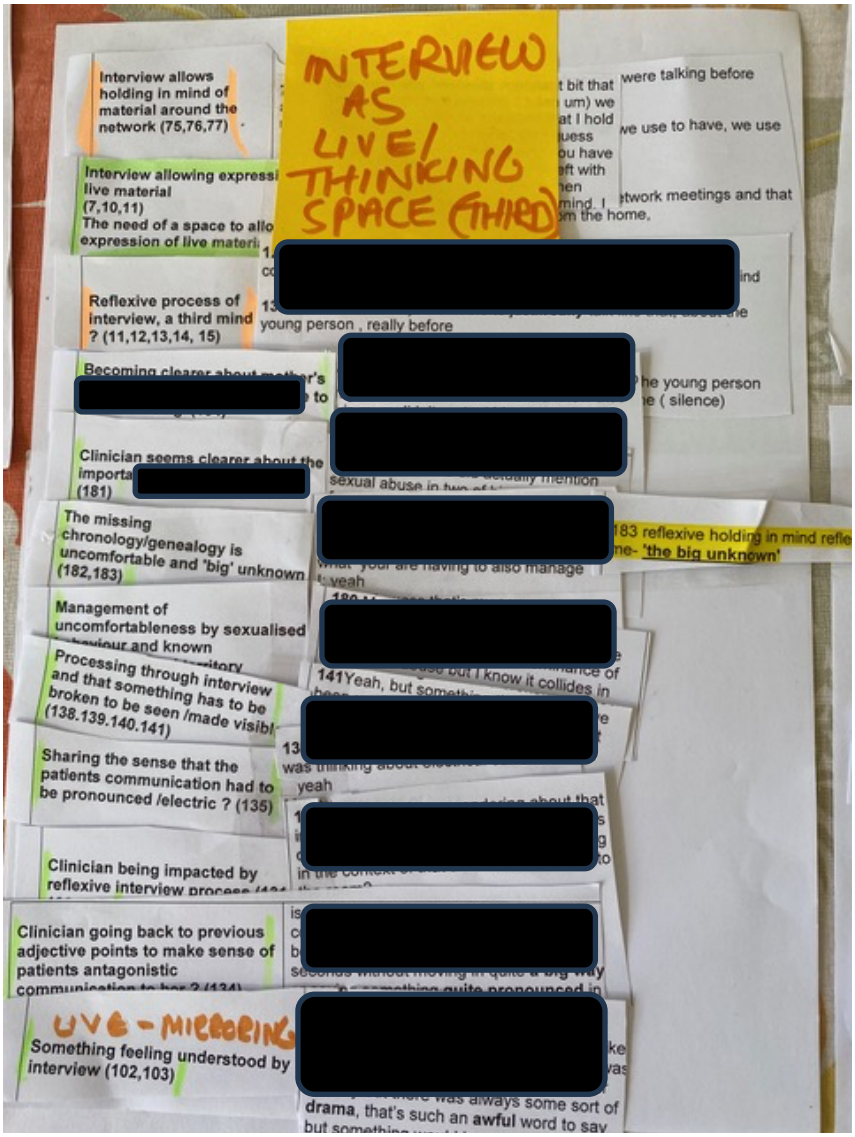
Appendix 10

Clustering Experiential Statements



Appendix 11

Example of an individual PET (Personal Experiential Theme)



Appendix 12

Ten Initial GETs

Enactment in interview process and trauma
Flexibility in approach – active and creative
Applying CP
It becomes personal and YP
Intersectionality and generation
Gender past and present
Questioning in the body – clinician and YP
Going back to basics (repetition)
Neglect and external management
Early trauma and gaps/absences