Bringing Psychoanalytic Consultation to the Table:

Experiences of CAMHS clinicians and practitioners who engage in a 1:1 consultation with a child psychotherapist about their work with adolescents with a history of intergenerational trauma

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A thesis submitted for the degree of Professional Doctorate in Child and Adolescent Psychoanalytic Psychotherapy

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Date of submission for examination: 31 March 2025

Abstract

Objective: This study explores the experiences of clinicians/practitioners (N=7) working in CAMHS, who sought 1:1 consultation with a child psychotherapist to support their work with adolescents impacted by intergenerational trauma (IGT). The project extends the current literature by exploring the specifics of child psychotherapy consultation taking place within a trauma-focused pathway.

Method: Semi-structured interviews were used to collect the data, which were transcribed verbatim and then analysed using Reflexive Thematic Analysis (RTA); no prior hypotheses were applied.

Results: From the qualitative analysis of participants' narrative accounts, five central themes emerged: ‘Psychoanalytic Markers’, ‘Digestion, Processing and Container-Contained’, ‘Consultation Through the Lens of IGT’, ‘Who’s the Expert’, and ‘The Impact of Consultation’. A distinctive contribution of this research was that these themes captured participants’ perceptions about the outcomes of child psychotherapy consultation, defined as the gains made by staff (micro-gains) and gains made for the patient and the organisation (macro-gains).

Conclusions: Consultation emerged as a vital support to staff groups in CAMHS working with traumatised children and families. Findings evidence that in IGT cases, staff are motivated to seek consultation as a valuable intervention of choice, helping them better understand their patients. Slowing down, containment, and digestion are indicated as essential ingredients to consultancy work. A key finding of consultation with a child psychotherapist is the unique contribution where negative feelings stirred by IGT cases can be endured, tolerated, and eventually understood within a

psychodynamic collaboration, widening the lens of sustainable practice and protecting against staff burnout.

Parallels between the findings and the existing literature on child psychotherapy consultation were found. This study warrants further consideration of the specialist contribution child psychotherapists make through joint consultation with NHS staff. It is argued that there is a need for a consultation offer to be made more readily available when working in trauma-focused services.

Keywords: Adolescents; CAMHS; psychoanalytic child psychotherapy; consultation; ghosts; intergenerational trauma; NHS staff; trauma interventions

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I would like to thank the dedicated CAMHS staff team where I worked during my research, especially those who participated in this study. My special thanks to Richard Tongue and Dr Janine Cherry-Swaine for their inspiration and support. My gratitude to Dr Rajni Sharma for her invaluable guidance and supervision. A heartfelt thanks to my family for their unwavering encouragement.

Dedication

This thesis is dedicated to my late grandparents, Audrey and Leonard Proctor.

Abbreviations List

ACP	Association of Child Psychotherapists
CAMHS	Children and Adolescent Mental Health Service
CBT	Cognitive Behavioural Therapy
CPD	Continued Professional Development
CAPPT	Child and Adolescent Psychoanalytic Psychotherapist
EBE	Expert/s by Experience
IGT	Intergenerational Trauma
LAAC	Looked after and adopted children
MDT	Multidisciplinary Team
NHS	National Health Service
PRF	Parental Reflective Function
RF	Reflective Function
RTA	Reflexive Thematic Analysis

CHAPTER ONE

Introduction

"Trauma sits at my kitchen table"

This powerful statement captures a parent's experience of intergenerational trauma (IGT) playing out and repeating in their everyday lives. This notion of undigested trauma planted a seed in my mind and emphasises the importance of 'real life' experiences.

This was back in 2016 when I was working within a multi-disciplinary post-adoption service delivering therapeutic parenting programmes. I was unaware that I had been growing this seed unconsciously. Meek (2003) suggests this unconscious mental processing is an integral and often unrecognised aspect of creative work, which is especially important for qualitative research. It is not the data alone which hold the findings, but also the processing in the researcher's mind. My trauma work with adoptive parents and the wisdom within their lived experience informed my research long before it was consciously realised.

Working with trauma is very difficult for families and staff alike, dealing with inchoate emotional reactions and the "Ghosts in the Nursery" (Fraiberg, 1975). Trauma is ever present and pervasive; it colours every aspect of a person's life; their relationships both internal and external and the relationship to the world in which they live in. Staff working with trauma can feel pressured to fix and find strategies or solutions as well as opening themselves up to emotional distress. These influences led me to the child and adolescent psychoanalytic psychotherapy (CAPPT) training in 2020, when I became curious about the interplay between the internal world and the real

difficulties presented for both staff and patients in treatment, where situations transferred from past to present. Psychoanalytically informed consultation focuses on these difficulties that impact the clinical work and relationships with colleagues where IGT dynamics are at play. My research interest was in questioning what psychoanalytic consultation could 'bring to the multidisciplinary table' for staff working in trauma-focused services. I found no evidence of research into staff's experience of consultation or what value or meaning they placed upon it. The lack of empirical research, and the left-out important staff voices on consultancy practice, were the impetus for this project. The participant narratives are the life blood of this research.

My study is a psychoanalytically informed inquiry into the experiences of clinicians working in a Child and Adolescent Mental Health Service (CAMHS) that have engaged in a 1:1 consultation with a child psychotherapist, about their work with patients who have a history of IGT. I chose to examine consultation in relation to IGT because of the immense challenges it poses for both clinicians and services making it a very appropriate and necessary area to study and understand. A further consideration is the impact of child psychotherapy consultation as consultancy outcome studies are non-existent.

A specialist trauma service based on the Tavistock's organisational consultancy systems-psychodynamic approach was already established in the NHS Trust where my study was carried out. The service offered staff consultancy to inter-agency partners including the Police, Social Care, and the voluntary sector who were working with traumatised adults. I was investigating the CAMHS-branch of the trauma service. The CAMHS Consultation Pathway was implemented around 4 years ago, led by a child psychotherapist, allowing as Shuttleworth (1999, p.30)

described, “new clinical pathways…that remain psychoanalytic and yet are viable in a setting that does not have psychoanalysis at its centre”. The pathway generated interest amongst the MDT especially owing to the high prevalence of complex trauma cases, yet it had never been reviewed before. Thus, the service was welcoming of my research into the consultee’s experiences, and I found myself wondering how they conceptualised consultation.

In our service the style of consultation is psychoanalytic. The consultant considers what the clinician brings both consciously and unconsciously and my study explores this through consultee’s personal accounts of their experience. It is important to consider the framework of consultation, ‘what it is’ and ‘what it is there to do’. This will be explored more fully within the literature review and the findings chapter where participant narratives from semi-structured interviews give examples of the work.

This project focuses on 1:1 consultation with a child psychotherapist working with the clinician (consultee) which typically involves: the consultant inviting the consultee to explore their thoughts and feelings and giving meaning to their experiences; helping the consultee understand and reflect upon their own emotional experience as a source of information about the work situation i.e. countertransference. The consultant tries to keep to the same room arrangements, to start and end on time and to avoid altering dates to establish safety and trust.

Through my observations and participation in consultations during my CAPPT training, I have had a positive experience of consultation and wonder how this will colour my counter-transferences to the field and affect my interaction and perceptions of the participants' engagement during interviews. My preconceptions are that consultations are supportive. Offering a shared experience and containment

may reduce the risk of staff burnout and defensive functions which ultimately affect the patient. This is my reflexive acknowledgement; the challenge now is to look afresh, explore objectively and interpret whilst being aware of my personal and professional bias.

CHAPTER TWO

Literature Review

2.1 Overview

This literature review briefly explores IGT within a historical and contemporary psychoanalytic context to define what it is and, ultimately, to provide a basis for understanding how IGT impacts the patient-therapist dynamic and the staff dynamics within a mental health service. IGT is often of a nature that transmits unconsciously and can result in a cycle of re-enactment across family generations. This can be mirrored within clinical settings (Britton, 1981). However, many trauma interventions are focused on individuals only. Child psychotherapy consultation focuses on the child/family on one hand and the organisation on the other. Ways of working beyond individual therapy presents an opportunity to investigate a link between psychoanalytic consultation and IGT that could inform multi-disciplinary practice.

After conducting a preliminary literature search, there was no evidence that IGT had been systematically studied within the context of child psychotherapy consultation. For this reason, I address the key concepts of this thesis in two main parts:

Part One: IGT [1]

This section starts by setting out the theoretical perspectives of IGT from the metapsychology of the Freud-Klein-Bion development in psychoanalysis with its internal focus on trauma and its transmission. Firstly described by Freud as “repetition compulsion” (1914), and later applied by contemporary Freudians (Fraiberg, Adelson and Shapiro, 1975). Klein’s (1946) concepts of projection and

[1] Refer to pp. 7–15

projective identification are of relevance when considering how IGT can occur through such processes within both familial systems (Zinner and Shapiro, 1972) and organisational systems (Menzies-Lyth, 1960).

Part Two: Consultation [2]

Looking into the possible points of theoretical overlap between consultation and IGT warrants that the concepts of repetition compulsion and re-enactment are revisited, with the relationship between the individual and organisation in mind. Bion's (1962) container-contained and significance of the transference and countertransference are considered not only core to individual psychotherapy, but also of relevance within the consultation framework adopted by child psychotherapists.

2.2 Literature Review Method

After setting the theoretical picture, I conducted a systematic search for research evidence with emphasis on psychoanalytic studies within the two distinct fields of IGT and consultation looking for points of convergence between the two. (Detailed search strategy in Appendix A). A large body of IGT research was generated. One field was Holocaust studies, where several writers approached IGT from an unconscious perspective. These studies were briefly touched upon. Attachment research was also briefly included as part of the broader discussion around how IGT can emerge as a result of attachment difficulties within the parent-child relationship. The study of epigenetics offers further robust scientific evidence for the existence of IGT through the observed biological changes passed from parent to child, yet this

[2] Refer to pp.16 – 35

literature was restricted in the review due to space and relevance to the research question.

In contrast, the empirical support relating to child psychotherapy consultation was sparce, although a small number of qualitative projects and doctoral studies were identified. Points of overlap between IGT and 1:1 psychoanalytic consultation were found from a theoretical viewpoint only, as these two areas had yet to be systematically studied together. Therefore, articles with clinical phenomena relating to consultation by child psychotherapists were searched within the 'Journal of Child Psychotherapy'. I have given a brief overview of the articles relevant to my research question.

I review the following areas specifically:

- IGT and its theoretical conceptualisation from a psychoanalytic perspective
- IGT as understood and developed through contemporary clinical practice and research
- The framework of child psychotherapy consultation
- IGT theory and research applied to psychoanalytic consultation
- Evidence of the impact of psychoanalytic consultation on MDT professionals
- Gaps within the literature.

2.3 PART ONE: Intergenerational Trauma

2.3.1 Psychoanalytic Perspectives

Trauma is a broad and complex subject. IGT is inter-relational, occurring within relationships and impacting other relationships, having profound effects beyond the

individual; it is the notion that traumatic effects are repeated down the generations without direct exposure to the precipitating event or events (Kellerman, 2001).

Freud (1920) conceptualised how trauma can disturb mental functioning in “Beyond the Pleasure Principle”. He considered how traumatic events can bring about a breach in the “protective shield” of the mind, events that are powerful enough to pierce through and flood the mind with overwhelming anxieties leaving a “wound” on the psyche.

These profound anxieties can become deeply buried in the unconscious. Put simply, we cannot but forget. Freud (1914) hypothesised that what cannot be remembered gets repeated. Trauma survivors try to overcome overwhelming experiences by replaying or acting them out through dreams, flashbacks, or re-enactments within families and the therapeutic relationship. “The present is lived as if it were the past” (Freud, 1938, p.176). This is a central concept to understanding how trauma gets passed down the generational line affecting future offspring, even though they didn’t experience the trauma first-hand. Atlas (2022) refers to “emotional inheritance” describing how later generations “inherited feelings of the parents’ unprocessed trauma” (p.20). Kellerman (2001) found that second and third-generation Holocaust survivors felt their parent’s devastation and grief, even though the parents never talked about their experiences directly. Such findings suggest that emotions not experienced consciously by the first generation are unconsciously handed over to the children of the next generation, as Atlas (2022) describes.

In treatment, when patients (and clinicians for that matter) are not able to untangle their (or the patient’s) emotional experiences they are only able to act out unprocessed material, which is repeated, never thought about. “A thing which has

not been understood inevitably reappears like an unlaid ghost it cannot rest until the mystery has been solved and the spell broken" (Freud, 1909, p.122). In summary, one might contemplate that within the inter-relationships between frontline staff, (who look after patients with complex trauma) and the consultant, (who support the staff) trauma may also play out in the transference.

2.3.2 Contemporary Theoretical Applications to IGT:

"Why doesn't this mother hear her baby's cries?" — Fraiberg et al (1975, p.392)

Intergenerational trauma studies enter contemporary psychoanalysis through "Ghosts in the Nursery" (Fraiberg, Shapiro and Adelson, 1975), a profoundly moving interpretation of trauma transmission. Building on Freud's understanding of repetition compulsion, their clinical cases tell the story of how ghosts from the parent's childhood reappear to haunt the relationship with their children, unconsciously transmitting trauma to the next generation. Unlike Freud's analysis on the couch, Fraiberg's work was conducted in the family home, gathering around the 'kitchen table' they witnessed and heard painful stories unfold, allowing the 'truth' to be known and therefore breaking the cycle of repetition.

In the clinical illustration of Mrs March (the mother whose cries had not been heard or responded to in her childhood) she could not hear the cries of her own baby in the here-and-now. Fraiberg described, "the parent seems condemned to repeat the tragedy of her childhood with her own baby". She hypothesised that if they could help the mother see the repetition of her past in the present, then "the ghosts depart" and the mother could then hear her baby's cries, preventing re-enactment or harm to the child. If we are to accept Fraiberg's view, it seems the psychoanalytic work is to recognise the unspoken parental trauma or "ghosts", witnessing, and containing

them within a therapeutic setting; these original ideas remain unchallenged (Hopkins, 2008). Fraiberg was writing before the scientific study of epigenetics had surged in the 1990's, investigating the interaction between trauma and biological changes in the body. Sohye and Strathearn (2017) found despite an increasing number of studies linking a person's oxytocin dysfunctions to a history of early trauma, stress and attachment problems later on, that artificially increasing the level of oxytocin alone did not itself offer promise of breaking the cycle of IGT. They claim, "the importance of processing and working through trauma cannot be underscored more, both in Fraiberg's times and in the present" (p.219).

In a controlled study entitled "Measuring the Ghosts in the Nursery", Fonagy et al (1993) tested Fraiberg's hypotheses and quantitively demonstrated that a crucial factor in the transmission of maladaptive attachment patterns was "parental reflective function" (PRF). Caregivers with more consistent ability to reflect on their own traumatic events and organise these into a coherent narrative, were more likely to have securely attached infants. Poor PRF was linked directly to second and third-generation attachment insecurity and suggested as an indicator of parents' predisposition to transmit trauma (Fonagy, 1999). These findings have been extensively tested over three decades yet were often limited to mother-infant dyads (Steele et al., 2008).

Fonagy's case study (1999) details his in-depth analysis of an adolescent and explores the efficacy of psychoanalytic treatment in this third-generation Holocaust survivor. He argues that if psychotherapy is to be useful for adolescents impacted by IGT, ways of addressing PRF deficits were needed. Emanuel (1996) concurs. Fonagy's empirical research which aids his psychoanalytic work pushes the profession forward, allowing understanding that capacity for PRF is a

transgenerational acquisition. Steele et al (2022, p.303) hold that “reflective functioning is thus a powerful antidote to the pernicious effect that trauma has on mental health”. Such findings have gone on to be the keystone to Parent-Infant Psychotherapy, bringing attachment theory and psychoanalytic theory closer together. Empirical research in this area is growing rapidly (Barlow et al, 2016). Approaches to IGT research continue to be developed by paying close attention to the significance of PRF and the need to work beyond the individual child (Edginton, 2017).

2.3.3 Intergenerational Lack of Containment

In his theory of thinking Bion (1962) states, thoughts require “an apparatus to cope with them” (p.110); this apparatus is called thinking. Thinking is an experience that first takes place in the emotional events between a mother and infant, in which the mother receives and contains her baby's overwhelming anxieties and is able to return them, modified. This containing capacity in the mother is imperative for the establishment, or not, of the capacity to think in the infant, and creates the basis for healthy psychic development.

Unresolved trauma can be linked to Bion’s notion of unsymbolised or ‘uncontained’ experiences which are too destabilising to process, thus relegated to the unconscious. Stern (2009) noted that when the patient takes flight into dissociation, traumatic memories are not represented by metaphor. Ciccone (2018) suggests IGT exemplifies that which was not “modified” or “metabolized” psychically, that which was neither inscribed nor represented. For Ciccone, IGT then, is due to failure to symbolize, and the traumatic effect is produced by the absence or limited capacity to process the traumatic event. Freud (1920) understood that it was not possible to symbolise repressed material, therefore the individual can only repeat the

traumatic situation compulsively, demonstrating the cyclical power of unsymbolised trauma.

Linking with Bion's (1962) theory of thinking, IGT could be thought about in terms of an *intergenerational absence of containment.* Experience becomes unspeakable and unprocessed, evoking a "nameless dread" (p.309). In Fraiberg's work, the mother remembered her past experiences but not the suffering, this was repressed in the unconscious. Fraiberg hypothesised that parents' traumatic experience needs a process that would mirror parental containment but in the here-and-now. The final banishing of the ghosts requires re-experiencing the repressed effect alongside a containing presence attributing it to its traumatic origins.

The notion of containment remains a central concept in psychoanalysis today. Hopkins (1986) describes the centrality of containment in the recovery from trauma in "Solving the mystery of monsters",

> Perhaps Freud was right to suppose that ghosts of the past can never fully rest until they have been understood, but meanwhile the therapist's capacity for containment can reduce the pressure to repeat the past and so allow new relationships to develop (p.15).

The capacity to emotionally contain and to be contained are important factors for the patient and for staff working with the emotional dynamics of trauma.

2.3.4 Projective Identification and IGT

The phenomenon of projective identification was conceptualised by Klein (1946) and later developed by Bion (1962) who focused on the projective identification into the mother and the mother's capacity to transform these projections through the process of containment or "reverie". Bion considered projective identification as an

unconscious communication of an emotional experience and is relevant to IGT, where the containing process fails, and the ghosts are passed by intrapsychic means. Goren (2020) suggests traumatic and intolerable situations move through families silently yet actively, thus, transmission may take place unconsciously through projective identification.

Grotstein (2000) argues that projective identification is really about what goes on intersubjectively between two people (sender and receiver), rather than purely in phantasy and strictly intrapsychic, "I now conceive of the interactional aspects of projective identification as *'projective transidentification'"*. IGT within a transidentification lens could be thought of as a trauma that:

> Someone somewhere had at some time, echoing in our lives now, as it replays repeated reflections of its original configuration. It is speaking to us in the only language it has: our experience. It is a trauma that someone could not contain because they were too alone and too hurt. It migrates once or many times, still fresh, still original, still potent, and still willing to be heard and healed. Melanie Klein called it projective identification (Brinton, 2009, p.73).

Reid (1997) discusses the developmental consequences for children who have been massively projected into by their parents, which is different from the everyday failures of the 'good enough' parent. The child becomes so full of unthinkable, unmetabolised experiences of both his own and of his caregiver that he is in a state of "double jeopardy". Reid suggests that massive projective identification seems to happen where traumatic experiences have occurred in the grandparent generation which have then been 'passed on' as projective identifications, first into the parents and then into the infant.

IGT is not constrained solely to internal processes such as projective identification, the child is also seen within the family setting. Winnicott (1965) considered the impact of the external environment the mother provided, the “holding environment”, which, according to Britton (1998) is in many ways analogous to Bion’s “container”. When the good enough mother (father or carer) provides their distressed child with a “holding environment”, they are actually “containing” and detoxifying their child’s projections (described by Bion). Attachment-focused research also calls attention to the holding environment and influences of the external world, more than on the development of internal factors (Main et al, 1985; Main and Hesse, 1990).

2.3.5 Trauma Resilience

The cycle of IGT can be interrupted by “Angels in the Nursery” (Lieberman et al, 2005). Angels are the metaphor for the intersubjective experiences between parent-child in which the child feels understood, accepted, and loved. These experiences can be drawn upon when the child becomes a parent. Narayan (2019) found mothers with more positive/elaborated angel memories to be intergenerationally protective factors.

Music (2011) referring to Roisman (2002), describes how the ability to form a coherent narrative of one’s experience is pivotal to breaking the cycle of IGT. “Those parents abused as children who somehow manage to break the cycle of abuse are those who develop a capacity to form narratives and stories that make sense of their lives” (p.210).

2.3.6 PART ONE: Discussion

The literature presented has evidenced some important considerations for child psychotherapists working with IGT. Key themes have been identified and involve:-

repression of the traumatic memory and its effect, the defensive representation of its affect in an unconscious space (projective identification) and a high propensity for compulsive repetition of the experience through (re)enactments. The literature demonstrated that attending to the ‘cry out’ in the repetitions and projections within a supportive relationship, is one of the most evidenced factors that may be responsible for breaking the cycle of trauma and putting the ghosts to rest.

Research literature confirms that IGT and attachment are inextricably interwoven. The evidence base for treatment approaches to IGT stress the importance of improving PRF. There is a lack of research exploring the transmission of trauma in later child development, particularly adolescence, where the focus has been largely on early intervention with mothers/infants. Yet with many adolescents entering CAMHS, this presents a research gap of particular interest.

Fraiberg laid the groundwork for placing value on multi-disciplinary work at the heart of their IGT caseloads; the seeds of consultation are already rooted and the value of bearing witness to trauma and offering containment through the therapeutic relationship was consistently discussed as contributing to therapeutic efficacy. Can organisations, in turn, become “holding environments”? Kanter (2020) recognises that Fraiberg’s “therapy in the kitchen transpired without the privacy of the analytic consulting room, without the usual time frame of a fifty-minute hour, and definitely without an analytic couch” (p.119). Can the psychoanalytic ideas and approaches discussed so far be applied beyond the individual and expanded to encompass a consultative framework for IGT?

2.4 PART TWO: Psychoanalytic Consultation

Little has been studied about how psychoanalytic child psychotherapists consult with professionals in cases involving IGT, and even less is known about the consultees' experience. This offers a starting point for research. The risk of trauma transmission is not just interfamilial. Ghosts have long been adopted as a metaphor in psychoanalysis to draw attention the complexity of unmetabolized intergenerational traumas which can be mirrored within organisations. Staff may re-enact or replicate the difficulties displayed by their patients, as described by Ron Britton (1981) in his paper "Re-enactment as an unwitting professional response to family dynamics". Harris et al (2016) point out in "Ghosts in the Consulting Room", that IGT infiltrated their theories, practices and training institutes.

2.4.1 Organisational Consultancy

It is a natural defence to protect ourselves against thinking about painful trauma. A large body of literature, based on Tavistock's system psychodynamics model, considers how practitioners in healthcare settings may defend against their overwhelming anxieties arising from their emotive working environments (Menzies-Lyth, 1960). The premise of organisational consultation is that if professionals' experiences can be shared, faced and thought about, then ultimately, they can manage the difficult feelings encountered in their work and relieve anxiety by 'de-toxifying' rather than defending against them.

Robson (2009) talks about adopting a "consultative frame of mind" as a way of thinking together about unconscious processes. Professionals working with IGT may also need to be supported in such ways, through consultation, to manage the leakage of ghosts and feelings of anguish not only between family members, but

also between family members and professionals; professionals and professionals; professionals and organisations (Britton, 1981).

2.4.2 Child Psychotherapy Consultation

Whilst the core work of child psychotherapists remains in the practice of individual psychotherapy, work in a variety of contexts also takes place outside the consulting room, consultation being a prime example (Robinson et al, 2017). To broadly define consultation, Gibbs (2009) suggests that child psychotherapy consultation is mainly concerned with establishing a collaborative relationship. Its context is predominantly that of information exchange, clarification, and the achievement of a shared understanding within a psychoanalytic paradigm. Wilson (1999) describes the essence of psychoanalytic consultation as “residing in its capacity to contain, to receive feelings and observations, to tolerate uncertainty, to allow for reflection and thought and ultimately empower staff to move forward in their own way” (p.165). Wilson cautiously warns that consultation is not supervision, as the professional responsibility for the work lies with the person seeking consultation, whereas in supervision, the supervisor assumes managerial responsibility. Consultation may include reflective practice elements, with some similarities to work discussion groups (Rustin and Bradley, 2008) drawing from Bion’s (1962) theory of containment and Bick’s (1964) method of child observation. Child psychotherapists are well-versed through their training in using observation to promote a reflective stance. This involves turning to look at what is communicated verbally and non-verbally, to see and take-in the emotions and behaviours to reflect, contain and translate these into words. An observational stance creates a strong holding context within a consultative space to bring very difficult states of mind (Ironside, 2012).

Several child psychotherapists have written about their experiences of consultation born out of supporting frontline staff working with children and adults traumatised by sexual abuse, neglect and those with a history in the looked-after system. Important clinical papers written by Cherry-Swaine (2024), Cregeen (2008), Emanuel (2002), Nathanson (2024), Sprince (2000, 2002), Rocco-Briggs (2008), and Wilson (1991, 1999) discuss providing consultation to professionals who work with complex trauma, also considering technique and its application. More systematic research is needed in this area, but I shall consider the empirical findings first, then move into the papers by child psychotherapists.

A study by Robinson et al (2017) identified that 76.7% of child psychotherapists conducted consultations with professionals in their work with Looked-After and Adopted Children (LAAC), whilst 82.3% provided individual child therapy. The high demand for consultation was evident within the professional network, “respondents spoke about consultation as being a space within which to encourage reflective practice” (p.269). Reflecting upon network dynamics, e.g., “splits in the network”, was important in ensuring professionals did not re-enact the child’s past trauma. A link to Fraiberg’s hypothesis comes to mind. Robinson et al conclude that consultation is a vital aspect of child psychotherapy in bringing defences and enactments to a conscious level.

In a study closely matched to my research, Robinson et al (2020) interviewed a small sample of child psychotherapists (N=9), about their experiences of consulting with the network around LAAC. The researchers suggest, “the psychoanalytic approach had something unique to offer to reflective practice with complex networks around looked after children” (p.321). Participants spoke about the importance of “slowing

things down” enabling thinking to become “unstuck”. This brought the complex processes in consultation alive (p.318).

As there were no multi-professional views about consultation my study aims to address the views and experiences of this group where there appears to be a gap in the research. My study acknowledges Robinson’s findings that research into consultation within child psychotherapy is sparse.

According to Cregeen (2008) child psychotherapists are “well-suited” to the work of consultation through their analytic training in working with transference and countertransference phenomena, allowing them to bring to bear complex dynamics within networks. Cregeen highlights the core psychoanalytic concepts that define the consultation model. These are, “the paranoid–schizoid and depressive positions, the relationship between container and contained… and projective identification, in both its communicative and evacuative functions” (p.173).

I draw further upon a book entitled “Through Assessment to Consultation” by Horne and Lanyado (2009), who agree with Cregeen’s consultation framework and make clear several additional psychoanalytic concepts specific to consultation. A strength of this book was how evident these and other concepts could be of value when consulting within a range of different clinical and community settings. These include:

- Repetition compulsion (Freud, 1914) and re-enactment (Britton, 1981)
- Projection and projective identification (Klein, 1946)
- Container-contained (Bion, 1962)
- Transference (Freud, 1914) and countertransference (Heinemann, 1950)
- Reflective function (Fonagy, 1991)

Within a psychoanalytic frame, these concepts are the basis for understanding the influence of the past on present behaviour, for gaining a deeper insight into defences and bringing unconscious anxieties to light which then go on to inform practice. Each of these concepts were extensively explored including the impact on the multi-disciplinary professionals and the team within which they worked.

2.4.3 Ghosts in the Network

In Part One, I addressed how peoples relation to objects in the past can transmit and repeat across generations, where new individuals become conduits for re-enactment, albeit largely unconscious. Britton (1981) argues that the same phenomenon exists within organisations. He describes the patterns of object-relationships that are at risk of being replayed. More primitive forms of unconscious communication abound when working with families impacted by IGT, when projective identification predominates and intolerable feelings are located elsewhere (e.g., in the professional). Furthermore, if professionals' anxiety in an organisation are left uncontained, this can lead to them operating in the paranoid-schizoid position[3] (Klein,1946), mirroring that of the family. Britton says, "the cast changes but the plot remains the same" (p.2).

Child psychotherapists Cregeen (2008), Emanuel (2002) and Sprince (2000, 2002) all argue that professionals working in emotive environments can re-enact aspects of undigested traumatic experiences. Emanuel (2002) uses the term "triple deprivation" to describe the perceived deprivation that networks can put onto traumatised children and families. The first source of deprivation is external arising from the original trauma experienced, the second from internal sources as the child develops

[3] Projection, a defence mechanism in the paranoid schizoid position (Klein, 1946), is the unconscious displacement of unwanted or threatening emotions onto another person, usually to get rid of painful feelings.

defences preventing them from accessing external support (Henry's (1974) concept of "double deprivation"), and the third occurs when professionals, facing the barrage of the child's projections, end up repeating the child's defences against anxiety. This is not only an outcome of the effect on the individual but also on the professional and the network they are part of. Wakelyn (2008) relates the unconscious inclination of professionals to repeat aspects of family trauma to Freud's theory of repetition compulsion, often leading to splits and conflict within the network. Several papers have noted the psychotherapists' role in providing consultation to overcome such conflicts (Emanuel, 2002; Rocco-Briggs, 2008; Sprince, 2000).

It follows that little change is mobilised unless the unconscious dynamics are thought about, rather than supressed, and their psychic meanings made sense of (Britton, 1981). Consultation is a valuable intervention to unwitting re-enactments in response to family dynamics (Britton, 2004). Britton draws attention specifically to the intergenerational patterns of relating, and the changes that are possible:

> The thesis which is argued here is that 'realisation', and a change as a consequence of 'realisation' rather than change as an alternative to 'realisation' may prevent patterns which cross not only individual but generational boundaries (Britton, 1981, p.54).

He suggests that accepting small yet significant changes is important for professionals where intergenerational patterns repeat. The professional is bearing the struggle to "realise" rather than "repeat", and to "resist unconscious collusion" in order to gain a better understanding of the family.

Cregeen (2008) discusses his experiences in children's residential care highlighting the interplay of IGT and the challenges of consultancy, entitling them "ghosts in the

unit". What emerges within consultation is the disturbance of the young people which is transferred onto the care staff and enacted at all levels, between the adolescents and their workers, through the team and consultant. Wilson (1991) suggests that consultation helps when someone or some group "gets stuck" with disturbing feelings noting how consultation attends to what is going on under the surface. Cumulatively, these papers made me aware of possible re-enactments in my own research.

2.4.4 Projective Identification

IGT transcends the individual and his/her family's life and reverberates amongst those associated with them. The concept of projective identification may underlie this phenomenon[4]. Moylen (1999) describes patients' projective identifications as unconsciously communicating aspects of their experience to their workers. However, it can be incredibly difficult to decipher what belongs to the trauma survivor, and what belongs to the staff in a messy 'projective parcel' of feelings. Consultation is crucial in supporting staff with disentangling "the agglomeration of conflictual feelings" (Cherry-Swaine, 2024).

Networks may also function as a projective system when the staff group are flooded with painful emotions as they attempt to defend themselves against the difficult experience of working within trauma services:

> In my work with staff groups and communities, I am struck by the parallel strength and confusion of emotions engendered in those attempting to work with them, which can affect me as strongly as my work with individual

[4] Refer to p.12

> survivors. This is a measure of the power of the projective system (Cherry-Swaine, 2024, pg.111).

Sprince (2000) describes how powerful projections can infiltrate the entire system and create cycles of blame in staff and defences to guard themselves. Acknowledging each other's pain and 'truths' replaces blame. She argues eloquently, the necessity of bringing together the individuals that form a "network" of care around a child and for the power of a psychoanalytic model in helping them integrate their thinking. This is achieved through consultation.

Rocco-Briggs (2008) suggests that traumatised children may project different aspects of themselves into different staff in their network, who may each separately hold pieces of the child's distress. Consultation allows the professionals to link these separate fragments of trauma thereby establishing an integrated network. The consultant acknowledges the splits and fragmentation occurring which can prevent staff from acting defensively from feelings that are unmanageable.

Emanuel's (2002) paper is a powerful example of how children project elements of their disturbance into the network. It focuses on the unconscious processes that take place in network consultation and talks about the value of consultation to the family and network as a prelude to individual psychotherapy. By building relationships and communication with the network first, professionals could bring themselves in a genuine and open way. The function of consultation initially involves surviving the projections:

> professionals find themselves swamped by unconscious projections from their clients which affect their powers to work and think. We find ourselves feeling stupid, helpless, blind to the obvious, or full of uncomfortable responses

> tinged with contempt, anger, or rejection' (Bradley and Emanuel, 2008, p.135).

It is through consultation that staff discover such feelings are often the nonverbal communications from patients of their desperate suffering. Emanuel concludes that drawing attention to re-enacted dynamics via consultation requires the endorsement and support of senior management for a more reflective approach to filter down to frontline professionals, like a model of how well-functioning parental values help create a family culture. Nathanson (2024) suggests that whilst the consultant attends to the projections originating from the patient, at the same time, the consultant's task is to consider all the other ghosts and the staff member's specific valency to being unconsciously activated by them (p.166).

2.4.5 Containing the Network

Bion's concept of container-contained (1962) is apt when considering the staff network and is core to the task of consultation as the literature confirms (Nathanson, 2024; Sprince, 2002). Whilst containment appears a simple concept, it may be much more difficult to put into practice. Consultants must first recognise the activity of projective identification in work with families and the resulting professional symptoms (Britton, 1981). Understanding and containing projections help integrate the network (Sprince 2000).

Containment offered to staff through organisational consultation in trauma services positively impacted the decisions made about patients' care (Witkon, 2012) and improved the skills of staff by expanding a culture of therapeutic thinking which was less defensive (Nathanson, 2024). It could be speculated that the internalisation of

containment as a learnt experience in staff, could lead to the team being able to support each other in this way.

2.4.6 Countertransference and Secondary Trauma

There may be a personal cost to the individual professional involved in being the regular recipient of a family's distress, and the countertransference experience may also become cumulatively traumatising for the organisation. Lanyado (2009) discusses exhaustion and burnout of staff (e.g. in children's residential care), where there is a lack of consultation for countertransference feelings to be acknowledged and reflected upon. The impact on the worker of what is 'received' during demanding relationships can lead to secondary traumatisation which affects the wellbeing of staff and their ability to continue to support their traumatised patients (Bober and Regehr, 2006). Lanyado (2009) views psychoanalytic consultation as essential for the "emotional health and safety" of staff working on the ground within highly emotive environments. She advocates for consultation to be embedded within day-to-day practice so that staff can acknowledge their countertransference in a contained setting.

Cregeen (2008) draws attention to how workers become "repositories for so much of the [children's] evacuated emotional experience" (p.175) and in the unworked countertransference. "There may be multiple phantoms carried within the adolescents into the care setting, which seek refuge, attention and containment. The emotional demand on workers is complex and substantial" (ibid). In Robinson et al's systematic study (2020) of consultation, one participant said that networks often experience secondary trauma… "you get very bruised and battered" (p.314).
The study made me question why there was no reflective space for child

psychotherapy consultants to work through their own consultancy experiences together as a group in light of secondary trauma. This could be an area for future research; an idea that crystalised in my mind from reading the literature. Countertransference can also offer benefits where valuable information about the patient's communications can be unearthed and thought about.

2.4.7 Working with Transference and Countertransference through Consultation

Ghosts manifest in the transference: a here-and-now process by which the child or family actively use the therapist (or consultant) as an object in which to put their unwanted states of mind. Professionals can operate at a transference level, where members of the group represent figures from the child or family's past. Cregeen (2008) views consultancy "not as a diluted version of psychoanalytic work but rather, it describes another clinical context in which thinking and working in the transference is at the heart of the encounter" (p.173). Cregeen's paper is an example of how residential staff often endure the transference of children's painful emotions from their birth families, making it a challenging and sometimes overwhelming environment to work in. He posits that the task of the child psychotherapy consultant is to bear the negative transference on behalf of the staff group. Cregeen relates this work to Bion's (1962) concept of containment arguing its importance at the heart of work with children and staff in residential settings.

Positive transference is also attended to in consultations. Fraiberg (1975) highlights the positive transference between mother and therapist to help internalise new healthy objects and model appropriate behaviour. Emanuel's (2002) view is that healthy containment needs to be modelled throughout the organisational ranks. In

other words, the network needs the consultant to not only bear the negative transference but also hold a sense of hope (Havel, 1990).

Child psychotherapists Cregeen (2008), Emanuel (2002), Lanyado (2009) and Sprince (2000, 2002) all bring to bear the centrality of the workers' countertransference experience in consultation. When these feelings can be openly addressed and thought given to the extent to which they may represent communications about the patient's experiences, then a major shift takes place. Acting out is replaced by reflection and more appropriate responses. In each paper I could hear the authors' conviction in the transformative and developmental process of addressing the countertransference through consultation.

Lanyado (2009) notes that it is attention to the workforces' countertransference that offers vital support to staff, taken together with consideration of the organisational dynamics, the intense anxieties inherent in the work can be adequately contained. Child psychotherapists may have to hold on to countertransference feelings and struggle with them for some time, this can be a lengthy process of being receptive to the unconscious communications and having to survive and bear the projected emotions, both personally and organisationally. Cregeen's consultative experience resonates with Lanyado's views about the countertransference pressures on the child psychotherapy consultant. Lanyado (2009) appreciates the complexity and sophisticated nature of this internal world thinking which requires the consultant to retain the capacity of a sense of who they are themselves.

It is important to highlight the transference/countertransference to the network when working alongside traumatised families so more professionals can be vigilant to the signs of trauma which may be reawakened, displaced or repeated through their

work. Furthermore, the “meeting of minds” (Ironside, 2012) within a consultative space is important when exploring the complexities of transference, countertransference and projections. A different way of describing this was elaborated by Bion (1970) who developed his theory of container-contained in relation to social systems.

2.4.8 Reflective Function and Mentalisation

The term “reflective function” (RF), first formulated by Fonagy et al (1991), refers to the capacity to hold others’ minds in mind; this concept has also proved a source for understanding the possible mechanisms underlying intergenerational transmission of attachment difficulties[5]. The concept of RF has been recently applied to the consultation model. When the staff network had a space in the consultant’s mind to think about the powerful sometimes destructive raw emotions of their patients, this allowed staff a thinking space in *their* minds for the child/family they were working with (Robinson et al, 2020).

Mentalisation is the ability to reflect upon and understand the mental state of oneself and others (Fonagy and Target, 1998). During consultation, the network develops capacity to think about each other’s feelings, needs, and points of view, as well as those of their patients. Through awareness this can help reduce risks of “triple deprivation” to families (Emanuel, 2002). The consultant helps staff consider the importance of *all* relationships and how they affect each other; the consultant–staff relationship, the staff-patient relationship, and the parent-child relationship and how these might influence each other.

[5] Further detailed on p.10 of this thesis

2.4.9 Consultation across NHS Settings

The NHS Long-Term Plan (2019) requires child psychotherapists to be trained on qualification with systemic leadership skills which includes providing consultation and supervision. Around 90% of child psychotherapists conduct their work within NHS CAMHS (Petit and Midgley, 2008) offering consultancy to their colleagues and network agencies. Therefore, there is a need to systemically investigate and evidence the impact of the benefits/deficits of a consultancy approach specifically within the NHS.

Faull's doctoral study (2012) explores consultation with staff in children's homes. As an NHS CAMHS psychotherapist consultant, he provides outreach group consultations to staff through "systemically informed" practice. The study evaluates the consultee's experience of consultation working within a trauma-focused service in collaboration with an NHS CAMHS. This work is of particular interest to me as I focus on consultation within CAMHS but with a psychoanalytic approach.
Staff and managers frequently reported that consultation should focus on team dynamics and the reflective aspect of consultation. Baldwin's (1990) research supports these findings. Faull suggests the role of consultation gave the possibility of "safer practice" that might prevent "dysfunctional organisational patterns" arising. The term "offloading" frequently used by staff during consultation suggested how staff might manage their emotional response to the work.

Some staff felt the "openness" consultation required was a "threat" to team relationships and highlighted their ambivalence about consultation. Faull links this finding to existing literature relating to staff stress and burnout and the high levels of emotional distress amongst this particular staff group. Creating a sense of safety in

consultation was paramount. I was keen to know more about the emotional experiences of staff consultees that may be understood through transference and countertransference, and of the possible projections received by staff as communications from their client group. Attending to unconscious communications is specific to psychoanalytic consultation described by child psychotherapists in my thesis. To my knowledge, no studies have yet investigated the experiences of NHS staff receiving psychoanalytic consultation.

2.4.10 Consultation in Trauma-Focused Services

Witkon's (2012) paper is written from a child psychotherapist's perspective and addresses the paucity of research into consultation for adolescents and their families impacted by IGT. The paper describes the first year of a therapeutic outreach service of applied psychoanalytic work (including consultation) to families, networks and agencies for adolescents on "the edge of care". Seven families participated. Witkon identifies the significant behavioural challenges in these adolescent cases (e.g., extreme risk-taking), that was traced back to problems caused by unresolved parental trauma. Network consultation was offered at initial referral stage, then again as a 6-month follow-up intervention after ending the intensive treatment phase (individual sessions for both the adolescent and parents). Consultation aided the networks understanding of extreme acting-out behaviour and parental difficulties in terms of their underlying trauma. The challenges of working where there is unresolved parental trauma came across strongly. Witkon values the significance of containment in the treatment of adolescents and families in crisis as well as in supporting the professional network. Consultation facilitated staff learning, "skilling up the workforce" (p.155). In my research I consider how the workforce themselves may view their experience of being the recipient of consultation.

In line with existing literature, Wikon's study highlights the importance of understanding and containing projections as "crucial to holding the network together, understanding the family, and working towards its rehabilitation" (p.160). This approach was largely successful in avoiding the young people being placed in care. Consideration of the professionals' countertransference and secondary trauma was not mentioned in the paper. This might have been a helpful subject to include in an otherwise very detailed paper with case study analysis.

Witkon found consultation might be applied pre *and* post-individual psychotherapy where there is IGT in the family history offering ongoing containment for adolescent and parental anxieties.

2.4.11 Ghosts in the Nursery Revisited

I circle back to Fraiberg and her amazing capacity to work within a consultative and collaborative framework when so many emotions and defences are generated by past ghosts. I found my own struggle in finding research pertaining to the use of consultation for IGT, concluding there is a profound gap in this area. I did discover a paper entitled, "Death in the family: Post 9/11 at Pier 94 Manhattan" by Victoria Hamilton, published in Horne and Lanyado's (2009) book. This paper was distinctly different where the impact of Hamilton's intense accounts of listening, witnessing and thinking about (in a reflective way) the families' accounts of trauma in the wake of the 9/11 bombings still remains prominent in my mind. Hamilton's writing is insightful. Its conscious effort to narrate what is hard to put into words gives sensitive attention to the families' and victims' stories of the missing or killed in The World Trade Centre. Hamilton, an experienced psychoanalyst and psychotherapist, does not address why

her memoir was located in Horne and Lanyado's book[6] offering no analytic explanation of her intervention. It speaks for itself. Threaded within the stories of human tragedy is the tremendous aid witnessing provides. She remains close to the survivors' intense grief whilst maintaining the capacity to be emotionally available. To my mind this is closely aligned with Fraiberg's findings, and as Coles (2019) posits, "narrative and witnessing are possibly the antidote to haunting".

2.4.12 PART TWO: Discussion

Part Two of this literature review aimed to deepen understanding about how IGT can present within organisations and to understand the role of child psychotherapists as consultants to staff groups.

Traumatised people unable to tell their stories through words may unconsciously communicate their narratives through re-enactments of traumatic experiences. It was possible to extrapolate these parallels in the professional network. The consultation model described in this review attends to the high levels of anxiety and emotional experience of professionals in their work with traumatised patients, and difficulties within the networks, to break the cycle of repetition. Cregeen (2008), Emanuel (2002), and Sprince (2002) speak with conviction about the containment experienced by the multi-professional network as a consequence of consultation. This was seen to positively impact the MDT services, clinical formulations and the decisions made about patient care.

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[6] "Assessment Through to Consultation" (Horne and Lanyado, 2009) collectively focuses on theoretical and clinical accounts of child psychotherapists' assessment and consultation work; however, Hamilton's paper (Chapter 8) is *"a different personal account, equally of finding an intervention 'appropriate to the occasion', of a practical and humane response to the human tragedy of 9/11"*, (p.3).

In the same way that Fraiberg asked the question in her work with mothers and babies, psychoanalytic consultation asks the question: can the unspoken become heard? The literature suggests that consultation can be viewed as a collaborative endeavour that involves the consultant supporting professionals to slow down and reflect on observations and ideas. Thus, allowing them to navigate their way through a barrage of projections so that insights could emerge. Reflective consultation was also a mechanism for realisation and understanding the internal dynamics of the traumatised child/family and allowed the staff group to support and learn from each other.

Child psychotherapists applied their psychoanalytic understanding of projective processes, transference, and most markedly countertransference to their consultation practice, aiming to take in disturbing feelings and emotions, sustain thinking against the undercurrents of defences and withstand becoming traumatised themselves. I found this work impressive yet pondered whether such depth of intervention would be possible within the CAMHS I would be researching. In many of the clinical papers, consultants supported staff who worked with severely traumatised and abused children in a wide range of settings. This highlighted the flexibility and responsiveness of the child psychotherapists who bring treatment to where it is needed. My curiosity was ignited by Witkon's (2012) study of consultation in community-based settings, reminiscent of Fraiberg's early methods of treating the person in their environment for cases of IGT, although a justifiable question may be whether this kind of consultation work is truly analytic?

Bion's (1963) concept of container-contained offered value to the network and appeared central to the approach and technique applied by child psychotherapists

consulting in cases of complex trauma, highlighting the consultant's role of container for the network first.

In all the papers discussed, I noted the resilience of staff was rarely acknowledged and I feel attention should be given in this area. Robinson et al (2020) acknowledged that there were times when the professionals needed to maintain their existing defences (keeping super busy) to survive the work with families.

Just as traumatised people need a “holding environment” (Winnicott, 1965), so does the professional, which through consultation may facilitate holding the staff groups. A strong theme in the literature is that consultation supports a space for thinking about the work context and/or organisational system.

At the present time, the field of child psychotherapy research has not grappled with the treatment of IGT in adolescents, with most studies focusing on preventive and early intervention approaches in parent-infant psychotherapy. Neither has it considered systematically the value and outcomes of consultation to professionals as a stand-alone intervention.

Fraiberg (1987) states the importance of research “in scientific casework we want to be able to know exactly why a method works… in order that we can duplicate the results under similar conditions” (p.428). Most of the evidence for consultation by child psychotherapists has been collated through case studies and clinical accounts, but there are pockets of research where IGT has been supported through consultancy frameworks, e.g., parent-infant psychotherapy and LAAC. There needs to be specific attention given to the theories of Freud, Bion and Britton as they evidence the consequences of not addressing IGT. Through a consultancy

framework within our mental health services, the difficulties of working with IGT could be addressed.

Coles (2019) states, “we must be open to the possibility that there may be some uninvited guests whom we need to bring to our psychoanalytic table and ask them why they are there?” All of this builds up to questioning: Can we offer a seat at our multidisciplinary table for the forgotten yet ever-present ghosts and give them acknowledgment so that new integration of painful stories can take place (Fraiberg, 1987). I conclude that not enough is known about the impact of consultation in supporting CAMHS clinicians/practitioners so they can reflect on their practice and support their patients. These questions need to be asked and addressed through research.

CHAPTER 3

Methodology

3.1 Study Setting

At the time of this research, I was employed as a Child and Adolescent Psychotherapist training in the North of England within a CAMHS setting. During my formative career in fostering and adoption services and later during my four-year clinical training in CAMHS, a high proportion of my patients were adolescents whose development had been impacted by IGT. I wanted to consider a doctorate project in which I could firmly plant my clinical interest in IGT and represent the needs of a marginalised population.

This study is highly relevant to the CAMHS context where the research took place as the surrounding locality has been affected by intergenerational issues. The Consultant Child and Adolescent Psychotherapist within the Trust set-up a consultancy-based Trauma Service to support staff groups working with adult trauma survivors. A CAMHS-specific branch was developed from this (Figure 1). The CAMHS Trauma Consultation Pathway, led by a Child Psychotherapist, supports colleagues in understanding the consequences of trauma upon the child's physical and mental health, personality development, and attachment relationships, as well as considering the impact of working with trauma on staff themselves. The psychoanalytically informed consultation pathway covered a diversity of clinical work.

I became interested in exploring the impact of trauma dynamics that could be unpacked safely within the consultant-consultee relationship. I noted that staff tended to bring concerns about a child's difficult, risky, and/or puzzling presentation

that was connected with some sort of early trauma identified in the child's and/or parent's/grandparents' history. Putting together the two ideas of IGT and consultation fitted with my clinical interests; strategically, it was important to consider what aspects of IGT make clinicians/practitioners seek consultation. The Trust was in support of the research for its potential insights about how the psychoanalytic model may help the MDT in ways that had not been understood before and to further develop the service provision.

The consultation pathway was well-established within CAMHS and because of this, the service managers and I felt that staff could be safely and sensitively engaged in research highlighting their individual experiences. As a clinician working in the team that I was researching, careful consideration was given to the methodological approach and the importance of reflexivity (discussed in this chapter).

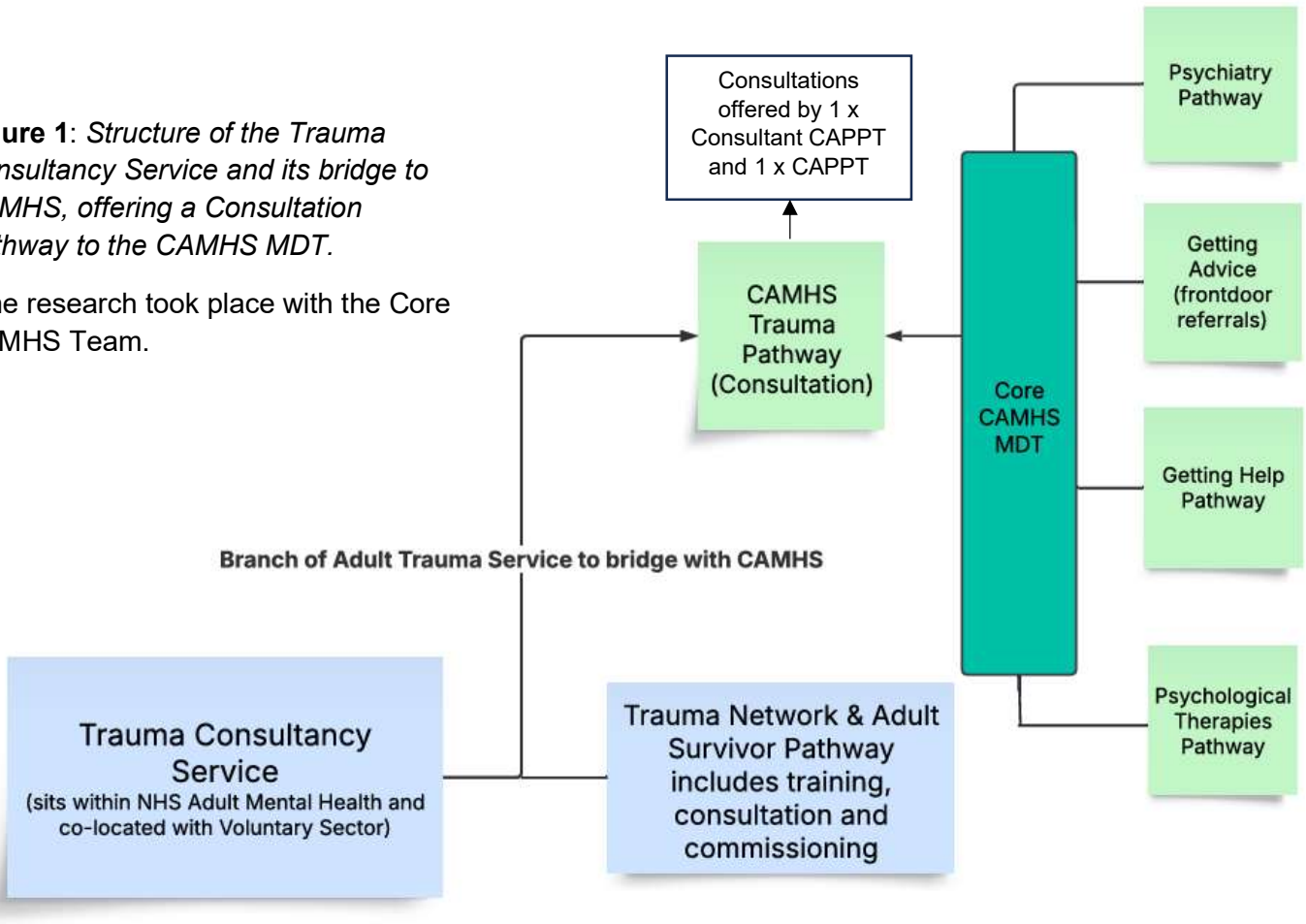


Figure 1: *Structure of the Trauma Consultancy Service and its bridge to CAMHS, offering a Consultation Pathway to the CAMHS MDT.*

*The research took place with the Core CAMHS Team.

3.2 Aims and Research Questions

The literature review highlighted the positive implications that child psychotherapy consultation can have on staff and the network, yet consultation is grounded in clinical practice rather than empirical evidence. One study explored consultants' perspectives of child psychotherapy consultation (Robinson et al., 2020), but no studies have investigated consultees' experiences within a trauma-focused service. My study aims to explore this gap, contributing to the field of consultancy practice. The primary aim was:

To capture the experiences of CAMHS clinicians/practitioners accessing 1:1 consultation with a child psychotherapist in supporting their direct work with those impacted by IGT. Specifically, the study aimed to explore four broad areas with the following questions:

- What motivates clinicians/practitioners to seek consultation?
- How do the clinicians'/practitioners' experiences of consultation inform their direct work and clinical practice?
- What is the impact of consultation on the clinicians'/practitioners' professional development?
- What is the impact on the patient and the service/organisation?

At the heart of this research is "epistemological containment" (Ruch, 2008, p.300), that is, tolerating uncertainty and the not known during the live interviews and data analysis. As Freud (1915) postulates, "I hold that one should not make theories – they should arrive unexpectedly like uninvited guests, while one is busy investigating details" (p.73-74).

The aim would be to generate insights into the potential contribution of child psychotherapists as consultants within the NHS and to explore ideas for development that are potentially transferable to some other contexts (e.g., wider CAMHS and NHS trauma-focused services).

3.3 Research Design and Theoretical Positioning

A qualitative design was employed as the study was conducted within the context of 'real world' consultation and lends itself to an exploration of clinicians' perspectives. In particular, this research demanded a methodology that could be sensitive to signals of trauma (i.e., projection), tensions, and resistance, identified as inherent complexities operating under the surface in IGT. Thus, a qualitative approach was warranted "to get at the inner experiences of participants, to determine how meanings are formed, and to discover rather than test variables" (Glaser and Strauss, 2017, p.13).

Menzies-Lyth (1960) demonstrated how nursing staff unconsciously repressed or filtered their emotional pain; thus, I worked from the assumption that participants were "defended subjects" (Hollway and Jefferson, 2013), bringing their unique defences as protection from the impact of IGT. Semi-structured interviewing was employed as the most appropriate qualitative methodology to engage with participants in discussions about potentially sensitive and complicated topics (Brinkmann and Kvale, 2018). It was important to illuminate the day-to-day stressors and anxieties staff face when supporting patients with IGT and to shed light on staff's experience of consultation when engaging with this hard-to-reach population. For example, when consultees experience uncomfortable feelings about their work, how do they understand, process, and manage them?

A further consideration in choosing a qualitative design was the potential to make links between “micro-processes” and “macro-structures” (Willig, 2013, p.11); an important aspect of this study as child psychotherapy consultation focuses on the individual staff member and their patient on one hand (micro) and the organisation on the other (macro).

This study is underpinned by a critical realist ontology and epistemology. Ontologically, critical realism as described by Bhaskar (1975) viewed reality as “stratified” into three overlapping domains: “empirical” (observed experiences), “actual” (unobserved but actual experience) and “real” (the deepest level where causal mechanisms have potential to produce events at the actual level). Critical realism maintains that the reality of these causal mechanisms cannot be known but only inferred by their effects, which, according to Rustin (2019) has an affinity with psychoanalytic theory, i.e., Freud showed the transference and countertransference are understood to be the ‘effects’ of the unconscious. This study incorporated both surface and deep aspects of qualitative analysis by investigating at the empirical level (participant experiences) and by intending to answer explanatory questions (what motivates clinicians to seek consultation and its impact) suited to a critical realist ontology (Sayer, 1984).

A critical realist approach assumes that although research data can tell us something about what has a real, objective existence ‘out there’ in the world, it respects the epistemological idea that our data cannot apprehend a direct reflection of reality because it is subjectively filtered and interpreted through our brains (mental processing), language, culture and methods (Westthorp et al, 2013). Thus, epistemologically, critical realists respect that the ‘truth’ is elusive, not to be taken at face-value; it requires interpretation, sitting well within psychoanalysis which is also

an interpretive endeavour. I acknowledge that research interpretations emerge from the researcher-participant relationship rather than from the mind of one person (Ogden, 1999).

Silverman (1993, p.1) argues that “without theory there is nothing to research”, highlighting the importance of the interpretive framework of the researcher. The psychoanalytic theory that was brought to bear on this research complements my professional training and contains underlying assumptions about the existence of an unconscious reality (O’Shaughnessy, 1994). It is a lens through which data was analysed and interpreted so that conscious and unconscious experiences of both participant and researcher could be explored.

3.4 Participant Recruitment

Participants were recruited from the CAMHS MDT in which I worked during my clinical training as a Child and Adolescent Psychotherapist. Purposive sampling identified a list of seven potential interviewees, using inclusion criteria identified (see 3.5) ensuring a range of disciplines were covered. Once ethical approval was confirmed, I approached each potential participant individually to explain the opportunity and what it would involve. All seven verbally agreed to take part and were sent a confirmation email thanking them for expressing interest. I provided them with the study information sheet (Appendix B). Informed consent was attained prior to clinicians/practitioners being accepted onto the study (see Appendix C).

3.5 Inclusion and Exclusion Criteria

Suitability for inclusion followed usual practice, that is, a clinical judgement was made by the child psychotherapist to determine whether the consultee and the case

they are holding would benefit from psychoanalytic consultation, plus the following inclusion/exclusion criteria in Table.1

Table 1. *Inclusion and Exclusion Criteria for Participants*

Inclusion Criteria
• Participant has engaged in a 1:1 consultation with a child psychotherapist within the last 12 months on a case currently open to CAMHS where the researcher is based.
• The consultation is based around the participants' direct work with an adolescent with a history of IGT – which broadly can be identified as trauma of various kinds in the adolescent's parents and/or grandparent's generation that may be impacting the adolescent's mental health or manifesting in the adolescents presenting difficulties.
• **Exclusion Criteria**
• Participants who are working with families I currently offer psychotherapy for.
• Participants who I currently work closely with.
• Participants who have only had group consultations.

3.6 Sample

Participants were seven experienced mental health professionals working in CAMHS. They represented a mix of front-line NHS professionals within psychiatry, mental health nursing, clinical psychology and CBT. The diversity meant I hoped to gather experiences from multiple perspectives. Participants included six females and one male. Two participants held leadership roles. All participants were white British and ages ranged from mid-twenties to late middle age.

The sample size was intentionally small, in part due to the limitations and time constraints of the CAPPT training I was undertaking, but also importantly, to allow for consideration of the uniqueness and complexity of responses. This sample size follows the guidelines of between 6-13 participants for a Professional Doctorate employing a thematic analysis (Terry, Hayfield, Clarke, and Braun, 2017).

3.7 Data Collection

3.7.1 Semi-Structured Interview Schedule

Semi-structured interviews allowed for an in-depth and creative engagement with a small number of participants. In this way, the 1:1 interviews mirrored the 1:1 consultation experience. Interview questions were designed to explore the psychoanalytic consultation experience and its impact on the consultee, taking into account any changes that consultees might perceive in their practice and in the lives of their adolescent patients. The central aim when structuring the interviews was to create a safe space where the participant could trust, relax and allow their feelings, thoughts, reflections, and representations to emerge. My multiple positions of colleague, researcher and clinician had implications for participants and their freedom (or not) to express themselves during the interview. Thus, careful steps were taken in formulating open-ended questions to ensure they allowed exploration of any challenges, resistance, and/or anxieties, as well as what might be helpful (see Appendix D). I encouraged participants to give their honest opinions, reminding them it was not the individual consultant under review, but rather the consultation pathway as a whole.

As participants were consulting to a trauma service, the interviewing process was cognisant of trauma-informed practice, e.g., being guided by the participant, attuning to the “temperature and distance” of the conversation (Meltzer, 1976), and offering space for misunderstandings or concerns to be considered. I felt it was vital to allow participants to speak freely with minimal interruption from myself when discussing sensitive experiences. I demonstrated my genuine interest by attentive listening, keeping questions open, and allowing different tangents to be explored.

Immediately after the interviews, I made detailed notes of the experience paying particular attention to the emotional texture and responses of both researcher and participant. These countertransference experiences were discussed in supervision.

3.7.2 Conducting the Interviews

Out of seven interviews, five took place in the CAMHS clinic whilst the remaining two were held online at the clinicians' request. All interviews were audio recorded and lasted between 42-76 minutes. All participants were conversational and their stories unfolded in an emotionally live way. Participants used a rich array of metaphors suggesting they were able to think and symbolically represent their experiences, as fundamental to in-depth qualitative interviews as symbolisation is rooted in experience (Froggett and Briggs, 2012).

I held in mind the defences and tensions in play between the participant and myself during the interviews (Hollway and Jefferson, 2013; Tietel, 2000). Tietel argues that the meaning in the interview situation is not only created in the concrete/manifest relationship between the researcher and the interviewee, but is also present in the hidden, unconscious tension within the “inter-relational space”. I offer a brief example: I noted how I felt awkward and in a position of ‘not knowing’ when one participant adopted an uncomfortable amount of jargon belonging their professional discipline. Later, they see-sawed adopting psychoanalytic ‘jargon’ and I sensed *their* discomfort in ‘not knowing’. I considered whether my researcher position may have created a power imbalance, along with the difficulties of working with the unknown in psychoanalytic consultation. Acknowledging the dynamics respectfully enabled us to continue the interview with empathy. By following the tangent the participant took, latent anxieties and inter-relational tensions around the consultant being perceived

as the ‘all-knowing one’ surfaced. Later, I was able to demonstrate how such tensions offered insight into understanding participants’ experiences of consultation.

At the end of each interview, I asked how participants had found the process. I realised this could lead to important discoveries. One participant disclosed their anxiety about verbalising their work worries fearing that they would feel exposed. This ‘last glimpse’ into the participant's experience illustrated how the interview had played a part in allowing their defences to loosen to share a professional vulnerability. They could leave with me a powerful message about how difficult it was to feel safe about being uncertain in their role.

I completed all interviews with a verbal debriefing to participants, which was also offered in writing (Appendix E). The emotional engagement during interviews was impactful. I became really interested in the third position, which initially came from rich participant data about how much they valued the ‘outsider perspective’, and this transferred into my clinical thinking and practice as well.

Interviews that occurred face-to-face were bound to hold a different quality compared to the interviews offered online. The bodily communications and sensations that one usually attunes to can be missed, reducing the sense of containment for participants. Overall, I did not feel the conversations online were any less meaningful, and in fact, virtual interviews could be advantageous in terms of offering a layer of ‘distance’ from which to explore more negative dynamics.

All audio recordings were sent for external transcription. Once completed, I read the verbatim transcriptions while listening to the recordings to check for accuracy. I then read them repeatedly for familiarisation. During this process, I made notes of my initial thoughts and countertransference, thus applying a psychoanalytic lens.

3.8 Data Analysis

3.8.1 Rationale for Reflexive Thematic Analysis (RTA)

RTA was chosen as the most appropriate method to analyse data due to my research questions being exploratory (surface/semantic) and explanatory (deep/latent) and to consider my subjectivity. RTA takes account of researcher 'reflexivity' without losing analytical rigour (Morrow, 2005). This was a crucial choice in selecting the method due to the practice-nearness of my research. RTA focuses on reflexivity providing a foundation for exploring subjectivity as an integral part of the research process, adding richness and depth rather than being confounding (Braun and Clarke, 2022a). Braun and Clarke hold that "themes cannot exist separately from the researcher" (2021, p.3), in other words, the researcher's self is regarded as a significant scientific tool, also reflecting the critical realist position.

RTA offers a systematic and flexible method for identifying patterns of meanings across a dataset, for analysing themes and the relationships between them. Consistent with my psychoanalytic orientation, RTA provides "a method which works both to reflect reality and to unpick or unravel the surface of 'reality" (Braun and Clarke, 2006, p.81), which seemed best suited to answering my research questions.

I have approached the analysis by blending inductive and deductive "orientations" (Braun and Clarke, 2022a, p.9). This abductive method requires theories to be held 'lightly', "ready to discard them when they are in danger of becoming rigid and reified" (Reason and Marshall, 2001, p.417). This approach is demonstrated across the five themes identified in the analysis that 'give voice' to staff experiences with insights that follow about the impact of consultation.

3.8.2 Data Analysis Process

To analyse the interview data, I conducted a RTA defined by Braun and Clarke as a recursive six-phase process (2022a). They emphasise that “creativity is central to the process, within a framework of rigour” (Braun and Clarke, 2022b, p.9). With this in mind, I will now illustrate how I engaged systematically with each phase in Table 3.

Table 3: *Illustrates the six-phase RTA process undertaken in this study*

Phase 1. Familiarisation of the data	After removing any participant identifying material to protect confidentiality, I began familiarising myself with the data by listening to, reading and re-reading the interview transcripts. These repeated passes allowed me process the material several different times and in different ways. Thus, becoming deeply immersed in the data. I made notes in the margin on each participant's transcript relating to:- any transference and countertransference responses relating to the interview dynamics, any ideas that emerged from the participants’ responses in relation to research topic and my ‘free association’ thoughts in connection with what participants expressed. See extract below taken from my notes during familiarisation: *I think they are put in touch with worry, feeling in bits – her communication reflects something a bit more fragmented? What’s unsettled her? What is she in touch with? Have I unwittingly put her in an expert position with the question ‘it sounds like you’ve had a lot of experience’, has this created some concern? She then refers to alien language – does the psychoanalytic approach give rise to primitive anxieties around not knowing (previous links to what she called the outsider eye – who’s on the outside is shifting).* During this phase, I applied brainstorming to extracts of data that could have multiple meanings to ensure that I did not impose my preconceptions. I also highlighted any specific phrasing that struck me as potentially significant. Finally, I reflected on each participant's dataset as a whole noting any links between consultation and IGT.

Phase 5. Refining, defining and naming themes	Over time, names given to themes were continually refined and assessed for best 'fit' in terms of their contribution to the analytic narrative, for example, in discussion with my doctorate supervisor 'capabilities and capacities' was re-named to 'who's the expert' as we agreed this was interpretative of the tensions grounded within the data. I continued to refine the thematic map which over time I further refined into 5 themes and 6 subthemes (see Findings; final thematic map).
Phase 6. Finalising the analysis (writing up)	In developing the thesis narrative, I continuously compared this to the codes and re-read the interviews to ensure they were fresh in my mind so that my analysis was representative of the participants' narratives, including example quotations for each theme and each subtheme.
Generating initial themes	dataset then formed themes. This was achieved by inputting all 1,509 initial codes onto a spreadsheet and organising them into broad topics within the data e.g. 'views and perceptions of consultations'. Codes were honed down by merging duplicate or similar codes then grouped together into 10 preliminary themes.
Phase 4. Developing and reviewing themes	The themes were reviewed to ensure that the developing themes fitted with the coded extracts and full dataset. I arranged developing themes into a thematic map (Appendix G) exploring links and relationships in the data. Taking a critical realist position, I recognised that I could not be removed from the data analysis which inevitably impacted the development of the themes. As a way to triangulate data, themes were discussed in supervision. To avoid an overly fragmented analysis, some themes collapsed into each other, for example, this development involved 'unconscious anxieties and defences' amalgamating with 'psychoanalytic markers'. Over time themes emerged as distinctive from each other, whilst being interrelated in different ways.

In summary, I mainly had empirical themes and subthemes, referring to the experiences, intentions, hopes, concerns, beliefs and feelings captured across the dataset, but I also had some inferential themes – conceptual redescriptions using more abstract language e.g. subtheme three encapsulated ‘Transmission of the Psychoanalytic Approach’.

3.9 Researcher Reflexivity

‘Coming to the table’ was a central metaphor and positional anchor within the design, reflecting my intention to capture clinicians’ experiences within a naturalistic, everyday setting of consultation. At the same time, I was conscious of the need for the careful deliberation of my own subjectivity throughout the methodological approach as a clinician-researcher working inside the service I was studying. I was aware that I was not simply observing consultation from a distance; I was also ‘at the table’ myself, bringing my own clinical identity, assumptions, and emotional responses into the research process. This required ongoing reflexivity about the different positions I occupied and how these may have shaped my role as a researcher.

All participants were known to me, a potential bias, as existing relationships could influence their interview responses, both consciously and unconsciously. The overall feeling was that my colleagues were enthusiastic about my research endeavours as the trainee in the team, whilst paradoxically, the undercurrent of a power struggle was evident during interviews when my research role stirred up competition. During my first interview, I began by being appreciative and welcoming, suggesting we could have a “free-flowing dialogue”. Noting afterward, I repeatedly used the words *“I*

just want to ask". Reflexively, I considered this was an unconscious dynamic as I downplayed my position to make participants feel at ease.

I gave considerable thought to the time taken to undertake the interviews as I was aware of the time pressures in the working day and the staff's heavy workload. This subsequently emerged as tension within consultation. As the time given over was only an hour and participants were keen to engage I viewed this as acceptable. I was open to letting participants choose to attend interviews in person or online.

I continually and actively questioned my own assumptions and ideas about what consultation was throughout the research process. I questioned that I might attach high value and importance to consultation due to my experience within CAMHS and knowledge of the literature which could risk a one-sided analysis, neglecting the negative experiences of consultation. Through my clinical training working with resistance, I learned to value constructive feedback, both positive and negative. This is evidenced in the interviews when all participants expressed strong resistance against the service monitoring consultation outcomes. Although appreciative of consultation, nearly all the participants displayed an aspect of guardedness. No negative outcomes for patients were acknowledged. Froggett and Briggs (2012) describe the importance of undertaking practice-near research as opposed to research undertaken by policymakers and think tanks who are "practice distant". In my study, staff appreciated my closeness to the research, rather than as one participant expressed, "*feeding the organisational machine with outcomes*". The interviewee constructed a dehumanising image for the researcher filling them with unease, making the feelings come alive in the moment that felt shared and 'in touch' with what Cooper calls "the smell of the real". Thus, "practice-near research will bring us close to people in a visceral, bodily, and therefore live emotional way" (Cooper,

2009, p.432). This could be one motivation for staff volunteering to take part in the study. One negative aspect of being close to the participants is that it is hard to remain objective or dispassionate about the subject and boundaries of the researcher's self can become blurred and uncertain (Cooper, 2009).

Supervision as a way of triangulating the data added to the study's rigour. Regular doctoral supervision offered space to reflect more deeply on samples of data, discuss emerging themes, consider countertransference responses, and kept me on track by remaining with the unknown. Hinshelwood (2013) in "Research on the Couch" describes analysis of the countertransference as a means of triangulation, a perspective that resonated with my own process. I frequently brought notes of my countertransference responses arising during interviews and data analysis into supervision as a way of triangulating the data. Through maintaining reflective notes and discussing the development of my findings with my supervisor and colleagues, I was able to examine the extent to which my interpretations were shaped by my clinical experiences and assumptions or grounded in participants' accounts. This reflective work also made me increasingly aware of a parallel process inherent within the research: I found myself actively adopting a 'consultative stance' during the interviews, analysis, and writing-up. This stance involved consciously holding a third position—observing and reflecting from multiple possible perspectives—and it supported me to remain creative and flexible in my thinking. In this way, the consultative stance helped counter the sense of "stuckness" that was evident within the data and literature as a feature of IGT.

Through the process of undertaking this research, I have been struck by the impact that consultation had on the range of clinicians that participated, the curiosity it generated, whilst also being incredibly moving to hear the difficult emotions stirred,

as they navigated extremely challenging trauma work. The collaborative and supportive stance of consultation has enabled us to hear the voices of staff working in these vital frontline services.

3.10 Ethical Approval

I received ethical approval from the Tavistock & Portman NHS Trust Ethics Committee in October 2022 (Appendix F).

3.11 Ethical Considerations

Minimising risk of harm to participants is the most central ethical consideration. CAMHS clinicians/practitioners are engaged in direct work with traumatised families as part of their everyday practice. This means they have an in-depth and rich knowledge of the lives and needs of their patients, however, this can also leave them more susceptible to stress and burnout. There was a potential risk that discussions around trauma could trigger emotional and physical responses in participants.

These factors were taken into ethical consideration when interviewing participants. Before the interview, I provided each clinician/practitioner with a participant information sheet advising them of the risk of distress due to the nature of the subject matter advising them how any distress caused would be responded to and the subsequent support that was in place for them (Appendix B). Furthermore, the CAPPT's clinical training, including intensive personal analysis, prepares them for work with high levels of disturbance in patients and the networks around them. Participants were advised that they could pause the interview or withdraw entirely from the study up to four weeks after their interview took place. No participants withdrew from this study. At the end of each interview, all participants were offered a debriefing. I offered this in the first instance, and should their need arise a debriefing

with a qualified psychotherapist from the specialist Trauma and Resilience Service was available.

Ensuring the confidentiality of the participants and patients discussed was a primary concern. During the interview participants were asked not to use patients' real names or provide identifying information. I ensured that any data to the contrary were redacted from interview transcripts. The data collected (audio recordings and transcripts) was anonymised with an ID number (later replaced by pseudonyms) and stored on an NHS secure network until completion of the project when it will be securely deleted.

To create an optimal environment of safety, participants were reassured of confidentiality and anonymity, and I explained that the interview was a very separate space from the consultations at work. To minimize the impact of the dual nature of my relationship with participants (as a researcher and trainee in placement), I did not interview colleagues with whom I have a close working relationship.

CHAPTER FOUR

Findings

This chapter presents the findings from seven semi-structured interviews exploring CAMHS clinicians' and practitioners' experiences of 1:1 consultation with a child psychotherapist in their work with adolescents impacted by IGT. The analysis followed an in-depth reflexive thematic analysis (RTA) process. Across the full dataset, 1,509 initial codes were generated through close, line-by-line engagement with the transcripts including semantic codes (the literal description of how participants described their experiences of consultation) and latent codes (the underlying meaning of what is being said) (Braun & Clarke, 2006).

Across two iterative coding phases, labels were developed and refined to capture recurring ideas and impacts relevant to the research aim. These codes were then organised into conceptually related clusters within an Excel spreadsheet, allowing similar ideas to be brought together and redundant or overlapping codes to be merged. Following this, initial themes were synthesised and refined to build a coherent account of clinicians' overall experience of psychoanalytic consultation. To reduce overlap and strengthen conceptual clarity, the ten preliminary themes were consolidated into five that most clearly captured participants' experiences, supported by illustrative data extracts. A thematic map was developed to illustrate the five final themes and six subthemes, depicted in Figure 2 below.

Whilst I present the data within distinct themes, this does not diminish the overlapping elements across them; their interconnectedness reflects the complexity of psychoanalytic consultation. Commentary follows each data extract, with interview

quotations in *italics*. Table 2 summarises the types of consultation undertaken, and participants are identified by pseudonyms.

Figure 2: *Final Thematic Map*

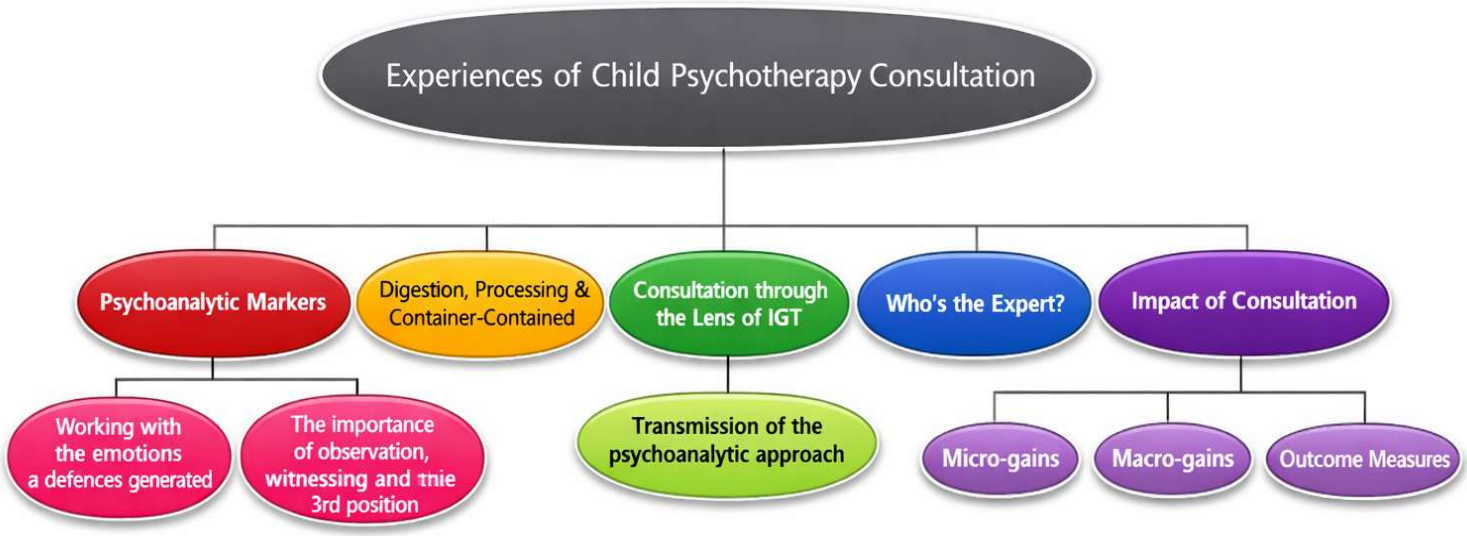


Table 2. *Type of Consultation Participants Engaged in with a CAPPT in the CAMHS MDT*

Participant	**CAMHS Pathway participant works in**	**Types of consultation engaged with a Child & Adolescent Psychoanalytic Psychotherapist (CAPPT)** **In meeting inclusion criteria, all participants had engaged in a 1:1 consultation with a CAPPT*
'Emily'	Psychological Therapies Pathway	• 1:1 consultation with a CAPPT • Network consultation with a CAPPT
'Hazel'	Psychological Therapies Pathway	• 1:1 consultation with a CAPPT • Work discussion group with a CAPPT
'Amy'	Getting Help Pathway	• 1:1 consultation with a CAPPT • Network consultation with a CAPPT
'Susan'	Getting Help Pathway	• 1:1 consultation with a CAPPT • Network consultation with a CAPPT
'Tom'	Getting Advice Pathway (front door)	• 1:1 consultation with a CAPPT • Network consultation with a CAPPT • Regular consultations in schools with a CAPPT
'Jennifer'	Getting Help Pathway	• 1:1 consultation with a CAPPT
'Camilla'	Psychiatry Pathway	• 1:1 consultation with a CAPPT • MDT consultation with a CAPPT

4.1 Theme One

Psychoanalytic Markers

Although none of the participants in the study had been analytically trained, there was evidence of their psychoanalytic thinking and understanding in the interviews, including thoughts about what was unique to child psychotherapy consultation. Participants' frequent use of metaphorical language in relation to psychoanalytic markers lent itself to enabling the researcher to consider the unconscious aspects of the participants' experiences, alongside the more conscious narratives.

Within this theme, I considered two subthemes. To illustrate each subtheme, I applied a participant quote linked directly to the title heading.

4.1.1 Subtheme: Working with the emotions and defences generated:

"Helping me with really uncomfortable and hostile feelings"

Working with emotional responses, at depth, was indicated as a fundamental marker of psychoanalytic consultation. It aims to help consultees think about their emotions, those of others, their reaction to these feelings, and the impact on one another. Helping staff attend to and unpack the uncomfortable emotions engendered through their clinical work supports staff so they do not feel alone or overwhelmed. In turn, this can help with facing work-life realities.

All participants spoke about their emotions and their place in consultations, working with, *"that gut feeling"*, and trying to understand *"something that sits with you"*, or *"where things are coming from"*. Participants also said consultation explored *"what's*

underneath the behaviours" and *"driving the feelings"* of both them and their patients. One participant reflected, *"child psychotherapists pay attention to very heightened emotions"*, and another observed, *"in consultation, people are willing to bring their feelings about a case"*.

Having a consultation enabled participants to think about their emotional experiences with their patients and helped them confront difficulties in day-to-day practice:

> *If things are feeling a little bit, kind of, muddy, just thinking about the emotion that comes into that and maybe bringing how I'm feeling into it more than I would naturally do myself. Consultation's a helpful thing that's made me feel less avoidant of going into the therapy room and dealing with some of the issues.* (Hazel)

Several participants seemed to trust that they could bring honest and unexpected emotional responses to the consultant, enabling them to reflect on negative feelings aroused by their patients:

> *I'd feel confident to say things like feeling 'repulsed' because I know it would be understood.* (Hazel)

Participants expressed appreciation for the steadiness of the consultant and being able to *"book-in a time and space"*. It was also evident that consultants took care when exploring the consultees' emotional responses to the work by shouldering the uncomfortable feelings:

> *The child psychotherapists I know are very approachable. I would book a time and space… I was 'leaning in' a lot more. I really wanted to be talking about something like...I'm really worried about this feeling.* (Emily)

Expanding on this, Emily referred to the importance of boundaries within the consultation where difficult and uncomfortable feelings could be brought to light and reflected upon in a safe environment:

> *You sit there and your kind of like, ah, that could actually be my stuff. So, it's helpful, it's knowing that boundary around consultation and how to use it, in a way. I think that's the hardest task of consultation. Sometimes the uncomfortable feelings might be harder to know more explicitly…I think it allowed me to connect with my emotions more.*

In creating a dynamic space where the consultee's challenging feelings could be safely expressed, consultation could be thought of like the boundary of the patient/therapist relationship. Yet, the *"hardest task"* is the ambiguity and trust within this frame of the professional partnership and the extent to which the participant feels guarded.

When speaking about their direct work with adolescents impacted by IGT, participants were very candid about their emotional responses, described as: *"jumbled, overwhelmed, foggy, repulsed, avoidant, disgruntled, bored, sleepy, bogged-down, drowsy, confused, shook-up, hostile, bizarre, grieving".* These particular types of emotional experiences connected with IGT, were described by five participants as the *"drive"* behind seeking consultation in the first place. Sorting out these reactions helped participants understand and hold all kinds of difficult feelings. For some, the consultation experience felt very accepting of the challenges faced when working with difficult patients:

> *It feels like I've taken a metaphorical jigsaw puzzle to consultation. Gathering all things that might make you feel really uncomfortable, wondering about it*

> *and helping me with really uncomfortable and hostile feelings that came up in the room with the patient. So, what I remember from consultation is, 1) it helped me get back in the therapy room, 2) where those feelings might have come from, but also what the young person is really trying to communicate.* (Emily)

Consultation in this description is not unlike Bion's (1962) beta elements (unprocessed emotions) to be gathered up and thought about. Yet consultation also stirred participants' anxieties in knowing more about their own feelings, particularly when feelings of hate towards a patient arose describing this as *"a taboo topic"*, or *"the fear around my own stuff".* Such thoughts evoked defensive behaviours (e.g., laughter and avoidance of the subject). Working with the emotions came with some risk to participants of feeling exposed, yet it was notable that participants kept going to these emotionally challenging places by actively seeking consultation so that personal and professional advances could be made:

> *It's asking quite probing questions about my reactions and responses to things which is helpful… it hits you, and I was like, okay, where the fuck have I been? That was an interesting moment.* (Amy)

A worthwhile reason for participants relaxing some of their mental defences was in the service of realisation and learning how one's own experience can colour decision-making if not brought into awareness:

> *Having consultation as a practitioner helps you to understand your journey and where your experiences are as they may drive some of your decision-making.* (Tom)

Some participants identified that working with the emotional dynamics evoked in work/life was unique to child psychotherapy consultation:

> *It was a really interesting reaction to feel 'oh yes, that's why that's bothering me', or 'that's where that's rooted from.' Which I've probably never quite experienced in other kinds of supervision. Consultation is a bit more emotional. I remember really feeling some things.* (Amy)

An important experience reported in all interviews was that working through the feelings helped to move things on for the patient as well as helping the participant in ongoing clinical practice:

> *Paying more attention to not just what's happening in the room but how I'm feeling in that space often gets asked in consultations. So, I'm more conscious and aware of that, both in practice and in my own life if something doesn't sit quite right.* (Emily)

The idea of participants actively bringing their emotions into consideration within their work and personal lives suggested shoots of internalisation; growth of a consultative state of mind. This could speak to the effectiveness of consultation enhancing professional and personal development.

Finally, one participant reflected on how valuable it is to have child psychotherapists in the MDT:

> *Consultation helped the MDT take a direction that's much more compassionate I would say. And more thoughtful. It helps us to imagine how things would be for the child and family putting ourselves in their shoes. There's definitely a sense of team working, and I think it feels a very nice safe space too.* (Camilla)

In the interviews, it became apparent that consultation can reach beyond the individual consultee. Professionals may feel contained enough to take down some of their defences to explore their emotional responses within the MDT. A sign of a healthy team that then impacts upon what they can provide to their patients.

4.1.2 Subtheme: The importance of observation, witnessing, and the third position

"Looking beyond the presenting symptoms"

To think psychoanalytically is to develop the ability to observe and listen with the "third ear" (Aragno, 2011). Emily described *"needing that outsider eye",* whilst Tom viewed triangular space as the *"purpose of consultation".*

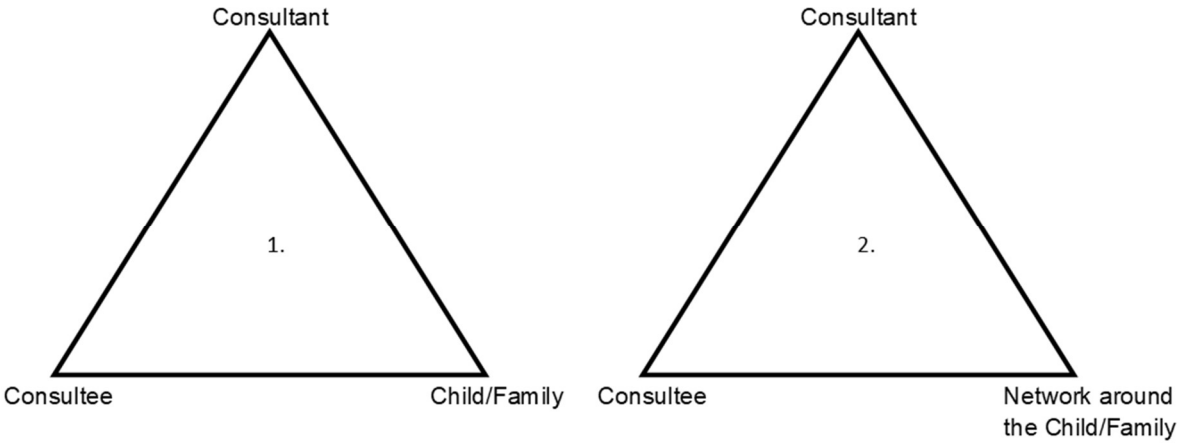
All participants described their need for a *"different perspective"* motivating them to seek consultation when working with their complex cases:

> *Sometimes you can't see the wood for the trees can you? It's something so simple. Somebody else with another set of eyes, another set of ears looking at it.* (Susan)

This same metaphor, used by Tom and Jennifer, captured the need for a third position (to have a more objective view) because they could not see the whole situation for the family clearly being too closely involved in the case, or *"in the thick of it"*. Four participants spoke of the third position as helping to identify their own *"blind spots"*. Tom described the value of having a wider view *"beyond the presenting symptoms"*.

The value of working within a ‘therapeutic triangle’ was evident and this took shape in two ways as depicted in Figure 3 below.

Figure 3. *The therapeutic triangle in consultation depicted in two different ways*



Triangle 1: The consultant does not meet directly with the child and family themselves, the consultee does the direct work but the child/family are present in the triangular relationship as they are held in mind by the consultant and the consultee. Therefore, the consultative stance is observational, outside of the direct relationship between consultee-child/family relationship; a third position.

Triangle 2: In network consultation the consultant typically attends the meeting with professionals (e.g. Emanuel, 2002; Sprince, 2002). The consultant may also consider network dynamics in 1:1 consultations with the consultee from the same third position as in triangle 1.

In the first triangle, Susan and Jennifer felt that seeking a third position was ultimately in the best interests of the child:

> *It gives a broader view on things, doesn’t it? At the end of the day, you want to do right by that child.* (Susan)

Tom said that consultation prevented families from feeling *“over-assessed”* or *“processed”* by allowing a space to observe, listen, talk, and *“get things out there”* in the open when held within the boundary of the triangular space. On a personal level Tom felt more grounded in reality, with his *“feet back on the floor”* when facing unbearable amounts of pressure to *“fix things”* for the patient.

In the second triangle, Camilla talked about the value of the third position when considering unconscious processes in the network:

> *We're not conscious of what's happening sometimes, and the system isn't conscious, and it needs somebody on the outside to analyse that. Child psychotherapy consultations have helped me to reflect on what's going on because everybody just carries on acting out… we're all running around like idiots. Nobody's directing this show. It's playing out on living bodies. I've gone to a child psychotherapist about it before.*

The need for the third position cannot be underestimated, particularly when the disturbance can be acted out in the network and where the issues are linked to IGT. It's like something has possessed the system, an idea that connects to the symbolism of haunting apparent in the literature. Furthermore, the embodied nature of consultation in relation to thinking about trauma came across in the powerful language of Camilla, describing *"living bodies"*. This may capture the physical presence needed in consultation with people who are willing to be together in a room to think with time, care, and attention, in creating a holding environment.

The ability to tolerate uncertainty came across as important to holding the third position:

> *We have to be mindful of not falling into this trap of assuming we know about something. I think you have to be open, don't you, to think about things from a different perspective?* (Jennifer)

Susan appreciated that challenging the consultees takes courage from the consultant:

> *Covering some of the negative things makes you look at things differently… that's what you need to tackle.*

Triangulation had potential for *"professionally reassuring"* the participant and most participants believed what was often needed was a space to check out their thinking with an interested, concerned other, before undertaking direct work with the adolescent. Yet triangulation also had the propensity for disturbing participants with a new approach:

> *On the flipside, one of the difficulties could be that you (consultee) could get easily overwhelmed.* (Jennifer)

This resonated with Susan's first experience of consultation, something of a culture shock:

> *They [consultant] said, 'bring a case and talk about the case.' At first you were sitting and thinking… 'what the shitting hell? I've got better things to be doing with my time than sat here…' It wasn't until they started to look at things differently and I thought I'm missing something, I don't want to miss this.*

The frustration in Susan's first responses to consultation can be heard, yet within the triangular space she began to realise the value of seeing things from a different perspective:

> *Sometimes you don't always get what you think you're going to get back, you get something different. Maybe it's not what you thought, and you might be disappointed, but you get over that. You get something more than you were expecting and you think… Wow, that already worked for that; it works for that patient as well… I've wanted to do more, you think… This is working.*

The participant gains something of value from the different perspectives. The request for a consultation required trust in the consultant, and it seemed that consultation was viewed more positively when consultees knew the consultants (and their approach) well. Susan had engaged with consultation since the birth of the provision… *"since day dot"*, and all participants worked closely with consultants in other day-to-day practices.

Several participants in this study described the third position in a positive light, such as *"shining a light on a problem"* and offering a *"lightbulb moment"*. Whilst some participants felt under the *"spotlight"* or *"microscope"* in terms of their own practice *"blind spots"* and emotional responses.

To summarise the impact of this sub-theme, Emily described how the third position enlightened thinking and helped them manage intense emotional encounters when *"embodied in the work"* with the patient.

4.2 Theme Two

Digestion, Processing and 'Container-Contained'

Participants' experiences of consultation seemed closely aligned with Bion's (1962) theory of containment and the idea of time needed to 'metabolise' trauma. These concepts were considered a nourishing process in child psychotherapy consultation and a shaping experience by all participants' accounts. The need for containment was further linked with reasons for seeking consultation, e.g., to help with digestion around stuck cases and a place to process trauma to think about it in a more bearable way. The recurrent metaphor used by participants describing consultation was *"slowing things down",* placing value on the importance of time to allow a

process of thinking. Whilst this seems a simple notion, what unfolded was an amazing unpacking of experience:

> *Consultation helps slow down my thinking because I do think a million miles a second all the time. It felt quite a containing and protective space to really communicate the initial feelings I was having. It helped slow me down to see a different way.* (Emily)

The opportunity for processing emotional experiences was bound with a need to slow things down in the digestive process, linked to needing time to *"unpick"* cases of a troubling or perplexing nature. This built-up to acknowledging that staff need containing too:

> *I just needed a wondering, an unpicking, and a slowing down. Consultation is kind of like you're giving yourself permission to slow stuff down, it makes you think. It takes a lot of energy as well, so it's actually quite hard work to have consultation for a new case and thinking it through. So, I think that's some of the challenges when you're busy and working in chaos.* (Emily)

Unpicking a case appeared related to the need to pull apart and examine complexity in detail to gather understanding of the patient's life. The nature of unpicking also gave insight into the difficulties of thinking, where thoughts can feel tangled or constipated when working in busy, emotional climates like CAMHS. Cases people may feel stuck with were identified by five participants as the type of cases taken for consultation, suggesting a blockage in the thinking process and a need to get the digestive process moving, *"to help unstick it"*. Words such as *"unpicking"* and *"scratching beneath the surface"* also conjured associations to something unpleasant, a possible unconscious anxiety that a psychoanalytic process can leave

the consultee skinless or defenceless. The clear feedback, however, was that's not what happens, as all participants described consultation as a vital space for thinking.

Another important element of *"slowing down"* was the capacity to resist premature action. This was expressed as *"putting the brakes on"* and *"taking a step back"*, *"taking their foot off the gas"* and *"not just ploughing on"*. Furthermore, Tom linked slowing down with the reality of change requiring time:

> *I took away from the psychotherapists that change takes longer, and over a longer time, this can be more effective, so let's slow things down. You're not going to get an instant fix through consultation but something sustainable. Over a number of weeks, you might start to see change, it starts to become embedded, you see some resilience.*

Two participants described the cases taken for consultation as *"heavy"* and *"high risk"*. One participant imagined taking *"a bag of shit"* to consultation, which emphasised the mess and disturbance they carried. Emily's jigsaw metaphor was used to describe the fragmented picture of IGT. The sheer gravity of overwhelming fragmentation, mess and confusion of the clinicians/practitioners was expressed as the catalyst for seeking consultation by all participants:

> *It feels like I've brought a jigsaw puzzle to the consultation and I haven't got a clue what piece is missing. Some of the cases that I'm requesting for consultation, it's just so jumbled... I don't even know what the image is. I don't even know what the picture is. I don't even know if I've got all the pieces. Then, consultation just helps me sort it, and especially for those that are so jumbled, it just helps contain that.* (Emily)

Participants brought alive the internal experience of needing to process and metabolise aspects of trauma which felt entirely jumbled within themselves, as a projection of their patients' difficulties. Consultation was expressed as great value in the management of complex IGT cases.

Alongside the digestion process seemed to be a parallel need for containment to *"put a lid on things"* between consultations keeping thoughts and thinking safe and tolerable, returning to them at a later date.

Practitioners' rich and detailed expressions evidenced trust in the containment process, a core function of consultation which helped prevent burnout. The containing effect was not just about the consultant thinking about the practitioner's case, it worked much deeper than that as practitioners became really engaged and interested, *"figuring things out together"* along with *"real team working"*, allowing a shared experience:

> *To sit down with professionals in that consultation, that is the most valuable time you could ever have.* (Susan)

The containing effect was also evident within the network:

> *Consultation slows the team down and gets them thinking. It means that we're not just charging along and coming up with plans and things, it opens up a more reflective space in the team generally I would say… So yeah, child psychotherapists kind of steady the ship in a major way.* (Camilla)

Consultation was not only about bringing the network together; the depth was in the engagement and reflections of others because they were emotionally contained by the consultant who acts as the container for the network's projections, as Camilla

aptly described the steadiness offered by the consultant. The data also evidenced participants mirroring of the process of containment with families:

> *What some of these families need is just to offload to somebody, and they don't necessarily always need you to do anything. Just listen and perhaps do some reflecting with them.* (Jennifer)

There was a process of digestion in consultation that felt nourishing, associated with an *"appetite"* for consultation amongst participants and a sense of gratitude. Hazel expressed, *"I'll bring a case!"* Susan valued the joint endeavour of *"bouncing ideas off people"*. Consultation even sparked a love for the work, *"like a fire in your belly"*, expressing the participant's appetite to learn, be challenged and develop. Susan further described *"feeling satisfied"* following consultation, referring to consultation as a nourishing process. The sense of mutual desire to untangle, identify and develop better ways of working with complex patients, whilst supporting clinicians in this endeavour, can benefit both the team and work with families:

> *When I have been very stressed or anxious about a case, consultation probably has made me feel a bit more contained, and more settled, which would have been directly reflected through my work. I think that's been the main bit that jumps into my mind.* (Hazel)

These poignant developments are considered within a backdrop of organisational pressure where emotional containment for staff was felt to be inadequate:

> *Consultation is very helpful for the MDT. I wouldn't ever want those clinical consultations to get spoiled by some kind of organisational feeding the machine process, which can happen with outcome measures.* (Camilla)

The metaphor *“feeding the organisational machine”* evokes a ruthless taking-in and expelling of results, the polar opposite of the time needed to metabolise the families' circumstances and needs. This may present a paradox for the clinician when considering the positive impact of consultation.

There was ample evidence of participants bringing their professional curiosity to consultations. Emily said consultation was *“not a dumping ground”*, indicating there is much more to the process than simply offloading. Rather, she described consultation as *“being alive in a therapeutic space”*, where she could connect with her resources, emotions, knowledge, and thoughts in *“partnership”* with the consultant. As reflection started to *“become the norm”* (Jennifer), improvements were made in participants’ ability to interact with their patients and offer containment and understanding to their colleagues (perhaps acting in the third position for each other). Duly noted was the **relationship over time** for this to happen, circling back to the need to *“slow things down”*. This speaks directly to the necessity of considering time in IGT, which leads into the next theme.

4.3 Theme Three

Consultation Through the Lens of IGT

Six participants gave case-specific examples of IGT discussing issues such as sexual abuse, racism, child sexual exploitation, domestic violence and neglect. Hazel recognised the consultant’s interest in *“what gets passed on generationally”*. Several participants held the opinion that the impact of the past matters:

> *You wonder about history repeating itself and are worrying about that. That’s not something that you would take to the client. I probably would take that to consultation.* (Emily)

Participants wanted to grab the researcher's attention immediately in relation to trauma. Within the first few minutes of the interview, Camilla spelled out the problem:

> *Consultations, they're about trauma.*

Emily began by describing trauma work as her *"bread and butter"* indicating how steeped she was in the work. Both examples communicated a fundamental need to think about trauma in consultations. The consultant was seen to work in a way that allowed this to take place, withstanding the experience of hearing some of the *"terrible things"* that had happened to the adolescent or family. Consultation involved thinking about where trauma gets located and where trauma is held.

Trauma located in the clinician

When working with IGT described as *"a whole line of trauma"*, disturbance appeared heavily located in the clinician:

> *The history of the parent and that young person's experience of the parent was coming into the room, and maybe those alien feelings associated with that… It (consultation) made me realise how much of an impact a parent's presence has and the layers of difficulties and how they feed into sessions. It was like… something has happened to her, but it might have been…. something has not happened to her. Or… Something has happened to someone.* (Emily)

In this layered description, the participant appeared to be describing a feeling of being projected into by the child getting rid of the traumatic experiences. These were picked up by the clinician. This gave rise to "alien" feelings that captured the complexity of not knowing where such feelings came from, bringing alive the disturbance located within the clinician. Picking up the trauma in this way was very

difficult for participants, where consultation was vital in *"disentangling"* and *"unpicking"* the *"frightening experience with a young person".* Emily went on to say:

> *I needed a space to really think it through and really understand the processes of why that had happened.*

Understanding why patients projected their difficult feelings into them helped clinicians/practitioners to recognise the relational complexities of IGT and to empathise with their patients' suffering:

> *You would take cases to consultation, and it would make you realise just how complex everything was... a lot of these parents who have had their children very young, their relationships are not very healthy. They may have had difficulties with their parents, who then also may have had difficulties with their parents - we can see that coming back.* (Amy)

The data highlights the difficulty in distinguishing the ownership of feelings. Do they belong to the patient, parent, or clinician? This could lead to the clinician identifying with the patient/parent resulting in defensive responses. Furthermore, participants described the feeling of being left with the trauma, evoking a strong sense of fear within them when there was nowhere for the feelings to go:

> *Trauma work is hard. It's hard for the young people and their families that we're working with, but it's bloody hard for the therapist, going from one to another. Yes. They talk about 'vicarious trauma', don't they? I think sometimes NHS trusts know that, but what meaning do they give to that?* (Susan)

This resonated with another participant struggling with the intensity of working with trauma day-in and day-out:

> *It's only this week I think I said, 'I'm all trauma' d out today'… We can go 'boom, boom, boom' with sessions and not give ourselves permission to reflect before going on to the next client. So, it makes me quite angry in that sense. It's like, 'How do we leave stuff at work?' The feelings I have, that's the stuff that follows me home.* (Emily)

These excerpts demonstrated how burdensome secondary trauma can feel when there's nowhere for it to be processed, other than following the participant home. This echoes the literature on IGT linking to the symbolism of ghosts. In quiet desperation Hazel said:

> *Can someone else hear some of this stuff that I'm dealing with? You need a place to put that.*

Consultation provided a place for these feelings to go and provided a *"shared responsibility"* so clinicians would not feel they were *"managing alone"*:

> *Without doing the trauma training and taking it to consultation to develop and explore it, I wouldn't be here today doing what I'm doing with young people.* (Susan)

Tom also felt *"very empowered to carry on"*. Regular consultation helped the practitioner to survive the trauma with the child.

Interview material suggested that consultation involves certain psychoanalytic processes that are pertinent to helping the clinician when feelings of trauma are felt to be located in themselves. This included the two previously identified psychoanalytic markers in Theme One plus enabling the participants' capacity to hold and contain projections whilst considering the impact of secondary trauma.

Trauma located in the child

Several participants explicitly noted that one of the problems in CAMHS is that services are set up to treat the individual child, without considering wider difficulties within the family. Consultations offered a particular space to consider links to the child's environment and developmental history, but this was not always welcomed by families. Three participants felt anxious about reopening old wounds and *"re-traumatising"* families by gathering historical context directly. On the other hand, consultations were viewed as *"non-blaming"* and encouraged thinking about the child within their environment rather than focusing on the child in isolation.

One participant described a clinical dilemma about whether to treat the child or engage with the wider network, worrying that the work would *"spiral out of control"* beyond what was manageable for the practitioner and the team:

> *People locate the problem, don't they, inside a child often? And that feels more tolerable, for some of these families. And I think as I've grown in experience, and through consultations, I feel better able to have those discussions, but it feels uncomfortable.* (Jennifer)

Consultation gave participants a sense of agency to think about trauma with families, to have difficult conversations and not necessarily just agree with a push for actions. Consultation was viewed as bringing the emotional experience of the child to life and was seen from an ethical standpoint as *"you want to do right by the child"*, which Susan felt was at the heart of seeking consultation.

Tom valued exploring family histories when given a consultation framework to hang this on:

> *I enjoyed looking at the historic stuff, building up that kind of framework. I like the nuts and bolts of how it all fits together, seeing how it all shapes.*

This idea of fitting things together in consultation was not unlike Emily's jigsaw metaphor, perhaps symbolizing something equating to a *"whole experience"* in consultation. In other words, the complex interplay between the internal world and the real difficulties presented required the consultant and consultee to bring together a picture of the child's whole situation. This was seen as unique to child psychotherapy consultation:

> *You don't just work with an individual child, you also focus on the wider family and context. That's missing, isn't it in other trainings? I think child psychotherapists tell an aspect of their whole experience really. Making all those links stands in the work of child psychotherapists.* (Camilla)

<u>Holding trauma in the consultation</u>

The central tenet all participants conveyed was the importance of listening, observing, and witnessing patients' stories which stayed close to feelings. The participants' developing capacity to explore difficult emotional responses during consultations allowed them to stay in touch with the complexities of IGT:

> *By doing consultation I've learnt to really involve families in more reflective discussions like, 'I noticed this', or 'When we had our last appointment you mentioned'… 'I wonder if you could tell me a bit more about that?' Inviting people to share their views about what might be.* (Jennifer)

Hearing the families' stories and finding a way to put words to traumatic experience was profoundly important. All participants repeatedly commented on the need for

"thought over action" and speaks to the work of Fraiberg bringing to bear the painful truths with families.

Jennifer reflected on how *"trauma shouldn't be the elephant in the room"*, speaking about *"courageous conversations"* with families following a consultation. Working with IGT, rather than disavowing it, also brought radical changes to services such as the implementation of 'Me and My Brain Group', a trauma stabilisation project for adolescents:

> *The specialist trauma consultations we've had have continued through putting the 'Me and My Brain Group' together. This stemmed from doing training and consultations, to working individually with young people, then putting it together as a group. We've adapted the adult trauma stabilisation model for young people. Working on consultation is the best thing that can happen for networking and pulling things together.* (Susan)

4.3.1 Subtheme: Transmission of the psychoanalytic approach

"It's a kind of modelling thing"

This subtheme considered how positive aspects of psychoanalytic consultation get transmitted inter-relationally from consultant to consultee then from consultee into direct work with the families. This process (extrapolated from participants' interviews) may have significant implications for demonstrating the effectiveness of psychoanalytic consultation as an opportunity to break a negative cycle of IGT.

Hazel described, *"something gets translated through the work"*. There is a *"shift"* for the patient and something *"unsticks"* in the clinical work:

> *What I've learned from exposure to child psychotherapy informs what I might say to other clinicians and supervisees, and how I might formulate with those families as well. It's a kind of modelling thing.* (Camilla)

Participants spoke of *"sticking with it"* in their work with families, modelling what the consultant did for them during the consultation process. Several participants noted an internal process of change within themselves, passing their skills down when working with families:

> *Sometimes you would get resistance from families who've not talked or opened up before, they can be quite sceptical. Your skills as a practitioner change and your language changes and your questions change to get a response from that family.* (Jennifer)

Consultation, as a containing space for participants, appeared mirrored in the clinicians' practice:

> *She [patient] has experienced trauma, but she doesn't know the extent of her mum's trauma. Consultation helped me to hold in mind a space for that stuff that I can't bring into the room. I know that information, but the young person doesn't. I cannot bring it into the room, but I can kind of work it through.* (Emily)

The consultant's capacity to hold the families' experiences could be seen as transformational to some clinicians in their development.

4.4 Theme Four

Who's the Expert?

This theme sets out the various tensions of consultation as perceived by participants these were:

- Expert versus Collaboration
- Threat versus Help
- No Answers versus Solutions
- Task versus Processing
- Idealisation versus Denigration
- Reflective Function versus Clinician Under Fire

The headline finding was the participants' pervading sense of anxiety about who held the expertise in consultations. Participants predominately placed the consultant in the expert position, although this was not a fixed view as it fluctuated during interviews. For example, one participant used psychoanalytic terms and then expressed psychoanalytic jargon as a barrier to thinking. This demonstrated the rivalry that the consultant's expertise might stir up.

Most frequently noted was the participants' need for the CAPPT's specialist knowledge in cases of IGT:

> *You're needing that outsider eye, you're needing expertise in that.* (Emily)

> *We should make use of our child psychotherapy expertise to look at what's going on under the surface.* (Camilla)

The kinds of expertise some participants needed from the CAPPT was linked to the psychoanalytic markers in Theme One and seemed to instil a sense of confidence and validity in coming to consultation. However, there were quite contrasting responses such as idealisation of the consultant, feeling the child psychotherapist was *"powerful"* and *"golden"*. Some seemed to feel stripped of their own expertise and professional capabilities:

> *I'd walk away and think, 'God, yes.' I find [consultant] really powerful, really good, really helpful. Then I look and I think, I wish I could do that.* (Susan)

The consultant was most often idealised in the context of discussing network power dynamics, in which case the consultant was viewed as superior, having *"more weighting".*

There were complex differences in how the various anxieties around who's the expert were communicated. Some participants were direct about their worries whilst others were more subtle when projective processes seemed at play. For instance, I faced great discomfort about using the word 'expert' in the theme title, wanting to create a level playing field by re-naming the theme 'Capabilities and Capacities'. Yet, 'Expertise' spoke volumes to the tensions and dynamics that were absolutely grounded in the data.

Consultation on the whole was seen as collaborative, with both parties as experts in their own experiences and disciplines:

> *Coming from nursing, I would come at it from a mental health approach, but you've got to walk it and talk it together. Combining that and blending it together.* (Susan)

> *The ones that I have taken for consultation, it has contained me. Not contained me in, I needed containing but to contain the unknown stuff. It doesn't stop me from going down the rabbit hole of wondering, but consultation gives me a framework to wonder with, if that makes sense.* (Emily)

Findings suggested the consultant must keep in mind that the consultee may feel ambivalent about the consultant's position and their own, and defences against anxiety may underpin the contrasting perceptions around 'who's the expert'. Whilst participants may wish to explore their work from a psychoanalytic perspective, they did not want to get too lost or caught up in it. Consultees still needed to maintain their professional identity otherwise they may feel too threatened, eliciting reluctance about the consultation process:

> *The difficulties we have in our team is that there are often lots of opportunities for consultation, and the approach would be very different then people become conflicted in their own mind.* (Jennifer)

One participant's expectations of consultation were likened to personal therapy, evoking the feeling of being personally scrutinised:

> *Sometimes, I have experiences of having consultation where it almost feels like I'm being therapized.* (Amy)

When the who's the expert dynamic was in play, participants' expectations of consultation could be negatively impacted by unconscious stereotypes of

psychoanalysis which stirred an anxiety of being looked right into, or fear of getting caught up in some bizarre, alien notions. These tensions could potentially make it difficult for the consultant to stand up for the uniqueness of the approach provided (like I found in wanting to take the edge off the word ‘expert’ as discussed).

Amy conveyed that the best outcome of consultation was for the consultant to take on the case for therapy:

> *I might bring a case to consultation because I want someone to do something. Sometimes, if someone will say, ’Actually, we can do some therapy with this young person’. That's probably the best-case scenario. Sometimes, it's practical, actual help that I'm looking for, to release some of that caseload.*

At times, consultees wished to divest themselves of their own responsibility by getting rid of their workload rather than thinking together. The tension was owing to time constraints. To talk about a patient that people are struggling with takes time away from a busy clinic whilst exposing themselves to areas of difficulty, frustration, and no perceived solutions:

> *In the past, it felt like all anyone was doing was consultation, and it felt a little bit like you were holding all these cases. I was getting four, even five new cases a week and it was like, ‘Oh, well, we can give you consultation’. I'm like, ‘But no, I can't keep the case’. I don't want to be consulted through working this case. I want this case to go somewhere.* (Amy)

Whilst consultation was also experienced as time well-invested:

> *I’ve got a problem in my mind that I want some help with… and I’ve really valued that time to kind of think with people about a case.* (Hazel)

Tensions around time also connected to anxieties around NHS resources and service constraints. Time needed for processing during consultation led to many mixed feelings and could be judged by some colleagues as a less effective use of clinical time. Whilst the experience was perceived as something "*worth protecting"* (Camilla), there was also an attack on it with an important question raised about: Does consultation really make a difference anyway?

> *One of the downfalls of a consultation model is that we could forever wonder, but what tangibly changes for that family?* (Jennifer)

> *Some people will comment, bloody going to talk to them about it, what good is that?* (Susan)

This powerful idea of what good is consultation if it doesn't give answers or doesn't let staff discharge somebody was a repeated tension within participants' experiences.

<u>There's no quick fix</u>

There was a clear perception from all participants that consultations do not provide answers:

> *With a consultation it's that wondering and leaning. It didn't give me an answer, but it did give me an answer in the sense it shifted something.* (Emily)

Rather than having answers, clinicians/practitioners had a sense of accessing something deeply meaningful by connecting with their own feelings in turn, helping to create meaningful shifts for their patients. Yet, several participants demonstrated how hard thinking about IGT can be when the clinician felt under fire, needing to

move through cases quickly due to service pressures and a massive need for diagnosis, clarity and answers:

> *Sometimes I think that what families want is to bring their child to us, we therapize them an hour a week every week, and they take them away completely fixed. It can be quite shocking to families when we start to formulate a trauma-type presentation and start thinking about the family and what their needs are, and that's difficult for professionals to manage because it stops being treating one person and becomes this huge network of people that are really dysregulated.* (Jennifer)

Offering consultation around trauma provoked high levels of anxiety for clinicians/practitioners, suggesting it creates a lot of mess and more disturbance rather than getting on with the task. Wanting answers from the doctor appeared a defence against the reality of pain and struggle in thinking about IGT:

> *Really honestly there are occasions in MDT's where they want somebody to have medication rather than think about the case.* (Camilla)

In circumstances of IGT it was really difficult for participants to claim a reflective and thinking space in their work with one of the participants needing to give themselves *"permission to think"*. Consultation was perceived as a *"luxury"*, even though many felt it was in *"the best interests of the child"*:

> *I feel like going for consultation would get frowned on because it would be like, 'Well, you could see clients in that time' and feeling like it's a secret operation sometimes when we're booking in. I'm like, 'Should I put it in my electronic diary where everyone can see?' 'Oh, I'm just nipping out to have a*

> *chat about a case'. It's like a closet operation sometimes (Laughter), but it shouldn't be like that.* (Emily)

Consultation was most subject to denigration when related to time pressures and service priorities around discharging patients. One participant said*, "they got more than they bargained for"* from consultation where thinking implicitly became an action that felt impossible to do without space to unpack and think. The undercurrent of anxiety, illuminated by going for consultation in secrecy, seemed not only fuelled by time constraints and the worry of offering too much, it mirrored the secrecy and shame felt by the families.

All participants conveyed an undeniable tension between processing and task. The task cannot be achieved without processing, and staying in process too long impedes the task:

> *I think psychoanalytic consultation helps with a more long-term approach to treatment. You know treatment's gonna take time and it's a process. And it could take a long while, but then I know that can cause some difficulty in the sense that it's well, you know, too long. So, you've got that conflict.* (Camilla)

It was hard for practitioners to notice their patients' progress whilst struggling with time constraints and processing. One participant described consultations as *"hot air"* when it was hard to see tangible changes for the family.

4.5 Theme Five

The Impact of Consultation

This theme encapsulated participants' views on the impact of consultation at micro-gains and macro-gains levels. Micro-gains comprise the smaller objective markers of change over time and macro-gains comprise the larger organisational changes and improvements for patients. This section concludes the findings chapter by examining whether the gains of consultation can be turned into meaningful outcome measures (ways of measuring the progress of patient care support and treatment). The risks and benefits of using outcome measures are also considered.

4.5.1 Subtheme: Micro-gains

All participants gave compelling accounts of their perceived professional and personal gains as a result of consultation, captured as follows:

- Consultation supported clinicians/practitioners in managing work-related stress and anxiety, preventing or reducing burnout.

Having a place to acknowledge and verbalise the strains staff experienced in their work led to reduced stress:

> *It's helped me advance and stay in CAMHS as long as I have done. Rather than feeling isolated and burnt out, consultation has helped me to have a longer career in CAMHS.* (Tom)

- Consultation encouraged professional curiosity.

Participants reflected that consultation stimulated their professional curiosity and supported less rigid practice by taking an observational stance, to ponder relational

dynamics with families and work within the therapy room. When asked what they took away from consultation, Jennifer said:

> *What's the word? – curious perhaps. I think definitely, 'How could I approach this situation? How could I be more curious about that? Observant perhaps'. I think they probably would be the main things.*

- Consultation boosted the clinicians'/practitioners' learning and development.

Rather than stripping participants' confidence in their work abilities by having to seek support, consultation was felt to boost their confidence in learning and development:

> *It's about supporting you to do the best you can. It's motivated me, I've learnt things, 100% I want to learn more, I want to progress, I want to take this further.* (Susan)

- Consultation supported clinicians/practitioners with stuck cases.

The cyclical nature of trauma made participants feel very stuck at times, yet five participants described becoming *"unstuck"* as a significant outcome of consultation. They had been able to identify a way forward and had greater confidence in continuing to hold and work with the patient:

> *I think me and my supervisor would have been really stuck and I probably would have disengaged from the work. My final thought is just the impact consultation had on my practices; they would not have progressed to the point that they have done.* (Amy)

- Consultation contained clinicians'/practitioners' distress, reducing emotional wear and tear:

> *So (patient) has experienced trauma, but she doesn't know the extent of her mum's trauma and all the family is very stressed and then you get quite stressed. That's been helpful for me to have a consultation about.* (Emily)

- Consultation helped clinicians/practitioners feel validated in their work, empowering them to continue with IGT cases and helping them to assess risk.

Consultation gave healthy recognition that the clinician's work is valued, allowing them to remain involved and compassionate towards the patient's suffering:

> *Consultations make people feel validated. I think that the more aware we are of our own professional limitations, and seeking support where we need it, the better-quality care we can provide to young people.* (Jennifer)

- Gaining understanding through consultation was good enough as an intervention in itself.

Questions around whether consultation itself would be enough to create meaningful change for families was something all participants grappled with, but most participants felt strongly that something got *"translated through the work"* and could be enough to be helpful. Yet this was hard to quantify when measuring outcomes.

> *The power of consultation is that it doesn't have to have a solution or an outcome, it's a consultation and then if individuals want to take that information and change or they don't, either way, it's an outcome isn't it?* (Tom)

4.5.2 Subtheme: Macro-gains

Whilst multiple micro-gains were identified, it was very difficult for participants to see how individual gains might add up to a macro-level in day-to-day practice within an NHS system that can, at times, prioritise numbers. Susan and Jennifer reflected that consultation was *"just a drop in the ocean"*. This metaphor appeared to describe how smaller gains may get undervalued in the organisational system.

Yet five participants did reflect on the larger markers of change organisationally and for the patient.

- Consultation supported clinical formulations and joint decision-making.

Clinicians spoke to the clinical complexity of IGT caseloads and the value of discussing the patient's trauma first through consultation before treatment began:

> *If we've got a particular complex trauma case or a complex family dynamic, we might be at a crossroads looking at different options for that patient, so we would arrange a consultation to get everyone around the table to formulate within CAMHS and other professionals to see the best plan forward. It's not just about therapy.* (Tom)

- Consultation helped achieve better outcomes for patients:

> *Consultation is really about getting the best outcomes for families. So, helping the families to achieve the change that they want to see.* (Susan)

This resulted in larger service developments (Me and My Brain Group), bringing new trauma-informed services directly to adolescents in their CAMHS locality.

- Consultation was adaptable and flexible, making it cost-effective, and brought the staff team and professional networks together:

> *Going out into the community and giving those consultations is actually beneficial for time management. We have to remember that as an organisation, we have to be flexible.* (Tom)

> *Accessing consultation has improved working relationships. And I think that that has had a significant impact. The more cohesive we work as a team, the better impact that has for young people.* (Jennifer)

4.5.3 Subtheme: Outcome measures

Can the gains of consultation be turned into meaningful outcome measures?

All participants questioned whether the gains/outcomes of consultation could be measured. Emphasis on organisational pressures to evidence effectiveness within the NHS was an anxiety felt by participants:

> *I wonder if organisations see the power of consultation, because you can't really put it on paper, I think, exactly how it informs the work. So, I'm not going to go in and do an outcome measure and go… right, this consultation has really helped promote this, but you know that it shifts the work and you're not stuck anymore. But you can't name it.* (Emily)

Emily's quote illuminates the difficulty in measuring the impact of consultation. Relational and internal changes in the practitioner may not be fully accessible to conscious awareness nor quantifiable. Emily felt she had personally changed as a result of consultation, but it was hard to describe how.

Furthermore, internal changes for the patient did not readily translate into 'measurable outcomes', as emotional developments are complex and hard to quantify as they happen over time:

> *Consultation definitely feels helpful but I'm struggling to give you concrete ways that it has been. Yes, it feels like it's just become a part of my next session and taken it from there really. I couldn't say I've been, you know, 20% more effective.* (Hazel)

In an outcome-focused NHS, if consultation is not only hard to describe but impossible to put on paper, how can the impact of consultation be recognised and understood, especially when a great deal of time has been invested? This question which grew out of the data cannot be ignored or denied.

Participants reported how painful it can be for both the patient and the clinician/practitioner to manage the hope of improvement versus measuring outcomes of extremely difficult cases, creating resistance.

Additionally, the organisational pressure to move patients on was poignantly captured by Tom, *"there's always someone waiting"*, giving a sense of working in impossible climates where clinicians are trying to do something valuable with not enough time or money.

<u>Perceived risks of using outcome measures for consultation</u>

Five participants feared that target-driven measures would dilute the emotional and relational changes made through consultation. A compelling argument was that organisational processes risk appearing inhumane, posing conflict between what is in the child's best interests and what is measured. At what cost does effectiveness come?

> *Organisational processes can feel inhumane. We have to be mindful people are people and that they're not just there to be processed.* (Tom)

Processes that were implemented with the intention of improving efficiency were felt by participants to be disempowering. Jennifer described *"a conveyor belt"* of demand, and Camilla expressed pressure for *"feeding the organisational machine"* with outcomes. A pertinent issue to commissioning is how to keep the patient's complex, individual needs central whilst measuring the impact of consultation:

> *We shouldn't be measured on process. I think we should be measured on experience… Consultation is about meeting together and sharing the work so does it have to have a target? The organisation should have that flexibility to allow yourself to have that consultation which is valuable but not measure it. It's very much a balance. What becomes organisational 'procedure' doesn't work.* (Tom)

Time was repeatedly reported as a constraint in valuing the gains of consultation:

> *You know treatment's going to take time and it's a process - so if its longer term, which is a strain on the NHS, then you need to evidence why that is needed. Consultation takes time.* (Camilla)

Working through *"the ebb and flow"* of consultation was viewed as a factor in embedding systemic change. Thus, any outcome measures would need to stand the test of evaluating longitudinal change as change takes time to ripple down (although due to complexity and costs this is highly unlikely).

Several participants gave a strong impression of wanting to protect the consultation pathway and questioned whether organisational outcomes could really be measured at all?

> *The outcomes are for that patient and their network, it helps to gather communication that's often missed. Bringing the network together in*

> *consultation is valuable data, seeing that trauma cycle repeating itself, so it is valuable but as an organisation, it's not a measurable outcome.* (Tom)

Perceived benefits of using outcome measures for consultation

Several participants felt that if consultation was not able to measure its outcomes, it may risk being devalued organisationally.

> *Because there's no measured outcome, the organisation doesn't want a lot of consultations. They want appointments to be measured, that's how we get paid.* (Tom)

Jennifer reflected that consultation may grow exponentially, beyond which the system could cope, wondering *"where do you stop?"* There is undeniably a reality that the service cannot provide endless consultation, even when there is need; *"I'd potentially take all my cases to consultation"* (Emily), and it all risks becoming overwhelming. Therefore, one benefit of adopting outcome measures is to validate the gains made to contain these anxieties, rather than everyone trying to offer everything. Jennifer later reflected on the potentially helpful nature of goal-based outcomes for consultees by thinking together with the consultant about, *"What are you bringing to sessions and what are you expecting from me in return?"*

On systemic issues Jennifer offered a fascinating *"staff lottery"* metaphor around how some staff will access consultation and some will not, ultimately impacting the service the patient receives. The notion of a staff lottery is an ambivalence that undermines consultation, implying there's no power organisationally to influence how consultation becomes a part of everyone's roles/responsibilities. It may be beneficial to monitor decisions around which cases progress to consultation and which do not:

> *It's quite a long time since we've discussed what people can bring for consultation. I don't actually know these days what the general view is about what could or should be brought. Some people might think they can bring their experience being part of the team and bringing cases. Others might have an idea in their head like you can only take a case if they're very high risk.* (Camilla)

Clarifying the pattern of cases that are brought to consultation may be part of more practitioners becoming involved and therefore, lead to better outcomes. Sharing the findings of this study could contribute to understanding the diverse and complex interrelating aspects of consultation alongside considering the possibility of implementing future outcome measures. The time required for change to occur in families impacted by IGT should be borne in mind organisationally.

4.6 Summary of the Findings

Table 4. *Summary of the findings: The psychoanalytic markers connected to the functions of consultations by child psychotherapists and the possible gains (impact) of these on the individual and the wider system as captured by participant data (N=7).*

Psychoanalytic Marker	Function	Impact
Container-contained (Bion, 1962) Holding environment (Winnicott, 1965)	The emotions and defences generated by the individual's work can be safely explored within the boundary of the consultant-consultee relationship. Consultant shoulders the anxiety and the not knowing of the consultee so they can occupy a more reflective position (this develops over time). Given time and space to explore countertransference responses in order to reach understanding of the patient's and consultee's difficulties.	Consultee develops resilience to explore rather than react. This is enabled through the safety and trust within the consultant-consultee partnership. Unblocks thinking capacity in staff and networks and helps stuck cases move forwards with positive impact for the child/family. Reduces negative feelings in the consultee of feeling alone with 'the problem', reducing work-related stress and protecting staff and team from secondary traumatic stress and burnout. Collaboration, safety and trust transmits into working practices with colleagues, patients, and networks.
Triangular space or third position (Britton, 1988)	Promotes understanding by gathering multiple perspectives and develops the ability to look beneath the surface of presenting symptoms. Can make the process of metabolizing the patients' trauma more manageable for staff working in emotive situations.	Reduces the impact of personal and professional blind spots informing better decision-making. Values the consultees own knowledge, resources and expertise, and in so doing reduces the risk of activating defensive behaviour/ambivalence towards the consultation process (e.g. who's the expert tensions).
Infant Observation (Bick, 1964; Fraiberg, 1975)	Consultants model and develop the consultees capacity to closely observe themselves and their patients as a way of gathering a deeper understanding.	Facilitates staff learning and confidence in professional practice. Learning the value of observation in the child's development helped staff with care planning.
Witnessing/ gathering narrative stories (Fraiberg, 1975; Lieberman & Van Horn, 2008).	To try to understand earliest patterns of relating. The meeting of multiple minds supports the development of a trauma narrative for families accessing CAMHS.	Expanding a culture of therapeutic thinking in trauma-facing services where survivors are able to safely tell their stories, be listened to, and be believed (links to containment).
Reflective function (Fonagy et al, 1991)	Collaborative endeavour may help mitigate against who's the expert dynamics through joint curiosity and interest.	Transmission / integration of reflective functioning in consultees' professional practice and in team relationships.

- The five themes and six subthemes in this study went beyond reporting participants' experiences. Themes also captured participants' perceptions about the functions and impact of child psychotherapy consultation in this study, as demonstrated in Table 4.

- The model of 1:1 consultation, depicted in Table 4, is an initial blueprint for exploring further the transferability of the consultation model to other CAMHS MDTs and trauma-informed services where there is availability of a qualified CAPPT.

CHAPTER FIVE

Discussion

Seven CAMHS clinicians/practitioners working directly with adolescents and their families impacted by IGT talked passionately about the importance of consultation as captured in their rich, individual testimonies. From the outset their language (and metaphors) communicated powerfully, the emotional toil and strength of the emotions aroused whilst working in trauma services. Participants' engaging accounts and their willingness to share their honest experiences, evidenced how the participants made use of consultation within their teams. It enabled them to sustain their work in CAMHS, giving a strong indication of how consultations added to the quality of the service provided. Thus, it has become very clear how essential and effective consultation is, and conducting the qualitative thematic analysis has attended to the aims of the study.

In this chapter, I will discuss and reflect upon how the findings from the research have informed the aims set out and this will be examined in the context of existing literature. This chapter concludes by considering the strengths and limitations my research before offering some recommendations, both to the specific CAMHS within which the research was conducted and more widely to NHS services.

5.1 Socio-Economic Context and the Dynamics of Power and Othering

The area of England where the CAMHS is located within which the work of consultation was taking place, could be characterised as one with a strong component of IGT. A battered and bruised community, highly sensitive to the issues of discrimination and prejudice, is further disadvantaged by high levels of

unemployment and health inequalities. Some participants in this study lived in the same communities as the patients and were well-versed in trauma, described as the *“bread and butter”* of their professional lives. These staff had not moved away from the work, rather, they sought more training and support to sustain the work. The core need for containment was recognised as a universal need, in the staff group, as well as for the patients they were treating. Nathanson (2024) advocates that when working with staff in trauma-focused services, “the only way to make a real impact and effect change is to offer containment through intensive, long-term personal and organizational consultation” (p.170).

It is notable that the child psychotherapy consultants also came from the region and could identify with the needs of the community. The multi-faceted role of the consultant is paramount. They must hold the crucial third position (Britton, 1988) which may risk the consultant being viewed as *“alien”* in terms of their psychoanalytic thinking and understanding. This tension could lead to splits in how participants saw themselves in relation to the consultant; consultant as ‘expert’ and themselves as not. The openness of a shared space for thinking in consultations mitigated against the perceived power differential… being curious, and not knowing together, put the relational dynamics on an *“equal footing”*. Hazel went on to describe her growing capacity to hold multiple perspectives in mind as a positive impact of consultation, acknowledging difference and diversity issues. Consultants, consultees, and staff groups alike need to engage in a committed exploration of their own countertransference responses (Cherry-Swaine, 2024) in order to help those most traumatized and at risk of marginalization.

IGT can become embedded in local norms, expectations, and relational patterns, influencing how distress is expressed, understood, and responded to (Herman,

1992). The data suggested that culturally embedded trauma may heighten participants' anxieties, initially describing psychoanalytic thinking as strange or unsettling, and this was evident in how consultees positioned the consultant and the reflective work they offered:

> *Psychoanalytic consultation is a different way of speaking, and every time I come, I'm always thrown by it. At first, I thought, 'this weird', but then it's helpful in the way it's used to make sense of something.* (Emily)

This mirrors observations in psychoanalytic consultation literature within Tavistock traditions, where the consultant can be perceived as a stranger to the institutional culture, bringing a reflective frame that can unsettle established practices (Hinshelwood, 2001). When something different is offered—something other than action-oriented formulations—the reflective space can stir anxiety, leading to the work itself becoming othered. Consultants may be unconsciously placed in an omnipotent position, particularly when their interpretations appear to transform raw clinical material into meaning. Participants' descriptions of the consultant as someone who could *"transform shit"* illustrate how this otherness can slide into idealisation, positioning the consultant as omnipotent and unreachable, and a threat to the consultees' sense of agency. This underscores the need for consultants to be attentive to the ways in which difference and unfamiliar ways of thinking can evoke feelings of rivalry, competition, or exclusion within traumatised systems. Trauma-informed organisational literature (Cherry-Swaine, 2024; Menzies-Lyth, 1960) suggests that systems exposed to chronic stress often develop defensive cultures characterised by splitting, idealisation, and heightened sensitivity to difference — dynamics that were evident in this study and discussed further in 'Who's the Expert? theme.

5.2 Seeking consultation

5.2.1 *"Working with the emotions and defences generated"*

The findings of this study provided a wealth of information with regard to the reasons why clinicians/practitioners seek consultation when working in trauma-focused services. Of central importance was the participants' need to discuss and *"unpick"* their difficult emotions which were generated in their clinical work with trauma survivors and perceived this approach as unique to child psychotherapy consultation. When speaking about their direct work they described their emotional responses as *"being alive"* in the workspace. Through consultation, they could connect with their feelings and thoughts in a safe *"partnership"* with the consultant in the here-and-now. Cregeen (2008) discussed this consultation model (described by Obholzer and Roberts, 1994), where the work is very much "emotionally alive" (p.174), connecting relational processes occurring in the room and in their work in the aid of developing a capacity to tolerate highly charged emotional states.

Participants also sought consultation to acknowledge the feelings that their patients left with them. The powerful emotional states stirred by their patients could feel completely alien and overwhelming. Without the understanding of transference, countertransference, and projective identification (Klein, 1946), participants needed to understand *"what could actually be my stuff"*. The presence of these psychoanalytic 'markers' in the participants' interviews supports the notion that they were seeking, perhaps unconsciously, a psychoanalytic approach to consultation. In the literature, it was claimed that working with emotions and tracking countertransference phenomena was an important source for understanding the emotional world of the patient (Emanuel, 2002; Sprince, 2002; Lanyado, 2009). It

was evident in this study that participants trusted the consultant enough to bring and reflect upon their honest emotional responses, through which they began to differentiate what feelings belonged to them and what belonged the patient.

The consultant explores the consultees' difficult feelings by thinking about these as an ingredient of the countertransference, informed by the consultant's training. As Child Psychotherapist Sprince (2002) explained, “I became increasingly concerned about how to find a methodology for using my countertransference to help an organization as a whole, just as I had been taught to use it to help an individual” (p.149). In this study, participants' frequent descriptions of consultation helping to *“unpack”*, *“unpick”*, *“disentangle”*, *“put together fragmented pieces”*, and *“sort out the mess”*, could represent the complex “methodology” Sprince describes. Trying to understand the emotional responses of consultees mirrors the psychotherapist’s clinical work of working in the transference and countertransference, using these as a lens in consultation as a way to engage with the consultee’s material, but remaining careful not to interpret. Participant’s troubling, muddled, and foggy feelings (to name a few) were given *“time and space”* in consultation. Exploring and processing the experiences rather than leaving the clinician/practitioner with a “parcel” of undigested projections links to existing theory (Cherry-Swaine, 2024). As Lanyado (2009) highlighted, it is the consultant’s attention to the workforce’s countertransference that offers vital support to staff, so the intense anxieties inherent in the work can be adequately contained.

Learning to tolerate some of the difficult emotions allowed staff to connect with their own feelings, in turn helping them to think more fully about the child/family’s feelings. In this study, the consultant's ability to remain steady and shoulder the difficult emotional responses of the consultees helped them internalise a “consultative state

of mind" (Robson, 2009, p.130). In this state of mind, the consultee can occupy a more reflective and curious position. Tentative findings point towards when consultation works in this way through repeated experiences of containment, practitioners will become their own internal consultants per se.

As a psychoanalytic thinker and clinician, working with the countertransference is one of the ways of understanding our patients' experiences. There is a justifiable question in the literature about whether this can be applied outside of the therapy room. There is an ambiguity between the patient's projections onto the staff in consultation as they themselves are not the patient, only the recipient of the patient's projections. Findings from this project suggest that using the consultant's and consultee's countertransference is valuable when working with NHS professionals. Yet, participants have enabled us to recognise some difficulties of applying the countertransference to staff and the technical adaptations that may be required by the consultant.

Feeling *"therapized"* was indicated as an initial worry that several consultees had about consultation. Sensitivity to this finding should be acknowledged. However, the general feeling was that participants felt very safe during the consultation. The rigorous CAPPT training and understanding of transference phenomena creates a strong holding context for staff in consultation. This is essential for public sector work, as recognised in the NHS Long-Term Plan (2019, p.78). The work is incredibly skilled and may be captured in the participant's need to seek 'expertise'. Interview data from this study suggested that the consultant should not directly interpret the transference or peel back staff defences in consultation. CAPPT's consultation work was informed by the transference rather than making it a central intervention. It was suggested CAPPT's occasionally commented on the transference to help *"move*

something on" and when it approached in this way, participants experienced exploring the transference dynamics as less exposing.

At times, professionals needed to maintain their defences to survive their work with traumatised children and families (Robinson et al, 2020). Early discussions about what to expect from consultation, particularly for new consultees who may experience initial anxiety about feeling exposed or vulnerable, should be borne in mind. These thoughts and feelings should be brought out into the open so any myths about a psychoanalytic model can be dispelled.

A significant gap in the literature was the lack of attention paid to the resilience of professionals working in trauma services. This study revealed that despite the personal demands on the consultee to explore the very difficult feelings stirred up through their work, they kept going to these emotionally challenging places by seeking consultation which seemed to develop their resilience. They were also motivated to seek consultation for help with stuck cases where issues were complex. Feeling *"pressure for action"* and working in *"isolation"* alongside carrying the patients' difficult emotional responses were all linked to seeking help from the consultant. As professionals became more in touch with their own and their patients' emotions, they were able to become "unstuck" (Robinson et al, 2020).

One participant felt *"haunted"* (Abraham and Torok, 1994) by their patient's trauma which followed them home and resulted in them seeking consultation to disentangle the intensity of these feelings. Such experiences can happen to any one of us working with IGT. All participants' fear-laden feelings generated by their patients' trauma had a strong relationship with seeking consultation. The overall evidence from this study suggests that seeking support was vital in enabling staff to carry on

with challenging trauma work and in becoming unstuck. My findings resonate with Fraiberg's (1975) understanding of the significance of this experience, "it will be safe with me to speak of the frightening memories and thoughts, and when you speak of them you will no longer need to be afraid of them; you will have another kind of control over them" (p.412). Participants gained confidence that insights would emerge if they were able to wait, reflect and trust in the process.

Evident in my findings was how clinicians/practitioners felt supported with a *"space for thinking"* about the difficult work in a safe "holding environment" (Winnicott, 1965). One participant conveyed thoughts of a healthy, holding organisation describing the MDT meetings as *"a very nice safe space"* where professionals felt contained enough by the child psychotherapist to take down some of their defences. What must also be acknowledged is the emotional "wear and tear" (Stokoe, 2021) of clinicians'/practitioners' everyday work in trauma services. This requires multiple minds exploring the complexity of emotional dynamics. The establishment of consultation within MDT meetings in this project conveyed how the team took care of their "emotional health and safety" (Lanyado, 2009). Rather than the emotions and anxieties being denied, they were *"worked with"*, helping them to develop a healthier organisational functioning. The benefit of the consultancy "methodology" for noticing and working with the emotions (and defences) generated, reduced staff stress, burnout and rigid practice. Such developments do not come without a great deal of commitment by individuals and organisations; the consultants worked hard to put in boundaries and feel compassion towards participants who felt threatened or *"therapized"*. Participants spoke of their passion *("fire in the belly")* for the collaborative process that worked to, "understand and detoxify the complex parcel of

emotions that had been projected into individual survivors and through them into the staff groups attempting to help them" (Cherry-Swaine, 2024, p.112).

5.2.2 The importance of observation, witnessing and the third position

Participants benefitted from thinking through a case with another person who could offer a *"different set of eyes and ears"*. The idea of seeing, looking, and hearing what might be beneath the surface was a strong aspect of this theme.

The third position refers to Britton's (1988) concept of triangular space, "the process of observing one's own subjective encounter with the patient from a third position" (p.55). For staff groups working in CAMHS, there is no personal analysis to help disentangle the complexities of the transference dynamic and projections from the patient. This is where consultation comes in, offering the third position to help the consultee discover more realistic feelings they are holding about their patient. Hazel gave a powerful example of this when she sought consultation about a patient who had suffered intergenerational racial abuse. She was enabled to see her patient as a *"survivor rather than victim"* and was supported to hold *"different and competing views in mind"*. When she next saw her patient, she could evaluate and free herself from the way she had been relating to them, *"trapped"* by the trauma history belonging the patient.

The third position also helped when the clinician/practitioner felt stuck with a particular patient or was feeling blocked in their thinking. The spirit of observing was exemplified by Britton (1981) as a vehicle for "realisation" of the existence of trauma not yet witnessed, heard, or spoken about. By recognising the activity of projection in work with families, the professionals had something to get hold of and work on something that resonated with the child's/family's inner state. This was illustrated by

Tom who talked about his appreciation for what could be considered the triangular relationship in consultation, and the psychoanalytic “methodology” (Sprince, 2002) which helped to look beyond the presenting symptoms:

> *The purpose of consultation was to have a wider view of what we were seeing or missing. We would take time to gather information about the child’s history and the family's background then reflect, bringing it back for consultation to work things through in a methodical way. I found consultation very very helpful. Often a trauma that’s not been recognised is only seen as a behaviour or symptom.*

Tom’s narrative appears to capture what Britton (1981) described; realisation rather than transformation may be a more appropriate therapeutic goal to working with those impacted by complex trauma. Mapping and gathering a wider view of the patients' life led to thinking beneath the surface, the child psychotherapists “methodology” provided a bounded and consistent psychotherapeutic frame offering reflection and containment.

An intriguing discovery was the centrality of embodiment and togetherness in creating a triangular space. Camilla found working with IGT in the CAMHS team like:

> *something playing out on living bodies. I’ve gone to a child psychotherapist about it before when I’ve been entangled in that situation for a while…. Consultation is about standing back and saying, let's take time to think about this and being quite strong about that, not being swayed. To not be swayed and dragged in all directions by the currents of emotion running around the team.*

This participant evoked the ‘physicality’ and ‘bodily’ aspects central to relationships when two minds come together seeking consultation for an understanding of the emotional undercurrents of their work. Reflecting on my literature review, I noted how commonly child psychotherapists were able to take in disturbing feelings and emotions on behalf of the staff, sustain thinking against the undercurrents of defences and withstand becoming traumatised themselves (Bradley and Emanuel, 2008). My research corroborates these findings in the literature review. The consultations discussed in this study took place in-person with bodies and minds together creating a “holding environment” (Winnicott, 1965). Notably, Camilla’s reference to *“something playing out on living bodies”* shares some commonalities with the literature. Cregeen (2008) and Wilson (2009) noted how transference phenomena (ghosts) passed between different workers, and from one situation to another, and an important factor of the consultation experience was that workers could begin to direct their attention to what was going on under the surface and give insight into painful experiences. Facing very stretched services within the NHS, there could be a pull towards offering consultations online, and one must weigh-up the complexity of what happens when people come together in a room.

Participants appeared to enjoy the aspect of *“togetherness”* that consultations afforded. Puzzling together and trying to unpack what the patients/families might be communicating in their verbal and non-verbal responses was commonly expressed as a *“joint endeavour”*. Diamond describes the third position as “what we create when we make genuine contact with one another at a deeper emotional level of experience, whether in dyads, groups, or organisations” (2007, p.142).

It is not suggested that staff groups will always appreciate or seek this way of working. Whilst having an *“outsider view”* on a case had the potential for reassuring

the consultee they were *“going in the right direction”*, it could equally disturb them with discovery of their *“blind spots”*; areas which some staff may wish to avoid, like feeling *“under the microscope”*. As Susan reflected, *“some people will say what bloody good is it going to talk to them about it”*. Jennifer used the metaphor of a *“staff lottery”* to capture how some staff will seek consultations, and some will not. There is pressure on CAMHS clinicians to manage patients from diagnosis to discharge, yet as participants described, *“consultation doesn’t provide answers”* and *“it doesn’t let me discharge somebody”*. The consultation model discussed in this study was a choice and was not enforced on staff. This risks creating a negative view of those who don’t voluntarily engage, seeing the staff member as not doing their job properly. It would be beneficial for consultation to be available as and when needed, yet there are obvious external difficulties to rolling out consultation more widely in the NHS, such as budgetary pressures and availability of a qualified CAPPT. The real question is, can they afford not to? In the whirlpool of emotions, behaviours, and stress, consultation is one thing that can help colleagues share anxieties and support them in navigating the difficult work with families impacted by IGT.

The drive within the NHS for diagnosis, clarity, and answers is in constant conflict with the need to unpack and process which takes time, putting pressure on limited resources. This study indicated hope that there can be both triangular space and also a way to compartmentalise, *“put a lid on things”*, what feels beyond the remit of the service, and to get on with something sustainable and effective for the service users. It would be in no one's interest, particularly within IGT, to delve into something uncontainable, and the consultant should carefully monitor the “temperature and distance” (Meltzer, 1976). Participants expressed anxiety that the consultant might hit on something that remained unconscious in the consultee, sending them

“spiralling out of control”. If colleagues don’t trust the process they are going to stay away, increasing the risk of projecting the whole tangle of feelings into others. Within this anxiety there remained a deep need for a triangular space that could be created within the team, where witnessing and listening to colleagues' stories, with their resulting personal affects, could be shared.

The links made between the present study’s findings and the theories described in the literature review do suggest that child psychotherapy consultation can offer something unique in terms of working with emotional world phenomena, through the third position, that can aid with understanding the patient and can inform new or different ways of thinking and working for the clinician.

5.3 Slowing Down

5.3.1 Digestion, processing, and ‘container-contained’

In the data, descriptions of a need to *“slow down”* became a central metaphor for the process of mental digestion. This was supported by similar metaphors, *“taking a step back”* and *“putting the brakes on”*. The importance of slowing down was frequently connected to the fragmentation and disturbance, *“the terrible things”*, brought to consultation around IGT cases [*“missing pieces”, “bag of shit”*] that clinicians faced in their work. From these metaphors, it was possible to evidence that consultation provided a slowed-down thinking space, allowing the mind time to process. The place of stillness, the consultant's ability to stand back, but hold in mind the challenges that staff faced, allowed the consultee to find a clearer path through the mire of IGT. This appeared linked to the value of the consultant having witnessed the consultee's struggles, which Eshel (2019) calls “withnessing”, in the intersubjective moments of relational connection, along with being present and still. Waddell (1991)

speaks of “symbol formation being the entrée to thinking about meaning”, and in this study, the wide array of symbols/metaphors used by participants seemed to help them connect with their lived emotional experiences, which was crucial to their understanding.

Creating symbols is the basis for thinking, Bion (1962) calls this “alpha function”. This is first, the capacity of the mother who takes on the emotional distress of her infant (beta elements) and gives it back to them, having made it more tolerable. He describes this process as a mental ‘metabolising’ of the infant's distress, providing containment that is profoundly important, shaping the way individuals can think and process their anxieties in the future. Bion explains that emotional containment is a psychological process, the person doing the containment being the container. Applying container-contained to the consultation model, the consultant can take in and process the trauma and return it to the consultee in a more bearable way. Thus, the consultee is contained.

There was a high level of reporting in this study of participants seeking a feeling of containment, and when received through consultation, it came across as a profoundly shaping experience. Some participants described consultation as helping them survive and contain the flurry of projections and strong emotional currents within their work; others such as Susan, described their appetite for consultation as a *“fire in the belly”*. She was clearly gaining a lot from the containing experience that generated curiosity, which Huffington (2004) describes as “pro-tainment”.

The sheer complexity of working at emotional depth with families impacted by trauma came across in Emily’s idea of a fragmented jigsaw with missing pieces (possibly capturing beta elements). Rocco-Briggs (2008) described her work with

traumatised children who communicated different aspects of their feelings to different professionals in their network. She argued for consultation as did the participants in this study, who needed the consultant to be a container for the fragments and mess, so it could be slowly disentangled and pieced back together.

The interlocking elements of intense emotional projections and the participants' feelings of fear/panic were factors that influenced participants to seek containment. Using Bion's theory of container-contained helps us to understand the consultant-consultee dynamic where staff can bring the bombardment of projections often faced in the trusted presence of the consultant. Slowing down, containment, digestion, and the emergence of a third position were essential ingredients of consultancy work in this study, particularly when supporting colleagues working with IGT.

When there is no alpha function (consultant), "the projections into its services have an aggregated force that is particularly hard for staff groups to think about or to contain" (Cherry-Swaine, 2024, p.112). Teams become highly defensive, where everyone is prioritising actions over thinking and trying to push the trauma elsewhere into one another. Primitive anxieties can become mobilized where staff are provoked into acting secretly to access consultation, *"a secret operation"*, due to time pressures and service priorities around waiting lists and discharging patients. When containment is absent, re-enactments of the patient's secrecy and shame related to IGT risk being played out by staff.

The evidence from this study demonstrates that the provision of consultation, within a framework of container-contained, improved the consultee's capacity to tolerate the high anxieties inherent in their work and enabled them to sustain work with their patients. Consultation positively impacted decisions, removing the defensive need to

solve unbearable situations with quick-fix decisions. Jennifer described feeling more confident as an outcome as she didn't feel pressured to solve all her patient's problems for them.

This research also supports Nathanson's (2024) idea that adolescents suffering complex trauma "can only be treated in a total therapeutic environment" (p.164). Containment for staff was key to seeing total situations. Past and present experiences, as well as emotions and object relations are considered (Canham, 2004), gathering a picture of the child's "total situation" (Klein, 1952). Emily's jigsaw metaphor of gathering the pieces perhaps symbolizes how she gathered together a picture of the patient's total situation.

5.4 Trauma and resilience

5.4.1 Consultation Through the Lens of IGT

This project extends the literature by exploring the specifics of child psychotherapy consultation taking place within a trauma pathway. In their case examples, participants talked about interactions and feelings *"playing out"* with patients/families and within the staff group, and reflected upon the echoes of trauma, *"the feelings I have, that's the stuff that follows me home"*. This resonated with the literature related to IGT and projective identification (Brinton, 2009). Freud's repetition compulsion was also significant in that trauma that has not been processed needs to be repeated. Participants' notion of the importance of time when working with IGT was compelling, linking with the literature on how trauma lives in the present as patterns are acted out unconsciously and without a known source, *"feeling like something really bad had happened to someone"*. The unique contribution of child

psychotherapists was their approach to the temporal aspect of digestion and processing of repetitions.

Conversely, allowing time for consultation could be difficult when participants spoke of the *“conveyor belt”* of patients and the busy nature of their roles making it hard to stop and think. Emanuel (2002) applies Bick’s (1968) theory of second skin defences to the network, where professionals who have become repositories for evacuated distress defend against anxiety by presenting as hyper-busy which then becomes a substitute for thought. This could be compounded by consultations that are ad-hoc or not followed up. This research demonstrated that IGT cannot be worked with without some knowledge that time is shaping for people. Consultants must consider how to protect a space and look after it. Careful consideration should be given to the value of informal consultations, e.g., corridor conversations, whereby staff may wish to quickly get rid of their anxiety by drawing the consultant into the expert role unwittingly to give advice. Clinicians' need for support in managing, treating, and containing IGT patients cannot be underestimated and the opportunity to follow-up should be valued.

5.4.2 Locating the problem

Distress appeared heavily located in the clinicians working with IGT. As identified in the literature review, evidence from this study suggests that the patient’s projections into the clinician serve as an important function (Britton, 1981). The clinician in consultation can start to get a sense of the child/family's inner state. Through their understanding together, the clinician can develop the capacity to empathise with their patients.

Understanding the extent of secondary trauma on the clinician as a consequence of projective processes presents a research gap. The risks related to secondary trauma were made explicit by participants in this study. They described strong feelings of being left with the trauma which evoked a fear within them as there was nowhere else for the feelings to go. The impact of working with trauma day-in and day-out was conveyed viscerally, *"boom, boom, boom"*, as Emily expressed, moving from one case to another, with little sense of a space to breathe. Susan believed that NHS trusts knew about secondary trauma but turned a blind eye to it. A responsibility of this research is to give voice to these impactful consequences for staff. Consultation offers a vital place of safer practice that might prevent "dysfunctional organisational patterns from arising" (Faull, 2012). Susan recognised that professionals needed containing, often as much as the child/family, due to the flood of their projections and found consultation was *"the most valuable time you could ever have"*.

Consultation requires certain psychoanalytic processes that are pertinent to helping the clinician when feelings of trauma are felt to be located in themselves, as evidenced in this study. This included working with the emotions and defences within the clinician whilst the consultant held the third position. The consultant facilitates the consultee's capacity to recognise, hold, and contain the projections thus, reducing the impact of secondary trauma. The benefit of offering a work-based consultation to CAMHS staff is, that it "locates the problem in the emotionally difficult work and its concomitant projections rather than suggesting that it is located in the psychopathology of the individual" (Cherry-Swaine, 2024, p.121).

Owing to the nature of IGT, there are multiple generations to address in the consultation process. What experiences of the child's parents have been brought to

the table? We need to ask these questions to create a space for such traumas to be addressed, rather than focusing solely on the child.

> When our therapy has brought the parent to remember and re-experience his childhood anxiety and suffering, the ghosts depart and the afflicted parents become the protectors of their children against the repetition of their own conflicted past (Fraiberg et al., 1975, p.421).

Consultation is an appropriate way to assist in this process. Yet, given the intergenerational dimensions of each family, it can seem like an enormous and unwieldy load as Jennifer captured, a fear of things *"spiralling"* beyond what the individual and team can manage. This may be one reason for keeping the focus on the child, yet the evidence from this study suggests consultants and consultees worked hard to consider what was being passed on generationally.

5.4.3 Transmission of psychoanalytic "methodology"

Containment, curiosity, and the capacity to think are positive attributes that the consultee can pass on to the patient. This particular aspect of transmission is under-explored within the literature. Participants' narratives indicated how the process of introjection and integration might happen through modelling the consultant. Camilla talked about her experience of consultation as *"a kind of modelling thing"*. She described the calmness of the consultant as *"steadying the ship in a major way"*, an experience of containment that she consciously modelled to her team and could be seen as transformational in their development and resilience. Over time, the relational way of containing anxiety could expand within the team, demonstrating the potential transferability of the consultancy model.

Emanuel (2002) endorsed the support of management advocating a reflective approach to filter down to frontline professionals. As Camilla, Susan and Emily described, modelling the consultant in their own practices may trickle down to the staff group. So, how might this get passed to the patient? A key factor seems to be the capacity for reflective functioning, Slade (2005) says it is the capacity for "maternal reflective functioning" which is the key to the transmission of secure attachment from one generation to the next. Might this process of reflective functioning be an aspect of consultation that is transmitted from consultant-to-consultee-to-patient? Participants described modelling what the consultant did for them during the consultation process, which then transferred to work with families. This process of 'taking in' or introjecting the functions of consultation was identified by Lawlor's (2006) PhD outcome study of consultancy at the Tavistock as an important yet under-theorised concept in understanding client/consultant dynamics. There is great potential for further investigation in this area, as internalisation on an individual level may lead to change at an organisational level (Mirco and Macro gains).

The consultant should bear in mind that whilst participants may seem to come to consultation for a third position, with the distinctiveness of parental function, bearing these dynamics requires the consultee to put themselves in a vulnerable position. This could make them susceptible to feeling overwhelmed, or threatened, generating ambivalence about consultation. Such feelings may be related to high levels of emotional distress when working with traumatised individuals (Faull, 2012).

5.4.4 IGT and Storytelling

This project presents the hidden narratives and accounts of our colleagues who seek consultation in supporting those traumatized families who present the most complex problems. This research has enabled us to really hear the experiences and significant dynamics our colleagues face in a way that is accessible and engaging.

Stern (2010) said “to know what our experiences are, to think and feel, we need to tell the stories of our lives and we need to tell them to someone to whom they matter, listening to ourselves as we do the telling” (p.127). In doing so, staff become the conduits through which patients get to tell their stories. A key message in the literature, and this study, is that untold traumas need time to unfold. Coles (2019) argued that narrative and witnessing were the antidote to haunting. Inviting a seat at our multidisciplinary table for the forgotten yet ever-present ghosts is possible through consultation, attending to the emotional experience of professionals in their work, and containing the high levels of anxiety in the hope of breaking the cycle of repetition. It’s a process that mirrors parental containment alongside a containing presence; resilience and capacity to help trauma ‘emerge from its shadowy influence into the visible, knowable, shareable experience of both parent and child’ (Moldawsky Silber, 2012, p.107).

Hazel conveyed just how difficult it was to stick with the patient’s story as she cut-off during the interview to think about outcomes, *“you have to put a goal on the system because the system needs one”*. Implying that what the organisation needs is very different from what the patient needs. This reflected the powerful nature of the ‘quick fix’ tendency of moving away from the patient’s story to ‘doing’ or action planning. Tom described this conflict as *“inhumane”*. The organisation defended against being

in touch with the patient's trauma through the mechanism of applying system protocols, reflecting poignantly with Menzies-Lyth's (1960) findings. This could be addressed through consultation by offering recognition and validation to the consultee that their work is valued, allowing them to remain involved and compassionate towards their patients:

> *It's about recognizing the work you're already doing and also saying it's difficult, its trauma, but carry on.* (Tom)

It is equally worthy of emphasis in any intervention that deals with trauma to offer a reminder of strength, resilience, and hope (Lieberman et al, 2005), as Hazel's case exemplified:

> *The material was quite heavy. There was a lot of trauma and racism and she [patient] brought lots of stuff. In a way, it felt kind of… hopeless and it was going to be a lot of work to unpick just by talking about it… It was the consultant who picked up that the young person sounded resilient… That led to a bit of a shift in my mind and affected the way I was working with her from then onwards. Talking to her as someone who has resilience, rather than… a victim.*

5.4.5 Bringing consultation to the multidisciplinary table

In Witkon's (2012) study the process of containment was effective in improving outcomes for families impacted by IGT when it reached across the consultant-family-network triad. In the literature collectively, one of the most reported therapeutic changes came from child psychotherapists' clinical accounts of integrating the network (Sprince 2020, 2002); the need for multiple minds to process and digest the many kinds of trauma that professionals face on the ground. 'Coming to the table'

involves the MDT in a joint endeavour of sharing and digesting information with the CAPPT consultant that they can then take away and feed into their care plans and strategies for supporting families. Consultation as an intervention by child psychotherapists can give consultees a flavour of the situations that are being re-enacted in the here-and-now. Being in the moment of realisation in “live company” (Alvarez,1992) takes away the sense of being alone with the dynamics of trauma and shame.

It was not clear within the literature whether child psychotherapists were applying the model of consultation to themselves in terms of the support they may need. For example, were there any opportunities for child psychotherapy consultants to meet together as a reflective group? Perhaps an ACP special interest group for consultants with a CPD element would be beneficial in supporting best practice.

5.5 Addressing Tensions and Ambivalence

5.5.1 Who’s the expert?

The ‘who’s the expert’ dynamic was a central tension that appeared underpinned by anxiety and a potential risk to the consultee's disengagement. Whilst participants were motivated to seek consultation, they could also fear and experience it as *“alien”*. A psychoanalytic approach welcomes staff to bring their negative emotional responses about their work, yet it can feel deeply unsettling. Participants described their experiences of consultation as contradictory and complex, and were ambivalent about who held the expertise, although they continued to seek the specialist help of the consultant where a triangular space was paramount. Tensions could be stirred up when they perceived the consultant as the expert which could make them feel othered rather than feeling able to bring themselves as respected professionals.

Consultants need to address these tensions sensitively in the task. Encouragingly, Robinson et al's (2020) findings suggested that child psychotherapy consultants appeared aware enough to monitor themselves against the risk of coming across as "omnipotent" (p.319).

The consultees' predominant perception of the consultant as expert should be borne in mind by any child psychotherapist embarking on this work if one is to avoid a culture where staff are to follow "prescriptive instructions" (Nathanson, 2004, p.163). My research supports this and further suggests that getting close to emotional experience can evoke a sense of the consultee feeling analysed themselves when the objective is to support them in their clinical work. Initially, some consultees were frustrated and angry at being offered consultation that did not give them answers or release them from their heavy caseloads as time to slow down and talk about a case can feel like a *"luxury"*. In this climate, compassion and empathy are much more difficult to develop and sustain (Hinshelwood and Skogstadt, 2002, p.11).

One participant idealised the psychotherapist as *"golden"* able to transform *"a bag of shit"*. Placing the consultant in an all-powerful position risks reducing the clinician's self-belief and potency. Most consultees developed their authority as the ones who knew the young people best and felt upskilled in their practice:

> *It just makes a big difference to your work. Being more confident when other people are asking you things. You can think… we've spoken about that in consultation.* (Susan)

'Me and My Brain Group' grew out of a long-term period of regular consultation. The rich ideas came from the staff's expertise and knowledge of the adolescents they saw in CAMHS. The adolescent group benefited from a 'good object' to think with

them about the impact of trauma on their bodies and their brains. The consultation model invites the consultee to connect with their own resources, which includes their knowledge, training, and emotions in partnership with the analytically trained consultant.

The consultant can also be denigrated as offering something that any professional in the NHS could provide. Yet evident in the findings was the specialist knowledge of the child psychotherapist being central in providing the collaborative dynamic space, in which there is containment, and capacity to bear not knowing. The psychotherapist takes onboard everything that the consultee brings, acting as a container whilst at the same time reflecting and mentalising (Fonagy, 1991). Psychoanalytic training takes many years, is tough to learn, and risks appearing superior to colleagues. Thus, there may be a struggle to promote consultation as a specialist provision in an attempt to create a level playing field with staff. As a researcher, I felt compelled to remove the word ‘expert’ from this theme owing to the contentious dynamics during the interviews when some participants were actively vying for the position of expert.

The participants were conflicted in their need for the consultant to be an expert who provided magic solutions to problems. This was expressed both explicitly and implicitly by all participants. Anxiety about something that doesn’t provide an immediate solution left some participants feeling overwhelmed in their work. This appeared inherited from the situations of the families they worked with.

5.6 The Impact of Consultation

This is the first study to develop a small evidence base within child psychotherapy that looks into the outcomes of 1:1 consultation. The outcomes illustrate the

professional's gains (micro-gains) and highlight the wider benefits for the patient/family and organisation (macro-gains). Reporting the outcomes of consultation, which grew out of the data, felt like a worthy avenue to explore in-depth in order to consider its value. One question one would hope to answer is, does consultation make enough of a difference?

Participant narratives captured an enlivening quality in how consultations helped them to sustain their work and remain interested. This indicated their capacity to work with the life instinct despite facing IGT histories that could fill the individual and groups with dread and anxiety. When there is space to think together, rather than a rescuing, or curative response, staff were able to take steps forward.

5.6.1 Micro-gains: The collective power of validation, containment, observation and metaphor

Becoming *"unstuck"* in clinical work was a significant outcome of consultation as consultees felt empowered to find a way forward with their patients. As Daws (1985) notes, the expertise of staff needs to be respected and reinforced; this was a function of consultation helping staff feel validated in their work and empowering them to continue with very complex cases.

It became apparent that staff also seek consultation for the container-contained function, as a result clinical progress for the patient and development for the clinician/practitioner was made. Two participants spoke about the efficacy of consultation in reducing the risk of burnout and giving them longevity in their CAMHS careers. The emotional wear and tear generated through their work lessened as they developed trust with the consultant.

Participants reflected that consultation helped them to realise the importance of taking an observational stance, giving them time to take in and ponder the relational dynamics within families. As IGT is not always conscious, observation is central as the effects of the unconscious can be observed through the transference and countertransference. For example, Fraiberg et al (1975) found that in close observation of mothers and babies, ordinary gestures could capture something profound.

The impact of thoughtfulness and deeper reflection was far-reaching when observation was part of consultation. Participants felt able to make more informed assessments of families when they slowed down, listened, and took in mindfully what the families were communicating. Hazel saw her patient in *"a totally different way"*, and Camilla put herself, *"in the families shoes"*. Observation enabled participants to get closer to the families *"total situation*". Furthermore, through the participants modelling of the consultant, they learned to metabolise case material in a collaborative way. This helped them feel less driven to act and more able to reflect. Tanner (1998) reinforced this. Through such processes, observation can be internalised by the participant and transmitted into their work with the patient.

Developing an understanding of observation benefited staff by *"boosting"* their confidence as several participants were keen to develop their skills further from a child development perspective:

> *Being more observant has definitely been one of the positives about consultation. It helps us to feel more confident by really noticing what we're seeing, and to have those difficult discussions around trauma. It's useful in terms of how we formulate with families.* (Jennifer)

In addition, this project evidenced how metaphor is at the heart of consultation. As Modell (2005) explains, metaphoric processes help categorise and map emotional experience. The metaphoric lens helped the consultees clarify something they were trying to understand as they communicated what they were feeling in relation to the patient, e.g., *"going down the rabbit hole"*. Metaphors allowed the patients'/families' trauma to be communicated and thought about creatively. In the words of the participants, it's that new discovery, *"a lightbulb moment"*, *"ah that's what it is"*, *"what have I been missing?"*, which leads us to human connection and empathy, resulting in a more patient-focused outcome. A unique space for this to take place in the NHS is offered through consultation.

The positive outcomes of consultation took place over time and had an aggregate nature. It was this collective overall effect that was powerful. I will now consider the wider organisational gains and whether consultation is embedded into the culture of the MDT.

5.6.2 Macro-gains

Professional networks were brought together through consultation, a view that resonated with the literature. Participants in this study perceived this as a system benefit leading to better outcomes for patients and families where it was a catalyst for change within services, particularly within IGT, opening up 'Expert by Experience' (EBE) pathways.

A significant outcome of consultation was the reported improvement in the quality of decision-making. Firstly, it helped practitioners with the clinical complexity of IGT caseloads where trauma could be unpacked before making treatment plans. Secondly, it allowed practitioners to share the weight of decisions, and by adopting

an observational stance they felt further equipped to consider developmental risk for the young person within the context of their assessments.

A further finding was that the child psychotherapy consultant was attending the MDT meetings regularly, creating a culture in which the staff were talking about the anxieties in their work rather than denying them. Healthier organisational functioning was noticed, although I did not explore this further due to my focus on 1:1 consultation. This could prove to be a missed opportunity to explore the yet-to-be-discovered benefits of having an internally-based consultant within the CAMHS MDT.

5.6.3 Barriers to evaluating outcomes

While the potential gains of consultation at an individual and service level have been uncovered, there were staff anxieties around measuring outcomes specifically. Participants were conscious of a need to build an evidence-base for child psychotherapy consultation if it were to be perceived as valuable to the organisation. Considerable anxieties were felt about their relational work being measured. Multiple risks and benefits of translating participants' emotional experiences of consultation into outcome measures were identified (see Findings Chapter). The predominant view was that whilst there are perceived benefits to collecting consultation data, the quality of the provision cannot be judged by measurable outcomes alone. Similarly, Rustin (2008) posed the question of whether outcome measures adequately reflect the quality of services, especially in interventions where relationships are a central component of the work. It is argued that consultees' narratives can address the "missing areas" that quantitative outcome measures cannot capture. This project has been a springboard for considering how we continue to capture and evidence the

value of psychoanalytic consultation and warrants further investigation about how quantitative evaluation could sit alongside qualitative evidence.

Consultation, the relationship established within it, and the understandings reached were also viewed as an outcome in itself in this study. This finding supports the view of Hunter (1999) that consultation can be a service provided in its own right.

5.7 Implications for Child Psychotherapy Practice

In the process of writing up, when discussing my themes with child psychotherapy colleagues, I noted their strong negative reaction to the word ‘outcomes’ (Theme Five). This made me consider how outcomes can provoke resistance and concern. As an organisational requirement, outcomes could be perceived as intrusive and persecutory. However, taking this stance risks psychotherapy outcomes being viewed as lacking traction which would prevent them from being fully ingrained in the CAPPT’s work. The work of consultation captured throughout this project was collaborative and collectively beneficial. The quality and the effectiveness of its provision generated a curiosity amongst consultees about how we can measure the outcomes, and this was felt to be a powerful message from this research.

This study does not offer a prescribed approach to consultation but does suggest that the provision of consultation should not be down to luck or a *“staff lottery”*. Managers and commissioners have an opportunity to argue the value of consultation to their staff as it ultimately impacts the treatment families receive. The key point, as my research findings reinforce, is “to convince services and commissioners of the value of investing in consultation-based services” (Robinson, 2021, p.258).

5.8 Limitations

The current research derived patterns of meaning from consultees' experiences of consultation with a child psychotherapist, suggesting how it provides containment for the unconscious transmission of IGT and supports staff wellbeing and resilience. It is important to consider these findings within their specific context. The data represents a one-time snapshot gathered from a small staff group, all of whom were White British—one male and six female—from a single service in the North of England. The researcher was careful about conducting a focused study that centred the emphasis on consultees' experiences; however, this required maintaining a degree of separation from the child psychotherapists, decisions that inevitably introduce bias. Another group of participants might have emphasised different aspects of the consultation process, while still sharing elements of overlap with the current sample group. The limited body of research on consultation processes more broadly restricts opportunities for comparison with other consultation models. This constrains the extent to which the processes identified in this study can be situated within, or contrasted against, wider consultation practices.

A fundamental limitation is that the researcher was a psychotherapy trainee in the CAMHS team where the interviews took place. The researcher's established working relationships with participants may have influenced their openness in discussing any negative views of child psychotherapy consultation (notably, no negative patient outcomes were described). It is possible that the CAMHS clinicians and practitioners were positively influenced by the psychodynamic insights gained through having two child psychotherapists offering consultation within their team. The impact of participants feeling "therapized" during consultation, and the need to guard

themselves, may have been an active dynamic during the interviews, shaped by the ambiguity of my multiple roles as psychotherapy trainee, researcher, and colleague.

The participant sample was also very distinct in this study; participants were recruited from one community CAMHS team with a significant local history of IGT. This added richness to the findings yet may not be representative of other CAMHS practitioners seeking psychoanalytically informed consultation. Given more time and resources, it would have been valuable to interview clinicians across multiple CAMHS teams and other NHS trusts to establish greater confidence in the findings. With regard to transferability, further research is needed to explore whether the outcomes—defined as the gains made by staff (micro gains) and gains for the patient and organisation (macro gains)—are perceived similarly by other CAMHS teams. Whilst this is a small study, future research could establish whether there is enough similarity to develop a shared outcomes framework (an initial blueprint for further exploring the transferability of the consultation model has been set out in Table 4, refer to p.94). This blueprint is a coalescence of the approach of child psychotherapists offering consultation in the NHS that I have discerned from studying this sample group; gathering the data and the literature to present something digested and accessible. The blueprint is a beginning point for future research, rather than a competency framework, and one imagines that other child psychotherapists could add to this blueprint in the future.

The decision to focus on IGT in adolescent cases presents a missed opportunity to understand how consultation may be experienced by staff working with different patient groups. Further research is therefore needed to understand the findings more fully across different populations and networks.

5.9 Recommendations for Future Research

Although this is a very small study, my conversations with other child psychotherapists about consultation suggested my findings were representative of what my colleagues described in clinical practice. RTA could easily be applied to replicate this study within other clinics, services and staff groups where the themes identified might be confirmed, denied or could generate new insights around the consultation experience.

The importance and function of boundaries, helping colleagues to endure, tolerate, and contain, would bring into question whether this could be achieved by offering online consultations. This study does not explore this area, however, given the pressure on resources within the NHS, this may be a worthy avenue to consider in future consultation research.

One of the unique findings of this study concerns how the consultative stance appeared to be transmitted within the consultation relationship through to the patient. Making the impact of the consultant's modelling of a curious, third-position explicit opens up an important area for further investigation. Future research could explore whether similar processes occur across different settings, modalities, or professional groups.

It would be enlightening to conduct a hybrid evaluation approach to consultation in practice, capturing numerically the insights gained through this qualitative study (do staff retention rates improve and sickness rates fall when there is a consistent consultation offer?) Although beyond the remit of this study, opportunities to integrate qualitative and quantitative data would develop robust ways to evidence the effectiveness of future consultation in practice.

CHAPTER SIX

Conclusion

"Consultation steadies the ship in a major way" (Camilla)

Motivation for this research was my interest in how child psychotherapists were applying their psychoanalytic understanding in supporting staff in complex trauma work. This study has given me an opportunity to investigate the consultation process in a systematic way. Alongside this project, my professional journey has contextualised consultation. Qualifying as a Child Psychotherapist, I transitioned into two NHS-based roles where offering consultation and supervision to colleagues was important in creating a reflective space where difficult cases could be considered. Through the process of undertaking this doctorate, I have come to appreciate in-depth how collaborative consultation feeds my clinical work, developing me as clinician.

The findings specifically highlight the important role of consultation to staff working in trauma-focused services so they can develop their skills and practice. This is consistent with Cherry-Swaine's (2024) recommendation for staff supporting trauma survivors. The particular focus of this study, 'bringing psychoanalytic consultation to the table', could perhaps be extended to new client groups and other multidisciplinary teams in the NHS and social care.

This study interpreted that the psychoanalytic markers in theme one, and the metaphors connected to *"slowing down"* evidenced containment as key to the positive experience of consultation which echoed the views of other child psychotherapists writing about their consultancy in clinical settings.

My research concludes that consultation is strengthened by the uniqueness of the psychoanalytic frame approached from a third position, which works with the emotions and defences and engages in the spirit of observation. Specifically, the liveliness that can be achieved through a collaborative endeavour helped participants to think, be curious and sustain working with complex trauma patients, as the IGT narratives exemplified. This also requires a great deal of sensitivity and carefulness from the consultant, who is trained and equipped to offer the container-contained relationship, where consultees can feel safe enough to *"slow down"* in order to explore the raw emotions evoked through their direct work with patients. If left unprocessed, staff risk feeling haunted by overwhelming feelings. This resonates with the child psychotherapy clinical literature. Thus, this study raises questions about the impact of working with trauma where there is no provision of consultation, because without it, something more dehumanising can be played out in the staff dynamics (Menzies-Lyth, 1960).

The findings add an appreciation of the complex dynamic around 'who's the expert?' which may negatively impact upon the consultee's engagement. Child psychotherapists should consider the technical adaptations they might need to make to reduce the risk of consultees feeling *"exposed"* or *"therapized"*. As Wilson (1999) noted, in engaging with the personal issues of the staff during consultation, psychotherapists may be misperceived as providing psychotherapy for staff; thus, CAPPTs must be clear in their own minds that they are not psychotherapists in this context. Based on my findings, a place of stillness, listening and emotional containment allows for the realisation of what's under the surface, benefitting the well-being of CAMHS staff and patients alike.

CHAPTER SEVEN

Some Recommendations

The findings of this research will be shared with the CAMHS MDT within which this project took place in order to reflect upon the fundamental role that consultation by a child psychotherapist has played in the interventions offered to adolescents and their families. Disseminating to managers and commissioners the knowledge of how child psychotherapy can be adaptable and flexible beyond individual long-term therapy could offer insight into the benefits and potential for staff and networks. The robust theoretical framework that consultation offers can be well utilised to support staff with a sense of safety and help them sustain and develop their careers in CAMHS.

For staff in this particular project, consultation was actively sought as an intervention of choice when working with IGT. It could be beneficial for the CAMHS MDT to reflect on whether these findings of consultation resonate with other clinicians who have received consultation but were not interviewed in the study. Additionally, reviewing which kinds of cases get taken for consultation and by whom, alongside the outcomes achieved, may help educate the wider team in understanding the impact of consultation provision and opportunity.

Further recommendations are focused on wider NHS services working with traumatised children and families. This small-scale study was able to demonstrate why consultation should be offered as an intervention in trauma-focused services:

- If the NHS could grow their own internal consultants by investing more in consultation, the filter-down could be enormously beneficial to staff as they

share their experiences, support one another, and prevent burnout.

- The consultant's third position can make the process of metabolizing the impact of IGT more manageable for staff working in emotive situations. The centrality of containment is also apparent. Child psychotherapists are best placed to conduct this essential work due to their specialist psychoanalytic training and skills. Child psychotherapists therefore have an important role in supporting national and local initiatives to embed trauma-informed care, particularly through the provision of consultation to professionals working with affected children and families.

- Psychoanalytically focused consultation in trauma services can reduce the levels of secondary traumatic stress and staff burnout. Considerable savings could be made in terms of staff sickness, retention, and improved performance, which warrants further research to add empirical support to the practice of using a consultation approach more widely in trauma-focused services.

- The meeting of multiple minds can help build a coherent trauma narrative[7] with acknowledgment of the past through the witnessing and observing that takes place during consultation, without staff and families feeling re-traumatised in the process.

[7] In some CAMHS, building a trauma narrative, may at times be referred to as building a 'developmental history' of the child and family context.

- Services should use consultation to extend therapeutic thinking across the network, particularly in cases where direct therapy is not possible. Consultation can help clinicians hold, think about, and respond to trauma even when formal treatment cannot be offered.

- The resilience of staff working in trauma-focused services can be strengthened by consultation; attention is paid to all relationships and staff are supported to keep in mind other family members so the problem is not located solely in the child.

- Furthermore, with individual child psychotherapy considered too thin on the ground (Wilson, 1999), providing consultation to staff and supporting them to do the work directly themselves could be more cost-effective by increasing the reach of suitable trauma interventions for children, families, and their networks.

- As part of the NHS directive for “cascading” skill sharing (Hunter, 1999), consultation has positive implications for the staff’s motivation to learn, developing reflective practice, acquiring psychodynamic insights as well as helping patients. Staff can support one another by developing a consultative state of mind within their professional networks and associations.

- The tensions underlying the ‘who’s the expert’ dynamic in staff consultations could be addressed at an organisational level by raising awareness through training about the purpose and functions of child psychotherapy consultation in order to demystify the model.

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Appendix A: Detailed Literature Search Strategy

In November 2022, a range of scholarly databases were searched through the Tavistock Electronic Library including: PsycINFO, PsycARTICLES, PEP Archive and PsycExtra, using the key terms in the table below. These databases were selected to give breadth and depth of coverage within psychology and psychoanalysis disciplines.

List of Boolean search terms used in the literature search are shown in the Table 5 below.

Table 5: *Detailed Literature Search Strategy*

Research question: Bringing Psychoanalytic Consultation to the Table: Experiences of CAMHS clinicians and practitioners who engage in a 1:1 consultation with a child psychotherapist about their work with adolescents with a history of intergenerational trauma		
S1	Consultation	'Consult*' (to include consult and consultant) or 'Consultation' or 'Consultancy'
S2	Child Psychotherapist	'Child Psychotherap*' (to include Child Psychotherapists and Child Psychotherapist and Child Psychotherapy)
S3	Intergenerational Trauma	'Intergenerational Trauma' or 'Transgenerational Trauma' 'Multigenerational Trauma' 'Cross-generational Trauma' 'Parental Transmission'
S4	Child and Adolescent Mental Health Service	'Child and Adolescent Mental Health Servic*' (to include services or service) or CAMHS
S5	Adolescents	'Adolescen*' (to include adolescent and adolescent and adolescence)
S6	Empirical study	'Empirical study' or 'empirical research'.

I carefully identified and refined the best search terms to capture each central concept within the research question by cross-referencing within the keywords of the relevant papers which emerged.

Truncation was applied to keywords e.g., *psychotherap*, to retrieve multiple word beginnings/endings.

Combining S1, S2, S3, S4, S5 & S6 using Boolean Operator ‘AND’ generated 6,782 results. (Screenshot A)

Inclusion and exclusion criteria were defined to ensure the search was appropriately targeted to the research question.

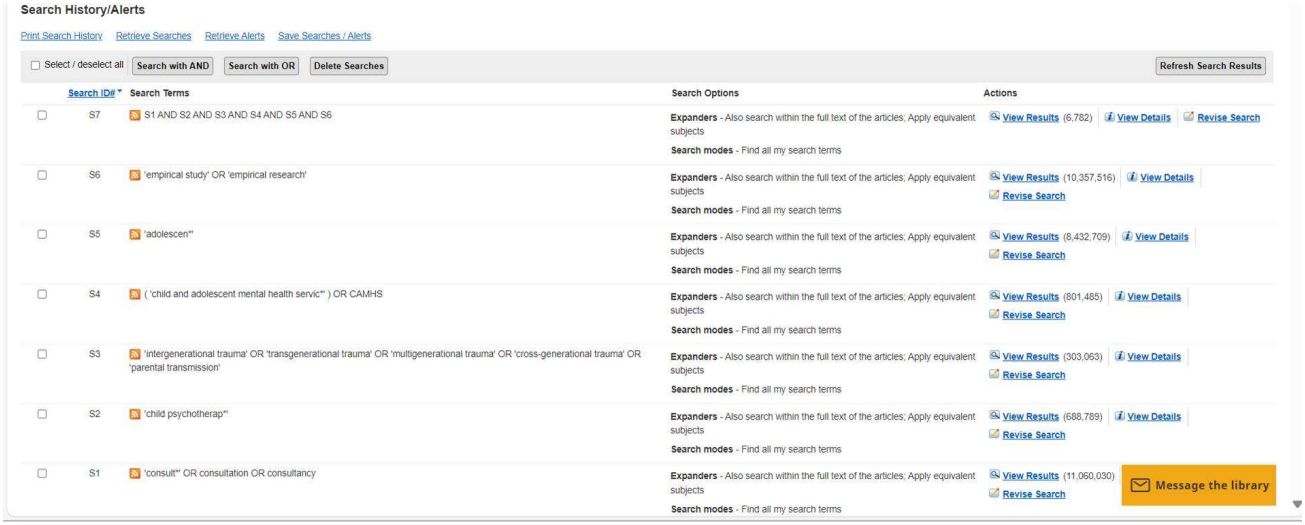
Inclusion Criteria	**Exclusion Criteria**
1. Papers are written in English	1. Papers not written in English
2. Full text available	2. Full text unavailable
3. Papers discussing, exploring, or evaluating Child Psychotherapy consultation with staff in a multidisciplinary CAMHS setting with a trauma focus	2. Papers that focus on psychoanalytic consultation with patients.
4. Papers focusing on Child Psychotherapy interventions for children, adolescents and families with a history of IGT within CAMHS settings	3. Papers that focus on IGT with no psychoanalytic concepts.
5. Papers focusing on interventions for children and adolescents with a relational-attachment focus, as part of the psychoanalytic research family	4. Papers that focus on IGT with no exploration of relational-attachment based focus.
No age limiters for participants were set due to multigenerational factors	

Applying the inclusion/exclusion criteria and limiting articles to the following subjects “adverse childhood experiences”, “attachment”, “intergenerational relations” “resilience”, “psychoanalysis”, “psychotherapy”, “research”, and “trauma”, narrowed to 689 results. Titles and abstracts were scrutinised to ensure fit with inclusion criteria and exclusion requirements. I considered a mix of historical and contemporary studies to explore emerging patterns/themes over time.

I found a large volume of literature that was not grounded in the psychoanalytic tradition, for example focusing on family therapy or CBT. Other papers focused on the educational settings, including behavioural regulation approaches for traumatised children.

I identified most empirical research related to IGT within the context of parent-infant psychotherapy, attachment studies and Holocaust studies. An EBSCOhost search using the same search terms and limiters identified several psychoanalytic psychotherapy books and the bibliographies were reviewed. This was helpful in sourcing and snowballing further relevant references relating to consultation within trauma settings.

Screenshot A



Extension of the search based on initial findings

In my initial search, described above, I was struck by the high frequency of the repeated term ‘intergenerational trauma’, which was often coupled with an evocative word such as ‘ghosts’. As this engaged my curiosity, I conducted a new search purely on the search terms for ‘intergenerational trauma’ as already defined in Table 5 (S1) within the title of books/journals and articles. The search included only papers in the English with no-date parameters so as to capture seminal and recent conceptualisations.

Amongst the titles of over 1,000 articles/books, the words used in reference to the phenomenon of IGT included ‘ghosts’, ‘phantoms’, ‘echoes’ ‘shadows’, ‘wounds’, ‘pain’, ‘prisoner’ ‘secrets’ ‘buried’ ‘harrowing’ ‘unthinkable’ ‘ancestral’… and these

words were repeated over again. It appeared the intent of the titles was to break through, shock or grab the reader (consciously and unconsciously). In my mind, my methodical search serves to convey the emotional and unconscious depths I may tread throughout this research project. This powerful experiment remained with me throughout my project, as it spoke volumes to the need to symbolise IGT if it is to be spoken and known about.

Appendix B: Participant Information Sheet

Northern School of Child and Adolescent Psychotherapy

The Tavistock and Portman NHS Foundation Trust

Research Project

Bringing Psychoanalytic Consultation to the Table:
Experiences of CAMHS clinicians and practitioners who engage in a 1:1 consultation with a child psychotherapist about their work with adolescents with a history of intergenerational trauma

Dear Colleague,

Thank you for your interest in this research. My name is Sarah Huntington and I work for the Trust as a Trainee Child and Adolescent Psychotherapist in [location redacted] CAMHS. I am undertaking research as part of my Clinical Doctorate at the Northern School of Child and Adolescent Psychotherapy (NSCAP), which is a centre for the training of child and adolescent mental health professionals. The accrediting university of this doctoral project is the University of Essex in partnership with the Tavistock and Portman NHS Trust.

I have a special interest in trauma and learning about how trauma can be transmitted within families, often referred to as Intergenerational Trauma. In [location redacted], one of the ways in which we work alongside CAMHS colleagues in the treatment of patients impacted by various kinds of trauma is to offer a consultation with a child psychotherapist via the Consultation Pathway. My research project involves thinking about the Consultation Pathway to explore the gains and challenges of this way of thinking about complex cases (those impacted by intergenerational trauma) as well as reflecting on what makes clinicians/practitioners seek consultation. Attention will also be paid to the clinical contribution of child and adolescent psychotherapists within the CAMHS MDT. As this study is mainly of a psychoanalytic focus, the interviews and data analysis will be approached by the researcher through this lens.

Invite to participate

You are invited to participate in one semi-structured interview. This interview will take around 1 hour and you will be asked to draw on your experiences of using the Child Psychotherapy Consultation Pathway and whether this has influenced your clinical practice. The interview will occur at a time that suits you. You can choose whether to take part in person at the CAMHS clinic or online (via Microsoft Teams). Your interview is separate to any existing consultation meetings you might currently be involved with.

Before you decide whether to take part in providing verbal feedback to inform the research, it is important for you to understand why the project is being conducted and what your participation will involve. Please take the time to read the following information carefully. You are welcome to ask further questions if you wish.

What is the purpose of the project?

The purpose of this project is to gain an in-depth understanding of clinicians/practitioners' experiences of consultation with a psychoanalytic child psychotherapist and the possible impact on clinical practice. The findings of the research may be used by the Consultation Pathway to support the continuous improvement of the consultation offer.

Why have I been chosen?

All practitioners who have used the consultation service in relation to case discussions around patients with a history of intergenerational trauma have been invited to participate in this project.

Recording of interviews

To ensure that the analysis and findings are accurate and of a high quality, it is necessary to audio record your interview. Audio recordings will be transferred to an encrypted NHS drive following your interview and then deleted from the audio recording device. The audio recordings of our interview will be transcribed (typed up) and will be used only for analysis. No other use will be made of them and no-one outside the project will be allowed access to the original recordings. Your interview data will be destroyed after completion of the thesis write-up. Your personal details will be stored and protected according to General Data Protection Regulations 2018 (GDPR).

How will the data be used?

All the information that we hold we be kept strictly confidential in accordance with the terms and conditions of Data Protection legislation, https://tavistockandportman.nhs.uk/about-us/governance/policies-and-procedures/

Your interview data (transcripts) will be anonymised (i.e., any information that can identify you will be removed) and analysed. However, there are some limits to anonymity:

1) as the evaluation involves using qualitative data (i.e., conversations) anonymised quotations will be used, from which you may be able to identify comments that you made during our interview.

2) it is our duty of care to inform appropriate services if you disclose that you or others are at risk of harm. Any necessary steps for safeguarding purposes will remain your responsibility.

Do I have to take part?

It is entirely up to you whether to take part. If you do decide to participate, you will be given this information sheet to keep, and you will be asked to sign a consent form prior to starting the interview. The interviewer will go through the consent form with you before the interview starts. You can withdraw at any time, up to four weeks after completing your interview, and you will be under no obligation to provide a reason for

this. Withdrawing will not impact on any future support you may seek from the Consultation Pathway.

If you wish to make a complaint about this process or have any concerns about the research you are being asked to provide consent for, you can contact the Organising Tutor of the Clinical Doctorate in Child and Adolescent Psychotherapy.

What are the possible disadvantages or risks of taking part?

The nature of the clinical work which involves patient trauma is potentially distressing, therefore, there is a possible risk that the interview may trigger distress when reflecting on your experience. If this occurs, it may be appropriate to signpost you to debrief with a psychotherapist from the Trauma Service or you can seek supervision within your service.

What are the possible benefits of taking part?

There are no immediate benefits for those participating in the project. However, this research will help the CAMHS to better understand the value of its Consultation Pathway and how this might be improved in the future.

Use, dissemination and storage of evaluation data

There will be restricted access to the completed thesis via the Tavistock and NHS library. Additionally:

1. A summary of key findings will be shared managers and colleagues with the CAMHS service.
2. It is hoped that the project will be published in a journal article.
3. Given the importance of evaluation data, the findings from the project may be used for additional research.

As a small-scale study, there is a very small risk that some identifying features may be discoverable, however, every effort will be taken to ensure confidentiality.

Has an ethics committee given permission for this research?

This research was approved by Tavistock's Research Ethics Committee (TREC) on 28th October 2022.

Sarah Huntington, Trainee Child and Adolescent Psychotherapist is contactable via email at: [email]

Sarah Huntington is supervised to conduct this project by Dr Rajni Sharma who can be contacted at: [email]

If you have any concerns about the conduct of the researcher 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)

Thank you for taking the time to read through the information. If you have any questions that you would like answered before you might feel ready to take part, please contact me on my email address provided.

Appendix C: Participant Informed Consent Form

Northern School of Child and Adolescent Psychotherapy

The Tavistock and Portman NHS NHS Foundation Trust

Participant Consent Form

Title of Study: Bringing Psychoanalytic Consultation to the Table: Experiences of CAMHS clinicians and practitioners who engage in a 1:1 consultation with a child psychotherapist about their work with adolescents with a history of intergenerational trauma

Name of clinician: Sarah Huntington

1. I have read and understood the participant information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. I am also aware that the study is academic research.

2. I understand that my participation is voluntary and that I can stop taking part without giving a reason up to four weeks after completion of the interview.

3. I understand that as part of this study, I will be recorded by an audio recording device during an interview. I understand that the recordings will be transcribed and used in the analysis of the study.

4. I understand that the material used in this research will be anonymised and that I will not be identifiable in the thesis (i.e., you will not be using my name or giving details that would identify who I am).

5. While I will take every step to ensure your contribution is not identified, because of the small scope of the study, it may well be possible for persons to identify you.

6. I understand that if key findings from the research are submitted for publication, this would be to an appropriate professional journal, and every care would be taken to prevent my being identifiable in anyway.

7. I understand that it is the researcher's duty of care to inform appropriate services if you disclose that you or others are at risk of harm. Any necessary steps for safeguarding purposes will remain your responsibility.

Name (please print): ……

Signature: …… Date ……

This research has been approved by TREC Ethics Committee on 28/10/22

Appendix D: Semi-Structured Interview Schedule

Northern School of Child and Adolescent Psychotherapy NHS

The Tavistock and Portman NHS NHS Foundation Trust

Preamble

We are meeting today to think about your experiences of 1:1 consultations with a child psychotherapist. You can express yourself freely and openly, there are no right or wrong answers, I'd like to hear your thoughts. Please take your time if you need to think.

I will be enquiring about whether the consultations have impacted your work with adolescents and their families with a history of intergenerational trauma. I'd like to offer you a definition of intergenerational trauma before we begin.

(Researcher reads aloud) Definition: Intergenerational trauma can broadly be identified as trauma of various kinds in the adolescent's parents' and/or grandparents' generation that may be impacting on the adolescent's mental health or manifesting in the adolescent's presenting difficulties.

1. **Could you say a little bit about yourself?**
    a. What is your role in CAMHS?
    b. How long have you been in this role?

2. **Thinking back to the start of your consultations, did you have any expectations about it and how did it make you feel?**

3. **How were the consultations arranged?**
    a. Did you approach the child psychotherapist, or were you approached with an offer of help?

4. **Can you talk about your reasons for seeking consultation with a child psychotherapist?**
    a. Did anything specific trigger the request?

5. **How do things work in the consultations?**
    a. What worked or didn't work for you?

6. **Can you tell me as much as you can about your experience of the consultations?**

7. **What sorts of issues are you able to bring to the consultation?**

8. **Did anything surprise or worry you about the consultations?**
    a. Do you remember details from the consultations?
    b. What sorts of things do remember?
    c. What do you take away?

d. How might you process the things you have discussed in the consultations?
e. Were there any strong negatives or anything that left you feeling concerned?

9. What aspects of the consultations have you found helpful or challenging?

10. Can you describe what impact attending the consultations has made on your work?

What, if any, differences have you noticed in:

a. the way that you think about your work?
b. the way you carry out your work?
c. your relationships with staff and patients?
d. your awareness of your own anxieties as a result of taking part in the consultations?

11. How has engaging in consultation helped to increase your understanding of the adolescents and their families you work with in your CAMHS setting?

12. How have the consultations contributed to the way you work with adolescents and their families impacted by trauma?

13. Describe anything you do differently at work, or in your practice as a result of consultation?

a. Have you done further reflection, discussion with colleagues, reading or training?

14. How might you continue thinking about the things you have discussed in the consultations?

15. What learning might you have taken away from the consultation meetings?

a. What are the main learning points which you have gained from the consultations?
b. How might the consultations have impacted on you personally?

(Prompt: Now I'll be starting to bring the interview to a close with a few final questions)

16. What is the biggest impression the consultations have made on you?

17. Is there anything else that you would like to say that you haven't had an opportunity to say so far?

18. How did it feel to take part in this research interview?

Thank you for taking part in this interview, I appreciate your time and responses.

Appendix E: Participant Debriefing Sheet

Northern School of Child and Adolescent Psychotherapy

The Tavistock and Portman NHS NHS Foundation Trust

To be read to participant at the end of the interview

Study Title: Bringing Psychoanalytic Consultation to the Table: Experiences of CAMHS clinicians and practitioners who engage in a 1:1 consultation with a child psychotherapist about their work with adolescents with a history of intergenerational trauma

Thank you for your involvement in the interview today as a contribution to my research in which I hope to gather an understanding of the MDT CAMHS experiences of 1:1 consultation with a child psychotherapist, especially when considering work with adolescents with a history of intergenerational trauma (IGT).

The Consultation Pathway, which has not been reviewed before, is really interested in learning from consultees about what has been helpful to them, and where improvements may need to be made. Since starting my training placement at CAMHS, I have observed in my own clinical work, that many of my referrals are often trauma related, moreover, that there is often trauma that can be tracked back to the parents/grandparents' generations. I think this demands a great deal on the clinician, and that talking to others about such complex cases can offer a space to share concerns, allow curiosity around the case and offer a sense of containment. This is my experience as a trainee psychotherapist, but I wondered how other members of the MDT experienced consultation and whether there was anything specific to IGT that may trigger a request for consultation, as well as exploring at a deeper level how mental health professionals support each other in cases of deep complexity. I aim to approach my research with an open mind, I don't have a specific hypothesis that I am trying to prove or disprove, rather I want to find out what is the lived-experience now of the mental health professionals that do use the service and whether there are there any themes in common between mental health professionals, and what are the differences. I hope to gather these aspects in my findings and will be producing a thesis which will document the whole research process, as well as discussing the main themes that emerged. I am happy to share the key findings with you once I have written up my thesis.

I just want to re-iterate that your data will be treated with complete confidentiality and anonymity. Also, that you have the right to withdraw from the study including all of your data, up to four weeks after this interview has taken place, without giving a reason.

If you are interested in further consultation on a case, please contact [name redacted], Child and Adolescent Psychotherapist, in the first instance [email redacted].

If the interview has brought to the surface any difficult emotions or feelings around trauma, I would be happy to explore that with you now, or alternatively, I can arrange for a further debrief with one of our Psychotherapists in the Trauma Service, or you have the option to raise this with your own workplace supervisor.

Thank you again for your participation.

(Copy of debrief form to be given to participant).

Appendix F: Ethical Approval

The Tavistock and Portman NHS
NHS Foundation Trust

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

Tel: 020 8938 2699
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Sarah Huntingdon

By Email

28 October 2022

Re: Research Ethics Application

Dear Sarah,

Title: Bringing Child and Adolescent Psychotherapy Consultation to the Table: Experiences of MDT CAMHS clinicians'/practitioners' who engage in 1:1 consultation about their work with adolescents with a history of intergenerational trauma

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.

The assessor did make a minor recommendation re thesis title: *It does not say in the research title what sort of consultation or who the consultation is with. In the TREC it is made clear that these consultations are 'psychoanalytic consultations, with a Child Psychotherapist'.*

I wondered if for the purposes of clarity for the reader, it might be helpful to have (something of) this in the research title. I understand of course that this may make the title overly long.

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

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

I am copying this communication to your supervisor.

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

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

cc. Course Lead, Supervisor, Course Administrator

Appendix G: Initial Thematic Map