The Role of containment and holding in Psychoanalytic Psychotherapy with Children in Care

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Abstract:

This thesis is an evaluation comprised of two studies exploring the implementation of a new pathway for Children in care (CiC), and the experience of Psychoanalytic Psychotherapists from the same CAMHS who deliver treatment to children in care. In 2018, the CQC gave a rating of 'requires improvement' for safety to the CAMHS due to long waiting times. In response, a Children and Young People Joint Agency Pathway (CYPJAP) was implemented in April 2019 to replace the previous Looked After Children's pathway.

Routinely collected clinical data were used to examine waiting times for first appointment and length of treatment for the historical LAC pathway (2018 –2019), the new CYPJAP (2019 – 2020) and Core CAMHS (2018-19/ 2019-20) as a control. It was hypothesised that there would be a significant difference in waiting times for first appointments between the two pathways for children in care. A Mann Whitney U test indicated a significant reduction in waiting times on the CYJAP ($p<0.0001$).

The interview study aimed to explore the Psychotherapists' experience of containment (Bion, 1962b) and holding (Winnicott, 1963) in work with CiC and how this may present in the clinical work. Four Psychotherapists were interviewed, and thematic analysis used to analyse the data. The themes which emerged described the child's journey through Psychotherapy. This included 'holding and containing the network'. The second stage of the journey explored children's communications related to their early life in 'projections, enactment and the depriving therapist'. In the third theme 'being in touch with what's missed', the children recognised experiences they had missed. The final theme, 'journey to integration' described children's improved emotional regulation, indicative of a more integrated state of mind.

The new pathway significantly improved CiC's access to a specialist treatment, and psychotherapists demonstrated a shared understanding of CiC's need for containment and holding to improve mental functioning.

Key words: Containment; holding; children in care; primary maternal preoccupation; skin-to-skin; integration; journey; Psychotherapy

Declarations

I declare that the content of this study is all my own unaided work, and that ethical approval has been granted by TREC. Confirmation of approval is in Appendix 1.

Acknowledgements and dedications

With thanks to my first supervisor, Dr Lerleen Willis. Your time, patience and support have been instrumental in the development of my work. To my second supervisor, Dr Janet Shaw. Your encouragement, thoughts and experience have been invaluable. To my parents Lorraine and Phil Unsworth for believing in me, and for all your assistance in making this possible. To my husband, Tim Baker, for your constant love and support, and to my daughter Sofia, my motivation.

Abbreviations

LAC – Looked-after Child/children

CIC – Child/Children in Care

EOT – Enhanced Outreach Team

CYPJAP – Children and Young People's Joint Agency Pathway

Contents

1. Introduction

The history of children in care dates to 1838 where children without parents, were considered to be in the care of workhouses. Overtime, the 1989 Children's Act which sets out the Local Authority's duty to safeguard children in care was developed (Higginbotham, 2017). This duty was referred to as 'corporate parenting' meaning the Local Authority holds parental responsibility for the child (Children's Act, 1989). These children may be removed from their birth parents due to abuse, neglect, or their parent's inability to provide adequate care.

Research has indicated that Children in care are four times more likely to need mental health support than those children who remain with their birth families (Tarren-Sweeney, 2008) and Hambrick et al. (2016) describe increased experience of post-traumatic stress disorder, anxiety and low mood in children in care. Poor education attainment and poor lifetime outcomes both socially and financially are associated with poor access to mental health services.

Children in care are frequently referred to Child and Adolescent Mental Health Services (CAMHS) and often access Psychoanalytic Psychotherapy. When carrying out Psychoanalytic psychotherapy with this group, additional thinking about working style and adaptations may be required, both in terms of practical considerations, and the emotional environment the work takes place in (Lanyardo, 2017). This may relate to different aspects of the work, including difficulties with managing breaks in treatment and time (Canham, 1999), the network (Emanuel, 2002), and the experience of being understood (Kenrick, 2005). The way in which children and their internal worlds can be held and contained is an important consideration in relation to all young people that are seen, but due to institutional dynamics, early life

experience, attachment, and relationships, it may be that children in care may find it more difficult to establish a therapeutic relationship (Van IJzendoorn et al. 2011; Turner et al. 2019; Furnivall, 2011; Hillman, Cross & Anderson, 2020).

The thesis is mixed methods and is comprised of two studies; a quantitative service evaluation of a new pathway being implemented specifically designed for children in care, and a qualitative study, exploring the role of containment and holding in Psychotherapy with children in care. A mixed methods study was the requirement at the time of commencing the thesis, and degree in Psychology and my previous experience as a researcher-practitioner encouraged me to use both quantitative and qualitative analysis methodology. The topic was of interest due to experiences as a trainee, in which much of my work was with children in care. The supervision and teaching I received enabled me to consider technical adaptations and allowed thinking about how to work with children who may never have had a good experience of being contained or held in mind. The deprivation, which was apparent, impacted on their ability to build a relationship, and at times, to be in the clinic room. My interest in this population, and their experience in Psychotherapy links to work I carried out in my training. My latency intensive case was a child in care, and I observed patterns in his behaviour, alongside an awareness of my own powerful countertransference experience. I became aware of the intensity of my experience with children in care, and the way in which I was pushed into positions of needing to catch, sometimes physically hold, and offer a containing space in the room, when the children would run or struggle to allow themselves to have a therapeutic experience. I noticed links between other training cases I worked with who were children in care, and my curiosity about whether other psychotherapists experienced similar themes within their work lead to the development of this research. The theory I had become

familiar with in my training; in particular Bion's (1962b) theory of containment and Winnicott's (1963) description of holding felt pertinent, and these two theories, which offered slightly different perspectives on similar processes were key in the thinking I was doing with supervisors, colleagues, and individually. The Looked After children seminar I had attended had developed my interest in Winnicott (1963) particularly when thinking about adaptations in the creation of a holding environment. The service evaluation of the new pathway implementation was also beneficial for the service I work in and provided some insight into waiting times for treatment for children in care.

The introduction of a new pathway, within the CAMHS where I am based, designed specifically to offer a more streamlined service for Children in care entering the service, enabled an opportunity for a service evaluation to ascertain the impact of the new pathway on waiting times to first appointment, as well as referral numbers and length of time in treatment in the period April 2019 – March 2020 as compared to April 2018 – March 2019 on the previous LAC pathway.

Both the qualitative and quantitative studies describe work with children in care, however, whilst the quantitative study describes the treatment pathway for children in care who may receive a range of interventions, the qualitative study refers solely to Psychotherapists' experience of children in care who access Psychoanalytic Psychotherapy in the service.

The first chapter of the thesis is this introduction to the topic, and overview of the thesis structure.

The second chapter of the thesis is a literature review, which explores the two concepts of containment (Bion, 1962b) and holding (Winnicott, 1963), technical

adaptations in work with Children in Care, as well as literature on attachment (Bowlby, 1958) and a background to Children in care.

The third chapter presents the quantitative study, which presents data for the old LAC pathway, and the new CYPJAP, comparing time to first appointment, with the hypothesis that the new pathway will impact waiting times.

The fourth chapter is the methodology for the qualitative study, describing data collection, and the method of analysis (Thematic Analysis, Braun and Clarke, 2006)

Chapter five presents the findings and discussion of the qualitative data collected from the interviews, with findings presented as four themes, exploring the child in cares journey through Psychotherapy following analysis of interviews using thematic analysis.

Chapter six is the conclusions, which considers the key findings from both studies, along with strengths, limitations, and recommendations for future research.

The final chapter is the reflections of the author on the process of completing the thesis, including challenges, and learning points.

2. The Literature review

Decades of research have examined the use of Psychoanalytic Psychotherapy with Children in Care (CIC) and themes such as deprivation (Henry, 1974; Emanuel, 2002), time and boundaries (Canham, 1999) and challenging behaviours (Rustin, 2001, Kenrick, 2000,2005) are frequently cited when reflecting on work in this area. Adaptations in technique when working with this group have been considered (Lanyado, 2017; Kenrick, 2005), and core Psychoanalytic concepts such as Containment (Bion, 1962b) and Holding (Winnicott, 1963) are frequently reflected upon in research (Durban, 2017; Hopkins, 2000; Sandler, 1985; Emmanuel, 2012).

2.1 Aims of the review:

This literature review aims to explore the concepts of containment and holding in relation to psychoanalytic psychotherapy work with children in care.

2.2 Objectives

- To Identify, define, and critically evaluate the key theoretical concepts and research related to containment and holding
- To Consider the role of Psychoanalytic Psychotherapy, Containment, holding, and technical adaptations in work with children in care.

2.3 Method

2.3.1 Narrative review

A narrative review has been chosen for the current study as this type of review aims to describe and appraise articles, allowing key concepts to be discussed, and evaluated individually and then summarised in relation to the research questions (Ferrari, 2015). A narrative review is an appropriate review method as it allows for a

critical appraisal of the synthesised literature available. Although this method of review provides a broad overview, making it difficult to generalise, it considers published and therefore often peer reviewed literature. This method allows for consolidation and summation, enables duplication of research to be avoided and enables identification of gaps in the subject (Jahan, Naveed & Zeshan, 2016; Ferrari, 2015; Green, Johnson & Adams, 2001).

A potential weakness of this type of review is that the full scope of data is not considered, rather the researcher is selective in the papers presented, and this could lead to bias, or omission of research which may not fit with the researcher's viewpoint (Jahan, Naveed & Zeshan, 2016) however, a systematic literature search, using inclusion and exclusion criteria can help address this (Pautasso, 2013; Byrne, 2016).

2.3.2 Literature Search

The search employed the key terms in the research question 'what is the role of holding and containment in Psychoanalytic Psychotherapy with Children in care'. The terms used were 'Holding (OR "Physical Holding", "Emotional Holding", Touch, Gather, Winnicott); Containment (OR Boundaries, Regulation, Projection, "Projective identification", Bion, Countertransference); "Psychoanalytic Psychotherapy" (OR Psychother*, Psychoanal*, "CAPT", "Child and Adolescent Psychotherapy"); "Children in care" (OR "LAC"Foster*, Child*, "Looked-after child*", "State care", "Children's home") and Role (OR Function*, Contribut*, Part, Place, Position, Capacity). The terms Bion AND Containment, and Winnicott AND Holding were also searched for separately to identify theoretical papers for the review.

The following databases were searched: Psycinfo, PepArchive, Medline, SocIndex and Social care online. PsycInfo, and Medline were chosen for their relevance to Psychoanalytic Psychotherapy.

Initially, high volumes of papers were returned, so inclusion and exclusion criteria were applied.

2.3.3 Inclusion and exclusion criteria

2.3.3.1 Source

- Papers dated within the past 60 years (this range was chosen due to theoretical concepts dating back over this time period which are key to the explanation and description of the concepts)
- Papers in peer reviewed journals, dissertations, reviews, or book chapters
- Papers which originated from the UK, USA, or Europe, and were written in English.

2.3.3.2 Study Quality

The majority of empirical papers in this area are case studies or small cohort studies, which led to the inclusion of these, despite limitations such as the potential for a lack of generalisability. There was a recent large-scale survey of the profession of Child and Adolescent Psychotherapists, relating to their work with Children in Care (Robinson, Luyten & Midgley, 2017) but no randomised controlled trials in this area. Theoretical papers were also included, as they enabled the key concepts of holding and containment to be defined.

2.4 Search results

The combined search produced 64 results. PSYCINFO covers interdisciplinary research about behavioural and social science, Medline is a bibliographic database of articles from healthcare and medical journals. PepArchive is a database of peer-reviewed journals, and theoretical books for Psychoanalytic studies. The PepArchive was chosen to allow exploration of more theoretical concepts around holding and containment. Government Guidelines, such as the Children's Act and papers linked to Children in care were also searched for using a standard search engine. These were felt to be important in defining the term "children in care", and giving background into the development of fostering, and related legislation Each of the 64 papers were read, and relevant information extracted. The reference lists of key papers were explored, which led to a further 8 papers being added to the review, with 72 papers in total.

2.5 Structure of the review

Each of the 72 papers were individually read and reviewed and then organised into six topics: Children in care, Psychoanalytic Psychotherapy, Containment, Holding, Attachment & Deprivation, and Technical Adaptations.

Common findings were considered and collated, and information from the papers is presented under these topic headings.

2.6 Children in care

The National Society for the Prevention of Cruelty to Children (NSPCC) defines a Looked-after child (LAC), as a child who has been in the care of the local authority

for more than 24 hours (NSPCC, 2021). Looked- after children are often referred to as Children in Care to avoid the problematic nature of the term, 'LAC'. For instance, Lewis (2019) described the importance of the 'language of care', giving an example of a 12-year-old, who asked why they were lacking, when being described as a LAC child.

The history of children in care dates back to 1838 when children were reported as living in workhouses without parents, as they had been orphaned, or deserted. These children were therefore considered to be *in the care of* the workhouse (Higginbottham, 2017). Poor Law commissioners advised in 1842 that children under 16 could be detained in the workhouse if they were considered to be in danger if they left. By 1853, the first foster families were created, when children were removed from a workhouse in Cheshire, and placed with local families. In 1889, the Poor Law was extended to officially allow children whose parents were dead or unfit to be kept under the care of the workhouse without their parents (Henriques, 1968).

In 1889, the first Act of parliament for the prevention of child cruelty was passed, known as the children's charter and in 1908, this was extended to introduce the registration of foster parents. This act worked to regulate the care of children, aiming to prevent dangerous work practices, and prevent children from being detained with adults in prisons. In 1932, the Children and Young Person's Act was passed, to establish working conditions for young people leaving school, and introduced supervision orders for orphans. The 1933 Children and Young People's Act was expanded to include all legislation from the previous charters and following the death of a child at the hands of his foster carers, the 1948 Children's Act was introduced (Higginbotham, 2017). The 1948 Children's Act created a children's committee and children's officer in each Local Authority. Social services departments within the

same localities were brought together to include children's services in 1970 and over the next two decades these services developed, leading to the 1989 Children's Act. The Children's Act aimed to ensure all children had the right to protection from abuse and exploitation, and Section 22(3) sets out the local authorities' duty to safeguard and promote the welfare of children in their care. This duty can be referred to as 'corporate parenting', and means the Local Authority holds parental responsibility for the child (Children's Act, 1989). The Children's Act, (1989) also ensured that children who did not wish to or were unable to reside in foster care placements, were able to have safe children's home placements (Parker, 2011; Higginbotham, 2017; Quali, 2017).

The term 'Looked after Child' as defined in the 1989 Children's Act, refers to a child who is in the care of the local authority. The Act allowed for children to be removed from their birth parents, and placed in foster care, kinship care, or a children's home. Private companies were also allowed to offer foster placements and private adoption but only after a decision has been made by the local authority that the child could not remain in the care of their birth parents. The reasons for removal from birth parents can be complex, and may involve concerns around neglect, physical, or sexual abuse, or the birth parent's inability to provide adequate care (NSPCC, 2014).

The impact of being a child in care on mental health and well-being has been well researched, and significant psychological morbidity, psychiatric disorders, self-esteem difficulties or impaired psychological function have all been found to be potential outcomes for children who are in care, primarily due to the reasons which led to them being taken into care (Blower et al. 2004; Richardson & Lelliott, 2018; Stanley, Riordan & Alaszwski, 2005; Goodman & Goodman, 2009).

A logistic regression of data collated from child welfare services allowed estimation of the association between placements and mental health service utilisation. The findings of the study indicated an increased usage of mental health services for those children who experienced greater placement numbers (Rubin et al. 2004). Research has also indicated that those children who receive a diagnosis of behavioural disorders such as Attention Deficit and Hyperactivity Disorder (ADHD) are more likely to access physical health services, and in turn, mental health services (Li et al. 2021; Guevara et al. 2001; Mandall et al. 2003). Danielson et al. (2015) also reported that children in foster care were three times more likely to have ADHD.

Increased access to mental health services, and social support have been found to increase good attachment and improve ability to ask for what they need alongside improved mental health and self-esteem outcomes for children in local authority or state care (Antcil, 2007; Burns et al. 2004; Chapman, Wall & Barth, 2010; Orme & Buehler, 2004).

Lush, Boston & Grainger (2009) discuss the evaluation of psychoanalytic psychotherapy with children in care, reflected on the historical concerns about whether children in care, were ‘untreatable’, given that prior to the 1980s, many psychoanalytic patients were middle class children who were generally able to communicate through orderly symbolic play. In contrast they discussed the way in which deprived children would often spend time both in and out of the room, which required the psychotherapists in such situations to adapt their way of working. Boston, Lush and Grainger (1991) designed a questionnaire to enable therapists to rate the progress of young people in a systematic way and thereby reduce some of the potential for bias. At the end of the 2-year Psychoanalytic Psychotherapy

treatment, 26 of 31 young people were considered to have made some degree of improvement, and 23 of these definite or considerable improvement. None of the children were considered to have got worse.

Psychoanalytic Psychotherapy has been demonstrated to work with young people who are in care, and the development of this way of working can be dated back to Freud (1895).

2.7 Psychoanalytic Psychotherapy

The British Psychoanalytic Council describes Psychoanalytic Psychotherapy in the following way:

"*Psychoanalytic or psychodynamic psychotherapy draws on theories and practices of analytical psychology and psychoanalysis. It is a therapeutic process which helps patients understand and resolve their problems by increasing awareness of their inner world and its influence over relationships both past and present. It differs from most other therapies in aiming for deep seated change in personality and emotional development" (BPC website)*.

Freud was the creator of psychoanalysis, initially describing his methods in 'Studies in Hysteria' (1895) where he considered physical symptoms to be manifestations of repressed conflicts. Freud's theories developed over the course of his work, initially drawing criticism for being based upon his analysis of himself, or a limited number of patients (Robinson, 2010). Freud used methods such as free association, in which patients speak aloud whatever presents in their mind (Thurschwell, 2009).

2.8 Development of Child Psychotherapy

Klein (1932) considered that using the theoretical base of adult psychoanalysis and adapting the adult's free association or use of the couch to include play would enable children to express fantasy, anxieties, and defenses in their play. Klein's work involved providing the children with a playroom and a box or drawer which was for them individually and contained materials such as paper, pencils, a ball, and some figures of people or animals (Klein, 1932). Klein goes on to suggest that observing a child in their play gives access to their inner world and enables exploration and interpretation of their anxieties. This is still the way in which child and adolescent psychotherapists work in the present day. Betty Joseph's 1998 paper, 'Thinking about the playroom', considers that children may use these materials in many ways, and their toys may get damaged, or destroyed, but that in these situations, the therapist should not be punitive, but instead, think about the internal world that may have been revealed, and consider options to repair (Joseph, 1998). Thinking around games, and whether the therapist should join in is also considered with Joseph suggesting that therapists should ask about the motivation, what we might learn from the game, whether the game is taking on a defensive function, or whether something is being communicated when playing (Joseph, 1998).

2.9 Research developments

Research into the efficacy of child psychotherapy in the treatment of mental health difficulties in young people has been limited, and often captured in individual case studies. A move towards more empirical measurement of change has begun and continues to develop involving thematic analysis and process review alongside quantitative measures (Target & Fonagy, 1994; Carlberg, 2009; Gorin, 1993;

Muratori et al. 2002; Trowell et al. 2007). Studies indicative of changes in behaviour, and emotional regulation in children when attending psychoanalytic psychotherapy are steadily increasing (Kennedy, 2004; Kennedy & Midgely, 2007; Deakin & Nunes, 2009).

Historically, Psychoanalytic Psychotherapy has been criticised for its lack of an evidence base or the over-use of single case study papers. For instance, Hinshelwood (2013) discusses the struggle psychoanalysts have had because they have not appeared to respond to more systematic scientific methods. However, Hinshelwood places value on the single case study as a way of generating knowledge and refers to many scientific findings being based upon small sample laboratory results. He claims that there is a place for theory to be tested, and truth to be found from clinical sessions and single case studies (Hinshelwood, 2013).

2.10 Child and Adolescent Psychotherapists

The Association of Child Psychotherapists (ACP) describes the role of the child psychotherapist in working with young people who may have experienced long term mental health difficulties, neglect, abuse, or problems in attachment. The role of a psychotherapist is described thus: *'A child psychotherapist will seek to bring about symptom relief by helping the child or young person to make sense of their experiences and feelings. It is hoped that by being understood and through developing a thoughtful relationship with their therapist, they will find new and healthier ways of managing their difficulties'* (ACP, 2021). Many children who are placed into Local Authority care, experience this removal from their family home as a secondary trauma. Placement changes and a lack of permanence magnify this

sense of discontinuity (Unrau, Sieta & Putney, 2008; Connell et al. 2006; Ryan & Testa, 2005).

NICE (National Institute for Clinical Excellence) Guidelines refer to Psychoanalytic psychotherapy as a treatment for depression and abuse and neglect. For 5–11-year-olds, it is considered as one of the first line treatment options, and for 11–18-year-olds, it should be considered if CBT is not suitable (NICE, 2018). Psychoanalytic psychotherapy is also recommended as a therapeutic intervention after sexual abuse for girls aged 6-14 years. Parent work sessions for non-abusing parents or carers are also recommended as support alongside individual work. These guidelines should therefore be considered in relation to work with some Children in Care who have experienced neglect or sexual abuse prior to being removed into local authority care.

A survey of the profession of Child Psychotherapists was carried out in 2017 (Robinson, Luyten & Midgley, 2018) and findings indicated that Children in care were frequently offered Child Psychotherapy. The professionals suggested that a gradual approach was often needed, and long-term, intensive work was beneficial to develop a relationship. Attachment difficulties and trauma from early life experiences were reported as the most prevalent reasons for referral to mental health services, and therefore it seems pertinent to consider theories which relate to early life experience when working with this group.

Several Psychoanalytic theories relate to early life experience, particularly the first interactions between parent and infant, which indicate there were disruptions in these relationships for children in care. Container/contained (Bion, 1962b) is one of the key theories on which psychoanalytic interventions with young people is based.

2.11 Containment

Containment relates to the theory posited by Bion (1962b) who initiated the theory of the container/contained in which he describes a ‘reverie’ between mother and child; a process by which the mother takes on her infant’s projections, metabolises these, and returns them in a more tolerable form. Bion suggests the (infant’s) projections go into the mother, as the container, and the projections as the contained (Bion, 1962b)

Klein (1946) described projective identification as a process in which aspects of the self, or an internalised object, are split off and attributed to an external object. This process is considered to occur between an infant and their mother, where the infant projects bad feelings into a ‘good breast’, which can then be removed, and re-introjected. Whilst these feelings have been placed into the good breast, they are felt to have been changed to allow them to become tolerable to the infant on re-introjection (Bion, 1962b). The theory of containment suggests that babies have sensations, both inside and out, and both pleasurable, and painful. Bion (1962b) describes reverie as a process of ‘mental digestion’ by the mother and feels this is a mutually beneficial process. When a mother can be receptive to her infant’s projections, she can be considered a containing object. Thus, reverie provides a limit which enables development of reflective capacities and meaning in the infant. When there is a failure of reverie (Bion, 1962b; Vaslamatzis,1999; Jones, 2010) meaning can be stripped away, and psychic development impacted. St Clair (2000) describes Klein’s idea of a part object in which the infant initially relates to things by their function, so for example a good breast is the breast which is providing milk and when the infant is hungry there is a bad breast. As the infant develop in a good enough environment these part objects can be understood as whole objects - a mother that has both good and bad.

In a similar way to the mother, the Psychoanalytic Psychotherapist can adopt the role of container for the projections of a young person. Waddell (2006) considered that an individual's ability to introject (or take in) the object's (in this case, the therapist's) qualities and use them for growth and development depends on their previous experience of secure emotional containment. Through containment by the Psychotherapist, the hope is that the child will internalise a helpful and caring object to help them manage fear and pain. A Child in care may not have experienced containment in early life, and therefore may present as 'uncontained' (Willis & Holland, 2009; Coman & Devaney, 2011; Simkiss, 2019). Such a child's presentation may be experienced as emotional states which are unable to be processed, meaning they struggle to verbalise thoughts and feelings, may demonstrate excessive projective identification, and may appear to allow things to 'spill out' (Weightman & Smithson, 2019).

Riesenberg-Malcolm & Roth (1999) comment that the term containment can often be misused to refer to someone's capacity to bear something but should be considered an active process between two people which can be viewed as psychic, rather than physical.

In considering Bion's theory, Wakelyn (2008) proposed that the primary containing relationship is a model for future relationships, and emotional communications referencing Bion's (1965) use of the term 'alpha function' to describe receiving, processing, and responding to a communication. Bion took Klein's theory of object relations – which relates to the process of introjecting good and bad objects - and defined three forms of making links, L, H and K, which represented Love, hate and knowledge, which he believed underpinned all relationships. When two objects form a K-link, there is a shared meaning created between them. (Bion, 1963)

He also described the projected elements of emotional experience which may or may not be processed in the mind of the parent as beta elements. When beta elements intensify or are not contained, primitive defences such as denial or splitting occur, to enable survival for the baby. Bion stated that if this is left to continue, a minus-k state of mind occurs for the baby and thinking, and curiosity cannot take place. In this state of mind, it seems that joining up with another or thinking, may be seen as a threat to the splitting defense (Bion, 1959). Bion (1959) refers to the response to these 'threats' as attacks on linking when the link with the other or one's own thinking mind are attacked.

Different thoughts have been given to the therapeutic setting and what is important about it; silence and stillness (Baerson, 1994), regularity, interpretation, and duration (Freud, 1913) and the frame (Milner, 1952). To allow a child to explore thoughts and feelings and begin to understand more of their internal world an environment which promotes structure and containment in the absence of an internal structure is considered beneficial (Sklar, 1988).

Kenrick (2005) describes the ways in which deprived children may demonstrate their anxieties by rushing from the clinical room or a wish to obliterate anything which may represent loss. Kenrick asks how one can create a balance to enable a deprived child to feel understood. She reflects on how unbearable this may feel when they are responded to after a long experience of deprivation; that it may be too much to be in touch with the pain or find it so different from their previous relationships that they are reminded of what has been lost (Kenrick, 2005). Kenrick also discusses attacks on linking, as theorised by Bion (1962b), considering that an experience of receiving what they have never previously had, can feel too much for a child in care, leading to their feeling of deprivation being more pronounced, as well as leading to feelings of

umbrage at the previous deprivation. So, these children are at the same time keenly aware of what they have been deprived of but unable to embrace what has been offered. (Kenrick 2005)

Kenrick (2005) considers how therapists must work to bring the past into the present and explores how to use the countertransference feelings to do this. She suggests that by noticing their own feelings, therapists can gauge the pace at which the child is able to manage, as well as noticing when things become more intense or difficult to stay with. Psychoanalytic psychotherapists can consider the early life experience of looked after children and recognise that the wrong interpretation or a feeling of intensified pain could lead to a life or death feeling in a child in care. Alternatively, an interpretation of unmanageable intensity could be experienced as something violating, or intrusive (Boston & Szur, 1983). McLoughlin (2010) presents an approach for those working with children in care that is depicted as concentric circles of containment, using an example of a working model in a Pupil Referral Unit. This is shown in fig 2.1 below.

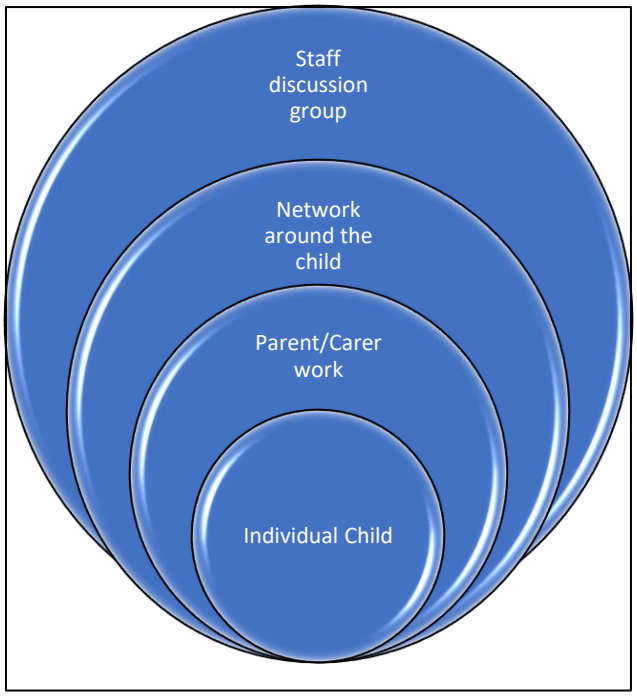

Fig 2.1 Concentric Circles of containment model (McLoughlin, 2010)

Four 'circles' were identified: Individual therapy for the young person, parent work for the family / carer, a holding of the network and a discussion group for staff. It is identified that the clinical setting needs to be a closed, secure container, where patients gradually communicate their external world, but also highlights the importance of the other circles. The staff group was found to be helpful in considering collusion and projections and allowed group thinking to take place. Parent work for the parents/ carers on the other hand can be a useful tool to support psychoanalytic psychotherapy by providing opportunities for parents and carers to think more about behaviours the child may be displaying, and perhaps feel less persecuted by them (Green, 2000; Jarvis, 2005; Hindle & Schulman, 2008; Hopkins, 2005).

With reference to Children in care, Hopkins (2000) concludes that "*the most crucial contribution to their willingness to risk further attachment is probably the therapist's*

capacity to contain all the negative emotions of the fright without solution, as they are gradually externalised". She describes the way in which the psychotherapist can avoid repeating patterns such as attack, rejection, helplessness, and humiliation. Hopkins suggests that by avoiding enactment of these experiences, the child is enabled to see the possibility of new attachment forming, at first with the therapist, and then with others. Hopkins' (2000) case study describes her experience of work with a young boy who was adopted as an older child and the way in which he maintains his defensive systems and attempts to control his emotional distance from her in the work. She considers that the subjective reassuring safety of what is familiar can be hard to relinquish, even when objectively this is a deprived experience (Hopkins, 2000).

Winnicott's concept of a holding environment is also relevant to the discussion of creating a context where therapy can take place (Winnicott, 1963). Bion's theory of container/contained (1962b) has been considered a more process driven concept whereas Ogden (2004) describes holding as a more dynamic interaction between mother and child, in which the infant's unconscious thought can be modified by the mother and her capacity for thinking.

2.12 Holding

The term 'holding' refers to the theory that was described in a basic form in Winnicott's 1945 paper but developed and detailed by Winnicott in 1963 and relates to the total dependence a baby has on their mother. The term holding describes not only the physical holding of the infant, but also the environment in which the child is raised should be 'good enough' to enable emotional integration. Emotional integration relates to Winnicott's theory that amalgamation of the id impulses into

control of the ego is one of the primary developmental tasks of infancy, a process in which the good enough mother supports the infant.

Ogden (2004) describes holding as an ontological concept in which the infant's continuity of being is protected by the mother, by her primary maternal preoccupation in which the mother 'disappears' and is consumed with insulating the infant and submitting to the infant's experience. Conversely, Riesenberg-Malcolm (1999) states that holding reflects a primary narcissism where the infant and mother merge, and fuse, so that the baby is in full identification with the mother, eventually being able to individualise, and separate as it develops.

Sandler (1985) uses the example of work with a young boy to demonstrate the value of interpretation as opposed to holding. The paper explores the concept of holding, which she describes as elastic and changeable in accordance with what is needed in relation to the care of an infant (Sandler, 1985). Winnicott's holding environment (Winnicott, 1960) is used as a descriptor for the analytic setting and provides a metaphor for aspects of the analytic process and situation. Emanuel (2012) wrote about work with under-fives and considered the move through the therapy from a more defensive 'holding on', towards the child feeling held in mind. Sandler describes the maternal function of holding the infant, as important, but acknowledges that the non-literal, caretaking holding, such as support, reliability and reassurance, saying things at the right time, and showing knowledge and understanding of the deepest anxieties also form part of the concept (Sandler, 1985). A child in care is unlikely to have experienced a holding environment and therefore the experience of psychotherapy, and the therapy space, may either feel alien to them, or be difficult to manage (Borg, 2013)

Sandler explored work with severely disturbed children, and the difficulties which may arise in understanding the nature of what is happening. Her conclusion was that in these cases, holding the psychoanalytic framework rather than offering interpretations may be all that feels possible. She argues that even in such cases, the value of interpretation to reduce anxieties is high and holding may not be all that can be offered or managed (Sandler, 1985)

A non-psychoanalytic definition of holding refers to the physical restraint of a child using techniques such as Team Teach (Matthews, 1997), a physical process. Physically holding a child in a bodily restraint contrasts with the psychic process of being held emotionally. Additionally, programmes to support behaviour such as Non-violent resistance training (Omer et al. 2012) are designed to support parents/carers in managing disruptive behaviour using verbal techniques.

Sandler (1985) discusses ego weakness, and a severe super-ego, which can be seen in ‘disruptive children’, which can evoke in them shame and humiliation when they experience frustration. Sandler discusses violent behaviour being controlled by interpretation but concludes that both physical and psychic holding also allow the therapists to serve their purpose as an auxiliary ego function and hold in this context (Sandler, 1985).

Winnicott (1963) stated that during therapy, holding sometimes must take a physical form, but only whilst the therapist helps the child to develop their understanding so they can verbalise. Hopkins (1987) discusses physical holding in her paper about failure in the holding relationship, though alludes to the holding situation as described by Winnicott and makes links to Bowlby’s theory on attachment. Winnicott’s description of the earliest anxiety as being related to being insecurely

held (1963) formed the basis of his work. He went on to develop this idea linking it to the idea that the process of analysis symbolically holds the patient by being able to describe their deepest anxieties verbally.

Reed (2013) discusses her move from being a medical doctor, to a psychotherapist, and gives thought to the idea of touch and holding within this transition. She presents ideas around relational touch, illustrated by a session of Winnicott's Psychotherapy, in which he used a holding and rocking motion when with a distressed patient, linking this approach to the mutuality of the mother-infant dyad. Reed therefore claims that relational touch can aid self-regulation in a patient and links this type of holding and touch to something more instinctual. She discussed the importance of touch in the medical profession and how reassuring and valuable it can be in establishing a helpful and supportive relationship (Reed, 2013). Conversely, it has been theorised that touch could contaminate the transference, prevent unconscious material from emerging, and that touch from the therapist could evoke infantile desires, which in phantasy they believe the therapist may fulfil, potentially making analysis of them more difficult (Rodman, 2003; Warnecke, 2011; Kupfermann & Smaldine, 1987). Smith at al. (1998) consider the position of the psychotherapist as being impersonal, and non-judgemental and suggest that touch may impact upon this and obstruct the usual dynamics in the therapy.

Winnicott wrote: "*A correct and well-timed interpretation in an analytic treatment gives a sense of being held physically that is more real...than if a real holding or nursing had taken place*" (Winnicott, 1960). Casement (1982) postulates that understanding goes deeper than touch suggesting that this is a primary goal of the work. Winnicott's initial observations about the maternal preoccupation and close

interaction between mother and infant began during his paediatric work, as a medic, and his observations about the nature and importance of holding, although based primarily on single case study work, have been described or replicated in further Psychoanalytic work, such as Sandler's (1985) or Ogden's (2004), lending a more robust sense of reliability to the theories.

Both theoretical concepts of holding and containment, refer to early life relationships with a caregiver. In addition to these Psychoanalytic concepts, Bowlby (1958) himself originally a psychoanalyst presented the idea of attachment, which was based in Psychological, and Child Development schools of thought.

2.13 Attachment and Deprivation

Bowlby's (1958) theory of attachment emerged from observations of children who had experienced maternal deprivation. Bowlby (1958) reported the impact of deprivation as delinquency, mental health difficulty, and Psychopathy. Bowlby was a Psychoanalyst and Psychiatrist but felt that some psychoanalytic theories of the maternal relationship with their infant were somewhat '*detached from reality*' or *'outdated'*. Bowlby (1958) instead described an innate drive in the infant to form a close attachment to a main figure, usually the mother. He proposed four stages of the attachment process:

1. Between 0 to 6 weeks, the pre-attachment phase, in which the infant works to attract adults by crying/ gurgling / eye contact.
2. Between 6 weeks to 6-8 months, the attachment in making phase, in which the infant begins to develop some trust and dependency on the main caregiver (usually the mother).

3. Between 6-8 months to 18 months -2 years, the clear-cut attachment stage, in which there is an observable and established relationship with the caregiver, and some separation anxiety may occur, which can be managed with soothing and care.
4. From 18 months to 2 years onwards, the reciprocal relationship is formed, and an internal working model in which the caregivers may come and go, with the child feeling secure they will return is developed. (Bowlby, 1958)

Ainsworth worked to develop Bowlby's theories on attachment, presenting concepts of attachment styles following the 'strange situation' study (Ainsworth, 1970). The attachment styles set out were secure, avoidant, and resistant. In 1986, Main and Soloman identified a further attachment style, which they described as disorganised. The disorganised attachment style describes a child who has no organised way of making contact when distressed. These children are often considered controlling, in either a punitive or care-giving way (Main & Soloman, 1986). Hopkins (2000) considers experiences such as neglect and loss during infancy, and how they prevent a secure attachment forming; she posits that this experience is similar to 'fright without solution' (Main, 1995), nameless dread (Bion, 1962a) or 'unthinkable anxieties' (Winnicott, 1963). The defensive mechanisms that can develop in such children, such as dissociation or splitting are discussed in Hopkin's (2000) paper, where the disconnect between attachment, thinking and feeling is explored. This could relate to Bion's (1959) attacks on linking theory, which was previously discussed.

Hopkins feels that children with a disorganised attachment style may use control to regulate their emotional distance, and gives an example of a boy, Max, with whom

she worked, who was able to make use of his therapy as a developmental opportunity and build a relationship in which fright without solution could be externalised (Hopkins, 2000).

Ainsworth et al. (1978) avoidant attachment styles can be linked to rejecting mothers, as well as mothers who may have had a similar experience of being rejected when babies themselves. Babies who show avoidant attachment traits may show anger which appears out of context or may attempt to be self-sufficient to avoid feeling rejection from their mother. Winnicott (1963) therefore describes the idea of a 'false self' which can emerge in these cases, which involves the over-identification with a parent and a mimicry of gestures, or mannerisms, so that the parent is not needed as the child has taken on their persona.

In Hopkins (2000) paper emotional self-sufficiency is discussed in the context of a child in therapy who wishes to avoid developing closeness to the therapist, the struggle of rejection of a new attachment coupled with an omnipotent claim on the therapist and clinic, which may defend against a more meaningful attachment. The idea of a loyalty conflict is considered, which can often be seen in work with adopted or children in care as well as the subjective reassuring safety of the familiar, even when the reality of home life may have been depriving or negative (Hopkins, 2000) The relinquishment of the idealised birth mother or family means an acknowledgment of how badly the child may have been treated, as described by Gianna Henry (1974). Hopkins describes a six-year-old girl, Claire, whom she saw for psychotherapy and links Claire's being accident prone to her avoidant attachment style. Claire's worry about no-one comforting her is conveyed in their work, and her pull to not depend. Claire's response to these anxieties being named and managed, allow her to firstly turn to her therapist for comfort and later to her mother (Hopkins,

2000). Hopkins also describes a powerful image created by another young person with whom she worked, who developed a fascination with moths being drawn towards a flame, which leads them to be killed. Hopkins links this to the girl's wish to be loved by a mother despite her anger in response to continued rejection by her mother. (Hopkins, 2000)

Gianna Henry's (1974) paper on double deprivation describes the process of one case of a Child in care. Henry describes the process of Children in care where the parent has not been present, identifying with an idealised internal object, who can therefore be considered perfect yet inaccessible. Henry also describes her patient's contempt towards the more needy parts of himself, and how he could then choose to deprive himself of what he needed. This enabled her to develop her theory of double deprivation, and the process by which the deprivation is replicated because of a struggle with dependence (Henry, 1974). Double deprivation can be connected to Bion's attacks on linking (1965). When a patient and therapist begin to think together, they become a creative couple, though this can lead to the patient identifying with the excluded party and cause a painful emotional response.

Henry describes the struggle between the Looked-after child's wish to be held onto and claimed on the one hand and their struggle with dependence on the other. (Henry, 1974). This may be present in many therapeutic situations but appears to be particularly acute with Children in care (Canham, 2004; Rustin, 2001; Kenrick, 2005).

Henry discusses the way in which she could feel pulled to provide multiple things; time, emotional response and material items; the awareness for some children in case of the missing mother and the need to be very clear about the limits of the work, for example in relation to touch, or physical limits of the work (Henry, 1974). An

expressed wish for more help or additional sessions may be viewed as hopeful, but it may also be important to pause and try to understand what the motivation is for the request. The power and struggle of her work are beautifully conveyed as describes the end of the work with the boy asking, '*if it hurts, how can you call it getting better?*' (Henry, 1974).

Kenrick's (2000) paper 'be a kid', talks about the key themes linked to working therapeutically with Children in care. Discussion around the adult attachment interview (George, Kaplan & Main, 1984) highlights the impact of the multiple separations which children in care may have experienced and the resulting lack of self-regulation. Kenrick comments on other research, such as that carried out by Hodges & Steele (2000) who used a narrative play technique to examine the effects of past abuse on the development of the internal world and relationships to others. In their study, they worked with children who had suffered abuse and asked children to complete stories. Patients' responses indicated the impact of their history on their internal representation of relationships between parents and children. This highlights the importance to have developed reflective self-functioning for individual mental health (Fonagy et al. 1997). Kenrick considers that the ability to reflect enables understanding and attachment of meaning to experience. She suggests that Hodges and Steeles' (2000) research supports the idea that children in care, who may have had limited experience of attachment, but rather have experienced repeated and unplanned separations from caregivers could utilise psychotherapy to develop their capacity for self-reflection. The discussion of use of the adult attachment interview to enable adults who have been in care to reflect on their experiences, alongside the narrative technique used by Hodges and Steele, provides validated and well-known measures to support the findings within her own work and suggests a sound

evidence base, despite the limiting factors of using smaller case studies (Kenrick, 2000).

The struggle to hold narrative to meaning, its roots in early life trauma, difficulties in managing boundaries, with attacks on linking and how this relates to clinical work are all clearly described by Kenrick. Themes of containment, abuse and deprivation are key to this paper, where Kenrick attempts to speak more generally about the similarities when working with Children in care, as well as considering technical adaptations that may be required to facilitate therapeutic interventions with CiC (Kenrick, 2000).

Henry (1974) discusses a ‘cycle of deprivation’ for a child who has experienced neglect, or deprivation, who therefore chooses to defend against this by becoming unreachable. The therapist or others around the child may also experience being rejected or humiliated and therefore give up in their attempts to think or be with the child. The introjection of these adults and their responses towards the child, confirm in the child’s mind that they may be unlovable or rejected. Hoxter (1983) on the other hand discussed the therapist’s exposure to suffering, rejection, and disappointment, and warned of the risk of them being drawn into a cycle of deprivation.

When working with children in care in CAMHS there may be numerous services involved in their care and communication between the network is crucial in providing a consistent and stable environment for the child. In her paper on Triple Deprivation Emmanuel (2002) describes the implementation of a therapeutic LAC service and the struggles felt within the team as well as the wider network. Triple deprivation builds upon Henry’s concept of double deprivation, by considering that not only does the child have the doubly deprived experience from their birth parents, then

themselves, but thirdly issues within the network can lead to a third level of deprivation. All the professionals and people involved in the network may be seeking to claim the child, as the child was not claimed in early life, and this can lead to splitting and rupture in the network. It may be that everyone wishes to demonstrate they know the child best, or it may be that the child gets lost in the system (Emmanuel, 2002). Emmanuel also considers a social worker who feels caught between removing a child permanently from their birth parents' care, and worries about finding an appropriate foster placement, and the way in which a 'freeze' mechanism can occur through indecision within the network, replicating the child's more disorganised attachment style (Emmanuel, 2002; Ainsworth, 1970).

Networks are important to consider in work with Children in Care and technical adaptions both with professionals and carers as well as with the child in the clinical room may be necessary to facilitate the work (Emmanuel, 2002).

2.14 Technical Adaptations

Canham (2004) uses his clinical work as a basis for discussion of the technical difficulties which can be faced when working with Children in care. He acknowledges that children who may have been physically abused may kick or hit out, so the therapist experiences the hurt in the same way (Canham, 2004). Canham discusses Klein's' term 'total situations' (Klein, 1952, as cited in Canham, 2004) to consider past and present experiences, as well as emotions and object relations. Thought is given to projections and pull to enactment that can be experienced when working with this group, particularly when the child becomes violent and abusive, and the therapist can be pulled into feeling violent or abusive themselves (Canham, 2004).

The idea of a therapist feeling helpless, or a witness or at the mercy of attack (Brenman-Pick, 1985) relate to the danger of enactment, the therapist giving harsh interpretations, or ending sessions early. Canham (2004) explores the importance of setting and containment is considered in the context of the value of knowing a fifty-minute session can be held onto and the necessity of using supervision to allow the therapist to be and feel contained. Rustin (1999) makes links to triangulation which occurs during supervision and the way in which the therapist and supervisor can become a 'parental-couple' which may be lacking in other aspects of the child in care's life (Rustin, 1999).

Canham gives practical consideration to measures which therapists may need to protect themselves in the room, as well as how to balance both maternal and paternal function within the therapist, to provide a secure, containing, holding environment (Canham, 2004). Rustin (2001) on the other hand describes technical adaptations when working with children in care, highlighting safety issues due to climbing or jumping, which may be linked to a child needing the therapist to feel cruel, or neglectful if they fall and injure themselves, or for the therapist to be forced to watch something disturbing or dangerous (Rustin, 2001). She considers that the room may be more difficult for the LAC to manage, feeling more claustrophobic and, causing them to break out, as well their need to set their own boundaries, and take control (Rustin, 2001). Rustin's paper refers to key factors being good external support for the therapist, and the work, the imagination of the therapist, and the length of time needed for a piece of work when considering the lengthy traumas these children may have experienced (Rustin, 2001). Boston (1972) discusses how the therapist must prove they can contain the violence and reduce omnipotence by withstanding it and surviving, as the original phantasy object did not.

Kenrick (2005) describes work with CIC, and the way in which theory and practice have influenced technique. She describes the process in which deprived children may have had experiences of either little contact with an object able to manage their projections, or an object that returns their projections to them in a way that means the child feels under attack or persecuted because the projections remain unmodified. Kenrick also refers to one patient, who when she made an interpretation about feeling dropped at the end of the session, the patient's reply was *'how can I feel dropped, when I have never felt held?'* For Kenrick this was a recognition that experiencing being in touch with something you have never had, is a painful experience (Kenrick, 2005).

She describes the risk of missing something and not relieving the powerful anxiety in work with a boy who liked to attack his therapist a moment after he had proudly showed her something. The boy's experience of being noticed by the therapist, but then being in touch with not having been noticed whilst on a holiday break leads to an attack on the therapist (Kenrick, 2005). Kenrick's view that being able to talk to this experience and modify the powerful projections enables the boy to manage something and have an experience of a different kind of object who can take his anxiety, and make it more digestible for him, further substantiates Bion's theory of containment (Kenrick, 2005).

The idea of a process of interpretation as a useful tool in managing differentiation with children in care, allowing them to understand the difference between what belongs to them, and what is an intrusion. Kenrick describes these process interpretations as a more tolerable form of interpretation and her experience was that they may enable children to hear the interpretation, rather than them immediately needing to rush from the room. The concept of reporting what has happened using

the therapist's own countertransference response rather than the transference at times when meaning may not be clear is described by Kenrick as having a Winnicottian transitional feel, a gentler way of speaking about anxieties (Kenrick, 2005).

Another dilemma present when working with LAC can be the way in which past and present are brought together (Kenrick, 2005). The complicated life situations, involving numerous sets of parents, birth, foster or adoptive, as well as siblings and the child's experience of this and the loss or confusion can be difficult to explore. Kenrick gives several examples of containment in relation to this type of presentation and discusses how to support a patient to think about something, or when to help them stop, but without the stopping causing the anxiety to become split off. Kenrick instead considers naming the feelings, but also speaking to the patients' wish to stop thinking about something and finding a way to support this (Kenrick, 2005).

The idea of wrong interpretation being less well tolerated by children in care is discussed (Kenrick, 2005) with an idea that an experience of not being understood may be felt as more persecutory in children in care than other children or an incorrect or inappropriately timed interpretation may feel to be a matter of life and death, due to the abusive or neglectful experiences they may have had historically.

Lanyado (2017) discusses the nurturing relationships, kindness and flexibility needed when working with children in care or adopted children. She discusses the idea of children in care having insufficient opportunity to mourn losses and how they can often be left feeling despairing and lost and may struggle to trust as they develop. Lanyado considers the stages of work with children in care and adopted children, the first part being 'boundary setting' in which the child and the adults need to

understand the importance of the room, and the timing of the session. She believes that once these anxieties can on some level be contained, the ‘roots’ can be put down, with the therapeutic relationship as the groundwork, allowing the young person’s sense of self to emerge (Lanyardo, 2017).

Lanyado (2017) uses two cases to provide some background for her formulations, describing a young girl, who makes repeated demands for a drink in her session, and the way in which the therapist experiences this as demanding, controlling, and is left feeling exasperated. Over time, sticking to the boundaries and developing the relationship with the girl, it appeared that the girl was able to see on some level that she was getting a helpful relationship, rather than a repetition of being deprived of something from the therapeutic relationship. The girl was able to ask, in a different way, why she could not have a drink at her sessions and the relationship developed through this communication. Knowing more about the little girl enabled the therapist to respond to this specific request and the way in which it was asked, and did decide to provide the drink, which she reflected on, as something of a transitional object, aiding the move between the external world and the therapy (Lanyardo, 2017).

Wakelyn (2008) describes a model of working within a CAMHS clinic which offers a treatment model called ‘transitional psychotherapy’. She introduces the idea that previous theory and research have highlighted the way in which repetition compulsion (Freud, 1920) and patterns of double, or triple deprivation (Henry, 1974; Emanuel, 2002) can occur in work with Children in care, and patterns seen in school, social care and therapy, can seem to replicate the conditions within the families (Wakelyn, 2008). The network is highlighted by Emmanuel as well as the value of avoiding institutional repetition of these dynamics by good communication, consultation, and liaison within the network (Emmanuel, 2002).

Wakelyn describes a concept of ‘pulsed intervention’, in which 6 or 7 weekly sessions are offered to the child, in conjunction with fortnightly work with parent/carer, and regular network reviews (Wakelyn, 2008). This repeated experience of repair after a less than perfect interaction shows that damage can be managed and survived (Murray & Trevarthen, 1985). This pulsed intervention method allowed attention on internal and external worlds and aims to model a boundary between external and internal, which is resilient and permeable, allowing communication, and containment to be internalised. Hunter-Smallbone (2009) discussed the need for psychotherapists to be employed by social services, so that more joined up work can take place. The value of consultation, sometimes to offer another viewpoint and at other times for direct work, is highlighted (Hunter-Smallbone, 2009).

Time and rhythm have also formed part of thinking about working with CiC in Psychoanalytic Psychotherapy, and Canham (1999) spoke of the CiC’s struggle to be aware of the day or time and how long sessions may last. The idea of this being linked to early life experience of no rhythm or routine for a child, in relation to eating or sleeping is discussed, and chaotic experience or lack of regularity may impact on the child in this way. CiC may also have experience of being rushed, or moved onto a new placement quickly, or without warning and therefore Canham speaks of the importance of speaking clearly about breaks in treatment, to ensure there is a feeling of returning to each other (Canham, 1999).

Again, the main body of papers in this area, are single case studies, but with similar themes, and considerations reported about work with Children in care. A greater body of evidence drawing similar conclusions, even when individually they lack generalisability, suggests a greater likelihood of the conclusions being appropriate.

2.15 Conclusions

This review aimed to identify, define, and critically evaluate the key theoretical concepts and research, related to containment and holding in Psychoanalytic Psychotherapy with children in care. Attachment, deprivation, and technical adaptations were also considered. A broad body of research and theory is discussed and a key theme of early life experience and its role in enabling the development of good objects within an internal world, as well as good attachment is present. The concepts of holding and containment appear relevant in consideration of work with Children in care. There is increased experience of mental health difficulties (Hambrick et al. 2016), and observation of a struggle to engage in Psychotherapy for children in care without making some technical adaptions (Canham, 2004; Kenrick, 2005). This may be due to complications in forming relationships and trusting others to hold them in mind, without persecution. When considering the theoretical stance of container contained (Bion, 1962b), or Winnicott's 1963 theory of holding, we can conclude that without a mind which facilitates processing of emotional experience alongside the infant, this can have long term impacts on relationships for that child. That is, both concepts of containment and holding, consider the way in which the primary relationship between mother and infant is significant in developing capacity for thought.

The focus of much of the presented literature is drawn from single case studies, which are written by Psychotherapists, describing their own interpretation of the child and their internal world. Individually, this could make it difficult to generalise, but recurring themes within the literature, linked to the child's experience and initial struggle to form a relationship, and frequent citation of Bion's (1962b) container/contained theory and Winnicott's holding theory (1963) suggest these

concepts can be considered key when exploring work with Children in care. It is apparent from the literature studied, that a considerable proportion of child Psychotherapist's clinical work may be with children in care and therefore the technical adaptions, and consideration of the key principles may be important.

The research studied showed that although there are differences in the theories of containment and holding, the key theme of relationship development, was present within both. The level of impact and the increased experience of mental health problems in children in care, is both concerning and expected. It is clear that prior to the 1980s, work with this group was infrequent, despite children being in the care of the government since 1838, and it appears that this group was considered as untreatable. Positive results in a small cohort study, indicated an encouraging change in children in care, following psychoanalytic psychotherapy intervention (Boston, Lush & Grainger, 2009).

A profession-wide survey (Midgely et al. 2017) indicated the high numbers of Children in care who constitute a Child and Adolescent Psychotherapist's caseload and discussed feedback from the survey about the high proportion of those presenting with attachment difficulties, or problems due to the impact of trauma. This aligns with the single case studies reviewed which indicate that early life experiences have impacted significantly upon the mental wellbeing of these children in care and that the lack of emotional regulation support and person to keep them in mind, makes it difficult to form relationships throughout life.

It may be, that containment and holding are alluded to, rather than explicitly named in the literature, and because these key theoretical concepts form the basis of Psychoanalytic work, a level of understanding is assumed. To gain further

understanding of the way in which these concepts are operationalised in Psychoanalytic work with Children in Care, it may be useful to explore these concepts in discussion with Psychotherapists, as this explicit consideration is missing from current literature. Discussion of these concepts will enable consideration to be given to technical adaptations and resources needed in CAMHS to enable these young people to receive the intervention needed to develop relationships with others.

Section 2: Quantitative Study

3. An exploratory quantitative study: Understanding the impact of a new Joint Agency Pathway on CAMHS treatment for Children in care.

3.1 Introduction

Children in care are four times more likely to need mental health support than those children living with their birth families (Tarren-Sweeney, 2008). Renewed interest in the mental health of children in care has led to changes in guidance issued by the department of health .and the department of education, to aim to promote health and mental well-being in Children in care (Statutory Guidance, Department for Education/ Department of Health and Social Care, 2015).The report indicated that almost half of children in care would meet the criteria for a Psychiatric disorder, as opposed to one in ten of those children in the general population who are not in local authority care (Statutory Guidance, Department for Education/ Department of Health and Social Care, 2015).

Hambrick et al. (2016) demonstrated that children in care commonly present with disorders such as Attention Deficit / Hyperactivity Disorder, Post Traumatic Stress Disorder, disruptive behaviour disorders, anxiety, and low mood. Bazalgette et al. (2015) also considers that a significant proportion of Children in care present with more than one mental health problem. Dale et al. (2016) comment on the poor physical health outcomes associated with children spending a significant amount of time in the care system, including alcohol and drug use and the increased likelihood of smoking. Children in care are also between 4 and 5 times more likely to end their own lives than children from outside the care system (Dale et al. 2016).

Accessing mental health services can be more difficult for children in care for numerous reasons. Children in care may not meet the threshold to access support at the start of their difficulties and this may lead to the opportunity for early intervention being missed (Bazalgette et al. 2015). Early intervention allows for better long-term outcomes and may prevent the likelihood of needing support from services in adulthood (Membride, 2016). Movement between placements can mean that Children in care who are added to waiting lists may have moved areas or placements before the opportunity to begin treatment occurs and a lack of communication between the child's network of professionals, such as education, social care and mental health services, may mean that shared concerns are not always discussed (Bazalgette et al. 2015). Additionally, only 1% of the NHS budget was dedicated to CAMHS in 2019, the consequence of which is that child mental health services are not always able to offer appropriate treatments to young people in need (National Youth Advocacy Service, 2019).

In a survey by The Mental Health Foundation (2002) care leavers reported that non-joined up care had a negative impact on their experience with their mental health and left the care leavers feeling as though this made it more difficult to get the help they needed. High turnover of social work staff can also cause a lack of consistent care which can lead to missed referrals (The Mental Health Foundation, 2002). When considering Children in Care, NICE suggests that commissioners from CAMHS and directors of children's services should jointly set up and fund services and suggests that more flexible and accessible services are needed for the improvement of Children in Care's mental health and emotional well-being (NICE, 2015).

The guidelines suggest that educational psychologists and health and social care providers should work collaboratively with headteachers and classroom teachers to provide training on how attachment difficulties begin, how they present and how they can be supported (NICE, 2015). Recommendations for health care professionals are made for them to provide training to enable recognition and assessment of attachment problems and parenting quality, recognition of socioeconomic factors that may increase the risk of challenges with attachment, recognition of additional mental health difficulties and knowing when to refer for evidence-based interventions for such concerns. The guidelines indicate that those children in care who are considered to have experienced mistreatment, should be considered for interventions recommended for post-traumatic stress disorder, or trauma focussed cognitive behavioural based interventions. It is highlighted that joint work between all agencies involved with the child, is considered valuable and allows for a more coherent care pathway (NICE, 2015).

NICE guidelines for supporting Children in care, also set out that these children should be considered a priority for mental health services and that particularly when moved out of area, it is important to work to address their needs promptly (NICE, 2015).

In March 2020, there were 80,080 young people in care in the UK (NICE, 2021) and of those in residential care, 72% required support with their mental health compared with only 5% of those in foster placements. It is therefore not unexpected that when examining CAMHS teams across the UK, many have dedicated Children in Care teams (R-DASH, 2021; Black Country Minds, 2021; Nottinghamshire CAMHS, 2021).

The consequences of Children in care being unable to access timely support are discussed in statutory guidance set out by the Department of Health and Department of Education (Department of Health/ Department of Education, 2015), in which the cost implications of not investing in specialist children's services are highlighted, being linked to higher levels of access to adult mental health services, as well as increased prison admissions in later life. These economic costs to society, alongside poorer health and social outcomes for those young people in adulthood are clear if support is not given to avoid deterioration of their mental health. In their NSPCC report, Bazalgette et al. (2015) describe poor educational attainment and poorer lifetime social and financial outcomes later in life for children in care who are unable to access the mental health treatment needed when they are still children. WhoCares? Scotland (2014) discusses the long term and complex mental health problems seen in those adults who were in care, who did not receive appropriate treatment as a child. In the shorter term, placement instability and breakdown are found to increase when children and foster carers are not supported to manage the child's mental health needs (Bazalgette et al. 2015).

It appears that a joined up, connected approach which involves social workers, foster carers, health professionals and education providers is seen as key in providing the best outcomes for Children in Care. Supporting children in care with their mental health should also be the responsibility of all these services jointly (Luke et al. 2014; Dixon et al.2015; Bazalgette et al.2015).

3.2 Background Context

The service evaluated in the current chapter is based in the UK, in a small city, with a primarily White British, working class population. All referrals for CAMHS come through the Single Point of Access, where they are triaged to gather information about concerns and difficulties and then are allocated to the appropriate team within the wider CAMHS. The referrals to the CYPJAP can come via the Single point of Access, or other methods as discussed on page 61. There is a Core CAMHS pathway, which is the route for all young people to enter the service, unless they fall under a designated pathway. The initial triage at the single point of access will determine whether the young person belongs under the care of a designated pathway. There are 4 designated pathways: eating disorders, learning disabilities, Crisis, and the Enhanced Outreach Team. The designated pathways were established in 2019/20. The Core CAMHS team is split over two bases. The main clinical space for each of the teams are health centres, but appointments also take place in schools, young people's homes and online, via a secure digital platform. Previously there was a pathway for the assessment of Autistic Spectrum Disorders, however, these cases now go to the local Paediatric service for assessment.

All the pathways, including Core, would involve the young person being offered an initial assessment. Initial assessments in CAMHS are carried out by clinicians from a range of disciplines, including Family therapists, Art therapists, Psychoanalytic Psychotherapists, Cognitive Behavioural Therapists, Mental health nurses, and Mental Health practitioners. Each young person will be assessed by a practitioner who is allocated to them by the team manager based on availability. The practitioners are divided into small multidisciplinary groups, and following the initial

assessment, they meet to review the assessments and treatment plans as a group, to ensure different therapeutic disciplines are considered and to allow triangulation when making treatment decisions.

Core pathway interventions typically involve both the child and parent/carer and are usually fortnightly sessions lasting up to one hour in length. The Core sessions use talking therapies or techniques specialised to the clinician to offer short term support in managing a variety of mental health difficulties, including, anxiety, low mood, phobias and body image. The treatment is regularly reviewed and if appropriate, a referral to a specialism can be made during, or at the end of the Core intervention.

Up until April 2019, Children in Care, entered the service through the historical Looked After Children pathway and would follow this standard route through to treatment. Anecdotally it was acknowledged that for Children in care, onward referrals were frequently made to specialist Core pathways, due to the complexity of the cases. Specialist core pathways involve a specific therapy, such as family therapy, psychoanalytic psychotherapy and Cognitive behavioural therapy. Under the previous system, young people who were referred for specialist work after the Core intervention could find themselves waiting up to a year to receive the assessment which would give them access to specialist work, which when considering the need for timely intervention, was not an acceptable time frame.

3.3 The Historical Looked-After Children Pathway

Up until April 2019 referrals for Children in care entered CAMHS via the Local Social Services team, or the standard Single Point of Access (SPA) in CAMHS. Referrals were specifically for those children who were in foster placements, or children's

homes, and where the Local Authority held Parental Responsibility. Children in kinship care, or special guardianship arrangements were referred and seen through the standard Core CAMHS pathway, as social services are not standardly involved on an ongoing basis with children in these types of placements.

The needs of children that were under Local Authority care were discussed at a weekly meeting attended by link clinicians from CAMHS, alongside colleagues from Social Services, usually therapeutic social workers. The clinicians who attended these meetings were considered to be a Looked-after Children team, though clinicians were not solely seeing referrals from this team. The cases were then divided between social services and CAMHS and young people were offered a range of interventions. The cases were discussed on an individual basis, and the needs were matched with what was considered to be the most suitable intervention, and the service which was best placed to offer this.

Those referrals that were placed within CAMHS, followed the standardised pathway of Core CAMHS and could be seen by any clinician. Conversely, those referrals placed within the social care team were usually those that involved more work with the network such as foster carers, education services, or health services, or where it might be considered that the child was struggling with something which may not be defined as a mental health disorder. Children who were initially placed within the social care team could be reallocated to a CAMHS practitioner if it was later felt that their needs had changed or could not be met by the social care team.

As previously indicated, young people seen by the Looked After Children's team in CAMHS who were referred on for specialist work could be waiting for up to a year before they accessed the intervention required. The Care Quality Commission

(CQC) carries out inspections of health and social care services, and rates them on five key domains, asking if they are safe, effective, caring, responsive to needs, and well led (CQC, 2018). In 2019, the Care Quality Commission rated the CAMHS as good, with the caveat that the 'safety' component was rated as 'requires improvement' due to waiting times for young people sometimes in excess of 18 weeks. The 'safety' component of the CQC inspection is rated based upon the statement 'protected from abuse and avoidable harm', and therefore the suggestion was that prolonged waiting times could lead to harm which could be otherwise avoided.

3.4 The Children and Young People Joint Agency Pathway

The National collaborating centre for mental health (2019) suggests that evidence-based Mental health pathways should promote timely and equal access for effective treatment and healthcare (CQC, 2018). As previously discussed, NICE guidance has also indicated that Children in care have a need for prompt support (NICE, 2015)

Rogler & Cortes (1993) define pathways to care as *'the sequence of contacts with individuals and organisations prompted by the distressed person's efforts and those of his or her significant others to seek help, as well as the help that is supplied in response to such efforts'*. Studying pathways allows identification of potential delays and barriers to treatment (MacDonald et al. 2018). A systematic review of the literature about pathways to care for young people with mental health problems which highlighted the impact of support, help seeking behaviours, the importance of prompt GP referrals, motivation for change and the cost when accessing services was carried out by MacDonald et al. (2018). Those with good family support, were frequently found to engage in help-seeking more quickly than those without such a

network. The paper highlights that the most common pathways considered in the literature are those for first episodes of psychosis, which have a specific set of steps, but posits that other conditions in young people's mental health may be more transient and overlapping (MacDonald et al. 2018).

In light of the CQC report in 2019, it was recognised within the CAMHS service which is under consideration that some changes were required to better support Children in care. As a result, funding was sought to enable the development of a team specifically to support these children. Demand for services and capacity within CAMHS to respond were also considered and it was felt that changes should be made across the whole service to reflect the needs of the current population. It has been recognised that this CAMHS receives a higher volume of referrals for children in care than neighbouring CAMHS services with a similar population, which may be indicative of a higher number of children in care within the locality, however figures regarding the number of children in care in each area are not widely reported (Children and Young People Joint Agency Pathway, Internal Document, 2019).

Funding to address this demand was sourced from the Government and provided initially for five years. The local Children in Care team in social services and CAMHS jointly created a pathway to address this need and were awarded additional government funding to operationalise the teams for this pathway; one within social care, and one within CAMHS.

The change to the service aimed to improve the offer of mental health services to children in the area; aiming to meet the needs of those most complex or vulnerable young people and families. The new pathway, which has been in place since April 2019, is described as the 'Children and Young People Joint Agency Pathway', with

teams from CAMHS and Social care working to facilitate the pathway. Within CAMHS, this is called the Enhanced Outreach Team (EOT), and within social care, it is called the Emotional Well-being Team (EWBT). Weekly meetings take place within the Emotional Well-being team, attended by link practitioners from the Enhanced Outreach Team. The pathway aims to provide proximity working, timely access, upskilling to those involved in care and to support therapeutic needs (Children and Young people Joint Agency Pathway, Internal document, 2019).

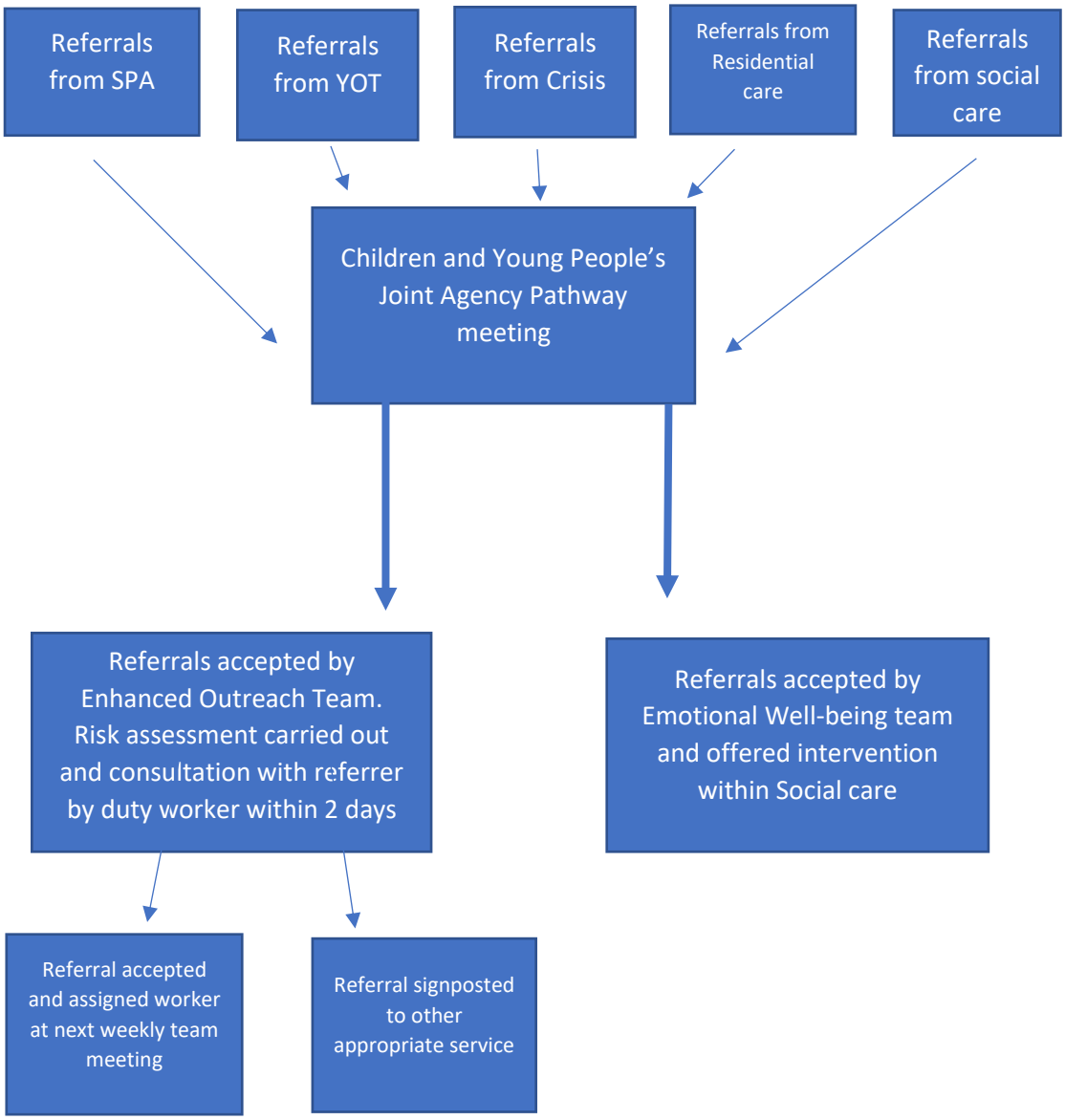

Fig 3.1 Referral process for the Children and Young People Joint Agency Pathway

The Children and Young People Joint Agency Pathway (CYPJAP) accepts referrals through one of five services – The Emotional Well-being team in social care bring any referrals made directly to them, or cases they are working with, the Youth Offending Team, CAMHS Single Point of Access (which includes self- referral, and GP referrals for children who are known to be in care), a Residential Unit, or via the Crisis team. All referrals are then taken to the weekly CYPJAP meeting, which includes professionals from both CAMHS, and Social Care. The referrals are discussed, and a joint decision is made about the best team within the pathway to offer support; either the Enhanced Outreach Team (EOT) in CAMHS, or the Emotional Well-being Team in social care. The Emotional Well-being team (EWBT) accepts referrals which are not deemed to meet thresholds for CAMHS and offer therapeutic parenting work, facilitate foster carer drop-in sessions, deliver training such as parenting skills for foster carers or to education providers to enable teachers or support staff to provide appropriate interventions. Consultation, as well as other therapeutic interventions, where appropriate are offered by the EBWT. They work to the principles of PACE (Hughes, 2004), which embodies Playfulness, Acceptance, Curiosity and Empathy in all aspects of the work.

If the referral is accepted by the EOT, a safety plan is created to manage risk and for all of these referrals a consultation with the referrer takes place within two working days. All consultations have one of two outcomes; to signpost the young person/child to another appropriate service or offer advice or to accept the referral for a first contact. If the referral is accepted, it is taken to the next possible weekly EOT meeting to be discussed and allocated to a clinician and the team aims to offer a first contact within two weeks of allocation. The team consists of a Child Psychotherapist,

a psychologist, a filial therapist, several mental health practitioners and a team manager.

In setting up the Children and Young People's Joint Agency Pathway, the expectation was that the new approach with two dedicated teams within it to support children in care, would reduce waiting times in CAMHS by enabling children in care to be referred more quickly for specialist care. The referrals process was designed to be more streamlined and to ensure that children in care were accessing specialist care within 2 weeks. The practitioners within this pathway, will solely work with children in care.

3.5 Aims and objectives

3.5.1 Aim

The aim of this chapter is to compare referrals, waiting time to first appointment, number of discharges, and length of time in treatment for children in care who accessed CAMHS via the previous Looked-after children's pathway (between April 2018- March 2019), and the new Children and Young People Joint Agency Pathway (between April 2019 – March 2020). Referral and waiting times data from the Core CAMHS team for each of the two time periods (April 2018- March 2019 and April 2019- March 2020) will be used as a control.

For the purpose of this chapter, only the CAMHS data from both the original Looked-after Children's Joint Agency Pathway and the Children and Young People's Joint Agency Pathway is examined as social care data was not accessible, however the conclusions drawn from the examination of CAMHS data will be used to consider the impact of the implementation of the new pathway as a whole. The main aim of the

study is to establish whether there is a difference in waiting time to first appointment for those children in care who are accessing CAMHS via the new CYPJAP.

3.5.2 Study hypothesis

The expectation is that there will be a statistically significant difference in waiting times following the implementation of the new Children and Young People's Joint Agency Pathway in April 2019.

3.5.3 Objectives

The main objective of this exploratory study is to compare the waiting times for first appointment between the previous and current CAMHS teams (Looked After Children's Team / Enhanced Outreach Team), that form part of the Joint Agency pathways for Children in Care. Other objectives are to:

Make comparisions between the data for both specialist CAMHS teams (EOT/LAC) under each of the pathways in the following areas:

i. length of time to first appointment

ii. length of time in treatment, allowing consideration of placement breakdown, or movement which may impact upon length of treatment.

iii. the number of appointments offered allowing some understanding of capacity for the specialist teams.

iv. the number of referrals to allow one to gauge how aware people were of the pathways, and to examine whether the pathways were being utilised.

v. Present data for the CORE CAMHS pathway (standardised pathway into treatment) at the two time points to act as a control.

vi. Present the age, gender and ethnicity data for all patients for each team (LAC, EOT, CORE time 1, CORE time 2) to give demographic background information for the service and allow for consideration of whether the young people attending CAMHS are representative of the population of the area.

3.6 Design

The study is a quantitative service evaluation comprising of the analysis of routinely collected patient data.

3.6.1 Participants

3.6.1.1 Sample

The four data sets are opportunity samples, totalling 3044 young people, who accessed CAMHS. There are four data sets: One for the LAC team between April 2018 – March 2019, one for the EOT between April 2019 – March 2020, and two separate time period data set for the Core team over a period of two years. The Core team data set is from April 2018 – March 2019 and April 2019 – March 2020 respectively. These time periods were chosen to reflect the data sets available online, which are organised according to financial years. The new pathway was implemented in April 2019, therefore the earliest data set for the CAMHS part of this pathway dates from April 2019, and due to the global pandemic and Lockdown which began in March 2020, it was felt that later data sets may have been impacted by Covid restrictions.

3.7 Patients in Treatment

3.7.1 First Time period: April 2018 – March 2019

Within this group, 1438 young people were recorded as in treatment in CAMHS either referred on the Core pathway, or the LAC pathway. 1396 of these were treated in Core CAMHS, and 42 by the LAC team.

3.7.2 Second Time Period: April 2019 – March 2020

Within the second cohort, there were a total of 1605 young people recorded as in treatment in CAMHS, with 1530 young people on the Core CAMHS pathway, and 75 recorded as being in treatment by the Enhanced Outreach Team via the CYJAP.

A summary of the demographic data is presented in the table on the following page.

	Control by Time Periods				Intervention Teams/Pathways			
	Core 18/19 (Core T1)		Core 19/20 (Core T2)		LAC		EOT	
	N	%	N	%	N	%	N	%
Variable								
Gender								
Male	632	45.27	652	42.64	28	33.33	38	50.67
Female	764	54.72	877	57.32	14	66.66	37	49.33
Undisclosed	0	0	1	0.07	0	0	0	0
Age								
Under 16	1253	89.75	1104	72.11	39	92.85	56	74.66
16-17	143	10.24	406	26.52	3	7.14	19	25.33
18 and over	0	0	21	1.37	0	0	0	0
Ethnicity								
White British	1263	90.47	1388	90.71	34	80.95	60	80
Any other White	35	2.5	27	1.76	4	9.52	0	0
White / Black African	4	0.28	5	0.32	0	0	0	0
White / Black Caribbean	8	0.57	5	0.32	0	0	0	0
White / Any other	6	0.42	5	0.32	0	0	0	0
Black African	3	0.21	2	0.13	0	0	0	0
Black Caribbean	0	0	0	0	0	0	0	0
Any other Black	0	0	0	0	0	0	1	1.33
Pakistani	9	0.64	5	0.32	0	0	0	0
Indian	3	0.21	2	0.13	0	0	0	0
Chinese	1	0.07	2	0.13	0	0	0	0
Any other Ethnicity	11	0.78	8	0.52	2	4.76	2	2.66
Any other mixed	8	0.57	6	0.39	0	0	1	1.33
Not recorded	14	1	17	1.11	0	0	1	1.33
Not Stated	31	2.22	58	3.79	2	4.76	10	13.33

Table 3.1: Demographic data for all cohorts.

3.8 Data collection

The data came from the Clinical notes system, SystemOne used by the Trust. The patient data is routinely uploaded by the Trust data analysts to a Trust reporting page and can be accessed by staff in the trust. Data was collected by the

researcher retrospectively for two blocks of time. The data collected is for the time period April 2018 – March 2019 for the LAC team and April 2019 – March 2020 for the EOT. The Core CAMHS data was collected for each of these two time periods for comparison. The data for Core CAMHS in 2019/20 did not include those young people who were placed on a designated pathway. The new CAMHS EOT began to accept referrals from April 2019, and therefore this was an appropriate time point to start data collection.

Routinely collected data is already analysed into mean values for each of the teams. To facilitate a more detailed analysis, it was necessary to request a breakdown of the data from the Data Analysis team within the Trust. The data was requested for each of the four data sets: LAC, EOT, Core T1 and Core T2.

Demographic data was requested to give a detailed picture of the sample of young people in the service, and the following information was also requested for April 2019-March 2019, and April 2019-March 2020:

- Number of referrals – *allowing consideration of whether the rate of referrals changed over time and indicating whether the new pathway allowed more referrals from children in care to enter the service.*
- Number of discharges - *this allowed exploration of whether being seen more quickly, led to shorter treatment length, and therefore to a higher number of discharges.*
- Number of appointments – *Enabled consideration of whether Core Time period 1 (T1) and Time period 2 (T2), and the CAMHS teams on the LAC Pathway and CYJAP offered similar amounts of appointments, or if there was an observed difference*.

- Length of time in treatment (in days) - *Allowed for consideration of whether shorter/longer treatment times were needed if referrals were picked up more efficiently.*
- Time waited until first contact from the service (days) – *Enabled exploration of whether referrals were offered first appointment ore quickly under the new pathway, as 'safety' was considered an area in which the service was requiring improvement, partly linked to extended waiting times to access the service.*

3.9 Data Analysis

Demographic data was analysed using descriptive statistics to show the mean age, ethnic and gender breakdown for each team, and to explore potential differences between these characteristics in the young people seen in each team. Descriptive statistics, for the demographic data are presented.

Statistical analysis was used to determine whether there was a statistically significant difference in waiting time to first appointment for children in care who were referred to the CAMHS LAC and EOT respectively. Initial descriptive statistics indicated that there were large standard deviations for all data sets. The measures of central tendency showed differences in the mean and median values, and consequently, box and whisker plots were run to allow the distribution of the data to be considered. The skewness of the distributions for all data sets demonstrated the data sets were not normally distributed and therefore a non-parametric, Mann Whitney U test was carried out using SPSS. This analysis was an appropriate tool for hypothesis testing, though the test used did not account for causality, or other confounding variables which may have impacted on the waiting time, such as school

holidays, breaks, difficulties in making contact, as these could not be controlled for since this study used routinely collected data.

3.10 Ethics

Ethical approval for this study was obtained from the Tavistock Research Ethics Committee at the Tavistock and Portman Foundation Trust (Appendix 1) alongside my NHS Trust's approval and registration of the project. The raw data was extracted upon request from the clinical data team, and demographic data was available on the Clinical Outcomes reporting system, which uses data entered from SystemOne. All potentially identifying information, such as address, and postcodes were removed prior to the data being accessed. Upon entering the service, individuals are asked to consent to the anonymous demographic and treatment data to be used for research purposes. Only data from individuals who gave this consent was used in the study. Data is anonymised prior to being uploaded to the Trust reporting system, and therefore no patient identifiable information was accessible.

3.11 Results

3.11.1 Demographic Trends

3.11.1.1 Time Period 1

On the Core CAMHS pathway, of the 1396 recorded as in active treatment the gender split was 632 (45.27%) males, and 764 (54.72%) females. There were 42 young people recorded as in active treatment with the CAMHS LAC team of which 14 (33.33%) were female, and 28 (66.66%) males.

Of those young people who were recorded as in active treatment on the LAC pathway between April 2018 – March 2019, 3 (7.14%) were between 16-17 years old, and none were over 18, with the remaining 39 (92.86%) being under 16. In the Core team, 143 (10.24%) were between 16-17, and 1253 (89.76%) were under 16.

3.11.1.2 Time Period 2

On the Core CAMHS pathway, of the 1530 young people recorded as being in active treatment, 652 (42.6%) were male, and 877 were female (57.32%) and one undeclared (0.07%). Of the 75 young people recorded as in active treatment on the CYJAP, within the Enhanced Outreach Team there were 38 (50.67%) males, and 37 females (49.33%).

On the Core CAMHS pathway, 1104 (young people were under 16 years, 406 were 16-17 years, and 21 were over 18 years. The enhanced outreach team had 56 young people under 16 and 19 people who were 16-17 years.

3.11.2 Referrals

Referrals to the Core CAMHS pathway and both the LAC, and EOT were examined. Referrals to Core CAMHS were considerably lower in 2019-2020 than in the previous year. The Enhanced Outreach Team received almost double the number of referrals that had been made to the LAC team in the previous year.

Referrals in Core CAMHS decreased between the two time periods, by 70.11%. from 1790 to 535. On the other hand, the referrals into the EOT showed an increase of 72.5% when compared to those made in the previous year to the LAC team, increasing from 62 to 107. The referral data does not relate to those in active treatment on each pathway, but rather any new referrals into the pathways within the

time periods. In 2018-2019, all new referrals were directed onto the Core CAMHS pathway, however, in 2019-2020, there were additional pathways developed and referrals could be directed to Core, EOT, Eating Disorder, and neurodiversity pathways. In addition, a number of practitioners were placed in schools to avoid some children needing CAMHS referrals but rather receive prompt access to short term mental health support within the school environment. An initiative was introduced to the Single Point of Access in 2019/20 to encourage signposting to other services in addition to these new pathway options. These new pathways meant there were different pathway options from the single point off access, and not all referrals would be directed to Core as they had been previously. The data for 2019/20 did not include young people on the designated pathways.

Team	**Number of referrals**	**Team**	**Number of referrals**	**Difference**	**% increase/ decrease**
Core T1 (On Core Pathway)	1790	Core T2 (On Core Pathway	535	1255	**70.11% decrease**
LAC T1 (On LAC pathway)	62	EOT T2 (On CYJAP)	107	45	**72.5% increase**

Table 3.2: Referrals to each Team (via relevant pathways) for Time Period 1 & Time Period 2

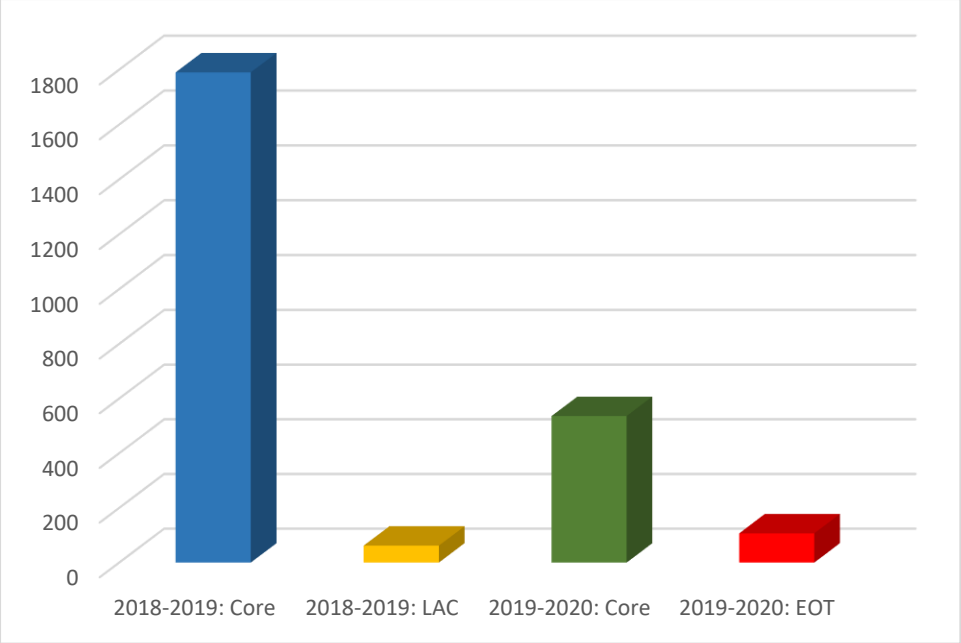

Fig 3.2: Number of referrals to each team (via pathways) for Time 1 and Time 2

3.11.3 Discharges

Between April 2018 – March 2019, 1907 young people were discharged from the Core Pathway, compared to 1019 in the same period between 2019-2020. The LAC team within CAMHS which formed part of the LAC Pathway, discharged 78 young people between April 2018 – March 2019, and 61 young people were discharged from the EOT which was part of the CYPJAP between 2019-2020.

Pathway	Number of discharges	Pathway	Number of discharges	Difference	% increase/ decrease
CORE T1	1907	Core T2	1019	888	**46.56% decrease**
LAC T1 (On LAC pathway)	78	EOT T2 (On CYJAP)	61	17	**21.79% decrease**

Table 3.3: Discharges for each Team (via relevant pathways) for Time Period 1 & Time Period 2

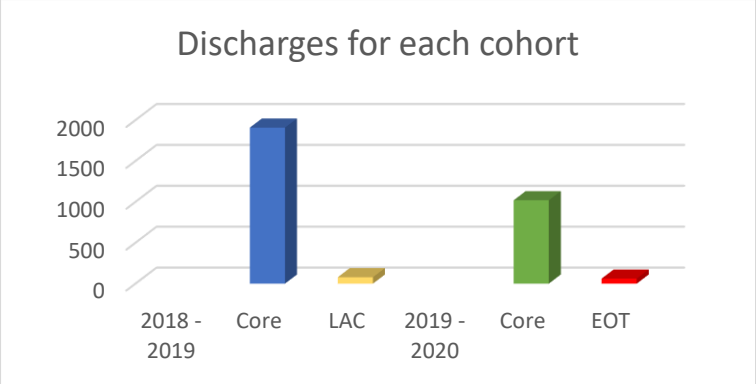

Fig. 3.3: Discharges for each Team (Via Pathways) for Time 1 & Time 2

3.11.4 Planned appointments

It can be seen that 8913 appointments were offered by Core CAMHS team on the Core pathway in 2019/20, 3614 less than in the previous year, which represents a decrease of 28.84%. The appointments offered in Core CAMHS did not include appointments offered on the designated pathways. The EOT, offered 564 appointments, compared with 274 offered by the LAC team in the previous financial year, an increase of 105.84%.

Pathway	Number of planned appointments	Pathway	Number of planned appointments	Difference	% increase/ decrease
CORE T1	12527	Core T2	8913	-3614	**28.85% decrease**
LAC T1 (On LAC pathway)	274	EOT T2 (On CYJAP)	563	289	**105.84% increase**

Table 3.4: Number of planned appointments offered by each team (via pathways).

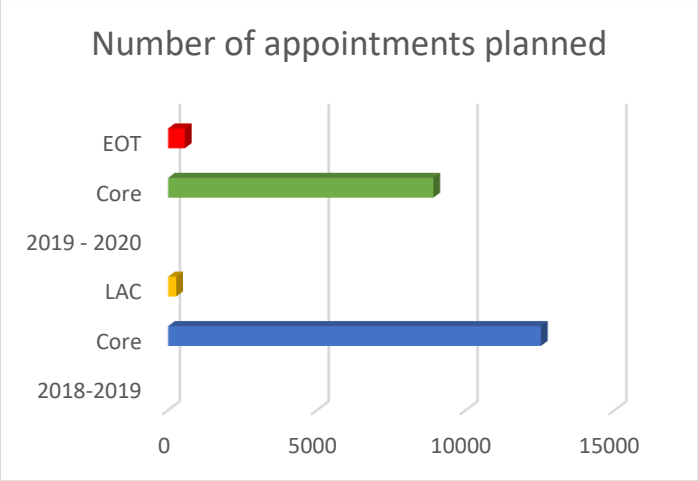

Fig 3.4: Number of planned appointments offered by each team (via pathways)

3.11.5 Length of time in treatment

The mean time in treatment on the Core CAMHS pathway increased from 238.35 days in the previous financial year to 403 days in 2019-2020, an increase of 164.5 days or 69.07%. The mean length of time that Children in care were in treatment decreased by 65%, from 160 days in the LAC team in the year 2018-2019 to 56 days in the EOT (2019-2020). The mean time in treatment relates to the number of days from the start of treatment, until discharge from that team or pathway.

Pathway	**Mean length of time in treatment (days)**	**Pathway**	**Mean length of time in treatment (days)**	**Difference**	**% increase/ decrease**
CORE T1	238.5	Core T2	403	164.5	**69.07% increase**
LAC T1 (On LAC pathway)	160	EOT T2 (On CYJAP)	56	104	**65% decrease**

Table 3.5. Mean length of time in treatment (days) for each team (via pathway)

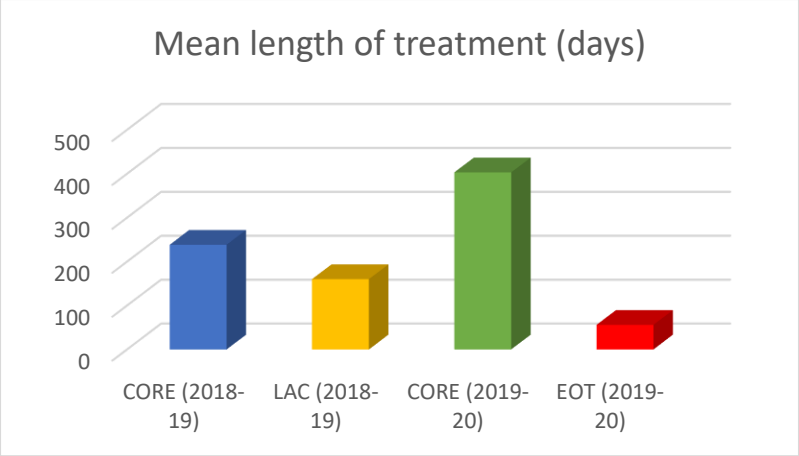

Fig 3.5. Mean number of days in treatment for each team (Via pathways)

3.11.6 Mean time waited (days) to first contact for treatment

The first contact relates to the first appointment offered after initial assessment. In Core CAMHS, the young person is usually sent a letter detailing their appointment, following a period on a waiting list after an initial assessment to determine the appropriate treatment. In LAC and EOT teams, the first appointment would be offered following acceptance of the referral by the CAMHS team at the CYPJAP meeting. The EOT offers an initial phone contact, equivalent to the initial assessment offered in Core and updates risk within two days, but this first contact described in this section refers to the first planned appointment with the assigned practitioner.

Pathway	Mean waiting time to first appointment (days)	Pathway	Mean waiting time to first appointment (days)	Difference	% Change
CORE T1	77.02	CORE T2	105.79	28.77	37.35% increase
LAC	107.48	EOT	16.46	91.02	84.68% decrease

Table 3.6. Mean waiting time to first appointment (days) for each team (via pathways)

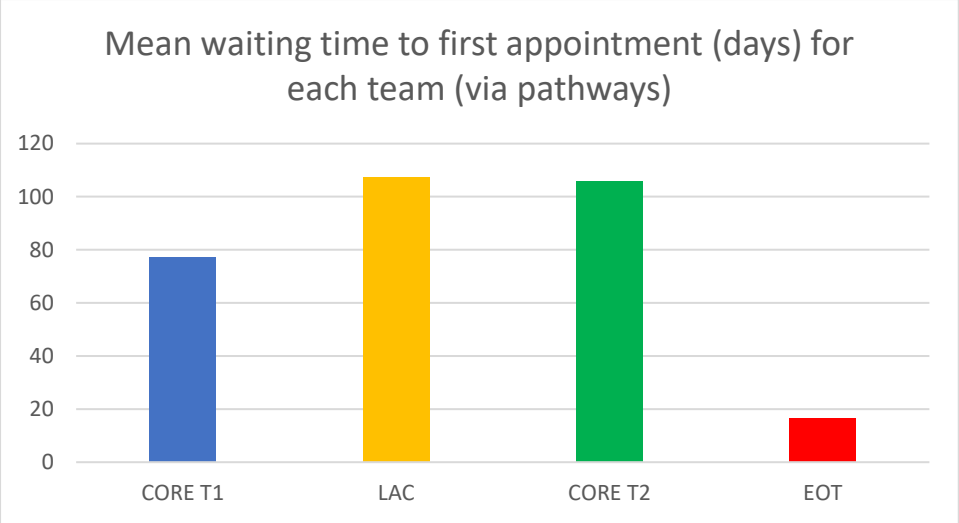

Fig 3.6. Mean number of days to first contact for each pathway

The mean number of days waited to first contact increased by 37.35% from 77.02 days in Core 2018/2019, to 105.79 days in 2019/2020 on the Core CAMHS pathway. Conversely, children in care referred to EOT via the CYPJAP, waited an average of 16.46 days to first contact between April 2019 and March 2020 in comparison to those in the previous cohort, who entered the service via the LAC pathway, who on average waited 107.48 days. This represents a decrease in waiting time of 84.68%, indicating an important reduction in wating times between the two pathways for children in care, and suggesting they were seen more quickly.

It was noted that the waiting times for all groups has a large range, and standard deviation, not indicative of normally distributed data. This information is presented below:

Pathway	Number of young people	Mean (days)	Standard deviation	Range	Median
CORE 18/19	879	77.02	90.42	0-528	51
CORE 19/20	619	105.79	141.03	0-762	33
LAC	37	107.48	152.3	0-508	27
EOT	84	16.46	22.77	0-169	11

Table 3.7. Mean, Median, Range and Standard deviation for pathways

The data presented in table 3.7 above shows the mean number of days that young people waited for their first appointment. The data shows that between the two Core time points the mean number of days waited increase from 77.02 days to 105.79 days, an increase of 28.77 days. On the other hand, the number of days that children in care waited for their first appointment in EOT reduced to 16.46 days from 107.48 days when under the LAC team, a reduction of 91.02 days.

On examination of the standard deviation, it is apparent that these numbers were high, and that this may indicate that the mean is not the best measure of central tendency for this data set. The ranges for all data sets were large, suggestive of widely spread data, which may be less consistent. The median values differ considerably from the mean values; for Core 18/19 (M = 77.02, Mdn = 51); for Core 19/20 (M =105.79, Mdn =33 days); for LAC (M =107.48, Mdn =27) and for EOT (M =16.46, Mdn =11 days).

In normally distributed data, it would be expected that the mean and median would be the same and fall in the middle of the distribution with no outliers. The data collected and the calculated measures of central tendency show that the data for mean number of days to first appointment cannot be considered normally distributed.

It was noted that within the raw data sets, there were a large number of 0 values, and on discussion with the data analysts within the NHS trust, it became apparent that the 0 value was used when individuals did not opt into treatment or were incorrectly added to the waiting lists and later removed. All zero values were therefore removed from the data sets, and box and whisker plots were produced to allow consideration of outliers in the data. This is shown below:

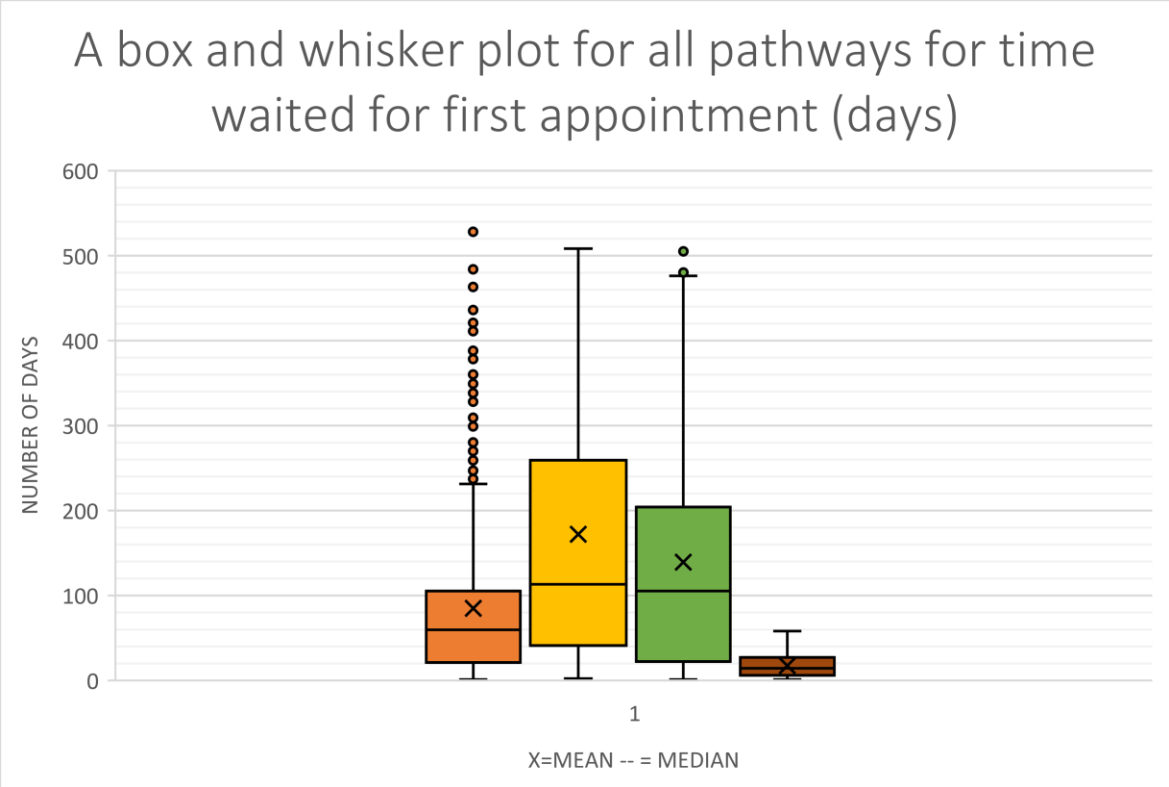

Fig 3.7 A box and whisker plot for all pathways for time waited to first appointment in days.

The shape of the box plot shows the distribution of the data, and any outliers. The box plot shows the minimum value, the 1st quartile value is the start of the box, the median is represented as the line across the centre of the box, the third quartile is the top of the box, and the line at the top is the maximum value. The dots shown represent outliers, and the cross is the mean value. The box plots show the data continues to be skewed, even with the 0 data points removed. The outliers identified on the box plot were removed and the mean, median and range were recalculated for each time point. These are shown in the table below:

Pathway	Number of young people	Mean (days)	Standard deviation	Median
CORE 18/19	734	64.07	54.04	55
CORE 19/20	440	139.02	133.83	105
LAC	23	172.08	162.51	113
EOT	68	20.13	23.84	14

Table 3.8. Mean, Median and Standard deviation for pathways

The days for core 18/19 data set shows M = 64.07, Mdn = 55; the days for core 19/20 data set shows M= 139.04, Mdn =105. LAC data shows that with the outliers removed, M= 172.08, Mdn = 113, and the EOT data shows M =20.13, Mdn =14. These differences in the median and mean values, alongside high standard deviations, would suggest that despite removal of outliers, and 0 values, the data distribution remains skewed, and therefore in order to calculate the significance of the findings, we would need to carry out a non-parametric test.

The Mann Whitney U test calculates whether the difference between samples is significant and does not require the data to be normally distributed, meaning it is an appropriate statistical test for this data set. The Mann Whitney U test was run for the data using SPSS and the results are displayed in the table below:

Comparison	Mann Whitney U value	p value	Significant difference	One or two tailed	Sum of ranks in columns
Core 18/19 vs Core 19/20	114604	<0.0001	Yes	Two tailed	384349, 312442
LAC vs EOT	200.5	<0.0001	Yes	Two tailed	1594, 2412

Table 3.9. Mann Whitney U values for comparisons between groups

Table 3.9 show the results of the Mann-Whitney U tests. A two-tailed Mann-Whitney U test was conducted to determine whether there is a difference in waiting time to

first appointment between Core 18/19 and Core 19/20. The results indicate a significant difference between groups, [U = 114604, p<0.0001]. The sum of ranks indicates that there was a higher waiting time in Core 19/20. A two tailed Mann-Whitney U was also conducted for difference in waiting time for LAC and EOT. These results also indicated a significant difference in waiting time between groups, [U=200.5, p<0.0001]. The sum of ranks shows a reduction in waiting time for EOT.

3.12 Discussion

The present chapter describes a cohort study and aims to explore the impact of a new Joint Agency pathway using routinely collected patient data from the teams in these pathways which are part of the CAMHS. It was hypothesised that the creation of the joint agency pathway and therefore the dedicated EOT team within CAMHS would make a significant difference to the waiting times for young people in care, therefore addressing the concerns highlighted by the Care Quality Commission, about safety in its last inspection in 2018, where it was noted that the patient safety category, was rated as 'requires improvement' due to long waiting times for specialist treatment.

The LAC team treated a higher number of males compared to females (66.66% male v.33.33% female), unlike the EOT which had an almost even gender split (50.67% male v 49.33% female). In 2021, the Department for Education released a breakdown of gender for children in care. In 2018, 56% of those in care were male, and 44% female, and in 2019, 57% were male, and 43% female. Ogundele (2014) states that males were more likely to present with aggression, or behavioural disorders, and this may have led to a higher number of males being seen by the

CAMHS team of the original LAC pathway rather than social services when it was less clear how the referrals were divided. As the more streamlined referral process of the new pathway developed, it may have allowed for discussion of all new referrals by the two agencies and perhaps this led to a different split of the referred cases, with social care offering some consultation or behavioural support for male patients rather than these cases immediately coming to CAMHS. The needs of female patients may also have been better accounted for when there was greater discussion of referrals, or young females who may be more likely to present with self-harm, or more risky behaviours (Hartas, 2021) may have previously been seen by the Crisis team, due to presenting with a more immediate need than the LAC pathway could provide for. The new CYPJAP may allow for more thinking about the appropriateness of the services offered, and this may have led to a more even gender split in young people accessing the service.

The Core team had a slightly higher number of females than males in each cohort, with 54% of young people being female in 2018/19, and 57% female in 2019/20. This could be due to demographics in the area or females seeking support more actively. The majority of referrals in both cohorts, for all teams were under 16. The CAMHS is for young people up to the age of 18, and from 17, young people can also access support via local charitable mental health support services, which may have a greater range of appointments available, and therefore this result would be as expected.

The number of referrals reflects the number of *new* referrals, rather than those who are recorded as already being in active treatment. On examination of the number of referrals to each team during each period, we can see that there are more referrals to Core CAMHS in 2018-19 than in 2019-20, reducing from a high of 1790 in

2018/19 to 535 in 2019/20. The CAMHS also engaged in the development of a school's work programme, a neurodiversity pathway, and looked to strengthen its eating disorders pathway around this time, which could account for the reduction in Core referrals, as young people may have been directly placed on a designated pathway in 2019/20. It also appears that a large number of young people who entered the service in 2018-19 were still involved in CAMHS in 2019-20, which is supported by examining the numbers of young people in active treatment on the Core pathway which remained similar, with 1396 in 2018/19 and 1530 in 2019/20, despite lower referral numbers.

The data for mean days in treatment would also support this thinking, as the days for 2018/19 is 238.5 for Core CAMHS, compared to 403 for 2019/20. The number of days in treatment for the latter Core CAMHS period is noted to be longer than a year, and therefore some young people may have been counted twice, as they were still being treated in 2019-20. Some staff who had previously worked on the Core pathway, moved to support staffing of the new pathways in their implementation, which then impacted staffing on the Core pathway and meant fewer new young people could be seen.

The referral data also shows the increased referrals to the Enhanced Outreach Team when compared to the LAC team. The number of discharges is higher in LAC than in EOT, which may be linked to the pathway closing, and patients being discharged. Some young people may have also been transitioned to the new CYPJAP.

More appointments were offered during the 2018-2019 cohort by Core CAMHS with a 28.85% decrease in the number of appointments offered in 2019-2020. As

discussed, this was due to young people remaining in treatment for longer during 2019/20, and therefore young people may be seen fortnightly, rather than weekly, or intensively (twice or more a week). The greater number of referrals and appointments in 2018/19 may have meant clinicians had less capacity to take on new referrals in the following year.

The CYPJAP CAMHS team, EOT offered more appointments than the previous pathway's LAC team. The data also shows that despite the higher number of appointments offered, the EOT saw young people for shorter periods of time, with the mean time in treatment reducing by 65%, from 160 days to 56 days, which may be indicative of more intense, shorter interventions. We can also consider this in relation to waiting times as previous literature has indicated that earlier intervention and shorter waiting times can improve outcomes, which could lead to less treatment being needed in the longer term (Early Intervention Centre, 2018) as early intervention may prevent deterioration, allow the network to feel supported, and lead to placement stability (Antcil, 2007; Burns et al. 2004; Chapman, Wall & Barth, 2010; Orme & Buehler, 2004).

The Mann Whitney U test demonstrated a statistically significant difference in time to first appointment on the CYPJAP in the CAMHS EOT compared to the LAC team which formed part of the LAC Pathway.

Descriptive statistics allowed examination of trends within the data, and it appeared that referrals to Core CAMHS decreased in 2019-20, when contrasted with 2018-19 data. The length of time in treatment for the Core cohort also increased in 2019-20 indicating that there may had been fewer patients, but longer periods of engagement

in this time. The number of discharges was higher in 2018/19 with 1907, compared to only 1019 in 2019/20, which fits with this thinking.

The new Enhanced Outreach Team protocol sets out to offer a first contact within 48 hours of referral, and an appointment within two weeks. After removing 0 values and outliers, the data suggests that an average of 20.13 days elapsed before first contact, but using Excel, the standard deviation was calculated as 20.13 suggesting that despite addressing outliers within the data, it remains a data set that is not normally distributed. The median value of 14 days indicates that a mean value is not necessarily an appropriate measure for exploring this data.

We can see changes in the number of referrals to the Core CAMHS between 2018/19 and 2019/20, with a reduction of 70.11% and it was reported by clinicians that signposting to other services at the point of referral had increased, along with some of the referrals that would previously have been seen in Core CAMHS being sent to the Eating Disorders team, some being seen in Schools by the Primary intervention team, some being managed in home-based treatment by the Crisis team, which had increased staffing and one adult service based in the city, accepting referrals from age17 onwards, rather than 18 and potentially could be impacted by Children in care no longer being referred to Core Pathway in 2019/20. Research around accessing mental health treatment, suggests that at 17, and 18, some young people become more aware of information sharing, privacy, and confidentiality, and chose to move away from CAMHS (Colucci, 2017).

Section 2: Qualitative Study

4. Methodology

This qualitative study aimed to explore practitioners' experiences of working with Children in care, considering the concepts of Container/contained (Bion,1962b) and Holding (1963). The way in which aspects of the two concepts are discussed by psychotherapists in relation to their psychoanalytic work with young people, as well as the observations in the interviews made about the presenting problems which may be linked to a lack of early life experience of these two concepts are explored. The two concepts offer different theoretical backgrounds to similar processes and there will be crossover in relation to the conceptual ideas. Both relate to early life experience within a mother/infant relationship and both lead to essentially the same clinical practice. My thinking around concepts specific to holding or containment, such as reverie, or primary maternal preoccupation led to the use of both theoretical positions in the development of the interview schedule.

As discussed in the literature review on page 32, the concept of holding relates to theory defined by Winnicott (1963) which considers the dependence which an infant has on its mother, alongside the physical holding, the environment and the ability to develop a 'true sense of self'. Containment refers to the theory of container/contained, which Bion (1962b) indicated was the process by which the mother takes on her infant's projections, digests these and returns them to the infant in a more tolerable form. These processes enable the child to regulate their own emotions, develop their capacity to think and develop their sense of self, as an individual, separate from their parents, but when these early life experiences do not take place, it can lead to problems with emotions, attachment and separation and relationships (Bion, 1962b; Winnicott, 1963).

When considering methodological design, it is important to consider the goals of the research, and the philosophical, and theoretical underpinnings. A paradigm relates to the set of assumptions about the world, and consists of the epistemology, theory, and ontology as well as methodology (Punch, 1998). An interpretivist ontology places value on social interaction as the basis of knowledge; research using this ontological approach involves the researcher using their own knowledge and skills to try and understand how others understand their own world (O'Donaghue, 2007). The concepts considered in the current study link to theoretical concepts which date back to the 1960s and are part of the theoretical stance which shaped Psychoanalytic Psychotherapy practice with children and young people. The researcher's, and participants' familiarity with the concepts under investigation, should enable the interviews to provide insight into these concepts brought to life in the work. The researcher will be reflecting on their own knowledge of work with children in care and attempting to understand and explore participants' experiences of working with children in care, how these theoretical concepts both shape and inform their work, and the impact which the lack of these early life experiences may have on children in care.

4.1 Thematic Analysis

A diversity of qualitative methods is applied to the study of Psychoanalytic interactions, and Rustin (2016) describes the movement from single case studies in Psychoanalytic research, to the use of qualitative methods, such as Grounded Theory (Glaser & Strauss (1967), and IPA (Smith, 1999). He references Midgley's (2006) statement that qualitative methods appeared to have moved to Mental health

research since he began his work, which indicates the development of Psychoanalytic research.

Thematic analysis (Braun & Clarke, 2006) is the process of identifying patterns or themes within a body of data. Braun & Clarke (2006) describe thematic analysis as a method, rather than a methodology, and therefore can be considered more flexible without theoretical or epistemological constraints (Maquire & Delahunt, 2017).

The goal of thematic analysis is to identify themes, from patterns in the data - both qualitative and quantitative. The current study uses qualitative data. When using the deductive approach thematic analysis allows interpretation of data to make sense of information, using theory as a base (Braun & Clarke, 2006). Thematic analysis is considered particularly useful when looking at subjective experiences, such as through interviews, or surveys (Braun & Clarke, 2006). Thematic analysis can be used as an inductive approach, whereby data is analysed, and themes are created without preconceptions (Crosley, 2021). Crosley (2021) also describes thematic analysis being used as a deductive approach, in which the researcher enters the analysis with themes in mind which have been informed by concepts, theory or research. A semantic approach to thematic analysis involves themes being developed based only on explicitly stated ideas, as opposed to the latent approach, which examines underlying meaning and offers some interpretation (Crosley, 2021).

Braun & Clarke (2006) describe these two levels of themes: semantic and latent. They consider semantic themes to be '…*within the explicit or surface meanings of the data and the analyst is not looking for anything beyond what a participant has said or what has been written.'* (p.84). They consider that latent analysis *'…starts to identify or examine the underlying ideas, assumptions, and conceptualisations – and*

ideologies - that are theorised as shaping or informing the semantic content of the data' (p.84)

Holloway & Todres (2003) describe thematising meanings as one of the few generic skills across qualitative analysis. Dyman & Bernard (2006) comment on thematic coding as a process performed within other methods as opposed to a method in its own right. In contrast, Braun & Clarke (2006) argue that thematic analysis should be considered a method and highlight the value of flexibility of the method. Braun & Clarke (2006) describe qualitative methods as being divided into two groups; those such as Interpretative Phenomenological Analysis (Smith & Osborne, 2003) and Conversation Analysis (Hutchby & Woofitt, 1998) which have little variability in their application, and methods such as Grounded Theory (Glaser, 1992) which can be used more broadly. Some methods, such as Thematic analysis are considered independent of theory and epistemology and can be applied across a range of theoretical and epistemological approaches (Braun & Clarke, 2006).

Arenson (1994) alluded to Thematic Analysis as a realist/experiential approach, but Braun & Clarke (2006) consider Thematic analysis to be compatible with both essentialist and realist paradigms which report experiences, meanings and the reality of participants or a constructionist method which considers the way realities and experiences result from discourses in society.

Psychological research has frequently employed thematic analysis (Blake et al., 2022; Childs-Fegredo et al., 2022; Tilley et al., 2022; Karr, Roberson & Tilura, 2020; Wright & Gabriel, 2018) and it is used when views, or experiences are being considered with a conceptual framework in mind.

Some of the advantages of thematic analysis relate to its use with large data sets and its approach of interpreting themes supported by data (Guest, MacQueen & Namey, 2012). The method is considered to allow both an inductive, and deductive development of codes, thereby offering flexibility (Saldana, 2009). This flexibility has also been considered as sometimes problematic by Braun & Clarke (2006) who suggest that it could cause difficulties in decisions about what to focus upon. They also consider that the method does not allow for technical claims to be made regarding language, unlike other methods such as discourse analysis and narrative analysis. Frith & Green (2004) used thematic analysis in their study about men's views on body image and considered the method to provide a nuanced and conceptual method of analysis. Ahlstrom et al. (2022); Boyd & Ivey (2023) and Stefana et al. (2021) all utilised the method within psychoanalytic psychotherapy studies and have considered experience, and both representation and construction of phenomena.

Thematic analysis can be considered as an appropriate analysis method for this study, as the concepts of holding (Winnicott, 1963) and containment (Bion, 1962a) guide the research, and fit with this deductive approach.

4.2 Research Design

This is an interview study using semi structured interviews. The interviews are with child psychotherapy professionals, to explore aspects of their practice.

4.3 Setting and Participants

4.3.1 Setting

The participants for this study were recruited from a community CAMHS team located in a small city.

4.3.2 Participants

There were 4 participants in the study; three were qualified Child and Adolescent Psychoanalytic psychotherapists, and one was a trainee Child and Adolescent Psychoanalytic Psychotherapist at the time of interview. Three of the participants were based in one NHS Trust CAMHS, and one had previously worked within the same Trust but had left to start a new role based in a Charity. Three of the participants were female, and one was male. The participants were aged between 29 and 55. The qualified Psychotherapists had been qualified for between 6 months and 25 years. All the participants were White European. All had experience of working with children in care as this was the main inclusion criterion for recruiting participants.

4.3.3 Recruitment of participants

The current research was initially presented for discussion at a Psychotherapy meeting within the CAMHS team. The current research was discussed with the four Psychotherapists within the team. They were advised that the interviews would last approximately 45 minutes and would consist of several questions linked to their experiences of working with Children in Care. At the time of recruitment, the term Looked-after Children was being used and was changed to Children in care following the interviews taking place after discussion about the terms used by the CAMHS team, feedback, and further reading. After reflection, the terminology was changed throughout the paper, due the negative connotations and thinking about the term ‘LAC’ (Lewis, 2019) The four Psychotherapists who were approached initially, were the four participants in the study.

4.4 Researcher position

The position of carrying out research within a team I was working as part of, namely as a trainee psychotherapist feels an important point to consider. As a clinician working within the CAMHS setting that all the participants who were interviewed were part of and knowing some of the young people they referred to meant that some of the accounts of young people were familiar and my own responses to some of these young people needed to be considered in the analysis and became part of the research process. My awareness of interviewing qualified psychotherapists, and the additional pressure I may have felt, alongside interviewing another trainee, and perhaps using different language or more detailed prompts may have impacted on my research and feel important to consider and acknowledge.

4.5 Ethics

The study was registered as a service-evaluation in the NHS Trust Research and Development Team and received ethical approval from the Tavistock and Portman Foundation Trust Research Ethics Committee.

The Psychotherapists were offered an information sheet to read in their own time, and approached 10 days later, to ask if they were willing to participate. The information sheet provided details of the study as well as the names of the interviewer's research and clinical supervisors and contacts at the Tavistock in case of any concerns with the conduct of the research.

Prior to commencing the interviews, participants signed a consent form, which confirmed:

- They had ample opportunity to ask any questions they had about the study

- They were made aware they had the right to withdraw at any time,
- They were made aware of the confidentiality process, which included maintaining the therapists' anonymity by removing any identifiable information from the transcript. In the analysis, all quotes were attributed by interview number, and patients were referred to as 'he/she' rather than by name or pseudonym.
- That data collected for the study would be stored for 6-8 years in accordance with Trust Policy
- That the interview would be recorded and transcribed, and files would be stored securely in accordance with Trust policy
- That for safeguarding purposes, if any information was disclosed which put the individual, or a young person at risk, this may need to be shared, following discussion.

4.5 Data Collection

Data was collected using semi structured interviews, each lasting between 30-60 minutes. The interviews were carried out over a 2-year period between 2019- 2021.

Interviews took place face to face in the clinical space in which the psychotherapists worked at a mutually convenient time, except for one interview which took place after the Covid-19 pandemic had started and was completed via Microsoft Teams, a secure video conferencing platform used within the NHS Trust. Participants were interviewed by the researcher and the interviews were audio recorded with a Sony ICD-PX240 Digital Voice recorder.

The structure of the interview included 11 pre-prepared questions. The initial questions aimed to allow the participants to feel at ease, and invited discussion about their job role and experience, as well as enabling them to define the term 'looked-after children' and what this may evoke for them. Several questions explored elements of the concepts of holding, and containment, and explored how components of these concepts manifested in their practice.

4.5.1 The interview questions

The main aim of the study was to examine the role that the two concepts, holding and containment have in Psychoanalytic work with children in care, in relation to the presentation of children in the room, and what can be observed about this, as well as in relation to how the therapist adapts and manages these behaviours or communications which they attribute to children in care more than other children they work with. The interview questions reflect these topics (For full interview schedule, see Appendix 4).

The questions related to the experience of the therapist in the clinic room with children in care, in relation to the network surrounding the child, and adaptations in their work with this group. Exploration of these factors in the interview allowed thinking about the ways in which the therapist may contain or hold the child to allow them to develop, along with the observations about what happens when children who have experienced abuse, or trauma may present when they have not experienced being contained or held in infancy. It was hoped that the therapists might provide some of their own theoretical views on what occurs in the room, and how they make sense of how children in care communicate their needs. It is

important to note that the interviews reflect the therapists' experience of the children in the room, rather than the child's direct experience.

The final interview question allowed participants to raise anything which they deemed relevant which had not previously been discussed. The semi structured interview allowed participants to provide answers which were linked to the research questions, but did not shut down the thinking process, or prevent individual ideas being discussed and developed (Barriball & While, 1994).

4.5.2 Operationalising concepts

As previously discussed in the literature review on page 36, difficulties in establishing early attachments have been suggested to impact upon a child's ability to communicate and regulate their emotions (Bowlby,1958; Winnicott, 1960; Bion, 1962b). There were several key elements which could fit within both theoretical descriptions of holding and containment:

- Enactment – a scenario or situation is played out without verbal communication
- Tolerating emotions – managing a range of emotions, and bearing with them
- Countertransference – the therapist's emotional responses
- Defences – unconscious ways of protecting oneself by behaving in a particular way
- Omnipotence – a feeling of being all powerful to defend against anxieties

The two concepts have key theoretical elements to them which are presented below.

4.5.3 Holding

Holding (Winnicott, 1963) is considered both a concrete and symbolic concept, and in terms of a therapeutic interaction, it is linked to meeting the patient where they are and providing an environment which is protected, and in which the analyst can bear the strain of projections, emotions and behaviours and remain alongside the child, which allows for the development of the idea of the therapist as someone separate to them and can allow the child to gain an understanding of their own feelings, and survive and accept anger. There are several key patterns which were looked for either as descriptors of technique, adaptations, or presentation of the child:

- Lacking 'as if' quality – this relates to the presentation of the child and therapist's responses regarding their ability to symbolise, and whether play can be symbolic, or instead becomes more literal therefore lacking an 'as if' quality.
- True / false self (Winnicott, 1958) – these are ideas about what the child might present in the room, for example, showing a 'false self' by a more stuck on persona they have used to help manage anxieties. For example, this could be being very obliging and sweet to make themselves more bearable to be with. Emergence of a 'true self', allowing the therapist to see anger, or something more real, could be considered progress in the therapy.
- Physical holding – This relates to the presentation of the child, and the idea of a push for physical holding or touch, for example the child putting themselves in danger and the therapist feeling pulled into something more physical, which could be trying to catch them if they are jumping, or wanting to sit close to, or on the therapist. (Canham, 2004)

- Surviving / bearing projections – this relates to the way in which the therapist might respond to the child and describe staying alongside the child when there is an experience of intense emotional projection, or trauma. This could be an experience for the therapist of being made to feel helpless, or useless (Kenrick, 2000)

4.5.4 Containment

As discussed in the literature review (page 27) containment comes from Bion's theory that the parent metabolises emotions and difficult communications from the infant and gives them back in a tolerable and manageable way (Bion,1962b). Therapeutically, ideas linked to the concept of containment may present in the ways listed below:

- Capacity to symbolise – the way in which the child can communicate using symbolism, rather than something more literal. This could overlap with the 'lack of as if quality' discussed in holding, but subtle uses of language will allow thinking about whether the therapist makes sense of the behaviour driven by a particular theoretical background (Bion, 1962b).
- Attacks on linking (Bion,1959) – The way in which the child disrupts the thinking in the room and makes it hard for the work to take place, and the links to be made. The child may attack links by choosing to leave the room, by screaming, by appearing to not listen, or by hurting the therapist.
- -K States of mind (Bion,1959) – this links to the idea above but relates to the creation of a non-thinking space and the way in which the therapist may feel

stuck, or the child may experience this non-thinking state of mind, based on what was missing from their early life.

- Reverie (Bion, 1962b) – the relationship in the room between the therapist and the child could be thought about in terms of the reverie and the way in which they respond to each other. The term reverie was used by Bion to describe the intense interaction between mother and infant.
- Introjection / Object relations (Klein, 1948) – The way in which the therapist notices the child's ability to take something in.
- Projective identification (Klein, 1938)– The therapist may have an experience of the child projecting into them the hated part of themselves which they have introjected from their birth parents. For example, this could be reported in the therapist having an experience of feeling like an angry father which may link to the child's real-life experience.

4.6 Data Analysis

4.6.1 Procedure

The files were uploaded to an NHS approved professional transcription service via a secure portal for transcription and were returned to a secure NHS.NET email address on completion as Microsoft Word documents, and were password protected on return for storage on an NHS laptop. The interviews were printed out to be read through, analysed, and annotated. The paper files were kept in a locked cabinet, accessed only by the researcher, and contained no identifying information.

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analysed, and annotated. The paper files were kept in a locked cabinet accessed only by the researcher and contained no identifying information.

Thematic analysis can be approached in different ways (Alhojailan, 2012; Javadi & Zarea, 2016; Braun & Clarke, 2006). The six-step process as set out by Braun and Clarke (2006) appears to offer a clear approach to carrying out the analysis. The steps are shown below:

1. Become familiar with the data

The first step involves reading and re-reading the transcripts, making notes, and recording early thoughts on the data. Unlike other methods, such as IPA, the transcripts are re-read collectively before starting the initial coding.

2. Generate initial codes

In this stage, the data begins to be organised in a more structured way, so coding is used to reduce the data into smaller groups, which have some meaning. The data was analysed with a theoretical stance in mind, so this was a deductive analysis, rather than inductive, however, the way the data is coded can be different depending on the research question. The data in this project was coded with the theories of containment (Bion, 1962a) and holding (Winnicott, 1963) in mind. Any segment of the data which appeared to link to elements described as part of these concepts were coded, but data that did not relate to these was not. Line by line coding was not necessary as there was a theoretical stance, and research question in mind. Open coding was used, as there were no pre-determined codes, but rather the codes were developed as the analysis took place.

I noticed links in the experience of the therapists in describing the emotional pull and strong responses to children in care, as well as progression linked to perceived

emotional regulation and tolerance in the children. I noticed the emotive language used frequently to highlight points, for example, words such as ‘bombarded’ or repetition of words such as ‘that’s it, that’s it, that’s it’.

The initial codes were created based on identification of similar points, for example ‘holding the network in mind’, ‘a lack of as if quality’, ‘an emerging true self’ and ‘a solid framework’. These initial codes allow the next stage of searching for themes by identifying conceptual codes that captured key experiences.

3. Search for themes

This phase involves creating themes from the coded data. A theme is a pattern that relates to the data, and research question, and when there are codes which seem to fit together, these can be grouped together to form the initial themes. In the case of the current study, there were clear coded data sets that fitted together, related to the elements of the concepts being thought about. All of the codes in the current study fitted within the themes described but Braun & Clarke, 2006 consider the use of a miscellaneous theme to cover all of those which do not clearly fit within a specific theme. The initial codes which appeared to describe similar processes or experiences with children or how the children’s needs were responded to.

4. Review themes

The reviewing stage looks at development and modification of the initial themes developed in the previous step. All the data linked to the individual themes is collated, and then the data is re-read to ensure it does support the themes created. It is important to consider how this works across all data from all interviews, and make sure these feel appropriate in the context of all the interviews. It is also important to consider the following points:

- Is the theme too big – does it include too much data?
- If themes overlap, should they be joined together?
- Are there subthemes – themes within the initial themes
- Have any themes been missed?
- Does the data support the themes?

Some of the subthemes created from the initial coding were joined together, and this included ‘noticing and withstanding trauma’ and ‘tolerating and regulating feelings’, which seemed to overlap. ‘Skin to skin’ and a ‘place inside the therapist’ which were both initial codes, appeared to work as one subtheme.

5. Define themes

This step links to considering the ‘essence’ of what each theme is about (Braun & Clarke, 2006). This stage involves consideration of how the themes relate to each other, as well as how subthemes relate to the main theme. I created lists for the initial codes, and then themes that had been created. I printed these, cut them up, allowing me to move them round, and ensure all had been considered, and seemed to fit within the correct theme.

6. Write up

The write up involves discussion of the themes, and subthemes, alongside quotes to support the themes that have been presented. There were 8 substantial themes created from the initial coding. Four of these themes were selected for further analysis and presentation as they were the themes which each of the therapists reflected on and contributed too. The themes which were selected appeared to represent each stage of the psychotherapist’s experience of the child’s (along with the people around them) journey through Psychotherapy even before the therapy

commenced. The four themes selected for presentation also allow consideration of both the concepts of holding and containment and enable thinking about how a lack of these experiences in early life may present as well as how the theoretical knowledge of the therapists guides their work. The four themes which were selected are presented in table 4.1 on the following page. See appendix 5 for the full list of themes.

Theme	Codes
Layers of containment / Holding the network in mind	*Supervision and joined up thinking*
	With parents and carers in mind
	Managing trauma for the team and network
Projections, Enactment & the therapist	*Spilling out: It's all out there*
	A sense of action
	The countertransference
	Projective identification
	Enactment and the depriving therapist
	Capacity to symbolise
	Noticing and withstanding trauma / tolerating and regulating feelings
	The therapist outside the room
Being in touch with what's missing	*Skin to skin / A place inside the therapist*
	Maternal preoccupation – staying in the mind of the therapist
	What has the child missed?
	A wish to be known and understood and a different kind of experience
	Endings and loss
A journey to integration	*A regression to dependence*
	A lack of progress, something stuck
	False self, true self and reality
	A journey to integration

Table 4.1: Themes identified for analysis with subthemes.

4.8 Themes

As stated, the codes were grouped into a total of 8 substantial themes. Restrictions on time and word limits, meant that all 8 of the themes could not be presented in the analysis. Four themes were selected for further analysis and presentation as they were themes which each of the therapists reflected on and contributed to. The

themes that were selected appeared to represent stages of the child in care's journey (along with the people around them) through Psychotherapy, even before the therapy commenced. The four themes selected for presentation also allow consideration of both the concepts of holding and containment and enable thinking about how a lack of these experiences in early life may present, as well as how the theoretical knowledge of the therapists guides their work. The four themes which were selected are presented table 8 below. See Appendix 5 for the full list of themes.

5. **The role of containment and holding in Psychotherapy with Children in care**.

5.1 Aim

The aim of the qualitative study was to examine the role that the two concepts, holding and containment have in Psychoanalytic work with children in care. These concepts are considered in relation to the presentation of children in the room and what can be observed about their behaviours and communications, as well as in relation to how the therapist adapts and manages these. As described in the methodology chapter, there were four themes identified from the 4 interviews with child psychotherapists. The interviews and excerpts presented are the psychotherapists' experience and views of the children in care, rather than direct experiences of the child. The themes will be presented in an order which describes the journey for the child in care in Psychotherapy, so initially considering the process of setting up the therapy, and the working with the network, then the work in the therapy room and how this is observed by the psychotherapists. In the final stages of the journey, the themes describe the changes observed in the children in care and the move to a more integrated state of mind.

The first theme, 'Layers of containment / holding the network in mind', will explore three initial codes which have been grouped together; 'supervision and joined up thinking', 'keeping the parents and carers in mind' and 'managing the trauma for the team and network'. The second theme is 'projections, enactment and the depriving therapist', and describes 8 codes; 'Spilling out: It's all out there', 'a sense of action', 'the countertransference', 'projective identification', 'enactment and the depriving therapist', 'capacity to symbolise', 'noticing and withstanding trauma' and 'the

therapist outside the room'. The third theme is 'being in touch with what is missed' and is made up of 5 codes; 'skin to skin', 'maternal preoccupation', 'being in touch with what's missed', 'a different kind of experience and a wish to be known and understood', and 'endings and loss'. The final theme presented is 'a journey to integration', which comprises of 4 codes; 'regression to dependence', 'a lack of progress: something stuck', 'false self, true self and reality' and a move to integration.

5.2 Layers of containment, and holding the network in mind

This theme's three initial codes, all linked to the network, and how careful thinking around the network was present from before the work began and throughout. The first of the three is 'supervision and joined up thinking', which relates to the therapist's description of the use of supervision to develop their thinking outside the session, alongside the importance of including the network in the thinking and planning for the child and trying to reduce rivalry between those involved. The second is 'keeping the parents and carers in mind' and relates to the value of parent work, and how this may support parents/carers in feeling less persecuted by the child and have a space to try to understand the behaviours they may observe. The third is 'managing the trauma for the team and network', and links to the way in which the psychotherapists described feeling as though due to their training and style of working, they are the people involved with the child in care who are able to hold the trauma and think about, rather than turning away. Thinking about the network was present in all four interviews. Theoretically, it seemed that ideas linked to both concepts of holding, and containment were linked to keeping the network

supported and that without consideration of the wider network, the child in care, may find themselves in a situation in which difficulties they had experienced in their early life, such as deprivation were replicated in their experience in the network. Ideas of 'layers of containment' as well as 'holding the network in mind' seemed to present both concepts as important, which would fit with previous research indicating the value of the network, and management of dynamics (Henry, 1974; Emmanuel, 2000; McLoughlin, 2010).

5.2.1 Supervision and joined up thinking

> *'I think, again, probably for me, more than any other group that I am working with, with looked after children, supervision is crucial…' (Line 246 – 248, Interview 1)*

The notion of supervision was present in three of the four interviews, with acknowledgement of the value of supervision when working with Children in care. The idea that without supervision, there may be increased likelihood of *'enactment'*, or *'concrete thinking'* which may replicate the experience of a child who does not feel held. The position of the supervisor as external to the work, may enable the disturbance to be held onto and thought about, without avoidance, or action. One therapist spoke of '*heavy*' cases, which may require that '*extra supervision needs to be sought'*, due to a *'risk of becoming desensitised*'.

Winnicott (1963) describes the importance of the therapist being able to allow themselves to be immersed in the work and allowed themselves to experience the projections. Becoming *'desensitised'* to the trauma, or abuse experienced by a child in care limits the capacity of the therapist to provide a sensitive and well-timed interpretation, which is part of the creation of the holding environment. If the therapist is unable to create this for the child, it has the potential to impact negatively on the

work with the child as it could lead to a replication of their previous negative experiences or prevent the child from developing capacity to manage their own emotions and regulate themselves. The supervision is also considered to enable thinking about the external reality for the child and the changes that may be observed outside of the room and taking a *'backwards step through supervision'*, enabled bigger changes to be seen, with an acknowledgement that these changes *'weren't necessarily seen positively by the people around'*, referring to teachers, social workers and foster carers and others in the network. The supervision, or work discussion groups appears to be thought of as developmental for the therapist, allowing them to observe the changes which were taking place with the child and as discussed on page 143, the therapists could be left with feelings of stuckness, or lack of progress, which the supervision may enable them to understand. It appears that the therapist appeared to be noticing that when they felt held by supervision, that they in turn might be better able to hold the child. As discussed in the literature review, Rustin (1999) comments on the need for the triangulation of supervision, to enable the therapist and supervisor to become like a 'parental couple' in their thinking about the child, with the perspective of another adding to the therapeutic process.

The joined-up thinking enabled by using supervision also appeared to link to work with the wider external network, effectively holding the network in mind and providing a holding environment which could be a thinking space for the child to be considered. One psychotherapist considered the way in which an experience for the child could be replicated in the network, such that if people aren't *'kept in the loop'*, it can quickly lead to *'re-enactment'*:

> *'Yes, again [regular reviews should take place], I think otherwise it can very quickly lead to something being re-enacted in the network, if people aren't kept in the loop, in the know, feeling involved. A bit like how they looked after child themselves could feel on the periphery of something. It's really key that those meetings happen regularly'. (Interview 1, Lines 372 – 377)*

Previous research such as Louise Emmanuel's (2002) Deprivation x3 paper highlighted the difficulties which may arise in a network surrounding a child in care, such as a child being further deprived of therapy, because an agreement cannot be reached in relation to treatment planning. This deprivation which may be replicated due to dynamics in the network could lead to significant disadvantage for the Child in care. Dynamics which could impact on the child in care those such as rivalry between the importance of mental health or education, or a situation being perceived as an attack or criticism of another person in the network. The '*thinking around the system'* is described by interviewee 4, alongside how this allows development of the *'thinking partnership'* between the therapist, and the other adults involved in the child in care's life. The layers of thinking are also described, with the phrase layers of containment, in line with Emmanuel's position:

> *'I think there is so much- what I've found, the constant is always the need for several layers of containment around the child and the placement, and sometimes child placement and social worker'. (Interview 4, Lines, 345 – 351)*

Emmanuel's paper was an extension of work by Henry (1974) on double deprivation, in which she describes how the deprivation is compounded by the institutions around the child, when replication of the collapse of strategy seen in babies with disorganised attachment styles can be seen in the *'drift'* in the wider network surrounding the child. This deprivation can lead to treatment delays, or removal,

which in turn, could impact upon long term recovery for the child (Bazalgette et al. 2015).

Emmanuel suggests that the disorganised states of mind which may be experienced by the social workers involved with children in care and the ways in which social workers, or other professionals can become identified with children, foster carers or birth parents is what may lead to their thinking becomes impaired. As a result, the splitting and rivalry can emerge in the network around the child in care, which can lead to replication of deprivation for the child in such that they do not get the treatment needed (Britton, 1981; Sprince, 2000).

The replication of deprivation which can occur for children in care is discussed by interviewee 2, who describes the situation of a particular child in care who was assessed as needing intensive psychotherapy to meet their needs:

> *'It was thought by myself and my tutor at the time that she would have been an intensive case, but the foster carer just was unfortunately not willing to support it really, and the social worker was a temporary social worker' (Interview 2, pages 285-290)*

This example highlights, not only the deprivation which can be replicated, in the child not receiving the intensive psychotherapy which they need, but also the power dynamics in the thinking about the child and who has responsibility for them, and the decisions made about their care. As reported in the literature review on page 21, for children in care, the parental responsibility lies with social care and therefore the therapist would need to appeal to social services for a decision to be overruled.

5.2.2 With parents or carers in mind

The need for parent or carer work was also communicated in three of the four

Interviews. Support to enable carers to feel contained, and to support their understanding of the child in care's behaviours seems to be considered crucial. The time and space given to foster carers or parents appeared to allow them to feel held. Enabling some understanding or curiosity about what the child may be communicating prevented the foster carers feeling persecuted, or as though the child was not making progress. One therapist spoke about a particular child in care and the parent work being done to support the individual work for the child. The situation in the foster carer's home had changed as they had taken on an additional foster child after '*a long time of stability'.* The therapist described a recent behaviour which had occurred, and how they understood this. The therapist tried to think with the foster carer about it, particularly in relation to the child who was in therapy, maybe feeling '*displaced*' or that the foster carer doesn't have *'enough time or space'* for them:

> *'The child in question started to do things like throwing all the shampoos and soaps and beauty care products of the foster carer in the sink, which is something that was a very old behaviour. Suddenly that behaviour reappeared… …. I tried to help the foster carer think, apart from being very angry about losing all her lovely lush products down the drain, but to think that perhaps there was a communication that was a very young communication in this now older child that had to do with feeling displaced, with feeling that she doesn't have enough time or care or space for the particular foster child.*
>
> *So that's the type of work that usually needs to be done actually with foster carers because these communications that looked after children have can be particularly demanding for people, quite hard sometimes not to react with anger…' (Interview 4, Lines 184 – 191)*

The description of the child above by interviewee four, indicates that in the therapists view the child appeared to be communicating their feelings of displacement, or not being valued Thinking in this way with the foster carer appears to allow them to consider things from think about the child's perspective and indeed, be able to use

this understanding should the behaviours arise again. Without support, the foster carer may be left feeling persecuted, or frustrated and feel a call to take action, rather than trying to understand and make sense of what the child maybe experiencing. Henry (1974) describes the way in which children in care may push people away to '*protect themselves'*. Space for the foster carer to think about more challenging issues which arise whilst feeling contained by the psychotherapist who is providing parent work may have long term benefits in supporting less frequent movements of placement and allowing the child to feel more understood (Hopkins, 2009). When receiving parent work, the foster carers may feel more contained and better able to reflect on the child in care's behaviour as a communication of feelings, rather than as an attack directed at them. By the foster carers feeling held themselves, they are in a better position to understand and support the child in care. As discussed in the quantitative chapter, page 53, the outcomes for children who move placements frequently and are therefore unable to access therapy, have poorer long-term outcomes, both in terms of their physical health (Dale et al. 2016) and mental health (Bazalgette et al. 2015)

Parent work has been indicated as being of value, both for the children in care, the foster carers and financially as it leads to improved outcomes for children in treatment and helps to promote understanding of the child's needs by providing a consistent and steady environment for the parents or carers as well as the child (Rustin, 2009; Klauber, 1998; Novick, 2022).

Parent work appears to strengthen the parent or carer's ability to think about and understand the child's needs without feeling persecuted by the child. Two of the therapists acknowledged that without support for the carers/parents, the therapy could be jeopardised and described the process as a *'thinking framework around the system'* and another states that:

> *'Without having a framework around the therapy, the individual work, then it can be precarious or in jeopardy because the deeper the level of anxieties or trauma, or whatever, it would be important to think about and be expressed, or find a way to put words to and so on, the more that it could stir up in people around the child, so there needs to be a kind of proportional level of network or support for carers or parents'. (Interview 3, Lines 464 – 471).*

This links to the idea that what could be *'stirred up'* for people around the child needs to be considered and that proportionate support should be available, with the acknowledgement that higher levels of trauma for the child may have a greater impact on the parents or carers and therefore those parenting children in care, may need a greater level of support for themselves during the psychotherapy with the child.

5.2.3 Managing trauma for the team, network and child

This code was present in three of the four interviews which took place. Winnicott (1963) describes the way in which the therapist must allow themself to experience the projections of the child, and where appropriate, interpret sensitively what the child is communicating, through projections, words or behaviour. The extensive training of a child and adolescent psychotherapist, involving their own long-term

analysis, aims to provide them with the skills to manage the experience in the countertransference with complex and demanding cases (ACP, 2021).

The therapists describe the way in which the team may not be able to manage to be in touch with some of the disturbance generated by the child, based upon their early life history, for example sexual abuse, or neglect and the way in which the psychotherapist takes that on:

> *'You know, people do struggle with dark disturbance. They really, really do. I'm not sure if there is that capacity to really go there with the team'. (Interview 2, Lines 643 – 645).*

The team relates to the wider Multidisciplinary team, which is described in the Quantitative chapter on page 56 but encompasses psychologists, family therapists, mental health practitioners, health care assistants and play therapists. The description of the team being at times unable to think about the traumatic early life experiences of the child suggests that due to their training and way of working, the therapist is able to work in a way that does allow this thinking to take place, which perhaps places them in a position of holding this disturbance for a team who may not have the '*capacity*' to be able to think about the more disturbing experiences.

Winnicott (1963) describes the holding environment as elastic and changeable, and identifies the need for a mother, or therapist who can be alongside the child or infant in the face of disturbance and anxiety. The therapist would aim to resist a call to action, which could lead to an enactment of difficult experiences, or cause the child to feel people can't hold and bear their trauma or distress (Winnicott, 1963). One therapist spoke of the way in which the team felt more comfortable with action, rather than thought:

'I think because they are such, sort of, perverse, dark, disturbed thoughts, you know, people don't want to share them, and they will say something of me as well. So, you do have to be very careful, and you almost have to be careful. The team that I'm within, they don't strike me as the type of team that, you know, can do that. I mean, it's not necessarily appropriate to do that anyway, but there is a sense of really, sort of, shutting down and a real response, especially for the mental health practitioners, "Right, what do we do? What do we do? What can we do?" which it does feel sometimes a little bit non-thinking'. (Interview 3, Lines 372 – 377)

Bion (1959b) states that when two people share a link, this is a 'k-link' and there is shared meaning between them. He purports that for some people, they do not have the ability to form these links, possibly because they have taken in an experience of an 'other' being destructive, or unresponsive to them in their early life. This state of limiting meaningful connections, he terms '-k'. Bion's (1957) theory of attacks on linking, relates to the 'fragmentation or numbing of thinking, which he posits is a communication of the internalisation of the destructive mother and infant relationship. If we consider the early life experience of some children in care, we can see how this 'non-thinking' state may occur, if the links between the child in care and the therapist are attacked.

The repetition of the phrase *'what do we do'* highlights the drive to help by *'doing'* by the other members of the team. The idea of the *'privilege'* of the psychotherapists to be able to understand and work with the child's communications is put forward by participant 4 and the concern that children could end up being *'hurt'* emotionally if they are not worked with therapeutically:

'I'm also wondering about the fact that I feel that we're privileged as child Psychotherapists to have a certain knowledge about how people hear and how these children would hear and would see us and hear our communication. I think it's good that we can educate colleagues

> *to that because sometimes that's lacking, and colleagues who may be very well-meaning but not trained, or not trained in this particular area end up hurting them, end up not being therapeutic with these children'. (Interview 4, Lines 447-455)*

Sandler (1985) describes the importance of providing a safe and secure environment for Psychotherapy where disturbance can be held, whereas Casement (1997) suggests that understanding and being with the child goes deeper than physical holding. The Association for Child Psychotherapists describes the way in which Psychotherapists are *'highly skilled and rigorously trained'*, which would link to the interviewee's idea that for this particular type of work, Psychotherapists are well suited.

The team and network were also thought about in relation to Bion's (1962b) theory of container/contained. Bion (1962b) suggested that the mother takes the projections of the infant and metabolises them in the reverie. As described by the therapists, the sense of trauma present with children in care appears difficult for other members of the team to manage, as they might not be trained to take in and process the child's anxieties. In contrast, if we apply Bion's ideas, we could consider that the psychotherapists are able to take in and process the trauma and in doing this, can return the thinking about what the child is communicating to the team in a more bearable way. The therapist may take on the role of providing a psychoanalytic perspective for the team, which may allow thinking about the child's behaviours and needs, much like when working in this way with foster carers as discussed in the previous subtheme.

The feeling of the therapist being left in the room with the trauma came up in one of the interviews, with the therapist noticing their experience that frequently a child would *'skip out the room, all sweetness and light'*, but acknowledging regularly that

they as the therapist would be left *'disturbed, traumatised and abused' (Interview 2, Line 307 – 309)* The therapist appeared to be describing a feeling of being projected into, that is, that the child could expel the disturbing and traumatic experiences and instead, these were picked up by the therapist. This experience allows the therapist to begin to metabolise and process the communications and return them to the child in a more tolerable way. The therapist describes being left with something and being prepared to take on the projections and sit with them, whilst perhaps awaiting the child being ready to take something back in a different way. Being able to sit with this child and the disturbance links to the experience of showing the child that the therapist can manage their distress.

There is an acknowledgment that this process of receiving these communications, and picking up the trauma can be difficult, with interviewee 3 acknowledging the difficulty in *'staying with feelings'* when this is alongside a *'wish to reject'*, or a *'wish to not think about these feelings:*

> *'So, it's not just the difficulty that's evoked one to one and staying with those feelings and the wish to reject or the wish to not have to think about these things, so I would say that although that's hard, like therapeutic work individually, what's harder to maintain is thoughtfulness in the people around that child'. (Interview 3, Lines 381-386)*

The therapist later speaks of extreme feelings being provoked, linked to humiliation, or something abusive and how at times, the important thing is to bear the feelings, rather than reacting, or responding, but that registering and thinking about it is the work of the child psychotherapist. The '*extra sensitivity'* required when working with children in care, is considered by one of the psychotherapists explicitly, acknowledging that this is needed to prevent *'re-traumatising'* the child:

> *'I feel that's something that I find very important, this extra sensitivity in how we talk to this type of children, because otherwise there is a risk of them having an experience that would re-traumatise and that would just, sort of, confirm the worst and not help. I feel as child psychotherapists we've got this maybe unique way of looking at it that is not perhaps- it's not known or shared by our CAMHS colleagues when they work with looked after children. So, I would want to speak on behalf of that if I had the chance in teams and so on'. (Interview 4, Lines 432 – 440)*

The Tavistock (1980) created a workshop which was specifically for thinking about working with Children in care and allowed exploration of psychoanalytic work with children in care. As the workshop developed, the poor ego structure, lack of emotional register and developmental deficit of children in care were considered, and the technique of classic interpretation was noted to sometimes raise anxieties in this group of psychotherapists in a work discussion format (Alvarez, 1992, Hindle, 2000).

5.3 Projections, Enactment and the therapist

This theme relates to the way in which the therapist allows themselves to take on the projections from the child, and manages this in the room, particularly in relation to enactment. There are 8 initial codes which fall under this theme. The first of these is 'spilling out: it's all out there', which links to the lack of containment in the children in care, particularly at the start of their work. The second is 'a sense of action', which describes the therapist's experiences of action being used to communication with children in care. The third code is 'the countertransference', which encompasses the emotional responses stirred in the therapists in their work with children in care and how they react to these feelings. The fourth is 'projective identification', which considers the use of this defence by children in care, and how this is presented in the clinic room. The fifth is 'enactment, deprivation and the redundant therapist', which presents the therapists descriptions of noticing when the deprivation or *'uselessness'* experienced by the child in care in their early life, becomes enacted in

the therapy, and how the therapists try to work to avoid this. The sixth code is ‘capacity to symbolise’, which relates to the observations of the therapists that children in care find it difficult to symbolise and the lack of play and creativity is considered in the children they describe. The seventh in this theme is ‘noticing and withstanding trauma and tolerating and regulating feelings’, which describes the therapist’s role in bearing the disturbance, and supporting the child to begin to tolerate and regulate their emotions as the work progresses. The final code is ‘the therapist outside the room’, which considers breaks and endings in the therapy and how they might be experienced by the children who the therapists have worked with.

5.3.1 Spilling out: It’s all out there

This relates primarily to the concept of containment, and the language used by the therapists, as well as the described process which seemed most closely aligned with Bion’s (1962b) theory. Two of the four therapists discussed the way in which they viewed that Children in care had emotions closer to the surface and were less contained than children who were not in care. This relates to Bion’s (1962b) theory of containment and the way in which the children may not have been on the receiving end of a primary carer who was able to process their anxieties and distress as infants and have therefore not developed the capacity to manage their own emotional regulation. One therapist described the *‘tangible’* emotional pain and discomfort which the young person appeared to be feeling and the more *‘immediate’* way in which the difficulties the child has been experiencing, for example expression of anger, or more manic behaviours, might be observed in the room. One therapist spoke of the feeling of bombardment and the experience of being with a child whose emotions appear so quickly, and on the surface that space to think becomes difficult:

> *'You know, I felt like there was no space for me and I couldn't be heard, and I do think actually, yes, that is really quite likely to mirror their experience, but there was something, there was a mania to it though. There was a mania to it that could be really disorienting and bombarded. I remember the word 'bombarded', I used to use a lot then'. (Interview 2, Lines 252 – 258).*

Another described the feeling of everything emerging from the child:

> *'The children who weren't looked after might have actually been a bit more withdrawn. That might have been their difficulties, and more, sort of, internalised anxiety and they're withdrawing. So, there was perhaps more space to respond because they were often much more quiet, whereas perhaps the children in care, there is something that just is spilling out of them. You know, "It's this and it's this and it's this and it's this." There's just so much, and yet they don't really want to give space for anything to be thought about too much'. (Interview 2, Lines 265 – 273)*

This therapist described the differences in their experience of both children in care and those who are not. The spilling out described, as opposed to something more withdrawn and internalised, fits with a sense of lack of containment.

Bion (1962b) describes the concept of container/contained, as previously introduced in the literature review on page 27. This early life experience for the infant shapes the way in which they are able to think and process their anxieties in the future and without the metabolising of distressing emotions for the infant by the mother, the capacity to manage emotion is reduced. This can present in many ways and indeed, much previous research has described behaviours associated with abusive, or neglectful early life experience, such as violence and aggression, manic defences, poor emotional regulation and difficulties in forming attachments, and relationships (Canham, 2004; Kendrick, 2000; Kendrick, 2005; Rustin, 2000, Emmanuel, 2012). Klein (1930) postulated that the infant needed to develop the ability to survive anxieties and that without the development of this, emotional states could remain on the surface, or 'spilling out'. This theory would be supported by the descriptions of

the therapists, in which the therapists feel these children who have not been able to manage their anxieties, find their emotions very much accessible and free flowing.

5.3.2 A sense of action

As previously considered, the *'on the surface'* quality of the emotions in these children is linked to something uncontained emotionally. One therapist discusses that for these children, they feel their way of communicating is linked to action, rather than words:

> *'There is more of a clearer sense of an action that is looking for meaning. This Sounds a bit strange, because we look for meaning in the communications of all children, but there is something about the impulsivity, the quality of reaction to something that I feel is similar in this group'. (Interview 4, Line 108-114)*

The sense of '*grabbing', 'jumping'* and *'acting things out by action'* is described as the way in which the children may use behaviours to communicate as this feels more manageable than perhaps something more symbolic, or verbal. As previously considered, it is observed that emotions are closer to the surface, however it seems that the vocabulary for describing and naming emotions, as well as the understanding of what they might be trying to convey are not developed in the child, but rather things are acted out, or the therapist needs to make sense of the actions and projections for the child. When we relate this to holding (Winnicott, 1963), we can consider the false self, as well as repetition and regression. The projections and on the surface emotions, enable the therapist to begin to use interpretation to consider what might be being communicated and to engage with the child around

this, to enable progress. The therapist also uses their countertransference to be able to relate to the child in whichever way is possible for them to communicate initially.

5.3.3 The Countertransference

All the therapists discuss the way in which they use their countertransference to guide them in their work, and with their interpretations and responses. Countertransference can be defined as '*the total affective disposition of the analyst in response to the patient and his/her transference, shifting from moment to moment, and providing important data of information to the analyst. The* countertransference*, thus defined, may be partially derived from unresolved problems of the analyst, but stems as well from the impact of the dominant transference reactions of the patient, from reality aspects of the patient's life, and sometimes from aspects of the analyst's life situation, that are emotionally activated in the context of the transference developments' (Kernberg, 1987).* The concept has shifted since Freud (1910) first described the idea of unresolved and reactivated transference reactions of the therapist and has evolved, with some positing that this can have a negative or positive impact on the work, depending on what is stirred up (Klein, 1932).

Heimann (1950) asserts that being in touch with their countertransference gives the therapist opportunity to consider what the child may be experiencing and supporting them to allow their anxieties to be reprocessed and explored and perhaps then reinternalised in a different way. There was an acknowledgement from all the therapists, that some of the challenges could be '*being pulled into worrying', 'wanting to take them home'* or *'being bombarded'*.

One therapist spoke of their feeling of identifying with their patients and there was a sense of something of a drawing in despite the challenges of the work:

> '*There is this quality to these children, they are challenging, but I end up wanting to- I kind of feel like I want to take them home because I feel this kind of push to help, and I think that's maybe a feature of my- maybe a vulnerability that I have towards identifying with my patients across the board. I think there is something about some of these children that they are quite- I don't know what the word would be, seductive is not the right word, they are quite, [Patient Name], [Patient Name] there is this quality to them that in spite of how hard they may want to push you. There is something about, with some of them anyway, them being so out there, so clear to read, so available sometimes that it's different. There's a kind of wanting to reach out'. (Interview 4, Lines 268 – 280)*

Bion (1962b) describes the process of metabolising in the reverie, the process in which the mother takes on the emotional distress of the child and gives it back to them, having made it more tolerable. Bion (1962b) discusses the importance of the experience of emotional response to allow the child a different experience of their feelings being processed and given back to them in a more manageable way, which may be a new experience based on their early life. Children in care may often have experience less sensitive or responsive parenting, due to abuse or neglect and therefore this may be different. The interviewees appear to describe the *'stirring'* emotions experienced with these children, and the *'pull from the thinking space'*, which requires effort to return to. The term thinking space appears to relate to the mind of the therapist being present and able to experience the projections of child and interpret to them, and the description of being pulled from this seems to be a sense of being unable to think or work due to the need to respond in a different, more explicit way, or physical way. Three of the therapists seem to highlight that their awareness of their countertransference can be beneficial in avoiding enactment, meaning that when they can be aware of their own emotional response

to the patient, and not react in a way which replicates some of the abusive, depriving or neglectful experience of the child, though there is a sense that projective identification can make this difficult at times, and indeed, Breman-Pick (1985) describes the wish for the therapist to reduce discomfort, whilst the patient may be seeking an enacting response. The sense that the child may push for a particular and familiar response is important to consider, as the child may anticipate this is what will happen. The unfamiliar, responsive experience for the child may at times be hard to accept.

5.3.4 Projective Identification

Projective identification is the process in which, when in the paranoid schizoid position, an individual's ego splits off intolerable parts and puts them into another. These are usually 'bad' parts of the self and are feared in the other (Klein, 1932). The way in which the therapists describe this in the children they work with, appears to be linked to them being related to by the children as '*cruel*' or *humiliating*. Two of the therapists spoke explicitly about projective identification, naming this process in relation to elements of children they had worked with, which they felt were projected into themselves, but this concept was alluded to in all four interviews. As discussed in the literature review, the term relates to the way in which the patient's feelings or unwanted parts of themselves are put into the other. Ogden (1979) considers that the mechanism can be used in different ways; as a defence by creating psychological distance from frightening, or unwanted parts of the self; as a communication by the patient's feelings being induced in someone else; as part of relating to an 'object' or other as a way of being with an object or progressive, as a way of the feelings being reprocessed by the therapist who experiences something, and then reinternalised by the young person.

One of the therapists spoke of the way in which they had an experience of being projectively identified with a particular individual:

> *'but she, I think, had had really quite a cruel and sadistic mother, and in the transference, she could be really, really cruel to me. I would, sort of, almost become sometimes quite… I think, protectively identified with being a very cruel, cruel mother, a cruel mother figure, a very denying, withholding and cruel mother figure in her mind'. (Interview 2, Lines 300-306)*

This perceived use of projective identification by the child allows the experience of something cruel to be thought about in the room, with the therapist having the opportunity to work with the complex feelings which relate to the birth mother. The defence of projective identification allows communication of difficulties unconsciously, meaning the child does not need to be able to verbalise their feelings, but rather the onus lies with the therapist to work with it.

Two of the therapists described a feeling of being 'pushed aside' and the way this may 'mirror' the experience of the child was considered. When reflecting on what could be stirred up by the child, one therapist spoke of:

> *'Anger, rage, something about vulnerability and helplessness and humiliation, I think. And again, that spans across different types of problems and cases that have different histories. Yes, but I think across all of them there were sexual elements that were connected with those feelings of humiliation or powerlessness, so again, connected with boundaries that were broken, at a stage or age that were too much for the children to manage, and something of that being evoked in the therapy with me'. (Interview 3, Lines 343 – 351).*

There appeared to be links in the therapist's mind, about possible sexual abuse, and how this was experienced in the work, with the therapist becoming someone who could humiliate, and this may have allowed exploration of these feelings without explicitly needing to make links at first to sexual abuse experienced in reality, which may have linked to these feelings of shame. The therapist appears to be considering

the importance of avoiding enactment and the possibility of becoming someone who humiliates or abuses.

5.3.5 Enactment and the depriving or redundant therapist

This initial code was present in two of the interviews and brought to mind work such as that by Hopkins (2000), Kenrick (2005) and Canham (2004) in which consideration of technical adaptations when working with children in care are considered alongside work by Henry (1974) and Emmanuel (2000), who consider deprivation and replication of these dynamics in the therapy. There was a sense in the interviews that therapists felt at times, that something was enacted in the room, or the wider network. When the network can be supported and therefore contained, or feel held, it is less likely that enactments will occur, and this will benefit the child and the progress of the work. One aspect of enactment that has been frequently discussed in relation to children in care is linked to deprivation, and the way in which the therapist, or the network, or the child can further deprive the child in care from accessing appropriate support or utilising the therapy.

The enactment and deprivation were primarily considered in relation to breaks and endings, with one therapist describing the way in which the child might miss the last session prior to a break:

> *'I think breaks are really denied. They deny that there's any sort of… you know, initially, especially in the beginning, there's a real denial that the break has any impact. Often, if a break's coming up, sometimes, you know, they'll miss the session before the break. So, they break from me first...' (Interview 2, Line 324 – 328)*

The therapist is describing the process of a child choosing to break from their sessions early, therefore being the one who deprives themselves of that last session before the planned break. The child may also have an experience of feeling less humiliated or dropped if they are the ones who makes this decision. The phrase *'they break from me first'* seemed a powerful choice of words in describing something potentially disruptive. An idea of the '*space being left'* and the anxiety this might cause is discussed in relation to the potential historical experiences of children in care and the child may be left feeling as though they are not contained, or held mind, or trust that the therapist will be there on the return from the break, as has potentially been their experience with their birth parents, or unexpected moves of foster placements. Powerful language choices, such as the use of the word *'abandonment'* in relation to the breaks is noted and the disturbance in the room in enactment, can be shown by words such as *'insidious'* and '*disturbing*'. The idea of a '*useless'* therapist is also mooted by one of the therapists, describing themselves as being 'blocked' as well as noting that the resources such as the child's therapy box, or the therapist could be *'redundant'* in the room, and *'untouched'*. The therapist's experience of feeling redundant may link to the internalised feelings of being unwanted, or useless belonging to the child. The replication of the deprivation experienced by the child in care can be thought about in relation to Gianna Henry's 1974 paper, doubly deprived. The paper discusses the way in which children can recreate a depriving situation by not making use of what is offered.

5.3.6 Capacity to symbolise

The therapist's experience of the child's capacity to symbolise was discussed in all four interviews, with two of the therapists expressing a view that Children in care appeared to find it more difficult to symbolise, and something more *'literal'* would

often be seen in the room. Bion (1962b) theorised that without early experience of containment, the child would not develop the thinking capacity that would allow something more symbolic in their play. Similarly, Winnicott (1963) purported that without the holding experience in infancy, there was less capacity for 'as if' thinking. Although there was a sense of *'roleplays'* and something *'dramatic'*, which was reported by one interviewee, but with a view that such interactions often came from films, or perhaps were an enactment of something more real from past experience rather than something which represented or symbolised the experience. One therapist described a concrete way of thinking they had observed with this group:

> *'I think sometimes, again, just from my own experience, but some of these children can be quite concrete in their thinking and their way of relating. They sometimes have difficulty playing symbolically. Again, I have got another looked after boy, who often, if he is scared, will literally run. He will literally run out of fear'. (Interview 1, Line 106-112)*

The therapist suggests that the way in which the child will *'literally run'* implies that the child may be responding in a way they have previously, where perhaps he has needed to keep himself safe and that they are unable to manage their anxieties by the use of play, instead something more literal occurs, rather than a symbolic communication. Bion (1962b) suggested that a lack of early containment experienced from a mother means anxiety cannot be tolerated and the thinking apparatus is not developed within the child, part of which relates to symbolising.

Another therapist concluded that they found it difficult to attribute a lack of symbolism to all children in care and that the child's age and the nature of their difficulties were also part of this struggle to symbolise. The fourth therapist considered that with *'lots of neglect and abuse, people have not had the opportunity to learn'* and that it is

'likely their thinking might be impaired', however also described the *'resilience of the human mind, that they can survive in the most appalling situations'*:

> *'Of course, if there's been lots of neglect and abuse and people have not had the opportunity to learn and so on, it's likely their thinking was going to be impaired, but it doesn't follow just because somebody is in foster care. In fact, sometimes you end up amazed at the resilience of the human mind that they can survive in the most appalling situations'. (Interview 4, Lines 253 – 260).*

This resilience described, reminds us that despite the overwhelming suggestion that there may be impairments in thinking and ability to symbolise, there will always be those who have managed to develop despite this.

5.3.7 Noticing and withstanding the trauma / Tolerating and regulating feelings

> *'It saddens me. Sometimes, it can feel really intrusive, like thinking, "Oh, they've had these experiences." It's unbearable sometimes, but I do allow myself to think about it. I allow myself to imagine all sorts of things that may not have happened to them at all, but I completely go there in my own mind. I think I do anyway. I do allow myself to have some quite dark, disturbed thoughts' (Interview 2, Lines 611-617).*

All of the therapists spoke of the '*trauma*', or '*disturbance*' they had felt in the room with children in care and the need to withstand the experience of knowing about some of the things that may have happened to the child and be alongside the child in this. Boston (1972) discusses the need for the therapist to survive the trauma with the child, where the mother or primary carer did not. The *'terror'* and *'horror'* is spoken about by two of the therapists and the experience of being alongside a child who might be appearing to play hide and seek but having the feeling that '*they've had to hide*' for real. The therapist must therefore notice, and bear the real fear in the child, and enable the child to bear these feelings, and try to contain the anxieties by interpreting and being with the child.

The need to tolerate and regulate the communications of the child is discussed, with the therapists acknowledging that part of the initial development of the relationship is the ability to not run from the trauma, anger, or confusion the child may bring, and stay with them. It is discussed by one of the therapists, that it feels important for the child to think that '*you know my experience'* and '*can be alongside me in an ordinary way'*. Winnicott (1963) posits that at times, the patient might not be ready for the interpretation and being alongside is important, but that when a sensitive and well-timed interpretation is given, it can allow the patient to feel more held than if they were physically held:

> *'I'm also thinking about it as what this appeal that they are having towards me, what this might be saying about the transference to me and how might I find the appropriate words to come close to them, to transform it into words that would make sense to them so that they can have the experience of being understood and of things making sense to them'. (Interview 4, Lines 294-299)*

The need to tolerate and regulate the child's feelings links to being able to make interpretations as described above and enables the child to make sense of something and gives them an experience of being understood, which both theoretical concepts of holding and containment, would consider to be important in allowing the child to gain the capacity to manage their own feelings.

Another acknowledges how it can be *'easy to slip out of something'*, which they link to the difficulty of *'not being pulled into enactment'*. The need to '*modify how one talks to children who have actually suffered a lot through environmental damage'* is mentioned with an idea that careful thought must be given to the external world, for example the reality of a difficult foster placement, or contact with birth parents, and the difficulties which may have been experienced.

These two codes appear to overlap and consider the expectation that the therapist will take on communications, projections, bear with, tolerate and interpret enables development of a capacity for thinking and regulating feelings (Bion, 1959; Klein, 1930; Bion, 1962a). The need for the therapist to have the capacity to work in this way appears to be highlighted by the therapists, when they consider what is '*stirred up'* in them by the child, as well as when they acknowledge how '*difficult it can be to be on the receiving end of those feelings'.*

5.3.8 The therapist outside the room

The therapists consider separation and curiosity and discuss this in relation to breaks and endings particularly, with one noticing a change in child in cares reactions to breaks as the therapy continues:

> '*it feels like now more than ever, the breaks are quite difficult. I don't know whether that is because we have been working together for quite a number of years now. There is a closeness and I think she is only really just recently starting to have a real curiosity in me, who I am, who I am with when I am not with her. So, I think the breaks, for her, for example, are more tricky'. (Interview One, Lines 320-325).*

Although it may initially appear that the breaks becoming more difficult could indicate a lack of improvement, we might consider that the beginning of acknowledging the separateness of the therapist is considered a move to progress and Bion (1962b) considers that this view of an '*other*', enables the object's qualities to be introjected, enabling growth and development. Winnicott's (1963) concept of true self emerging may also allow the child to show their vulnerability and therefore due to progress, be able to be more in touch with sadness or feelings of loss linked to the break.

Another therapist discusses the *'denial'* of the breaks and separation:

'I think breaks are really denied. They deny that there's any sort of… you know, initially, especially in the beginning, there's a real denial that the break has any impact'. (Interview 2, Lines 523 – 525)

Bion's (1962b) theory suggests that part of the development which occurs when an infant experiences containment, is the ability to develop the 'I am' quality and recognise themselves as separate from the mother. It could be that the experience of denial of the break's links to the child not fully acknowledging themselves as separate from the therapist and therefore the breaks are not a separation. Winnicott (1963) considered that there was 'no such thing as an infant', meaning the mother and child are effectively as one in the early days of the child's life. This would link with the idea that the replication of the holding environment occurs in the psychotherapy and that perhaps the child feels completely part of the therapist, in a relationship, that as previously discussed, could perhaps mimic maternal preoccupation

5.4 Being in touch with what's missing

This theme relates to the way in which therapists work with children in care, whilst taking account of what has been missed by the child in care. For example, in their early life, and experience in first relationships, they may not have been cared for appropriately or may have suffered trauma or abuse. It was clear from the interviews that the therapist's conscious awareness of children in care having missed out on something was present in both the minds of the therapists, and of the children they worked with.

There are 5 codes which were linked to this main theme, which are described in detail below. The first is 'skin to skin or a place inside the therapist', described by 3

of the 4 therapists, which relates to the description from the therapists that the children in care they have worked with frequently wished to be close to the therapist, sometimes in a way which could feel adhesive, sometimes a wish for physical closeness, to be alongside or a wish to be 'inside' the therapist. The second describes the maternal preoccupation (Winnicott, 1956) feeling described by the therapists, in which they consider the way in which children in care stay in their minds when they are outside of the room and this experience of being kept in mind by another may be a new experience for these children. The third code named 'being in touch with what has been missed out on describes the way in which the therapists understood the children in care's responses to having a different experience in therapy than growing up, in which they feel supported, and understood in a way they haven't experienced before, which the therapists acknowledge can be painful at times. The 4th describes a 'different kind of experience and a wish to be known', in which the therapists make links to the children in care wanting to be thought about and known, despite the challenges which this process entails. The final code relates to endings and loss and refers to the challenges of breaks and endings, as well as the initial denial of these experiences and feelings attached to the breaks in therapy, as well as links to the loss experienced, both previously, and in the work.

5.4.1 Skin to skin, or a place inside the therapist

Three of the four therapists refer to a closeness, or more bodily interactions in their work with children in care, commenting on a feeling of the child almost seeming to want *'skin to skin'* contact. Skin to skin contact relates to the process of a new-born infant having a physical experience of being close to their mother, or father and both the World Health Organisation, and the United Nations Children's Fund recommend

‘*that all healthy mothers and babies, regardless of feeding preference and method of birth, have uninterrupted skin-to-skin care beginning immediately after birth for at least an hour, and until after the first feeding, for breastfeeding women’* (Crenshaw, 2014).

One therapist describes this skin-to-skin quality, which they interpret as the child wishing to be close:

‘I have got a girl who I am seeing intensively, who is in foster care, and she often will be very, very close to me and wants to almost have skin to skin contact. It’s hard then to not feel like that could be a rejection if you were to not… to push her away. But I think that is her way of communicating her wish for closeness with somebody’ (Interview 1, Lines 93-99).

The therapist wonders about whether the child’s wish to be so close demonstrates her way of communicating this need and the phrase ‘*skin to skin’*, conjures up thoughts of the first moments of life, and this immediate close contact which the infant often has with their mother. Skin to skin is said to benefit short- and long-term health, regulation of temperature and breathing, and bonding between mother and infant, alongside developing instinctive behaviour and maternal responses (Winberg, 2005; Widstrom et al. 2019; Essa, Abdel & Ismail, 2015).

Another concept linked to skin and contact, relates to the work of Ester Bick (1968) on skin formation. Bick suggests that for the infant, the internal function of containing parts of the self, are largely dependent on the introjection of an external object, capable of doing this. Bick posits that the optimal containing object is the nipple of the mother in the baby’s mouth, along with the mother’s touch, talk and smell. Bick suggests that until this containing function has been introjected, the concept of a space for the infant does not exist and without this developing, projective identification continues. Bick inferred that the containing object is experienced

concretely as skin and suggests that any disturbance of this process leads to the development of a 'second skin', in which the child may develop pseudo-independence, or struggles with communication, and an unintegrated state. The therapist aims to be a containing object, which the child can introject, and therefore develop this skin formation and be relieved of the second skin defences.

The idea of children in care being viewed to be relating to the therapist in a *'bodily way'*, may suggest that the psychotherapist may experience this second skin defence from children in care who may not have had a good enough early life experience of this bodily containment and being held together. Indeed, one therapist wonders about simple physical interactions as a way of building a relationship by allowing a bodily interaction in a boundaried way:

> *'Well, you know, the idea of containment, that there is another thinking person who can take in what they're saying, and maybe it is the physicality of those interactions. Handing something, something very bodily, something very physical, something very, sort of, interactive that I think does build on a relationship, otherwise perhaps you are more at a distance (Interview 2, Lines 529 – 534)*

The therapist discusses the *'physicality'* and *'bodily'* aspects of the interactions with this child, and the building of the relationship, which is based upon interaction, which perhaps prevents the therapist from being viewed as at *'more of a distance'*. These seemingly small interactions may link to Winnicott's (1963) descriptions of sometimes making small adaptations for individual patients, in order to create the holding environment.

In addition to closeness, or skin to skin, there was also a sense in which closeness can feel more intrusive. One of the therapists spoke of their feeling of the child wanting to be '*closer than skin to skin, almost inside'*. The therapist appeared to be

referring to the way in which their own emotional responses can be stirred as well as what may be communicated by the child.

Therapists also mentioned that children wanted to be close to them in different ways:

> *'You know, she would try and cut my hair. She would be so close to me. If she could be skin-to-skin, she wanted me to take off my shoes so she could try them on. She just wanted to get into me'. (Interview 2, Lines 466-470)*

This way the therapist experiences being related to, appears to mimic the concept of adhesive identification, a more stuck on way of being with another, which Meltzer (1975) described and linked to the experience of the lack of a containing object in early life.

Meltzer's theories specifically made links to infants with disorganised attachment patterns, and autistic children, but the feeling of a child '*trying on'* the feelings of the therapist or mimicking them could suggest this pattern of defences could also be related to children in care, who may not have had a good containing experience in early life.

5.4.2 Maternal preoccupation - staying in the mind of the therapist

All of the therapists spoke of the way in which children in care, frequently were children that remained in their minds, outside of their session times. The powerful emotional responses in relation to the children discussed previously seemed to lead to the therapists remaining in touch with their thinking after the appointments:

> *'Yes, I would say that although it's very hard work in the room during therapy sometimes, that more of the work takes place outside of the room with those cases; that they occupy a – I wouldn't say a disproportionate – but occupy a larger proportion of mental space outside of the therapy'. (Interview 3, Line 141 – 143)*

It seemed that keeping the children in mind happened in different ways, including their own thinking, by discussing cases in supervision, or by finding themselves interested in the history, or network around the child.

The idea of the *'legacy'* of a session, and the *'piece of mind'* these children took up is present, and one therapist speaks about the way in which they experience themselves thinking much more about traumatic or shocking details about the child and trying to make sense of them, in comparison to the network, in this case, the social worker:

> *'I said, "What are your thoughts about that?" and she [social worker] said, "I don't want to think about it. It keeps me up at night." I really had to respect that, and I thought, "Yes, okay. Just because I could perhaps picture something in my mind, it doesn't mean everybody else can' (Interview 2, Lines 674 – 678)*

The therapist may therefore be uniquely placed to keep thinking about the child and keeping him/her in mind. This enables some of the early life experience that has been missed to be replicated with the child being the centre of someone's mind and retaining a large part of the therapists thinking.

Just as Bion (1962b) describes the maternal reverie, and the to and fro between the mother and child, and Winnicott (1956) describes the maternal preoccupation – the intense relationship between mother and child experienced in an ordinary development, it seems the therapists perhaps take on some replication of this early life relationship, and particularly with children in care. I postulate that the child staying so powerfully in the mind of the therapists may link to this missed or diluted experience, and it is interesting to note that this is so apparent for all the therapists, in work specifically with CIC. This opportunity of becoming lodged in the therapist's

mind may provide a second chance at developing a sense of being held, or contained, thereby allowing them to become more integrated, and manage their heightened feelings.

It may also be the case that as these children can at times be viewed to make attacks on links, or make thinking more difficult, that it is necessary for the therapist to continue to think and try to make sense of their experience with the child whilst they are apart. One therapist stated that '*what was possible to think about in the room, as it took place was limited*', suggesting that the work and thinking about the child needed to continue after the sessions:

> *'With the looked after children that I'm thinking about, that wasn't possible in the room. It was about almost bearing it and not reacting in an unhelpful way or a way that would be expected by the child, which would be abusive. So, yes, so what was possible to actually think about in the room together as things took place was limited sometimes'. (Interview 3, Lines 360 – 365)*

The idea that at times there was not space to think or make sense of communications, or projections, without something being enacted, or feeling too much is described by the therapist, with the feeling that it may be important to allow the space to process some of the communications separately.

5.4.3 What has the child missed out on?

Two of the therapists think about children in care having an experience of developing a relationship with their therapist, which may be different than their usual experience of relationships and perhaps *'saying more than they normally would to anyone'(Interview2)*. Loss seemed to be in both therapist's minds', thinking of how the child may feel in the face of losing the therapist after allowing a closeness to

develop between them and links were made to loss due to breaks in the therapy, or as they moved towards endings:

> *'so once attending therapy regularly becomes a thing for them and they invest in some way in a relationship – in a therapeutic relationship – then facing the loss of that person not being there, or some structure changing, that needs very careful thought'. (Interview 3, Line 275 – 279)*

As discussed in the literature review, Kenrick (2005) explores the impact for a child in Psychotherapy when they feel understood and the way in which this could potentially put them in touch with emotional pain or increase their understanding about what they didn't get from their caregivers in early life. Kenrick makes links to Bion's (1959) paper 'attacks on linking' and emphasises that this experience of being understood can be so unbearable. Indeed, children may respond by being unable to stay in the room, or need to obliterate the loss, and anxieties around this, by lashing out, or leaving the room. It seems that initially, building a relationship can be difficult to bear.

One therapist describes a feeling of '*nothing being fixed'*, and '*there were no rules'*, when thinking about the attempt to maintain a containing structure for the session. The need for the child to begin to feel the therapy is a good experience seems important, and one therapist spoke of how difficult it could be to maintain the more concrete structure of the session until the child felt able to stay with the therapist:

> *'I think pretty much every looked after child I have worked with, at one moment or another, has left the room. That seems to be when they just need some space to get away, to get out when something feels too much, when they don't feel held and contained. They have just got to go'. (Interview 1, Lines 213 – 217).*

The need to support the child to feel able to allow themselves to develop a different kind of relationship seems crucial, and there is a sense of an inevitable struggle at the beginning of the work with many children in care as part of this process.

5.4.4 A wish to be known and understood / A different kind of experience

'To be known and understood' (Interview 2) was one therapist's view of what children in care wanted from the Psychotherapy. The therapist emphasised, that in their opinion the goal or expectation of the work was not for the therapist to '*make it all better'*, but rather to provide a difference experience of being with another. The children in care's previous experience maybe linked to an early life experience of relationships with others being violent, neglectful, or abusive. The role of the therapist is also different than relationships with other professionals, such as social workers or teachers. One therapist spoke of seeing a deep need in children in care whom they had assessed for psychotherapy and described the life or death feeling that they associated with this thinking at times:

> *'Yes I would say it's [parent work] essential, there are some cases where I have got to know through assessment a child and I have got close to something really traumatic and desperate and to the need of the child for that kind of understanding, that kind of help. I was able also to see the capacity of the child to make use, very good use of it, in fact sometimes I would conclude that for that particular child psychoanalytic child psychotherapy is like a lifeline'. (Interview 4, Lines 196 – 204).*

The therapist is considering the child's need for the opportunity to be able to continue to be supported by the psychotherapist, to consider the trauma which has begun to emerge even as early as the assessment, in the way the child communicates. The child's ability to hear the interpretations made, and the way they respond to this way of working in the assessment, as well as working within the

psychoanalytic framework are considered prior to making a case for the child to access psychotherapy.

Canham (2004) explores the way in which the therapist must be aware of the potential to be pulled into enactment particularly in relation to the presence of violence and hostility in the room and what this could stir up for the therapist, and child. One therapist discusses the '*privilege of the child psychotherapist'*, reflecting on how the training may enable understanding:

> *'I'm also wondering about the fact that I feel that we're privileged as child psychotherapists to have a certain knowledge about how people hear and how these children would hear and would see us and hear our communication'. Interview 4, Lines 444-449)*

The different experience is also reflected on in relation to team members and the network, who one therapist states *'are not trained in this field'*.

5.4.5 Endings and loss

The idea of endings was thought about by all four of the therapists and it was clear that '*space to think about the ending'* was important. The struggle for the child in developing a new relationship has been discussed and it clear that when the child invests in the relationship, the ending may be felt acutely. The therapist being '*clear'* in their own mind, as well as *'explicit'* about the ending was discussed, with an acknowledgement that sometimes '*endings were out of their control'*. The thought that perhaps, '*a longer time'* was given to working towards an ending in cases of Children in care was reflected on by two of the four therapists.

One therapist spoke of the way in which the network surrounding the child might also need the ending to be discussed in a timely way, which might differ from how children who are not in care are dealt with:

> *'I think the job is to prepare and to pick up the sense of having been dropped with the foster carers, because I find that when treatment gets interrupted it's usually to do with the carers and they can be foster carers or adoptive parents even'. (Interview 4, Lines 181 – 184)*

Over the whole analysis, the network has been in the therapists' minds, and it clear that this continues as the end of the work is approaching. Canham (2004) places great value on retaining the structure of the session as a fifty-minute piece of work, and that this will enable the child to feel contained.

The experience of *loss* was also considered by three of the four therapists, in relation to being in touch with painful feelings of the child at the loss of sessions either at breaks or endings and the way in which this could perhaps be linked to early life loss. The idea that '*facing the loss'* needs '*careful thought'*, and that at times the children may report '*I don't care at all'* in relation to breaks or endings, but that in reality they '*care very much'* was present for three of the four therapists.

5.5 A journey to integration

This theme comprises of 4 initial codes, which demonstrate a child in care's journey through Psychotherapy, and link more closely to the concept of holding (Winnicott, 1963). The first is 'the regression to dependence', which relates to the way in which the children in care appear to regress to behaviours which demonstrate their need explicitly to the therapist. The second code is 'A lack of progress', which relates to the feelings of stuckness or acknowledgement of repetitive behaviours in work with children in care. The third is 'The false self, true self and reality', which relates to Winnicott's theories around the self which may be presented if holding has not occurred in the early life relationships, and this theme begins to consider movement towards a 'true self', as described by Winnicott (1963). The final code is the move to

integration, which describes the therapist's reflections about a move towards a more integrated sense of self, with a view of children being more able to regulate and manage their feelings, particularly in relation to anger.

5.5.1 Regression to dependence

The idea of regression to dependence (Winnicott, 1963), links closely with the second code, with an idea of stuckness, and repetition, but highlights the beginning of the therapeutic journey, and the way in which the child may present at the start, and the need for them to allow the therapist to see their vulnerability. The working through of early life experience in a therapeutic setting is described by Winnicott (1963) who considered that the therapist's reparative role, creating the holding space by offering empathy and understanding, enables the patient to relive and repair trauma from their early life alongside a symbolic 'mother'. The regression to dependence relates to Winnicott's early ideas of an infant being doubly dependent on the mother and how as they move towards independence, they do this from a position of being able to fully depend on another.

The regression to dependence on the therapist can be seen as the child in care '*risks*' being in a position of dependence to the therapist. The interviewed therapist s described that in some cases the regression is displayed as dangerous or risky behaviours, which lead to the therapist feeling bombarded. Alternatively, the therapists describe the way in which the vulnerability or struggle being worked through enables this regression to take place. In two of the interviews, there was a clear sense of the therapist noticing some regression, in which they felt that children '*allowed*' themselves to show a struggle, and that children might be able to bring their '*despair and hatred*' to the therapy.

One interviewee described the raw experience of emotions and feelings that have been communicated, acknowledging the vulnerability they felt had been shown by children in care:

> *'Anger, rage, something about vulnerability and helplessness and humiliation, I think. And again, that spans across different types of problems and cases that have different histories'. (Interview 3, Lines 343-345)*

The description of the helplessness and humiliation suggests that the children are allowing a regression to dependence, by communicating these emotions and experiences. Winnicott (1963) suggests that re-experiencing and reprocessing aspects of the early life relationship promotes development by enabling the split of parts of the self, caused by a failed early life interaction, to reintegrate and led to greater emotional regulation. Sweden (1995) also considers this regression as a second opportunity for ego integration.

The therapists suggest that this regression allows them to work with the child in care and this return to a more dependent position, allows for the child to begin to have an experience of relying upon and experiencing this dependent relationship which they may not have had in their early life. Winnicott (1963) suggested that this re-experiencing of this type of relationship can benefit the child in their development of the self.

5.5.2 A lack of progress: Something stuck

Within the interviews, it appeared that at times there was a sense of stuckness which could lead to a feeling of little progress being made:

> *'Yes, so what happened was things would, sort of, come up in the room and then they'd almost get packed away, and then the next week, it would be the*

same again. You could never really, sort of, progress or develop something'. (Interview 2, Line 297 – 300)

This was spoken about in the context of a wish to offer more intensive work by this participant, thinking about the need for this repetition and for the child to have an experience of a holding environment (Winnicott, 1963). Winnicott posits that in infancy the experience of being held, enables the child to develop a sense of being and this in turn, is the beginning of integration and the ability to develop emotional regulation and thinking. The repetitive nature of an infant's routines, in relation to sleeping, feeding and contact are perhaps being replicated in this lack of movement forwards which is felt by the therapist. It is likely that this repetition of activities to enable them to work through and develop, which the infant does implicitly, is witnessed by the therapist, but this can be harder to note as progress in the room. As discussed previously, the value of supervision or work discussion in thinking about children in care, may allow thinking about how this may be leading to progress, rather than the stuck feeling which may be experienced in the room.

Interviewee 2 describes a young person who appears to be unable to move forwards and instead, brings the same things to the session each week. A link could be made to the double deprivation experience discussed previously, in which the child deprives themselves from the benefit of the work, but this could also relate to the need for repetition in order to process and move forward. Child development research indicates that repetition in children's behaviour is a key part of development (Bower, 1974; Barr et al. 2007; Greenfield & Savage-Raumbaugh, 1993). Freud's (1914) work on remembering, repeating and working through was the basis for the development of Winnicott's (1954) thinking about regression and repetition, and its

value in allowing reparation of the early life experiences. Winnicott made links to repetition of behaviours in the psychoanalytic relationship as this may be considered a ‘safe’ setting to work through some of the failed experiences of early infancy.

One therapist describes the repeated experience of children in care carrying out the same actions, which were often dangerous, and the pull for the therapist intervene to prevent behaviour:

> *‘By either, as I say, a repeat of running out the room, or grabbing hold of me, or wanting to be held themselves. Jumping. These kinds of slightly manic, dangerous really, activities in the room that keep you very on edge. There definitely seems to be a pattern of that’. [in response to enquiry about any observed patterns in the work]’ (Interview 1, Lines 287-291).*

The experience described, leads to the therapist to feel they are in a position in which they are required to act, and this action is repeated. The child may be wanting physical touch, after an experience of neglect or only know of physical responses and find this easier to relate to than emotional response. The experience of the therapist creating a holding environment by interpreting the behaviour and responding to the child’s communication may need repeating numerous times due to the level of deprivation experienced by the child. The response will begin to be internalised and this may support the child in a move to integration, and the ability to regulate their emotions. The experience of the therapist being pulled into something more physical in terms of holding can also be considered. Winnicott (1963) described the sensitively timed and appropriate interpretation as more powerful as an experience than being physically held but acknowledged he would do what was necessary to enable the patient to feel held, giving examples of providing biscuits to one patient, or to knocking on the door and allowing the patient to answer the door to

support them in making progress. Winnicott suggested that these patients required a demonstration of care, or an allowance of being in control to facilitate the holding experience for them.

For some children in care, as in this case described by interviewee 1, there might be a need for physical holding as this may feel more bearable, or easier to understand than emotional holding. Physical communication may be something that feels more familiar to them, and that they are better able to tolerate initially. It may also be linked to the reprocessing, where perhaps their previous experience of closeness has been violent and this experience in the safety of the therapy allows a different kind of touch.

The process of integration requires some experience of the holding environment, and a developing capacity to process and think, which most commonly occurs during infancy, in a time where feeding, sleeping and contact are repeated (Winnicott, 1963). This physical touch that was noted at times to be needed by the children in care described may also be linked to this innate physical experience the infant would usually have in early infancy, but for the child in care, was missed.

5.5.3 The false self, true self, and reality

The concept of false self (Winnicott, 1962b) relates to the way in which the real personality and character may be hidden due to a lack of maternal response in infancy, which would have enabled a sense of being and an ability to demonstrate their true character and sense of self to others. The false self is considered to be the outcome of a situation in which the baby has not been provided with a good enough experience of their needs being met, leaving them on the edge of unthinkable

anxiety at all times and with an undeveloped ego function, or an ego which lacks maturation and needed to manage things themselves. In his paper on ego formation, Winnicott (1962b) describes the ensuing defence as self-holding, or a caretaker self. The caretaker self relates to the way in which the child develops a persona to protect themselves from feelings of inadequacy and relates to their previous experience of needs not being met in infancy, causing them to feel as though their 'true' needs are not acceptable. This often leads to the child presenting as compliant, acting to please others, as well as lacking in creativity and spontaneity. This may link with experiences described in the code regarding capacity to symbolise on page 126 in which one therapist discusses the lack of play in their experience of working with children in care.

One therapist discusses the presentation of a young boy they work with, whom they describe as having learning difficulties. The therapist indicates that the young boy presents as a *'really tough, macho guy'*. The presentation of the boy does not seem to accurately reflect the reality, however, but it seems that he has been unable to develop the ego function to show a true self, which may be more vulnerable, and able to be in touch with and process anxieties. The theory is based on the idea that when an infant feels reassured, or understood by their caregivers in early life, that their need and anxieties can be managed and dealt with, then the child will trust that they can be managed as their true self, but that without this experience, a false self may develop. If the mother fails to enable the child to feel 'real', then Winnicott suggests that experiences of 'existential continuity' occur, in which there has been interruptions to the infant's standard innate development. This false self-development may make them more manageable for their birth parents, as they are more likely to act in ways which accommodate others needs and therefore finding

themselves less exposed to feelings of disappointment when their true needs cannot be met. Daehnert (1998) wrote of the four functions of the false self as previously described, as well as positing her own fifth idea; as protection of the true self from the mother (Winnicott, 1960a); to allow a connection to be maintained with the mother (Stern, 1985); to protect from the destructive infant (Glasser, 1992); to eliminate oedipal conflict anxieties, (Cassimats, 1984) and as a way to 'disidentify from the mother' (Daehnert, 1998).

Interviewee 3 describes a boy who they consider can be both '*endearing and sweet'*, but at the same time '*violent and aggressive'*, making it difficult to know what the therapist will find in the room on any given day. The two presentations may both be adapted personas for the child, which protect from vulnerability and anxieties in different ways; one by omnipotent defences, and the other by compliance (Winnicott, 1960a; Stern, 1985; Daehnert, 1998). The violence may be more linked to something truer, and the child could be testing the therapist to see what the therapist can manage of their behaviours.

One of the therapists describes the movement from demonstration of 'false' to 'true self', is described by one of the therapists:

> *'…being out of the room is one example of spending quite a bit of time on the opening and shutting the door or on the threshold of the room or wanting to attack limits or boundaries in a very concrete way in other ways. From there to actually being able to not need to attack, but want these boundaries and appreciate them, so that does happen in that kind of work. If things go well and if there is enough space for it there is enough trust so that people, can actually bring their own despair and hatred etc. rather than needing to be superficially sweet and accommodating and not causing trouble'. (Interview 4, Lines 403 – 412)*

The false self is often '*superficially sweet and accommodating'* and the move to the child being able to '*bring their own despair and hatred*' thereby showing more of the upset and anger and finding this state can be tolerated and borne by the therapist, enables them to begin to develop the capacity to think. The process of integrating all these parts of the self can develop and the ego formation allows for object relations and sense of 'I am' to come to being (Winnicott, 1962b).

The child in care's move to something more '*alive*', and exposed is considered by all of the therapists to be '*small steps in the right direction'* but two acknowledge that this move can also bring more '*trouble*', and that again, the network and parents/carers need support to understand the progression in this *'livelier'* presentation:

> *'But becoming more alive meant allowing himself to get in touch with some feelings of anger, rage, and those things were so delicate, incredibly delicate and scary for him to experience, think about, so it was very tentative, delicate work over a long period of time with slow changes'. (Interview 3, Line 436 – 440).*

The therapist describes the way in which they work to gently support the child to feel safe to communicate and think about more '*dangerous*' feelings such as rage and anger. The therapist acknowledges the lengthy piece of work required to enable the child to slowly begin to make these changes. Meyer (1988) describes the use of defences as impairing the person's ability to test reality; instead, they are 'hidden' behind something, which although it can be steadying, which Winnicott describes as having 'good promise', they are ultimately unable to sustain it. Winnicott's view is that something more borderline or Schizoid occurs if these difficulties are not dealt with. The notion of holding, as bearing and registering the projections and when appropriate, using interpretations to make movements, links to this description by interviewee 3, with the idea of movement at a pace which allows the child in care to

work with the therapist. Winnicott's (1971) transitional space, and Alvarez & Reid's (1999) work, relate to the lack of liveliness and therefore lack of creativity in children who have been deprived and how this can impact on the work, with the therapist perhaps needing to rely on their own resources initially to enable the child to be able to relate in a way that allows spontaneity or creativity. Reid (1999) states that 'the therapist must have a mind for two, energy for two, hope for two, imagination for two'.

5.5.4 A journey to integration

As described in the previous section, the move to expression of the 'true self', and a more integrated state of mind, was described as '*slow progress'*, with *'small changes'.* The therapists seemed to describe this as a marker for progress, in observing this in the children alongside observed self-regulation:

> '*I think the children I have worked with for quite a while now are beginning to be able to tolerate some of their feelings a bit better. They are better able to self-regulate some of their emotions, so they can stop before just going into flight of manic activity. But it's a very slow process'. (Interview 1, Lines 298 - 306).*

Self-regulation is broadly defined as the ability to understand and manage one's own emotions and behaviours (Posner & Rothbart, 2000). The Adult Attachment Interview (George, Kaplan & Main, 1984) considers that multiple early life experiences of separation can lead to a lack of emotional regulation and findings in the Robinson et al. (2017) study, indicated that psychotherapists reported a lack of emotional regulation leading to a struggle in relationship formation among children in care. Improved emotional regulation has been previously described in children, following a psychotherapy intervention, supporting the observations of the psychotherapists

interviewed who also described observing this progress. (Kennedy, 2004; Kennedy & Midgely, 2007; Kenrick, 2005).

Gross (1998) discusses the importance of emotions in decision making, promoting learning, providing information for behavioural intentions and giving some understanding of 'good' and 'bad'. The development of more implicit emotional regulation would therefore be considered a positive development for a child in care. The child described by the therapist in the quote above, may have begun a process of *'being able to better tolerate some of their feelings'* and this '*very slow process*' of being better able to self-regulate suggests the therapist has observed that something is changing for the child on this journey to integration, even though this may be steady and slow.

Another therapist described their perception that there was greater '*emotional intelligence'* in the child as they progressed. The therapist spoke of some sadness remaining for the child, but acknowledged that there was something less defended about the children after a period of time in work:

> *'I think they were less manic. I think they were more aware of their defences and they were a bit more aware of some of their actions. I think a lot of the sadness was still there and a lot of the difficulty was still there, but I do feel that there was more of an emotional intelligence to them'. (Interview 3, Line 771 – 775).*

This supports thinking that the holding environment created in the therapy enables the child to feel understood and allows them to become more in touch with emotions, recognising the self and rely less upon defences to manage emotions. The emotional pain and early life experiences remain, but the child appears to have developed ways in which they can manage more of their own emotional states. The therapist

states their view that the child is '*less manic'*, and '*more aware of their defences'*, which feel progressive, and indicative of some change. The therapist acknowledges that *'a lot of the sadness'* and '*a lot of the difficulty'* are still there, reflecting the feeling of slow progress and change as described by other therapists, but the therapist notices that there '*was more of an emotional intelligence to them*'.

The sense of psychotherapy allowing progression for these children was present throughout and the therapist's description of children appearing to be in a more '*integrated state'* after engaging in Psychotherapy seemed representative of this. The holding environment created in psychotherapy appears to enable the child to become less defended and more aware of themselves as a separate individual, which would usually happen in early life in the development of the first relationship, and recognition of themselves as having a thinking mind and being able to use this to begin to be aware of their own emotions and understand and manage these. This is the process of the integration of the ego (Winnicott, 1960a). The therapeutic relationship allows the child to have the experience of being held in mind, whilst their anxieties are both held by the therapist and also interpreted. Winnicott (1962b) describes the integration of the ego and posits that as the ego becomes more integrated the child can regulate anxiety more successfully.

6. Conclusions

This chapter sets out the main conclusions from this two-part thesis, including a service evaluation, and a qualitative study. Both studies were evaluating different aspects of Psychoanalytic Psychotherapy provision for Children in care in a given CAMHS.

The quantitative study aimed to explore the impact of a new pathway for children in care on waiting times for first appointment. The qualitative study aimed to explore the experience of containment and holding from the perspective of the Psychotherapists providing Psychotherapy to children in care.

6.1 Quantitative Study

Previous research has indicated that an effective pathway can lead to better treatment outcomes in mental health services and to allow people to access appropriate support more promptly (Alang and McAlpine, 2019; Allen et al. 2011; Adrianes & Steihaug, 2013). The quantitative study aimed to examine the impact of the implementation of a new dedicated pathway for Children in care (CYPJAP) to reduce the waiting times for treatment using routinely collected data. Core CAMHS data acted as a control. It was hypothesised that there would be a significant difference in the waiting time to first appointment between the LAC Pathway and the CYPJAP. The demographics were also presented.

We can see that there is a statistically significant difference in waiting times between the LAC pathway, and the CYPJAP. The data allows observation of the higher number of referrals to Core CAMHS in the first cohort, contrasted with a higher number of referrals for children in care in the second cohort. It may be considered

that the development of specialist pathways within the service has allowed a more streamlined service with fewer referrals going to Core due to other options for treatment being present, or that there was less capacity for accepting referrals in Core CAMHS, due to individuals in the previous cohort requiring higher numbers of appointments. This would be important to consider in relation to the recommendations from the CQC about reducing waiting times for all young people to provide a safe service. It may be that the emphasis on one team reducing their waiting times could create increased waiting times for another team.

Further exploration to make links between shorter treatment length in the EOT, shorter waits until first contact, and the number of appointments offered would enable thinking about whether more prompt access to shorter, more intensive treatment promotes better outcomes.

Key points to note from the demographic data related to gender access to the pathway. Whereas the gender balance was 66% males and 33% females under the historical LAC pathway, under the CYPJAP, this had evened out to 50.67% males and 49.33% females. On the other hand, the gender balance on the Core CAMHS pathway remained stable, at 54% females at time period 1, and 57% at time period 2. Other areas which remained stable were the age groups presenting in both Core CAMHS and the LAC and CYPJAP, where the majority of young people were under 16 years old.

The area in which the CAMHS is based, is a predominantly White British area, with 92.8% of the population identifying as White British. The most common minority ethnic group was ‘White Other’. The demographics for all the pathways indicated a large percentage of White British young people (Time 1 Core, 90.47%, Time 2 Core,

90.71%, LAC, 80.95% and CYPJAP, 80%), with the second highest ethnicity recorded as White Other for all pathways. It can be observed that slightly more minority ethnic groups accessed the Children in care pathways than the Core pathways. The Core CAMHS sample would therefore appear representative of the local population. The Not recorded ethnicity group was equivalent or higher in number than other ethnicities, highlighting the importance of proper recording of data for accurate results.

The decrease of 70.11% in referrals between the two time points on the Core pathway may be related to the increase in the availability of specialist pathways, including the CYPJAP. The number of referrals relates to those young people entering the Core CAMHS Pathway for treatment, and at this time, the Single Point of Access for the CAMHS, was engaged in an initiative to signpost and refer on to other services, or specialist teams wherever appropriate. This included referrals to the In School's project, the Eating Disorders team, the Learning disabilities team, and the Crisis team. There was also a developing groups project which some young people who would previously have accessed the Core CAMHS pathway. It is also important to note, that during that year there remained a similar number of people on the Core Pathway, however, there were fewer new referrals into it.

There was an increase in referrals for the CYPJAP of 72.5% compared to the LAC pathway which suggest that more young people could be referred into the specialist pathway, and not have to access Core treatment prior to this.

There was a 46.50% decrease in discharges from Time 1 on the Core pathway, and Time 2, and a decrease in discharges of 21.79% between the LAC pathway and the CYPJAP which suggests that more young people may have remained in treatment

overlapping the two time points on the Core pathway. The number of planned appointments decreased in number between the two Core pathway time periods but increased by 105.84% in the CYPJAP compared to the LAC pathway, illustrating the increased capacity of the team, or perhaps linked to a higher number of appointments over a shorter time period, a more intensive approach or an increase in referrals. This would tie in with the length of time in treatment changes that were observed, with a 65% reduction in time in treatment on the new CYPJAP compared to the historical LAC pathway, suggesting young people were seen more quickly, but for less time and that it could be concluded that earlier intervention reduces treatment need.

It can be concluded that the waiting time for the first appointment is significantly reduced when children in care access the new CYPJAP therefore meeting the aims of the evaluation. Additionally, there appears to be a reduced treatment duration for those children on the CYPJAP, compared to the historical pathway, which may be indicative of prompter access to treatment reducing the need for lengthy treatment. The data set reveals a more even gender split in those accessing the new CYPJAP compared to the historical LAC pathway. The number of referrals onto the Core Pathway reduced in the second time period, which may be linked to increase options of specialist pathways within the CAMHS.

My role as a trainee within the Trust meant I did not carry out any Core work and wasn’t as aware of challenges within the service linked to waiting times, and new pathway implementation. The quantitative work allowed my position as a researcher within the team to provide a set of objective, numerical findings, which were able to be shared with the team.

6.2 Qualitative Study

The aim of the qualitative study was to examine the role that the two concepts, holding and containment have in Psychoanalytic work with children in care. The study aimed to consider these concepts in relation to the presentation of children in the room. The study explored what can be observed about how children in care behave in the room as well as in relation to how the therapist adapts and manages these behaviours or communications which they attribute to children in care more than other children they work with.

Four themes emerged from the findings:

1. Layers of containment and holding the network in mind

This theme described the complex network surrounding the child in care, and the therapists discussed the importance of parent/carer work. The therapists described the value of parent work to develop a better understanding of the child's behaviour and communications, enabling the carers to feel less persecuted. This was considered the first stage of the child's journey in psychotherapy, with the need for the network to engage with the therapy from the start. The therapists discussed their concerns about dynamics within the network and the responsibility and decision making around the child, as well as their own need for supervision and discussion or the layers of containment needed to ensure the needs of the child are met. It is clear that the Psychotherapists feel as though they are taking on a containing function for the child in care, the network around them and the multidisciplinary team. It is apparent that without the support of the network, the child in care may be deprived of the therapeutic experience, and this reiterates the importance of engaging with, and enabling the network to feel held by the therapist.

2. Projection, Enactment, and the depriving therapist

This theme explored the therapist's descriptions of the children in the room, and the way the child would project into them, leading to a pull to enact, or for the therapist to become a bad object in the mind of the child. The powerful experience of the therapist's countertransference was considered, and the therapists discussed the children who displayed manic states of mind or were omnipotent. This stage of the journey linked to the therapist's recognition of the impact of the lack of containment and holding, and how the child may present in the room due to being deprived of these experiences. Whilst the therapist was experiencing being pulled into enactment, or being on the receiving end of the projections, they were able to - through supervision, or their training – keep the child in care and their experiences in mind. The therapists described being able to interpret about the pull to enactment in the therapy and demonstrate to the child that they could bear the distress and remain alongside the child in care. The therapist feeling as though the child in care has confidence that the therapist could take their projections and return them in a more metabolised way enables them to start to consider that their anxieties can be managed, and this is the process described by Bion (1962b) as containment.

3. Being in touch with what has been missed

The third theme related to the children becoming more aware of the experiences they had missed out on. The therapists recognised the investment which the child was making in developing the relationship with the therapist and often defending against this by attacking the links being made or disrupting thinking in the room. The therapists also considered the physicality of the children in care and the bodily closeness they frequently sought perhaps in lieu of the experience they missed from

their birth parents. The therapists were able to recognise the lack of physical contact and emotional holding that the children in care may have had and were able to consider how what had been missed for these children was sought out. The concept of primary maternal preoccupation was considered, with the therapists discussing the large part of their minds the children in care took up outside of the therapy room, both in supervision, but also in their own time. The experience for the children of being held, or contained for the first time, or in a positive or nurturing way through the psychotherapy appeared to be noticeable for the therapists at this time. This stage in the journey for the child in care, appeared to carry a lot of pain, and distress, at the recognition of what it is to be held in someone's mind. The Psychotherapists were able to interpret and understand this bittersweet experience for the child in care, and rather than turning away from the child as they appeared to not want to engage in the therapy, the Psychotherapists were able to talk about this and the pain being stirred up.

4. A journey to integration

The final theme, and stage of the journey through treatment was the recognition by therapists that the children appeared to make small, but observable changes in the way they managed emotions, and were able to better regulate themselves. Some of the therapists spoke about this in relation to a change in the management of breaks and endings, and others commented on something more integrated about the child. This integration is suggestive of the child having benefitted from experiences of being held, or contained by the psychotherapist and through this process, beginning to internalise these good experiences and thus developing their thinking, and concept of themselves as separate people who are able to better regulate their emotional responses.

The move towards integration was characterised by children being more able to regulate their emotions, and use less defences such as manic defences, or omnipotence. These were considered small changes, which were indicative of more substantial change and were suggestive of this move to a more integrated state.

At the start of the children in care's journey through Psychotherapy, they were described as struggling to symbolise, or lacking in 'as if' qualities (Winnicott, 1963), and often the therapists were left experiencing distressing projections. As the therapy developed, it appears that the therapists felt that the experience of both the network around them, and the child in care themselves feeling contained, and held in the therapist's mind, enabled them to begin to internalise a different experience, and a move to them showing more of their 'true self' (Winnicott, 1963).

The findings from the qualitative study suggest that both containment and holding and the processes the describe are beneficial in the progress of children in care when used in the Psychoanalytic Psychotherapy.

The findings from the qualitative study suggest that both containment and holding play a role in psychotherapeutic work with children in care. The training undertaken by Psychoanalytic Psychotherapists, provides a theoretical background for the work, and indeed, it is important to note that all of the Psychotherapists who were interviewed in this study, undertook a Kleinian training, with greater emphasis placed on concepts postulated by Bion, namely containment. When analysing the data, it was apparent that both concepts of holding and containment were present in the minds of the therapists, however, the therapists were more likely to refer more to containment in their work, even if not explicitly. The analysis allowed thinking about the theoretical overlap between the two concepts alongside the differences. Initially

the planned analysis was to separate out the concepts, and to present themes which related to each concept separately, however it became apparent that as the concepts described similar processes, it was difficult to attribute many of the themes to just one of the concepts due to overlaps between them.

One of two key points which stood out from the qualitative study was the idea of maternal preoccupation (Winnicott, 1963), which related to the idea of the children in care remaining in the mind of the therapist more than other children. The clinicians appeared to respond to the needs which children in care manifested and offered something which had been missed for them in early life. The second code which stood out, linked to skin-to-skin contact, and the observation by all of the therapists that the children wished to be physical close to the therapists. Two therapists described this closeness as a 'skin-to-skin' experience. Children in care appeared to communicate their need for this 'skin-to-skin' experience by touch, a wish to 'try on [the therapist's] shoes' or by jumping or leaping towards the therapist. The therapists appeared to describe a pull to respond with physical contact but were able to consider the importance of verbally acknowledging what was happening and offering interpretation.

These codes, and the themes developed build on understanding of the deprivation of children in care, their initial lack of containment and holding during infancy and how this manifests in children in care when they receive treatment. The journey through Psychotherapy, and the therapists' recognition of a need to create an experience of what 'should have been' in early life with the therapist, allows these children to move towards a more integrated state of mind.

My position as a trainee within the team, meant I had familiarity with the participants, and some of the cases discussed in the interviews. My own experiences of working with children in care were what had led me to research this subject area and meant there were thoughts about potential ideas which may emerge from the interviews – some of which came to fruition and others which didn't. Through carrying out the research I was able to develop my knowledge in work with children in care, and develop my learning, and formulations with a theoretical base. The psychotherapy team, and the EOT were interested to learn about the findings, particularly in relation to thinking about the value of supporting the network.

6.3 Strengths and limitations

This thesis consists of two studies, using a mixed methods approach to carry out an evaluation of the impact of implementing a new referral pathway for CiC and the impact of the work of psychotherapists with children in care. This approach allows a rich set of data, both qualitative and quantitative to be presented in thinking about containment and holding, and children in care. The quantitative study showed that where a dedicated pathway exists for Children in care to be referred directly for the required treatment, waiting times for first appointment were reduced, and as a consequence, treatment started earlier, and a shorter intervention was required. This could be related to the needs of the Children in care being held in mind by CAMHS, and therefore a recognition that additional support is needed. The qualitative study explored Psychotherapy with children in care and demonstrated how Psychotherapists were able to use the concepts of containment and holding to both recognise and respond to the early life deprivation of these children.

A possible limitation of the evaluation of The Children and Young People's Joint Agency Pathway was that it was in its implementation phase and the data provides a

snapshot of the first year of the pathway, in which it was still new and possibly unfamiliar to some referrers. Changes were also occurring within the Core CAMHS pathway, with new specialist pathways, and in-school work developing, meaning that this may not have been a useful comparator. Earlier Core CAMHS data was not used, due to a change in the clinical recording system, which would have created difficulties in extracting a systematic set of data.

A limitation of the qualitative study was the small sample size, and the exclusively white, European participants. The participants were all from the same service, and all had undertaken a Kleinian training, meaning they were more likely to approach thinking from that perspective. Thematic analysis is a suitable method of analysis when used on a small, homogenous group, but it is important to acknowledge that it may be difficult to apply the findings to other contexts and different demographic groups. The word count and time limitations of a mixed methods thesis meant that only 4 of the 8 themes which were initially identified could be discussed in detail. Further thinking about the other 4 themes which emerged from the data could in future provide a richer analysis of the therapeutic relationship between CAPTs and Children in care.

6.4 Future Directions

6.4.1 Quantitative Study

Further exploration of patterns in treatment length, and time waited before first appointment would provide an interesting basis for consideration of adaptations in work with children in care. The NICE guidelines (2015) discuss the importance of prioritising children in care's mental health and suggest that prompt treatment is essential for this group. Future research may allow for measures such as Goal

Based Outcomes (Law, 2006) or Strengths and Difficulties Questionnaire (Goodman, 2009) to be used to assess mental health outcomes for the children in care who have accessed the new pathway. A more detailed study of association between time to first contact and length of treatment could be carried out, to understand possible links between prompter access to treatment leading to less intervention being required (Taylor, Scott & Pilling, 2019; Heywood et al. 2003; Sharp et al. 2005).

It might be important to explore the length of time in treatment from a health economic or social return on investment perspective (Nystrand et al. 2020), along with examining longer term outcomes, to establish whether children in care return for further treatment after discharge. Funding for this type of longitudinal research may also enable testing of hypotheses about earlier intervention leading to less intervention being required later in life. The numbers of children in care referred into the pathway, will allow need and demand to be considered. There could be several reasons why a young person was discharged from treatment, such as treatment completed, opted out of treatment, disengaged from treatment or a placement move and data exploring reasons for discharge would be useful in considering the outcomes of the pathway.

6.4.2 Qualitative Study

Further interviews with individuals who have graduated from other training schools would allow greater understanding of whether a similar approach to working with children in care occurs across the training schools. Supervision and work discussion groups, and the ‘layer’ of containment which they offer could be explored further, particularly in relation to addressing the feeling of the child in care being ‘stuck’ that therapists reported by thinking with someone outside the therapeutic relationship.

Technical adaptations in work with children in care have been researched previously (Robson, 2009) which identified similar ideas relating to the value and importance of engaging the network, working with the maternal transference, and pacing interpretations whilst working with deprivation. Emanuel's 2012 paper about work with under-fives, also produced similar thinking around the containing role of the therapist, and the move from a defensive 'holding on' to the more symbolic concept of being held in mind (Emanuel, 2012). Although the network has been thought about in Psychotherapy research previously (Emanuel, 2002; Henry 1974), it may be important to think more explicitly about how this evolves in CAMHS.

6.5 Final conclusions

This thesis aimed to evaluate whether the implementation of a new pathway for children in care impacted waiting times for treatment, and to understand the experience of psychotherapists delivering treatment to children in care and how containment and holding were experienced in the sessions, including the impact of psychotherapy through the lens of these concepts. It can be concluded in relation to the Mann Whitney U test that during the first year of the new pathway being implemented for children in care, there was a significant difference in waiting time to first appointment, and the data shows this was a decrease in waiting time and that their treatment lasted for a much shorter time.

With respect to the interview study, Psychotherapists described how the lack of containment and holding which children in care had experienced was manifested in the sessions and placed value on the modality in inciting change and enabling a more integrated state of mind to develop over the course of the treatment.

7. Reflections

My training as a Child and Adolescent Psychotherapist involved working with children in care and in my second year, when thinking about a topic to research, I was at the beginnings of working with my latency intensive case, a child who was in foster care. In those initial few months, I felt his deprivation acutely and felt he needed me to claim him by chasing him down corridors, being shouted at, having things thrown at me, and being shut out of the clinical room by him. It was painful for me to experience and to be in touch with his experiences of deprivation and sadness. I noticed that I often held the sadness for us both, whilst he was omnipotent or angry and I would be left with him in my mind long after the end of the session.

At the time of choosing the topic for my dissertation study, I had been having a repeated experience in the room with him, in which he would climb onto a chair, or desk, and fling himself towards me, causing me to feel danger was close and needing to respond with physical touch to prevent him injuring himself. Discussion with my intensive supervisor and other colleagues made me realise that I was not alone in experiencing such raw communications from children in care, and this gave rise to the thesis.

At the time of beginning my doctoral work, I was part of the first cohort to complete the ‘embedded’ thesis as part of the training and was encouraged to do a mixed methods study. My background in research was mixed; I had completed an undergraduate Psychology degree and later an MSc in Health Psychology prior to undertaking the clinical training and this gave me a solid grounding in research. I went on to work in a role as a researcher-practitioner and had 3 papers published

whilst in this role, but my experience of research in Psychotherapy was primarily through qualitative studies. I felt unsure about how the methodologies would fit together but could also feel the usefulness for my CAMHS in completing a service evaluation.

During my final year of the training, I became pregnant with my first child and had a year away from the workplace on maternity leave just after qualifying. For the first six months after having my daughter, research was not in my mind and the global pandemic struck when she was seven months old. My careful planning of having her maternal grandparents take care of her for a day a week to allow me to slowly get back in touch with my work was disrupted and I was unable to find space to return to my thesis until much later.

I noticed my own maternal preoccupation, and how difficult this made giving part of myself to the thesis. Reading about painful early life experiences of children in care felt much more difficult, with my own baby in front of me. I found myself resenting the extra time away from my daughter and at times, I was close to giving up on the work. I found myself more detached from the painful experiences I was reading about initially, to protect myself whilst trying to provide a containing experience for my daughter which had been lacking for these children.

As COVID-19 restrictions reduced, I was able to plan more time to work on research but didn't account for my daughter having to isolate from nursery, or the number of illnesses that she later suffered. I became more aware of the challenges of a mixed methods study, and particularly when completing my qualitative analysis, I found myself wanting more words available to write about the themes I had extracted. The different ways of thinking and understanding to produce a quantitative and qualitative

piece of work have been both helpful and challenging. At times, it has felt easier to analyse numerical data, rather than people's words and experiences. I have felt some regret about taking on the quantitative project and the extra work and time it has taken, but on completion, I can see the value it has added. In hindsight, I think working to complete more of the research before going on maternity leave would have helped and may have provided more motivation initially on my return to the work.

Whilst completing the analysis, there were many experiences that the Psychotherapists described that I could relate to. As a trainee interviewing Psychotherapists with varying degrees of experience, I felt some pressure to demonstrate my own knowledge on the subject and to be able to follow the thinking and reflections of the Psychotherapists I was interviewing. On reading the transcripts, I noticed that when interviewing the trainee psychotherapist in the service, I led more than with the other interviews. The interview that was completed on my return as a qualified Psychotherapist provided the richest data and I wonder if my own confidence and experience allowed me to gather more from the final participant.

When analysing the data, I felt very reconnected to experiences I had during the training with children in care, but also noted that my own prior beliefs about what might emerge were not always met, particularly in relation to the child staying in the therapy room, which had been a large component of my intensive work. I felt sadness when thinking about endings in the work and that despite the progress, the ending is difficult, even with a child who is more integrated.

The process of completing a doctoral level piece of work, particularly after a period of maternity leave has been a challenge and at times, I have felt exposed and vulnerable in submitting drafts of my work. Despite completing research earlier in my career and at University I felt at times, I was starting again in my thinking about the design, and methodologies. I had not used thematic analysis previously and needed to further develop my work to account for the depth of analysis on completing a doctoral study. This learning process, alongside managing the Psychoanalytic processes, and using different research approaches has been challenging.

The theme of maternal preoccupation has been of great interest, following my experience of my latency case discussed previously, who certainly remained in my mind outside of sessions and stirred up for me the experience of then becoming pregnant and my own baby taking up a space in my mind. This is something I am keen to think more about and explore. I also felt the loss of work with children in care, as with a specialist team now in the service, I no longer work with this group, and this has felt like a significant change. In completing this thesis and immersing myself again in the literature it has confirmed for me that I want return to work with this group in the future.

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2. Appendices

Appendix 1: 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
https://tavistockandportman.nhs.uk/

[redacted]

By Email

5 November 2018

Re: Trust Research Ethics Application

Title: Investigating the experience of illuminating organisational culture via psychoanalytic observation.

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

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

I am copying this communication to your supervisor.

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

Yours sincerely,

Best regards,

[redacted]

[redacted]

Appendix 2: Information sheet

Participant Information Sheet

Exploring the role of Psychotherapy in work with Looked After Children

You are being invited to take part in this research project. Before you decide to do so, it is important you understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.

Why have you been asked to take part?

This research project aims to explore the use of psychotherapy in working with looked after children in CAMHS. I am interested in exploring the reasons these young people are referred to CAMHS, as well as understanding more about the themes of the work. As you currently work as a Psychotherapist in CAMHS, I am interested in your experience of working with this demographic.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be able to keep a copy of this information sheet and you will be given a consent form to complete. You can still withdraw at any time. You do not have to give a reason.

What will happen if I take part?

If you choose to take part, you will be interviewed about your experience of working with looked after children in a CAMHS setting. The interview will take place with one researcher, and will be individual. The interview will last around 60 minutes, and you can choose not to answer any of the questions should you wish to decline.

What are the potential risks or benefits of taking part?

Participating in the research is not expected to cause you any disadvantage or discomfort. The interview questions could potentially elicit recall of difficult sessions, or experiences and you will be given the opportunity to pause should you need a break in the interview process. A potential benefit of the research is that it may further understanding of working with this demographic, and allow ideas and theory to be expanded. The sharing of the analysed interview data may benefit other psychotherapists or professionals in their work or understanding.

What if something goes wrong?

If you have any complaints about the project in the first instance you can contact the researcher, or the contact at the bottom of this sheet. If you feel your complaint has not been handled to your satisfaction you can contact the Tavistock and Portman Quality Assurance, as stated at the bottom of this information sheet.

Is this research confidential?

All the information that we collect from you during the course of the research will be kept strictly confidential. You will not be able to be identified or identifiable in any reports or publications unless you explicitly choose to do so. Any data collected will be stored as encrypted audio files in a form protected by passwords and other relevant security processes and technologies. Data collected may be shared in an anonymised form to allow reuse by the research team and other third parties. These anonymised data will not allow any individuals or their CAMHS to be identified or identifiable.

Will I be recorded, and how will the recorded media be used?

The interview will be audio recorded, and the audio file will be stored as an encrypted file. The interviews will be transcribed be the researcher, and used to identify themes. The files will be stored in accordance with Trust policy, and kept for a period of six years.

What will happen to the results of the research project?

Results of the project will be submitted as part of a Doctoral Thesis, and be read by markers at the University. The results may be published in a journal in the future, but will be anonymised, unless you explicitly state you wish to be named.

Who is organising and funding the research?

The project forms part of a doctoral thesis, and is linked to the Northern School for Child and Adolescent Psychotherapy, the Tavistock and Portman Trust, University of Essex, and South West Yorkshire Partnerships Foundation Trust. No funding has been obtained for this project.

Who has ethically approved this project?

This project has been registered with SWYT, as well as receiving ethical approval from Health Research Authority, and the Tavistock and Portman Ethics Committee.

Contacts for further information:

Chief Investigator: Email provided

Project Supervisor: Email provided

Project Supervisor: Email provided

If you have any concerns about the conduct of the investigator, researcher(s) or any other aspect of this research project, they should contact [xxxx], Head of Academic Governance and Quality Assurance at Email address provided

Appendix 3: Consent Form

What is the role of containment and holding in Psychoanalytic Psychotherapy work wit Looked-After Children?

Participant Consent Form

Please read and complete this form to show that you give your consent to take part in the project, and for us to use the information you provide. If you require any more information about the project, please contact Sally Baker, as detailed on the information sheet.

Please tick and sign the following if you consent to taking part in the project:

I, the undersigned, confirm that (please tick box as appropriate):

1.	I have been given the opportunity to ask questions about the project and my participation and am happy with the responses given.	☐
2.	I understand I can withdraw at any time without giving reasons and that I will not be penalised for withdrawing nor will I be questioned on why I have withdrawn. Any data from the interview will not be used, unless it has already been processed prior to your withdrawal.	☐
3.	I am aware there is no obligation to take part in this project	☐
4.	The procedures regarding confidentiality have been clearly explained to me (e.g. use of names, pseudonyms, anonymisation of data, etc.).	☐
5.	The use of the data in research, publications, and archiving has been explained to me.	☐
6.	I understand that my interview will be audio recorded, and data files will be stored in accordance with Trust policy for 6-8 years.	☐
7.	I understand that should I disclose information which indicates that I, or others may be at risk, that this may need to be shared appropriately, following discussion with you.	☐
8.	I agree to sign and date this informed consent form thereby confirming I voluntarily agree to take part in this research project.	☐

Interviewee Name (please print) _____

Interviewee signature _____ Date _____

Interviewer signature _____ Date _____

Appendix 4: Interview Schedule

Semi Structured interview Questions: Child and Adolescent Psychotherapists

Purpose of interview:

To understand the experience of containment and holding when working with looked after children in a CAMHS setting.

Information to share with participants:

The purpose of this interview is to allow me to explore themes that have emerged in your work with looked after children throughout your career. The interview will last approximately 30-40 minutes, and will be recorded.

1.Can you confirm for the recording that you have read and understood the consent form and information sheet, and are happy to proceed?

2. Record: Todays date, topic of interview and name of interviewer and interviewee.

Background and introductory questions:

(Purpose of these questions is for background and to put participants at ease)

1. Can you tell me about your current role and workplace?

How long in post, specific areas of interest?

Caseload

Other Psychotherapists

Other Disciplines

Workplace

2. What does the term looked after children mean to you?

Specifics – kinship care, state looked after etc

Caseload

Psychotherapy – Experiences in the room
(Purpose of these questions is to think about being in the room with LAC, and the experiences specific to CAPT, and these questions bring in key concepts of holding and containment)

3. When thinking about your work with looked after children, can you give any examples of the communication between you in the room?

- *Is the child able to hear your interpretations?*
- *is it possible for formulate your own thoughts?*
- *Can you give me an example of that?*
- *Different to other groups?*
- *Timing*
- *Identifying*

4. Tell me a little bit about your work with looked-after children in which you have been on the receiving end of difficult feelings and how you might manage that in the room?

- *Space to process*
- *Allowed to experience something*

5. How do you find that LAC manage breaks or endings?

- *Can you give any specific examples of that?*

- What has been your experience of the child being able to stay in the room?

- *Planning*
- *Steady presence*
- *Box*

- How do you work to create a therapeutic space?

- Have you noticed a difference between LAC compared to other children?

6. When thinking about your own, and the children's capacity to think, symbolise and play, what do you find have been the particular experiences of these when working with looked-after children?

- *How often do LAC children tend to play, in your experience?*

- *What type of play?(I.e.. Symbolic, or real?)*

- *What is the nature of their play?*

7. When reflecting on your work with Looked after children, what have you noticed about your countertransference responses?

How do you manage your countertransference response?

What are some of the challenges?

What are some of the strategies you might use to stay with the child?

What are some of the issues that might be challenging?

8. When considering your interactions with LAC, and how you are able to sustain the reverie, do you notice it can breakdown more easily?

Experience of re-enactment

Ability to tolerate

Reflections:
(Purpose of these questions is to allow anything that has not been asked about to be brought up, as well as a reflection of the work more generally)

10. Are there any particular issues that you regularly see or notice in your work with LAC?

- *How do these issues manifest themselves/are they acted out etc.?*
- *Examples?*

11. When thinking about your work with looked after children, what if, if any, have been the changes you have noticed in the child during the work?

Ability to tolerate

Capacity to contain themselves

12. Anything else you want to mention which you haven't had an opportunity to talk about so far?

Thank you for your time.

Appendix 5: Additional Themes

The themes which were written about are presented in a table on Page 100 of this thesis. This table presents the themes which were not written about in detail due to constraints of word count.

Themes	***Codes***
Communication and defences	*No 'as if' quality*
	Concrete thinking
	Too close to reality
	Correct, well timed and sensitive interpretation
	Allowing experience of projections
	Bearing with and surviving
	Staying with unintegrated states of mind
	Identifying with the child
	The humiliated therapist
	Omnipotence to obliterate anxiety
	Taking control
	Aggression for integration
The holding environment	*Leaving the holding environment*
	Exposed and not held
	Preparing for breaks and endings
	A new experience of being held
	Held in the therapist's mind both inside and outside the room
	A holding environment
	Knowing the therapist is there
	Physicality and holding
	A push for something physical
Defences, Anxiety and Attacks on links	*Obliterating anxiety with loss*
	Danger and staying in the therapy room
	Fear and anxiety
	Without memory & desire: An impossible task
	Omnipotent defences and aggression
	Defences
	Attacks on linking
A non-thinking space	*Alpha function*
	A therapist who can't win
	Minus K-states of mind
	Pack, Unpack: No place to call home
	No place for creativity

Table 9.1 Additional themes identified.