Aggression in the consulting room: An Interpretative Phenomenological Analysis of the ways aggression is experienced and understood by Child and Adolescent Psychoanalytic Psychotherapists.

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Abstract

Child and Adolescent Psychoanalytic Psychotherapists (CPTs) regularly encounter and work with different expressions of aggression in their consulting rooms. This is an important aspect of clinical practice because aggression can be found in the work with most patients. This study aims to investigate the CPT's lived experience and understanding of aggression in the room. The findings of this study suggest that CPTs attempt to experience their patient's expressions of aggression with the aim to attribute meaning and develop understanding as part of the therapeutic process, which separates them from professionals from other disciplines. This dynamic and an awareness of the CPT's own relationship to aggression impact on the containment of patients and their development. CPTs can also express aggression in form of enactment or retaliation as part of projective identification. An awareness of this potential dynamic can prevent enactment and retaliatory responses. Some expressions of aggression can be understood as an important and creative aspect of therapy. Interpretative Phenomenological Analysis (IPA) was used to analyse the data from seven semi-structured interviews of CPTs. The findings are discussed in relation to psychoanalytic literature.

Keywords: Aggression; Violence; Psychotherapy; Children; Adolescents; Clinical Practice; Psychoanalysis; Object Relations; Countertransference; Projective Identification; Containment; Interpretive Phenomenological Analysis (IPA); Qualitative Research

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Abbreviations

ACP	Association of Child Psychotherapists
CAMHS	Child and Adolescent Mental Health Service
CBT	Cognitive Behaviour Therapy
CP	Child and Adolescent Psychoanalytic Psychotherapy
CPT	Child and Adolescent Psychoanalytic Psychotherapist
GT	Grounded Theory
IPA	Interpretative Phenomenological Analysis

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Chapter 1: Introduction

In this chapter, I will outline and discuss the context and aims of my study. Context will be provided through a discussion of the relevance to Child and Adolescent Psychoanalytic Psychotherapy (CP) and how I got interested in this subject.

1.1 Intention of this study

Society at large struggles to make sense of and tackle destructive aggression found in domestic violence, gang-culture, knife-crime, bullying, suicide, self-harm, and other forms of destructive behaviour. This has a significant impact on a child's experience of growing up and their developing relationship to aggression. Adults and children can struggle to regulate aggressive impulses and this dynamic is likely to enter the consulting room in different ways. Aggression is an important aspect of human existence and has links to development and survival. However, a child's expression of destructive aggression and violence is not helpful as it impacts on their daily life, relationships, ability to learn, and engagement in therapy. Children with difficulty in expressing aggression appropriately are often referred to child and adolescent mental health services (CAMHS) and receive CP treatment (Lewis, 2012; Slater, 2014).

My study looks closely at the ways aggression can be experienced in CP and investigates how it can be found meaningful and develops our understanding of the complexity of responding to aggressive patients. These themes will be investigated through the following research questions:

1. What different experiences do CPTs identify in relation to different expressions of aggression in their clinical work?
2. Are there recognisably different forms and manifestations of aggression?
3. How is aggression in the consulting room understood by CPTs and in the existing psychoanalytic literature?
4. What are the implications for clinical formulations and therapeutic relationships?

I have decided to use the term ‘aggression’, as I wanted to explore a wide spectrum of aggression in the room and not just one aspect of it (e.g., violence). Laplanche and Pontalis (1988, p. 17) point out that psychoanalytic thinking has given great importance to aggression and describe aggression as the “tendency or cluster of tendencies finding expression in real or phantasy behaviour intended to harm other people, or to destroy, humiliate or constrain them”. CPTs are interested in the negative transference as part of the therapeutic relationship, which can include destructive and positive aspects of aggression. Harding (2006) suggests that the term ‘aggression’ is often used in reference to its destructive aspect, which overlooks its necessary and positive functions. Aggression can have libidinal components and be seen as a creative energy or

drive. This energy is needed to fully engage in life and maintain development. Sigmund Freud linked the sublimation of aggressive and sexual impulses to great achievements in civilisation, such as art and professional activity (Strachey, 1961). Heiman and Valenstein (1972) suggest that aggression can be understood as a way of doing things and not as an activity. Laplanche and Pontalis (1988, p. 17) state that “there is no kind of behaviour that may not have an aggressive function” (positive or negative).

Experiences and the quality of a patient’s object relations impact on how aggression is expressed or defended against, which can be problematic and destructive. For example, hatred can be a defensive response intended to control aggression (Rosa, 2015).

My study includes an extensive literature review and a qualitative analysis of a new interview dataset gathered specifically for this study. The literature review will give an overview of relevant psychoanalytic literature to provide a theoretical foundation for my study. The data for the qualitative part of my study will be collected through seven semi-structured interviews. I will use Interpretative Phenomenological Analysis (IPA) to analyse the data from the interviews and discuss the findings in relation to the literature. The different chapters are written in first person to emphasise my immersion in the research process.

1.2 Relevance to CP

The subject of my study is unique and relevant for the CP discipline. Aggression in the room can have a significant impact on CPTs and lead to technical difficulties (Canham, 2004). Slater (2014) suggests that CP can promote a positive change for aggressive patients. My study aims to help CPTs promote this positive change by looking closely at how aggression can be experienced and understood when it occurs in the room. Alvarez (2011) points out that progress in CP of highly aggressive children is often slow and that the nature of the work and disturbing symptomatology is likely to put pressures on the transference and countertransference relationship. There are increasing pressures to offer short-term interventions. Research conducted by Fonagy and Target (1994) suggests that children with behaviour disorders may benefit from intensive and lengthy psychotherapy with additional parent work. My study aims to provide a theoretical and practical exploration of this important aspect of clinical practice. I believe that further research and a better understanding about the subject will lead to more containment in the room, manageable degrees of aggression, and effective ways of responding to aggression.

1.3 My interest in writing about the subject

My interest in the experience and understanding of aggression in the room as a research subject began with three-year-old Jamie, who I saw three times a week as part of the CP training. One day he arrived with a heart attached to a stick, which he took to the room. He hit me in the face with it following a moment of meaningful contact. This incident caused confusion and significant anger in me. Additionally, I started to notice that different aspects of aggression

seemed to be a significant factor in the work with most of my patients. As part of my infant-parent work, I also observed some form of aggression between infants and their parents. Throughout my training, I have read clinical papers and case examples, heard about different expressions of aggression in supervisions and workshops, and experienced it in my own clinical work. I have experienced that aggression can have a significant impact on CPTs.

Before training as a CPT, I worked for twelve years at a therapeutic community for highly disturbed and aggressive children. My experience of this work with extreme aggression and physical violence will have some impact on how I interpreted the data from the interviews and my research findings. I will come back to this in my discussion.

Chapter 2: Literature Review

In this chapter, I will describe the method of my literature review and present my findings. The literature review consists of two phases: a narrative literature review and a systematic literature review.

2.1 Purpose

Booth, Sutton, and Papaioannou (2016) describe literature reviews as major components of academic theses, which aim to show how studies contribute to the understanding of the subject under review. In line with Ridley (2012), my literature review aims to:

- provide a brief historical background about the development of the concept of aggression in psychoanalytic thinking,
- provide an overview of where the study is situated in contemporary publications and debates,
- discuss relevant theories and concepts which underpin my study,
- introduce relevant terminology and use of different terms,
- describe relevant research and how my study addresses a gap in the field of my study,
- discuss how relevant aspects of clinical practice and experiences of aggression in the room are discussed in the context of CP.

du Plock (2014) writes that literature reviews aim to identify the specific research focus and should take a reflexive stance. A reflexive stance seems most relevant considering the research methodology of my study (IPA). Smith, Flowers, and Larkin (2009, p. 55) describe qualities required of an IPA researcher as: “open-mindedness; flexibility; patience; empathy; and the willingness to enter into, and respond to, the participant’s world”.

I wanted to be able to pay close attention to my interviewees during the data collection process and decided to carry out my literature review after the data collection process. This aimed to prevent me from leading my interviewees towards my pre-existing ideas and theoretical concepts obtained during the literature review and seemed most suited for phenomenological research and psychoanalytic thinking.

Phenomenology was developed by the philosopher Edmund Husserl, who saw epoché, “the act of suspending the taken-for-granted assumptions of the everyday natural attitude”, as a key concept (McLeod, 2011, p. 102). Smith, Flowers, and Larkin (2009) write about the importance of bracketing pre-existing concerns and theoretical ideas during the interview phase and suggest that this process helps interviewers to enter the interviewee’s world. My chosen approach aimed to support the qualities of an IPA researcher outlined by the authors. Bion (1970, p. 31), a leading psychoanalytic thinker, wrote that the process of paying close attention can be supported by “the positive act of refraining from memory and desire”.

I wanted to include a wide range of relevant literature and not just write about familiar ideas and theoretical concepts. I had exposure to publications on aggression during the clinical training in CP and in preparation for my study. During the data collection process, I have spoken to CPTs about theoretical concepts and relevant literature. Without a systematic literature review, this was likely to impact on my selection of publications. Both phases of the literature review aim to reduce bias during the selection process (Ferrari, 2015; Booth, Sutton & Papaioannou, 2016). My systematic literature review aims to ensure a more comprehensive review of the existing research and publications relevant for the subject of my study. I will also find out if the understanding of aggression in the room differs or if there is homogeneity.

According to Ferrari (2015), systematic reviews aim to design a well-defined question, followed by a quantitative and qualitative analysis of the evidence. She writes that narrative reviews can be linked to more than one question and inclusion criteria can be less explicit. A narrative review of the literature is important for this study as it allows me to include selected psychoanalytic papers on the work with aggressive children. These papers (e.g., Rustin, 2001; Canham, 2004) were part of my clinical training and are likely to shape the CPT's understanding of aggression.

2.2 Method

I started my literature review by searching the following five databases via EBSCOhost with the aim to identify relevant research papers and relevant publications:

- PEP Archive
- APA PsycInfo
- APA PsycArticles
- APA PsycBooks
- Psychology and Behavioral Sciences Collection

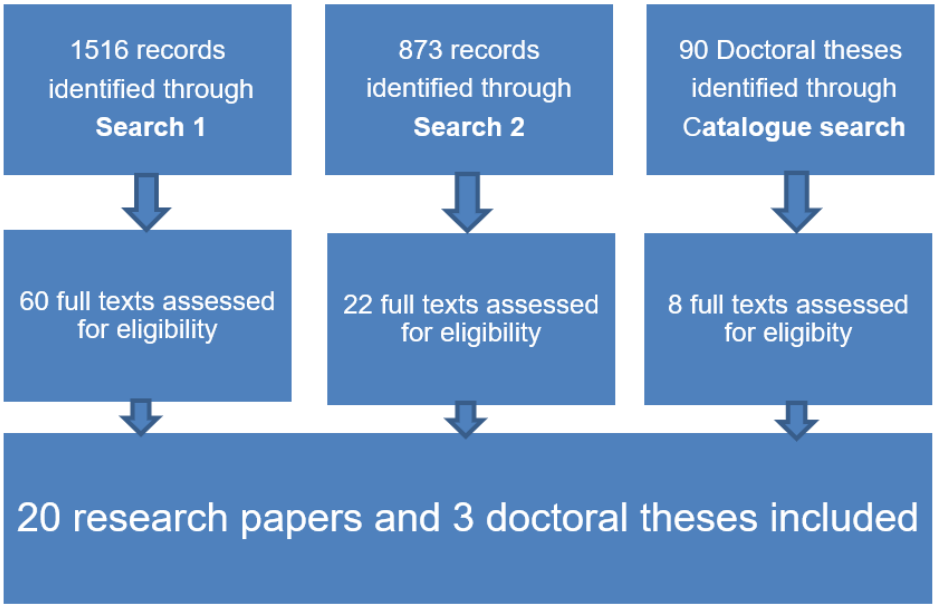
The selected databases are most relevant for psychoanalytic psychotherapy and research in clinical practice. ‘Aggression’ AND ‘Psychotherapy’ were the keywords for this search (Search 1). I used the keywords with a Boolean logic (Ridley, 2012).

An age-limiter (0-17) was applied during the database search to ensure that findings relate to the target age group of this study. As my study is concerned with the CPT’s understanding of aggression in the room and linked to a post-Kleinian CP training, I limited all searches to the period between 1960 and 2020. This period seemed most appropriate for my study as I was interested in publications written by post-Kleinian practitioners and contemporary researchers. Contemporary CPTs see the countertransference as one of their main tools in their work with patients. For the exploration of the CPT’s experience, it seemed important to focus my literature review on papers which include this important development in psychoanalytic practice. The significance of this development will be discussed as part of my literature review. Some work of earlier psychoanalytic thinkers will be part of the narrative literature review to illustrate the development of aggression as a concept. Post-Kleinian researchers have been influenced by earlier psychoanalytic thinkers and this

will be reflected in their work. A total of 1516 records were retrieved with this search criteria (see Appendix A).

I initially tried to include the keyword ‘violence’, as violence is a form of aggression. However, I decided to omit this keyword, as it increased the number of results to an unmanageable level (55099 results, see Appendix B). A lot has been written about the impact of violence on children and adolescents (e.g., Reising, 2019 et al.). This is not the specific subject of my study and I decided it was preferable to not use the term to avoid this diluting effect. I did not exclude items that included the word when other criteria were met.
I saw benefits to including both general and discipline-specific searches, as I was concerned about missing psychoanalytic research papers focused on violence towards CPTs. A second search (Search 2) was carried out on the discipline-specific PEP Archive, a database for psychoanalytic publications. I used the keywords with a Boolean logic: ‘psychotherap*’ AND ‘aggressi*’ OR ‘violen*’. A total of 873 results were retrieved through this search (see Appendix C). I was aware that doctoral research carried out by CPTs would not be included as part of both database searches and decided to carry out a third search (Catalogue Search). The Tavistock and Portman Library catalogue was searched to identify relevant doctoral research carried out as part of the Tavistock Professional Doctorate in CP. Three relevant doctoral theses were found through the catalogue search. *Figure 1* shows identified, assessed, and included results through all three searches.

Figure 1: *Summary of papers identified and included*



My second phase of the systematic literature search included screening titles and abstracts of the identified records. I saved relevant texts for a closer assessment of full texts and noticed that a high number of results seemed related to play therapy (e.g., Ray et al., 2009) and cognitive behaviour therapy (CBT, e.g., Özabacı, 2011). Following my assessment, I was able to include 20 research papers and three CP doctoral theses in my literature review. I have not included papers related to different forms of therapy or age groups and papers unrelated to the understanding and experience of aggression in the room. Some papers in Search 1 and Search 2 were duplicated and I only added them once to the final number of studies and papers included.

As I have not included the term ‘violence’ in Search 1, I have decided to search the online databases of the Journal of Child Psychotherapy (Taylor & Francis) and Journal of Infant, Child, and Adolescent Psychotherapy (Taylor & Francis). Both journals are peer reviewed and a key source for publications in CP. This

search aimed to make sure that I would not miss relevant publications. I used the Boolean logic ‘aggressi*’ OR ‘violen*’ and no additional literature was found through this search.

My findings of the systematic literature review will give some insight into what is categorised as aggression in CP in the research literature. During the data analysis, it will then be possible to compare this insight with the data from the interviews with CPTs.

As part of the narrative review, snowball sampling (Ridley, 2012) was used to further examine the understanding and experience of aggression in the psychoanalytic literature.

2.3 Narrative review of core concepts

My narrative review outlines a brief historic perspective and discusses some important key concepts to provide a clearer picture of the scope of this study. The concepts have been selected to support a better understanding of my data analysis. I will discuss how the concepts of countertransference, projective identification, and the core complex are relevant for the understanding of aggression in the room and present some classifications of aggression. Some specific implications of violence as a form of aggression and ways of understanding aggression in clinical practice will be discussed.

Aggression is a key concept in psychoanalytic thinking. Several authors have written about the development of aggression as a concept in psychoanalytic

practice (Heimann & Valenstein, 1972; Laplanche & Pontalis, 1988; Perelberg, 1999). A summary of the development of the concept of aggression in the psychoanalytic literature offers a theoretical foundation for the understanding of my study.

2.3.1 Development of aggression as a concept

Perelberg (1999) provides a detailed review of the psychoanalytic understanding of aggression and violence since Freud's postulation of aggression as a drive and suggests that few psychoanalytic concepts have generated more controversy "than the question of whether aggression is a fundamental or irreducible human instinct, whether it is innate or reactive to the environment" (p. 19). Important psychoanalytic thinkers have continued to understand aggression as a drive (e.g., Abraham, 1927; Klein, 1975). Others (e.g., Ferenczi, 1933; Stern, 1985) have emphasised the reactive aspect of aggression following trauma, deprivation, and experiences of danger.

In *Beyond the Pleasure Principle (1920)*, Freud likens aggressiveness and the death instinct and writes about the opposition between the life and death instincts (Strachey, 1955). Strachey shows that Freud saw a similar polarisation between affection (love) and aggressiveness (hate) and that he likened this to object-love. Destructive and aggressive impulses can be turned outwards (towards an object) or the subject's own ego (Strachey, 1955).

Segal (1993) further reflects on Freud's understanding of the death instinct and writes that Freud's work on the death instinct was motivated by clinical

considerations in relation to the repetition compulsion, nature of masochism and murderousness of the melancholic superego. She writes that Freud thought that the death instinct silently operates in the body and that it is not possible to see the death instinct in its pure form. Segal points out that, in *The Ego and the Id (1923)*, Freud extended his theory of the death instinct and started to include neurosis in his considerations. Freud believed that it is possible to deal with the dangerous nature of the death instinct in different ways and found that the different ways might include erotic components or an aggressive diversion towards the external world (Segal, 1993). In *An Outline of Psycho-Analysis (1940)*, Freud describes that a holding back of aggressiveness can lead to illness and how aggressiveness can lead to self-destructiveness instead of violence towards someone else (Strachey, 1964).

Joseph (1988) discusses Freud's concept of the death instinct and makes links between addiction to near-death and self-destructiveness, especially sadomasochistic tendencies, which can emerge in the transference. She writes: "Yet in the transference one gets the feeling of being driven up to the edge of things (…) and both patient and analyst feel tortured" (p. 322).

Fairbairn (1990) suggests that from the second oral stage, differentiated aggression and libido can be directed towards the object, including ambivalence and a conflict of love and hate. According to Fairbairn, aggression develops in infancy in response to frustration related to the relationship with the mother. Anna Freud (1993) describes the process of 'identification with the aggressor' as a defence mechanism against instinctual impulses, by assuming the

aggressor's attributes and transforming the sense of feeling threatened into making the threat. She describes how children can identify with the aggressor (e.g., angry parent, dentist) and defend against anxiety by attacking the outside world. Freud shows how this dynamic can feature in phantasy and play. Furthermore, Freud (1972) studied aggression during analytic therapy and, like Fairbairn (1990), sees aggression as an ego-function. Freud regards the origin of aggression as a result of frustration linked to an unsatisfied instinctual wish or interference by the environment.

Perelberg (1999) suggests that contemporary Kleinian thinkers believe in a different equilibrium between the life instinct and death instinct. For example, Bion's concept of 'container/ contained' (Bion, 1962) shows an emphasis on the child's experience of the environment, containment, and links to aggression.

It is important to distinguish between aggression and violence. Glasser (1985) defines aggression as an innate part of an individual's biological system, which reacts to danger, and violence as an intent to inflict bodily harm to another person. Little has been written about the psychoanalytic understanding of violence in children (Glasser, 1998; Campbell, 2008). Yakeley (2018) describes violent acts as behaviour that has replaced thinking in response to early traumatic experiences. Campher (2008, p. 9) illustrates that children can express violence towards others by "kicking, biting, pushing, spitting, throwing things, attacking, bullying, assault, and homicide – and towards themselves – self-harming behaviour (head banging, scratching, or cutting) and suicide".

Brafman (2008) concludes that all psychoanalytic authors understand experiences of conscious or unconscious trauma or frustration as the trigger for violent behaviour. In the psychoanalytic literature related to the origin of violent behaviour, Brafman identified a split between two beliefs. According to him, some authors believe in the presence of an instinctual force, which is inborn and uncapable of elimination. Others emphasise the importance of the environment (Brafman, 2008).

In CP, there are two well-known accounts of psychoanalytic treatment of aggressive and psychotic children. In *Dialogue with Sammy (1960)*, McDougall and Lebovici (1989) provide a detailed account of the analysis of an aggressive child called Sammy. In this account, Sammy's disturbing behaviour is analysed, including threats and direct physical aggression towards his CPT and the room. Sammy shouted at her, asked her what she would do if he would cut off her leg and kill her, tried to grab her underneath her skirt, hit her, bit her, and threatened to stab her with a pencil. She interprets that Sammy was afraid of his projected destructive feelings, puts him firmly back into his chair and tells him that he must talk about it instead of acting on it (McDougall & Lebovici, 1989).

An account of an analysis of an aggressive latency-aged child, called Richard, is provided in *Narrative of a Child Analysis* (Klein, 1961). Klein reports threatening behaviour and incidents of physical aggression, such as throwing a stick at her, squirting water at her and attacks on the room. She suggests that the consulting room can be seen as a representation of the CPT (Klein, 1961).

Meltzer (1998) describes Richard's aggressive behaviour, such as biting, scratching, spitting, or urinating as attacks in form of projective identification.

Both accounts are descriptive and analytic but give very little insight into the CPT's experience. During aggressive incidents, both continue to provide interpretations linked to the transference and infantile anxiety. The lack of reports about the countertransference in both accounts reflects the psychoanalytic culture at the time. Our understanding of the countertransference has significantly developed since. Racker (1982) points out that the process of countertransference was seen as a danger or obstacle for a long time. The countertransference is now seen as an instrument for the understanding of psychological processes of patients (Racker, 1982; Rustin 2019). In contemporary CP, the concepts of countertransference and projective identification are understood as a form of communication.

2.3.2 Countertransference and Projective Identification

Core psychoanalytic concepts, such as countertransference and projective identification play an important role in the conceptualisation of aggression and violence in psychoanalytic practice.

The experience of working with aggressive children can bring up powerful feelings in CPTs. In *Hate in the countertransference*, Winnicott (1947) writes about the importance of the countertransference in the work with psychotic children. He stresses that the analysis of psychotic patients is only possible if the analyst is conscious of his own hate and has been analysed himself.

Winnicott illustrates how he learned to understand and manage his own hateful and murderous feelings towards a patient. In *The Antisocial Tendency*, Winnicott (1956) writes about his understanding of antisocial acts as a sign of hope and object-seeking in the treatment of children with antisocial tendencies and likens antisocial tendencies (e.g., violence) to the loss of a good early experience and sense of deprivation.

In *Notes on some schizoid mechanisms (1946)*, Klein (1975) introduces the term ‘projective identification’ as “the prototype of an aggressive object-relation” (p. 8) and likens it to oral and anal impulses. According to her, oral impulses aim to “suck dry, bite up, scoop out and rob the mother’s body of its good contents” (p. 8). Klein describes that anal impulses aim to expel hated “split-off parts of the ego on to the mother” (p. 8).

Bion later observed that projective identification can have a communicative function (Anderson, 1992). From my experience of the CP clinical training, supervisions, and clinical work with challenging patients, I feel that this is highly relevant for the understanding of aggression in the room. In CP, there is an understanding that children can project unbearable feelings into the CPT, arouse those feelings in the CPT (Anderson, 1992) and communicate in this way what it has been like for them. Several clinical papers discuss the understanding of aggression in relation to the process of projective identification (e.g., Horne, 2001; Rustin, 2001; Jackson, 2004; Canham, 2004).

Jackson (2004) writes about the intensive psychotherapy treatment of a traumatised five-year-old adopted girl, called Yasmin. Jackson noticed that Yasmin would attack the CPT violently when he tried to understand and talk about what was happening in the room. The CPT experienced her attacks as terrifying. Jackson writes about an example of her attacks, in which Yasmin appeared controlling and manic, kicked a cupboard, grabbed the CPT, kicked him, and spat at him. The CPT felt that Yasmin was fighting for her survival. Yasmin settled into her therapy, but again struggled when they approached the first break. She started her sessions by kicking and scratching the CPT, grabbing his tie, spitting at him, and trying to stab him with a pen in the eye. As a result, the CPT felt that Yasmin was in a state of abject terror and nameless dread (Bion, 1967) and understood these powerful experiences as a profound communication about Yasmin's experience as a helpless infant. Jackson describes a situation in which the CPT found himself pinching his own skin and pulling his hair and wonders if he was in a disturbing identification with someone desperately holding on to any stimulation.

Canham (2004) distinguishes between violence related to a patient's perverse way of relating and violence as a form of communication about violent experiences. Canham provides examples from a single session to illustrate how challenging it can be for CPTs to receive the communication, especially when the safety of the setting is under attack. He writes about how several of his patients with a history of physical abuse have repeatedly tried to kick him in areas where they were hit during the abuse. Canham describes the transference - countertransference relationship between the patient and the

CPT as the main place for communication and understanding and points out that CPTs have to experience their patient's internal worlds and object relations in the countertransference to be able to understand them without enacting these communications. Canham stresses that there is a significant risk of enactment during moments of violent projective identifications. According to him, CPTs must attempt to disentangle the variety of feelings generated in the session and work out what belongs where and to whom. He writes: "When a child is running around, throwing furniture, spitting, trying to hit you, both the external framework of the room, toys, and furniture is disturbed and also the physical safety and mental composure of the therapist" (p. 145). Canham suggests that CPTs can feel "a desire to protect oneself and not hear, to protect the room, to fight back when under attack, overwhelming feeling states of rage, sadness and despair" (p. 145). According to him, CPTs need high levels of support (e.g., supervision) to prevent an enactment of the role of the abuser or the abused in form of rough handling of children, cruel interpretations, ending sessions prematurely, not talking to anyone about the experience of being hurt, or tolerating being hurt for too long. Canham illustrates the impact relentless violence can have on CPTs and writes:

> Weeks of being spat at, kicked and hit can lead to desensitisation in the therapist, an accumulation of feelings of anger and resentment at being treated in such a way, and a suspiciousness about shifts in the patient which seem more helpful (Canham, 2004, p. 153).

Canham (2004) points out that he had to understand his patient's infantile experience and withstand his perverse tyranny. He observed that depending on

the form of violence, his countertransference could change from fearful and despairing to feeling exploited and angry (Canham, 2004).

Canham's (2004) paper is an attempt to conceptualise his experience and understanding of aggression in the room. He looks at the session material through the lens of physical aggression and this seems useful. However, I wonder if there is a danger of missing important aspects of the impact other, less obvious forms of aggression could have had on his countertransference.

Like Canham (2004), Rustin (2001) has observed that a patient's traumatic experiences can enter the room in form of violence and then impact powerfully on the CPT's countertransference. Rustin's paper includes two clinical examples and stresses that it was important for the CPT to survive the challenging behaviour before being able to tackle it. She describes how the CPT had to get some understanding of her patients' unbearable psychic pain and intolerable feelings and experience it in her countertransference during and between sessions to allow a positive shift. A positive shift in both children was only possible because of good support in the clinical setting, freedom to offer the time needed for this kind of work, helpful literature, and some understanding of her relationship to the theoretical concepts and own deeper values. Rustin writes about the CPT's experiences of violent attacks, having her earrings pulled out, being spat at, having objects thrown at her, miming of perverse sexual acts and the flooding of the room. The CPT experienced a sadistic quality of the attacks, which could feel like mockery. Rustin suggests that the patient wanted the CPT to break down in tears and feel enraged, hurt, stupid,

and humiliated. On some days of the sessions, the CPT woke up feeling sick with dread. Any firmness caused panic in the child. The CPT felt frightened of her patient's murderous state of mind, near-overwhelmed, vulnerable, and like a helpless victim. In a second case example of a 14-year-old profoundly sad boy, Rustin reflects on being made to wait as a form of passive aggression and suggests that minimal expression of anger can be linked to an enactment of abandonment and sense of deadly collusion. She writes that in the work with traumatised children, the experiences of horror in the CPT can mirror what the child is not able to deal with (Rustin, 2001).

Canham (2004) and Rustin (2001) argue that aggression can have a perverse quality, and this will be explored next.

2.3.3 Core Complex

Glasser (1986) sees aggression as a component of the core complex. He writes that the structures of the core complex are established in early infancy and distinguishes aggression from sadism and perversions. According to him, aggression has a self-preservative function and sadism aims to inflict pain. Glasser suggests that the aim of perversions is to merge completely with the object to obtain a sense of containment, security, and gratification.

The core complex conceptualises the perverse quality in aggression and is often applied to psychoanalytic practice with aggressive patients (Glasser, 1986; Horne, 2001; Parsons, 2011; Slater, 2014; Music, 2016; Trice, 2016; Ruszczynski, 2018).

Music (2016) applies the concept of the core complex to CP and argues that the concept can give insight into aggressive and sadistic children, as their state of mind cannot tolerate closeness nor separation from the object. He describes that the core complex is linked to unsatisfactory early experiences. Music suggests that professionals can have some investment in seeing children as ‘angels’, which can lead to an avoidance of the disturbance in such children. According to him, others can “see such children as innately aggressive and destructive, almost as evil incarnate, with no redeeming features” (Music, 2016, p. 303). Music understands the task of CPTs to work between those extreme positions. He describes withdrawal from the object as a central feature of the core complex and suggests that the resulting sense of aloneness and dread, which is experienced as unbearable, leads to a need to control and possess the object. In his conclusion, Music argues that core complex anxieties can be addressed in therapy, if feelings stirred up by the intimacy of the therapeutic contact and in the gaps between therapy sessions, support a real object relating.

2.3.4 Classifications of aggression

Music (2016) differentiates between cold and hot aggression. He suggests that some children display impulsive aggression in response to feeling provoked or upset. They often feel bad about their aggression. According to him, some patients’ aggressive acts can be proactive, calculated and even enjoyed by the aggressor. He describes that those patients do not feel bad about their aggression and often have experienced early trauma and abuse. Music provides a case example of a 12-year-old boy with cold features and illustrates

how the boy cut up, tortured and mutilated dolls with enjoyment. Music describes a sense of dread before seeing him and that he felt chilled in his presence.

Alvarez (2011) distinguishes between disorder (aggression linked to an internalised terrifying or dangerous external figure), deficits (ego deficits and deficits in internal representations of positive figures) and deviance (identification with an aggressor, addiction to violence or perverse excitements). Alvarez concludes that the transference – countertransference relationship aims to help children turn action and the concrete into thought and the symbolic. She suggests that this work is, and needs to be, upsetting. Alvarez (2017) further expands on her distinguishing factors and writes about the importance of paying close attention to the motivation and emotion linked to the aggressive behaviour and whose violence it is when studying the internal world, internal objects, and representational figures. In her paper *Motiveless malignity*, Alvarez (2012, p. 100) suggests that “it is necessary to look evil straight in the eye” instead of denying, condemning, or colluding with the aggression.

Alvarez (1999) discusses different types of destructiveness in neurotic, borderline and psychopathic children. She writes about anger in neurotic children, desperate and vengeful hatred in borderline children, and a cold addiction to violence in psychopathic children. Alvarez suggests that addictive violence can start as a defence against horror and then gradually develop motiveless sadistic and exciting overtones. In a clinical example, Alvarez writes about a psychopathic little girl who used to regularly kick her and throw chairs at

her. She learned to understand that the girl liked kicking people and that this had a sadomasochistic element. Alvarez argues that it is important to avoid the superficial use interpretations that, for example, repeatedly link physical aggression to a therapy break. Case material of a little boy called Peter is used to illustrate a more borderline state of mind. Peter was aware that his therapist would be leaving and started to overturn chairs. The CPT used a defence interpretation and voiced that Peter was angry because she was leaving, which made Peter even wilder. Alvarez argues that it was not enough to interpret anger and that it would have been important to voice the child's despair and helplessness by relating some of the badness to the therapist for leaving him. She suggests that it is more manageable for borderline patients when the badness is located externally to them, for example in the CPT. Alvarez argues that a sense of shame, despair, humiliation, and revenge can otherwise lead to aggressive outbursts.

2.4 Systematic review of recent empirical studies

My systematic review will identify and critically evaluate previous thinking and research related to my study. Very little research has been conducted on the subject of the study and psychotherapy for aggressive children and adolescents. Daldin (1992) supports my observation and writes that aggressive behaviour is often only mentioned in passing in publications. In the Journal of Child Psychotherapy, I was only able to locate four publications with direct links the experience of aggressive behaviour in the room in the title or abstract over a period of the last ten years (keyword 'aggression').

2.4.1 Large-scale study

One study with a larger sample size was found through my systematic literature search. I found studies about the impact of aggression on professional caregivers, nurses, or staff in inpatient units (e.g., Kind et al., 2018). I did not include these studies as they did not specifically refer to CP. It is likely that professional caregivers and nurses experience and understand aggression differently to CPTs. I believe that this is due to the nature of their different professional backgrounds and the CPT's experience of training analysis, in which they had their relationship to aggression analysed for several years.

Daldin (1992) presents his findings of a systematic clinical study of aggression in child analysis carried out at the Anna Freud Centre. He has examined indexed case records of 25 children between the ages of two to 14, who physically attacked their analyst (analytic candidate or student) and needed physical restraint along with verbal interpretation and intervention. The physical attacks occurred over the past 35 years and included biting, hitting, and kicking. The study focuses on the understanding of assaultive behaviour in the room and refers to psychoanalytic literature, mainly Anna Freud's ideas about aggression (e.g., Freud, 1972). The study aims to examine the meaning of the attacks, implications for technique referral issues and precipitants of the assault. Most children included in the study were in their early latency period. Daldin argues that this is because preoedipal and oedipal children are more likely to express their affect states and psychic life in a non-verbal way. Findings of the study suggest that the older the child is, the more likely it is that assaultive behaviour is noted and seen as pathological. Daldin found that feelings evoked

during the incidents were anxiety, guilt, increased anger, and fear of retaliation and gratification. He suggests that these “children needed physical restraint to help them gain control and shift to a mode where they could put into words how they felt, and to distinguish between the enactment of a wish and the wish itself” (Daldin, 1992, p. 479).

Daldin (1992) identified two primary groups: (A) children struggling with fear of abandonment and separation anxiety, and (B) children with a sadomasochistic way of relating which was re-enacted in their analysis. The study showed that children belonging to group A felt vulnerable, frightened, hopeless, rejected, and helpless in their attempt to achieve closeness with the object. They felt only little or no pleasure from the assault. Some children feared the closeness and intimacy of the analytic situation and acted out aggressively as a defence. Closeness with the object was both feared and desired. Children from group B tried to defend themselves against feelings of helplessness and vulnerability by projecting their frightening aggression into the analyst. Daldin (p. 481) writes: “These children attempted to provoke or enlist the analyst, as they did the parent, in their striving for physical and psychological pain and suffering, the purpose being adapt, defend and gain instinctual pleasure”. He states that many children from this group provoked the analyst as a desire to be punished, as they both wish and fear being attacked. Some analysts reported that the attacks had a sexual quality (Daldin, 1992). The two different groups seem to be in line with Music (2016) and his distinction between hot and cold aggression and his understanding of the core complex.

Daldin (1992) empathises that children from both groups need clear, firm, and understandable limits from the beginning of the analysis. He argues that ill-timed, inappropriate and confrontative interpretations can lead to an attack as a defence. Daldin suggests that the countertransference is key in the treatment of these children and states that only two indexed cases included vague information about the analyst's countertransference, reaction, and feelings.

Daldin (1992) does not elaborate on the nature of the case records, treatment technique (child analysis) and physical restraint, and at times uses own case examples to illustrate his points. This lack of clarity and rigour makes it difficult to fully make sense of the scope and validity of this study. However, Daldin provides systematic evidence of how aggression can be experienced and understood within a psychoanalytic setting.

2.4.2 Single case studies

Slater (2014) uses grounded theory (GT) methodology and psychoanalytic thinking to explore the role and function of violence and its manifestations in the room. He writes that Meltzer's concept of 'temperature and distance' (Meltzer, 1976) and the concept of 'time' and 'space' emerged through the application of GT. Links are made to the concept of the core complex (Glasser, 1986). This single case study of a violent latency-aged boy (Cory) in intensive CP explores the meaning of violence in children, specifically boys, who have experienced early trauma. Slater suggests that a paradoxical situation can arise whereby violence is seen as a necessary part of a process, which can also destroy the therapy. He reflects on Cory's increasingly challenging behaviour inside and

outside of the room. For example, Cory tried to take his box and furniture from the room and, when prevented by the CPT from continuing, lashed out with objects from his box. The CPT felt shocked, upset, and angry about this incident. Slater suggests that a negative transference was more acceptable for Cory, as it prevented him from feeling vulnerable, dependant and at risk of separation from a maternal object. Slater argues that aggression and violence were the only defence mechanisms Cory could use at this point. As the therapy progressed, Cory became less violent and developed a way of symbolising violent intentions without the need to act them out. Following an escalation in the external world, Cory became again increasingly violent in the room, which made the CPT feel enraged, anxious, upset, and utter despair. Slater describes the violent attacks as a splitting off from despairing and vulnerable parts of himself, which Cory was then violently projecting into the CPT. The CPT had to reflect on his rising temperature, anger, and fear for his safety. He was aware that he could have used his greater strength to overpower Cory and potentially harm him, which he would have understood as a re-enactment of a disturbing and terrifying figure from Cory's past. Cory's violence shifted to something more perverse. During a violent incident, Cory kicked a hole in the wall of the room. Cory seemed to take pleasure in this destructive act, which had a gang-like and narcissistic element. The CPT recognised his own passivity as an enactment of Cory's sense of helplessness. Slater understands the kicking of the wall as a communication of Cory's wish to kick the inside of the CPT with the aim to leave the unwanted and helpless part of himself for the CPT to experience. This placed the CPT in the position of the witness and voyeur, similar to Cory's experience of having to watch his father kick and damage his mother. Slater

concludes that violent acts decreased as Cory's ability to regulate affect and symbolise difficult feelings increased as part of the therapy. Through rigorous focus on the relationship between Cory and his CPT meaning was attributed to the violence and aggression, which helped Cory to experience a new kind of object (Slater, 2014).

Axelman (2006) discusses aggression as an expression of hope and applies Winnicott's ideas published in *The Use of an Object and Relating Through Identifications* (Winnicott, 1971) to the work with aggressive children. In his study, Axelman emphasis the importance of limit setting by the social environment whilst tolerating the child's aggression without retreating or retaliating. He suggests that when the significant adult survives the child's aggression, the child can move on from their lonely, anxious, and omnipotent position through a shared relational journey. The study includes case material of eight-year-old John, who used aggressive solutions to problems. John had a phobia related to flushing toilets and regularly passed gas with some pleasure. This felt offensive and was experienced as a 'stink bomb'. Axelman describes a discrepancy between competence of being able to use the toilet and a sense of omnipotence. This seemed linked to the boy's struggle with endings. Axelman reflects on an acute phase of the therapy in which the boy became aggressive at the end of sessions. The boy would then scream and throw toys at the CPT's head. The CPT found it very difficult to be with the boy and started to dread the end of the sessions. The boy eventually stopped using aggressive solutions and experienced relief in relation to the limits set by the CPT. Axelman suggests that the boy was able to progress from object relating to object usage during the

acute phase of the therapy. He writes that limit setting and tolerance helped the child move to a place of mutuality (Axelman, 2006).

2.4.3 Doctoral research studies

Three professional doctoral theses in CP are related to aggression in the room (Trice, 2016; Lewis, 2012; Ryan, 2011).

Ryan (2011) applied thematic analysis to case material of a deprived adolescent boy (Simon) with sado-masochistic tendencies in intensive CP. Initially, Simon actively rejected the CPT and pelted objects, such as paper planes, balls, pencils and wooden chairs at the room and her. He scratched, kicked, and drew on chairs and tables. The CPT experienced the sessions as an “orgy of destructiveness” (Ryan, 2011, p.8). Following his tormenting aggression, Simon would triumphantly exit the room and place the CPT in the role of a depriving mother. Ryan describes a disturbing feeling of the CPT being pushed to the limits of her own anger during moments of aggression and this seemed to fuel Simon’s sadomasochistic fantasies. The CPT felt her own sadism triggered by Simon’s aggressive and contemptuous behaviour. On one occasion, she could not wait for Simon to leave the room and shut the door with unnecessary force behind him. With support from her supervisor, she learned to accept some of Simon’s aggressive and disturbing projections without retaliating. This freed up space for her to process her countertransference and allowed a positive shift in Simon. Ryan concludes that psychic change is possible if the therapist is helped through supervision to stick to the child, even if the relationship seems damaged or damaging. She points out that CPTs

should acknowledge destructive feelings and create space for repair of mistakes and misunderstandings (Ryan, 2011).

Trice (2016) uses GT methodology to investigate links between violence and intimacy in intensive psychotherapy. The retrospective single case study analyses case material of Sam, a three-year-old traumatised boy. Sam acted violently following moments of emotional warmth. Trice suggests that there is a link between violence and intimacy if there is a sense of separation and loss between the child and the CPT as the object of intimacy. As a result, rage is directed towards the CPT. Trice states that the findings support earlier research related to lack of maternal containment and innate violence, oedipal struggles, and lack of capacity for thinking. She suggests that her findings challenge Glasser's (1979) theory of the core complex, as the findings suggest that it is the threat of loss of the intimacy that triggers the violence and not the intimacy itself. Trice provides several examples of Sam's aggression in the room. In the first example, Sam heard the siren of an ambulance and started to throw toys at her head, wrapped his arms tightly around her neck, pulled her hair hard, grabbed her face and tried to bite her arm. The incident ends with Sam collapsing into a foetal position. Trice suggests that Sam was in identification with a terrifying object during this overwhelmingly chaotic moment. In a second example, Trice describes a sudden attack in which she got kicked hard in the face whilst retrieving a vehicle from under the couch. It took some time for her to realise this, and she could not speak for some time. She describes a lack of countertransference feeling related to the kick. Sam then asked her if he should kick or bite the other side of her face as if this would make it better. A third

example shows Sam's fury and aggression directed towards her following an unplanned therapy break. Sam tipped water on the floor, kicked beakers around, called her 'naughty', yelled at her to 'shut up', hit her on the arm, pinched the skin of her arm, bit her and checked if he had left a mark on her arm. Trice suggests that Sam was not able to tolerate the unplanned break and experienced a sense of confusion about who had hurt whom. She felt that Sam was projecting his vulnerability into her and describes how she could experience violence in the countertransference. Trice could feel annoyed, shocked, and shaken by his violence. The study concludes that "although intimacy and violence are interconnected it appears that it is fear of losing intimate possession of the object or losing control of the object that triggers violence" (Trice, 2016, p. 120).

Lewis (2012) uses GT methodology to investigate impairments and arrests in the development of healthy aggression. She analyses material from two children in foster care and likens her findings to Henri Parens' concept of a spectrum of aggression (Parens, 1989). Lewis hypothesises that some children confuse ordinary healthy aggression with destructiveness, which inhibits development. The first case example, ten-year-old Philip, expressed almost all aggression through fantasy, which was often related to justifiable external dangers. In fantasy, he projected angry feelings into attacking father figures. In this way Philip could identify with a good father figure. This split seemed to reflect the contradictory parts of his father. At times, aggression was used by him to protect from or wipe out destructive and sadistic aggression, which seemed to protect him from feeling frightened. In the transference, Philip treated

the CPT as a “functional object” (p. 75). She reports that she felt like a spare part, an adjunct and his slave in the countertransference. Like some of the previous authors, Lewis (2012) understands the cause of the aggression as a fear of loss of the object.

Lewis’ second case example, five-year-old Lenny, seemed impulsively aggressive. He punched, kicked, and threw items towards the CPT. Lenny stopped when he was reminded of limits, but then wanted to leave the room. Lewis reports that Lenny used language to discharge excess energy, told her to ‘shut up’ even when she was not speaking and made threats. She suggests that Lenny tried to establish a self-object boundary and that he might have experienced the CPT’s thoughtful silence as an impingement. Lewis describes that Lenny has internalised parental hostility and that this caused Lenny’s aggressive presentation. She argues that Lenny seemed identified with an aggressor as a defence against feeling vulnerable and dependent, because of his early experiences. The study concludes that an understanding of the confusion between destructive and non-destructive aggression should determine levels of support and the nature of the most helpful intervention (Lewis, 2012).

The single case studies and findings from the doctoral research give an insight in how CP researchers have experienced and understood aggression in the room. However, there are clear limitations as all studies discuss the CPT’s experience and understanding in relation to material from single cases. Some of the case material is linked to children in intensive CP treatment. There is a lack

of transparency about the nature of the treatment and impact of this potentially being a training patient (e.g., dynamic of dependency). Trice (2016) challenges Glasser's well-established concept of the core complex in relation to her finding from her single case study. Her finding can only be seen in the context of her case example.

2.5 Summary

In summary, my narrative and systematic literature reviews show how important figures in psychoanalytic thinking and CPTs have started to make sense of the concept of aggression and their experiences of working with aggression in the room. Since Freud, aggression has been discussed as an instinctual force with links to the death instinct. The concept of aggression has been discussed and further developed by the originators of "object relations" theory, such as Fairbairn, Winnicott, and Klein.

Aggressive impulses can be directed towards the environment or the self. In the room, patients can express aggression in form of physical violence (e.g., hitting, kicking) or passive aggression. The examined literature clearly shows the significance of aggression in clinical practice and certain manifestations of aggression as part of CP treatment. The impact of aggression on CPTs can be significant and lead to certain responses, such as denial, retaliation, and enactment. The CPT's countertransference is seen by contemporary psychoanalytic thinkers as the main tool in working with different expressions of aggression in an attempt to attribute meaning to the challenging experience.

Throughout the reviewed literature, similar expressions of aggression (mainly violence) and their significant impact on CPTs have been illustrated. The reviewed papers show that very little attention has been given to expressions of passive aggression and I wonder if expressions of passive aggression are often not categorised as aggression. This represents a gap in the literature, which shows the importance of my study and further research.

There is some homogeneity in the understanding of aggression and violence within the psychoanalytic literature in so far that it is understood as a form of communication, defence mechanism, and linked to separation anxiety or fear of loss of the object (Daldin, 1992; Lewis, 2012; Slater 2014; Trice 2016). In CP, it is common understanding that CPTs help patients think about the meaning of their violent acts (Minne, 2003) and that CPTs need to pay close attention to their countertransference. Links are made between feelings evoked by expressions of aggression and the CPT's countertransference. Certain responses, such as retaliation and enactment, are often seen in the context of projective identification and the patient's projections related to internal conflicts and past experiences.

The core complex is a helpful concept for the understanding of children with a sadistic way of relating. Throughout the psychoanalytic literature, expressions of aggression and violence in the room are attributed to traumatic and unsatisfactory early experiences. Aggression and violence have been discussed in relation to the 'nature (innate) versus nurture (external)' debate.

2.6 Implications and discussion

Aggression is a fundamental concept in psychoanalytic psychotherapy and has been discussed by past and contemporary psychoanalytic thinkers. Surprisingly little has been written about the direct experience and understanding of aggression in the room. Maenchen (1984, pp. 393 - 394) argues that only few incidents of aggression are reported by child analysts, because “they are too uncomfortable to report procedures where they had to step out of the neutral role of the analyst and have recourse to essentially educative measures”. Daldin (1992) suggests that this avoidance is linked to the idea that physical handling is not part of psychoanalytic technique and therefore not reported. Grand et al. (2009) argue that psychotherapists can dissociate or deny their patient’s potential for aggression or violence as an attempt to maintain the therapeutic relationship.

This raises important questions about how aggressive patients are treated and perceived by CPTs within CAMHS. Some CPTs might feel well supported and contained through the supervision structure and wider team. Others might feel embarrassed, ashamed, or concerned about the impact an aggressive patient has on them, or about losing the patient if the aggression is reported outside of the room or psychotherapy supervision. This is particularly significant for trainees as they may experience pressure to hold on to their cases to meet their training requirements. Interestingly, a high proportion of the existing studies is related to the work of trainees (e.g., Daldin, 1992; Ryan, 2011; Trice, 2016). A lack of confidence and experience in trainees is likely to impact on how aggression is experienced, understood, and contained. At the same time, high

levels of clinical supervision and training analysis could contain and support trainees to continue their work with highly aggressive patients.

A high number of case examples are related male patients. This is not surprising as externalising aggression is often attributed to males. Case examples are mainly linked to younger children in care, deprived children, and traumatised children. This patient group is more likely to have experienced relationships and separations in a confusing and overwhelming way.

The reviewed research papers show an application of different theoretical concepts to materiel from mainly single case studies. There is no coherence in the use of specific theoretical concepts for the understanding of aggression, and I wonder if they are linked to personal interests rather than a common psychoanalytic understanding within the CP discipline. For example, Slater (2014) writes that certain theories emerged thought the application of GT and I believe that it is possible that a different researcher would have applied different theories.

Search 1 of my literature search identified papers mainly linked to play therapy, CBT, and CP. All papers seemed to have a clear emphasis on the context of the therapeutic approach. Papers related to play therapy mainly discuss how aggression features in play. CBT related papers focus on how CBT can support children be less aggressive in their everyday life. Psychoanalytic papers included in my study discuss the relational aspect of aggression in the room, progress, and the presenting transference and countertransference. The

literature emphasises the importance of supervision and support from the clinic, with the aim to prevent defensive responses.

In reflection, the literature review has partially answered my research questions in relation the experience and understanding of aggression in the room. Among other themes, the literature review provides an overview of the development of aggression as a concept, introduces relevant terminology and psychoanalytic concepts, gives some insight into how CPTs experience aggression in their clinical work, and shows the significance of aggression in the room as a subject of research in the field of CP. However, the experience of passive aggression is only mentioned in passing. This seems to reflect how passive aggression is discussed in the literature.

Chapter 3: Research Methodology

In this chapter, I will explain my choice of IPA, provide some theoretical foundations of IPA research, discuss recruitment of participants and the process of data collection and analysis. Confidentiality and important ethical considerations are discussed.

3.1 Purpose and decisions about research design

As a trainee I wanted to investigate the lived experience of an aspect related to clinical practice. I was interested in the lived experience of aggression in the room and wanted to engage with practitioners to get some real insight into their experience. A qualitative methodology seemed most appropriate for the purpose and context of my study. Midgley, Haynes, and Cooper (2017) write that qualitative research is concerned with language and can offer a rich understanding of processes in therapy. Qualitative methodology includes several approaches and frameworks (Creswell, 2013) and is generally concerned with meaning and the quality of experiences (Pietkiewicz & Smith, 2014). This seems in line with psychoanalytic thinking, which is concerned with processes and meaning.

When I was writing my initial research proposal, I had to choose the most suitable qualitative approach for my study. Following an initial search for studies

with a focus on the experience of working with a certain patient group, I was able to identify GT and IPA as the most suitable approaches for my study. An argument could be made for both methods. McLeod (2011) describes IPA as a variant of GT and shows similarities and differences between both approaches. Smith, Flowers, and Larkin (2009, p. 40) point out that "IPA is concerned with understanding personal lived experience and thus with exploring persons' relatedness to, or involvement in, a particular event or process (phenomenon)". An emphasis on the lived experience is more relevant for my study than the focus on the development of explanatory models, as in the case of GT (McLeod, 2011). Smith and Osborn (2015) point out that IPA is particularly useful in the examination of complex, emotional and ambiguous topics. The experience of aggression is complex, emotional, and ambiguous.

IPA has been used for similar research with a focus on the practitioner's experience of working a with specific target group or aspect of clinical practice (e.g., Gore, 2016; Howell, 2016; Serlin, 2017; Curen, 2018; Ramos 2018; Wills, 2019; Charura, 2020; Somasekar, 2020). For example, Wills (2019) considered the use of IPA and GT for her study about psychotherapy for patients with intellectual disabilities and writes about her decision-making process. Her decision to use IPA was based on the epistemological approach of her study, her interest in the individual's experience and the potential of interpretation and reflexivity. A similar stance applies to my study. This shows that IPA has been widely used for the exploration of similar topics, including CP doctoral research.

Rustin (2019) writes that IPA has shown to be well adapted to qualitative psychoanalytic research. There is common ground between psychoanalytic thinking and IPA, but also important differences. In Chapter two, I have written about similarities between IPA and psychoanalytic thinking. Smith (2004) discusses the different epistemological perspectives of psychoanalytic interpretations and IPA interpretations and their value for research. He points out that IPA interpretations are made with a general psychological interest in relation to what the interviewee said during the interview without the use of pre-existing theoretical ideas. Smith writes that, the distinction is often not as clear and likens this to the impact of the researcher's background and approach. This is linked to the double hermeneutic quality of IPA research and the researcher's attempt to make sense of the interviewee's attempt to make sense of their experience (Smith, Flowers & Larkin, 2009).

3.2 Interpretative Phenomenological Analysis (IPA)

I will now give an overview of the development and theoretical foundations of IPA research. Smith, Flowers, and Larkin (2009) explain that IPA was developed in the mid-1990s, provide a detailed account of the development and theoretical foundations of IPA, and describe phenomenology, hermeneutics and idiography as key concepts. The authors write that IPA has strong links to psychology and is increasingly used in health, human and social sciences. McLeod (2011) suggests that IPA research has increasingly been used in psychotherapy research, as it is both rigorous and flexible.

Smith, Flowers, and Larkin (2009) name Husserl, Heidegger, Merleau-Ponty and Sartre as leading figures in phenomenological philosophy. They explain that for Husserl, phenomenology focuses on the examination of human experience in its own terms and its perception. Heidegger, Merleau-Ponty and Sartre have further developed Husserl's ideas and "each contribute to a view of a person as embedded and immersed in a world of objects and relationships, language and culture, projects and concerns" (Smith, Flowers & Larking, 2009, p. 21).

Smith, Flowers, and Larkin (2009) describe that hermeneutics, the theory of interpretation, underpins IPA and name Schleiermacher, Heidegger and Gadamer as influential hermeneutic theorists. They understand phenomenology as a hermeneutic enterprise which examines how a phenomenon appears and point out that it is the task of the analyst to facilitate and make sense of this appearance. The particular is subject of idiography, which is in contrast with most psychology. In IPA, the particular consists of detail, depth of analysis, the meaning of something for a specific person and an understanding of "how particular experiential phenomena (an event, process or relationship) has been understood from the perspective of particular people, in a particular context" (Smith, Flowers & Larkin, 2009, p. 29). The hermeneutic circle is a resonant idea in hermeneutic theory and "is concerned with the dynamic relationship between the part and the whole" (Smith, Flowers & Larkin, 2009, p. 28).

I have illustrated my decision-making process in relation to the applied method and provided a theoretical foundation for my IPA study and will now discuss how I identified participants and research setting.

3.3 Participants and research setting

In IPA research, samples are selected purposively to ensure that they can offer relevant insight, which represents a perspective, rather than certain population (Smith, Flowers & Larkin, 2009).

I was interested in including CPTs with a wide range of levels of experiences and have decided to include trainees and qualified CPTs. In this way, it was more likely to get an insight into the real lived experience of aggression in the room. Initially, I was concerned that interviews of qualified CPTs would lead to more intellectualised data, possibly with less emphasis on the personal raw experience. Trainees are engaged in working intensively with challenging patients, have their own training analysis (usually four times a week), receive frequent supervision, and have contributed to CP research. I thought that it would be important to capture this lived experience when studying the ways CPTs can experience aggression in the room. My study does not aim to look for differences of experiences in trainees and qualified CPTs. However, the inclusion of trainees increases the likelihood for different experiences to be included, should they exist.

I decided to invite all CPTs and trainees working in a large training organisation to consider contributing to my study. The Trust employs many CPTs in various

teams and locations within London. It is also the base for the largest training school for the Professional Doctorate in CP and offers a high number of the existing training posts. I was concerned about time limitations in relation to interviews and ethical approval. My chosen research setting enabled me to conduct interviews in one setting, which was important due to the restraint in time available for the study. My sample was homogenous in that all practitioners shared a fundamental understanding of the value of psychoanalytic thinking and practice.

I am a member of the CP discipline and knew some the participants from the clinical training or other CP events. This dynamic might lead to very intellectual answers in relation to the experienced aggression instead of the real lived experience. I have considered this dynamic when I was defining the exclusion criteria for my study, outlined below, and closely observed this during the interview process.

Inclusion criteria:

- Association of Child Psychotherapists (ACP) registered CPTs (qualified or in training)
- CPTs working for the Trust where this study was sited
- CPTs expressing interest in the topic following recruitment flyer

Exclusion criteria:

- CPTs not available to meet for the interview in the time frame allocated for the interview

- CPTs with a prior/ dual relationship (e.g., individual supervisor, friendship)

I wanted to interview male and female participants to capture possible differences in the experience and understanding of aggression. My study is not designed to compare the experiences of male and female CPTs. This would require a study with a larger sample size and different goal and methods. However, I wanted to increase the likelihood of including different perspectives, should gender differences exist.

Smith, Flowers, and Larkin (2009, p. 49) suggest that a small sample size is appropriate for IPA studies because of the ideographic aspect in IPA research and the interest in “understanding particular phenomena in particular contexts”. Pietkiewicz and Smith (2014) refer to Turpin et al. (1997) and suggest that six to eight participants are appropriate for IPA research as part of clinical psychology doctoral programmes. I align my study with that and have chosen a sample size of seven semi-structured interviews. The sample exists of CPTs trained or training in a similar theoretical approach, which is regulated by the ACP. Pietkiewicz and Smith (2014) suggest that IPA researchers typically aim to analyse psychological differences and similarities within a clearly defined group. It is possible to examine similarities and differences between each participant, which allows some general claims (Smith, Flowers & Larkin, 2009). Pietkiewicz and Smith (2014, p. 9) point out that “it is inappropriate to think in terms of random or representative sampling when one is interviewing so few participants”. My study looks at ways in which aggression can be experienced by CPTs and cannot be seen as representative for the discipline as a whole.

3.4 Ethical considerations and confidentiality

I will now demonstrate ethical considerations and aspects of confidentiality from my study's ethical approval process to data analysis.

McLeod (2011) describe informed consent, participant autonomy, confidentiality, avoidance of harm and fairness as important ethical principles in qualitative research. Smith, Flowers, and Larkin (2009) point out that ethical considerations must be made to avoid harm to participants following their reflection on sensitive issues. In line with McLeod (2011), I have taken the following ethical considerations into account:

(1) Informed consent and participant autonomy: All participants have volunteered to take part in my study after reading the Participant Information Sheet (Appendix D). They were fully aware of the intention and context of my study and had the opportunity to discuss their participation in the interviews. I have briefed all participants on issues of consent and confidentiality verbally before starting the interview. All participants have signed a consent form (Appendix E) and were given the opportunity to opt out or not to answer questions. The participants had the chance to withdraw from my study within four weeks following the interview.

(2) Confidentiality: Strict confidentiality was maintained as much as possible. Pseudonyms were used for all participants. I have removed all identifiable information during the data analysis. All participants were aware that there are limitations to confidentiality. CP is a small discipline and certain perspectives, or

comments might hint to the work of a certain participant or setting. This has been discussed with all participants.

(3) Fairness and avoidance of harm: I was aware of a possible power dynamic as part of research relationships and have addressed this in my exclusion criteria. In CP, it is common practice to reflect on sensitive subjects, such as the impact patients can have on CPTs. All participants of my study have an existing support structure (e.g., training analysis, supervision). The impact of taking part in my study is unlikely to cause harm or bring up feelings that would have to be managed outside of their existing support structure. Qualified practitioners will have had at least five years of training analysis and extensive clinical supervisions of clinical work with challenging patients. Trainees are still engaged in this process as part of their training. The participants have received a schedule of the interview questions prior to the interview. This allowed participants to prepare themselves and minimised the possible emotional impact.

Creswell (2013) states that it is necessary to seek approval from an institutional review board before conducting a study. McLeod (2011) mentions the relevance of procedural ethics, which includes institutional requirements set by ethic committees and boards. As a doctoral student at the Tavistock and Portman NHS Foundation Trust, my research proposal has been approved by the Tavistock Research Ethics Committee (TREC) and the Tavistock's Research and Development Department. It was confirmed by my research tutors and the Tavistock's Research and Development Department that my study does not require further applications through the Integrated Research Application System

(IRAS) or the National Health Service Research Ethics Committee (NREC), as the participants of my study are exclusively professionals and not vulnerable.

3.5 Recruitment

I will now discuss factors affecting recruitment of participants for my study. As I was trying to recruit CPTs working for a specific Trust, I was aware that I needed to find a fair and effective way of contacting all CPTs working for the Trust. An effective way of achieving this goal was to ask the Head of the CP discipline to send an email and the Participation Information Sheet to all CPTs and trainees working for the Trust. In this way, I was able to reach all eligible candidates for my study. The number of replies was higher than the number of participants needed. Only two male qualified CPTs replied to my email. One of the male CPTs dropped out as it was not possible to identify a suitable time during the time I had set aside for the interviews. I was able to arrange interviews with all five qualified CPTs who offered to take part. Due to the high number if replies from trainees, I decided to only interview the first male and female trainee who made themselves available. In this way, I was able to recruit four qualified female CPTs, one qualified male CPT, one female trainee and one male trainee. The recruitment process was designed to gain access to the rich data required for IPA research (Smith, Flowers & Larkin, 2009).

3.6 Data collection and transcription of interviews

The data for my study was collected from seven one-to-one semi-structured interviews with individual CPTs. I have audio-taped the interviews. Smith, Flowers, and Larkin (2009) suggest that it is the norm to audiotape the

interviews as IPA requires a verbatim record for the data analysis. One-to-one semi-structured interviews are the preferred form of data collection in IPA, as it allows participants to talk freely and reflectively about their experience and understanding. Semi-structured interviews make it possible to modify the initial questions during the interview in response to the participant's answers and reflections. They allow the interviewer to keep the interviewee 'on task' to ensure that enough data is collected for the analysis (Smith, Flowers & Larkin, 2009).

All interviews were carried out in person and lasted between 60 to 90 minutes. I have tried "to ask open-ended questions free from hidden presumptions" and "to be aware of all verbal, non-verbal, and non-behavioral communication" (Pietkiewicz & Smith, 2014, p. 10). In addition, I have used some prompts and probing questions as suggested by Smith, Flowers, and Larkin (2009).

3.7 Data analysis/ IPA process

Pietkiewicz and Smith (2014, p. 11) recommend that IPA researchers "totally immerse themselves in the data or (…) try to step into the participants' shoes as far as possible" with the aim to provide "evidence of the participants' making sense of phenomena under investigation and, at the same time, document the researcher's sense making". Pietkiewicz and Smith (2014) point out that IPA researchers move between the emic and the etic perspective. According to them, IPA researchers try to make sense of the participants' and researcher's attempt to make sense of the phenomenon under investigation and interpret the data through a psychological lens (etic). An emic perspective helps researchers

to prevent psychological reductionism and higher levels of insight are promoted (Pietkiewicz & Smith, 2014).

Different variations of IPA exist in the literature. For a coherent and systematic approach to my data analysis, I will follow the six-step process for data analysis, suggested by Smith, Flowers, and Larkin (2009). They encourage IPA researchers to be innovative and flexible, and suggest the following steps as a guideline:

(1) Reading and re-reading,

(2) Initial noting (Appendix F shows examples of this process),

(3) Developing emergent themes,

(4) Searching for the connections across emergent themes,

(5) Moving to the next case,

(6) Looking for patterns across cases.

As described by Smith, Flowers, and Larkin (2009), I have divided exploratory comments as part of the initial noting into descriptive comments, linguistic comments, and conceptual comments *(Table 1)*.

Table 1: *Types of exploratory comments*

Descriptive comments	- Description of content - Participant's thoughts and experiences - Key words, phrases, and explanations
Linguistic comments	- Specific use of language by the participant (e.g., metaphors)
Conceptual comments	- More interpretative on a conceptual and interrogative level - Might prompt further questions - Reflection on what a code might mean

For IPA studies with a larger sample size of more than six interviews, Smith, Flowers, and Larkin (2009) recommend a focus on the emergent themes for the whole group. They point out that “great variety is possible in terms of the detail of the particular analysis and the relative weighting to group and individual” (p. 106). I will present my findings as an amalgam of the individual interviews, similar to other IPA doctoral research theses (e.g., Austen, 2016). Group level themes will be illustrated with references from the individual transcribed interviews. Through the processes of abstraction and subsumption (Smith, Flowers & Larkin, 2009), I have identified emergent themes and many codes related to the emergent themes. A list of codes from the individual interviews can be found in the appendix (Appendix G). Initially, I was able to attribute the codes to six super-ordinate themes with links to the key points from my research question. It was then possible to allocate the different codes to the super-ordinate themes. I have given each participant a different colour, printed out the different codes and allocated each code to one of the super-ordinate themes (Appendix H). It was then possible to group the different codes and identify sub-ordinate themes. Eventually, I settled with three super-ordinate themes with close links to my research questions.

The individual themes in each interview will collectively inform the discussion, and the making sense process as a whole. There are links to the idea of the hermeneutic circle, which is a concept related to “the dynamic relationship between the part and the whole, at a series of levels” (Smith, Flowers & Larkin, 2009, p. 28). The themes I have identified as part of this process are not exhaustive and have a subjective meaning to me as the researcher. They were

chosen as they seemed most relevant to the research question. This is in line with the double hermeneutic nature of IPA research and follows the idea of the researcher trying to make of the participant's attempt to make sense of an experience (Smith, Flowers & Larkin, 2009).

3.8 Strengths and limitations of research design

I have shown that a qualitative research design and IPA are suitable for my study, as it is concerned with the lived experience of a phenomenon. The recruitment process was designed to collect rich data needed for my IPA study. This will allow me to move on to the next step and to have a close look at the ways CPTs experience and understand aggression.

My study will use the data from the individual interviews to illustrate themes identified on a group level. The sample size for my study might appear small against some nebulous, generic study, but is appropriate for IPA research. Some questions can be raised over the transferability of my research findings. The ideographic perspective of IPA research allows the examination of what sense the participants are making of their experiences. Smith, Flowers, and Larkin (2009, p. 107) write: "Doing IPA with numbers of participants constantly involves negotiating this relationship between convergence and divergence, commonality and individuality". The participants of my study are members of the same discipline within a clearly defined research setting. This will impact on how I present my findings without revealing identifiable information about the individual participants or specific teams they are working in.

It is important to keep in mind that I have previously worked in a setting where I found myself at the receiving end of very physical aggression from children. This might have an impact on the individual interviews and on how I look at the data. However, there is a double hermeneutic element in IPA research (Smith, Flowers & Larkin, 2009) and the method will support me with a framework in my attempt to make sense of the participant trying to make sense.

There are some limitations to confidentiality as I have recruited participants from a relatively small discipline within one NHS Foundation Trust. Participants are aware of this, and it is very common practice for CPTs to reflect on their clinical experiences.

Chapter 4: Findings from semi-structured interviews

In this chapter, I will present my findings from the semi-structured interviews. Verbatim extracts from the interviews will be used to further illustrate the different sub-ordinate themes.

4.1 Overview

I have identified three super-ordinate themes *(Table 2)*. The first theme explores descriptive aspects of my findings, such as prevalence of aggression in the room, different manifestations, reasons, and the significance for CP. This theme illustrates the different ways aggression can be expressed in the room by patients. A distinction will be made between overt and covert aggression. This distinction was introduced by Alyssa during the interview and made sense to me when I looked at the data of the interviews. The second theme addresses different feelings aggression can evoke in the CPT. There is a clear link between feelings and the ways CPTs can respond. Different responses and the significance of the CPT's relationship to aggression are demonstrated as part of theme three. Defensive, avoidant, and retaliatory responses are explored. A summary of themes can be seen in *Table 2*.

Table 2: *Super-ordinate and sub-ordinate themes*

Super-ordinate themes	Sub-ordinate themes	Page
1. Prevalence and manifestations of aggression	1a. Aggression as core business in CP and useful therapeutic experience 1b. Overt forms of aggression and threat to physical boundary 1c. Covert forms of aggression 1d. Reasons for expressions of aggression	65 69 72 75
2. Feelings aggression can evoke in the CPT	2a. Feeling physically hurt, scared, and unsafe 2b. Anger, rage, and hateful feelings 2c. Helplessness, dread, and shock 2d. Shame, disgust, and humiliation	80 82 83 85
3. Responses aggression can evoke in the CPT	3a. The CPT's relationship to aggression 3b. Avoidance and denial 3c. Retaliation and enactment	86 88 90

Each participant has been given a pseudonym to guarantee confidentiality and to show the individuality of each account from the interviews. Details about the participants can be found in Appendix H.

4.2 Super-ordinate theme one: Prevalence and manifestations of aggression

The first theme introduces the significance of aggression in the room and shows the different ways CPTs can encounter aggression in their clinical work. Different reasons for aggression in the room and aggression as a useful therapeutic process are discussed as part of theme one.

4.2.1 Aggression as core business in CP and useful therapeutic experience

This sub-theme explores the participants' views of aggression as the core business in CP with a high significance for therapeutic work. All participants have experienced different expressions of aggression and brought across that aggression is a significant part of their lived experience as CPTs. They describe aggression as relevant and present in every single case.

> I think it's sort of in all of our, it's in all of the work we do. It's in every session quite often. (Sunan)

Max has a lot of contact with aggressive patients and describes seeing aggressive patients as his 'bread and butter'. He understands problems with aggression as a key feature of all patients.

> The hallmark of my thinking is really all the patients that I see here, maybe all the patients I ever see have problems with aggression. This is what makes patients patients. Their problems are aggression. I think so. More than anything else. All patients will have a problem with aggression. (Max)

Max voices that the service must be geared up to work with specific forms of aggression and able to contain them. He suggests that patients cannot be worked with if this is not the case and have to be discharged if the aggression is persistent.

Gabrielle voices that CPTs have always worked with aggressive patients and strongly brings across that violence can be encountered in a lot of the clinical work. She points out that little has been written about aggression in the room despite the high significance of the subject. She describes the ability to feel

aggression in form of projections as a normal part of the work and voices that CPTs should not be in the CP ‘business’ if they cannot feel those projections. Natalie describes aggression as something she expects and is dealing with all the time. She sees aggression as vital material in the work.

Erin elaborates on hostility as a form of aggression. She voices that hostility is a big part of CAMHS jobs and that this is something that is being dealt with all the time. Erin relates a high prevalence of hostility from parents and patients to examples from her work with patients with gender identity difficulties.

In a multidisciplinary context of CAMHS, all participants voice that aggression is more thought about within the CP discipline. This seems to create a sense if insulation and safety within the discipline. Nicole wonders if this is related to the general allocation of cases or her experiences of talking about aggression as part of her CP supervision group. Gabrielle expresses that CPTs experience aggression differently to professionals from other disciplines and suggests that CPTs can be seen as ‘the violent ones’.

> I think other professions hear about incidents of aggression but don’t experience it in the moment in quite the same way as child psychotherapists do. (Gabrielle)

Erin describes that thinking as a core approach in CP can increase the likelihood of experiencing aggression.

> Child psychotherapists often find themselves subject of more hostility and aggression because they wanted to think. (Erin)

Max describes aggression as a positive aspect of human experience and sees aggression as an indicator of engagement.

> Aggression is something I want to see in the consulting room. I want to see anger and aggression because this is part of human experience. It is those that leave it outside of the consulting room that are not actually engaging with therapy, both adults but also children. But violence is not something I would like to see in the consulting room, because you know it's inappropriate. (Max)

Natalie describes aggression as a creative process, which can be a helpful sign for development. She suggests that aggression can give the CPT a picture of the patient's internal world. Gabrielle understands the work with aggressive patients as the CPT suffering something on behalf of the patient for a good outcome. She sees shifts to symbolic communication and play as signs of progress. Gabrielle voices that violence should not be tolerated endlessly and describes the experience of aggression as a communication to gain deep understanding.

> We experience it as communication, that has to be, you know, ventured into a kind of deep understanding. We don't say 'Stop it' in a way another clinician would. (Gabrielle)

Sunan describes a patient showing anger and aggression as a useful therapeutic experience and development, which can feel good and unpleasant at the same time. He reflects on his awareness of his own aggression in response to the patient as an important part of therapy. Sunan talks about the importance of feeling safe in the work and to think about where the aggression is being placed.

> ask the question ‘Where is the aggression?’, ‘Where is that being placed?’. And so pretty much constantly thinking about that. (Sunan)

Nicole sees a shift to expressing aggression in play and a patient’s increased ability to make use of transference interpretations related to anger as signs of progress.

Alyssa discusses the importance of being able to experience, tolerate and think about aggression with the aim to process incredible distress on behalf of the patient. She sees the understanding of the communication behind the aggressive behaviour as the most effective way of minimising the risk to the child and CPT.

Natalie voices that it is important not to be afraid of aggression and for CPTs to know their body boundary, as this can communicate on an unconscious level. She suggests that CPTs need to be able to allow aggression to be present in the work, withstand it, reflect something back and try to understand the countertransference. Natalie stresses that it is important for CPTs to be pro-active at the beginning of the treatment and not allow the patient to cross the body boundary through physical harm. She talks about her experience as a trainee and how her lack of confidence and clarity impacted on her work with an aggressive patient.

> So I put up with a lot, because I thought I was failing. I thought, you know, when he bit me on the leg, I thought, well he is only six. Now if I had a six-year-old and they bit me on the leg, I would make, you know, I would make a big thing of it and say that’s not ok. So, I am more confident. (Natalie)

4.2.2 Overt forms of aggression and threat to physical boundary

All participants report that they have experienced direct physical aggression towards themselves or the waiting room. Initially, most participants understand aggression as mainly physical violence and then reflect on more covert forms of aggression. The reports of overt aggression are linked to a physical boundary being crossed or the direct threat of it. Gabrielle voices that there are different levels of acceptance between verbal and physical aggression. This suggests different implications for clinical practice and an idea that physical aggression should be prevented and stopped.

Aggression towards to room, therapy box, and waiting room

Erin, Natalie, Nicole, Alyssa, and Gabrielle talk about experiences of attacks on the room. This includes patients throwing furniture, attempts to flood the room, urinating on the floor, significant damage, damage to therapy box, and toys being thrown out of the window.

> he wasn't always just aggressive towards me, he'd try and break the radiator, or smash open cupboards or flood the room, you know, and it would be like 'Which onslaught will it be today'? (Nicole)

> you present a young person with their therapy box and one patient that I've worked with for a long time, he just destroyed it, you know, immediately, until it was in pieces and tatters. Every soft toy was disembowelled. Every three-dimensional object was flattened. The box itself ended up in pieces. (Natalie)

Erin talks about a patient who had been angry during the session and then started to throw things around in the waiting room after the session.

Threats

Sunan, Gabrielle, Nicole, and Max reflect on their experiences of physical and verbal threats towards them.

> And I was feeling that I was down in my chair whilst he was, he would pace around, and he would crack each knuckle which was particularly threatening. (Sunan)

Nicole talks about her experience of verbal aggression between patients. She has experienced a patient screaming at her. The patient then threatened to use objects from the room.

Cruelty, perversion, and manipulative behaviour

Participants reflect on experiences of aggression with a cruel, manipulative, controlling, perverse, sadistic, or sadomasochistic quality. Natalie and Max directly talk about their experiences with perverse, cruel, sadistic, and sadomasochistic patients and dynamics.

> And he presented as a lot of similar cases (…), where you feel that your patient is coming to see you in order to hurt you. They are not coming to therapy. They are coming to hurt someone who is there sitting down, and they feel that someone is under their control. (Max)

Nicole and Sunan express that some patients can show excitement and enjoyment about expressing aggression and the impact this can have on the CPT. Nicole talks about how she got physically attacked by a patient who was laughing in a cruel and sadistic way during the attack.

> what was really difficult about that experience as well, was how he was laughing as he did it. You know not in a casual way, it was in a quite a

> cruel, sadistic kind of, enjoying how scared he wanted to make me feel. (Nicole)

Physical violence towards the CPT and between family members

Physical attacks towards the CPT are reported in form of kicking, hitting, punching, biting, spitting, pulling hair, headbutting, use of objects and attempt to hurt the CPT's eye.

> Hitting, biting, kicking, spitting, pulling hair, having things thrown at you, having water thrown at you. That's what I would see as aggression. I am really looking at it in terms of actual physical aggression. (Gabrielle)

> she was trying to bite me, and she was repeatedly headbutting me, and I said "We need to stop". And I was trying to get out of the room, but she blocked it. (Nicole)

Alyssa discusses her experiences of physical violence and how she ended up in a physical 'tussle' in response to her attempt to enforce boundaries. She and Sunan have experienced physical violence between patients and a family member. Erin mentions the possibility of infectious aggression as part of a group dynamic in specialist settings.

Self-harm

Natalie, Sunan, and Alyssa report that patients can direct aggression towards themselves. Sunan and Natalie suggest that this can be experienced as threating.

> if he thought I was cross with him, he would hit his head against the wall, he put safety pins in his mouth, anything you know, that was a sort of like a threat to me. (Natalie)

4.2.3 Covert forms of aggression

All participants report experiences of covert aggression, which do not cross a physical boundary and is often referred to as passive aggression. This form of aggression has implications on the response and generally allows more time to think as there is no imminent risk involved.

Silence, withholding, and non-participation

Natalie, Alyssa, and Sunan reflect on their experiences of silence and non-participation as a form of passive aggression.

> I think silence and non-participation can be one of the most powerful expressions of aggression. A sort of neutering of the therapeutic space. And yeah, protecting a sense of impotence which is actually quite a violent act, a castrating act. (Alyssa)

Nicole talks about her experience of working with a patient who refused to enter the room as a way of avoiding overt aggression. She wonders if patients removing themselves from sessions can be seen as aggressive or as an attempt to prevent the expression of aggression. Sunan reports that non-attendance can feel like an attack. Natalie talks about lying as a form of aggression as an attempt to withhold the truth.

Provocation, verbal aggression, and hostility

Alyssa reflects on provocation which can be experienced by the CPT and patient. She describes a patient trying to break the rules as a form of aggression.

> I tried to be playful with him (…), but as soon as he sensed any reciprocity building between us, he stopped. The only thing he would do would be things to try and provoke aggression in me, by the need to enforce a boundary. (Alyssa)

Alyssa and Erin talk about aggression from parents. Erin suggests that thinking and questioning can be experienced as aggression and provocation by patients and parents. In her experience, hostility is often linked to a sense of entitlement and demand to capitulate. Aggression can be expressed towards CPTs or family members through rudeness, verbal aggression, and homophobia.

> I remember trying to talk about sexuality and the mother kind of turning around at me, (…) almost spitting 'My daughter is not a lesbian'. I mean that was such a shocking, such a hostile, such an aggressive thing to say. (Erin)

Sunan voices that aggression can be expressed through swearing and talks about his experience of being sworn at.

> there is one boy, who is sort of four, who tells me to 'fuck off' sometimes, quite striking from a four-year old (laughs). (Sunan)

Nicole talks about her experiences of her patient's specific use of language, which can come across as aggressive when this is thought about in more detail.

> I also think as well maybe some of the language as well that's used, maybe some of the taunting or ridiculing, that sorts of things could come under it. (Nicole)

Gabrielle reflects on her experiences of verbal aggression and that it is accepted to tolerate and work with it within the context of the therapy. She mentions racial abuse, harassment, and nastiness as verbal aggression.

Aggression in play and phantasy

Aggression can be expressed in phantasy or through play. Jennifer reflects on a patient who tried to keep herself grounded in response to an aggressive phantasy.

> she held on to the chair legs was because was she was tethering between holding on to something to keep herself grounded, not flying to violence, but also entertaining the phantasy of getting up and smashing the chair over my head. (Alyssa)

Sunan, Natalie, and Nicole talk about their experiences of aggressive play, which can be aggressive in nature or directed towards the CPT. They bring across a sense that aggression in play is healthy and an important part of CP.

> So all his play is, his toys get ripped apart, his box was smashed apart and he rips anything I bring into pieces, you know, everything is thrown around the room, ripped up, tortured and you know, everything is extremely violent in the play. (Nicole)

Sunan voices that aggression can be disguised as something friendly with the aim to denigrate the CPT.

> there was a latency girl who wanted to sort of do nothing but paint fairies and wanted me to be a pink fairy and you know that felt very much like, it's not to play a game with her, it's to degrade me, strip me from a potent adult you know. (Sunan)

Max reflects on a patient who progressed from physically attacking him to creating mess in the room. The patient enjoyed the idea that Max had to tidy up the mess afterwards and this was experienced as a form of aggression.

Aggression external to the room

Erin, Natalie, Sunan and Alyssa mention their experiences of patients expressing aggression towards them outside of the room. Erin has experienced aggression in form of formal complaints, request for a different clinician, attempt to split between clinicians and aggression expressed online. Sunan talks about his experience of a patient asking their parent to do the attacking. Natalie has received an aggressive letter from a patient. Alyssa describes a child making accusations as a form of aggression.

4.2.4 Reasons for expressions of aggression

The participants link aggression to adverse childhood experiences, neuro-developmental factors, dysregulation, and unbearable vulnerability.

Adverse childhood experiences

All participants suggest clear links between overt aggression and early experiences of aggression, trauma, abuse, or neglect. Gabrielle describes aggression as a form of communication about what the patient has been through and their previous experiences of aggression. She voices that CPTs need to understand something about this experience of deprivation or early trauma on behalf of the patient. Erin reflects on aggression as a result of an inability to mentalise and process earlier trauma and attachment difficulties. Max talks about aggression in response to past experiences of not being able to protect themselves.

> Because the violent ones are like this because they couldn't protect themselves, because they couldn't use aggression properly, because they

> were not strong enough or it wasn't available to them, because people were frightening them or hurt them or were stronger than them. Whatever it is that happened to them, they couldn't use aggression properly, so they had to find another solution. Becoming violently fierce worked for them. (Max)

Natalie suggests that a perpetrator has usually also been a victim of violence. She expresses that most violent patients need to be seen as a perpetrator and victim and that the therapy needs to help patients integrate both parts. Nicole talks about the importance of trying to balance the victim and perpetrator parts of patients. Max explains that it is important to find love for violent patients and to think about them as somebody who is hurting. Natalie makes links between aggression and traumatic experiences of being hurt, pre-verbal trauma, abuse, neglect, and corruption. In her experience, these patients can find intimacy of being in the room frightening because of their earlier damaging experiences.

Alyssa understands aggression as a form of communication about early traumatic experiences and lack of parental boundary setting. She suggests that patients can express aggression on behalf of the parent. Alyssa talks about a link between neuro-developmental factors (e.g., autism) and aggression.

In addition to adverse childhood experiences all participants liken aggression to vulnerability, dysregulation, and struggle to tolerate thinking.

Struggle to tolerate thinking

Erin reflects on her experience of aggression in response to patients feeling persecuted and discriminated by thinking. She has observed that some patients and their parents can experience reflections and thinking about meaning as

attacking. Erin has experienced a lot of hostility following her attempt to counter the narrative or patient's fixed idea about what should be offered. She describes that the CPT's questioning can be experienced as aggressive and lead to an aggressive response in the patient or parent. Erin describes aggression as a disavowal of affect, thought and fear.

> hostility and aggression is a manifestation of fear and anxiety. It's much easier to attack than to listen and to have to confront that we might be wrong. (Erin)

Gabrielle talks about aggression because of the patient's struggle to tolerate thinking about anything frustrating, upsetting or distressing. Patients can then lash out because of their inability to think. Max mentions that patients can feel slapped in the face by interpretations and react aggressively. Natalie reflects on aggression in response to a patient not being able to communicate something effectively which might be linked to an inhibited unconscious state.

Dysregulation and affect

The participants bring across that aggression is often linked to a patient's inability to regulate themselves because of a lack of containment in early life. Gabrielle talks about physical aggression in response to painful issues emerging in the session.

Max and Natalie notice that patients can use aggressive means as a defence or omnipotent cover up against feeling frightened and fearful. Natalie reflects on how patients can use aggression to show the CPT how afraid they are of what

they are capable of. Sunan talks about his understanding of aggression linked to a patient's limited capacity to process emotions and deep-rooted anxieties.

> this boy has such limited capacity to sort of process his emotions himself and he, you know, that it just gets an immediate, you know, something unpleasant inside him, the sort of sense that I was abandoning him (…) and gave me a bit of how angry he was. (Sunan)

Alyssa describes physical aggression as a destructive quality or sign of a need for self-regulation. She suggests that violence can be a cover up of shame. Nicole talks about her patient trying to hold in aggression due to her experiences of not feeling contained. She wonders if her patient repeatedly leaving the room is a form of aggressive power play or form of self-regulation.

Distance and sense of loss

Alyssa, Sunan, Natalie, and Gabrielle talk about aggression linked to the patient's fear of loss and being separate. They reflect on the impact of therapy breaks, separations, endings, and the patient's use of aggression to reconnect with the CPT. Gabrielle and Alyssa talk about their patient's revengeful responses in relation to separation and endings.

> But on this day with all the separations and endings going on, he turns in my arms and digs (…) his finger into my eye. (Alyssa)

Natalie talks about how patients can be aggressive following moments of meaningful contact because of their fear of attachment. She voices that aggressive means can be used by patients to gain closeness and feel looked-after.

> he hits his head against the wall in order to make me care about him, you know, to look after him, to make himself vulnerable, to make himself the victim and that I will need to look after. (Natalie)

Control and sense of threat

Nicole and Alyssa talk about their patients' experience of the therapy as a dangerous place and sense of vulnerability.

> he felt incredibly exposed and vulnerable in the psychotherapeutic space and the idea of mind, trying to know his mind. (…) I think the idea of him being known was quite frightening to him. And I think it made him, the vulnerability made him feel quite aggressive. (Alyssa)

Natalie reflects on aggressive means as a way of coping and controlling the space. Patients can use aggression to sabotage the therapy. Max voices that aggression can be used by patients with the aim to control their object as a form of distance regulation and as part of sadomasochistic tendencies in their search for a victim.

4.3 Super-ordinate theme two: Feelings aggression can evoke in the CPT

Theme two presents the different feelings that can be evoked by aggression and how these feelings can impact on CPTs. All participants have spoken about a wide range of feelings in response to their experience of aggression.

4.3.1 Feeling physically hurt, scared, and unsafe

The participants speak about how the feelings evoked by aggression impact on them. They bring across that it can be challenging to withstand aggression and to keep thinking.

> I think one of the things in face of aggression, the aggression and violence and, it can be really hard to just keep thinking in a really thoughtful way and actually hard not to just feel. (…) it's really difficult when being actually physically attacked or the room being attacked to remain thoughtful. (Nicole)

Gabrielle and Max talk about their experiences of feeling hurt by physical aggression, beaten up and like someone's punching bag. Nicole reflects on feeling in immediate danger of getting hurt and like armouring up for battle. Gabrielle brings across how the feelings evoked by aggression can impact on the CPT and the way they respond.

> I don't like it! (laughs) Nobody likes being beaten up! (laughs) I didn't like it! It was really uncomfortable, painful. At times, I had to really kind of hold myself together to continue. (Gabrielle)

Max, Sunan, and Nicole talk about feeling fearful, scared, or frightened in response to not feeling safe. Sunan reports feeling anxious that the aggression might escalate into physical violence.

> It felt very much that he was right at the edge of physical violence, of getting up. And this is an 18-year-old boy who is sort of quite large (…), that was a particularly frightening experience. And that was a sort of, one sort of real example, where I thought I actually do really feel scared, you know in the room. (Sunan)

Alyssa reports feeling real fear in response to her concern that a patient might physically attack her. She feels that something got into her at an unconscious level. Gabrielle talks about having experienced aggression like an ordeal, in which she felt very unsafe. She already noticed this feeling when she woke up in the morning of the patient's session, which shows that these feelings can continue outside of the room. Max reflects on his experience of sitting in a room with a violent patient.

> When you sit with them in a room, your first experience is feeling very unsafe, because they threaten you and because you heard the referral, and you know what they've done, and they start doing it to you. They feel very unsafe. Now, what happens when you feel unsafe? What do you do? Because you are basically just with them, and you feel kind of regressed in yourself, but also in relation to them, as a transference experience or countertransference experience, you try to survive it. (Max)

The age of the patient, understanding the meaning of the aggression and quality of aggression impacts directly on the CPT's experience. Gabrielle voices that a kick from a psychopath can feel harder to bear than a kick from a deprived child. Sunan has experienced physical violence from younger children and finds the prospect of physical violence from an adolescent especially frightening.

Natalie reports that CPTs can become reactive when they are feeling attacked and then become afraid for themselves and the patient. This can lead to a variety of defensive responses.

Erin voices that aggression can occur within the service and that the whole service can feel under attack. This can increase aggression in the room and create a culture of appeasement.

4.3.2 Anger, rage, and hateful feelings

Feelings of anger and rage are mentioned by Alyssa and Sunan. Alyssa reflects on her experience of her own anger and range in response to aggression in the beginning of her career and how this made her feel ‘shit’ at her job.

Two participants reflect on their hateful and furious feelings in response to their experience of aggression. Natalie felt furious with her patient who deliberately wet herself as an attempt to violently sabotage the session. Another participant describes how aggression can lead to hateful and murderous feelings in the CPT in response to feeling frightened. This person talks about the importance of being able to reflect on hateful and violent phantasies.

> Oh I wanted to kill him. If I had a gun, I would take it outside, ‘boom boom!’. And I felt good. I had these things in my mind. But then I was also frightened. The problem with these type of phantasies is that you can’t act them out. You know, and therefore you feel I can’t kill him, so what else can I do? I am fucked. So you try to manoeuvre it. (Participant)

These words are thoroughly unsettling to read. In a psychoanalytic context, the capacity to reflect openly on these more primitive and potentially disturbing feelings is valued. This participant seems to be able to allow themself to openly reflect on unsettling thoughts, as they appreciate this as a crucial part of the work with highly disturbed patients.

Erin and Nicole report feelings of irritation, annoyance, and resentment in response to hostility and violence. Nicole voices that this feeling became more complicated when she found out some information about her traumatic background and started to see her patient as a perpetrator and victim.

4.3.3 Helplessness, dread, and shock

Erin felt shocked when a patient made a complaint against her for the first time and following her experience of homophobia between a mother and daughter. Natalie and Nicole reflect on how aggression can be experienced as disturbing especially in response to sadistic, callous, and cruel behaviour. Natalie voices that a lack of support in the clinic can leave the CPT full of anxiety and unsure about what to do next when confronted by aggression. Sunan talks about feeling shocked after a young patient spat in his face and finds spitting particularly powerful.

Max talks about the impact a violent patient had on him inside and outside of the room, which led to him wishing that the patient would cancel.

> the night before I would know that the session is coming tomorrow, so already on my mind playing, and then in the morning, shit, you know, I wish he would cancel, no he is coming, fuck. And then I would think, ok, see him and he gives this blank smile, shit, like carrying a lamb to the slaughter. (Max)

Gabrielle mentions a similar dread about seeing a violent patient when waking up in the morning and a sense that the therapy is not going well during moments of aggression. Nicole reports her wish not to be near a violent patient in response to relentless “onslaught and chaos”. Natalie reflects on a sense of

hopelessness in the patient and CPT and her struggle to understand her countertransference in moments of aggression.

> I felt very controlled, and I felt very helpless. So, he did project his helplessness and impotence into me. (…) It just disabled me, it disabled him, and we were stuck in this kind of, you know. I was kind of feeling I was absolutely hopeless as a therapist, and he was feeling hopeless as a patient. (Natalie)

Natalie, Max, and Sunan report feeling helpless and controlled during moments of aggression. Natalie reflects on her experience of a patient hitting his head against the wall to make her care about him. She felt that nothing was working and a sense of failure. Max reports that trainees often feel controlled and helpless as they have to hold on to patients. He talks about a sense of extreme control in a patient's attempt to develop a sadomasochistic relationship with the CPT. This can lead to the CPT feeling masochistically victimised.

> you are being physically hurt, but you are pretending that this is part of your job. And you are talking to the patient about your experience. You are (…) accepting the fact that you are being beaten up and that you are being physically hurt. (Max)

Nicole reports feeling tricked, daubed, or fooled for having missed something that could have prevented physical violence. She talks about feeling inadequate and humiliated for having to ask for support from other clinicians. Nicole reflects on her feelings in response to a patient aggressively rejecting her attempt to show understanding and care.

> I can feel really paralysed or really quite desperate. What can I do? Trying all different things, but then you can end up feeling quite desperate really. (Nicole)

4.3.4 Shame, disgust, and humiliation

Alyssa reflects on shame linked to fearing being a victim or the perpetrator.

> I think something around the shame that is so often associated with either fearing being the victim of violence or fearing being the perpetrator of violence, that it's the things we might forget. (Alyssa)

Alyssa talks about her feelings of utter annihilation of the therapeutic space and a sense of castration following moments of violent non-participation. Sunan reflects on his experience of getting spat in the face and a strong sense of disgust in relation to this experience.

Gabrielle and Sunan talk about feeling completely humiliated, denigrated, and worthless in response to powerful aggressive projections from patients or a shut down in communication.

> you just feel like nothing, you can just be spat on, you know, something so worthless and degrading that. (Sunan)

In some of the interviews, there is a lot of laughing in response to talking about extreme violence and aggression. This could be seen as a defensive response against embarrassment, shame, and other painful feelings.

4.4 Super-ordinate theme three: Responses aggression can evoke in the CPT

All participants report different defensive responses in response to the feelings evoked by aggression. The CPT's relationship impacts on the way of responding. All participants have spoken about defensive, avoidant, and retaliatory responses.

4.4.1 The CPT's relationship to aggression

The participants make references to what CPT's can bring to the work with aggressive patients. Examples of physical aggression are often linked to an experience during the training. Natalie reflects on how she often got hurt by her training patient. She reports that she has not been hurt in her current position, even though she now works with in a setting with a high number of violent patients.

> I was often hurt by him. It wasn't usually too bad because he was five when I started working with him and nine when I stopped, and he wasn't so violent towards the end. (…) I work with much bigger, much more on paper violent young people, but I have never been hurt. (Natalie)

Gabrielle suggests that the CPT's long analysis and training make it easier to work with aggression. Sunan and Max reflect on dynamics related to being a trainee. Sunan talks about feeling powerless, helpless, and doubtful in relation to his training patient not coming to sessions, which he experienced as aggression towards him. He wonders if he responded more aggressively because of the imminent threat of losing his training patient. Max voices that there can be a dynamic similar to domestic violence when trainees feel that they have to hold on to violent patients. He has observed a dynamic in which trainees and new staff are being asked to take on the most challenging patients, possibly as they would find it harder to discharge them. Alyssa and Max talk about the importance of personal analysis and the CPT's understanding of their own aggression. Max suggests that it can be helpful to bring analysis and supervision together to support the CPT fully understand the impact certain patients can have on them. Gabrielle and Max suggest that the CPT's own

experience of violence can impact on their experience and ability to treat violent patients. Max's experience is that perverse, violent, and delinquent patients can tap into the CPT's sensitivities and traumas in their search for a victim.

> They are very sensitive to tapping into your sensitivities because they are looking for a victim. So, if you've been hurt before, or (…) if you have problems with aggression that a lot of psychotherapists have as a personality, they will tap into this and they will control you through that. (Max)

Max reflects on how patients can use the CPT's desire to help to engage in something sadomasochistic. Gabrielle talks about a dynamic in which treatment is seen as the last resort to prevent exclusion or prison later in life. This dynamic can impact on the CPT's desire to help and create pressure to hold on to patients. Max reports that CPTs can feel pressure to hold on to violent patients to prevent a sense of failure.

Nicole reflects on her struggle with boundary setting and rules around aggression. She suggests that experience impacts positively on the CPT's ability to set boundaries and contain patients.

Erin talks about the significance of the position and approach of the CPT. She reflects on the difference between inviting the patient to think and capitulating. In her experience, capitulating can avoid different expressions of aggression. She suggests that CPTs are more inclined to encourage patients to reflect and can be on the receiving end of hostility as a result.

Max and Natalie talk about feeling drawn to the work with highly aggressive patients, which seems to impact on their ability to contain these patients as part of a supportive team.

> I was always, always drawn to work with these kinds of patients. I always found them interesting, challenging, and creative. (Natalie)

4.4.2 Avoidance and denial

Max describes several ways CPTs can try to avoid aggression in response to feeling stuck in a room with a violent child. He has noticed that CPTs can become placatory or constantly feel like treading on eggshells. In these moments, aggression is often not challenged and CPTs can pretend that being hurt is part of their job. Max reports that CPTs can try to appease patients to avoid violence and anxiously try to give them what they want. He describes a process in which the CPT pretends to do therapy, but in reality, only makes placatory interpretations as part of a masochistic relationship. Max voices that this dynamic can feel similar to domestic violence relationships and suggests that there is a higher risk for trainees as they feel that they have to hold on to their training cases.

> So the patient comes in and you are already hypervigilant and high alert expecting to be beaten up and then what it induces in you is the need to make the patient feel nice, so that they don't beat you up, in a domestic violence sort of way. I need to know what it is they want and I gonna give it to them. I gonna anxiously provide so that they don't beat me up. Then they are nice. How was your week? Treading on eggshells. I don't challenge anything, and I don't talk about the past. And I don't talk about violence. (Max)

Max has observed that CPTs can try to avoid being in a room with a violent child by trying to escalate things quickly with the aim the end the session. He reports that CPTs avoid an authentic response by pretending that everything is alright to get through a session or to win time. CPTs can take on a victim position and learn their patient's triggers with the aim not to trigger them. Max reflects on how CPTs can feel scared and deny feeling scared as a defence against being a victim.

Nicole talks about turning a blind eye to the aggression as an attempt to hold on to something more positive and a desperate wish to see the patient as either a perpetrator or victim. She expresses that she has tried to cover up hateful feelings towards aggressive patients as a way of managing and can feel unsure about when to stop a session. This struggle seems related to her feeling unsure if aggression is being prevented in a helpful way or avoided.

Alyssa talks about her experience of trying to create distance or ending CP treatment because of aggression, which had an avoidant quality. She voices that she has tried to just tolerate covert aggression to see what happens and this has increased levels of aggression. Erin describes that it is possible to get used to aggression in a way that it stops thinking. Gabrielle talks about a problematic response of tolerating violence in a masochistic way.

> If we just keep on tolerating violence, then we become masochistic in a rather problematic way. So, there is a kind of judgement to be made, isn't there, when I am tolerating violence for potentially good outcome and when actually it sort of becomes rather problematic for the patient to keep going. (Gabrielle)

Natalie reflects on her difficulty to keep her mind in the room and wish to look away. She describes this as denial of the aggression.

> I just wanted to think about anything else other than the destruction that was going on. And you know to be in touch with, I think this is what's interesting, is that I can remember watching thinking I want to look away, I don't want to see this, I don't want to know about this. (Natalie)

Sunan reflects on his wish for the session to end in responds to aggression and expressed anxiety in relation to appropriate boundary setting in his work with a patient he was dreading seeing. Boundary setting is directly related to the question if aggression is avoided or challenged.

Alyssa talks about forgetting as a defence. She reflects on an example of working with a violent child, her need for more time to process the situation and then forgetting to take it to supervision. Alyssa and Nicole voice that the use of theory and intellect can act as a defence against painful feelings in the CPT.

4.4.3 Retaliation and enactment

Sunan, Gabrielle, and Max talk about their experiences of feeling drawn towards retaliation in response to aggression.

> I had to be very mindful of being drawn towards retaliation. I think, some patients actually were looking for that. He was, you know. He worked very hard to get me to retaliate and I think feeling that in oneself is hard. (Gabrielle)

Sunan talks about a patient who stopped attending sessions, which was experienced as aggressive. He reflects on being spat in the face by a patient and his instinct to retaliate or react in a punitive way.

> Sunan: I just felt disgusted and feel something to retaliate, you know, there was an instinct, a fear to hold back a response.
> Interviewer: What did you want to do if you could have?
> Sunan: Give him a, hit him on the, sort of (makes a spitting sound), you know, give him a slap, or do something, push him away.

Sunan and Max talk about a sense of aggression and retaliation in their use interpretations. Max reflects on his observation that CPTs can become fierce and punitive in response to feeling unsafe. This can create a feeling in the CPT that they are interpreting under fire, but actually fighting and slapping patients with words.

The participants bring across that stopping a session can be helpful but also create a difficult dynamic. Nicole suggests that it can be helpful to pause a session until the patient is calmer or to have a parent or colleague to call outside of the room. Gabrielle has noticed that stopping a session can increase aggression in the next session and thinks that stopping a session should be the last resort. Max suggests that the idea of stopping a session can be used in a protective and punitive way (e.g., as a weapon).

Erin talks about feeling hostile and aggressive in response to feeling attacked by a patient. She suggests that that hostility from patients can lead to a feeling of hostility and aggression in CPTs.

Alyssa talks about responding in a physical way which ended up feeling like a violent tussle. This was in response to the patient trying to eat tissue paper in a provocative way.

> I had to physically stop him from accessing which he would then get in quite a physical tussle with me, quite big so and then I would have to end the session. I actually could not allow him to eat a lot of tissue paper, it could harm him. I can't physically stop him without getting into quite a violent tussle. (Alyssa)

Erin talks about a response of wanting to prove that the patient is wrong which can feel like a power struggle. Natalie mentions an example of responding by turning into a 'health and safety officer' and a dynamic of being pulled into enactment and collusion.

Max sees it as crucial to notice change and progress. He voices that CPTs must remain reflective and regulate own feelings and states of mind in the presence of patients to avoid being drawn into complicated relationships. He explains that it is important for CPTs not to hide certain feelings (e.g., humiliation) to show patients that these feelings can be tolerated. Alyssa suggests that the work should focus on helping patients understand that the world can tolerate their levels of anxiety and aggression without retaliating.

Chapter 5: Discussion

In this chapter, I will discuss my research findings in relation to the research questions and provide context with reference to existing literature. My study aimed to explore the CPT's experience and understanding of aggression in the consulting room. Qualitative interviews were carried out and analysed using IPA to identify themes. The analysis of the rich data from the interviews offers insight into the lived experience of seven CPTs and trainees. The following section will discuss the salient results from the study, implications for CP, limitations, and recommendations for further research.

5.1 Prevalence, manifestations, and reasons for expressions of aggression

The findings from my analysis suggest that aggression is a core aspect in CP. Numerous overt and covert expressions of aggression were discussed by the participants and in the literature (e.g., Daldin, 1992; Slater, 2014; Trice 2016). At times, positive meaning is attributed to expressions of aggression in the room. Different forms of aggression, especially violence, are often seen in the context of unsatisfactory early childhood exercises or fear of loss of the object.

Aggression as a core aspect in CP

My study corroborates and clarifies that the expression of aggression is a core aspect in CP. This is a key finding of my study, as the literature identified through the systematic literature review did not state this as clearly. Lewis (2012) and Slater (2014) suggest that children with difficulty in expressing aggression appropriately are often referred to CAMHS. My study goes a step further and demonstrates the potential difficulty of most patients in expressing aggression appropriately. Most of the existing research and clinical papers refer to single case studies, which might have prevented previous authors from identifying aggression as a core aspect in CP. Prior to this study, I had observed that the difficulties of my patients (e.g., suicidal ideation, self-harm, eating disorders, depression, anxiety, violence) seemed related to their inability to know what to do with their anger and aggression. The findings of my study support my observation that most patients struggle to express aggression appropriately and suggest that aggression in the room is more thought about and accepted by CPTs than by professionals from other disciplines. This seems to be related to the CPT's focus on the transference and countertransference, which consistently can be found throughout the CP literature (e.g., Horne, 2001; Rustin, 2001; Canham, 2004; Jackson, 2004).

Manifestations of aggression

My findings show that CPTs can experience and work with overt and covert forms of aggression. Most participants and studies (e.g., Daldin, 1992) associate aggression in the room with physical violence, which is only one form of aggression. Covert expressions of aggression are often seen as an

afterthought. All participants reported experiences of both forms of aggression. Several participants emphasised the importance of focusing on where patients place aggression.

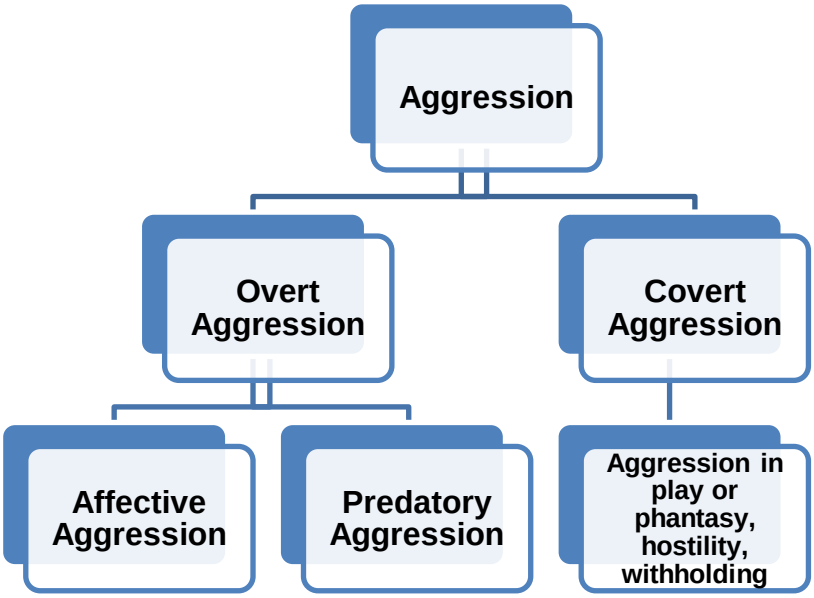
Experiences of overt aggression included hitting, kicking, scratching, spitting, hair-pulling, stabbing, having items thrown at them, and damage to the room. Similar expressions of aggression have been reported in the literature (e.g., McDougall & Lebovici, 1989; Daldin, 1992; Rustin, 2001; Canham, 2004; Alvarez, 1999; Ryan, 2011; Trice, 2016). Participants reported covert experiences of aggression in form of withholding, non-attendance, silence, hostility, violence in phantasy, and sense of entitlement. Similarly, Rustin (2001) understands being made to wait by a patient as an expression of aggression. The understanding of covert aggression is less conceptualised in the literature and expressions of covert aggressions are possibly often not categorised as aggression.

Participants reported that some expressions of overt aggression can have a different quality, which can be described as callous and calculated. My findings from the interviews and the literature consistently describe affective aggression and predatory aggression as two forms of aggression (Daldin, 1992; Meloy, 1996; Music, 2016), which seems helpful for the further understanding of overt aggression. Likewise, Music (2016) distinguishes between hot aggression (affect related) and cold aggression (calculated). Alvarez (2011) refers to Meloy (1996), who suggests a distinction between affective aggression (aggression linked to a perception of threat) and predatory aggression (destructive

aggression). Daldin's (1992) study identified two similar groups. The distinction between both forms of aggression is clinically relevant, as it impacts on the CPT's experience and response. The participants voiced a different quality and experience in relation to a child being aggressive because of an inability to regulate feelings (e.g., fear, anxiety) and a child that comes to sessions with the aim to hurt the CPT in a callous, calculated, or cruel way. The motivation behind the expression of aggression is an important aspect for the clinical formulation.

When I was looking at my findings related to the CPT's understanding of manifestations of aggression, I proposed a basic model of aggression to summarise my thoughts (*Figure 2*).

Figure 2: *Model of aggression in the consulting room*



The model shows overt aggression and covert aggression as two different forms of aggression. The categories of overt and covert aggression are often used in psychology (e.g., McEachern & Snyder, 2012) but have also been used

in psychoanalytic literature (e.g., Maenchen, 1984). Both, overt and covert aggression, include a wide spectrum of expressions of aggression. The distinction can be helpful, as the threat to the body boundary can have different implications for safety, therapeutic relationship, and clinical practice.

Participants expressed curiosity in the absence of healthy aggression within a CP context. They voiced that this needs to be addressed with patients and understood as part of the transference towards the CPT. There are links to Lewis' (2012) study and her case example of a boy who only used aggression in phantasy as a defence. As a result, Lewis was only seen as a 'functional object' (p. 75). CPTs are interested in thinking about where the aggression is being placed.

Reasons for expressions of aggression

The findings of my study show that CPTs link expressions of aggression to adverse childhood experiences, developmental factors, dysregulation, and unbearable vulnerability. The literature and case examples of overt aggression in the room (Heimann & Valenstein, 1972; Rustin, 2001; Canham, 2004; Jackson, 2004; Slater, 2014) and existing research (Daldin, 1992; Fonagy, 2008; Ryan, 2011) consistently link aggression to adverse childhood experiences, such as maltreatment of children, exposure to family violence, problems in attachment to parents and maternal depression. This is consistent with the findings from the interviews. Trice (2016) confirms earlier research about a link between lack of maternal containment, innate violence, and lack of capacity for thinking. Similarly, anxiety in relation to previous violent and

traumatic experiences can be defended against by what Anna Freud called ‘identification with an aggressor’ (Freud, 1993; Alvarez, 2011; Lewis 2012) and lead to expressions of aggression.

My findings show that CPTs can relate aggression to a struggle to tolerate thinking. This struggle might be linked to limitations in the ability to mentalise as a result of adverse early experiences. This finding corresponds to Bion’s ideas about thinking (Bion, 1967) and containment (Bion, 1970). Bion (1967) links the incapacity for tolerating frustration to an evasion of frustration instead of modification, due to a bad internal absent breast. The patient’s ability to think about thoughts impacts on their ability to modify frustration and the way aggression is expressed. Furthermore, Fonagy (2008) suggests that trauma and maltreatment may impact on the development of cerebral structures, which are crucial to mentalization.

I wonder if CPTs can experience some extreme expressions of aggression as blizzards of beta-elements in the room and aim to transform them into alpha elements and alpha-function. Bion (1984) describes that beta-elements are suited for use in projective identification and can produce acting out. He explains that alpha-elements are available for thought as they have been processed through alpha-function. Perelberg (1999) illustrates the relevance of Bion’s concepts for the understanding of violence. However, my findings from the interviews and literature review have identified surprisingly little evidence for the use of Bion’s ideas for the understanding of aggression in CP (e.g., Jackson, 2004).

In CP, the patient's aggression enters the dynamic relationship with the CPT, which is an important part of therapy. The existing literature (Horne, 2001; Rustin, 2001; Canham, 2004; Jackson, 2004) and findings from the interviews consistently suggest that expressions of aggression in the room are widely understood as a form of communication, which can be received by CPTs through their countertransference or projective identification. This profound experience can give CPTs a picture of their patient's internal world and early experiences.

Participants and the literature often link the patient's struggle to regulate affect and fear of loss of the object to aggression in the room (Daldin, 1992; Lewis, 2012; Slater 2014; Trice 2016). CPTs reported that aggression can increase before and after therapy breaks (Jackson, 2004; Lewis, 2012; Trice, 2016), which is linked to fear of loss and separation. Daldin's (1992) findings suggest that aggressive children can struggle with fear of abandonment and separation anxiety or have a sadomasochistic way of relating which is then re-enacted in relationship with their CPT. Both forms of aggression have links to Freud's ideas about aggression linked to the life and death instinct, and love and hate (Strachey, 1955).

Affective aggression is related to a fight/ flight response in face of a threat (e.g., fear of loss of the object, inability to regulate affect). Emanuel (2004) writes about a provocative patient with a history of abuse and likens his emotional behaviour to an innervated musculoskeletal system as part of the autonomic nervous system and flight/ fight system.

Predatory aggression aims to destroy any form of love and life. It can also aim to control the object to ensure that the object stays without getting too close. This idea is part of the core complex (Glasser, 1986). Participants and the literature often referred to the core complex in their attempt to conceptualise predatory aggression and perverse ways of relating.

As mentioned in my literature review, aggression is discussed as part of the nature versus nurture debate (e.g., Brafman, 2008). Interestingly, my findings show a high emphasis on the nurture aspect and early childhood experiences. Ridley (1993) sees ‘nature via nurture’ as a more helpful way of understanding human nature. My findings show that expressions of aggression are generally not discussed in relation to certain neuro-developmental conditions and clinical diagnoses, such as Autism Spectrum Disorder (ASD), Attention Deficit Hyperactivity Disorder (ADHD), Oppositional Defiant Disorder (ODD) or Pathological Demand Avoidance (PDA), which can be the case within CAMHS. Only one participant suggested a link between ASD and aggression.

Some participants have expressed that silence and withholding can be experienced as one of the most powerful expressions of aggression and can be understood as a need to control the therapeutic space or an attempt control affect. One participant expressed that non-attendance can feel like an attack. Surprisingly little has been written about this aspect of clinical practice in relation to aggression. Hostility and complaint are forms of covert aggression and can be part of the work with patients and parents. The participants talked about their patient’s sense of entitlement, demand to capitulate and reluctance

to think about meaning, which reflects Weintrobe's (2004) conceptualisation of links between different forms of entitlement, grievance, and complaint. Weintrobe suggests that grievances aim to punish the object which is held responsible for a failure of idealisation. She explains that by holding on to a grievance, it is possible to restore the ideal object in phantasy, which blocks mourning and denies any awareness of dependence on others. This seems particularly important in the work with hostile parents and adolescents.

Aggression as a positive aspect

My findings show that CPTs can understand non-violent expressions of aggression as a positive aspect of therapy and a creative process. Some participants and authors describe aggression as a useful therapeutic process. For example, the patient's anger about therapy breaks can show love and gratitude towards the therapeutic space. There are links to Winnicott's (1956) ideas about antisocial acts (e.g., violence) as a sign of hope as they show object-seeking.

In the literature, aggression has been described as an instinctual drive which is always present (Strachey, 1956; Perelberg, 1999). Heiman and Valenstein (1972) describe aggression not as an action in itself, but as a way of doing things. Furthermore, Freud discussed the link between the sublimation of aggressive impulses and great achievements (Strachey, 1961). It is important to pay close attention to where the aggressive force is being directed to, similarly, to paying close attention to the positive or negative transference and countertransference. This seems in line with Laplanche and Pontalis (1988)

who state that any kind of behaviour has an aggressive function. The development of a better understanding of the function is an important aspect in CP. As part of a process, I noticed that I have shifted from writing about aggression (e.g., aggressive patient) to writing about expressions of aggression. This shift seems important and emphasises the significance of the focus on how aggression is being expressed in more specific ways.

A shift from overt aggression to symbolic play or an ability to verbalise feelings is generally seen as signs of progress. Play can also have a destructive function and might have the aim to denigrate or control the CPT. Participants described the patient's ability to play out themes of aggression, instead of violently act them out, as a positive shift and development.

5.2 Feelings aggression can evoke in CPTs

My findings show some key features that impact on the CPT's experience, which are linked to a sense of isolation and threat to safety. The CPT's experience is subjective and not necessarily directly linked to the aggressive act itself. Expressions of aggression must be seen as part of a relational dynamic. The quality of the patient's disturbance and the CPT's relationship to aggression shapes the experience of aggression in the room.

The participants powerfully brought across the profound impact expressions of aggression can have on them. They reported feeling, physically hurt, scared, unsafe, and angry. They also reported feelings of rage, hate, helplessness, dread, shock, shame, disgust, and humiliation. Daldin (1992) identifies

increased anger, anxiety, guilt, and fear of retaliation and gratification as possible feelings in the CPT evoked by expressions of aggression. Similar feelings have been noticed in aggressive patients (e.g., Alvarez, 1999). The emergence of those feelings in the CPT can be linked to the patient's projections. Participants reported a sense of feeling pushed to their limits and that the CPT's own relationship to aggression can also impact on their experience. Ryan (2011) illustrates how the hostile dynamic in the room can evoke a sense of being pushed to the limits. Aggression can evoke similar feelings and responses in patients and CPTs. This corresponds with Canham's (2004) idea in relation to a sense of confusion about what belongs where and to whom.

As part of the interviews, the participants brought across how CPTs can feel shame and humiliation in response to expressions of aggression. This seems linked to feeling overwhelmed, pushed, unable to respond, a sense of not being able to deal with a young child, and dynamics with other clinicians. Similar feelings and dynamics are discussed in the literature (Alvarez, 1999; Rustin, 2001). This is in line with Laplanche and Pontalis's (1988) description of humiliation of another person as one of the functions of aggression.

The participants talked about the significance of the CPT's experience of training analysis in the work with extremely challenging patients and their fear of retaliation and enactment. Fear of retaliation (Winnicott, 1947; Daldin, 1992; Axelman, 2006; Ryan, 2011) and fear of enactment (Rustin, 2001; Canham,

2004; Slater, 2014) are discussed in the literature as a possible dynamic in the room.

The participants voiced that it is important for CPTs to be able to feel their patient's projections on behalf of them, process them, think about their meaning, and return something processed to the patient with the aim to support development. There are links to Bion's concept of container/ contained. Bion (1962) describes an aspect of the infant – mother relationship, in which the mother receives projections from a distressed infant, processes the distress on the infant's behalf and re-introjects something more tolerable for the infant. According to Bion, if the mother cannot facilitate reverie, the infant can only evacuate beta-elements and does not learn to self-regulate. The processes of container/ contained and reverie are also relevant for the relationship between patients and CPTs.

My findings show that the impact of covert aggression on CPTs can be significant. However, it generally seems more accepted as it does not impinge on the patient's or CPT's physical safety. One participant talked about silence and non-participation as one of the most powerful forms of aggression, which can be experienced as a violent and castrating act.

External factors impact on the CPT's experience of aggression and ability to work with it. Participants reported that regular CP supervision, having colleagues to talk to and support from the whole clinic impact on the CPT's ability to contain high levels of acting out. This external support is essential in

helping CPTs deal with potentially dangerous and emotionally challenging situations. The participants and literature showed that these situations can be experienced as frightening, scary, paralysing, and overwhelming, especially if the aggression has a sadistic, cruel, or unsafe quality (e.g., Rustin, 2001; Canham, 2004; Trice, 2016). Interestingly, the participants used war-like language (e.g., armouring up for battle), which shows that missiles can be thrown both ways. This dynamic impacts on the therapeutic relationship and the ways CPTs respond to expressions of aggression, which will be discussed next.

5.3 Responses aggression can evoke in CPTs

My findings show a link between the feelings evoked by the patient's expression of aggression and the way CPTs can respond, which can have a defensive quality. Participants reported avoidance, denial, retaliation, and enactment as possible responses in relation to expressions of aggressions. The CPT's relationship to aggression and own experiences can also impact on the ways they respond. An awareness of these possible dynamics and the willingness to reflect on the feelings evoked by expressions of aggression aims to prevent an unconscious acting out of unhelpful responses.

Avoidance and denial

My findings from the interviews show that CPTs can respond to an aggressive dynamic in the room with avoidance or denial. In these moments, participants reported that they can avoid challenging the expression of aggression, become placatory, and feel like treading on eggshells. This can lead to the CPT trying to avoid violence by anxiously giving patients what they want. As a result, a

dynamic similar to domestic violence can develop. CPTs can take on a victim position and deny feelings evoked by this dynamic. This might have some links to the idea that psychotherapists can dissociate or deny their patient' potential for aggression or violence as an attempt to maintain the therapeutic relationship (Grand et al., 2009). One participant voiced that CPTs can pretend that being hurt is their job as part of this dynamic. Some participants expressed that they could see violent patients as a victim or preparator and that they struggled to see both parts in one patient. Similarly, Music (2016) observed that professionals can avoid their patient's disturbance by seeing them as 'angels'. At other times, professionals can see their patients as 'evil incarnates' (Music, 2016), which can lead to other avoidant responses. The participants voiced that it is important to work with both parts, as perpetrators usually also have been victims of violence. One participant talked about denial in relation to her wish to look away and difficulty to keep her mind in the room. This unconscious pull towards 'turning a blind eye' has been discussed by Emmanuel (2012). A similar dynamic was noticed by Alvarez (2012, p. 100) when she concludes that "it is necessary to look evil straight in the eye" instead of denying or colluding with the aggression.

According to the participants, CPTs can avoid aggression by escalating things quickly to avoid being in a room with the patient. This can be played out in form of ending a session quickly and could show a struggle to hold on to positive aspects of the patient and the relationship. Canham (2004) discussed ending a session prematurely as an avoidant response to expressions of aggression.

Participants brought across that it can be difficult for CPTs to judge when to tolerate expressions of aggression for a potentially good outcome and when the dynamic in the room is not therapeutic for the patient. They voiced that it can be difficult to find the appropriate balance between tolerating some expressions of aggression and clear boundary setting. The participants and literature (e.g., Rustin, 2001; Canham, 2004) strongly suggested that regular support and supervision are essential in the work with these patients with the aim to improve complicated relationships (e.g., sadomasochistic relationship) and dynamics.

Enactment and retaliation

The participants powerfully brought across that CPTs can be pulled into certain dynamics in response to expressions of aggression. They discussed that CPTs can retaliate in phantasy or by using hurtful interpretations. Everyone has the capacity to retaliate. An awareness of this dynamic and regular supervision is necessary for the therapeutic work and prevent acting on retaliatory impulses and enactment.

One participant talked about their disturbing murderous phantasies in relation to a patient (see p. 82). In this case, the experienced CPT felt confident in reflecting on this disturbing dynamic, instead of unconsciously act on it (e.g., use of hurtful interpretations). Midgley et al. (2015) suggest that expressions of anger and rage can be considered as “irritability” (p. 277), which is a diagnostic criterion used in psychiatric discourse, where a psychotherapist recognises rage. In this way, the participant’s powerful words could do justice to the rage felt and communicated in projective identification. This short vignette from the

interview might fulfil the notion of what Eatough and Smith (2017, p. 201) identify as a “gem” in IPA analysis.

The dynamic of retaliation has been discussed in the literature. Winnicott (1947) reflects on his own murderous feelings towards a patient and the importance of the analyst’s awareness of their own relationship to aggression. This is particularly important for the work with children with a sadomasochistic and predatory way of relating. Daldin (1992) found that these children attempted to provoke the analyst as a desire to be punished and to gain instinctual pleasure. The participants brought across that it can be challenging to work out when ending a session prematurely is a helpful process or punitive retaliatory response. The threat of ending a session can be seen as a weapon. Interestingly, the participants used confrontational language (e.g., violent tussle, weapon, slap in the face), which provides further examples of how expressions of aggression can push CPTs into retaliation and enactment. My findings suggest that fear of separation can lead to expressions of aggression (e.g., Daldin, 1992; Salter, 2014; Music, 2016). In this way, a CPT’s attempt to end a session prematurely can be seen as a form of enactment, as part of projective identification. The concept of projective identification is widely used in clinical papers for the understanding of feelings and responses evoked by expressions of aggression (e.g., Meltzer, 1998; Canham, 2004; Jackson, 2004).

One participant talked about the instinctual aspect of retaliation and urge to retaliate in response to being spat in the face. Becoming punitive and the use of hurtful interpretations can be forms of retaliation, which can feel to the patient

feel like a slap in the face. According to Daldin (1992), ill-timed interpretations can increase violence in response to the patient feeling attacked. The findings of my study go further and suggest that certain verbal interpretations can be a retaliatory attack by the CPT and not just feel like one.

A power struggle was described as another form of enactment by the participants. They brought across that it is important to tolerate own and their patient's strong feelings without retaliating or being pulled towards enactment. Ryan (2011) writes about how she learned to tolerate her patient's violent behaviours without retaliating. CPTs need to be able to get alongside the patient and work with aggression in a safe, clear, non-defensive, non-punitive, and non-retaliatory way. Alvarez (2012) points out that aggression must be worked with in instead of denied, condemned, or colluded with.

The CPT's relationship to aggression

The participants brought across that the CPT's own experiences can impact on the dynamic in the room and present a significant factor in the work with expressions of aggression. For example, participants believed that levels of professional experience mattered. More experience is linked to a better ability to set clear boundaries and provide containment. My findings corroborate the significance of the CPT's own relationship to aggression, which impacts on the CPT's experience, containment of patients, understanding, and way of responding. This essential aspect is generally neglected in the literature.

Training analysis is a fundamental part of the CP training and provides the opportunity to analyse one's relationship to aggression. One participant talked about his belief that CPTs need to have their relationship to aggression successfully analysed as part of training analysis with links to clinical supervision. The training requirement of training analysis is a unique aspect of the clinical training in CP, which separates them from professionals from other disciplines. Winnicott (1947) points out that CPTs can only treat highly disturbed patients if they have analysed their own hate. An important part of the clinical training is to experience, process, and understand the impact aggressive projections can have on CPTs. I wonder if this is one of the reasons why a high number of case examples are related to training cases (e.g., Daldin, 1992). One participant talked about a paradoxical situation in relation to her experience of aggression in the room. She experienced significant overt aggression during her clinical training, but not in her work as a qualified CPT at a specialist setting with a high prevalence of violent children. The participants brought across that trainees need to hold on to their training patients and that this increases the likelihood of difficult dynamics (e.g., dynamic similar to domestic violence). There seems to be some understanding that training analysis and the experience of the clinical training enables CPTs to effectively work with expressions with aggression. One participant voiced that CPTs can have a complicated relationship to aggression. Participants pointed out that some CPTs might have experienced violence and suggest that this will make it more difficult for them to treat violent patients. This important aspect of clinical practice is neglected in the literature as it is personal and difficult to disclose.

Interestingly, two participants talked about feeling drawn to working with violent patients. They brought across a sense that their own interest, wish to understand, and resilience impacts on their ability to work with these patients effectively. I can relate to this perspective, which is reflected in my interest in this research topic, professional background, and clinical work. Resilience and a real wish to understand is important for the work with expressions of aggression, especially more extreme manifestations of overt aggression.

Something must be said about the experience of talking to the individual participants about their experience of aggression, which felt intimate and personal. Some of the participants reported an initial reluctance to talk about their experience of aggression. It mattered that I belonged to the same profession which seemed linked to a sense of insulation and fear of isolation. It generally seems to feel safer to talk to someone from the CP discipline. I suggest that this dynamic is linked to a fear of being criticised by someone from a different discipline, which could then impact on the continuation of the therapeutic relationship with patients. I have noticed laughter during descriptions of extreme violence. Even though it might feel safer to talk to someone from the CP discipline, the laughter could be a sign of embarrassment, shame, and caution. I have noticed that I was concerned about what I might hear from the participants and if I would be able to write about it as part of my study. This concern seemed related to retaliatory and physical responses to extreme aggression.

5.4 Implications of this study for CP

My study is the first of its kind to explore the CPT's lived experience of aggression in the room and has significant implications for the CP discipline and wider CAMHS settings. This phenomenological study of the experience and understanding of aggression provides original qualitative data, which is relevant for clinical practice, training considerations, and further research. It provides a coherent and comprehensive exploration of the work with expressions of aggression, which could contribute to a framework for this important aspect of clinical practice.

One of my key findings suggests that aggression is a core aspect in CP and present in the work with all patients. Aggression is not an action, but it can be defended against or expressed in appropriate or inappropriate ways. A better understanding of the ways aggressive impulses are defended against or expressed provides important insight into the patient's internal world and object relations. My study shows the complexities of experiencing the different expressions of aggression and possible disturbing responses, which can help CPTs to be aware and more open of possible dynamics as part of the therapeutic relationship. A better understanding of the relational aspect of aggression and appropriate support impacts on the experience of aggression and can prevent feeling victimised by patients.

My study shows how certain expressions of aggression in the context of CP treatment can threaten safety and this has significant implications for CP. Both, patients and CPTs, must be supported to be safe. It is important to withstand

aggression to show patients that it can be survived, worked with, and contained. However, if the predatory and overt forms of aggression are persistent, it can be difficult for those children to be treated within a generic CAMHS clinic, because of the impact they can have on CPTs, patients, and clinics. These children might need the support of specialist clinics that are geared up to treat the patient's disturbing way of relating in a containing and coherent way. CPT should have an active role in this process.

In their search for understanding and meaning of aspects related to aggression, CPTs can make use of their countertransference, observational skills, play and verbal interpretations. Paying close attention to the CPT's experience, countertransference and responses is a crucial part in the work with patients. This important aspect of clinical practice helps CPTs understand the meaning of the patient's communication and aims to promote more benign and helpful ways of relating.

The strong feelings and responses identified as part of this study highlight the importance of supervision and the support of the clinic. This has a containing impact on CPTs and patients, supports safety and can prevent burn-out. Trainees can feel unsure about their role and often feel the need to hold on to training cases. This can create a dynamic similar to domestic violence and has significant implication for the CP training. A thorough reflection on the dynamic within supervision and the wider service and a better understanding of the work with expressions of aggression are essential to shift this dynamic. I suggest that more guidance, an increased awareness of possible defensive responses (e.g.,

retaliation, enactment), an ability to conceptualise different reasons for expressions of aggression, and reflection on the CPT's own relationship to aggression can support trainees and CPTs to work more effectively and safely with expressions of aggression. My findings show that CPTs need to be supported to openly reflect on the impact of the work with highly disturbed and aggressive patients in regular supervision, which might include the reflection on retaliatory phantasies and placatory responses. Rustin (2001) writes about the need for support from the wider service, which can impact directly on the outcome of the work.

The training analysis and CP approach are unique assets for the work with aggressive patients as part of multi-disciplinary teams. CPTs are in a good position to work effectively with some of the most challenging patients, if appropriate support is in place. My study could contribute towards the development of a coherent framework for the work with expressions of aggression, which could increase awareness and prevent expressions of defensive, avoidant, or retaliatory responses in the CPT.

There was consensus between the participants in their belief that CPTs experience and understand aggression differently to other professionals within a multi-disciplinary team. CPTs feel that they are more open to work with expressions of aggression than clinicians from other disciplines. When well supported, they have the skills to actively work with expressions of aggression instead of just trying to stop it. This way of approaching aggression and violence seemed widely accepted by the participants and is discussed as part of case

examples (Rustin, 2001; Canham, 2004; Jackson, 2004; Ryan, 2011; Slater, 2014). One participant voiced that CPTs can be seen as “the violent ones”. This suggests that CPTs are known to work with the relational aspects of aggression and talk about it in a way that suggests that CPTs can express aggression, as well as their patients. More transparency, professional self-esteem, and training for CAMHS clinicians could create a sense of insulation as part of a multi-disciplinary team and ensures that patients can benefit from treatment.

My study also points out positive and creative aspects of aggression, and intuitive playful responses (e.g., sounds related to the feeling), which can support CPTs to be curious and interested in all aspects of clinical practice related to aggression. Different ways of working with aggression could be explored through further research.

I mentioned in the introduction that I have worked in a therapeutic community with high levels of acting out and suggested that this will have an impact on how I understand the data and findings of my study. I have experienced the destruction aggressive impulses can cause and had mainly associated aggression with violence and destruction. It was difficult to bracket this experience and keep an open mind for the significance of positive and less extreme forms of aggression. On reflection, I wonder if my selection of this research topic had links to some unanswered questions from my previous role. Perhaps in this way, I carried over my hopes that CP as a new discipline could address my unanswered questions more meaningfully. Before training as a CPT, I had some ideas about transference, countertransference, and

projections and this was helpful for the work. However, a deeper understanding of my relationship to aggression, clinical experience, and psychoanalytic theory significantly impacted on my understanding of aggression and my own responses. I believe that this has a containing effect on my patients, their networks and me as a CPT.

5.5 Limitations and validity of this study

Inevitably, there are limitations to my study and IPA research. This study looks out on the world through a particular ontological (psychoanalytic) and personal lens. Thus, it might have been helpful to work on the analysis in a team. Working together as part of a small team would have highlighted differences in interpretation between team members and facilitated thought-provoking discussions about meaning. Like two of the participants, I have always felt drawn to the work with violent children, and I might have felt drawn to the perspective of both participants. In some form, I will have carried over my own "object relations" thinking and previous experiences into the analysis, despite good efforts to achieve epoché. It is possible that a researcher with a different professional and theoretical background may have interpreted the data differently.

Tuffour (2017) describes IPA as a subjective research approach and suggests four main criticisms of IPA: unsatisfactory recognition of to the role of language; the possibility that opinions are captured instead of an accurate experience and meaning of experiences; problematic focus on perceptions without the

explanation why experiences occur; and the IPA's concern with cognition, which is not compatible with some aspects of phenomenology.

Throughout this study, I have attempted to address the limitations of IPA research. The language and metaphors (linguistic comments) used during the interviews were considered and analysed as part of the data analysis. CPTs are interested in language, experiences, and meaning. It is common practice to reflect on and articulate the lived experience of clinical practice. An awareness of this limitations helped me feel more vigilant during the interview process. Some participants might have chosen not to reflect on certain aspects of their experience, due to the sensitive and personal nature of the data. I am part of the CP discipline and have critically thought about how the findings will be received by CPTs and wider readership. This might have had some impact on the data collection and analysis, as I might have avoided certain aspects. Due to time and word count limitations, I was not able to discuss every aspect of the data in detail. As part of the sense-making process, I had to make decisions on what to leave out and what to reflect on.

My study is not only concerned with the experience and perception of aggression. I also explored why aggression may occur in the room. According to Smith, Flowers, and Larkin (2009), the hermeneutic, idiographic, and conceptual aspect of IPA supports a wider understanding of cultural positions in relation to the experiences. They point out that the IPA's focus on sense-making and meaning-making resonates with cognition.

Smith, Flowers, and Larkin (2009) suggest the use of Yardley's (2000) broad principles for the assessment of qualitative studies: Sensitivity to context; commitment and rigour; transparency and coherence, and impact and importance. I will only discuss the first three principles as impact and importance have already been discussed.

Sensitivity to context

Yardley (2000) suggests that sensitivity can be achieved through the awareness of the existing literature and sensitivity towards the data (e.g., verbatim extracts). Sensitivity has been established throughout the study through the literature review and the engagement with the particular and idiographic. Verbatim extracts from the interviews sensitively underpin the wider context of the lived experience and give individual participants a voice.

Commitment and rigour

Yardley (2000) describes that commitment can be demonstrated through the degree of attentiveness during data collection, care during the data analysis of each case and considerable personal investment. She describes rigour as the toughness of the study (e.g., appropriate sampling, quality of interview, completeness of analysis). I have tried to achieve commitment by paying close attention to what the participants are saying. As a doctoral student, I have immersed myself in the data and used supervision and additional literature to further develop my knowledge. The participants have been selected carefully and are CPTs in a specific setting. My data analysis aims to tell the reader

important aspects about the individual participants, whilst referring to important links to the themes they share.

Transparency and coherence

Transparency and coherence can be achieved in the write-up of the study, which includes a clear description of the research process and coherent argument (Yardley, 2000). I have described how the participants were selected and explained the interview process and the different parts of the data analysis. My study aims to coherently reflects on the significance of the CPT's lived experience in relation to aggression and demonstrates my attempt in trying to make sense of the participants trying to make sense of their experiences.

It is important to recognise that I have worked with highly aggressive children in a specialist setting for many years before training as a CPT and continued to have an interest in the topic for a large part of the CP training. This means that my own experiences, biases, assumptions might have impacted on the interview process and my interpretation of the data. However, the double hermeneutic element in IPA research (Smith, Flowers & Larkin, 2009) offered a helpful framework in my attempt make sense of the participant trying to make sense. All participants had an interest in the topic and volunteered to be interviewed. This will have impacted on my findings. CPTs with a different perspective might not have volunteered to be interviewed. There are some theoretical limitations. For most of the work on this study, I was part of the Tavistock training school as a trainee and have interviewed fellow trainees and CPTs working at the Tavistock. Potential different perspectives from CPTs

belonging to other NHS Trusts or training schools were not captured. Some of the limitations could be addressed through further research.

5.6 Recommendations for further research

I have identified some recommendations for further research. Midgley et al. (2009) suggest that there has been a marked tension between CP and research and describes the development of doctoral CP programmes as an important shift for the assessment of outcomes. My study is original, and no similar studies were identified through the systematic literature search. Almost all studies with links to aggression in the room are single case studies and often linked to training cases. The outcomes are generally positive. This suggests that the experience of working with children that cannot be worked with and contained within CAMHS is not captured in studies. As part of the literature search, I have searched the Tavistock catalogue for relevant doctoral research. Relevant doctoral CP research conducted at other national or international training schools could not be found through this search. A larger project could address these limitations of my study and investigate whether doctoral research has been conducted by other training schools in the United Kingdom and other countries. The experience of a larger group of CPTs working for different NHS Foundations Trusts could be explored through a larger project with a different methodology.

My findings suggest that CPTs approach and understand aggression differently to clinicians from other disciplines. A larger-scale study could investigate how members of a multi-disciplinary CAMHS team experience and understand

aggression could make sense of this difference with the aim to provide a more containing, therapeutic, understanding, and effective service. This could increase a sense of insultation and promotes learning from other disciplines.

I feel that the impact of covert forms of aggression has been slightly neglected as part of my study, due to the more evocative nature of overt aggression. A study could focus on the experience and understanding of covert aggression, as a better understanding of covert aggression can prevent overt forms of aggression.

My study does not aim to explore gender differences and differences in experience. A study could investigate if there are different forms of aggression expressed within a certain population or demographic (e.g., gender, race, levels of experience) and if they are experienced differently. My study focuses on CPTs' experiences and meanings and does not explore what to do with those observations in the room. Lemma (2016) and Fonagy (1999) explore a complicated link between experience, theory, and practice in psychoanalysis. Both authors describe that it is not possible to neatly translate theory into practice. In this way, I was not trying to force links between 'if you observe or feel this, then you should try that', as there is no direct concordance. More specific aspects of clinical practice (e.g., ways of working with aggression) could be explored by further research. The different data collection process as part of GT methodology (McLeod, 2011) would be suited to investigate specific aspects of aggression and further develop our understanding.

Chapter 6: Conclusions

My study aimed to investigate the CPT's experience and understanding of aggression in the consulting room. It is the first study of its kind in exploring the CPT's lived experience of aggression. I believe that IPA methodology was the most appropriate methodology for the analysis of the rich data which was collected through semi-structured interviews. My findings highlight the complexities of working with expressions of aggression within the therapeutic relationship. Aggression in the room is mainly associated with physical violence and direct hostility. Other forms of less direct aggression without a threat to safety have been expressed as a second thought. Aggression is a significant aspect in the therapeutic work with patients. My aim was to investigate the CPT's lived experience and I believe that this has been thoroughly addressed by the methodology and findings of this study.

Expressions of aggression in the room can be experienced in numerous ways and are an important part of CP treatment. While working with some of the most challenging patients, CPTs must be aware of their own relationship to aggression to be able to treat those children. An in-depth understanding of psychoanalytic theories, experience of training analysis and focus on meaning separate CPTs from clinicians from other disciplines and can provide containment and treatment for some of the most challenging patients.

Aggression can be present in phantasy, played out, talked about, but should not continuously be violently acted out. This statement relates to patients and CPTs. The findings of my study suggest that CPT can express aggression in form of enactment and retaliation as part of projective identification. This way of thinking might help CPTs to offer treatment in ways that support containment and transformation and prevents acting out of defensive, avoidant, or retaliatory responses. Transformed aggression is a result of challenging work, which helps patients internalise more benign and helpful ways of relating.

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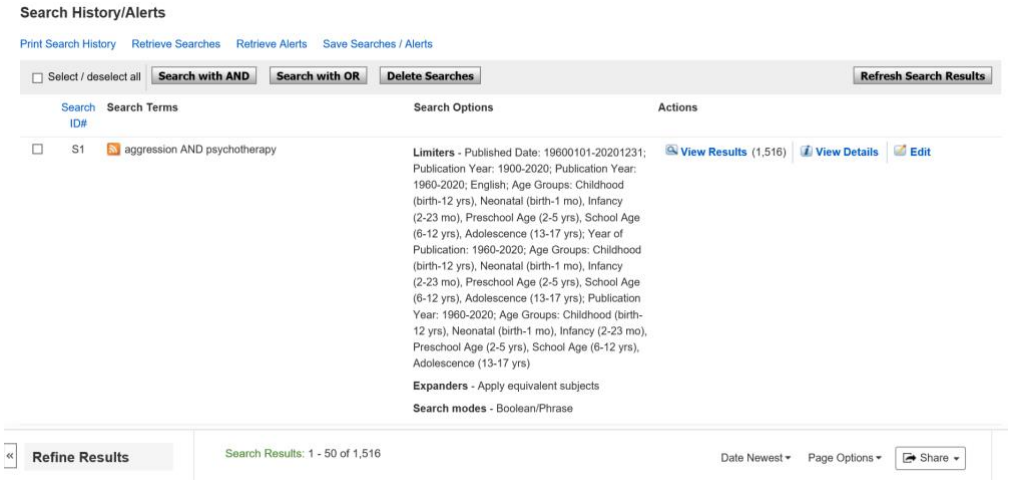
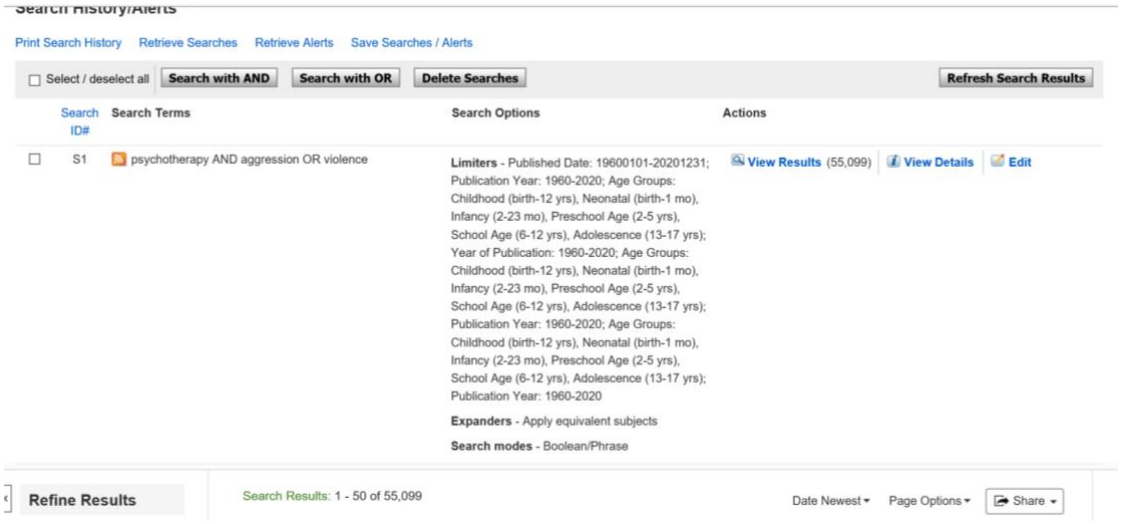
Appendices

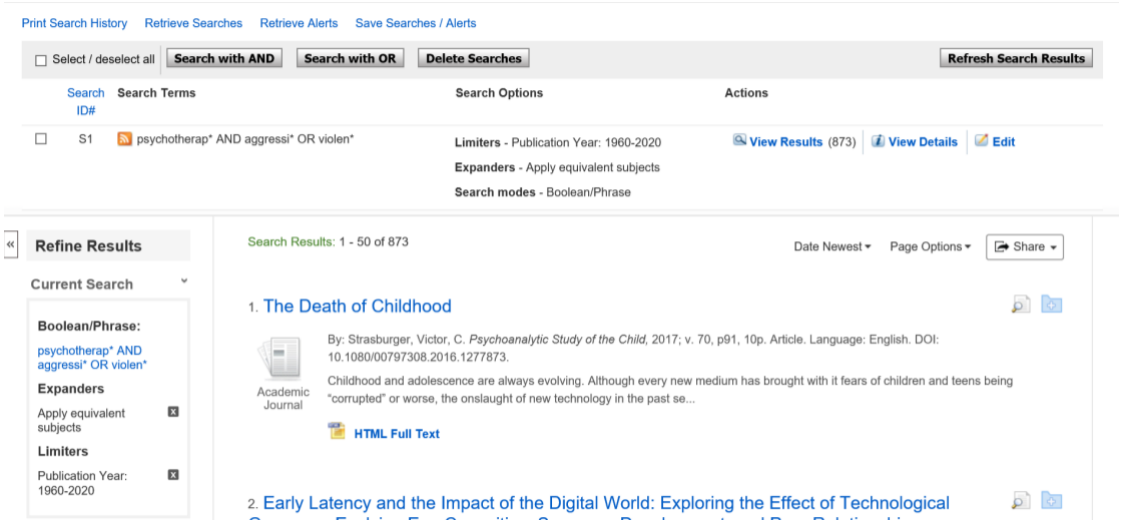
Appendix A: Literature Search 1



Appendix B: Literature search including the keyword “violence”



Appendix C: Literature Search 2



Appendix D: Participant Information Sheet

The Tavistock and Portman NHS Foundation Trust

Research Project

"The experience and understanding of aggression in the consulting room"

Are you a qualified Child and Adolescent Psychoanalytic Psychotherapist or Child and Adolescent Psychoanalytic Psychotherapist in Training?

Would you like to take part in a research project about the experience and understanding of aggression in the consulting room?

You have been given this information sheet because you are being invited to take part in a research project. This information describes the research project and explains what will be involved if you decide to take part.

What is the purpose of this research project?

Aggression is an important and often used concept in psychoanalytic thinking. In this research project I want to explore how Child and Adolescent Psychoanalytic Psychotherapists experience and understand aggression in their clinical work with patients. I would also like to explore if 'having a theory' insulate or isolate us as practitioners in these situations. Surprisingly, no research has been carried out on the research subject. A better understanding on the research subject will

be an important contribution to our discipline. The research has been approved by the Tavistock and Portman NHS Trust Research Ethics Committee (TREC).

Who is conducting the research project?

My name is Oliver Klott and I am a Child and Adolescent Psychoanalytic Psychotherapist in Doctoral Training at the Tavistock and Portman NHS Trust/ University of Essex with a clinical post at the Oxford Health NHS Foundation Trust. I am in the 4th year of my clinical training. Please contact Simon Carrington, Head of Academic Governance and Quality Assurance (academicquality@tavi-port.nhs.uk) should you have any concerns about the conduct of the researcher or any other aspect of this research project. It is possible to withdraw from the study at any time before the process of data analysis, without giving a reason.

What will participating in this research project involve?

If you agree to participate in this research project, you will be invited to take part in a semi-structured interview. I will ask questions about how you have encountered and experienced aggression in the consulting room. The interview will take place at a time and place convenient to you. It will last up to 90 minutes. With your permission, it will be recorded and transcribed. This is helpful for me as it means that I do not have to take notes during the interview.

What will happen with the information I give?

Any information I have about you and everything you say in the interview will be kept confidential. The sample size is relatively small, and this might have implications on confidentiality and anonymity. Child Psychotherapy is a relatively

small field and it might be possible to relate some of the content of the interview to you by an attentive reader of a potential publication. A transcript of your interview will be produced by me. Any details that could be used to identify you will be removed from the transcript. Any extracts from what you that are quoted in written work will be entirely anonymous. The data generated in the course of the research will be retained in accordance with the University's Data Protection Policy.

Oliver Klott

o.klott@gmail.com

Appendix E: Consent form

Consent Form

Research Project Title: "Aggression in the consulting room"

- I confirm that I have read and understand the information sheet provided for this study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
- I understand that my participation in this study is voluntary and that I am free to withdraw from the study within the next 4 weeks, without giving a reason. ☐
- I understand that the interview will be digitally recorded and then transcribed. ☐
- I understand that information given in this interview may be used by the researcher in future publications, reports or presentations. ☐
- I understand that any personal data that could be used to identify me will be removed from the transcript of my interview and that I will not be identified in any publications, reports or presentations. ☐
- I understand that there are some limitations in the levels of anonymity because of the small sample size of this research project. ☐

Participant's Name (Printed): _____

Participant's signature: _____ Date: _____

Researcher's signature: _____ Date: _____

Thank you for agreeing to take part in this study.

Your contribution is very much appreciated.

Appendix F: Example of transcribed interview with my notes

Ways aggression can be experienced: Aggression can be experienced differently within different age groups	different age groups. But, I suppose aggression comes across as sort of, in all sorts of ways, this is the full spectrum of something, you know, I was thinking last week, I had a adolescent girl that I see, one of the established ones. She spent the first 30 minutes pretty much in silence, just sort of saying nothing is on her mind. It felt kind of aggressive in a very sort of passive aggressive way. And that ranges from being spat at, hit, you know and all the that, you know, what goes with the work with under fives and punched and kicked as well. So it's in a sense I think it's sort of in all of our, it's in all of the work we do. It's in every session quite often. Aggression is on my mind quite a bit and that's probably why I wanted to take part in your study (incomprehensible) workshop as in (incomprehensible) ask the question 'Where is the aggression?, Where is that being placed?'. And so pretty much constantly thinking about that.	Can be experienced differently in the different age groups	Aggression comes across in all sorts of ways, 'full spectrum'. Will talk more about this later.	Experience of aggression is linked to age of patient.
Ways aggression can be expressed in the CR: Silence as a form of passive aggression		Silence as a form of aggression with links to adolescents. Patient says that nothing is on her mind. This felt aggressive.		Passive aggression
Ways aggression can be expressed in the CR: Being spat at, hit, punched and kicked		Being spat at, kicked, punched and hit.	'What goes with' the work with under-fives: Normal? Happens all the time in this age group. Why?	Physical aggression with under fives
Aggression as a core business in CP: Aggression can be found in every session		It's in all the work we do and can be found in every session. Quite significant.		
Ways of working with aggression: Thinking about where the aggression is being placed		Where is the aggression and where is it being placed? Constantly thinking about it.		

	Me: So quite a variety in how aggression can show in your work, not talking, physical stuff, spitting…			
Ways aggression can be expressed: Non-attendance as a form of passive aggression	S: I mean Aggression is being seen as passive as well, by people not attending a session. It feels very aggressive in a sense. It doesn't actually have to be in the room to feel like something is being attack.	People not attending is passive aggression.		Passive aggression. Does passive aggression exist? Withholding or rejecting aggression?
Ways aggression can be experienced: Non-attendance can feel like an attack	Me: Have you got an example of somebody not coming and where it feels quite aggressive?	Can feel like an attack. CPT might end up sitting in the cr on his own.		
Ways aggression can be understood: Aggression linked to therapy breaks	S: Yeah. My adolescent intensive, coming back from a break, from the Christmas break. There was a lot of missing sessions and then saying she, she then attended one, which was a psychiatric review as well and it felt like saying 'I go to the psychiatrist but I won't come to you', it felt quite attacking. She missed some more and then, it's an attack on the therapy. So that's quite frustrating.	Patient struggled to return from break. Felt like an attack on the therapy.		Aggression linked to intensive case/ training case. Aggression following a break.
Feelings aggression can evoke in the CPT: Non-attendance can feel like an attack				
Feelings aggression can evoke in the CPT: Frustration				

	Me: Do you know why that is?			
Ways aggression can be understood: Aggression linked to patient's limited capacity to process emotions	S: I just think, probably, it's how I see, this boy has such limited capacity to sort of process his emotions himself and he, you know, that it just gets an immediate, you know, something unpleasant inside him, the sort of sense that I was abandoning him and it just immediately (one word) to spit on me to feel worthless and angry with me and gave me a bit of how angry he was. I think with an adolescent, I would be quite sort of shocked as well. With physical aggression I would expect them to be able to process it a little bit more inside and to put it into words or to act it in a different way to let me know about it.	Boy had a very limited capacity to process his own emotions. E.g. in response to feeling abandoned or angry.	'Something unpleasant inside him': Has to come out. Evacuation?	Work with under fives
Ways aggression can be experienced: Aggression can be experienced differently within different age groups		Would be shocked if it would be adolescent. Would expect more capacity from an adolescent.		Importance of age
	Me: Thinking about the different forms, the kicking and the punching and the spitting. Do you think there is a difference in how you experience that? Sounds like the spitting had quite an impact on you. Do you think there is a difference?			

Appendix G: Initial super-ordinate and subthemes (codes)

Interview A - Alyssa

Interview Context	Alyssa (female) made herself available first. She is an experienced CPT. We have not met before and it took some time for us to work out how we relate to each other during this interview situation. Alyssa made several references to us having a similar understanding and theoretical background. I wonder if this was important because of the unique dynamic of the interview and my dual position as a researcher/ interviewer and trainee.
Superordinate Themes	**Subthemes/ Codes**
1. Aggression as a core concept/ experience in CP	- Massive part of the work - Relevant to every single case
2. Ways aggression can be expressed in the room	- Actual physical violence (e.g., kicking, attack to eye, use of furniture) - Aggression towards themselves (inwards) and not just outwards - Aggression can be passed on (projected in and acted out) - Silence, non-participation, and refusal - Provocation (feeling and being provoked) - Aggressive dynamic between child and CPT (tussle) - Aggression that can be worked with within a therapeutic relationship - Aggression from child towards parents - Child trying to break the rules - Child making accusations - Violence and anger towards the room - Aggression in phantasy - Aggressive parents
3. Feelings and responses aggression can evoke in the CPT	- Shame - Anger - Rage - Neutering/ sense of castration - Utterly annihilating - Feeling unprofessional and shit at job - Real fear

4. Reasons, triggers and understanding of aggression	- Violence as a cover up of shame - Form of communication - Adverse childhood experiences (e.g., deprivation, abuse, trauma) - Developmental factors/ Autism - Vulnerability - Lack of parental boundary setting - Expression of aggression on behalf of the parent - Fear/ CPT seen as potentially harmful and frightening and fear of retaliation - Internal world projected out - Separations and endings - Violence can be experienced as a desperate need for reassurance - Sense of threat and being separate) - CPT having a different view - Experiencing the CPT as intrusive - Feeling provoked - Overstimulated - Destructive quality vs need for self-regulation - Links to dynamic between girl and mother (maternal function) - Sense of injustice
5. Ways of responding/ reacting to aggression	- Attempt to minimise the risk to the child and CPT - Creating distance and ending the session or CP treatment - Enforcing boundaries/ clear message - Use of defences (e.g., use of intellect and theory) - Physical contact/ ending up in a tussle - Forgetting - Self-protection - Awareness of power differential/ self-assertion - Just tolerating it and see what happens - Use of verbal interpretations - Taking on a parental role - Stopping the violence quickly - Focusing on meaning - Working with parents and trying to help them understand that the child wants to be saved. - Helping the child understand that ‘the world’ can tolerate his level of anxiety and aggression without retaliating - Being able to experience, tolerate and think about aggression

	- Taking it to supervision/ Needing time to process and help to think about it.
6. Wider network implications	- Importance of the team and supervision - Keeping it within the CP discipline - Sameness and difference - Fear of being seen as unprofessional - Lack of multidisciplinary teamwork - Impact of the child's family
7. Things that open up a different response and promote change	- Personal analysis - Training in psychoanalytic thinking/ understanding of relevant theory - Being able to process incredible distress on behalf of the child - Regular supervision/ Ability to think psychoanalytically about aggression in patient and CPT

Interview B - Max

Interview Context	Max (male) is an experienced CPT and works in a setting with a high prevalence of children with significant aggressive presentations. The interview took place in this setting and I was able to join the CPT's professional world for the duration of the interview. This sense of me joining his world was activated when a patient of the service expressed some verbal aggression towards me in the reception area as I arrived for the interview. I have met Max in a professional development context before. There was a sense that I was talking to an expert in the subject of my study, which seemed linked to the CPT's experience and my pre-existing experience of this CPT in a professional context.
Superordinate Themes	**Subthemes/ Codes**
1. Aggression as a core business in CP	- A lot of contact with aggressive patients in different clinical settings - Trainees have very aggressive patients - Seeing aggressive patients is the 'bread and butter' of the work - All patients have problems with aggression

2. Ways aggression can be expressed in the room:	- It can be expressed appropriately and inappropriately - Patients can kick, chuck things at the CPT, try to humiliate the CPT and threatening the CPT - CPT getting hurt physically and physically threatened - Causing mess and expecting the CPT to tidy up - Perversion as a sexualised form of aggression - Cruel and manipulative behaviour
3. Ways aggressive patients can be experienced as:	- Cruel, cold, calculated, and unemotional - Unblinkingly sadistic and sadomasochistic - Patient is coming in order to hurt the CPT - CPT feeling masochistically victimised - CPT feeling beaten up - CPT feeling hypervigilant, high alert and expecting to be beaten up - CPT feeling scared or denying feeling scared - CPT feeling controlled and fearful - CPT feeling extremely frightened - CPT feeling unsafe, threatened and regressed - CPT feeling the need to placate and suck it up. - CPT wishing the patient would cancel and feeling like carrying a lamb to the slaughter - CPT feeling fearful, hateful or punitive
4. Dynamics in the work with aggressive patient	- Time and sense of development - CPT's relationship to the work with perverse, violent, and delinquent patients as a quality - Desire to help - Dynamic similar to domestic violence - Patient tapping into the CPT's sensitivities/ traumas in their search for a victim - Transference, Countertransference and Projection - The CPT's way of responding to aggression and valency - Trainees or new staff being asked to take on the most challenging patients as they would find it more difficult to discharge them - Feeling like needing to protect colleagues and their work with patients
5. Reasons and understanding of aggression	- Aggression as a feeling - Aggression as a positive aspect of human experience - Aggression as an indicator of engagement - Aggression as a defence against feeling frightened and fearful - Patient is unable to regulate - Patient feels slapped in the face by an interpretation and they react aggressively to protect themselves - Aggression to control their object as a form of distance regulation - Lack of capacity to use aggression appropriately

	- Aggression in response to past experiences of not being able to protect themselves - Sadomasochistic tendencies and search for victim - Aggression in response to domestic violence - Explosive or calculated aggression - Different categories of aggression (callous/ emotional/ psychopathic children, borderline children, and normal aggression in neurotic children)
6. Ways CPTs can respond to aggression	- Trying to placate the patient to prevent violence and pretending that being hurt is part of the job - Anxiously trying to give patients what they want to prevent violence - Treading on eggshells and don't challenge anything - Learning their triggers with the aim to not trigger them - Pretending to do therapy by the use of placatory interpretations as part of a masochistic relationship - Appeasing the patient to prevent violence - Placate the patient in response to feeling stuck in a room with a violent child - CPT taking on a victim position and avoid an authentic response - Feeling like interpreting under fire but actually fighting and slapping patients with words. - Defend against being a victim - Becoming fierce and punitive in response to feeing unsafe - Hating the patient and developing hateful phantasies - Trying to manoeuvre it by becoming placatory or feel like walking on eggshells - Pretending that everything is alright to get through a session or win time - Using the threat of ending the session as a weapon - Trying to escalate things quickly with the aim to end the session - Holding on to a patient to prevent a sense of failure - Discharge if aggression if persistent and not sustainable
7. Ways of working with aggression	- Trying not to be drawn into a sadomasochistic relationship - Provide interpretations as something patients can build from to enhance the relationship. - Bringing Analysis and supervision together - Finding a middle way between protecting and being punitive

	- Putting the idea of ending a session on the table as a form of protection and organise a system around it - Stop the session - Trying to survive it - Finding the middle way between being protective and punitive - The CPT remaining reflective and regulating own feelings and state of mind in the presence of the patient - Awareness of own body and respond slightly theatrical - Use of Humour - Convey what is going on in a nonthreatening way without feeling humiliated - Not hiding the humiliation and show that it can be tolerated - Playing in the presence of the patient to change the dynamic - The whole clinic needs to know them - Giving them the sense that the CPT/ clinic is here to see them and not that we need to get rid of them - Service geared up to work with specific forms of aggression and able to contain them. - CPT being able to talk in supervision about own hateful and violent phantasies - Find love for the patient and think about them as somebody who is hurting - Avoidance of the word 'you' as it can be experienced as aggressive - Noticing change and progress - Importance of supervision and wider team - Use of theoretical concepts (e.g., core complex)

Interview C - Natalie

Interview Context	Natalie (female) is an experienced CPT and works for a setting with a high prevalence of children with a significant aggressive presentation. The interview took place in the consulting room of the CPT, which means that I was able to enter the environment where the participant works with her aggressive patient group.
Superordinate Themes	**Subthemes/ Codes**
1. Aggression is core business in a CP setting	- Dealing with aggression all the time - Lots of examples

	- Aggression as the main focus of the work in the room - All patients are violent - Often hurt by training case - Aggression is vital material in the work - Aggression is expected and not extraordinary
2. Ways aggression can be expressed in the room	- It can be talked about - Aggressive play - Aggression towards therapy box and room - Aggressive use of objects - Aggressive body language - Aggression towards furniture - Self-harm - Hitting head against the wall - Telling lies - Silence and withholding - Cruelty - Lying - Perverse behaviour - Physical harm towards the CPT (biting) - Urinating on the floor - Patient sending aggressive letters to CPT - Constantly excluding and trying to trick the CPT
3. Feelings and responses aggression can evoke in the CPT	- Denial of the aggression - Difficulty keeping the mind in the room/ wanting to look away - Frightening and relentless - Turning into a health and safety officer - Nothing is working or helpful - Feeling controlled and helpless - Sense of hopelessness in the patient and CPT - Struggling to understand the countertransference - Sense of failure - Feeling cut off from any possibility of thinking, understanding, and connecting - Feeling drawn to the work and finding it interesting - Not feeling able to talk about it - Feeling full of anxiety and unsure about what to do next - Feeling attacked and unable to think - Becoming afraid for yourself and for the patient - Feeling furious with the patient - Experiencing the aggression as real destruction like an earthquake - Experiencing the aggression as disturbing, callous, and sadistic - Experiencing aggressive patients as ‘little shits’ who want others to suffer - Being pulled into enactment and collusion - Finding it comical and laughing about it afterwards

	- Ending sessions and treatment
4. Reason and understanding of the aggression	- Perpetrator is usually also a victim - Traumatic experiences of being hurt - Pre-verbal trauma - Aggression as a defence - Splitting - Bridging a body boundary through projection - Aggressive spoiling act following a moment of meaningful contact - Aggression as a picture of the internal world - Abuse, neglect, and corruption - Showing the CPT how afraid they are of what they are capable of - Aggression to make it their space - Finding the intimacy of being in the frightening because of earlier damaging experiences - Aggressive means as a way of coping and controlling the space - Aggression to re-connect with the CPT - Aggression in as an omnipotent cover up of frightening and helpless feelings - Not being able to communicate something effectively - Projection - Inability to process certain feelings - Vulnerability - Aggression to gain a sense of closeness and feel looked after - Inhibited unconscious state - Fear of attachment - Complicated relationship with survival - Creative process - Aggressive means as a way of developing trust - Aggression as a helpful sign for development - Patient trying to sabotage the session
5. Ways of working with aggression	- Being pro-active at the beginning - Letting the young person know that everyone knows (if referred because of their aggression) - The whole service being aware - Trying to integrate perpetrator and victim parts of young person - Helping the patient being more joined up internally, process what is going on and feel more regulated. - Trying to manage the balance between meaningful contact and the child's struggle to manage intimacy - Awareness and importance of the power differential and age - Repairing the damage that has been done - Not to be afraid of aggression - Keeping yourself safe and don't put up with it. - Knowing your body boundary

	- Interpretations vs thinking about the body (what rather than why) - Moving away from words and focus on body and sounds - Stopping a session or call in a colleague - Use of verbal language and body language - Withstand it and reflect something back - Allowing the aggression to be present in the work - Use of theory - Helping the network understand the behaviour - Being able to conceptualise the work with aggression can prevent physical aggression towards CPTs - Linking the aggression to an emotional response - Thinking outside the box - Making links that help the patient feel understood - Working out what the patient can take in - Building up a relationship and develop trust - Non-verbal therapy when aggression is linked to preverbal trauma - Getting alongside and feel the countertransference - Trying to understand the countertransference - Showing confidence - Not allowing patients to cross the body boundary through physical harm - Finding safe ways of allowing aggression as a form of communication
6. Systemic considerations	- Importance of regular supervision to see the communication in the behaviour - Importance of the team - Sense of insulation, sameness, and equality - Links to theory and concepts of aggression - Taking time to think and feeling supported - Experiencing colleagues as too health and safety focused - Trying to have an impact on the environment of the patient to allow development - Trying to mend the split in the network - Helping the network understand the aggression

Interview D - Gabrielle

Interview Context	Gabrielle (female) is an experienced CPT and has worked for CAMHS for many years. She has experienced a lot of aggression in her clinical work with patients and felt that there was not enough written about the topic. Gabrielle brings a more generic perspective to my study and felt that the area of my study is worth researching.
Superordinate Themes	**Subthemes/ Codes**
1. Aggression as a core business in CP	- Violence can be encountered a lot in clinical work - Ability to feel projections from patients as a normal part of the work - CPT have always worked with aggressive children
2. Different expressions of aggression in the room	- Hitting, biting, kicking, spitting, pulling hair, having things thrown at you (physical violence) - Verbal aggression - Racial abuse, racism, threats, harassment, and nastiness - Patient trying to flood the room - A lot of noise and throwing furniture - Being beaten up
3. Possible emotional responses to aggression in the CPT	- Finding it challenging to withstand aggression and keep thinking - Feeling hurt by physical aggression - Feeling that therapy is not going well during moments of aggression - Feeling unsafe - Pretty tough going - Feeling completely humiliated and denigrated - Uncomfortable and painful - Struggling to hold yourself together - Impact on the CPT's personal space outside of the room - Feeling like an ordeal - Loathing it and being in pain - Feeling like someone's punchbag - Understanding the meaning modifies the direct experience
4. Possible processes and dynamics in the work with aggression:	- Gathering of the transference - A better understanding of the process can give the CPT confidence

	- CPT suffering something on behalf of the patient for a good outcome - Stopping a session can increase aggression in the next session - Revenge for creating distance - A kick from a psychopath can be harder to bear than a kick from a deprived child - Being drawn towards retaliation - Patients commitment to violence as a way of communication - Seeing treatment as a last resort to prevent exclusion or prison later in life - The multidisciplinary team's understanding of violence in CP - Tolerating violence in a masochistic way - Importance of time - Impact of therapy breaks - Importance of supervision and having a supportive colleague to talk to about the experience - Having discussions about what is manageable and having the option to terminate treatment - Significance of CPT's own experience of aggression - Long analysis and training make it easier to work with aggression - Different levels of acceptance between verbal and physical aggression
5. Different ways aggression can be understood	- Aggression as a form of communication - Communication about they have been through - Aggression linked to experiences of deprivation and trauma - Patient's struggle to tolerate thinking about anything frustrating, upsetting or distressing - Physical aggression in response to painful issues emerging in the session - Same behaviour can have different meanings for different patients - Projective process - Patient looking for retaliation - Aggression in response to early trauma - Aggression to make the CPT experience their aggressive experiences - CPT needing to understand something on behalf of the patient - Use of theory - Inability to think before lashing out - Patient unable to regulate their mood or behaviour linked to lack of containment in early life - Shift to symbolic communication and play as a sign of progress

	- Shift to more thinking as a sign of progress - Glimmers of change building up over time as a sign of progress
6. Ways of working with aggression and possible responses	- Keep thinking about meaning and find an interpretation that can reach the patient - Developing a sense of understanding with the aim to reduce acting out - An accurate interpretation of what is going on can lessen violence - Interpreting the truth - Trying to divine what the meaning of the communication is - Finding your way to an accurate or truthful understanding - Changing a violent action into an area of understanding - Judging if a patient is in a place to hear the interpretation - Sit, think, and contain - Talking about it - Establish during the assessment process if there is a possibility of change and aggression can be treated - Not endlessly tolerating violence - Use of supervision and team to support clinical judgement - Experience aggression as communication to gain deep understanding - Working with violence as a key matter whilst promoting a context where violence is not tolerated - Asserting certain rules and work with breaches - Stopping a session as a last resort - Trying to manage it on a practical level as a form of protection

Interview E - Nicole

Interview Context	Nicole (female) is a trainee and has experience in working for a service with a high prevalence of aggressive and violent children. She has an interest in developing her understanding of the therapeutic work with children who act out violently.
Superordinate Themes	**Subthemes/ Codes**
1. Dynamics and processes in the work with aggression:	- Aggression mainly seen as violence

	- Importance of having a good relationship with the wider team - Trying to work out how to respond as part of the training in CP - Stopping a session seen as a sign of weakness in front of other CPTs - Leaving the room as a form of self-regulation or power play - Aggression being seen as badges of honour - Finding it easier to think about aggression in supervision or with someone from same profession - Staff can struggle to stay on the experience of aggression in team meetings - Getting hurt in response to wanting to trust the patient - Struggling with boundaries and rules around aggression - Aggression is more thought about within psychotherapy - Use of the multi-disciplinary team to get practical support - Importance of supervision for boundary setting - Impact of supervision on CPT's confidence - Process of boundary setting whilst being physically attacked can feel messy - Understanding of theoretical concepts can help CPTs understand the way they feel as a helpful process for the understanding of the patient - Use of theory as a defence against painful feelings - Desperately trying to see the patient as a perpetrator or victim - Having experienced progress in the work with aggressive patients can help the CPT feel more motivated and hopeful - Struggling to look aggression in the face and hoping for it to be something else as a defence
2. Ways aggression can be expressed in the room:	- Threatening and violence - Taunting and ridiculing language - Significant damage to the room - Using parts of the room as a weapon to attack - Patient laughing whilst physically attacking the CPT - Laughing in a cruel and sadistic way and sense of enjoyment about trying to make the CPT feel scared - Patient being physically violent and preventing the CPT from ending the session by deliberately blocking the door

	- Throwing furniture - Biting - Headbutting - Punching - Patient trying to flood the room - Screaming at the CPT - Trying to torment or bite - Throwing toys out of the window - Patient removing herself from the room to prevent physical violence towards the CPT - Patients can turn their own aggression towards themselves and can scared of their own aggression - Patient trying to hold in own aggression due to experiences of not feeling contained - Refusing to enter the room - Passive aggression - Patient tormenting another young person during a session - Attacks on the room from others during a session - Aggression towards other patients - Smashing a window - Damage to therapy box - Destructive/ aggressive play
3. Feelings aggression can evoke in the CPT:	- Feeling scared - Feeling terrified and in danger - Feeling unsure about how to respond - Feeling in immediate danger of getting hurt - Feeling disturbed by the reaction of the patient - Experiencing laugher as a different type of attack - Feeling left with something really difficult - Feeling like having to go back into the scary situation in the next session - Feeling inadequate and humiliated for having to ask for support - Feeling unsure about when to stop a session - Guilt for handing the patient back to a carer following moments of violence - Feeling like armouring up for battle and real dread - Loosing hope in response to relentless onslaught and chaos - Feeling paralysed and quite desperate - Feeling that everything is getting spoiled or manipulated - Feeling part of a community of people who have gone through the same - Ignoring negative feelings as a defence against hateful feelings towards patients - Experiencing the patient as cruel and not wanting to be near the patient

	- CPT trying to cover up horrible feelings towards patient as a way of manging - Just feeling the impact and struggling to think - Feeling a lack of confidence - Feeling frustrated and resentful towards the patient - Feeling reluctant or worried about seeing aggression - Feeling tricked, daubed, or fooled for having missed something
4. Ways of understanding of aggression in the room:	- Use of aggression as a form of enjoyment in the patient - Patient seeing the therapy as a dangerous and confusing place - Feeling understood by the CPT can be experienced as helpful or provoking and tantalising by patients - Providing something positive and wanted can be experienced as aggression/ provocation from the CPT - History of neglect as a cause for aggression - Providing something positive and wanted can be experienced as aggression/ provocation from the CPT - Showing understanding during moments of aggression can increase anger - Patient does not know how to express aggression appropriately - Role and helpfulness of theory in the work with aggression - Shift to expressing aggression in play as a sign of progress - Patient more able to make use of transference interpretations related to anger as a sign of progress - Aggression in response to a sense of rivalry
5. Ways of responding to aggression in the room:	- Trying to cling on to the learning from the CP training - Laughing when talking to others about the experience of aggression - Ending a session - Turning a blind eye to the aggression as an attempt to hold on to something more positive - Reacting as best as you can - Needing to restrain the patient
6. Ways of working with aggression in the room:	- Use of verbal interpretations - Importance of supervision - Having someone to call outside of the room - Involving the parent - Pausing a session and resuming the session when patient is calmer

	- Developing a sense of dependability and time can help a violent patient use the room in a more appropriate way - Managing distance and closeness - CPT trying to support the patient to show aggression in response to absence of aggression - Helping the patient find manageable ways of expressing aggression, anger and frustration - Trying to understand the countertransference and how the CPT is being made to feel - Trying to balance the victim and perpetrator parts of the patient - Feeling what's going on in the moment and trying to make something work - Trying to turn something scary into something more manageable

Interview F - Sunan

Interview Context	Sunan (male) is a trainee and has experienced aggression in both of his training placements and in his previous job. Sunan is very interested in aggression and can see it in some form in all of his sessions.
Superordinate Themes	**Subthemes/ Codes**
1. Aggression as a core business in CP:	- Aggression can be found in every session - CPT are more interested in aggression than professionals from other disciplines
2. Ways aggression can be expressed in the room:	- Silence as a form of passive aggression - Non-attendance as a form of passive aggression - Punching and kicking - Spitting - Patient pacing around in a dominating and threatening way - Cracking each knuckle in a threating way - Patient punching his own head - Verbal threats - Swearing - Aggression disguised as something friendly - Patient showing excitement about being able to spit - Physical violence towards family members - Play with the aim to denigrate the CPT - Different levels of tolerance in the work with aggression

3. Feelings and responses aggression can evoke in the CPT:	- One of the most challenging things to work with - Aggression can be experienced differently within different age groups - Non-attendance can feel like an attack - Frustration - Anger - Feeling powerless, helpless, and doubtful in relation to patient not coming to the session - Feeling unsure about how to deal with the situation - Aggression can feel good and fairly unpleasant at the same time - Feeling helpless in response to a shut down in communication - CPT feeling scared and frightened - Feeling that the aggression might escalate into physical violence - Struggling to remain thoughtful in the face of threat - Disgust - Feeling like retaliating - Feeling worthless and degraded - Feeling shocked - Getting spat at can feel particularly powerful - Dreading seeing the patient - Anxiety in relation to appropriate boundary setting - Aggression in interpretations - Feeling punitive or wish to retaliate - Wanting the session to end - CPT attacking back by a certain way of responding
4. Processes and dynamics in the work with aggression:	- Patient showing anger as a useful development in therapy - Patient asking parent to do the attacking - Threat of loss of training case can impact on how the aggression is experienced and worked with
5. Ways of understanding aggression in the room:	- Aggression linked to therapy breaks - Aggression linked to experiences of multiple transitions and changes in care. - Aggression linked to patient's limited capacity to process emotions - Aggression linked to a fear of loss - Aggression as a useful therapeutic experience - Ambivalence in aggression (love and hate) - Decrease in physical aggression as a sign of progress - Specific features of the CPT (e.g., gender, height, personality) might impact on severity of aggression - Use of theory

	- Aggression linked to deep rooted anxieties
6. Ways of working with aggression:	- Thinking about where the aggression is being placed - Email contact following non-attendance - CPT trying to be quite neutral - Use of supervision - Taking it up with the patient when aggression occurs between patient and CPT - Use of the wider team - Voicing an observation - Importance of safeguarding and feeling safe - Putting in a boundary and then talking about it - Trying to speak about the difficulty - Helping the patient experience that their aggression can be lived through - Stopping a session as a way of staying safe - Trying to develop some understanding of the meaning of the aggression - The place of the CPT's own aggression in response to the patient

Interview G - Erin

Interview Context	Erin (female) is an experienced CPT and wanted to bring across her experience of hostility in the consulting room as a form of aggression most significant in her clinical work.
Superordinate Themes	**Subthemes/ Codes**
1. Aggression as core business in CPT:	- Aggression is being dealt with all the time - CPTs are more likely to find themselves subject of aggression - Dealing with hostility is a big part of CAMHS jobs
2. Ways aggression can be expressed in the room:	- Hostility linked to demand and sense of entitlement - Throwing furniture as a form of physical aggression - Infectious aggression as part of a group dynamic - Verbal aggression - Formal complaint - Demand to capitulate - Hostility - Rudeness - Patient asking for another clinician - Aggression towards CPT can be expressed online - Homophobia

	- Patient trying to split between clinicians - Aggression between family members - Aggression towards the waiting room
3. Feelings aggression can evoke in the CPT:	- Feeling shocked - Feeling concerned - Feeling hostile and aggressive in response to feeling attacked - Feeling irritated and annoyed - Feeling concerned about the next session
4. Ways aggression can be understood:	- Aggression can be conceptualised as overt and covert aggression - Aggression in response to unbearable affect - Aggression as a form of communication but also threat - Aggression in response to feeling persecuted and discriminated by thinking - Aggression linked to seeing thinking as an attack - Hostility related to the patient's fixed idea of what should be offered - Aggression related to the CPT's attempt to counter the narrative - Aggression related to profound disagreement - Aggression in the context of a split, divided and polarised culture and society - Thought, thinking and reflection can feel like an attack - Aggression as a manifestation of fear, anxiety, and sense of persecution - Intolerable feelings can lead to aggression - Aggression in response to the CPT's attempt to think about meaning and make connections - Aggression linked to early experience of neglect and loss - Aggression linked to early experience of trauma, attachment difficulties and emotional dysregulation - Differences in approach ideology can lead to aggression - Aggression as a disavowal of affect, thought and fear - Aggression as a result of an inability to mentalise and process earlier trauma and attachment difficulties - Use of theory
5. Different dynamics in the work with aggression:	- Power struggle - Aggression within the service and impact of external hostility - Questioning can be experienced as aggressive - Culture of appeasement/ trying to appease - Whole service can feel under attack

	- Experience of aggression can depend on the position and approach of the CPT - Getting used to aggression and stop thinking about it - Wanting to prove that the patient is wrong - Capitulating vs inviting the patient to think about it
6. Ways of working with aggression:	- Physical management in response to overt aggression - Referring to specialist setting (e.g., Portman Clinic) - Going along with the Portman model - Help the patient mentalising and manage the risk

Appendix H: Process of identifying super-ordinate themes and subthemes